Electronically Delivered

October 28, 2026

Licensee
Destiny Home
7416 Colorado Avenue North
Brooklyn Center, MN 55443

RE: Project Number(s) SL35729016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 13, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

pursuant to this survey:

St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

To submit a hearing request, please visit:

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

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

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Destiny Home. Please contact Kelly Thorson at 320-223-7336 **on or before Monday November 3, 2026, to schedule the conference call.**

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.

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

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 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
	35729	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME	7416 COLORADO AVENUE NORTH BROOKLYN CENTER, MN 55443

(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: SL35729016-0 On October 12, 2026, through October 14, 2026 , 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 three resident(s); all of whom were receiving services under the Assisted Living Facility 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 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.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the correction orders from a survey completed November 26, 2024. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. This practice resulted in a level two 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	0 340		

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0 340	Continued From page 2 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 the residents). The findings include: On October 13, 2026, at 9:46 a.m., surveyor obtained a copy of the licensee's plan of correction dated February 6, 2025. The plan of corrections paperwork indicated corrections were made for tags 0780 and 0820. The record lacked correction documentation for tags 0470, 0480, 0485, 0660, 0680, 0970, 1530, and 1820. On October 13, 2026, at 2:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A acknowledged they had given us everything they had and stated, "Yes, yeah that's it. I gave you everything I can find." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and	0 470		

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0 470	Continued From page 3 (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice a year. This had the potential to affect all three 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 October 13, 2026, at 9:42 a.m., after asking	0 470		

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0 470	Continued From page 4 the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A multiple times for the facility staffing plan the surveyor located one staffing plan dated January 1, 2025, the licensee failed to develop and implement a staffing plan after January 1, 2025, to determine staffing levels to meet the needs of all residents. On October 12, 2026, at 2:55 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated, "Yeah, as for the staffing plan, no I have to do that. I don't have it." The licensee's Staffing policy dated February 17, 2022, indicated the CNS prepared and implemented a 24-hour daily staffing plan that ensured adequate staffing to meet residents' needs at all times. The policy further indicated the licensee's staffing plan was evaluated as part of the quality management program at least twice per year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with	0 480		

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0 480	Continued From page 5 one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part	0 480		

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0 480	Continued From page 6 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 12, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious	0 485		

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0 485	Continued From page 7 meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. 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 require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 12, 2026, at 11:57 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A	0 485		

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0 485	Continued From page 8 was asked if the licensee was familiar with current minimum assisted living requirements. LALD/CNS stated, "Yes, I am." The licensee's undated Assisted Living Contract, which is used by all residents indicated the monthly rent included three meals per day. The licensee's Assisted Living Contract lacked an option for residents to opt out of payment for one, two or three meals that a resident may not want. On October 13, 2026, at 3:19 p.m., LALD/CNS-A stated the cost of meals were not broken down for each meal. LALD/CNS-A further stated LALD/CNS-A was aware of the requirement to provide residents an opportunity to opt out of one, two, or three meals, however the licensee was not currently providing those options. The licensee's Food Service policy dated February 17, 2022, indicated the licensee served at least three nutritious meals, seven days per week with snacks available. The policy did not address the cost of meals. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated December 13, 2024, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		

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0 650	Continued From page 9	0 650		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of three employees (unlicensed personnel (ULP-D)). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	0 650		

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0 650	Continued From page 10 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: ULP-D began employment on May 18, 2026, to provide direct care services to residents. On October 13, 2026, at 10:15 a.m., surveyor observed ULP-D administer medications to R4. ULP-D's employee records lacked the following required items: - a current job description; - documentation of training of appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing (ii) care of teeth, gums, and oral prosthetic devices (iii) care and use of hearing aids (iv) dressing and assisting with toileting; - documentation of training of standby assistance techniques and how to perform them; - documentation of training of safe transfer techniques and ambulation; and - documentation of training of range of motioning and positioning. On October 13, 2026, at 12:12 p.m., ULP-D stated, "We did the virtual training it's a lot of videos a whole lot of videos and then there was testing at the end. It shows you everything you need to do to do your job and mainly videos and then a little bit of training with Shola the nurse on medications and like the showers and braces. She had to test me out for everything I do before I was allowed to do it independently."	0 650		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 11 On October 13, 2026, at 2:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A acknowledged they had given us everything they had and stated, "Yes, yeah that's it. I gave you everything I can find." The licensee's Staff Competency policy dated February 17, 2022, indicated employees who provided direct care services completed competency evaluations as part of the orientation process. The policy further indicated the licensee maintained proof of orientation and education in employee files. The licensee's Personnel Records policy dated February 17, 2022, indicated each employee record contained documentation of orientation and competency evaluations completed. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide	0 660		

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0 660	Continued From page 12 technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a current facility TB risk assessment. The licensee also failed to maintain screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for two of three employees, (unlicensed personnel (ULP)-D and ULP-E) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: TB RISK ASSESSMENT On October 12, 2026, at 11:21 a.m., administrator (A)-C provided the surveyor with the licensee's TB risk assessment dated June 27, 2024. On October 12, 2026, at 1:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A acknowledged the TB risk	0 660		

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0 660	Continued From page 13 assessment dated June 27, 2024 was not the most recent assessment the licensee had. LALD/CNS-A stated, "No, I will bring you the new one." Surveyor requested multiple times for the newest assessment and nothing was provided. SCREENING ULP-D ULP-D began employment on May 18, 2026, to provide direct care services to residents. On October 13, 2026, at 7:55 a.m., the surveyor observed ULP-D assist R2 with grooming services. ULP-E ULP-E began employment on November 21, 2024, to provide direct care services to residents. ULP-D and ULP-E's records lacked evidence of screening for active TB with either a two-step TST or blood test within 90 days of hire. On October 13, 2026, at 2:15 p.m., LALD/CNS-A stated, "Yes, yeah that's it. I gave you everything I can find." The licensee's Tuberculosis Screening/Prevention policy dated February 17, 2022, indicated the licensee conducted a formal TB risk assessment annually. The policy further indicated employees completed baseline symptom assessments and TB screening upon hire. The Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC,	0 660		

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0 660	Continued From page 14 2019 dated May 17, 2019, and the CDC guidelines indicate each provider licensed by Minnesota Department of Health is required to complete a TB risk assessment annually. Completion of this assessment will assist providers in the development of an infection control committee and in determining the frequency of screening. The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents.	0 680		

