Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 25, 2023

Licensee
Destiny Healthcare Services LLC
3013 Quarles Road
Brooklyn Center, MN 55429

RE: Project Number(s) SL39214015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on September 13, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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.

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39214	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HEALTHCARE SERVICES LLC	3013 QUARLES ROAD BROOKLYN CENTER, MN 55429

(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: SL39241015 On September 11, 2023, through September 13, 2023, 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 2 active residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: 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 included document titled, Food and Beverage Establishment Inspection Report dated September 11, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently;	0 680		

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0 680	Continued From page 2 (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 and interview the licensee failed to prominently post a written emergency preparedness plan (EPP). This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 11, 2023, at 11:20 a.m., a facility tour was conducted with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. The surveyor did not observe signage posted or	0 680		

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0 680	Continued From page 3 information regarding the licensee's EPP in the common areas of the facility. On September 11, 2023, at 11:42 a.m., the surveyor asked unlicensed personnel (ULP)-B where the EPP was located. ULP-B went to a two-drawer file cabinet near the desk in the common's area (staff desk, dining table and chairs, couch, TV) and opened the bottom drawer. ULP-B stated the EPP was "not there" (normal location). LALD/CNS-A said she took the EPP binder downstairs, adding she "knew" the EPP plan would need to be reviewed by the surveyor. On September 11, 2023, at 11:57 a.m., LALD/CNS-A stated the EPP location was not posted in the common area of the facility and would not be available to residents, or visitors. The facility's undated assisted living contract template noted an emergency preparedness plan was posted in the residence for review. The licensee's Emergency Preparedness policy, dated November 25, 2022, noted the Emergency Disaster Plan was prominently posted on each floor of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in	0 700		

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0 700	Continued From page 4 compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect the two of two residents (R1, R2) residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 11, 2023, at 4:14 p.m., the surveyor observed an open lap top computer sitting on a desk in the common's area (living room area/couch, TV, one (1) piece of exercise equipment, dining room table and chairs, staff desk and chair) displaying resident's personal and medical information. The surveyor observed unlicensed personnel (ULP)-C entering the common's area from a hallway which led to three bedrooms and a bathroom. R2 and a volunteer were sitting on the couch watching TV. The surveyor did not observe a staff member near the opened lap top computer.	0 700		

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0 700	Continued From page 5 Directly following the above observation licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A motioned to ULP-C and stated the computer screen should be closed. LALD/CNS-A said the residents could not read and would not look at the computer screen. LALD/CNS-A stated the computer screen should not be open displaying resident's personal and medical information. On September 12, 2023, at 7:58 a.m., the surveyor observed ULP-B administer R2's morning medication and document R2's medication administration on the lap top computer positioned on the desk in the common's area. On September 12, 2023, at 8:00 a.m., the surveyor observed the lap top computer with screen open sitting on the desk in the common's area displaying resident's personal and medical information. The surveyor did not observe ULP-B in the common's area. On September 12, 2023, at 8:04 a.m., ULP-B stated it was not "ok" to leave the computer screen open. ULP-B closed the computer screen. On September 12, 2023, at 10:13 a.m., LALD/CNS-A stated "those guys", (staff) had no excuse, adding, "but residents don't come over to nurse's station, to computer." LALD/CNS-A said the computer screen should not be left in the open position displaying resident information. The licensee's Resident Confidentiality policy dated November 25, 2022, noted, all resident information, including but not limited to personal, financial, and medical data, would be kept confidential and released only in the following	0 700		

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0 700	Continued From page 6 situations: -to authorized persons with an appropriate Release of Information -according to law -to employees or contractors of the facility -to another assisted living provider, a health care practitioner or provider, or an inpatient facility that required information to provide services to the resident, but only the information that was necessary to provide services -to representatives of the commissioner authorized to survey or investigate assisted living providers. The licensee's Privacy of Protected health Information policy dated November 25, 2022, noted no clinical records or personal health information about resident would be accessible in public areas of the office. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
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;	0 780		

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0 780	Continued From page 7 (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: Based on observation and interview, the licensee failed to provide smoke alarms in all resident sleeping rooms and interconnected smoke alarms in the resident rooms and corridors throughout the facility. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on September 13, 2023, at approximately 10:45 a.m. with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A it was observed that smoke detectors were installed throughout the facility,	0 780		

