



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 28, 2026

Licensee

Serenity Group Homes LLC
3234 Dupont Avenue North
Minneapolis, MN 55412

RE: Project Number(s) SL35193016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 10, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$500.00

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$1,000.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is written in a cursive, flowing style.

Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35193	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2026
NAME OF PROVIDER OR SUPPLIER SERENITY GROUP HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3234 DUPONT AVENUE NORTH MINNEAPOLIS, MN 55412		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35193016-0 On September 8, 2026, through September 10, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were two residents; two receiving services under the Assisted Living Facility license. An immediate order for correction was identified on September 9, 2026, issued for SL35193016-0, tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	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			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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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,	0 480			

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 9, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee on September 10, 2026.	0 480			

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0 480	Continued From page 3	0 480			
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a menu a week in advance and inform residents in advance of menu changes. This practice resulted in a level one violation (a violation that will cause only minimal impact on the residents and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	0 485			

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0 485	Continued From page 4 affect a large portion or all the residents). The findings include: On September 8, 2026, at 10:35 a.m., during the facility tour with registered nurse (RN)-E, the surveyor observed the licensee lacked a posted menu in the facility. On September 8, 2026, at 11:44 a.m., unlicensed personnel (ULP)-B stated they were unaware of a posted menu for residents and did not know where a menu would be kept. ULP-B stated they made meals for the residents. On September 8, 2026, at 11:49 a.m., RN-E stated there was a menu posted on the front of a three-ring binder which was kept in a wall holder, above a table in the living room above a table. The menu was dated July 2024, and included one week of meals. RN-E stated they cooked the same meals weekly, as shown on the menu. RN-E stated there was not a current menu posted and the menu should have been posted or provided to residents which it was not. On September 8, 2026, at 12:06 p.m., licensed assisted living director (LALD)-D stated they did not provide residents with a copy of the menus. LALD-D stated the menu should be posted for residents at least a week in advance. LALD-D stated they would accommodate requests if a resident did not like an item on the menu. The licensee's 12.01 Food Service and Menu Planning policy dated July 9, 2026, indicated, "1. Menus will be prepared at least one (1) week in advance and made available to all residents. [Licensee] will encourage residents' involvement in menu planning."	0 485			

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0 485	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place the information about the facilities' grievance procedure with the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances, the contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and the Office of Ombudsman for Mental Health and	0 550			

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0 550	Continued From page 6 Developmental Disabilities (OOMHDD). 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 the potential to affect a large portion or all of the residents). The findings include: On September 8, 2026, at 10:35 a.m., during the facility tour with registered nurse (RN)-E, the surveyor observed the licensee lacked a posting with information for the OOLTC and OOMHDD. RN-E stated they were unsure why the information was not posted. On September 8, 2026, at 10:45 a.m., licensed assisted living director (LALD)-D stated the information for the ombudsman should have been posted on the main level above the medication cart. On September 8, 2026, at 12:06 p.m., LALD-D stated the ombudsman information was located on a bulletin board with two papers over the top of it and the pages were all taped together, so would not have been visible to residents or family. The licensee's 2.10 Complaint / Grievance Posting policy dated July 9, 2026, indicated, "2. The posting will also have the contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and	0 550			

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0 550	Continued From page 7 Developmental Disabilities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the current license at the main entrance of the assisted living facility as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On September 8, 2026, at 10:35 a.m., during the facility tour with registered nurse (RN)-E, the surveyor observed the licensee lacked a posting of their current license. RN-E stated they were unsure where the license was posted but that it should have been posted. Licensed assisted living director (LALD)-D stated they had a	0 570			

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0 570	Continued From page 8 resident who had a behavioral incident and might have torn it down off of the wall. On September 8, 2026, at 10:45 a.m., LALD-D stated the current facility license should have been posted on the main level above the medication cart. On September 8, 2026, at 12:06 p.m., LALD-D stated the facility license was not posted as required. The licensee's 2.04 Assisted Living License and Posting policy dated July 9, 2026, indicated, "4. The original current license shall be displayed at the main entrance. If the facility has a campus license, a copy will be displayed in each location on the campus." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing	0 730			

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0 730	Continued From page 9 medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records included documentation that services were provided as identified in the service plan for	0 730			

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0 730	Continued From page 10 two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2's Addendum to Contract-Waiver-MN service plan dated December 21, 2026, indicated R2 received services including assistance with appointments, "assistance with self-administration", bathing reminder, dressing, grooming, housekeeping (heavy and light), behavior management (anxiety, self-injurious, verbal aggression, orientation, paranoia), meal tray, medication administration, medication set up, shopping, snack, socialization, and toileting. On September 8, 2026, at 12:48 p.m., the surveyor observed unlicensed personnel (ULP)-B administer medication for R2. R2's Service Recap Summary for August and September 2026, indicated the licensee lacked documentation for the following scheduled services: -appointment reminder/assistance; AM-August 21 and 22; PM (two entries)-August 4, 13, 17, 19 and 28; -assistance with self-administration; AM-August 21 and 22; PM-August 4, 13, 17, and 19; -bathing reminder; PM-August 4, 13, 17, 19 and	0 730			