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0 680	Continued From page 15 (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. [Additionally, the licensee failed to post the EPP prominently.] This had the potential to affect all residents receiving services under the provisional assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: The licensee's undated EPP lacked the following required content: -develop and maintain the EPP; -maintain and annual EPP updates; -policies and procedures for subsistence needs for staff and residents; -policies and procedures for tracking of staff and	0 680		

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0 680	Continued From page 16 residents; -policies and procedures including evacuation; -policies and procedures for arrangements with other facilities; -primary and alternate means for communication; -procedure for sharing information on occupancy and or needs; and -emergency prep testing requirements. On October 13, 2026, at 4:07 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated LALD/CNS-A reviewed the EPP annually and as needed however LALD/CNS-A did not document the reviews. LALD/CNS-A further stated the licensee's missing resident policy was reviewed annually and LALD/CNS-A was not aware statute required quarterly review of the policy. LALD/CNS-A stated, "I am aware of the requirement for the EPP. I am not sure why those items missing are not in the binder." The licensee's Emergency Preparedness policy dated February 17, 2022, indicated the licensee identified a plan to assure the safety and well-being of residents and staff during periods of an emergency or disaster which disrupted services. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance.	0 680		

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0 680	Continued From page 17 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 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, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private for one of three 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) 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: R2 was admitted to the licensee and began receiving services on March 21, 2023.	0 700		

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0 700	Continued From page 18 R2 had diagnoses to include post traumatic seizures. R2's signed Service Plan dated March 23, 2023, indicated R2 received services to include activity assistance, bathing, deep room cleaning, dressing, grooming, housekeeping, incontinence care, laundry, linens, behavior management, meals, medication administration, skin care, and toileting. On October 12, 2026, at 9:30 a.m., surveyor observed a sticky note on the dining room table in the common dining room that indicated, "-oxycodone pain meds every 6 hours -Rinse out [R2's] mouth when he wakes up - Tall bottle in his med drawer - New meds are as needed -No smoking at all -only soft foods (soup, soggy cereal, bananas) On October 13, 2026, at 3:03 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated, "All the residents' information is to remain behind closed doors and confidential. The staff are trained to not share any resident information. I will need to re-educate on that." The licensee's Resident Confidentiality policy dated February 17, 2022, indicated resident records were kept in a locked file and not accessible to the public. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		

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0 720	Continued From page 19	0 720		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that personnel and resident records were readily available for timely access to employees, vendors, and the commissioner authorized to access the records. 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 October 12, 2026, at 7:06 a.m., the surveyor sent an email requesting the following items be available at the start of survey at 9:30 a.m.: - current resident roster; - discharge or deceased resident roster; and - employee list. On October 12, 2026, at 8:24 a.m., the surveyor called the facility to initiate survey, and the phone	0 720		

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0 720	Continued From page 20 call was unanswered. On October 12, 2026, 8:32 a.m., the surveyor called the facility to initiate survey. The phone call was again unanswered, and the surveyor left a voice message which indicated the survey process was initiated. On October 12, 2026, at 9:30 a.m., the surveyor arrived at the facility and unlicensed personnel (ULP)-B called licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A to inform them of the arrival. On October 12, 2026, at 9:35 a.m., ULP-B acknowledged they did not have access to resident or employee records and stated "[LALD/CNS-A] should be arriving soon. They said not to get you anything, and they would get everything for you when they get here. They are on their way." On October 12, 2026, at 11:45 a.m., LALD/CNS-A arrived at the facility and the entrance conference was started at 11:52 a.m. On October 12, 2026, at 12:29 p.m., the surveyor provided a written request for R2 and R4's medical records. On October 12, 2026, at 12:45 p.m., an initial document request email was sent to LALD/CNS-A requesting the following documents: - NetStudy Roster (web based background study platform); - assisted living bill of rights; - Uniform Checklist Disclosure of Services (UDALSA); - website or advertising information; - blank assisted living contract;	0 720		

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0 720	Continued From page 21 - list of all licensed staff and evidence of current licensure, including LALD; - documentation of incidents, accidents, and/or medication errors for the past six (6) months; - abuse/neglect reports for the past six (6) months (MAARC); - any complaints for the past six (6) months; - 24-hour report book or communication book, if applicable; - ULP (unlicensed personnel) daily assignment work/shift forms; - admission information/packets; - current quality management plan x 2 (two) most recent meetings minutes; - facility staffing plan x 3 (three) most recent reviews; - this week's employee schedule; - TB (tuberculosis) facility risk assessment; - facility menu; and - plan of corrections from past survey. On October 12, 2026, at 1:52 p.m., the surveyor provided a written second request for the following documents: NetStudy 2.0 roster (web-based background check system), Assisted Living Bill of Rights, documentation of incidents, accidents and medication errors for the past six months, abuse or neglect reports for the past six months, and any complaints for the past six months. On October 12, 2026, at 2:15 p.m., the surveyor provided a second request in writing to LALD/CNS-A for R2 and R4's medical record. On October 12, 2026, at 2:16 p.m., the surveyor provided a written second request for the following documents: current quality management plan, three most recent staffing plan reviews, weekly employee schedule, facility menu, and the	0 720		

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0 720	Continued From page 22 licensee's plan of corrections from the previous survey completed on August 28, 2024. On October 12, 2026, at 3:48 p.m., the surveyor provided a third request in writing for R2 and R4's medical records. The surveyor requested the medical records be emailed to the surveyor by 8:00 p.m. On October 13, 2026, at 8:11 a.m., the surveyor emailed a fourth request for R2 and R4's medical records. On October 13, 2026, at 9:00 a.m., LALD/CNS-A provided R2's three most recent assessments, October 2026 medication administration record, and progress notes, however, the following documents from R2's medical record were not received: - signed assisted living contract; - signed service plan; and - signed provider orders. . On October 13, 2026, at 12:50 p.m., the surveyor verbally requested all outstanding documents previously requested be provided by 2:00 p.m., which included disaster drill documentation, signed service plans for R3 and R4, and R4's support plan, treatment plan, medication orders, and change of condition assessment. On October 13, 2026, at 2:15 p.m., LALD/CNS-A stated, "Yes, yeah that's it. I gave you everything I can find." The licensee's Resident Confidentiality policy dated February 17, 2022, indicated all resident files were kept confidential and released only to authorized persons, employees of the licensee, other healthcare providers, and to representatives	0 720		

