Electronically Delivered

August 21, 2025

Licensee
Serenity Living Care Inc
2300 Carver Avenue East
Maplewood, MN 55119

RE: Project Number(s) SL38782016

Dear Licensee:

On July 8, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on April 23, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the April 23, 2025 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on April 23, 2025, found not corrected at the time of the July 8, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0650-Staff Records-144g.42 Subd. 8 (a) - $500.00
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $500.00

The details of the violations noted at the time of this follow-up survey completed on July 8, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on July 8, 2025, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - $500.00

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. 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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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 addtion to any enforcement mechanism authorized in § 144G.20.

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.

We urge you to review these orders carefully. If you have questions, please contact Renee L. Anderson at 651-201-5871.

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

Sincerely,

Renee.L.Anderson@state.mn.us , Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 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
	38782	A. BUILDING: _____ B. WING _____	R 07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING CARE INC	2300 CARVER AVENUE EAST MAPLEWOOD, MN 55119

(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL38782016-1 On July 7, 2025, through July 8, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on April 23, 2025. At the time of the survey, there were three residents; three receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were issued and/or reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to record actions taken to comply with all correction orders from a survey completed April 23, 2025. The lack of action to ensure compliance with regulations 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) and was issued at a widespread scope (when problems are pervasive	0 340		

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0 340	Continued From page 2 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The result of the licensee's previous survey, concluded on April 23, 2025, was sent to the licensee via email on June 3, 2025. The communication indicated the licensee was granted an assisted living license. The longest time period for correction (the time frame in which the licensee must document and correct orders) was 21 days from the date the licensee received their results, or June 24, 2025. On Monday July 7, 2025, at 7:09 p.m., licensed assisted living director (LALD)-A provided, via email, the licensee's plans of correction (POC) from the survey concluded April 23, 2025. The licensee's undated POC from survey concluded April 23, 2025, lacked a documented plan of correction for the following orders: -0650, 144G.42 Subd. 8. (a) Staff records; and -0680, 144G.42 Subd. 10. Disaster planning and emergency preparedness plan. The licensee remained out of compliance with the above-listed statutes, and correction orders were reissued as a result of the current survey, ending July 8, 2025. On July 8, 2025, at 1:35 p.m., LALD-A stated he completed annual performance reviews on July 7, 2025, during the survey with all the licensee's employees. LALD-A stated he planned to complete annual performance reviews for all employees annually. Education and resources were provided to LALD-A on the plan of	0 340		

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0 340	Continued From page 3 correction components required. The Minnesota Department of Health (MDH) Correction Order Documentation Guidelines, dated January 3, 2023, indicated, correction order documentation should include the following: -identify how each order was corrected related to each individual client(s)/employee(s) identified in the order; -identify how each order was corrected for all the provider's clients/employees identified in the order; and -identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute. Include information about how the provider will maintain compliance in the future. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{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	{0 480}		

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{0 480}	Continued From page 4 supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.	{0 480}		

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{0 480}	Continued From page 5 This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this follow up survey.	
{0 650} SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the employee record contained the required content for two of two employees (clinical nurse supervisor (CNS)-B, and unlicensed personnel (ULP)-C).	{0 650}		

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{0 650}	Continued From page 6 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: CNS-B and ULP-C were hired to provide assisted living cares and services on April 9, 2021, and February 22, 2023, respectively. CNS-B and ULP-C's employee records lacked documentation of an annual performance review that identified areas of improvement needed and training needs. On July 7, 2025, at 11:11 a.m., licensed assisted living director (LALD)-A stated he did not have an annual performance review completed yet for CNS-B and ULP-C. LALD-A further stated he had not completed any annual performance reviews for the licensee's employees. On July 7, 2025, at 7:09 p.m., LALD-A provided, via email, annual performance reviews for CNS-B and ULP-C, that were completed after the start of the survey. The licensee's Performance Evaluation policy, dated December 15, 2023, indicated, "All paid employees, individual contractors and regularly scheduled volunteers providing assisted living services will participate in an annual performance evaluation. The purpose of the evaluation is to	{0 650}		

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{0 650}	Continued From page 7 measure job performance and assist the employee and supervisor to build on the strengths of the employee and identify those areas needing improvement." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{0 650}		
{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 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.	{0 680}		

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{0 680}	Continued From page 8 This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP, last reviewed April 25, 2025, lacked evidence of the following required content: -documentation of two emergency preparedness exercises (an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise). On July 7, 2025, at 11:48 a.m., licensed assisted living director (LALD)-A stated he had not yet reviewed the missing required contents of the licensee's emergency disaster preparedness plan. The surveyor referred to the licensee's policies, Minnesota Department of Health (MDH) Assisted Living website, and Minnesota (MN) Health Care Coalition website for information may be helpful to licensee regarding the requirements for the facility annual full-scale exercise or	{0 680}		

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{0 680}	Continued From page 9 individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise. LALD-A verbalized he had reached out to a consultant, and he verbalized they were not familiar with the information he was requesting. LALD-A stated he planned to complete the missing required EPP content. The licensee's Emergency Preparedness policy dated December 15, 2023, and referenced Centers for Medicare and Medicaid Services (CMS) State Operations Manual Appendix Z; MN Rules 4659.0100, indicated the licensee would have a plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The EPP plan would be reviewed and updated at least annually. In addition, a disaster drill would be documented and conducted at the residence at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{0 680}		
{0 775} SS=F	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:	{0 775}	Not reviewed during this follow up survey.	