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NAME OF PROVIDER OR SUPPLIER SERENITY GROUP HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3234 DUPONT AVENUE NORTH MINNEAPOLIS, MN 55412		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 730	Continued From page 11 28; -dressing; PM-August 4, 13, 17, 19 and 28; -grooming; PM-August 4, 13, 17, 19 and 28; -housekeeping-heavy; PM-August 4, 13, 17, 19 and 28; -housekeeping-light; PM-August 4, 13, 17, 19 and 28; -behavior management-anxiety; AM-August 9, 16, 21 and 22; PM-August 3, 4, 6, 13, 17, 19, 21-23, and 28; -behavior management-self-injurious; AM-August 9, 16, 21 and 22; PM-August 3, 4, 6, 13, 17, 19-21, 27, and 28; -behavior management-verbal aggression; AM-August 9, 16, 21 and 22; PM-August 3, 4, 6, 13, 17, and 19-21; -behavior management-orientation; AM-August 9, 16, 21 and 22; PM-August 3, 4, 9, 13, 17, 19-21, and 28; -behavior management-paranoia; AM-August 9, 16, 21 and 22; PM-August 3, 4, 6, 9, 13, 17, 19-21, and 28; -meal tray; AM-August 21 and 22; PM (two entries)- August 4, 13, 17, 19, and 28; -medication administration; AM-August 8, 21 and 22; PM- August 1, 4, 13, 17, 19, 23, 25, 29-30; and bedtime- August 1, 4, 13, 17-19, 23, 25-26, and 29-30; -medication set up; AM-August 16, 21 and 22; -record pain; 8:00 p.m. - August 4, 13, 17, 19, and 28; -shopping assistance; PM-August 4, 13, 17, 19, and 28; -snack; AM-August 16, 21 and 22; PM-August 4, 13, 17, 19, and 28; PM (3 entries)-August 4, 13, 17, 19, and 28; -socialization; AM-August 16, 21 and 22; PM (3 entries)-August 4, 13, 17, 19, and 28; and -toileting; PM-August 4, 13, 17, 19, and 28.	0 730			

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0 730	Continued From page 12 R3 R3's Addendum to Contract-Waiver-MN service plan dated November 14, 2025, indicated R3 received services including assistance with appointments, "assistance with self-administration", bathing-shower or bath, dressing, grooming, housekeeping light/heavy, manage behaviors (agitation, anxiety, hoarding, physical aggression, property destruction, repetitive, self-injurious, verbal aggression, wandering, withdrawal), meal tray, medication administration, medication reminder, medication setup, shopping, snack, socialization, and transportation. On September 9, 2026, at 11:22 a.m., registered nurse (RN)-E stated R3 was sent to the hospital on August 19, 2026, and had not returned to the facility. R3's Service Recap Summary for August 2026, indicated the licensee lacked documentation for the following scheduled services: -appointment reminder/assistance; reminder and AM-August 3, 10, and 17; -assistance with self-administration; AM-August 16; PM- August 4, and 13; -bathing assistance-shower or bath; AM-August 16; -dressing; AM-August 16; -grooming; AM-August 16; -housekeeping light; AM-August 16; -manage behaviors -agitation; AM-August 16; PM- August 4, and 13; -manage behaviors- anxiety; AM-August 16; PM- August 4, and 13; -manage behaviors hoarding; AM-August 16; PM- August 4, 13, and 17; -manage behaviors -physical aggression; AM-August 16; PM- August 4, 13, and 17;	0 730			

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0 730	Continued From page 13 -manage behaviors -property destruction; AM-August 16; PM- August 4, 13, and 17; -manage behaviors - repetitive; AM-August 16; PM- August 4, 13, and 17; -manage behaviors - self-injurious; AM-August 16; PM- August 4, 13, and 17; -manage behaviors - verbal aggression; AM-August 16; PM- August 4, 13, and 17; -manage behaviors - wandering; AM-August 16; PM- August 4, 13, and 17; -manage behaviors - withdrawal; AM-August 16; PM- August 4, 13, and 17; Overnight-August 2-6, and 10-13, and 17; -meal tray; AM-August 16; Mid-day-August 16; PM- August 4, 13, and 17; -medication administration; PM-August 4, 13 and 17; Bedtime-August 1, 4, 13, and 17; -medication reminder; AM-August 16; PM- August 4, 6, 13, and 17; -medication setup; AM-August 16; PM- August 4, 6, 13, and 17; -snack; Mid-day-August 16; Overnight-August 2-6, and 10-13, 17 and 18; and -socialization; AM-August 16; PM- August 4, 6, 13, and 17. On September 9, 2026, at 12:02 p.m., clinical nurse supervisor (CNS)-A reviewed R2 and R3's service recap summary reports. CNS-A stated documentation had been an ongoing issue, and they continued to provide education and re-education to staff on the requirements of documentation. CNS-A stated the expectation was all documentation would be completed. The licensee's 2.37 Resident Record - Documentation policy dated July 9, 2026, indicated, "1. Staff providing assisted living services will document, daily, medications, services, treatments, or therapies provided to	0 730			