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0 720	Continued From page 23 of the commissioner authorized to survey or investigate assisted living providers. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 720		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;	0 730		

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0 730	Continued From page 24 (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged 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). The findings include: R1 was admitted to the licensee on November 19, 2023, and discharged to another facility on October 11, 2026.	0 730		

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0 730	Continued From page 25 R1's record lacked a discharge summary that complied with Minnesota rule's part 4659.0120, subpart 9 to include: - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. On October 13, 2026, at 2:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A acknowledged they had given us everything they had and stated, "Yes, yeah that's it. I gave you everything I can find." At 3:18 p.m., LALD/CNS-A stated, "I will make sure to add that next time. I must have just overlooked it." The licensee's Clinical Records policy dated February 17, 2022, indicated resident records contained a discharge summary when applicable. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0120, Subp. 9, effective August 11, 2021, at the time of discharge, the facility must provide the resident, and, with the resident's consent, the resident's representatives and case manager, with a written discharge summary that includes: A. a summary of the residents' stay that includes diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; B. a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; C. a reconciliation of all predischarge medications with the resident's post discharge prescribed and	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35729	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME	7416 COLORADO AVENUE NORTH BROOKLYN CENTER, MN 55443

(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
0 730	Continued From page 26 over-the-counter medications; and D. a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and non-medical services the resident will need. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 775		

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0 775	Continued From page 27 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated October 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
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 (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;	0 780		

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	35729	A. BUILDING: _____ B. WING _____	10/13/2026

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0 780	Continued From page 28 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated October 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. 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;	0 790		

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	35729	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME	7416 COLORADO AVENUE NORTH BROOKLYN CENTER, MN 55443

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0 790	Continued From page 29 (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated October 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35729	A. BUILDING: _____ B. WING _____	10/13/2026

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0 800	Continued From page 30	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated October 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 800	Continued From page 31 TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=I	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 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff 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) Staff 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 staff 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.	0 810		

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0 810	Continued From page 32 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated October 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing;	0 900		

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0 900	Continued From page 33 (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written contract with the required content prior to the start of services for two of three residents (R3 and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 900		

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0 900	Continued From page 34 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3 R3 was admitted to the licensee and began receiving services on January 20, 2023. R3's record included an Assisted Living Contract signed on January 30, 2023, indicating 10 days had passed from date of move in, prior to receiving a signed contract. R4 R4 was admitted to the licensee and began receiving services on January 21, 2023. R4's record included an unsigned and incomplete Assisted Living Contract which lacked the following required content: -authentication by resident or resident representative; and -authentication by licensee representative. On October 13, 2026, at 2:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A acknowledged they had given us everything they had and stated, "Yes, yeah that's it. I gave you everything I can find." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
0 950 SS=D	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an	0 950		

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0 950	Continued From page 35 assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 950		

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0 950	Continued From page 36 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: R4 was admitted to the licensee and began receiving services on January 21, 2023. R4's record contained an unsigned Assisted Living Contract signed on January 17, 2023, which lacked the following required content: a place to identify the resident's designated representative and the required statutory language for the designated representative. On October 13, 2026, at 2:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated, "Yes, yeah that's it. I gave you everything I can find." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
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	0 970		

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0 970	Continued From page 37 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 licensee's liability for health, safety, or personal property for two of two residents (R2 and R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee and began receiving services on March 21, 2023. R2's record included an Assisted Living Contract signed on June 2, 2023. R3 R3 was admitted to the licensee and began receiving services on January 20, 2023. R3's record included an Assisted Living Contract signed on January 30, 2023. R4 R4 was admitted to the licensee and began receiving services on January 21, 2023.	0 970		

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0 970	Continued From page 38 R4's record included an unsigned Assisted Living Contract dated January 17, 2023. R2, R3, and R4's Assisted Living Contracts indicated, "Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [licensee] upon request. The resident acknowledges that [licensee] is not an insurer of the resident's person or property. The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [licensee] or its employees or agents. The resident hereby releases [licensee] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [licensee] or its employees or agents." R2 and R3's Assisted Living Contracts additionally indicated, "Indemnification: [licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [licensee] harmless from any claims or damages unless caused solely by negligence of [licensee]. It is recommended that renter's insurance be purchased at the resident's expense. Liability: The resident agrees to be liable and responsible for all obligations herein	0 970		

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0 970	Continued From page 39 referenced, monetary and otherwise, of the resident and where this Contract has been executed by a party designated below. Or where a separate Responsible Party Agreement has been executed by a third party, said third party and the resident shall be jointly and severally liable and responsible for all obligations, monetary and otherwise, of the resident herein referenced. On October 13, 2026, at 9:12 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A acknowledged the licensee contract contained incorrect verbiage and stated "I thought we redid those. I will need to get that done." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office	01060		

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	35729	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME	7416 COLORADO AVENUE NORTH BROOKLYN CENTER, MN 55443

(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
01060	Continued From page 40 of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (R4).	01060		

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01060	Continued From page 41 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: R4 was admitted to the licensee and began receiving services on January 21, 2023. R4's signed Service Plan dated January 20, 2023, indicated R4 received services to include bathing reminders, deep room clean, grooming, housekeeping, linens, behavior management, medication administration, psychotropic medication monitoring, and shopping assistance. R4's record included Discharge Orders dated October 11, 2026, which indicated R4 was hospitalized from October 7, 2026, through October 11, 2026. R4's record lacked evidence that a written notice, with the required statutory content, was provided to R4, R4's representative, or the ombudsman after four days of hospitalization. On October 12, 2026, at 1:23 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated, "[R4] just went in on Friday (October 9, 2026) and returned yesterday (October 11, 2026)." LALD/CNS-A also stated, "No, I don't do those. I just update the case manager, but I don't give them anything. What is it called that I need to give him?"	01060		

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01060	Continued From page 42 The licensee's Discharge and Transfer of Residents policy dated February 17, 2022, indicated in the event of an emergency relocation, the licensee issued as soon as possible a written notice of Emergency Relocation to the resident, the resident's legal representative, the resident's designated representative, the resident's case manager, and the Office of Ombudsman for Long-Term Care if the resident hadn't returned to the licensee within four days. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them;	01370		

