Electronically Delivered

September 8, 2026

Licensee
Destiny Home Care Services
9725 Oakland Avenue South
Bloomington, MN 55420

RE: Project Number(s) SL31508016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 23, 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 . . ."

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 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

factor.

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

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

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 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
	31508	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	9725 OAKLAND AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL31508016-0 On July 20, 2026, through July 23, 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 3 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 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 (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, interview, and record review, the licensee failed to ensure a staffing plan was developed, potentially affecting all licensee's current 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	0 470		

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0 470	Continued From page 2 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: During facility tour on July 20, 2026, at 10:30 a.m., the surveyor observed a posted staff schedule indicating which staff member was working on each shift. During interview on July 20, 2026, at 11:50 a.m., the surveyor asked licensed assisted living director (LALD)-C if a staffing plan had been developed by the clinical nurse supervisor (CNS). LALD-C stated she knew that the administration made the schedules for staff and believed that the previous CNS had developed a staffing plan for the licensee. LALD-C stated CNS-A had replaced the previous CNS and was in the process of onboarding and completing training with the licensee. LALD-C stated she would need to locate the staffing plan and the licensee's staffing plan policy and would provide to the surveyor as soon as they were located. Prior to exit of the survey, the licensee failed to provide a copy of the staffing plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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	0 480		

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0 480	Continued From page 3 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 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	0 480		

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0 480	Continued From page 4 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 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 July 21, 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	0 480		

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0 480	Continued From page 5 to the FBEIR for any compliance dates.	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management activities relevant to the size and services provided by the assisted living provider. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	0 580		

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0 580	Continued From page 6 The findings include: On July 20, 2026, at 11:00 a.m., during the entrance conference with licensed assisted living director (LALD)-C and house manager (HM)-D, the surveyor requested to review documentation of the licensee's quality management activities. During interview on July 20, 2026, at 12:30 p.m., LALD-C stated they had quality management meetings all the time but lacked documentation of the meeting minutes. On July 20,2026, at 3:02 p.m., LALD-C provided to surveyor via email a copy of the licensee's staff meeting notes dated July 6, 2026. The meeting notes did not include any quality management activities. The staff meeting notes included processes and updates on the licensee's needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 650 SS=F	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;	0 650		

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0 650	Continued From page 7 (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 interview and record review, the licensee failed to ensure the employee record contained the required content for three of three employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-B, 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 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: CNS-A had a hire date of January 14, 2026. CNS-A's employee record lacked documentation of a signed job description. ULP-B had a hire date of August 8, 2025. ULP-B's record lacked any documentation that training and competency testing in delegated	0 650		

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0 650	Continued From page 8 tasks had been completed. ULP-D had a hire date of June 18, 2026. ULP-D's record lacked any documentation of a signed job description. ULP-D's record lacked any documentation that training and competency testing in delegated tasks had been completed. During interview on July 20, 2026, at 12:00 p.m., licensed assisted living director (LALD)-C stated the previous CNS had provided all training and competency testing in delegated tasks to ULP-B at the time of hire. LALD-C stated all staff were trained by the previous CNS and had to return demonstrate competency for delegated tasks. LALD-C acknowledged the previous CNS had passed away, and they were not able to confirm the training for ULP-B. LALD-C stated she would need to look for the documents showing the training and competency had been completed. During interview on July 20, 2026, at 1:20 p.m., CNS-A stated she was not aware that she did not have a signed job description in her employee record. The licensee's undated Delegation of Assisted Living Services policy indicated prior to the delegation, the unlicensed personnel were trained in the proper methods to perform the tasks or procedures for each resident and were able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 650		

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0 660	Continued From page 9	0 660		
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. This MN Requirement is not met as evidenced by: Based on 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), to include completion of TB testing for one of one employee (clinical nurse supervisor (CNS)-A). 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).	0 660		