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0 780	Continued From page 8 but the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. The test button was activated on the alarm in the main floor corridor near the sleeping rooms and only that alarm sounded with test button activation. Smoke alarms are required to be interconnected so activation of one alarm activates all alarms throughout the facility. It was also observed that a smoke alarm was not installed inside resident room #4 in the basement. Smoke alarms are required to be installed inside every sleeping room. These deficient findings were visually verified by LALD/CNS-A at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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:	0 790		

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0 790	Continued From page 9 Based on observation and interview, the licensee failed to maintain portable fire extinguishers as required for the facility. 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 a facility tour on September 13, 2023, at approximately 11:00 a.m. with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A it was observed that the fire extinguisher installed on the main floor and basement were not maintained annually by certified personnel as required by MN Statute 144G.45. Fire extinguishers are required to be maintained annually by certified personnel in accordance with MN Statute 144G.45. LALD/CNS-A visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The	0 810		

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0 810	Continued From page 10 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 11 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 potential to affect a large portion or all of the residents). Findings include: A record review of available documentation and interview were conducted on September 13, 2023, at approximately 10:15 a.m. of documents provided by licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee provided room numbers on the fire safety and evacuation floor plan, but the numbers provided did not accurately indicate locations of resident rooms. The numbers on the main floor plan included the room numbers for the basement resident rooms and the numbers on the basement floor plan included the main floor resident room numbers. Resident room numbers are required to be included on the fire safety and evacuation floor plan for more accurate reference and communication of direction for evacuation. It was observed resident room #4 as identified by LALD/CNS-A did not have a room number posted to identify the room. Resident rooms are required to be identified with a room number for use along with the fire safety and evacuation floor plan.	0 810		

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0 810	Continued From page 12 Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents in the event of a fire or similar emergency located within the plan. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Training records were provided but did not include documentation specific to fire safety and evacuation. Employee training is required to be completed and documented specifically based on the facility fire safety and evacuation plan. All deficiencies were verified by LALD/CNS-A during the interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the	0 970		

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	39214	A. BUILDING: _____ B. WING _____	09/13/2023

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0 970	Continued From page 13 facility's liability for health, safety, or personal property of a resident. 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 the potential to affect a large portion or all the residents). The findings include: R2's Assisted Living Contract dated February 15, 2023, under the heading, liability on the last page of the contract included, "the resident agrees to be liable and responsible for all obligations herein referenced, monetary and otherwise". On September 11, 2023, at 3:10 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the contract came from an agency the facility used. LALD/CNS-A said the clause was to be used, for example, if they (resident) went out and the resident lost their shoes while with family. LALD/CNS-A stated she could see how the language noted above waived the facility's liability. On September 13, 2023, at 9:35 a.m., LALD/CNS-A stated all the contracts were the same. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		

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01640	Continued From page 14	01640		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan was revised to reflect the reflect current services provided 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, but was not likely to cause serious injury, impairment, or death), and	01640		

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01640	Continued From page 15 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included anxiety, depression, traumatic brain injury (forceful bump, blow, jolt or other injury to brain), suspected Parkinson's disease with Lewy body dementia (protein deposits affecting thinking, memory and movement/rigid and slow movement) and history of alcohol abuse. R1's service plan dated December 22, 2022, included the following services: -oxygen saturation monitoring two (2) times daily -temperature monitoring two (2) times daily. On September 12, 2023, at 8:46 a.m., the surveyor observed unlicensed personnel (ULP)-B prepare R1's morning oral medications and take them and a bottle of brimonidine eye drops (to lower eye pressure) to R1's room. On September 12, 2023, at 11:54 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated oxygen and temperature monitoring were no longer being done twice a day for R1. LALD/CNS-A stated R1's service plan had not been updated as required. R2 R2's diagnoses included schizophrenia (chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior) , depression, and colostomy (surgical operation in which a piece of the colon (large intestine/bowel)	01640		