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01370	Continued From page 43 (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of three unlicensed personnel (ULP)-D. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: ULP-D began employment on May 18, 2026, to	01370		

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01370	Continued From page 44 provide direct care services to residents. On October 13, 2026, at 10:15 a.m., surveyor observed ULP-D administer medications to R4. ULP-D's employee records lacked documentation of training and competency evaluations for ULP's providing assisted living services including: - reports of changes in the resident's condition to the supervisor designated by the facility; - awareness of commonly used health technology equipment and assistive devices; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. On October 13, 2026, at 2:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A acknowledged they had given us everything they had and stated, "Yes, yeah that's it. I gave you everything I can find." At 3:18 p.m., LALD/CNS-A stated, "I will make sure to add that next time. I must have just overlooked it." The licensee's Staff Orientation and Education policy dated February 17, 2022, indicated upon hire and before providing services to residents, all employees attended a general orientation conducted by the licensee and those employees providing direct services completed competency evaluations as part of the orientation process. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

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01530	Continued From page 45	01530		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on	01530		

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01530	Continued From page 46 topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the license failed to complete two hours of initial training on mental illness and de-escalation for employees hired prior to July 1, 2025, for one of three employees (ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D began employment on May 18, 2026, to provide direct care services to residents. On October 13, 2026, at 10:15 a.m., surveyor observed ULP-D administer medications to R4. ULP-D's employee record included ULP-D's EduCare (online training platform) which indicated ULP-D completed 1.25 hours of mental illness and de-escalation training. ULP-D's employee record lacked evidence of ULP-D having completed the required two hours of training on mental illness and de-escalation.	01530		

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01530	Continued From page 47 On October 13, 2026, at 2:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A acknowledged they had given us everything they had and stated, "Yes, yeah that's it. I gave you everything I can find." LALD/CNS-A added, "I thought they only needed one hour, we can get more scheduled for them." The licensee's Dementia Education policy dated February 17, 2022, indicated employees completed eight hours of initial dementia education within 160 hours of the employment start date. The policy did not address mental illness and de-escalation education requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the	01620		

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01620	Continued From page 48 resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive re-assessment following a change of condition for two of three residents	01620		

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01620	Continued From page 49 (R2, R4). In addition, the licensee failed to ensure the RN conducted ongoing nursing assessments not to exceed every 90-days for one of three 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee and began receiving services on March 21, 2023. R2's record included an Assisted Living Contract signed on June 2, 2023. R2's diagnoses included post-traumatic seizures (seizure activity due to a traumatic brain injury), anxiety, hemiplegia and hemiparesis (weakness or loss of control on one side of the body due to a stroke), right eye blindness, depression, hypertension (elevated blood pressure). R2's signed Service Plan dated March 23, 2023, indicated R2 received assistance with bathing, grooming, dressing, incontinence care and toileting, laundry, meals, behavior management, and medication administration. R2's record included comprehensive nursing assessments dated June 11, 2026, and September 16, 2026, respectively, which	01620		

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01620	Continued From page 50 indicated 97 days had passed since R2's last comprehensive nursing assessment. R2's record also included a change of condition assessment dated October 9, 2026, which lacked the following content required by the uniform assessment tool (UAT): -sleep schedule; -social needs and leisure activities; -spiritual and cultural preferences; -advanced health care directive and end of life preferences; -activities of daily living (ADL); -ability to self-manage medications; -housework and laundry; -cognition- including review of any neurocognitive evaluations and diagnoses as well as current memory, orientation status and decision-making ability, and -skin. R4 R4 was admitted to the licensee and began receiving services on January 21, 2023. R4's signed Service Plan dated January 20, 2023, indicated R4 received services to include bathing reminders, deep room clean, grooming, housekeeping, linens, behavior management, medication administration, psychotropic medication monitoring, and shopping assistance. R4's record included Discharge Orders dated October 11, 2026, which indicated R4 was hospitalized from October 7, 2026, through October 11, 2026. On October 13, 2026, at 10:15 a.m., surveyor observed ULP-D administer medications to R4.	01620		

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01620	Continued From page 51 R4's record lacked a change of condition assessment following hospitalization. On October 13, 2026, at 3:28 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated LALD/CNS-A was aware of the UAT however LALD/CNS-A utilized a paper assessment for R2 which lacked required content. LALD/CNS-A further stated change of condition assessments were to be completed on the same day a resident returned from the hospital and LALD/CNS-A was completing R4's change of condition assessment today. The licensee's Comprehensive Nursing Assessment policy dated February 17, 2022, indicated the RN (registered nurse) conducted a comprehensive nursing assessment utilizing the uniform assessment tool which addressed the above missing items. The licensee's Assessment and Reassessment policy dated February 17, 2022, indicated the RN conducted a comprehensive nursing assessment at the time of admission, and reassessed no more than 14 days after initiation of services. The policy further indicated the RN conducted ongoing resident assessment which did not exceed 90 days from the last date of assessment and as needed based on changes in resident condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 52 (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 current service plan included a signature or other authentication by the licensee to document agreement on the services to be provided for one of three residents (R4). In addition, the licensee failed to ensure a current written service plan was revised to reflect the current services assessed for three of three residents (R2, R3, and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01640		

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01640	Continued From page 53 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: SERVICE PLAN AUTHENTICATION R4 was admitted to the licensee and began receiving services on January 21, 2023. R4's record included an unsigned Assisted Living Contract dated January 17, 2023. R4's signed Service Plan dated January 20, 2023, indicated R4 received services to include bathing reminders, deep room clean, grooming, housekeeping, linens, behavior management, medication administration, psychotropic medication monitoring, and shopping assistance. On October 13, 2026, at 10:15 a.m., surveyor observed ULP-D administer medications to R4. R4's current service plan lacked a signature or other authentication by the licensee to document agreement on the services to be provided. On October 13, 2026, 2026, at 11:47 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated, "Oh I must have missed that." SUPPORT PLAN SERVICES ASSESSED R2 R2 was admitted to the licensee and began receiving services on March 21, 2023.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35729	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME	7416 COLORADO AVENUE NORTH BROOKLYN CENTER, MN 55443