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0 730	Continued From page 14 resident." and "2. All documentation must include the signature and title of the person who performed the service or administered the medication, treatment or therapy. Initials may be used if there is a completed signature page included in the documentation." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
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 ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 775			

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0 775	Continued From page 15 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days.	0 775			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780			

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0 780	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the	0 800			

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0 800	Continued From page 17 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810			

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0 810	Continued From page 18 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 810			

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0 810	Continued From page 19 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810			
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the	0 920			

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0 920	Continued From page 20 resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included a delineation of costs for the contracted services. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's blank Resident Contract for Assisted Living template, undated, lacked the following required information: -a delineation of the cost and nature of any other services to be provided for an additional fee; and -a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract.	0 920			

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0 920	Continued From page 21 R2 R2 was admitted to the licensee on December 20, 2025. R2's Addendum to Contract-Waiver-MN service plan dated December 21, 2026, indicated R2 received services including assistance with appointments, "assistance with self-administration", bathing reminder, dressing, grooming, housekeeping (heavy and light), behavior management (anxiety, self-injurious, verbal aggression, orientation, paranoia), meal tray, medication administration, medication set up, shopping, snack, socialization, and toileting. R2's Resident Contract for Assisted Living signed December 19, 2025, did not identify a delineation and description of any additional fees the resident may be required to pay if the resident's condition changed during the term of the contract. R3 R3 was admitted to the licensee on October 31, 2024. R3's Addendum to Contract-Waiver-MN service plan dated November 14, 2025, indicated R3 received services including assistance with appointments, "assistance with self-administration", bathing-shower or bath, dressing, grooming, housekeeping light/heavy, manage behaviors (agitation, anxiety, hoarding, physical aggression, property destruction, repetitive, self-injurious, verbal aggression, wandering, withdrawal), meal tray, medication administration, medication reminder, medication setup, shopping, snack, socialization, and transportation. R3's Resident Contract for Assisted Living signed	0 920			

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0 920	Continued From page 22 October 30, 2024, did not identify a delineation and description of any additional fees the resident may be required to pay if the resident's condition changed during the term of the contract. On September 9, 2026, at 1:44 p.m., licensed assisted living director (LALD)-D stated R2 and R3's assisted living contracts did not include a delineation of cost. LALD-D stated he was unaware that the assisted living contracts for residents who received waived services needed to have the delineation of costs. LALD-D stated they do have a different contract used for residents who pay privately that includes a delineation of costs. LALD-D stated the facility had not provided a delineation of costs in any form to any residents on waivers and the facility had never accepted a private pay resident. LALD-D was unaware a delineation of costs needed to be provided to residents on waivers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920			
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.	01290			

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01290	Continued From page 23 (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure they had an affiliated background study (BGS) on NETStudy 2.0 (web-based system used to submit BGS requests to the Department of Human Services (DHS)) with the assisted living licensee's health facility identification number (HFID) for one of nine employees (unlicensed personnel (ULP)-C). 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 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: The licensee's HFID was 35193. ULP-C was hired on May 30, 2024, to provide direct-cares for residents. The licensee's undated NETStudy 2.0 report for HFID 35193 was provided to the surveyor by licensed assisted living director (LALD)-D on September 8, 2026, and reviewed on September 9, 2026; it did not include ULP-C.	01290			

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01290	Continued From page 24 The licensee's Staff Roster, undated, indicated ULP-C was hired on May 30, 2024. On September 9, 2026, at 9:00 a.m., clinical nurse supervisor (CNS)-A provided the Weekly Staff Schedule, undated, which showed ULP-C worked from 11:00 p.m. to 7:00 a.m., Monday through Thursday. CNS-A stated it was the schedule for this week, September 7, 2026, through September 13, 2026. On September 9, 2026, at 9:38 a.m., registered nurse (RN)-E stated ULP-C was currently employed by the licensee and worked the overnight shift. On September 9, 2026, at 9:40 a.m., LALD-D stated they were cleaning up their NETStudy2.0 roster to remove employees who were no longer employed by the licensee and accidentally unaffiliated ULP-C. On September 9, 2026, at 9:45 a.m., LALD-D provided a NETStudy2.0 Final Registry Result Form completed on May 30, 2024, for ULP-C under HFID 35193 which indicated they were, "Cleared," to work. On September 9, 2026, at 10:00 a.m., LALD-D provided a NETStudy2.0 search for ULP-C which indicated ULP-C was affiliated with the licensee's HFID 35193 on May 30, 2024, and then unaffiliated by the licensee on February 2, 2026. The licensee's 4.02 Background Studies policy revised on July 9, 2026, indicated: "1. Using the MN OHS NetStudy online program, [licensee] will initiate a background study on all employees being considered for hire.	01290			