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01640	Continued From page 16 is diverted to an artificial opening in the abdominal wall). R2's service plan dated August 14, 2023, included the following services: -toileting, HHA/RA (home health care/resident assistant, unlicensed personnel) three (3) times per day. R2's assessment dated August 9, 2023, included: -uses colostomy bag. Staff to assist with emptying and changing colostomy bag -incontinent of bladder. Wears incontinent briefs. Staff to assist him in changing incontinent briefs Needs help with ostomy, colostomy bag. Registered nurse to change it twice a week. Staff to put on a new colostomy bag if it falls off. R2's profile notes included: -August 28, 2023, at 2:50 p.m., writer gave R2 a shower and changed colostomy bag, signed by registered nurse (RN)/CNS -August 30, 2023, at 12:22 p.m., writer gave R2 a shower and changed colostomy bag, signed by RN -September 5, 2023, at 10:17 a.m., writer colostomy bag changed, signed by RN. On September 11, 2023, the surveyor observed ULP-B provide R2 a clean brief. On September 13, 2023, at 10:22 a.m., ULP-B stated R2's ostomy bag was checked/emptied when R2 used the bathroom. On September 11, 2023, at approximately 3:15 p.m., LALD/CNS-A stated she could not figure out how to add colostomy/ostomy to R2's service plan. LALD/CNS-A said she "just put" toileting three (3) times a day on service plan.	01640		

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01640	Continued From page 17 On September 12, 2023, at 11:20 a.m., LALD/CNS-A stated she called customer service for her documentation system and learned how to include ostomy care on the service plan, adding she updated R2's service plan. The licensee's Service Plan policy dated November 25, 2022, noted the service pan must be revised, if needed, based on resident review or reassessment. The service plan and any revisions were signed by a representative from the facility and the resident or resident or resident's representative, indicating agreement with the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01650 SS=D	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	01650		

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01650	Continued From page 18 facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content 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 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's diagnoses included schizophrenia (chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior), depression, and colostomy (surgical operation in which a piece of the colon (large intestine/bowel) is diverted to an artificial opening in the abdominal wall).	01650		

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01650	Continued From page 19 R2's service plan dated August 14, 2023, indicated the resident received the following services: dressing assist, toileting, grooming assist, behavior management, medication administration, vital sign monitoring, laundry, and housekeeping. On September 12, 2023, at 7:54 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R2's morning medication. On September 12, 2023, at 10:01 a.m., the surveyor reviewed R2's service plan with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. R2's service plan was two pages in length. LALD/CNS-A said she would look to see if she had the other two pages of R2's service plan. R2's service plan lacked: - the schedule and methods of monitoring assessments of residents; - the schedule and methods of monitoring staff providing the services; a contingency plan that included the following required content: - the action to be taken if the scheduled service cannot be provided; - 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 the authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145 B and 145 C, and declarations made by the resident under these chapters.	01650		

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01650	Continued From page 20 On September 13, 2023, at 9:39 a.m., LALD/CNS-A said she could not find the other pages of R2's service plan. LALD/CNS-A stated R2's service plan was prepared quickly, and the computer system was new to her at the time R2's service plan was prepared. LALD/CNS-A said R2's service plan was missing the above-mentioned items. The licensee's Service Plan policy dated November 25, 2022, noted the service plan included the following: -a description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party -the fees for services and the frequency of each service, according to the resident's current review or assessment and resident preferences -the identification of the staff or categories of staff that would provide the services -the schedule and methods of monitoring reviews or assessments of the resident -the schedule and method of monitoring staff providing services -a contingency plan that included: -action to be taken if the scheduled service cannot be provided -names and contact information of person the resident wished to have notified in an emergency or if there was a significant adverse change in the resident's condition -the identification of and information as to who had the authority to sign for the resident in an emergency -circumstances in which emergency medical services are not to be summonsed and declarations made by the resident related to health care directives.	01650		

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01650	Continued From page 21 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions 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 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).	01750		

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01750	Continued From page 22 The findings include: R1's diagnoses included open-angle glaucoma (progressive increased pressure in the eyes/ loss of peripheral vision (tunnel vision, can see what is right in front, followed by central visual field loss.) R1's service plan dated December 22, 2022, included medication administration four (4) times daily. On September 12, 2023, at 8:46 am., the surveyor observed unlicensed personnel (ULP)-B prepare R1's morning oral medications and take them and a bottle of brimonidine eye drops (to lower eye pressure) to R1's room. R1's September 1, 2023, through September 11, 2023, medication administration record (MAR) included: -brimonidine 0.2% eye drops daily. Place one (1) drop into both eyes three (3) times daily: 8:00 a.m., 12:00 p.m., 8:00 p.m. -dorzolamide-timolol (to lower eye pressure) 22.3-6.8 milligrams (mg)/milliliter (ml) drops daily. Place one (1) drop into both eyes twice daily: 8:00 a.m., 8:00 p.m. -latanoprost (to lower eye pressure) 0.005% eye drops daily. Place one (1) drop into both eyes at bedtime: 8:00 p.m. -Refresh Tears 0.5 % drops, place one (1) drop into both eyes every two (2) hours as needed (PRN) for dry eyes. R1's September MAR did not include specific instructions for eye drop administration, including direction of which eye drop to instill first, and how long to wait between eye drops. R1's prescriber's order dated August 1, 2023,	01750		