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{0 780}	Continued From page 10	{0 780}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	{0 780}	Not reviewed during this follow up survey.	
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	{0 800}		

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{0 800}	Continued From page 11 (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:	{0 800}	Not reviewed during this follow up survey.	
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The 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	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38782	A. BUILDING: _____ B. WING _____	R 07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING CARE INC	2300 CARVER AVENUE EAST MAPLEWOOD, MN 55119

(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}	Continued From page 12 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:	{0 810}	Not reviewed during this follow up survey.	

Electronically Delivered

June 3, 2025

Licensee
Serenity Living Care Inc.
2300 Carver Avenue East
Maplewood, MN 55119

RE: Project Number(s) SL38782016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 23, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring - $3,000.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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
	38782	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING CARE INC	2300 CARVER AVENUE EAST MAPLEWOOD, MN 55119

(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 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: SL38782016-0 On April 21, 2025, through April 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents; three 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (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 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	0 480		

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0 480	Continued From page 2 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 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 April 21, 2025, 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 3 to the FBEIR for any compliance dates.	0 480		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter	0 620		

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0 620	Continued From page 4 knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report an incident of suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	0 620		

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0 620	Continued From page 5 situation has occurred only occasionally). The findings include: R2's diagnoses included bipolar disorder (mental health disease), chronic respiratory failure with hypoxia (low oxygen), type two diabetes, cirrhosis (permanent scarring) of the liver, and paranoid psychosis (paranoid beliefs with delusions and or hallucinations). R2's unsigned Service Plan - Modification dated April 22, 2025, indicated R2 received services including assistance with housekeeping, laundry, meals, dressing, grooming, behavior management, compression socks, blood glucose testing, oxygen delivery, and medication administration. An incident report dated August 31, 2024, at 7:05 p.m., indicated there was a fire in R2's bedroom. In addition, included, "1. Staff heard smoke alarms going on and resident calling for help. Staff ran down and found resident in living room area with smoke coming from resident's bedroom. Staff saw fire on resident's bed. 2. Staff heard smoke alarms going on and resident calling for help. Staff ran down and found resident in living room area with smoke coming from resident's bedroom. Staff saw fire on resident's bed. Staff immediately went into action and was able to put fire out. Staff saw cigarette butt [on] her bed. Resident stated that her oxygen tube caught fire while smoking in her bedroom. The fire damaged her bed, mattress, bedsheets and carpet that was on the floor. Director was notified immediately. Director came on site to help with cleaning, organizing the bedroom and talked to other residents about the incident. Director called Adapt Health (oxygen machine company) to	0 620		

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0 620	Continued From page 6 come make sure oxygen machine was functioning properly as the tubes were burnt." Finally, indicated, "This fire incident was caused by resident smoking in bedroom against facility rules. Facility has replaced bed, mattress, oxygen tubes and other items needed to ensure resident's wellbeing. Facility will be working with resident's team to explore options for safe smoking for resident." On April 22, 2025, at 11:16 a.m., licensed assisted living director (LALD)-A stated he was not aware he should have filed a MAARC report. Education provided to LALD-A on MAARC reporting requirements. On April 22, 2025, at 1:04 p.m., LALD-A verbalized he was feeling overwhelmed with the survey process and requested the surveyor assist the licensee to file a MAARC report for the fire incident dated August 31, 2024, on the licensee's behalf. On April 23, 2025, at 8:18 a.m., a MAARC report numbered 1000224874 was submitted by the surveyor on behalf of the licensee. On April 23, 2025, at 11:00 a.m., during the exit conference, LALD-A was updated on the MAARC report filed and provided the MAARC report number. The licensee's Vulnerable Adult policy, dated December 15, 2023, indicated, "5. f. When abuse or neglect directed toward a vulnerable adult is discovered, the employee is to report the incident in the following manner: 1) Internal Reporting: -The employee may make an oral report immediately by phone or otherwise to the Director	0 620		

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0 620	Continued From page 7 or Clinical Nurse Supervisor (see also number 2 below). -The employee shall be instructed to complete a written report of the abuse and/or neglect within 24 hours. -The Clinical Nurse Supervisor or Director will review the situation and investigate to determine if this is a reportable incident, and if so, the information will then be reported/submitted to the MAARC immediately or as soon as possible. -A copy of the report will be sent to the MARCC, and a copy will be retained in the clinical record. 2) External Reporting: Any employee may report directly to the MAARC if he/she does not want to report internally. The external report shall be completed/submitted immediately or as soon as possible. The oral report must be followed by a written report. A copy of the written report will be given to the Director. [Licensee] will not retaliate against any employee who reports externally." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the	0 630		