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01290	Continued From page 25 2. If hired prior to receiving the results of the background study, or the tentative background study results indicate more time is needed requiring supervision, new hires shall not be permitted to interact or provide services to tenants or clients of Serenity Group Homes except under the direct supervision (eyesight) of another qualified staff person. 3. Once an approved background study has been received, staff may act independently with residents, assuming all other requirements have been met. 4. Copies of completed background studies shall be kept in individual employee records." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered	01620			

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01620	Continued From page 26 planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive reassessment at least every 90 days for two of two residents (R2, R3).	01620			

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01620	Continued From page 27 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on December 20, 2025. R2's Addendum to Contract-Waiver-MN service plan dated December 21, 2026, indicated R2 received services including assistance with appointments, "assistance with self-administration", bathing reminder, dressing, grooming, housekeeping (heavy and light), behavior management (anxiety, self-injurious, verbal aggression, orientation, paranoia), meal tray, medication administration, medication set up, shopping, snack, socialization, and toileting. On September 8, 2026, at 12:48 p.m., the surveyor observed unlicensed personnel (ULP)-B assist R2 with medication administration. R2's electronic medical record indicated assessments were completed on the following dates: -December 20, 2025, comprehensive assessment; -January 1, 2026, comprehensive assessment; -April 5, 2026, comprehensive assessment (92 days after the previous comprehensive assessment); and -July 6, 2026, comprehensive assessment (92	01620			

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01620	Continued From page 28 days after the previous comprehensive assessment). R3 R3 was admitted to the licensee on October 31, 2024. R3's Addendum to Contract-Waiver-MN service plan dated November 14, 2025, indicated R3 received services including assistance with appointments, "assistance with self-administration", bathing-shower or bath, dressing, grooming, housekeeping light/heavy, manage behaviors (agitation, anxiety, hoarding, physical aggression, property destruction, repetitive, self-injurious, verbal aggression, wandering, withdrawal), meal tray, medication administration, medication reminder, medication setup, shopping, snack, socialization, and transportation. R3's medical record indicated assessments were completed on the following dates: -May 10, 2025, comprehensive assessment; -August 10, 2025, comprehensive assessment (92 days after the previous comprehensive assessment); -November 25, 2025, comprehensive assessment (107 days after the previous comprehensive assessment); -April 15, 2026, comprehensive assessment (155 days after the previous comprehensive assessment); and -June 2, 2026, comprehensive assessment (48 days after the previous comprehensive assessment). On September 9, 2026, at 11:10 a.m., registered nurse (RN)-E stated the licensee started using Residex (electronic medical records program)	01620			

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01620	Continued From page 29 around October 2025, and some of R3's assessments were completed on paper, which RN-E provided. On September 9, 2026, at 11:22 a.m., RN-E stated R3 was sent to the hospital on August 19, 2026, and had not returned to the facility. On September 9, 2026, at 12:06 p.m., clinical nurse supervisor (CNS)-A reviewed R2 and R3's assessments. CNS-A stated the process was to complete an admission assessment at the time of admission followed by a 14-day assessment and then at least every 90 days thereafter unless a change of condition was needed. CNS-A stated R2 and R3's 90-day assessments were late and did not provide additional explanation. The licensee's 6.01 Assessments, Reviews and Monitoring policy, dated July 9, 2026, indicated an initial nursing assessment must be completed. In addition, "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." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living	01640			

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01640	Continued From page 30 facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview, and record review, he licensee failed to ensure the service plan was revised, as needed, based on resident reassessment for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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:	01640			

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01640	Continued From page 31 R2's Addendum to Contract-Waiver-MN service plan dated December 21, 2026, indicated R2 received services including assistance with appointments, "assistance with self-administration", bathing reminder, dressing, grooming, housekeeping (heavy and light), behavior management (anxiety, self-injurious, verbal aggression, orientation, paranoia), meal tray, medication administration, medication set up, shopping, snack, socialization, and toileting. R2's Customized Living Rates Worksheet (6790G form) dated July 10, 2026, indicated the licensee was receiving reimbursement for the following services for R2: -assistance making appointments; -assistance with bathing; -assistance with grooming; -assistance with self-administration; -congregate meal prep for breakfast, lunch, dinner, snacks; -arrange non-medical transportation; -manage repetitive behaviors; -manage agitation; -manage self-injurious behaviors; -manage verbal aggression; -manage physical aggression; -manage property destruction; -meeting cognitive and other mental health needs; -meeting cognitive and other mental health needs a second time; -non-medical transport; mileage 1:1; -socialization individual staff ratios 1:1; -socialization individual staff ratios 1:2-5; -shopping; and -verbal or visual medication reminders. On September 9, 2026, at 9:05 a.m., R2 stated they were independent with, and did not receive,	01640			

