Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 28, 2024

Licensee
Destiny Home Care Services
9907 Wentworth Avenue South
Bloomington, MN 55420

RE: Project Number(s) SL27249015

Dear Licensee:

On October 8, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 25, 2024. This follow-up survey determined your facility had corrected all of the state correction orders issued pursuant to the July 25, 2024 survey.

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

Also, at the time of this follow-up survey completed on October 8, 2024, we identified the following violation(s):

0830-Local Laws Apply-144g.45 Subd. 3

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

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

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration

process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

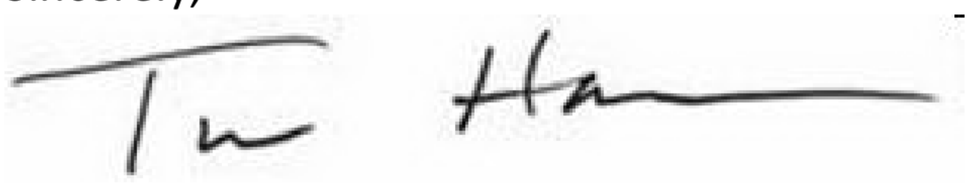
A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. §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

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

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,



Tim Hanna, Supervisor
State Evaluation Team
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27249	A. BUILDING: _____ B. WING _____	R 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	9907 WENTWORTH AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL27249015-1 On October 7, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on July 25, 2024. At the time of the survey, there were 4 residents receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 460} SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	{0 460}		

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{0 460}	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: No further action needed.	{0 460}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action needed.	{0 480}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	{0 780}		

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{0 780}	Continued From page 2 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action needed.	{0 780}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the	{0 800}		

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{0 800}	Continued From page 3 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action needed.	{0 800}		
0 830 SS=D	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to comply with all state and local governing laws, and codes for fire safety, building, and zoning requirements. By failing to obtain required permits for replacement of egress windows. This 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread 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 October 7, 2024, from 10:00 a.m. to 10:30	0 830		

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0 830	Continued From page 4 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-A. The surveyor confirmed that the windows in resident rooms 3 and 4 had been replaced and met the minimum opening requirement. In an email to the facility dated on October 7, 2024, at 12:25 p.m. the surveyor requested documentation that a building permit was approved by the City of Bloomington. On October 10, 2024, at 8:23 a.m., the surveyor called the City of Bloomington building department and confirmed the licensee did not have a recent building permit on file to replace windows. Under MN Rules 1300.0120, An owner or authorized agent who intends to construct, enlarge, alter, repair, move, demolish, or change the occupancy of a building or structure, or to erect, install, enlarge, alter, repair, remove, convert, or replace any gas, mechanical, electrical, plumbing system, or other equipment, the installation of which is regulated by the code; or cause any such work to be done, shall first make application to the building official and obtain the required permit. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 830		
{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:	{01750}		

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{01750}	Continued From page 5 (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: No further action needed.	{01750}		
{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 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: No further action needed.	{01760}		
{01820} SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically	{01820}		

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{01820}	Continued From page 6 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: No further action needed.	{01820}		
{01880} SS=F	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: No further action needed.	{01880}		
{02320} SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: No further action needed.	{02320}		
{02410} SS=F	144G.91 Subd. 13 Personal and treatment privacy	{02410}		

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{02410}	Continued From page 7 (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: No further action needed.	{02410}		

Electronically Delivered

August 22, 2024

Licensee
Destiny Home Care Services
9907 Wentworth Avenue South
Bloomington, MN 55420

RE: Project Number(s) SL27249015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 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 . . ."

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

DOCUMENTATION OF ACTION TO COMPLY
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

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL27249015 On July 22, 2024, through, July 25, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four resident(s); all receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on July 22, 2024, issued for SL27249015-0, tag identification 0820. On July 24, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of H.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week and failed to allow residents to choose the resident's visitors and times of visits. 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 the residents). The findings include:	0 460		

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0 460	Continued From page 2 On July 23, 2024, at 9:40 a.m. the surveyor observed a sign posted in the upstairs common area indicating "Friends/Family visitation hours 9am-8pm. Note: residents are only allowed to have visitors during these hours. No earlier or later from the time above! If a visitor comes to the household, they MUST respect [the facility] environment and be respectful to our staff and other residents. Thanks for heeding to this information. [the facility] Management." On July 19, 2024, at 1:50 p.m., a representative of the Office of Ombudsman for Long Term Care (OOLTC) stated she stopped by the facility on June 5, 2024, and was not allowed in the facility by staff and was told she needed an appointment and approval to get in. On July 23, 2024, at 10:40 a.m. registered nurse (RN)-B stated residents can only have visitors at certain times. Visitors have been disruptive in the past like eating other resident's food. On July 23, 2024, at 12:25 p.m. housing manager (HM)-A stated the visitor restrictions are because they have had several instances of resident's friends coming over in the middle of the night after partying and disrupting the household. This makes the staff feel unsafe if anyone can come in at any time. HM-A further stated they do use a certain amount of reasonableness with this house rule. On July 30, 2024, at 12:00 p.m., the same representative of the OOLTC stated she stopped by the facility on July 26, 2024, and was again denied entrance to see the residents. She was told by HM-A that she needed an appointment to see the residents and a picture of her	0 460		