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0 630	Continued From page 8 abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop and implement an up-to-date individual abuse prevention plan (IAPP) to include individualized interventions of the specific measures to be taken to minimize the risk of abuse, for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included bipolar disorder (mental health disease), chronic respiratory failure with hypoxia (low oxygen), type two diabetes, cirrhosis (permanent scarring) of the liver, and paranoid psychosis (paranoid beliefs with delusions and or hallucinations). R2 unsigned Service Plan - Modification printed April 22, 2025, indicated R2 received services including housekeeping, laundry, meals, dressing, grooming, behavior management, compression socks, blood glucose testing, oxygen delivery, and medication administration. An incident report dated August 31, 2024, at 7:05 p.m., indicated there was a fire in R2's bedroom.	0 630		

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0 630	Continued From page 9 In addition, included, "1. Staff heard smoke alarms going on and resident calling for help. Staff ran down and found resident in living room area with smoke coming from resident's bedroom. Staff saw fire on resident's bed. 2. Staff heard smoke alarms going on and resident calling for help. Staff ran down and found resident in living room area with smoke coming from resident's bedroom. Staff saw fire on resident's bed. Staff immediately went into action and was able to put fire out. Staff saw cigarette butt her bed. Resident stated that her oxygen tube caught fire while smoking in her bedroom. The fire damaged her bed, mattress, bedsheets and carpet that was on the floor. Director was notified immediately. Director came on site to help with cleaning, organizing the bedroom and talked to other residents about the incident. Director called Adapt Health (oxygen machine company) to come make sure oxygen machine was functioning properly as the tubes were burnt." Finally, indicated, "This fire incident was caused by resident smoking in bedroom against facility rules. Facility has replaced bed, mattress, oxygen tubes and other items needed to ensure resident's wellbeing. Facility will be working with resident's team to explore options for safe smoking for resident." R2's medical record included a nursing assessment dated February 4, 2024, which indicated under Respiratory Equipment, R2 "uses oxygen machine. Need verbal reminder to use oxygen machine." In addition, under the Safety category with Safe Smoking included, "Does the resident handle the lit cigarette responsibly? Yes." R2's Individual Abuse Prevention Plan, dated February 4, 2024, listed multiple areas of vulnerabilities which included: risk of; self-harm,	0 630		

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0 630	Continued From page 10 impaired judgement, alcohol, chemical, and/or other medication abuse; finances and abusing other vulnerable adults. R2's medical record lacked an updated assessment or IAPP completed since the fire incident in R2's bedroom on August 31, 2024. On April 23, 2025, at 8:42 a.m., clinical nurse supervisor (CNS)-B stated, via phone, she has been unable to get R2 to cooperate or communicate with the nurse to complete a nursing assessment or update R2's IAPP. CNS-B was aware R2's most current nursing assessment and IAPP had not been completed since February 4, 2024. Also, CNS-B stated R2's mental health challenges and R2's delusional thoughts interfere with the nurse's ability to complete the assessments. CNS-B verbalized she would plan to follow up with R2's medical provider and mental health provider and planned to ensure the nurses assessments and IAPP's were updated and completed timely. The licensee's Vulnerable Adult policy, dated December 15, 2023, indicated, "In compliance with Minnesota Statutes, all [Licensee] employees are required to individually assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse to that resident. In addition, all employees providing assisted living are mandated to report abuse and/or neglect (including suspected abuse or neglect) of the vulnerable adult according to this policy." In addition, included, "d. An individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living services are provided. 1) The plan shall contain an individualized	0 630		

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0 630	Continued From page 11 assessment of the resident' susceptibility to abuse by another individual, including other vulnerable adults 2) The plan shall contain the resident's risk of abusing other vulnerable adults 3) The plan shall contain statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. 4) The plan will be implemented immediately and evaluated at each supervisory visit or more frequently, if necessary. 5) Documentation will include results of the implementation." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs;	0 650		

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0 650	Continued From page 12 (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 two of two employees (clinical nurse supervisor (CNS)-B, and unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: CNS-B and ULP-C were hired to provide assisted living cares and services on April 9, 2021, and February 22, 2023, respectively. CNS-B and ULP-C's employee records lacked documentation of an annual performance review that identified areas of improvement needed and training needs. On April 21, 2025, at 2:18 p.m., licensed assisted living director (LALD)-A stated he did not have an annual performance review for CNS-B and ULP-C. LALD-A verbalized he had not completed	0 650		

