Electronically Delivered

October 29, 2026

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

RE: Project Number(s) SL27249016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 24, 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.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27249	A. BUILDING: _____ B. WING _____	09/24/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDERS In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL27249016-0 On September 21, 2026, through September 24, 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 four (4) residents; four residents 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.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed in the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: LALD-A was hired December 31, 2013, and began providing assisted living services for the licensee on August 1, 2021. On September 21, 2026, at 11:05 a.m., the Minnesota BELTSS website indicated LALD-A currently held an assisted living director license, effective May 6, 2026; however, LALD-A was not identified as the Director of Record for the licensee.	0 110		

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0 110	Continued From page 2 On September 21, 2026, at 11:10 a.m., LALD-A stated via telephone conversation, she completed the application to be listed as the LALD for the licensee; however, was not aware she was not listed as Director of Record for the licensee. LALD-A further started she would register with BELTSS as Director of Record for the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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 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	0 480		

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0 480	Continued From page 3 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 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	0 480		

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0 480	Continued From page 4 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 22, 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		
0 660 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 technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	0 660		

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0 660	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include baseline TB screening that included a two-step tuberculin skin test (TST) or other evidence of TB testing such as IGRA (Interferon Gamma Release Assay, a blood test) for one of three employees (registered nurse (RN)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee's Facility TB Risk Assessment dated January 21, 2026, indicated the facility was a low TB risk setting. RN-C was hired on January 27, 2026, and provided direct care and services to assisted living residents. Resident records indicated RN-C conducted face-to-face assessments for R1 on February 27, 2026, May 26, 2026, and August 21, 2026. RN-C's personnel record included a TB history and symptom screen dated January 5, 2026, and a negative first-step TST dated January 7, 2026.	0 660		

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0 660	Continued From page 6 RN-C's personnel record lacked documentation of a second step TST or a serum (blood test). On September 24, 2026, at 11:00 a.m., LALD-A stated RN-C's personnel record lacked a second TST, or blood test. LALD-A stated she was aware a second step TST was required but did not ensure RN-C completed the second step process for TB screening. On September 15, 2026, at 12:44 p.m., licensed assisted living director (LALD)-A stated licensee thought the requirement was that if an employee was born in the United States, they were only required to receive one TST. Furthermore, LALD-A stated the clinic where ULP-D received her first TST did not inform her that she would need to repeat the TST in 1-3 weeks after the first TST was negative. In addition, LALD-A stated he was unaware of the TST requirements. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines indicated, Baseline TB screening consists of three components: 1. Assessing current symptoms of active TB disease; 2. Assessing TB history; and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. In addition, "An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the	0 660		

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0 660	Continued From page 7 healthcare worker (HCW) starts working with patients." The guidance further indicated HCW's with a verbal (undocumented) history of a previous positive TB test should undergo the same screening procedures as HCWs without previous positive results. The MDH Assisted Living Resources and Frequently Asked Questions website updated April 16, 2026, included under Tuberculosis Screening, "Each facility must establish and maintain a comprehensive TB infection control program according to the most current tuberculosis infection control guidelines issued by the United States 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 licensee's undated Tuberculosis Screening policy indicated [licensee] would 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 (MMWR). Furthermore, that staff whose essential job functions require work within the same air space of home care clients would be screened and tested for tuberculosis prior to the staff being exposed to clients. In addition, screening would be conducted as follows: 1. New staff would be screened to active TB using the Baseline TB Screening Tool for Health Care Workers (HCW).	0 660		

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0 660	Continued From page 8 2. New staff would have an IGRA (blood test) or a two-step Mantoux/TST (skin test) conducted with results documented on the Baseline TB Screening Tool for HCW's. 3. No staff would be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux were read and documented, or a negative IGRA blood test result was received and documented. 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. (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	0 680		

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0 680	Continued From page 9 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 (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's emergency preparedness plan dated January 23, 2024, lacked the following required content: - EP plan reviewed and updated at least annually; - documented quarterly review of missing resident plan; - communication plan containing all required elements; - site specific emergency prep training upon hire and annually; and - annual testing to include either two community-based exercises, one community based and one tabletop exercise, and an after-action analysis, and plan revision based on	0 680		