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0 460	Continued From page 3 identification card was taken. OOLTC representative stated she eventually was able to get in to see the residents. On July 22, 2024, at 10:40 a.m. HM-A stated they do not have a call light system. They had a meeting about putting a system in place. HM-A further stated all their residents are ambulatory and mostly independent. They are looking for a system that is appropriate for their setting and their residents. The licensee's undated [facility] Visitation policy indicated residents are permitted to have guests in the residence. Residents and their guests must follow all visitation guidelines. [the facility] visiting hours are from 9am-9pm in every residence. Guests that arrive after visiting hours will be turned away. Overnight visits are not permitted. A resident is permitted to have a maximum of 5 guests per visit. Residents must notify staff/management when a guest is coming and inform staff/management how long the guest will be staying. Guests are prohibited from bringing any weapons or prohibited substances on the premises. Failure to do so will result in that guest being banned from the residence. If a guest poses a verbal or physical threat to the hosting resident/other residents/staff, they will be asked to leave the premises and will be banned from all [facility] residences. Guests are permitted to bring food into the residence. Guests may be asked to wear a mask in the residence due to COVID precautions. The licensee's contract, used for all residents,	0 460		

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0 460	Continued From page 4 indicated, I have the right to choose my visitors and times of visits made by my visitors. The licensee's undated Bill of Rights policy indicated residents have the right to meet with or receive visits at any time by the resident's family, guardian, conservator, health care agent, attorney, advocate, or religious or social work counselor, or any person of the resident's choosing. This right may be restricted in certain circumstances if necessary for the residents health and safety and if documented in the resident's service plan. Residents have the right to the immediate access by any representative of the Office of Ombudsman for Long-Term Care. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 460		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 480		

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0 480	Continued From page 5 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 July 23, 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		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and	0 780		

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0 780	Continued From page 6 (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 a working smoke alarm outside, in the immediate vicinity of sleeping rooms 1 and 2 on the main level. This affected 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). The findings include: On July 22, 2024, at 1:00 p.m., survey staff toured the facility with the housing manager (HM)-A. During the tour, it was observed a smoke alarm was installed immediately outside of sleeping rooms 1 and 2 on the main level but was not working upon testing. During the interview on July 22, 2024, at 1:30 p.m., HM-A stated the licensee failed to provide a working smoke alarm immediately outside of sleeping rooms 1 and 2 on the main level. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		

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0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 22, 2024, at 1:00 p.m., survey staff toured the facility with the housing manager (HM)-A. During the facility tour, survey staff observed the following items: In the bathroom on the lower level, it was observed that the baseboard cover was heavily rusted, and the paint on the baseboard was	0 800		

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0 800	Continued From page 8 peeling off from water damage. In resident room 3 on the lower level, the carpet was badly stained from water damage. There was also a stain on the wall with evidence of stained water splash. During the facility tour, HM-A visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 820 SS=H	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This affected the	0 820	This immediate correction order identified on July 22, 2024, has had the immediacy lifted as of July 24, 2024, however non-compliance remained a scope and level of H.	

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0 820	Continued From page 9 occupied resident in bedroom 3 and 4 on the lower level. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 22, 2024, at 1:00 p.m., survey staff toured the facility with the housing manager (HM)-A. During the facility tour, survey staff observed the following items: It was observed that occupied resident bedroom 3 and 4 on the lower level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 11 inches in height and 32.5 inches in width, with a total openable area of 357.5 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to HM-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress	0 820		

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0 820	Continued From page 10 window to be a complying bedroom for resident occupancy. HM-A verbally confirmed the findings. On July 22, 2024, at 1:40 p.m., during the interview, survey staff explained to HM-A that an immediate correction order was issued for the above finding. HM-A acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
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 interview and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific 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	01750		