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01640	Continued From page 32 the following services which were on their service plan or 6790G form: -assistance with self-administration of meds -dressing; -grooming; and -toileting. On September 9, 2026, at 8:50 a.m., licensed assisted living director (LALD)-D stated they had been trying to update R2's support plan with R2's case manager (CM) but had been having difficulty getting a response from them. LALD-D stated they recently received an update via email, but it was only in the email; there was no updated support plan at this time. LALD-D stated they would provide the emails documenting their attempts and updates. On September 9, 2026, at 11:44 a.m., LALD-D provided the emails supporting their efforts to update R2's CM and included R2's above-mentioned 6790 form; both supported LALD-D's claims they had been making efforts to reach R2's CM. On September 9, 2026, at 1:40 p.m., the surveyor stated R2's current signed service plan did not include the updates made in the email exchange with R2's CM. LALD-D and clinical nurse supervisor (CNS)-A stated they did not think they could update their service plan unless they had the updated documentation from R2's CM. The surveyor explained their service plans should be updated based on nursing assessments, not CM documents. The licensee's 6.02 Service Plan policy dated July 9, 2026, indicated: "2. The service plan and any revisions shall include a signature or other authentication by	01640			

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01640	Continued From page 33 Serenity Group homes and by the resident, or resident ' s representative, documenting agreement on the services to be provided. 3. Services plans shall be revised, if needed, based on resident reassessments and monitoring." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse documented specific instructions for medication administration when unlicensed personnel (ULP) were expected to make medication dosage decisions, which was outside of their scope of practice, for one of two residents	01750			

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01750	Continued From page 34 (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 Addendum to Contract-Waiver-MN service plan dated December 20, 2026, indicated R2 received services including assistance with appointments reminder/assistance, "assistance with self-administration", bathing reminder, dressing, grooming, housekeeping (heavy and light), behavior management (anxiety, self-injurious, verbal aggression, orientation, paranoia), meal tray, medication administration, medication set up, shopping assistance, snack, socialization, and toileting. On September 8, 2026, at 12:48 p.m., the surveyor observed unlicensed personnel (ULP)-B assist R2 with medication administration. R2's Med Admin Summary (medication administration record (MAR)) for August and September 2026, included the following medication for R2: -hydroxyzine HCL (hydrochloride) 25 milligrams (mg) tablet, "Take one to two tablets by mouth every six hours as needed for pain" The MAR lacked clear instructions to indicate when unlicensed staff should administer one versus two tablets of hydroxyzine.	01750			

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01750	Continued From page 35 R2's record included provider orders dated May 7, 2026, the orders indicated R2 was prescribed the following medication: - hydroxyzine HCL 25 mg, "Take 1 to 2 tablets by mouth every six hours as needed for pain." On September 9, 2026, at 10:41 a.m., ULP-B stated she would call the nurse prior to administering any PRN (as needed) medication to a resident. ULP-B stated she were unsure of how many tablets to administer for R2's hydroxyzine. On September 9, 2026, at 11:54 a.m., clinical nurse supervisor (CNS)-A stated ULPs were trained to administer one hydroxyzine tablet first for R2 and if that did not work then to administer another tablet. CNS-A stated staff were trained to follow the orders and did not need to call the RN prior to PRN medication administration. The licensee's 2.37 Resident Record policy dated July 9 ,2026, indicated: "1. Staff providing assisted living services will document, daily, medications, services, treatments, or therapies provided to resident. 2. All documentation must include the signature and title of the person who performed the service or administered the medication, treatment or therapy. Initials may be used if there is a completed signature page included in the documentation. 3. For medications administered or treatments and/or therapies administered, documentation in a resident's chart must include the date and time of the administration." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01750			

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01750	Continued From page 36 days	01750			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff documented the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	01760			