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01750	Continued From page 23 included: -brimonidine, TID (three times a daily), both eyes -Cosopt (dorzolamide/timolol) BID (twice a daily), both eyes -latanoprost every HS (hour of sleep), both eyes "Severe glaucoma, needs glaucoma drops, most important is latanoprost. Can be administered while asleep. " -Refresh tears 0.5 % drops, place one (1) drop into both eyes every two (2) hours PRN for dry eyes. On September 12, 2023, at 11:37 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1's MAR did not include specific instructions for R1's eye drops. The manufacturer's instructions for brimonidine dated August 1, 2023, noted if your doctor ordered two (2) different eye drops to be used together, wait at least five (5) minutes after you put the first medication in your eye to use the second medication This will prevent the second medicine form "washing out" the first one. The manufacturer's instructions for dorzolamide/timolol dated May 1, 2023, noted if your doctor ordered two (2) different eye drops to be used together, wait at least five (5) minutes between the times you apply the medications. This will help to keep the second medicine from "washing out" the first one. The manufacturer's instructions for latanoprost dated August 15, 2023, noted if latanoprost is used with other eye medications, allow at least five (5) minutes between each medication. The manufacturer's instructions for Refresh Tears dated September 23, 2016, noted if you use	01750		

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01750	Continued From page 24 Refresh Tears with another eye medication, leave at least 15 minutes between putting Refresh Tears and the other medicine. The licensee's Medication Administration policy dated November 25, 2022, noted the registered nurse would delegate medication administration to an unlicensed staff member (home health aide/unlicensed personnel) according to the following protocol: -the registered nurse had prepared written instructions for the home health aide in the proper methods to administer medications with respect to each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure medications were secure and permitted access to only authorized personnel 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	01880		

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01880	Continued From page 25 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 12, 2023, at 7:54 a.m., the surveyor observed unlicensed personnel (ULP)-B remove R2's medication bubble pack from a locked medication cabinet in the kitchen. ULP-B checked the medication in the bubble pack with R2's electronic medication administration record (EMAR) visible on a laptop computer. ULP-B placed R2's medication into a medication cup. On September 12, 2023, at 7:56 a.m., the surveyor observed ULP-B take R2's prepared medication cup to the couch where R2 had been seated. R2 was no longer seated on the couch. ULP-B walked back into the kitchen and placed the medication cup containing R2's medication on top of the dishwasher in the kitchen. ULP-B removed the lap top computer from the kitchen counter and carried the lap top computer to the desk area in the commons area. The surveyor observed ULP-B leave the medication cup on the top of the dishwasher unattended. On September 12, 2023, at 7:58 a.m., R2 returned to the living room and sat on the couch. ULP-B left the common's area and went into the kitchen to get R2's medication cup off the top of the dishwasher and administered R2's morning medication. On September 12, 2023, at 8:06 a.m., ULP-B stated it was not "ok" to leave R2's medications on top of the dishwasher unattended, adding,	01880		

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	39214	A. BUILDING: _____ B. WING _____	09/13/2023

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DESTINY HEALTHCARE SERVICES LLC	3013 QUARLES ROAD BROOKLYN CENTER, MN 55429

(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
01880	Continued From page 26 "but no one was out there." On September 12, 2023, at 10:13 a.m., licensed assisted living director/clinical nurse supervisor (LALD-CNS)-A stated resident's medications should not be left unattended. LALD/CNS-A stated ULP-B should have carried R2's medication cup with her. The licensee's Storage/Control of Medications policy dated November 25, 2022, noted when the facility was providing storage of medication outside of the resident's private living space, all prescription drugs were securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel had access to the stored medication. The licensee's Medication Administration policy dated November 25, 2022, noted residents at the facility were entitled to the safe administration of medications by qualified personal according to a written medication management plan written by registered nurse (RN). The RN could delegate medication administration to an unlicensed staff member (home health aide) according to the following protocol: -all home health aides had passed a competency evaluation with respect to all medication routes to be administered -the RN had communicated with/provided orientation to the home health aide regarding the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39214	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HEALTHCARE SERVICES LLC	3013 QUARLES ROAD BROOKLYN CENTER, MN 55429