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01750	Continued From page 11 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on April 29, 2011. R1's diagnoses included bipolar disorder, attention deficit hyperactivity disorder, polysubstance abuse, and diabetes mellitus type II. R1's service plan dated January 2, 2024, indicated R1 received services including medication administration. R1's prescriber orders dated July 18, 2024, included: - ibuprofen 200 mg tablets. Take 4 tablets every 8 hours as needed for pain. R1's medication administration record (MAR) dated July 1, 2024, included: -ibuprofen 200 mg tablet oral PRN (as needed) On July 24, 2024, at 1:45 p.m., licensed practical nurse (LPN)-D stated the ibuprofen order does not have specific instructions in the MAR and the orders and the MAR do not match. On July 24, 2024, at 1:45 p.m., RN-B stated she did not put the order in the computer, someone else did and the staff could just call the RN for directions. The licensee's Medication Management- Dosage	01750		

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01750	Continued From page 12 Box Setup policy dated January 1, 2022, indicated a licensed nurse will assure the medication orders are transcribed onto the Medication Administration Record (MAR). This profile includes: -dates of med setup -medication name -quantity of dose -times to be administered -route of administration -name of the person completing the medication setup -visual description of medication -drug classification and special precautions No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
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 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	01760		

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01760	Continued From page 13 by: Based on observation, interview and record review, the licensee failed to ensure medications were administered per provider orders. 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: R2's service plan dated January 2, 2024, indicated R2 received services including assistance with blood glucose monitoring and medication administration. R2's record included a prescriber order dated June 20, 2024, directed to administer Lantus insulin inject 40 units SQ (subcutaneous) at bedtime. Hold when blood sugar is less than 100. On July 23, 2024, at 9:25 a.m., the surveyor observed the medication refrigerator and found an empty vial of Lantus insulin belonging to R2. There were no prefilled syringes of Lantus insulin available either. On July 24, 2024, at 11:40 a.m., the surveyor again observed the medication refrigerator and found the empty bottle of Lantus insulin for R2. There were no prefilled syringes of Lantus either. On July 24, 2024, at 11:45 a.m., clinical nurse supervisor (CNS)-E stated the unlicensed staff working the evening before called her because	01760		

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01760	Continued From page 14 there was no insulin. R2's blood sugar reading was 119 so R2 should have gotten her 40 unit dose of Lantus insulin. CNS-E gave the unlicensed staff the okay to not give the insulin since they could not get any from the pharmacy that evening. CNS-E did not know why the Lantus had not been ordered sooner. R2's record showed she had been given her dose of Lantus insulin the evening of July 22, 2024. The licensee's undated Medication and Supplies-Reordering policy indicated nursing staff of [the facility] will assist residents to make sure medications and supplies are ordered and available as needed. The licensee's undated Medication Error policy indicated whenever a medication error occurs, the person responsible for the error or the person who caught the medication error will: 1. Contact a licensed nurse and explain the situation in detail with the medication name, dosage and amount given as well as the resident involved. 2. The licensed nurse will instruct the staff person on what to do next. This may include contacting the prescriber, family and/or 911. 3. If the staff on duty is unable to have timely two-way communication with a licensed nurse, the staff person will immediately contact the prescriber and explain in detail the medication given, the dosage and amount. The staff person will document exactly what the prescriber stated and any orders and then will carry out the orders. 4. The staff person involved will then complete a medication error report and document in the resident's record progress notes what occurred, date and time, who was contacted and what the actions were to correct the situation.	01760		

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01760	Continued From page 15 5. If the licensed nurse was unavailable, leave a detailed message on the voice mail. 6. The completed Medication Error Report Form will be left in the designated licensed nurse in-box for review. No further information provided TIME PERIOD FOR CORRECTION: Seven (7) 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 maintain current medication orders for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's service plan, dated January 2, 2024,	01820		