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01760	Continued From page 37 affect a large portion or all of the residents). The findings include: R2 R2's Addendum to Contract-Waiver-MN service plan dated December 21, 2026, indicated R2 received services including assistance with appointments, "assistance with self-administration", bathing reminder, dressing, grooming, housekeeping (heavy and light), behavior management (anxiety, self-injurious, verbal aggression, orientation, paranoia), meal tray, medication administration, medication set up, shopping, snack, socialization, and toileting. On September 8, 2026, at 12:48 p.m., the surveyor observed unlicensed personnel (ULP)-B assist R2 with medication administration. R2's Med Admin Summary (medication administration record (MAR)) for August and September 2026, lacked documentation that the following medications were administered, or the reason why medications were not administered as prescribed: -aripiprazole (antipsychotic) 10 milligram (mg) tablet, take one tablet by mouth daily in the morning with an end date of August 29, 2025; lacked documentation on August 8, 21, and 22; -naproxen (for pain) 375 mg tablet, take one tablet by mouth twice a day; lacked documentation on AM doses on August 8, 21, and 22 and PM doses on August 1,4, 14, 17, 19, 23, 25, 29 and 30; -SMZ/TMP (antibiotic) 800-160 mg, take one tablet once daily every 12 hours with food with an end date of August 29, 2026; lacked documentation on AM doses on August 8 ,21, and 22 and bedtime doses on August 1, 3, 13, 17-19,	01760			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35193	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2026
NAME OF PROVIDER OR SUPPLIER SERENITY GROUP HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3234 DUPONT AVENUE NORTH MINNEAPOLIS, MN 55412		
(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
01760	Continued From page 38 23, and 25-26; and -Ambien (for insomnia) 12.5 mg, take one tablet by mouth at bedtime; lacked documentation on August 1, 4, 13, 17-19, 23, 25-26 and 29-20 and September 6. R2's record included provider orders dated May 7, 2026. The orders indicated R2 was prescribed the following medication: - hydroxyzine hydrochloride, "Take 1 to 2 tablets by mouth every six hours as needed for pain." On September 9, 2026, at 10:41 a.m., ULP-B stated she would call the nurse prior to administering any PRN (as needed) medication to a resident. ULP-B stated she was unsure of where she would document how many. R2's MAR lacked a method to document how many tablets of hydroxyzine were administered. R3 R3's Addendum to Contract-Waiver-MN service plan dated November 14, 2025, indicated R3 received services including assistance with appointments, "assistance with self-administration", bathing-shower or bath, dressing, grooming, housekeeping light/heavy, manage behaviors (agitation, anxiety, hoarding, physical aggression, property destruction, repetitive, self-injurious, verbal aggression, wandering, withdrawal), meal tray, medication administration, medication reminder, medication setup, shopping, snack, socialization, and transportation. On September 9, 2026, at 11:22 a.m., registered nurse (RN)-E stated R3 was sent to the hospital on August 19, 2026, and had not returned to the facility.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35193	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2026
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01760	Continued From page 39 R3's signed provider orders dated June 1, 2026, indicated R3 was prescribed the following: -valproic acid 250/5milliter (ml) solution, take 15 ml (750mg) by mouth twice a day; -amlodipine 10 mg tablet, take one tablet by mouth daily for high blood pressure; -haloperidol 10 mg tablet, take 30 mg by mouth at bedtime (one 10mg and one 20mg), can take an additional 10 mg daily for agitated behavior as needed; -haloperidol 20 mg tablet, take 30 mg by mouth at bedtime (one 10mg and one 20mg), can take an additional 10 mg daily for agitated behavior as needed; -olanzapine 10 mg tablet, take three tablets (30mg) by mouth at bedtime for schizoaffective disorder. DOCUMENTATION R3's MAR for August 2026, lacked documentation that the following medications were administered, or the reason why medications were not administered as prescribed: -valproic acid (antiseizure medication)250/5 milliliter (ml) solution, take 15 ml by mouth twice a day; lacked documentation for AM dose on August 16 and bedtime dose on August 4, 14, and 17; -amlodipine (medication to treat high blood pressure) 10 mg tablet, take one tablet by mouth daily; lacked documentation on August 4, 13, and 17; -haloperidol (antipsychotic) 10 mg tablet, take 30 mg by mouth at bedtime (one 10mg and one 20mg), can take an additional 10 mg; lacked documentation on August 4, 13, 17; and -haloperidol 20 mg tablet, take 30 mg by mouth at bedtime (one 10 mg and one 20 mg), can take an additional 10 mg; lacked documentation on	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35193	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2026
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01760	Continued From page 40 August 4, 13, 17. The MAR lacked a space to document if the "additional 10mg" for PRN haloperidol was administered. TRANSCRIPTION ERROR R3's MAR for August 2026, indicated R3 was administered: -olanzapine (antipsychotic) 10 mg tablet, "Take one tablet by mouth every night at bedtime plus the 20 mg tablet for total daily dose 30 mg"; and -olanzapine 20 mg tablet, "Take three tablets by mouth at bedtime". The dosage documented as administered (70 mg) was different from R3's prescriber order, which indicated: -olanzapine 10 mg tablet, "Take three tablets (30mg) by mouth at bedtime." On September 9, 2026, at 12:02 p.m., clinical nurse supervisor (CNS)-A reviewed R2 and R3's MARs. CNS-A stated documentation had been an ongoing issue, and they continued to provide education and re-education to staff on the requirements of documentation. CNS-A stated the expectation was all documentation would be completed. The licensee's 2.37 Resident Record policy dated July 9 ,2026, indicated: "1. Staff providing assisted living services will document, daily, medications, services, treatments, or therapies provided to resident. 2. All documentation must include the signature and title of the person who performed the service or administered the medication, treatment or therapy. Initials may be used if there is a completed signature page included in the documentation.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35193	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2026