(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
01640	Continued From page 54 R2's record included an Assisted Living Contract signed on June 2, 2023. R2's diagnoses included post-traumatic seizures (seizure activity due to a traumatic brain injury), anxiety, hemiplegia and hemiparesis (weakness or loss of control on one side of the body due to a stroke), right eye blindness, depression, hypertension (elevated blood pressure). R2's signed Service Plan dated March 23, 2023, indicated R2 received assistance with bathing, grooming, dressing, incontinence care and toileting, laundry, meals, behavior management, and medication administration. On October 12, 2026, at 10:13 a.m., the surveyor observed ULP-B administer medications to R2. R2's Minnesota Department of Human Services Support Plan dated January 1, 2026, through December 31, 2026, indicated R2 was authorized to receive the following services: homemaking daily, shopping weekly, assistance making appointments daily, arranging non-medical transportation daily, breakfast, lunch, supper, snack times two, individual staff ratio 1:1 daily, individual staff ratio 1:2 to 5 daily, driver 1:1 non-medical daily, assistance with dressing, assistance with grooming, assistance with bathing, continence care, assistance with positioning, assistance with walking, assistance with wheeling, assistance with transferring, assistance with self-administration of medication, medication setups and monitoring, managing anxiety, managing agitation, managing self-injurious behavior, managing verbal aggression, and managing physical aggression. R2's service plan lacked the following authorized	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35729	A. BUILDING: _____ B. WING _____	10/13/2026

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01640	Continued From page 55 services: shopping, assistance making appointments daily, arranging non-medical transportation daily, two meals, socialization 1:1, socialization 1: 2 to 5, driver 1:1 non-medical, self-administration of medication, assistance with positioning, assistance with walking, assistance with wheeling, assistance with transferring, managing anxiety, managing agitation, managing self-injurious behavior, managing verbal aggression, and managing physical aggression. R3 R3 was admitted to the licensee and began receiving services on January 30, 2023. R3's record included an Assisted Living Contract signed on January 30, 2023. R3's diagnoses included quadriplegia incomplete (cervical spine was bruised, compressed, or partially damaged and not completely severed), abnormal gait and mobility, acute infarction of spinal cord (loss of blood flow to the spinal cord which causes tissue damage and neurological deficit), and insomnia (sleep disorder). R3's signed Service Plan dated January 30, 2023, indicated R3 received assistance with foot care as needed, skin care as needed, and medications. R3's Minnesota Department of Human Services Support Plan dated October 1, 2025, through September 30, 2026, indicated R3 was authorized to receive the following services: homemaking daily, shopping daily, individual meal preparation in own apartment weekly, assistance making appointments daily, arranging non-medical transportation daily, breakfast, lunch, supper, snack times two, individual staff ratio 1:1	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35729	A. BUILDING: _____ B. WING _____	10/13/2026

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01640	Continued From page 56 daily, individual staff ratio 1:2 to 5 daily, driver 1:1 non-medical daily, mileage 1:1 daily, assistance with dressing, assistance with grooming, assistance with bathing, continence care, assistance with walking, assistance with wheeling, assistance with self-administration of medication, verbal or visual medication reminders, other delegated tasks, medication setups and monitoring, manage repetitive behavior, managing agitation, case management paraprofessional services, case manager services, Access Pass for Metro Transit system, and employment exploration services. R3's service plan lacked the following authorized services: homemaking, shopping, assistance making appointments daily, arranging non-medical transportation daily, individual staff ratio 1:1 daily, individual staff ratio 1:2 to 5 daily, driver 1:1 non-medical daily, mileage 1:1 daily, assistance with dressing, assistance with grooming, assistance with bathing, continence care, assistance with walking, assistance with wheeling, assistance with self-administration of medication, verbal or visual medication reminders, other delegated tasks, manage repetitive behavior, managing agitation, case management paraprofessional services, case manager services, Access Pass for Metro Transit system, and employment exploration services. R4 R4's Minnesota Department of Human Services Support Plan dated March 1, 2026, through February 28, 2027, indicated R4 was authorized to receive the following services: transportation pass through ConnectAbility for community resources and appointments, homemaking daily, shopping daily, assistance making appointments daily, arranging non-medical transportation daily,	01640		

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	35729	A. BUILDING: _____ B. WING _____	10/13/2026

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01640	Continued From page 57 breakfast, lunch, supper, snack times two, individual staff ratio 1:1 daily, individual staff ratio 1:2 to 5 daily, driver 1:1 non-medical weekly, mileage 1:1 weekly, assistance with dressing, assistance with grooming, assistance with bathing, assistance with self-administration of medication, verbal or visual medication reminders, medication setups and monitoring, managing anxiety, managing agitation, managing self-injurious behavior, managing verbal aggression, and case management paraprofessional services. R4's service plan lacked the following authorized services: shopping daily, assistance making appointments daily, arranging non-medical transportation daily, snack times two, individual staff ratio 1:1 daily, individual staff ratio 1:2 to 5 daily, driver 1:1 non-medical weekly, mileage 1:1 weekly, assistance with dressing, assistance with grooming, assistance with bathing, assistance with self-administration of medication, verbal or visual medication reminders, managing anxiety, managing agitation, and managing verbal aggression. The licensee's Service Plan policy dated February 17, 2022, indicated the licensee implemented and provided all services as required by the current service plan. The policy further indicated the service plan must be revised, if needed, based on resident review or reassessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35729	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01760	Continued From page 58	01760		
01760 SS=F	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: Based on observation, interview, and record review the licensee failed to ensure medication was administered as prescribed for one of three residents (R4). In addition, the licensee failed to accurately transcribe two of three resident's (R2 and R4) prescriber orders into the medication administration record (MAR). 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:	01760		

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	35729	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01760	Continued From page 59 MEDICATION ADMINISTRATION ERROR R4 R4 was admitted to the licensee and began receiving services on January 21, 2023. R4's diagnoses included schizoaffective disorder (mental health condition combining psychotic symptoms like hallucinations or delusions and mood disorders like depression or bipolar disorder), scoliosis (abnormal side-to-side sideways curvature of the spine), and schizophrenia (mental health condition characterized by a mix of hallucinations, delusions, and disorganized thinking and behavior). R4's signed Service Plan dated January 20, 2023, indicated R4 received services to include bathing reminders, deep room clean, grooming, housekeeping, linens, behavior management, medication administration, psychotropic medication monitoring, and shopping assistance. On October 13, 2026, at 10:15 a.m., surveyor observed ULP-D administer medications to R4. R4's electronic medication administration record (MAR) titled Med Admin Summary- Actual- Month dated October 1, 2026, through October 31, 2026, indicated R4 received topiramate (controls seizure activity and prevents migraine headaches) 50 milligrams (mg) take two tablets by mouth twice daily on October 1 through October 12, 2026. R4's eMAR further indicated R4's topiramate instructions were changed on October 12, 2026, at 7:15 p.m. to read as follows: topiramate 50 mg take one tablet by mouth twice daily.	01760		

