Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE - LICENSE GRANTED

Electronic Delivery

December 12, 2025

Licensee
Serenity Living Care Inc
2300 Carver Ave East
Saint Paul, MN 55119

RE: Initial License Number 419780
Health Facility Identification Number (HFID) 41385
Project Number(s) SL41385015

Dear Licensee:

On November 24, 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 September 11, 2025. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective November 24, 2025.

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

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.

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,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

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Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

October 22, 2025

Licensee
Serenity Living Care Inc.
2300 Carver Ave East
Saint Paul, MN 55119

RE: Provisional Conditional License Number 419780
Health Facility Identification Number (HFID) 41385
Project Number(s) SL41385015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 11, 2025, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 45-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **December 6, 2025**.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $1,000.00. **MDH is not imposing these fines against your provisional license at this time.**

0495 - 144g.41 Subdivision. 1 (13) - Minimum Requirements - $1,000.00

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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

CONDITIONAL LICENSE ISSUED:
MDH will issue Serenity Living Care Inc. a conditional provisional assisted living facility license for 45 calendar days from the date of this notice. At an unannounced point in time, within the 45 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Serenity Living Care Inc.. is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

a. **No new admissions:** Serenity Living Care Inc. will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. Serenity Living Care Inc. must provide the Department:

   i. A list of the names and birthdates of any individuals Serenity Living Care Inc. is currently in the process of admitting. These individuals will be able to continue the admittance process.

   ii. A list of all current residents including:
      1. Name and birthdate of each resident

2. Current payment source for services
3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Serenity Living Care Inc. is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 45-day conditional provisional license period. If MDH determines Serenity Living Care Inc. is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Serenity Living Care Inc. If MDH determines Serenity Living Care Inc. is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

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

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 Casey DeVries directly at: 651-201-5917.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41385	A. BUILDING: _____ B. WING _____	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING CARE INC	2300 CARVER AVE E SAINT PAUL, 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 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: SL41385015-0 On September 9, 2025, through September 11, 2025, 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 was one resident; one receiving services under the Provisional Assisted Living Facility license. An immediate correction order was identified on September 9, 2025, issued for SL41385015-0, tag identification 0495. 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.	

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0 110	Continued From page 1	0 110		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the director of record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that 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). These findings include: The licensee's staff roster indicated LALD-D worked at the facility. On September 9, 2025, at 6:34 a.m., the surveyor observed the Board of Executives for Long-Term Services and Supports (BELTSS) website which indicated the licensee's facility was not registered on BELTSS, therefore LALD-D would be unable to affiliate themselves with the	0 110		

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0 110	Continued From page 2 licensee. On September 9, 2025, at 7:29 a.m., LALD-D stated they were they were the LALD for the licensee. On September 9, 2025, at 10:31 a.m., the surveyor observed LALD-D's license posted in the dining area. On September 10, 2025, at 11:01 a.m., LALD-D stated they attempted to register the licensee on BELTSS, but the website did not allow them to do so; LALD-D demonstrated this on their computer for the surveyor. LALD-D stated they had left multiple voice messages with BELTSS but had not received a call back. On September 11, 2025, at 11:15 a.m., LALD-D spoke to a representative with BELTSS who explained LALD-D would need to apply for a secondary license in order to register and affiliate themselves with a second facility. The BELTSS representative instructed LALD-D on how to apply for the secondary license. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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	0 485		

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0 485	Continued From page 3 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 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 9, 2025, at 10:31 a.m., the surveyor observed there was no menu posted in the kitchen or dining area. Licensed assisted living director (LALD)-D stated they had one posted but R1 took it down and tore it up. LALD-D began searching the facility and kitchen drawers but was unable to find a menu to provide to the surveyor. The surveyor inquired if a copy	0 485		

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0 485	Continued From page 4 of the menu was provided to R1; LALD-D stated they did not provide a copy of the menu to their resident. On September 11, 2025, at 11:32 a.m., LALD-D emailed the surveyor a copy of their menu; it was undated. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 495 SS=I	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide staff access to a registered nurse (RN) twenty-four (24) hours per day, seven (7) days per week. This had the potential to affect all residents and staff. 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: On September 9, 2025, during the survey, the	0 495		