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01760	Continued From page 41 3. For medications administered or treatments and/or therapies administered, documentation in a resident's chart must include the date and time of the administration." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01760			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure there were written or electronically recorded prescriptions for all prescribed medications the licensee was managing for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2's Addendum to Contract-Waiver-MN service	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35193	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2026
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01820	Continued From page 42 plan dated December 20, 2026, indicated R2 received services including assistance with appointments, "assistance with self-administration", bathing reminder, dressing, grooming, housekeeping (heavy and light), behavior management (anxiety, self-injurious, verbal aggression, orientation, paranoia), meal tray, medication administration, medication set up, shopping, snack, socialization, and toileting. On September 8, 2026, at 12:48 p.m., the surveyor observed unlicensed personnel (ULP)-B assist R2 with medication administration. R2's Med Admin Summary (medication administration record (MAR)) for August and September 2026, listed available medications, including: -"hydroxyzine HCL (Daily) Take 1 to 2 tablets by mouth every six hours as needed for pain." The MAR lacked a way to document whether one or two tablets of hydroxyzine were administered along with criteria for how many tablets should be administered when needed. R2's "E-script New Prescription Request" dated May 7, 2026, indicated R2 was prescribed the following medication: --"hydroxyzine HCL 25 mg oral tablet, Take 1 to 2 tablets by mouth every 6 hours as needed for pain." On September 9, 2026, at 10:41 a.m., ULP-B stated she would call the nurse prior to administering any PRN (as needed) medication to a resident. ULP-B did not have an answer on how to document whether one or two tablets were administered.	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35193	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2026
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01820	Continued From page 43 On September 9, 2026, at 11:54 a.m., clinical nurse supervisor (CNS)-A stated ULPs were trained to administer one hydroxyzine tablet for R2, and if that did not work then to administer another tablet. CNS-A stated staff were trained to follow the orders and did not need to call the registered nurse prior to PRN medication administration. R3 R3 was admitted to the licensee on October 31, 2024. R3's Addendum to Contract-Waiver-MN service plan dated November 14, 2025, indicated R3 received services including assistance with appointments, "assistance with self-administration", bathing-shower or bath, dressing, grooming, housekeeping light/heavy, manage behaviors (agitation, anxiety, hoarding, physical aggression, property destruction, repetitive, self-injurious, verbal aggression, wandering, withdrawal), meal tray, medication administration, medication reminder, medication setup, shopping, snack, socialization, and transportation. R3's MAR for August 2026, indicated R3 listed available medications, including: -haloperidol (anitpsychotic) 10 mg tablet, take 30 mg by mouth at bedtime (one 10mg and one 20mg), can take an additional 10 mg; prescribed; -haloperidol 20 mg tablet, take 30 mg by mouth at bedtime (one 10mg and one 20mg), can take an additional 10 mg; prescribed; -olanzapine (anitpsychotic) 10 mg tablet, take one tablet by mouth every night at bedtime plus the 20 mg tablet for total daily dose 30 mg; total dose of 30mg prescribed; and -olanzapine 20 mg tablet, take three tablets by	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35193	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2026
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01820	Continued From page 44 mouth at bedtime; not prescribed. The MAR lacked a way to document if the additional 10 mg of haloperidol was administered. R3's signed medication list dated June 1, 2026, indicated R3 was prescribed the following medications: -haloperidol 10 mg tablet, take 30 mg by mouth at bedtime (one 10mg and one 20mg), can take an additional 10 mg daily for agitated behavior as needed; -haloperidol 20 mg tablet, take 30 mg by mouth at bedtime (one 10mg and one 20mg), can take an additional 10 mg daily for agitated behavior as needed; -olanzapine 10 mg tablet, take three tablets (30mg) by mouth at bedtime for schizoaffective disorder. R3's MAR did not match R3's signed medication list dated June 1, 2026, indicating R3 was not being administered medications as prescribed. On September 9, 2026, at 11:22 a.m., registered nurse (RN)-E stated R3 was sent to the hospital on August 19, 2026, and has not returned to the facility. On September 9, 2026, at 12:04 p.m., clinical nurse supervisor (CNS)-A reviewed R3's orders and MAR. CNS-A stated the pharmacy entered the orders in the electronic MAR and then the nurse would review the orders. CNS-A stated the nurse must review the order prior to it being displayed on the MAR. CNS-A stated R3's orders needed to be further reviewed and clarified as there was confusion along with no place to document if a PRN haloperidol was administered.	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35193	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2026
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01820	Continued From page 45 The licensee's 2.37 Resident Record policy dated July 9 ,2026, indicated: "1. Staff providing assisted living services will document, daily, medications, services, treatments, or therapies provided to resident. 2. All documentation must include the signature and title of the person who performed the service or administered the medication, treatment or therapy. Initials may be used if there is a completed signature page included in the documentation. 3. For medications administered or treatments and/or therapies administered, documentation in a resident's chart must include the date and time of the administration." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