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	35729	A. BUILDING: _____ B. WING _____	10/13/2026

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01760	Continued From page 60 R4's record included a signed order dated September 15, 2026, which indicated R4 was ordered topiramate 50 mg take one tablet by mouth twice daily. R4's record also included a signed order dated October 11, 2026, which indicated R4 was ordered fluticason proprionate (reduces inflammation and swelling in the body) 50 mcg/act inhale one spray in each nostril daily however, this medication was not included on R4's MAR as of October 13, 2026. TRANSCRIPTION OF MEDICATION R2 R2 was admitted to the licensee and began receiving services on March 21, 2023. R2's diagnoses included post-traumatic seizures (seizure activity due to a traumatic brain injury), anxiety, hemiplegia and hemiparesis (weakness or loss of control on one side of the body due to a stroke), right eye blindness, depression, hypertension (elevated blood pressure). R2's signed Service Plan dated March 23, 2023, indicated R2 received assistance with bathing, grooming, dressing, incontinence care and toileting, laundry, meals, behavior management, and medication administration. On October 12, 2026, at 10:13 a.m., surveyor observed ULP-B administer medications to R2. R2's prescriber orders dated April 6, 2026, included the following: - acetaminophen ER (extended release) 650 mg take one tablet by oral route every eight hours as needed;	01760		

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01760	Continued From page 61 - cyclobenzaprine (skeletal muscle relaxant) 10 mg take one tablet by oral route every day as needed; - docusate sodium (stool softener) 100 mg take one tablet by oral route two times every day at bedtime as needed; and - omeprazole (stomach acid reducer) 40 mg take one capsule by oral route two times every day before a meal. R2's MAR dated October 1, 2026, through October 31, 2026, included the following: - acetaminophen 500 mg take one capsule by mouth three times daily as needed; - acetaminophen 500 mg take two capsules by mouth every six to eight hours as needed for seven days, ending October 16, 2026; - cyclobenzaprine 5 mg take one tablet by mouth at bedtime and take one tablet by mouth two times daily as needed; - docusate sodium 100 mg take one capsule by mouth twice daily; - omeprazole 40 mg take one capsule by mouth every evening. R4 R4's prescriber orders dated October 11, 2026, included the following: - ventolin HFA (treats wheezing and shortness of breath through rapid airway opening) 90 micrograms/actuation (mcg/act) inhale two puffs every four hours as needed; - atropine sulfate (treats inflammatory eye conditions) 1% (percent) opthalmic solution- use one to two drops sublingual (under the tongue) as needed for drooling at bedtime; and - benzonatate (cough suppressant) 100 mg take one capsule by mouth three times daily as needed.	01760		

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	35729	A. BUILDING: _____ B. WING _____	10/13/2026

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01760	Continued From page 62 R4's MAR dated October 1, 2026, through October 31, 2026, included the following: - ventolin HFA 90 mcg/act inhale one-to-two puffs every six hours as needed; - atropine sulfate 1% give one-to-two drops sublingual as needed; and - benzonatate 100 mg administer one capsule by mouth as needed. On October 13, 2026, at 4:11 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated medication orders received were processed by LALD/CNS-A as soon as possible. LALD/CNS-A further stated transcription errors were an oversight error on LALD/CNS-A's part. The licensee's Medication Orders policy dated February 17, 2022, indicated the licensee maintained current written or electronically recorded prescriptions for all prescribed medications which were managed for residents. The policy further indicated when written or electronic prescriptions were received, the orders were communicated to the registered nurse in charge and recorded in the resident's record. The licensee's Medication Incidents/Errors policy dated February 17, 2022, indicated the licensee recognized and promptly identified medication errors/incidents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions	01820		

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	35729	A. BUILDING: _____ B. WING _____	10/13/2026

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01820	Continued From page 63 There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of 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 was admitted to the licensee and began receiving services on March 21, 2023. R2's diagnoses included post-traumatic seizures (seizure activity due to a traumatic brain injury), anxiety, hemiplegia and hemiparesis (weakness or loss of control on one side of the body due to a stroke), right eye blindness, depression, hypertension (elevated blood pressure). R2's signed Service Plan dated March 23, 2023, indicated R2 received assistance with bathing, grooming, dressing, incontinence care and toileting, laundry, meals, behavior management, and medication administration.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35729	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME	7416 COLORADO AVENUE NORTH BROOKLYN CENTER, MN 55443

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01820	Continued From page 64 On October 12, 2026, at 10:13 a.m., surveyor observed ULP-B administer medications to R2. R2's electronic medication administration record (MAR) titled Med Admin Summary- Actual- Month dated October 1, 2026, through October 31, 2026, listed the medications, times to administer, and staff initials which indicated the medications had been administered to R2. The MAR indicated R2 received the following: - amlodipine besylate (lowers blood pressure) 5mg one tablet by mouth daily; - amoxicillin (treats bacterial infections) 500 mg one capsule by mouth three times per day. First dose give on October 9, 2026, at 9:00 p.m.; - buspirone (anti-anxiety) 10 mg take two tablets (20 mg) by mouth three times per day; - chlorhexidine (reduces bacteria in the mouth) 0.12% cleanse and rinse mouth with 10 milliliters (ml) of solution two time per day for seven days. First dose given on October 10, 2026; - ferrous gluconate (iron supplement) 324 milligrams (mg) one tablet by mouth every Monday, Wednesday, and Friday; - polyethylene glycol 3350 powder (treats and prevents constipation) take 17 grams (gm) mixed with full glass of water everyday; - vitamin D (supplement) 1000 units (u) take one capsule by mouth daily; - ibuprofen (manages pain and inflammation) 600 mg take one tablet by mouth once daily as needed; - naloxone hydrochloride (reverses opioid overdoses) administer one spray (0.1 ml) by nasal route once daily as needed; - nicotine polacrilex (nicotine supplement for smoking cessation) gum- chew one gum (2 gm) for 30 minutes every two-to-three hours as needed;	01820		