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0 650	Continued From page 13 annual performance reviews for the licensee's employees. The licensee's Performance Evaluation policy, dated December 15, 2023, indicated, "All paid employees, individual contractors and regularly scheduled volunteers providing assisted living services will participate in an annual performance evaluation. The purpose of the evaluation is to measure job performance and assist the employee and supervisor to build on the strengths of the employee and identify those areas needing improvement." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	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 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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-C was hired on February 22, 2023, and provided direct cares to the licensee's residents. ULP-C's employee record included a TB history and symptom screening form dated March 2, 2023, indicating no previous adverse reaction to a tuberculin skin test (TST). The record included a negative first step TST dated March 31, 2023. ULP-C's record lacked documentation of a second step TST. On April 21, 2025, at 10:37 a.m., the surveyor observed ULP-C assist R2 with blood glucose testing. On April 21, 2025, at 2:32 p.m., licensed assisted living director (LALD)-A and ULP-C stated they were not aware a two-step TST was required.	0 660		

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0 660	Continued From page 15 LALD-A and ULP-C verbalized there was not a second step completed for ULP-C. The surveyor provided education to the licensee on the TB regulations per licensee's request. The licensee's Tuberculosis Screening / Prevention policy dated December 15, 2023, indicated the licensee would observe the recommended precautions related to TB prevention as identified by the CDC and the Minnesota Department of Health (MDH). The precautions include the following elements: -Risk Assessment; -TB Screening; and -Staff Education. The 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 for 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 [blood test]." 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	0 680		

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0 680	Continued From page 16 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 received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to have a written emergency preparedness plan 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 680		

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0 680	Continued From page 17 The findings include: The licensee's undated EPP lacked evidence of the following required content: - annual review of the EPP; - quarterly review of missing resident policy; - process for emergency preparedness (EP) collaboration; - subsistence needs for staff and residents; - policies and procedures for sheltering in place; - policies and procedures for medical documents; - policies and procedures for volunteers; - roles under wavier declared by secretary; - emergency officials contact information; - methods for sharing information; - long term care family notifications; and - emergency prep testing to include a disaster drill. On April 23, 2025, at 10:03 a.m., licensed assisted living director (LALD)-A stated the documents provided to surveyor were the complete emergency disaster preparedness plan. The surveyor referred to the licensee's policies and LALD-A verbalized he had not completed all of the components of the EPP yet but planned on ensuring this was completed. The licensee's Emergency Preparedness policy dated December 15, 2023, and referenced Centers for Medicare and Medicaid Services (CMS) State Operations Manual Appendix Z; MN Rules 4659.0100, indicated the licensee would have a plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The EP plan would be reviewed and updated at least annually. In addition, a disaster drill would be documented and conducted at the residence	0 680		

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0 680	Continued From page 18 at least annually. The licensee's Missing Resident policy dated December 15, 2023, indicated, "The missing resident procedure will be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. Changes to the plan will be documented." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	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 comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 775		

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0 775	Continued From page 19 The findings include: On April 22, 2025, from 10:00 a.m. to 11:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. The following was observed. During the tour the surveyor observed fire damage on the floor next to the bed in resident room 4. LALD-A stated that the fire damage was caused by resident smoking with oxygen while in bed. LALD-A stated that the fire department was not notified because the fire was extinguished by staff. LALD-A provided the facility incident report dated August 31, 2024 - 7:05 p.m. The report lacked any indication that the fire department was notified of the fire. In the event an unwanted fire occurs on a property, the owner or occupant shall immediately report such condition to the fire department. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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	0 780		

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0 780	Continued From page 20 required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 22, 2025, from 10:00 a.m. to 11:00 a.m., on a facility tour with licensed assisted living director (LALD)-A, the following was observed: There was a hardwired smoke alarm missing in	0 780		

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0 780	Continued From page 21 resident room #3. There was a battery powered interconnected smoke alarm installed in the same room. Smoke alarms are required to be maintained as hardwired (receiving power from the building electrical system) as installed at the time of construction in accordance with current Minnesota State Fire Code. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 800		

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0 800	Continued From page 22 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 April 22, 2025, from 10:00 a.m. to 11:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. The following was observed. In resident room 4 there were burn marks in the carpet. LALD-A verbally confirmed the burn marks in the carpeting and stated that they would take care of it. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The 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	0 810		

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0 810	Continued From page 23 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 interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly 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) 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). On April 22, 2025, licensed assisted living director (LALD)-A provided documents on the fire safety	0 810		

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	38782	A. BUILDING: _____ B. WING _____	04/23/2025

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0 810	Continued From page 24 and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated December 15, 2023, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A stated that training was done through Educare and not on the facilities written FSEP. No other training documentation was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.	01060		

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01060	Continued From page 26 (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content after an emergency relocation, for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 on February 22, 2023, and began receiving assisted living services. R2's record included a signed service plan dated February 23, 2023. The service plan indicated R2 received services including assistance with housekeeping, grooming, behavior management, and medication administration. R2's record included a progress note dated February 8, 2025, indicating R2 was transported to the hospital. The progress notes indicated R2 returned from the hospital three days later, on February 11, 2025. R2's record lacked evidence of a written notice	01060		