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01890	Continued From page 27	01890		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for one of one resident (R1) using eye drops. 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 September 11, 2023, at 11:49 a.m., the surveyor reviewed the contents of the locked medication cabinet with unlicensed personnel (ULP)-B. ULP-B confirmed the following eyedrops were not dated with an open or expiration date: -opened latanoprost (to lower eye pressure) 0.005% eye drop solution for R1 -opened brimonidine (to lower eye pressure)	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39214	A. BUILDING: _____ B. WING _____	09/13/2023

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01890	Continued From page 28 0.2% eye drop solution for R1 -opened dorzolamide-timolol (to lower eye pressure) 22.3-6.8 milligrams (mg)/milliliter (ml) eye drop solution for R1 -opened Refresh Tears (dry eyes) 0.5 % eye drop solution, for R1. Directly after the above observation ULP-B stated the person opening the eye drop should date "the bottle". On September 11, 2023, at 11:51 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated eye drops should be dated when opened. LALD/CNS-A confirmed all four (4) opened bottles of R1's eye drop medications were not dated. The manufacturer's instructions for latanoprost eye solution dated August 15, 2023, noted once opened, the bottle can be kept at room temperature for 30 days. The manufacturer's instructions for brimonidine eye solution dated December 7, 2021, noted eye drops can be used for four (4) weeks once the bottle had been opened. Even if there is still some solution remaining after this time, discard it. The manufacturer's instructions for dorzolamide-timolol eye solution dated December 2022, noted dorzolamide/timolol should be used within 28 days after the bottle is first opened. Therefore, you must throw away the bottle 4 weeks after you first opened it, even if some solution is left. The manufacturer's instructions for Refresh Tears dated September 23, 2016, noted do not use more than 30 days after first opening.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39214	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01890	Continued From page 29 The licensee's Storage/Control of Medications policy dated November 25, 2022, noted the licensed nurse was responsible for dating time-sensitive medications when opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01920 SS=D	144G.71 Subd. 23 Loss or spillage (a) Assisted living facilities providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the resident's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations. (b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of one licensed assisted living	01920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39214	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HEALTHCARE SERVICES LLC	3013 QUARLES ROAD BROOKLYN CENTER, MN 55429

(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
01920	Continued From page 30 director/clinical nurse supervisor (LALD/CNS)- A 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 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 11, 2023, at 1:41 p.m., the surveyor reviewed the contents of a locked medication box with unlicensed personnel (ULP)-B. The surveyor observed 105 0.5 milligram (mg) tablets of lorazepam (anxiety) for R2. The surveyor asked ULP-B for the documented count for lorazepam in their on-line documenting system. ULP-B stated the count documented for lorazepam was 107. R2's prescriber's order dated April 14, 2023, included: -lorazepam 0.5 mg by mouth as needed take 1/2-1 tablet by mouth twice daily as needed (PRN) for anxiety at least six (6) hours in between doses. R2's August 1, 2023, through August 31, 2023, medication administration record (MAR) noted lorazepam 0.5 mg was administered on August 8, 2023. R2's August 2023 MAR noted, August 8, 2023, 2:05 p.m., lorazepam 0.5 mg tablet, charted at 6:06 p.m., for anxiety, response: client was not	01920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39214	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HEALTHCARE SERVICES LLC	3013 QUARLES ROAD BROOKLYN CENTER, MN 55429

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01920	Continued From page 31 showing any signs of anxiety. R2's September 1, 2023, through September 11, 2023, MAR did not indicate PRN lorazepam had been administered. On September 11, 2023, at 2:33 p.m., LALD/CNS-A stated she gave lorazepam, two (2) half tablets to equal 1 mg to R2. LALD/CNS-A said she forgot to document the medication administration. LALD/CNS-A stated she would look back and figure out when it was given, adding she would "fix it" (make the correction). LALD/CNS-A added she would continue to have ULPs count R2's lorazepam. The licensee's Medication Documenting policy dated November 25, 2022, noted each medication administered by staff would be documented in the resident's clinical record. Documenting would be complete, accurate and legible. Documentation of medication administration and medication set up would be completed promptly. For PRN medications, documenting would include, when appropriate, the reason for the medication and follow-up to determine its effectiveness. The licensee's Storage/Control of Medications policy dated November 25, 2022, noted when controlled substances were being managed, stored, and secured, the registered nurse would provide for security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01920	Continued From page 32 days	01920		

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *09/11/23*
Time: 11:00:00
Report: 1031231228

Food and Beverage Establishment Inspection Report

Location:
Destiny Healthcare
3013 QUARLES ROAD
BROOKLYN CENTER, MN55429
Hennepin County, 27

Establishment Info:
ID #: N066022
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #:
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.