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0 660	Continued From page 10 The findings include: During the entrance conference on July 20, 2026, at 10:00 a.m. with licensed assisted living director (LALD)-C, a request was made to review the facility's TB risk assessment. LALD-C stated the licensee had completed a facility TB risk assessment but was unsure where to locate it. LALD-C stated the licensee would attempt to find the assessment and provide it to the surveyor. CNS-A was hired on January 14, 2026, to provide direct care to the licensee's residents and supervision to the licensee's staff. CNS-A's Baseline TB Screening Tool for Health Care Workers (HCWs) was dated January 5. 2026. CNS-A's record also included one tuberculin skin test (TST) dated January 7, 2026. The test result indicated 0 millimeters (mm) induration and was negative for TB. CNS-A's employee record lacked a second TST test or a QuantiFERON blood test. During interview on July 20, 2026, at 12:15 p.m., LALD-C stated the licensee was not aware of CNS-A's employee record lacking the documentation of a completed TB testing. At the time of exit on July 20, 2026, at 3:30 p.m., the licensee provided a facility TB risk assessment to the surveyor which was dated January 26, 2026. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July	0 660		

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0 660	Continued From page 11 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. In addition, it noted TST documentation should include the date of the test, the number of millimeters (mm) of induration (if no induration, document "0" mm) and the interpretation (positive or negative). 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	0 680		

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	31508	A. BUILDING: _____ B. WING _____	07/23/2026

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0 680	Continued From page 12 make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete a written emergency disaster plan with all required content and failed to post the emergency plan prominently. This had the potential to affect all current residents receiving services under the assisted living license, staff, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 20, 2026, at 11:15 a.m., during the facility tour, the surveyor observed that the emergency disaster plan was not posted. The licensee's emergency disaster plan that had been reviewed by the licensee on April 23, 2026, lacked evidence of the following required content: - a comprehensive program to include infectious diseases and pandemics;	0 680		

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0 680	Continued From page 13 - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility); - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies; - the facilities role in providing care and treatment at alternative sites; - a communication plan that included: - names and contact information for staff, resident physicians, other facilities; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; -a method of sharing information from the emergency plan with residents and their families; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements.	0 680		

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0 680	Continued From page 14 On July 20, 2026, at 2:00 p.m., house manager (HM)-D acknowledged the licensee was missing required content in the emergency disaster plan and stated he believed licensed assisted living director (LALD)-C was responsible for developing the emergency preparedness plan. 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 additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 resident records	0 720		

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0 720	Continued From page 15 were readily available for timely access to employees, vendors, and the commissioner authorized representative. 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: On July 20, 2026, at 7:00 a.m., the surveyor emailed the licensee the entrance email that indicated resident records must be available for review. On July 20, 2026, at 11:05 a.m., during a telephone entrance conference, licensed assisted living director (LALD)-C stated the licensee was familiar with current minimum assisted living requirements. LALD-C further stated the clinical nurse supervisor and LALD-C both had extenuating circumstances and could not meet the surveyor at the facility. During interview on July 21, 2026, at 11:10 a.m., LALD-C stated all resident and employee records were kept on the computer of CNS-A or would be in the office and at the time did not have access to the records due to both CNS-A and LALD-C having extenuating circumstances that did not allow them to obtain the records when needed. CNS-A explained CNS-E had passed away and the licensee was still dealing with the issue in trying to obtain resident records records that	0 720		

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0 720	Continued From page 16 CNS-E had in their possession before CNS-E passed away. On July 20, 2026, at 11:28 a.m., the surveyor, via email, sent the licensee a list of requested documents, including discharge resident records. On July 20, 2026, at 11:52 a.m., LALD-C, via email, provided the surveyor with some of the requested employee documents. On July 20, 2026, at 1:15 p.m., via email, the surveyor requested additional resident and employee records. On July 20, 2026, at 5:53 p.m., LALD-C responded via email, providing the surveyor with additional employee records that had been requested. On July 21, 2026, at 11:43 a.m., LALD-C responded via email, providing the surveyor with additional records that had been requested. At the time of survey exit on July 23, 2026, at 9:00 a.m., LALD-C had not been able to obtain the requested resident records. The licensee's undated Resident Record - Information and Content policy, indicated the licensee maintains appropriate and accurate records for each resident that is receiving assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 720		

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0 775	Continued From page 17	0 775		
0 775 SS=D	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 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 July 22 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 18 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: 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	0 780		

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0 780	Continued From page 19 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 July 22 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days .	0 780		
0 800 SS=C	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.	0 800		

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0 800	Continued From page 20 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 July 22 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 800		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal	01500		

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01500	Continued From page 21 of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01500		