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01060	Continued From page 27 provided to the resident, the resident's legal representative, and designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. On April 22, 2025, at approximately 12:48 p.m., licensed assisted living director (LALD)-A stated he was not aware of the requirement to provide an emergency relocation notice for residents who were transported to the hospital, or to notify the OOLTC if a resident remained in the hospital for more than four days. LALD-A stated an emergency relocation notice, and notification was not completed for R2. The licensee's Discharge and Transfer of Residents policy dated December 15, 2023, under section titled Emergency Relocation, number 25, indicated, "In the event of an emergency relocation, the facility will, as soon as possible, provide written notice of Emergency Relocation to the following: a. The resident b. The resident's legal representative c. The resident's designated representative d. If the resident receives home and	01060		

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01060	Continued From page 28 community-based services, the resident's case manager e. If the resident has been relocated and not returned to Serenity Living Care within four (4) days, the Office of Ombudsman for Long-Term Care f. Notice of the right to appeal the decision under 144G.54. In addition, number 26, included, "The written notice shall include the following: a. The reason for the relocation b. Name and contact information for the location to which the resident has been located and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities d. If known, the approximate date range within which the resident is expected to return to the facility or a statement that the date is not currently known e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has a right to appeal the decision and contact information for the person to whom the resident should submit the appeal." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01440 SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a	01440		

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01440	Continued From page 29 registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted direct supervision of staff performing delegated nursing or therapy tasks within 30 days of first providing those services for two of two employees (unlicensed personnel (ULP)-C, 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) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	01440		

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01440	Continued From page 30 The findings include: On April 21, 2025, from 10:37 a.m., until 11:36 a.m., the surveyor observed ULP-C and ULP-D assist residents with personal care reminders, blood glucose testing, and medication administration. ULP-C and ULP-D were both hired on February 22, 2023, to provide direct care services to residents of the assisted living facility. ULP-C and ULP-D's employee records both lacked documentation of a 30-day supervision of a delegated nursing task to include observation of the staff administering the medication or treatment and the interaction with the resident. On April 22, 2025, at 12:15 p.m., clinical nurse supervisor (CNS)-B stated, via phone call, she was not aware of the requirement to complete a 30-day supervision of a delegated task for ULP-C and ULP-D. CNS-B verbalized she had not completed a 30-day supervision for ULP-C and ULP-D. The licensee's Supervision: Unlicensed Staff policy dated December 15, 2023, indicated, "Home health aides providing services to assisted living residents will be supervised to assure that the work is being performed competently and to identify problems and solutions to address issues relating to the employee's ability to provide the services to residents of [Licensee]. In addition, included, "4. Direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on	01440		

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01440	Continued From page 31 performance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01620 SS=I	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) 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. (e) 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 licensee failed to ensure the registered nurse	01620		

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01620	Continued From page 32 (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool no more than 90 days from the previous assessment or with a change of condition, for three of three residents (R2, R3, R4). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a 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 April 21, 2025, at 11:40 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated the licensee's nurse completed nursing assessments upon admission, within 14 days of admission, every 90 days, and with a change in condition. R2 R2's unsigned Service Plan - Modification printed April 22, 2025, indicated R2 received services including housekeeping, laundry, meals, dressing, grooming, behavior management, compression socks, blood glucose testing, oxygen delivery, and medication administration. R2's medical record included a comprehensive RN assessment, dated February 4, 2024. The assessment indicated R2 was able to safely smoke independently, extinguish a cigarette completely, used a smoking receptacle outside, and there were no burn marks present in R2's carpeting.	01620		

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01620	Continued From page 33 R2's record included an incident report dated August 31, 2024, at 7:05 p.m., that indicated there was a fire in R2's bedroom that damaged R2's bed and oxygen tubing. The report further indicated, "This fire incident was caused by resident smoking in bedroom against facility rules. Facility has replaced bed, mattress, oxygen tubes and other items needed to ensure resident's wellbeing. Facility will be working with resident's team to explore options for safe smoking for resident." R2's record lacked reassessment of R2's ability to maintain safety while smoking, after the incident. The record further lacked any 90-day reassessments after February 4, 2024, 442 days after the previous assessment as of the survey date, April 21, 2025. The record lacked evidence of attempts to assess the resident, or documentation of the residents refusal of assessment. R3 R3 was admitted on May 3, 2023, and received services including assistance with housekeeping, laundry, meals, and medication administration. R3's medical record included a comprehensive RN assessment, dated November 27, 2024, and no subsequent assessments as of the survey date of April 21, 2025, greater than 90 days after the previous assessment. R4 R4 was admitted on December 23, 2023, and received services including assistance with housekeeping, laundry, meals, and medication administration.	01620		