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	35729	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME	7416 COLORADO AVENUE NORTH BROOKLYN CENTER, MN 55443

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01820	Continued From page 65 - nicotine polacrilex (nicotine supplement for smoking cessation) lozenges- give one lozenge (4 mg) and dissolve in mouth/throat every hour as needed; and - oxycodone (pain reliever) 5 mg administer one tablet every six hours as needed. R2's record included orders dated April 6, 2026, which included the following incomplete orders: - ferrous gluconate 324 mg; - Miralax (polyethylene glycol 3350) 17 gm/ dose; and - vitamin D3 1000 u. R2's record lacked complete provider orders for the above listed medications. On October 13, 2026, at 4:11 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated order changes and new orders were processed as fast as possible. LALD/CNS-A further stated orders must include the resident's name, medication name, dose, route, instructions, and provider signature, and that order processing errors were an oversight on LALD/CNS-A's part. The licensee's Medication Orders policy dated February 17, 2022, indicated the licensee maintained a current written or electronically recorded prescription for all prescribed medications managed for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35729	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME	7416 COLORADO AVENUE NORTH BROOKLYN CENTER, MN 55443

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01910	Continued From page 66	01910		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record all required content for disposition of medications for one of one resident (R1) upon discharge. 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	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35729	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME	7416 COLORADO AVENUE NORTH BROOKLYN CENTER, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 67 a large portion or all of the residents). The findings include: During the entrance conference on October 12, 2026, at 12:03 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to the residents at the facility. The licensee's Discharge Resident/ Client Roster dated April 1, 2026, through October 12, 2026, indicated R1 discharged on October 11, 2026. R1's Medications- Current form dated October 11, 2026, indicated by handwriting in the right-hand margin, R1's medications were provided to R1 at discharge. The quantity of each medication provided to R1 at discharge was also handwritten next to the corresponding medication. R1's medication disposition record lacked a prescription number for all discharge medications. On October 13, 2026, at 3:21 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they completed medication disposition documentation when medications were destroyed. LALD/CNS-A further stated she was not aware of the requirement to include the prescription numbers as part of the documentation of disposition of medication. The licensee's Disposition and Disposal of Medications policy dated February 17, 2022, indicated upon disposition of medication, the licensee documented the follo9wing information in the clinical record: name, strength and	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35729	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME	7416 COLORADO AVENUE NORTH BROOKLYN CENTER, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 68 prescription number of the medication, quantity, method of disposition or to whom the medications were given, date of disposition, and the name and signature of employees who were involved in the medication disposition process. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded treatment orders were maintained for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35729	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME	7416 COLORADO AVENUE NORTH BROOKLYN CENTER, MN 55443

(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
01970	Continued From page 69 The findings include: R2 was admitted to the licensee and began receiving services on March 21, 2023. R2 had diagnoses to include post traumatic seizures. R2's signed Service Plan dated March 23, 2023, indicated R2 received services to include activity assistance, bathing, deep room cleaning, dressing, grooming, housekeeping, incontinence care, laundry, linens, behavior management, meals, medication administration, skin care, and toileting. On October 13, 2026, at 7:45 a.m., unlicensed personnel (ULP)-B stated, "I am going to get Chello up but he is getting a shower from James today so he is going to get dressed and put his TEDS on after his shower." R2's signed provider orders dated April 6, 2026, lacked an order for TEDS (compression stockings). On October 13, 2026, at 2:40 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A acknowledged R2 had TEDS and stated, "He has had them since May he just showed up with them one day, he didn't even have an order." Surveyor asked LALD/CNS-A if she ever got an order for the TEDS and she stated, "No, we just made sure to put them on him or offer them, but he refuses often as you can see from his care plan." On October 13, 2026, at 3:03 p.m., licensed assisted living director/clinical nurse supervisor	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35729	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME	7416 COLORADO AVENUE NORTH BROOKLYN CENTER, MN 55443

(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
01970	Continued From page 70 (LALD/CNS)-A stated, "I spoke to the doctor, and he will send over signed orders for the TEDS and I can send it to you by tomorrow." The licensee's Treatment and Therapy Management policy dated February 17, 2022, indicated the RN (registered nurse) obtained order for all treatments or therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

DESTINY HOME
7416 COLORADO AVENUE NORTH
Brooklyn Park, MN 55443
Hennepin County
Parcel:

Phone:

License Info

License: HFID 35729

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1018261182
Inspection Type: Full - Single
Date: 10/12/2026 Time: 8:54:54 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 4
Total Priority 2 Orders: 1
Total Priority 3 Orders: 3
Delivery:

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: Establishment does not currently have a certified food protection manager on site. Discussed this requirement with the manager, and sent CFPM resources with the report.
Comply By: 1/29/2027 Originally Issued On: 10/12/2026

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: Establishment was unable to produce an illness log for recording instances of illness in employees. Discussed requirement and sent illness log and illness reporting information with report.
Comply By: 10/14/2026 Originally Issued On: 10/12/2026

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: Raw shell eggs observed to be stored over ready to eat foods in the refrigerator. Discussed with kitchen staff that raw eggs should be treated like raw chicken, and stored at the bottom of the refrigerator.
Comply By: 10/13/2026 Originally Issued On: 10/12/2026

New Order: 4-200 Equipment Design and Construction
4-201.11GMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: Kitchen staff indicated that the facility saves leftover food items and reheats them for further use. Leftovers also observed in the refrigerator. Discussed with staff that this kitchen is not considered a commercial kitchen, and therefore may NOT save and reheat leftover food items. All food prepared in the facility must be for same-day service.

Leftovers observed in refrigerator during inspection were discarded.
Comply By: 10/13/2026 Originally Issued On: 10/12/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.12A *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.
COMMENT: Establishment does not currently have an appropriate thermometer for assessing food temperatures. Discussed requirement.
Comply By: 10/16/2026 Originally Issued On: 10/12/2026

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-702.11 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
COMMENT: Kitchen staff indicated that some dishes were done in the kitchen sink. Discussed with staff that this is not appropriate as there is not a sanitize step in the process. All dishes must go through the dishwasher and the dishwasher MUST be run on the SANITIZE cycle every time.
Comply By: 10/13/2026 Originally Issued On: 10/12/2026

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-703.11B *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.
COMMENT: Establishment was observed to be running the dishwasher on a regular cycle which does not achieve the appropriate temperature of 160F. Discussed with staff that the dishwasher must be run on the sanitize cycle at all times.
Comply By: 10/13/2026 Originally Issued On: 10/12/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: Kitchen was observed with heavy debris and grease build up on most surfaces, equipment, floors and inside the refrigerator. Discussed with staff to deep clean the kitchen.
Comply By: 10/16/2026 Originally Issued On: 10/12/2026

Food & Beverage General Comment

Inspection conducted with Allison Skillingstad (MDH) present.