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01500	Continued From page 22 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each twelve months of employment for one of one employee (unlicensed personnel (ULP)-B). 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-B had a hire date of April 30, 2009. ULP-B's employee records lacked any evidence of annual training for 2024 and 2025 annual education training period. During interview on July 20, 2026, at 1:55 p.m., house manager (HM)-D stated ULP-B had not completed any annual training. HM-D also stated that ULP-B was currently working on his education but did not have any record of ULP-B completing any of the required annual education. The licensee's undated Annual Training policy indicated all direct care employees would complete eight hours of annual education training for twelve months of employment. No further information was provided.	01500		

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01500	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=E	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	01530		

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01530	Continued From page 24 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 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 interview and record review, the licensee failed to ensure employees completed dementia care training and two hours of initial training on mental illness and de-escalation topics as well as 2 hours of annual dementia training and one hour of annual training on mental illness and de-escalation topics for two of two employees (clinical nurse supervisor (CNS)-A), (unlicensed personnel (ULP)-B)). This had the potential to affect all residents and staff. Based on interview and record review, the licensee failed to ensure direct care staff received the required 8 hours of demetnia2 hours of initial training on mental illness and de-escalation topics effective July 1, 2025, for two of two employee (unlicensed personnel (ULP)-B) as well as 2 hours of annual dementia training and one hour of annual training on mental illness and de-escalation topics. This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	01530		

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01530	Continued From page 25 situation has occurred repeatedly; but is not found to be pervasive). The findings include: CNS-A CNS-A was hired on January 14, 2026, and provided direct nursing care and services to residents, and supervision of staff. CNS-A's employee record lacked documentation they completed at least eight hours within 120 working hours of the employment start date and the required two hours of initial training on mental illness and de-escalation topics, effective July 1, 2025. CNS-A employee record also lacked documentation of 2 hours of annual dementia training and one hour of annual training on mental illness and de-escalation topics. ULP-B ULP-B was hired on April 30, 2009, and provided direct care and services to residents. ULP-B's employee record lacked documentation they completed at least eight hours within 120 working hours of the employment start date and the required two hours of initial training on mental illness and de-escalation topics, effective July 1, 2025. ULP-B employee record also lacked documentation of 2 hours of annual dementia training and one hour of annual training on mental illness and de-escalation topics. During interview on July 20, 2026, at 1:50 p.m., house manager (HM)-D confirmed CNS-A and ULP-B's employee records lacked documentation indicating that they had completed two hours of training on mental illness and de-escalation topics and lacked eight hours of dementia training.	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31508	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	9725 OAKLAND AVENUE SOUTH BLOOMINGTON, MN 55420

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01530	Continued From page 26 HM-D stated he believed they had completed the training and would need to obtain their education records and would provide the surveyor as soon as it was found. During interview on July 20, 2026, at 1:55 p.m., ULP-B stated he was in the process of completing his required education and acknowledged he had not completed at least eight hours within 160 working hours of the employment start date. During the course of the survey, the surveyor was unable to reach CNS-A to confirm if they had completed two hours of training on mental illness and de-escalation topics and eight hours of dementia training. HM-D stated CNS-A was dealing with an unforeseen circumstance and was not available. The licensee's undated Dementia Education policy indicated all employees would complete at least eight hours within 160 working hours of employment start date. The policy lacked documentation regarding the required two hours of initial training on mental illness and de-escalation topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each	01650		

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01650	Continued From page 27 service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31508	A. BUILDING: _____ B. WING _____	07/23/2026

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01650	Continued From page 28 a large portion or all of the residents). The findings include: R1 was admitted on May 8, 2026, with diagnoses that included schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania). R1's care plan (used as the service plan) dated May 8, 2026, indicated R1 received assistance with housekeeping, laundry, meals, and medication administration. R1's service plan lacked the following content: - the fees for services - the schedule and methods of monitoring assessment of the resident; - the schedule and methods of monitoring the staff providing services; and - a contingency plan that includes: the action to be taken if the scheduled service cannot be provided; information and a method to contact the facility; the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of an information as to who has authority to sign for the resident in and emergency; and the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On July 20, 2026, at 10:35 a.m., house manager (HM)-D stated R1's service plan did not include the required content as listed above. HM-D	01650		

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	31508	A. BUILDING: _____ B. WING _____	07/23/2026