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0 680	Continued From page 10 the after-action analysis. On September 21, 2026, at 1:50 p.m., housing manager (HM)-G stated licensee lacked the required content noted above. HM-G further stated licensee was unaware of all the requirements for an emergency preparedness plan and Appendix Z. The licensee's undated Emergency Preparedness policy indicated the licensee would have in place a general emergency preparedness plan, that was in alignment with facility's requirement to also comply with CMS Appendix Z. Furthermore, the emergency disaster plan would contain a plan for evacuation, address elements of sheltering in place, identify temporary relocation sites, and detail staff assignments in the event of a disaster or emergency. In addition, the licensee would provide emergency and disaster training to all staff during initial staff orientation and on an annual basis, licensee would make available training regarding emergency and disaster response to all residents of the facility. 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. No further information was provided.	0 680		

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0 680	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=A	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 one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 12 (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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27249	A. BUILDING: _____ B. WING _____	09/24/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810 SS=C	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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 810		

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0 810	Continued From page 14 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 one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01620 SS=D	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	01620		

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01620	Continued From page 15 the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the 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 interview, and record review, the	01620		

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01620	Continued From page 16 licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the previous reassessment, 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 safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4 was admitted to the facility on January 21, 2022, and began receiving assisted living services. R4's Service Plan dated January 2, 2024, indicated R4 received services including assistance with dressing, grooming, oral hygiene, hair care, bathing, medication reminders/setup/administration, nursing assessments, preparing modified diets, laundry, housekeeping, and behavior management. R4's record included a 90-day RN reassessment completed on February 24, 2026, and a subsequent 90-day RN reassessment completed on May 26, 2026, greater than 90 calendar days (91 days) after the previous reassessment. The record also included a 90-day RN reassessment completed on August 31, 2026, greater than 90 calendar days (97 days) after the previous reassessment. On September 23, 2026, at 2:24 p.m., licensed	01620		

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01620	Continued From page 17 assisted living director (LALD)-A stated via email, R4's reassessments had not been completed timely. LALD-A further stated R4's late assessments were most likely due to the transition from our previous clinical nurse supervisor (CNS) to licensee's current CNS. The licensee's undated Assessments policy indicated ongoing resident reassessment and monitoring would be conducted as needed based on changes in the needs of the resident and would not exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure prescription medications were stored according to the manufacturer's directions for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01880		

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01880	Continued From page 18 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 facility on December 28, 2006, and began receiving assisted living services under the licensee's assisted living license on August 1, 2021. R2's Service Plan dated January 2, 2024, indicated services included assistance with dressing, grooming, oral hygiene, hair care, bathing, medication reminders/setup/administration, nursing assessments, preparing modified diets, blood sugar monitoring, laundry, housekeeping, and behavior management. R2's Medication Administration Record (MAR), dated September 19, 2026, through September 25, 2026, indicated R2 received NovoLog® insulin (a fast-acting insulin), 5 units subcutaneous (SQ-under the skin), at 8:00 a.m., with lunch, and at 6:00 p.m., and LANTUS insulin (a long-acting insulin), 40 units SQ every evening via prefilled syringe. On September 21, 2026, at 12:40 p.m., the surveyor observed unlicensed personnel (ULP)-E assist R2 with insulin administration. On September 22, 2026, at 10:39 a.m., the surveyor observed the facility medication refrigerator. The following medications, belonging to R2, were in the refrigerator: -NovoLog® insulin- ½ vial and several prefilled	01880		

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01880	Continued From page 19 syringes of varying units; and -Lantus insulin- 1/2 vial and six (6) prefilled syringes of 40 units. Licensee's "Temperature Record" dated September 2026 indicated temperature readings for the medication refrigerator ranged from 37° fahrenheit (F) and 42°F on September 1, 3, 5, 7, 10, 13, 14, 17, 19, and 21, 2026. The temperature record lacked temperature readings on September 2, 4, 6, 8, 9, 11, 12, 15, 16, 18, and 20, 2026. The NovoLog® manufacturer instructions dated May 2026, indicated NovoLog® pens and vials would be stored in the refrigerator at 36°F to 46°F until expiration. The Lantus manufacturer instructions dated May 2025, indicated the following: - store unused Lantus vials in the refrigerator from 36°F to 46°F, (2°C to 8°C); - do not freeze; - keep away from direct heat and light; - and if a vial has been frozen or overheated, throw it away. On September 22, 2026, at 10:56 a.m., licensed practical nurse (LPN)-D stated she only checks the licensee's medication refrigerator temperature on Mondays and Thursdays, when she comes into the facility. LPN-D further stated she was aware that the medication refrigerator should be checked daily; however, she discards all unused prefilled syringes every 28 days and would open a new insulin vial at that time. The licensee's undated Medication Storage policy indicated medications will be stored consistent with manufacturer's recommendations	01880		