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01620	Continued From page 34 R4's medical record included a comprehensive RN assessment, dated December 27, 2024, and no subsequent assessments as of the survey date of April 21, 2025, greater than 90 days after the previous assessment. On April 23, 2025, at 8:42 a.m., clinical nurse supervisor (CNS)-B stated, via phone, she had been unable to get R2 to cooperate or communicate with the nurse to complete a nursing assessment. CNS-B verbalized making attempts to complete R2's assessment and was not sure how to handle this. CNS-B was aware R2's 90-day assessments had not been completed since November 27, 2024, and were greater than 90 days from last nursing assessment. Also, CNS-B stated R2's mental health challenges and R2's delusional thoughts interfere with the nurse's ability to complete an assessment. The surveyor provided education to CNS-B on nursing assessment requirements. CNS-B verbalized she would plan to follow up with R2's medical provider, mental health provider, and LALD-A to find ways to allow CNS-B to complete ongoing 90 days assessments for R2. In addition, CNS-B stated she did not realize R3 and R4's assessments were over 90 days and planned to get these assessments completed and a process in place to ensure an assessment would be completed every 90 days or with a change in condition for all residents. The licensee's Assessment and Reassessment policy, dated December 15, 2023, indicated, "An individualized initial evaluation of all new residents receiving assisted living services will be completed by a Registered Nurse in order to develop a personalized service plan. The assessment shall be revised regularly and as	01620		

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01620	Continued From page 35 appropriate." In addition, included, "7. The RN will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services. 8. Ongoing resident reassessments must be conducted by an RN and cannot 9. {sic} exceed 90 days from the last date of assessment." No additional information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640		

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01640	Continued From page 36 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan was revised and included a signature or other authentication by the facility and by the resident, or their representative, documenting agreement on the services to be provided for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted on February 22, 2023, and had diagnoses including bipolar disorder (mental health disease), chronic respiratory failure with hypoxia (low oxygen), type two diabetes, cirrhosis (permanent scarring) of the liver, and paranoid psychosis (paranoid beliefs with delusions and or hallucinations). On April 22, 2025, at 8:05 a.m., the surveyor observed unlicensed personnel (ULP)-D assist R2 with medication administration. R2's initial service plan signed February 23, 2023, indicated R2 received services to include assistance with housekeeping, shopping, grooming, behavior management, and medication administration.	01640		

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01640	Continued From page 37 R2's current Service Plan - Modification, provided April 22, 2025, indicated R2 received the following additional services not included on the signed service plan: compression stockings, oxygen administration, safety checks, and blood glucose testing. The updated service plan lacked a signature to document agreement with the revisions. On April 22, 2025, at 12:32 p.m., licensed assisted living director (LALD)-A stated he was not aware service plan revisions were required to be authenticated by the resident or resident's representative. LALD-A verbalized he thought the authentication was required on the initial service plan. The licensee's Service Plans policy dated December 15, 2023, indicated, "An individualized service plan is implemented for all residents. Serenity Living Care will provide all services required by the current service plan. In addition, included, "1. Beginning with the date assisted living services are first provided, a service plan is developed for the resident based on an agreement with the resident/responsible party and on the assessed needs identified in the comprehensive assessment. 2. The service plan will be finalized no later than 14 days after the date home care services are first provided, if not already completed. 3. The service plan must be revised, if needed, based on resident review or reassessment. 4. The initial service plan and any revisions are signed by a representative from Serenity Living Care and the resident or resident's representative, indicating agreement with the services to be provided." No further information was provided.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38782	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING CARE INC	2300 CARVER AVENUE EAST MAPLEWOOD, MN 55119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 38 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an annual medication reassessment for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2's current unsigned service plan, printed April 22, 2025, indicated R5 received services including assistance with medication administration. R2's record contained an Individualized	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38782	A. BUILDING: _____ B. WING _____	04/23/2025

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SERENITY LIVING CARE INC	2300 CARVER AVENUE EAST MAPLEWOOD, MN 55119

(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
01710	Continued From page 39 Medication Management Plan, dated February 4, 2024, but lacked documentation of a subsequent annual medication reassessment. On April 23, 2025, at 8:42 a.m., clinical nurse supervisor (CNS)-B stated, via phone, she has been unable to get R2 to cooperate or communicate with the nurse to complete a nursing assessment which includes the medication management plan. CNS-B was aware R2's medication assessment had not been completed since February 4, 2024. Also, CNS-B stated R2's mental health challenges and R2's delusional thoughts interfere with the nurse's ability to perform the assessments. CNS-B verbalized she would plan to follow up with R2's medical provider and mental health provider and planned to ensure the medications assessments were completed annually. The licensee's Assessment of Medications policy dated December 15, 2023, indicated, "2. d. Medication reassessment will occur at the following times i. Resident symptomology ii. Problems or concerns that may be medication-related iii. With new prescription, OTC or herbal products iv. Annually." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38782	A. BUILDING: _____ B. WING _____	04/23/2025