Establishment is a residential home with residential equipment.

Sink has two-basins with one used for hand washing and one used for dishwashing (discussed with kitchen staff that this should be for food prep and dishes should go through the dishwasher)

Dishwasher has sanitize function and test strip indicated appropriate temperature was achieved.

Floors are tiled, walls are painted and tiled and ceiling is popcorn.

Cabinets are wood and counter tops are laminate.

Equipment observed in functional condition.

Discussed pest control.

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

I acknowledge receipt of the Metro District Office inspection report number F1018261182 from 10/12/2026

Yemi Rotimi
Manager

Rebecca Prestwood, REHS
Public Health Sanitarian 3
651-201-3777
rebecca.prestwood@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

DESTINY HOME
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1018261182
Inspection Type: Full
Date: 10/12/2026
Time: 8:54:54 AM

Food Temperature: Product/Item/Unit: chicken**; Temperature Process:** Cold-Holding
Location: Refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

DESTINY HOME
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1018261182
Inspection Type: Full
Date: 10/12/2026
Time: 8:54:54 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

DESTINY HOME
7416 COLORADO AVENUE NORTH
Brooklyn Park, MN 55443
Hennepin County
Parcel:

Phone:

License Info

License: HFID 35729

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1018261190
Inspection Type: Follow-up - Single
Date: 10/19/2026 Time: 1:34:10 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 2
Delivery:

Previous Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: Establishment does not currently have a certified food protection manager on site. Discussed this requirement with the manager, and sent CFPM resources with the report.
Comply By: 1/29/2027 Originally Issued On: 10/12/2026

! **Previous Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: REPEAT ORDER 10-19-2026

Establishment was unable to produce an illness log for recording instances of illness in employees. Discussed requirement and sent illness log and illness reporting information with report.
Comply By: 10/14/2026 Originally Issued On: 10/12/2026

Previous Order: 4-200 Equipment Design and Construction
4-201.11GMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: REPEAT ORDER 10-19-2026

Leftovers also observed in the refrigerator. Discussed with staff that this kitchen is not considered a commercial kitchen, and therefore may NOT save and reheat leftover food items. All food prepared in the facility must be for same-day service.

Leftovers observed in refrigerator during inspection were discarded.
Comply By: 10/13/2026 Originally Issued On: 10/12/2026

Previous Order: 4-300 Equipment Numbers and Capacities
4-302.12A *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.
COMMENT: REPEAT ORDER 10-19-2026

Establishment does not currently have an appropriate thermometer for assessing food temperatures. Staff indicated thermometer may have been ordered and is in transit.
Comply By: 10/16/2026 Originally Issued On: 10/12/2026

Food & Beverage General Comment

Follow up inspection completed in order to assess compliance with orders initially issued on 10-12-2026.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1018261190 from 10/19/2026

Yemi Rotimi
Kitchen Manager

Rebecca Prestwood

Rebecca Prestwood, REHS
Public Health Sanitarian 3
651-201-3777
rebecca.prestwood@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

DESTINY HOME
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1018261190
Inspection Type: Follow-up
Date: 10/19/2026
Time: 1:34:10 PM

Food Temperature: Product/Item/Unit: chicken**; Temperature Process:** Cold-Holding
Location: Refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

DESTINY HOME
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1018261190
Inspection Type: Follow-up
Date: 10/19/2026
Time: 1:34:10 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL35729016	**Date:** 10/13/2026
Facility Name: Destiny Home	
Facility Address: 7416 Colorado Avenue North Brooklyn Park, MN 55443	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Two (2) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments: The residents had a designated smoking area in front of the house. There was a cigarette disposal receptacle provided at this location. Cigarette butts were found on walkway and all over the ground by the house. There was evidence of burn marks on the wooden boards.

3. Where smoking is permitted, suitable noncombustible ash trays or match receivers shall be provided on each table and at other appropriate locations. [Minn. Stat. 144G.45 subd. 2; MSFC 310.6]

   Comments: There was a disposal receptacle provided but the residents were using plastic pail instead.

4. Door handles, pulls, latches, locks and other operating devices shall be installed 34 inches (864 mm) minimum and 48 inches (1219 mm) maximum above the finished floor. Locks used only for security purposes and not used for normal operation are permitted at any height. {Minn. Stat. 144G.45 subd. 2; MSFC 1010.9.2]

   Comments: The night latch that was installed on the front door of the facility was installed 64 inches above the finished floor.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments: The smoke alarms in the two bedrooms in the basement were not interconnected with the rest of the smoke alarms in the house.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

   Comments: The fire extinguisher was sitting on the kitchen countertop and not properly mounted on the wall. The monthly checks by the staff were not being done as required.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are 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. [Minn. Stat. 144G.45 subd.2]

   Comments: Bathroom vent in the upstairs bathroom was full of dust and lint. The toilet cover did not fit properly on the toilet tank. The main floor in the hallway had some vinyl flooring missing.
   Deck finishes were coming off the deck in the backyard.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Two (2) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated that they had a fire safety and evacuation plan for employee actions to be taken in the event of a fire or similar emergency but were unable to provide it during the survey.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: LALD/CNS-A stated that they had a fire safety and evacuation plan for resident's actions to be taken in the event of a fire or similar emergency but was unable to provide it during the survey.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include 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. [Minn. Stat. 144G.45 subd.2]

   Comments: LALD/CNS-A stated that they have a fire safety and evacuation plan that include procedures for resident movement, evacuation, or relocation to be taken in the event of a fire or similar emergency but was unable to provide it during the survey.

4. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: LALD/CNS-A stated that residents received training on the proper actions to take in the event of a fire evacuation but were unable to provide the documentation at the time of the survey.

5. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: LALD/CNS-A stated that evacuation drills were being done every month but were unable to provide documentation at the time of survey.