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01880	Continued From page 20 (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medication was labeled with the resident name and prescription information, and that time sensitive medication was labeled with an opened date to indicate when it was first used and would expire for one of two residents (R3) with insulin administration. 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). R3 was admitted to the facility on April 9, 2011,	01890		

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01890	Continued From page 21 and began receiving assisted living services under the licensee's assisted living license on August 1, 2021. R3's Service Plan dated January 2, 2024, indicated services included assistance with dressing, grooming, oral hygiene, hair care, bathing, medication reminders/setup/administration, nursing assessments, preparing modified diets, blood sugar monitoring, laundry, housekeeping, and behavior management. R3's Medication Orders effective July 1, 2026, through December 30, 2026, indicated R3 was prescribed LANTUS SoloSTAR insulin (a long-acting insulin) 100 Unit/milliliter (ml), inject 10 units, subcutaneous (under the skin) every morning. On September 22, 2026, at 9:45 a.m., the surveyor observed unlicensed personnel (ULP)-E assist R3 with insulin administration. After administering the insulin, ULP-E handed the insulin pen to the surveyor. Surveyor observed that the Lantus SoloSTAR flex pen, which was a time sensitive medication, was not labeled with R3's name, and had not been dated with a date opened date. R3's Individualized Medication Management Plan dated January 2, 2024, indicated all R3's medications and supplies needed to administer his medications would be labeled with his name and stored per manufacturer's instructions. On September 22, 2026, at 9:55 a.m., licensed practical nurse (LPN)-D stated R3's Lantus Flexpen was not labeled with R3's name and did not indicate what date the Lantus Flexpen had	01890		

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01890	Continued From page 22 been opened. LPN-D further stated it must have been an oversite on their part and would ensure to reeducate staff on the information required to be on an insulin pen after first use. The manufacturer's instructions for Lantus SoloSTAR flex pen dated December 1, 2021, indicated that the flex pen was to be discarded 28 days after opening, even if it still had insulin left in it. The licensee's undated Insulin policy indicated only properly trained staff of [licensee] would provide medication assistance or administration, ULP's would be trained, and competency tested by a registered nurse (RN), with documentation on file, and insulin medications would be administered according to the prescribers' orders. Furthermore, staff would compare the information from the medication administration record (MAR) with the label on the medication container, and the following information would be in all the places: - resident name - name of the medication; - the strength and dosage of the medication; - the route; - the time that the medication is to be given; and - any special instructions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Destiny Home Care Services
9907 WENTWORTH AVENUE SOUTH
Bloomington, MN 55420
Hennepin County
Parcel:

Phone:

License Info

License: HFID 27249

Risk:
License:
Expires on:
CFPM: Ceclilah B. Mwebi
CFPM #: 62634; Exp: 10/18/2028

Inspection Info

Report Number: F8044261362
Inspection Type: Full - Single
Date: 9/22/2026 Time: 9:14:08 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 8
Delivery: Emailed

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: Upstairs refrigerator holding TCS foods above 41 degrees F.

All TCS foods discarded while on site. Refrigerator temperature turned down while on site.
Comply By: 9/22/2026 Originally Issued On: 9/22/2026

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: Leftover TCS foods from 7/21 for residents in upstairs refrigerator.

Leftover foods are not allowed to be served to residents.
Comply By: 9/22/2026 Originally Issued On: 9/22/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: Orignally issued on 8/6/2024.

OBSERVED CHIPPING PAINT ON THE VENT HOOD ABOVE OVEN.

9/22/26: Reissued. Broken drawers, worn gaskets, water leaking, and ice accumulation (in freezer) in upstairs refrigerator.

Refrigerator must be replaced.

Cupboards must be replaced. Contact Michael before cupboard replacement.

Chipping and word laminate counters.
Comply By: 9/28/2026 Originally Issued On: 9/22/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.13 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0745 Microwave ovens shall meet the safety standards specified in 21 CFR 1030.10.
COMMENT: Hole in bottom of microwave.