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01650	Continued From page 29 further stated the same service plan was used for all residents. The licensee's undated Service Plan policy dated March 2026, indicated the service plan would include following: a. a description of the services that are to be provided based on the most recent assessment and resident preferences; b. fees for services to be provided; c. the frequency of each service to be provided based on the most recent assessment and resident preferences; d. an identification of staff or categories of staff who will be providing the services; e. a schedule and method for the next planned assessment or monitoring; f. a schedule and method for the next planned monitoring of staff providing services; and g. a contingency plan that includes: - action's the facility will take if scheduled services cannot be provided; - information regarding how the resident can contact the facility; - the names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition; - identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency; and - how the facility will support documented resident health care directive decisions, if any- including circumstances when emergency medication services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31508	A. BUILDING: _____ B. WING _____	07/23/2026

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01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider had managed for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to licensee on May 8, 2026, with a diagnosis of schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania). R1's assessment dated May 8, 2026, indicated R1 required assistance with medication administration.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01820	Continued From page 31 R1's resident record lacked signed prescriber's orders for medications administered by the licensee or any documentation that faxed medication order forms had been sent to R1's primary physician for signature. On July 20, 2026, at 2:30 p.m., the surveyor attempted to contact clinical nurse supervisor (CNS)-A but was unable to reach them. House manager (HM)-D verified R1's record lacked signed prescriber's orders. HM-C stated that the licensee had faxed the medication order form to R1's primary care provider for signature approximately upon admission but had not received the form back and was still waiting for a response from the provider. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

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 CARE SERVICES
9725 Oakland Ave So
Bloomington, MN 55420
Hennepin County
Parcel:

Phone:

License Info

License: HFID 31508

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

Inspection Info

Report Number: F8041261092
Inspection Type: Full - Single
Date: 7/21/2026 Time: 11:30 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

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: ISSUED 6/20/24 (REPEAT): NO CERTIFIED FOOD PROTECITON MANAGER FOR THIS FACILITY. AMEN TOGERI COMPLETED A FOOD SAFETY COURSE, BUT STILL NEEDS TO APPLY FOR STATE CFPM CERTIFICATE. LINK TO APPLY ONLINE SENT TO OPERATOR.
Comply By: 7/21/2026 Originally Issued On: 7/21/2026

Food & Beverage General Comment

Inspection was completed with Edward Marshall.. Elyse Jones was the HRD nurse evaluator.

Facility has a residential kitchen. Food must be prepared for same day service only. Kitchen has a popcorn ceiling, vinyl flooring, wood cabinets with a hollow base and a laminate countertop.There is a refrigerator located in the basement.

Establishment has a whirlpool dish machine with a sanitize cycle option that achieved a utensil surface temperature of at least 160F.

Discussed the following:
- Employee illness policy and logging requirements
- Reporting foodborne illness complaints to the health dept.
- Handwashing
- Date marking
- Glove-use and bare hand contact
- Proper food storage
-Vomit clean-up procedures
- Restrictions concerning serving a highly susceptible population

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 F8041261092 from 7/21/2026

Edward Marshall
Manager

Sarah Conboy,
Public Health Sanitarian Supervisor
651-201-3984
sarah.conboy@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 CARE SERVICES
Bloomington
County/Group: Hennepin County

Inspection Info

Report Number: F8041261092
Inspection Type: Full
Date: 7/21/2026
Time: 11:30 AM

Food Temperature: Product/Item/Unit: turkey**; Temperature Process:** Cold-Holding
Location: kitchen refrigerator at 41 Degrees F.
Comment:
Violation Issued?: No

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

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL31508016-0	**Date:** 7/22/2026
Facility Name: Destiny Home Care Services	
Facility Address: 9725 Oakland Ave S, Bloomington, MN 55420	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; 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. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

   Comments: In resident room 4 there were multiple relocatable power taps and multiplug adapters daisy chained together near the window.

☒ **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 outside and inside of resident room 4 were not interconnected with the rest of the smoke alarms in the facility.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 1; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) 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: The stairs leading to the lower level were heavily soiled.

The gutters around the entire facility are full of debris and have vegetation growing from them.

The north side yard had a large pile of dirt, concrete and an old broken window and multiple refuse items.

On the NW and NE corners of the facility there were holes in the siding with signs of wildlife living in them.