7-200 Toxic Supplies and Applications

7-204.11 ***** Priority 1 *****

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

SANITIZER SPRAY MEASURED > 200PPM CHLORINE. SPRAY WAS REMADE TO PROPER CONCENTRATION. USE SANITIZER STRIPS WHEN PREPARING CHLORINE SPRAY.

Corrected on Site

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.

ESTABLISHMENT DOES NOT HAVE A THIN PROBE THERMOMETER.

Comply By: 09/14/23

4-300 Equipment Numbers and Capacities

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

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

ESTABLISHMENT DOES NOT HAVE SANITIER TESTING KIT ON SITE. PROVIDE AND USE TEST KIT TO CHECK SANITIZER CONCENTRATION.

Comply By: 09/14/23

Type: Full
Date: *09/11/23*
Time: 11:00:00
Report: 1031231228
Destiny Healthcare

Food and Beverage Establishment Inspection Report

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.

MICROWAVE MOUNT DETACHING FROM UPPER CABINET. REINSTALL MICROWAVE.

Comply By: 09/25/23

Surface and Equipment Sanitizers

Chlorine: > 200 at Degrees Fahrenheit
Location: Sanitizer Spray
Violation Issued: Yes

Chlorine: = 100 at Degrees Fahrenheit
Location: Sanitizer Spray (remade)
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Milk
Temperature: 35 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

Inspection conducted by Chris F.

All violations discussed with Edele during the inspection.

NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.

- Staff must prepare sanitizer spray using sanitizer test strips.

- Establishment does not have 3-comp sink or commercial dishwasher - can use dishwasher to wash, rinse, and sanitize (use sanitize setting on washer).

- - Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.

- 2-Comp sink has left basin designated for handwashing and the right basin for product washing/prep sink.

- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

Type: Full
Date: *09/11/23*
Time: 11:00:00
Report: 1031231228
Destiny Healthcare

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Environmental Health inspection report number 1031231228 of 09/11/23.

Certified Food Protection Manager: Edele Anako

Certification Number: FM118025 Expires: 07/08/26

Signed: _____

Edele Anako
Person in Charge

Signed: _____

Chris Foster
Public Health Sanitarian II
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us

Report #: 1031231228

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 09/11/23
Time In 11:00:00
Time Out

Destiny Healthcare	Address: 3013 QUARLES ROAD	City/State: BROOKLYN CENTER, MN	Zip Code: 55429	Telephone:
License/Permit #: N066022	Permit Holder:	Purpose of Inspection: Full	Est Type:	Risk Category:

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	(IN) OUT	PIC knowledgeable; duties & oversight		
2	(IN) OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	(IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN) OUT	Proper use of reporting, restriction & exclusion		
5	(IN) OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT (N/O)	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	(IN) OUT N/O	Hands clean & properly washed		
9	IN OUT N/A (N/O)	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN) OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	(IN) OUT	Food obtained from approved source		
12	IN OUT N/A (N/O)	Food received at proper temperature		
13	(IN) OUT	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	(IN) OUT N/A N/O	Food separated and protected		
16	(IN) OUT N/A	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A (N/O)	Proper cooking time & temperature		
19	IN OUT N/A (N/O)	Proper reheating procedures for hot holding		
20	IN OUT N/A (N/O)	Proper cooling time & temperature		
21	IN OUT N/A (N/O)	Proper hot holding temperatures		
22	(IN) OUT N/A	Proper cold holding temperatures		
23	(IN) OUT N/A N/O	Proper date marking & disposition		
24	IN OUT (N/A) N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT (N/A)	Food additives: approved & properly used		
28	IN (OUT)	Toxic substances properly identified, stored, & used	X	
	Conformance with Approved Procedures			
29	IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT (N/A) N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36	X	Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 09/11/23

Inspector (Signature)