Staff indicated that unit is broken and not used.
Comply By: 9/22/2026 Originally Issued On: 9/22/2026

New Order: 4-600 Cleaning Equipment and Utensils
4-602.13 *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0855 Clean all non-food-contact surfaces of equipment at a frequency necessary to preclude accumulation of soil residues.
COMMENT: Originally issued on 8/6/2024.

OBSERVED CRUMBS/DUST/DEBRIS THROUGHOUT THE KITCHEN DRAWERS/CABINETS, UNDER THE SINK, AND ABOVE THE FRIDGE.

9/22/26: Reissued. Soiled interior and exterior of kitchen cabinets. Food residues, hypodermic needles, dead insects on bottom of cabinet below kitchen sink.

Soiled radiator in kitchen.

Soiled interior of oven.
Comply By: 9/22/2026 Originally Issued On: 9/22/2026

! **New Order: 5-200B Plumbing: cross connections**
5-203.14C *Priority Level: Priority 1 CFP#: 51*
MN Rule 4626.1085A Provide a reduced pressure zone (RPZ) backflow preventer to protect water distribution lines subject to back pressure, such as the water supply serving a boiler.
COMMENT: No backflow prevention for boiler.

Since this facility houses the public, an RPZ is required.
Comply By: 10/5/2026 Originally Issued On: 9/22/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.12 *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.
COMMENT: No paper towels for upstairs bathroom.
Comply By: 9/22/2026 Originally Issued On: 9/22/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14A *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT: Sign not posted at handwashing sink in upstairs bathroom.
Comply By: 9/22/2026 Originally Issued On: 9/22/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.11 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1515 Maintain the physical facilities in good repair.
COMMENT: Originally issued on 8/6/2024.

LARGE HOLE IN THE WALL UNDERNEATH THE SINK.

9/22/26: Reissued. Stained ceilings in kitchen.

Remove textured ceiling to provide a smooth, easily cleanable surface.
Comply By: 11/22/2026 Originally Issued On: 9/22/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.112 *Priority Level: Priority 3 CFP#: 38*
MN Rule 4626.1570 Remove dead or trapped birds, insects, rodents, and other pests from the premises.
COMMENT: Dead insects at bottom of cabinet below kitchen sink.
Comply By: 9/22/2026 Originally Issued On: 9/22/2026

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: Dust, dirt and debris beneath stove, between stove and cabinet.
Comply By: 9/28/2026 Originally Issued On: 9/22/2026

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Rhonda Makela. Inspection report reviewed on site with Edward Marshall.

Domestic kitchen consists of vinyl flooring, wooden hollow-base cabinets, laminate counters, wallpapered walls, textured ceiling, and domestic equipment.

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 Rochester District Office inspection report number F8044261362 from 9/22/2026

Edward Marshall

Michael DeMars, RS
Public Health Sanitarian 3
michael.demars@state.mn.us

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Establishment Info

Destiny Home Care Services
Bloomington
County/Group: Hennepin County

Inspection Info

Report Number: F8044261362
Inspection Type: Full
Date: 9/22/2026
Time: 9:14:08 AM

Food Temperature: Product/Item/Unit: Milk, rice, baked beans, mixed vegetables**; Temperature Process:** Cold-Holding
Location: Upstairs Refrigerator at 43.0 Degrees F.
Comment:
Violation Issued?: Yes

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Upstairs Refrigerator at 45.0 Degrees F.
Comment:
Violation Issued?: Yes

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Basement Refrigerator at 38.0 Degrees F.
Comment:
Violation Issued?: No

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Establishment Info

Destiny Home Care Services
Bloomington
County/Group: Hennepin County

Inspection Info

Report Number: F8044261362
Inspection Type: Full
Date: 9/22/2026
Time: 9:14:08 AM

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

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL27249016-0	**Date:** 9/22/2026
Facility Name: Desitny Home Care Services	
Facility Address: 9907 Wentworth Ave S, Bloomington, MN 55420	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 1; Isolated **TIME PERIOD OF CORRECTION:** Seven (7) 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. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

   Comments: The exterior of the east egress path was obstructed by vegetation at the bottom of the deck stairs.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Isolated **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: On the east deck there was a board that was rotting through that could cause a falling or tripping hazard.

   The light fixture in the lower-level bathroom was extremely rusted.

DEPARTMENT OF HEALTH

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 1; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans (FSEP) upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: There was no documented staff training in the FSEP and HM-G could not provide documentation when asked.