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01820	Continued From page 16 indicated R1 received medication administration services. R1 had diagnoses including bipolar disorder, attention deficit hyperactivity disorder, and polysubstance abuse. R1's medication list dated July 18, 2024, included the following scheduled medications: -propranolol 80 mg ER capsules. Take 1 capsule PO QHS -levothyroxine 0.05 mg tablet. Take 1 tablet by mouth every morning. Except 2 tablets one day per week (on Wednesday) -Wellbutrin XL 300 mg tablets. Take 1 tablet by mouth every morning -Trazodone 100 mg tablet. Take 1 tablet PO every night at bedtime -blood sugar three times a week -clozapine 100 mg tablets. Take 1 tablet PO every night at bedtime. -metformin 1000 mg tablets. Take 1 tablet by mouth twice daily with meals -famotidine 20 mg tablets. Take 1 tablet by mouth twice daily -sodium chloride 0.65% nasal spray. Spray 2 sprays into both nostrils daily as needed for congestion -melatonin 6 mg tablets. Take 1 tablet by mouth daily at bedtime -ibuprofen 200 mg tablets. Take 4 tablets q8hrs as needed for pain -senna-docusate 8.6-50 mg tablets. Take 1 tablet PO daily as needed for constipation R1's melatonin was not included on the medication administration record (MAR). On July 24, 2024, at 1:45 p.m., licensed practical nurse (LPN)-D stated R1 had a virtual	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27249	A. BUILDING: _____ B. WING _____	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	9907 WENTWORTH AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01820	Continued From page 17 appointment over the computer, and he requested that the Melatonin be discontinued, and the provider gave a verbal order to discontinue the medication, but the nurse did not send the order to the provider to be signed, they just discontinued it in the MAR. The licensee's Medication and Treatment Orders-Receiving policy dated January 1, 2022, indicated verbal orders received from a prescriber must have the RN/LPN: Record and sign the order. A record of the verbal order will be kept in the resident record All verbal orders received will be written and then forwarded to the prescriber for the prescriber's signature. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01820		
01880 SS=F	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, interview, and record review the licensee failed to ensure prescription medications were stored according to the manufacturer's directions.	01880		

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	27249	A. BUILDING: _____ B. WING _____	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 18 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: On July 23, 2024, at 9:25 a.m., the surveyor observed the facility medication refrigerator. The following medications were observed in the refrigerator: -Novolog insulin- ½ vial and several prefilled syringes of varying units for diabetes -Lantus insulin- one empty vial for diabetes -epinephrine- 2 pens for allergic reactions The manufacturer's instructions on the box indicated epinephrine pens should be stored at room temperature. On July 23, 2024, at 9:25 a.m., registered nurse (RN)-B stated she was not aware the epinephrine pens were to be stored at room temperature. The licensee's undated Medication Storage policy indicated medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). 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
	27249	A. BUILDING: _____ B. WING _____	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	9907 WENTWORTH AVENUE SOUTH BLOOMINGTON, MN 55420

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02320	Continued From page 19	02320		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: 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 employee (unlicensed personnel (ULP-C). 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: ULP-C had a hire date of June 20, 2011. ULP-C's employee record contained documentation that ULP-C had completed a medication administration competency evaluation with registered nurse (RN)-B on June 18, 2024. On July 23, 2024, at 12:10 p.m., the surveyor observed ULP-C complete medication administration for R3. ULP-C took oral	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27249	A. BUILDING: _____ B. WING _____	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02320	Continued From page 20 medications out of the medication setup box, placed them in a medication cup, and gave them to R3 without looking at a medication administration record (MAR). ULP-C did not watch R3 take the medications, R3 placed the medications in her hand and walked into the living room to sit down on the couch before swallowing them. On July 23, 2024, at 12:15 p.m., registered nurse (RN)-B stated the expectation is for staff to check the MAR before giving medications. On July 24, 2024, at 9:05 a.m., ULP-C stated he does not look at a MAR before or during administering medications, he just selects the correct day and time from the medication bar the nurse sets up and gives what is in there. The licensee's Medication Management Administration and Setup policy dated January 1, 2022, indicated for active assistance with medications from the dosage box system, the ULP will use the MAR for documenting medications given from a dosage box and will refer to the medications profile listing the medication name, dosage, date, and time administered. It will also include the purpose of the medication and any special instructions if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02410 SS=F	144G.91 Subd. 13 Personal and treatment privacy	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27249	A. BUILDING: _____ B. WING _____	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02410	Continued From page 21 (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain residents personal and treatment privacy when they established standing orders for random drug and alcohol testing for four of four residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02410	Continued From page 22 the residents). The findings include: On July 24, 2024, at 2:30 p.m., the surveyor observed the house standing orders for all the residents. The standing orders included random urine sample to test for drugs and ETOH (alcohol) upon suspicion of use. On July 24, 2024, at 2:45 p.m., licensed practical nurse (LPN)-D stated that some of the resident's had problems with drugs and alcohol when they first came to the facility and so this has always been on the standing orders, but they do not use this order for the residents anymore and can remove it. Registered nurse (RN)-B stated if they were to drug test on a resident, they would need an order for the testing but did agree the standing orders for all the residents have this random test order on it. The licensee's undated Protecting Resident Rights policy indicated it is the policy of [the facility] to protect the rights of our residents. [the facility] will not request or require that any resident waive any of the rights provided at any time for any reason, including as a condition of admission. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02410		

DEPARTMENT OF HEALTH

Type: Full
Date: *07/23/24*
Time: 13:03:14
Report: 1036241139

Food and Beverage Establishment Inspection Report

Location:

Destiny Home Care Services
9907 Wentworth Avenue South
Bloomington, MN55420
Hennepin County, 27

Establishment Info:

ID #: 0038057
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528887172
ID #:

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

The following orders were issued during this inspection.