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SERENITY LIVING CARE INC	2300 CARVER AVENUE EAST MAPLEWOOD, MN 55119

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01880	Continued From page 40 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 medications were stored securely for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 unsigned Service Plan - Modification printed April 22, 2025, indicated R2 received services including housekeeping, laundry, meals, dressing, grooming, behavior management, compression socks, blood glucose testing, oxygen delivery, and medication administration. R2's After Visit Summary dated June 19, 2024, indicated R2 was prescribed the following medications: -insulin aspart (fast-acting) 100 units (u) /milliliter (ml), inject 5 units subcutaneously with each meal daily; and -insulin glargine (long-acting) 100 u/ml, inject 30 units subcutaneously every morning. On April 21, 2025, at 12:39 p.m., the surveyor	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38782	A. BUILDING: _____ B. WING _____	04/23/2025

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01880	Continued From page 41 observed, with ULP-C, a white refrigerator located in the dining area of the facility. The refrigerator contained two unopened Novolog (short-acting) insulin pens, and one unopened Lantus (long-acting) insulin pen. ULP-C stated this was where the licensee stored some extra unopened medications, and did not know why the medications were not locked. ULP-C verbalized she would update the nurse about the medications found unlocked. On April 21, 2025, at 1:19 p.m., licensed assisted living director (LALD)-A stated he had not realized the medications in the refrigerator should be secured and planned to implement a secure storage system for the medications requiring refrigeration. On April 23, 2025, at 8:42 a.m., clinical nurse supervisor (CNS)-B stated, via phone, she was not aware the medications stored in the refrigerator were required to be secured and agreed these medications should be locked. The licensee's Storage/Control of Medications policy dated December 15, 2023, indicated, "When [licensee] is providing storage of medications outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38782	A. BUILDING: _____ B. WING _____	04/23/2025

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SERENITY LIVING CARE INC	2300 CARVER AVENUE EAST MAPLEWOOD, MN 55119

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01890	Continued From page 42	01890		
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 date time-sensitive medications with opened or expiration dates for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 unsigned Service Plan - Modification printed April 22, 2025, indicated R2 received services including assistance with medication administration. R2's After Visit Summary dated June 19, 2024, indicated R2 was prescribed the following medication: -insulin glargine (long-acting) 100 u/ml, inject 30 units subcutaneously every morning.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38782	A. BUILDING: _____ B. WING _____	04/23/2025

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01890	Continued From page 43 On April 22, 2025, at 8:05 a.m., the surveyor observed unlicensed personnel (ULP)-D assist R2 with insulin administration. The licensee's locked medication cabinet included one opened Lantus (long-acting insulin) pen for R2. R2's Lantus insulin pen lacked an opened date to indicate when it was first opened and used. ULP-D stated the caregivers were trained by the nurse to label the insulin pens when first opened. The manufacturer's instructions for Lantus insulin pens revised June 2022, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. On April 23, 2025, at 8:42 a.m., clinical nurse supervisor (CNS)-B stated the staff were trained to label and date multi-use insulin pens when opened. The licensee's Storage/Control of Medications policy dated December 15, 2023, indicated, "When [Licensee] is providing storage of medications outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01950	Continued From page 44 perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for blood glucose testing for two of two employees (unlicensed personnel (ULP)-C, 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) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C and ULP-D were both hired on February 22, 2023, to provide direct care services to residents of the assisted living facility.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38782	A. BUILDING: _____ B. WING _____	04/23/2025

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01950	Continued From page 45 On April 21, 2025, at 9:26 a.m., ULP-C and ULP-D stated they both assisted R2 with blood glucose testing during their shifts of work. On April 21, 2025, at 10:37 a.m., the surveyor observed ULP-D assist R2 with blood glucose testing. ULP-C and ULP-D's employee records lacked documentation of training and competency testing in performing blood glucose checks for R2. On April 23, 2025, at 8:42 a.m., clinical nurse supervisor (CNS)-B stated she thought the licensee's orientation checklist included blood glucose testing training and competency. The surveyor educated CNS-B the orientation checklist did not include treatments. CNS-B verbalized if it is not on the orientation checklist then there is no evidence of blood glucose competency testing for ULP-C and ULP-D in their employee records. CNS-B stated she planned to follow up on the licensee's orientation documentation to ensure all employees are trained and competency tested for all treatment provided to the residents. The licensee's Delegation of Assisted Living Tasks policy, dated December 15, 2023, included "The clinician (Registered Nurse or licensed health professional) is responsible for appropriately delegating tasks to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks in accordance with the appropriate Minnesota Practice Act. In addition, indicated, " 6. The clinician may delegate procedures according to the following a. The clinician instructed the home health aide in	01950		

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01950	Continued From page 46 the proper methods to perform the procedure with respect to each resident. b. The clinician provided the home health aide with written instructions specific to the resident. c. The home health aide demonstrated to the clinician competence in the procedure. d. The procedure is documented in the resident's clinical record. e. The home health aide's competence is documented in his/her personnel file." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

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

Serenity Living Care Inc
2300 Carver Ave E
Maplewood, MN 55109
Ramsey County
Parcel:

Phone:

License Info

License: 0041262

Risk:
License: -1
Expires on: 12/31/2023
CFPM: Rebecca B. Vuluyen
CFPM #: 115901; Exp: 03/07/2026

Inspection Info

Report Number: F1021251010
Inspection Type: Follow-up - Single
Date: 4/30/2025 Time: 2:11:18 PM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

Today's follow-up inspection was conducted to address and resolve previously issued orders from a full inspection on 04/21/25. 5 out of 5 orders were cleared from the report.