SERENITY GROUP HOMES LLC
3234 DUPONT AVENUE NORTH
Minneapolis, MN 55412
Hennepin County
Parcel:

Phone:
mustafa@serenitygrouphomes.com

License Info

License: HFID 35193

Risk:
License:
Expires on:
CFPM: MAHAMED NUR FARAH
CFPM #: 67242; Exp: 5/8/2029

Inspection Info

Report Number: F1029261309
Inspection Type: Full - Single
Date: 9/9/2026 Time: 12:30:49 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery:

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

3-302.11A(1) Priority Level: Priority 1 CFP#: 15

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

COMMENT: UNPASTEURIZED RAW SHELL EGGS ON HIGHEST SHELF IN FRIDGE ABOVE READY TO EAT ITEMS AND HIGH CONTACT SURFACES. PIC INSTRUCTED TO STORE ON A LOWER LEVEL AND/OR IN A LEAKPROOF CONTAINER WITH HIGH SIDEWALLS. CORRECTED DURING INSPECTION - PIC MOVED EGGS TO LOWEST LEFT FRIDGE DRAWER.

Comply By: 9/9/2026 Originally Issued On: 9/9/2026

New Order: 4-100 Equipment Construction Materials

4-101.18 Priority Level: Priority 3 CFP#: 47

MN Rule 4626.0493 Discontinue using cleaning aids or utensils that can scratch or scour the nonstick coating of pots, pans, griddles, cookie sheets, waffle makers and other cookware.

COMMENT: NONSTICK COOKWARE WITH CHIPPED AND SCOURED NONSTICK COATING. PIC INSTRUCTED TO REMOVE DAMAGED COOKWARE FROM ESTABLISHMENT AND TO ONLY USE CLEANING AND PREPARATION ITEMS ON NONSTICK COOKWARE THAT WILL NOT CAUSE DAMAGE (i.e., DON'T USE METALS AND SHARP ITEMS - USE PLASTICS, SILICONE, POLYMERS, ETC.).

Comply By: 9/9/2026 Originally Issued On: 9/9/2026

New Order: 4-300 Equipment Numbers and Capacities

4-302.13B Priority Level: Priority 2 CFP#: 48

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

COMMENT: ESTABLISHMENT'S THERMAL STICKERS FAULTY. PIC INSTRUCTED TO OBTAIN WORKING THERMAL STICKERS/TAGS OR TO USE A MIN/MAX IRREVERSIBLE THERMOMETER TO VERIFY THE DISHWASHER'S SANITIZING TEMPERATURES. PIC INDICATED THEY WOULD OBTAIN NEW THERMAL STICKERS.

Comply By: 9/11/2026 Originally Issued On: 9/9/2026

Food & Beverage General Comment

Food and beverage inspection conducted as part of HRD survey of ALF

HRD Surveyors:

Joey Keen, BSEd, RN, State Nurse Evaluator

Nancy Kimmes, RN, Nursing Evaluator

Establishment's kitchen-food service area residential in nature with laminate floor, covered wood/composite wood drawers and cabinetry, composite laminate countertops, smooth painted walls, tile backsplash, and slightly textured but cleanable ceiling. Establishment is required to have a same-day food service for prepared TCS foods.

Establishment uses Whirlpool dishwasher with Sani Rinse to sanitize dishes and glassware in accordance with NSF International NSF/ANSI Standard 184 for Residential Dishwashers which raises the main wash temperature to 135°F (57°C) and the final rinse temperature to 156°F (69°C) with an added time of 0:05 to 1:06

Foodborne illness prevention and food safety reviewed with establishment's PIC

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 F1029261309 from 9/9/2026

MAHAMED FARAH
PERSON IN CHARGE (PIC)

Trevor McCliment
Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

SERENITY GROUP HOMES LLC
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1029261309
Inspection Type: Full
Date: 9/9/2026
Time: 12:30:49 PM

New Record: Product/Item/Unit: MILK; Temperature Process: Cold-Holding

Location: FRIDGE at 38 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

SERENITY GROUP HOMES LLC
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1029261309
Inspection Type: Full
Date: 9/9/2026
Time: 12:30:49 PM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine
Location: Greater Than 150 Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL35193016-0	Date: September 10, 2026
Facility Name: SERENITY GROUP HOMES LLC	
Facility Address: 3234 DUPONT AVE N, Minneapolis, MN, 55412	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Two (2) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: In the facility living room there was a TV mounted on the wall that was continuously powered by an extension cord.

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

Comments: The smoking area had an appropriate non-combustible ashtray; the area had several cigarette butts on the ground.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: The facility had different brand battery powered alarms throughout the facility that were not interconnected. In the facility basement there was one hard-wired alarm that wasn't interconnected with the battery alarms throughout.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

-
1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

Comments: In resident room two, the egress window didn't stay open.

The side exit door had a broken pane of glass with glass shards still there.

The front concrete steps had large cracks and pieces missing.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

-
1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

Comments: The surveyor observed the evacuation plans lacked accurate identification of resident rooms and layout. Exit plan diagrams must be correctly labeled to reduce confusion for emergency responders and potential obstructions for egress in a fire or similar emergency.

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

Comments: The FSEP 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

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

Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

Comments: The facility used an electronic care plan website for standard resident evacuation procedures. The FSEP didn't include standard resident evacuation procedures and failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.

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

Comments: The licensee failed to provide any record of staff training on the FSEP. Staff should be trained on the FSEP upon hire and at least twice a year thereafter.

6. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

Comments: LALD-D lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.