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

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

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

OBSERVED EGGS BEING STORED OVER RTE FOOD. ISSUE CORRECTED ON SITE.

Corrected on Site

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.

OBSERVED TCS FOODS OVER 41 DEGREES F IN KITCHEN FRIDGE *SEE NOTES. ADVISED TO TURN DOWN FRIDGE AND MONITOR TEMPERATURE AND UTILIZE BASEMENT FRIDGE IF NOT ABLE TO MAINTAIN. ITEMS DISCARDED ON SITE.

Comply By: 08/06/24

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

THE KITCHEN HANDWASHING SINK IS BEING UTILIZED AS A WASH/RINSE BASIN FOR DISHES. ADVISED TO UTILIZE ANOTHER CONTAINER TO WASH/RINSE/SANITIZE DISHES AND KEEP ONE BASIN DESIGNATED FOR HANDWASHING ONLY.

Comply By: 08/06/24

2-100 Supervision

2-102.12AMN

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

NO CURRENT CFPM EMPLOYED AT ESTABLISHMENT. INSTRUCTIONS AND CFPM APPLICATION PROVIDED AND EXPLAINED DURING INSPECTION.

Comply By: 08/06/24

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

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

OBSERVED SECONDARY STORAGE FOOD CONTAINERS WITH NO LABELS. ISSUE CORRECTED ON SITE.

Corrected on Site

4-100 Equipment Construction Materials

4-101.11BCDE

MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.

OBSERVED A DAMAGED PLASTIC CONTAINER LID REPAIRED WITH TAPE STORING RICE. ITEM DISCARDED ON SITE.

Corrected on Site

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

NO THERMOMETERS WERE INSIDE EITHER THE KITCHEN OR BASEMENT FREEZER. PROVIDE AND MAINTAIN.

Comply By: 08/06/24

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.

THE DISH MACHINE IS CURRENTLY NOT FUNCTIONING PROPERLY. REPLACE/REPAIR AND MAINTAIN.

Comply By: 08/06/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

OBSERVED CHIPPING PAINT ON THE VENT HOOD ABOVE OVEN AND A LARGE HOLE IN THE WALL UNDERNEATH THE SINK. REPAIR AND MAINTAIN.

Comply By: 08/06/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

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

OBSERVED CRUMBS/DUST/DEBRIS THROUGHOUT THE KITCHEN DRAWERS/CABINETS, UNDER THE SINK, AND ABOVE THE FRIDGE. CLEAN AT A GREATER FREQUENCY TO PREVENT SUCH ACCUMULATION.

Comply By: 08/06/24

Surface and Equipment Sanitizers

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

Food and Equipment Temperatures

Process/Item: Cold Hold/MAYO
Temperature: 46 Degrees Fahrenheit - Location: KITCHEN FRIDGE-DISCARDED
Violation Issued: Yes

Process/Item: Cold Hold/BUTTER
Temperature: 45 Degrees Fahrenheit - Location: KITCHEN FRIDGE-DISCARDED
Violation Issued: Yes

Process/Item: Ambient Temp
Temperature: 43 Degrees Fahrenheit - Location: KITCHEN FRIDGE
Violation Issued: Yes

Process/Item: Ambient Temp
Temperature: 10 Degrees Fahrenheit - Location: KITCHEN FREEZER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 39 Degrees Fahrenheit - Location: BASEMENT FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 9 Degrees Fahrenheit - Location: BASEMENT FREEZER
Violation Issued: No

Type: Full
Date: *07/23/24*
Time: 13:03:14
Report: 1036241139
Destiny Home Care Services

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	1	7

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR WAS WENDY ROBARGE. INSPECTION CONDUCTED IN PRESENCE OF CHRISTIAN UDEH, THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH THE PERSON IN CHARGE AND SURVEYOR DURING INSPECTION.

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

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION AND LOG
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- THERMOMETER USE/CALIBRATION
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- DATE MARKING
- PROPER FOOD STORAGE
- ANSI 184 DISH WASHER

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

*INSPECTOR WILL BE RETURNING FOR A FOLLOW-UP VISIT.

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

Type: Full
Date: *07/23/24*
Time: 13:03:14
Report: 1036241139
Destiny Home Care Services

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 inspection report number 1036241139 of 07/23/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
CHRISTIAN UDEH
DIRECTOR

Signed:_____
Jeff Johanson