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 F1021251010 from 4/30/2025

Melissa Ramos

Elvis Vuluyen
LALD

Melissa Ramos,
Public Health Sanitarian 3
651-201-4495
melissa.ramos@state.mn.us

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *04/21/25*
Time: 12:40:27
Report: 1021251115

Food and Beverage Establishment Inspection Report

Location:
Serenity Living Care Inc
2300 Carver Ave E
Maplewood, MN55109
Ramsey County, 62

Establishment Info:
ID #: 0041262
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON-SITE. DISCUSSED EMPLOYEE ILLNESS POLICY AND RECORDING WITH LALD. AN MDH EMPLOYEE ILLNESS LOG SENT WITH REPORT.

Comply By: 04/22/25

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

OBSERVED STAFF WASH AND RINSE A FEW DISHES IN THE SINK. DISCUSSED WITH STAFF THAT ALL DISHES AND UTENSILS NEED TO BE SENT TO THE DISH MACHINE TO GET SANITIZED. STAFF WILL PLACE THE DISHES IN THE DISH MACHINE. COMPLY WITH RULE ABOVE.

Comply By: 04/21/25

7-200 Toxic Supplies and Applications

7-207.12 ***** Priority 1 *****

MN Rule 4626.1665 Store medicines that require refrigeration, belonging to employees or to children in a day care center, in container that is kept inside another covered, leakproof container that is identified as a container for medicine and located to be inaccessible to children.

OBSERVED INSULIN AND OTHER MEDICATIONS STORED ON THE DOOR OF THE UPRIGHT COOLER WITHOUT ANY PROTECTIVE MEASURES IN PLACE. DISCUSSED WITH STAFF THE IMPORTANCE OF STORING MEDICATIONS IN A SECURE, DESIGNATED AREA SEPARATE FROM FOOD ITEMS. SEE COMMENTS.

Comply By: 04/22/25

4-300 Equipment Numbers and Capacities

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

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

NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF SANITIZER. PROVIDE.

Comply By: 04/29/25

4-300 Equipment Numbers and Capacities

4-303.11B

MN Rule 4626.0721B Provide chemical sanitizers to sanitize equipment and utensils during all hours of operation.

NO CHEMICAL SANITIZERS ON-SITE. DISCUSSED WITH LALD AND STAFF THE DIFFERENT APPROVED FOOD CONTACT SURFACE SANITIZERS. SANITIZER FACT SHEET SENT WITH REPORT. PROVIDE A CHEMICAL SANITIZER TO SANITIZE EQUIPMENT, UTENSILS AND FOOD CONTACT SURFACES.

Comply By: 04/23/25

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: MILK - FRIGIDAIRE REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: SLICED HAM - FRIGIDAIRE REFRIGERATOR
Violation Issued: No

Process/Item: Ambient Temperature
Temperature: 39 Degrees Fahrenheit - Location: FRIGIDAIRE REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: MILK - UPRIGHT COOLER
Violation Issued: No

Type: Full
Date: *04/21/25*
Time: 12:40:27
Report: 1021251115
Serenity Living Care Inc

Food and Beverage Establishment Inspection Report

Process/Item: Ambient Temperature
Temperature: 37 Degrees Fahrenheit - Location: UPRIGHT COOLER
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH LALD, ELVIS VULUYEN, NURSING ASSISTANT, MADINA HUSSEIN AND HEALTH REGULATION DIVISION NURSE EVALUATOR, DEDE HINNENDAEL.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 3 CLIENTS AND THE FACILITY CAN HAVE UP TO 4 CLIENTS.

FOOD IS FOR SAME DAY SERVICE. LEFTOVERS ARE DISCARDED AT THE END OF SERVICE.

CONTINUATION OF MN Rule 4626.1665
STAFF WILL STORE ALL MEDICINE IN A SECURE LOCATION.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, WOOD FLOOR, LAMINATE COUNTERTOPS, PAINTED DRYWALL. PHYSICAL FACILITY ITEMS WILL BE MONITORED DURING FUTURE INSPECTIONS.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021251115 of 04/21/25.

Certified Food Protection Manager: REBECCA B. VULUYEN

Certification Number: FM115901 Expires: 03/07/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
MADINA HUSSEIN
NURSING ASSISTANT

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us