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0 495	Continued From page 5 licensee had a current census of one resident. R1 was admitted to the licensee on April 3, 2025. R1's diagnosis included bipolar disorder, autism, post-traumatic stress disorder (PTSD), and attention deficit hyperactive disorder (ADHD). R1's Service Plan dated September 9, 2025, indicated R1 received services for management of behavior including agitation, anxiety, physical aggression, property destruction, verbal aggression, paranoia, safety checks, dressing, grooming, housekeeping, incontinence care, and bed making. On September 9, 2025, at 8:50 a.m., the surveyor approached the front door of the facility. The surveyor could hear someone yelling inside of the house through the walls; the front door of the facility was shut. Unlicensed personnel (ULP)-B let the surveyor into the facility into the entry way. R1 was at the base of the basement stairs and demanded to know who the surveyor was. The surveyor identified themselves and explained they would be surveying the facility to make sure the licensee was taking care of their residents; R1 stated, "well they aren't," then slammed the door. On September 9, 2025, from approximately 8:50 a.m. to 9:45 a.m., the surveyor observed R1 exhibit disorganized thought, labile emotions, sweating, and shaking throughout her body. R1 was yelling, screaming, and threatening staff constantly to the point that licensed assisted living director (LALD)-D and the surveyor were unable to have a conversation as R1 would not allow time for others to speak. R1 stated, "I'm not	0 495		

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0 495	Continued From page 6 an aggressive person but I fuckin' can be." On September 9, 2025, at 9:45 a.m., LALD-D stated the observed behavior was R1's baseline behavior. On September 9, 2025, at 9:56 a.m., LALD-D stated clinical nurse supervisor (CNS)-A was also employed at another job outside of their role as the CNS for the licensee, but the surveyor would have to ask CNS-A for more details about their other job. On September 9, 2025, at 10:59 a.m., CNS-A stated they worked for both of the licensee's facilities (they own two facilities). CNS-A stated they also worked part time as a floor nurse at a skilled nursing facility two to three shifts per week. CNS-A stated during those shifts they would not be able to go to the licensee's facility but would be available by phone. CNS-A stated the licensee did not have a backup nurse to cover for them while they worked at the skilled nursing facility. CNS-A also stated the above-mentioned behavior was normal behavior for R1. On September 9, 2025, at 11:29 a.m., owner/ULP (O/ULP)-C stated CNS-A had another job working at a skilled nursing facility but did not know which one. O/ULP-C stated CNS-A was the only nurse they employed. On September 9, 2025, at 11:42 a.m., CNS-A stated they had a direct care patient assignment during their shift at the skilled nursing facility, but stated they were able to step away and take calls. CNS-A stated if they were unable to visit the facility due to their other job, they would call	0 495		

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0 495	Continued From page 7 911 to deal with the resident's problems. CNS-A stated they worked eight-hour shifts at the skilled nursing facility. On September 9, 2025, at 12:32 p.m., CNS-A's text message indicated when they worked their shift at the nursing home they were assigned, "like 20 residents." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495		
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 original 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 9, 2025, at 10:31 a.m., the	0 570		

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0 570	Continued From page 8 surveyor observed the licensee posted a copy of their license in the dining area. LALD-D stated they did not post the original license due to concerns of R1 tearing it up. LALD-D stated they carried the license with them and produced the license from a bag they carried with them to the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
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.	0 680		

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0 680	Continued From page 9 (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to prominently display their written emergency preparedness plan (EPP) with all the required content for staff, residents, and visitors to view. 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 9, 2025, at 12:34 p.m., licensed assisted living director (LALD)-D stated the EPP was not kept at the facility. LALD-D stated R1 tried to pry the book out of their filing cabinet and had to take it out of the facility as they thought the EPP had their records in it. LALD-D stated they took the EPP out of the facility and use it for staff training; they stated they could send the surveyor a digital copy. On September 10, 2025, at 10:13 a.m., LALD-D provided their Emergency Preparedness Manual for the surveyor to review. LALD-D questioned if all required information was required to be in the EPP manual onsite. The surveyor explained everything needed to be in the EPP and it	0 680		

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SERENITY LIVING CARE INC	2300 CARVER AVE E SAINT PAUL, 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
0 680	Continued From page 10 needed to be onsite so in the event of an emergency situation the staff could access it and have everything they needed to deal with an emergency situation. The licensee's Emergency Preparedness policy dated December 15, 2023, indicated, "[Licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 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;	0 730		

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0 730	Continued From page 11 (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 of services provided for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 730		

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0 730	Continued From page 12 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: R1 was admitted to the licensee on April 3, 2025. R1's Service Plan dated April 3, 2025, indicated R1 received services for behavior management, safety checks, housekeeping, and garbage removal. R1's Service Recap Summary for September 2025, lacked documentation of services provided for the following services and dates: -manage behavior - anxiety; September 1-8, 2025; -manage behavior - anxiety; September 1-8, 2025; -manage behavior - physical aggression; September 1-8, 2025; -manage behavior - property destruction; September 1-8, 2025; -manage behavior - verbal aggression; September 1-8, 2025; -manage symptom - paranoia; September 1-8, 2025; -remove garbage; September 1,2, 4-8, 2025; and -safety checks; September 1-9, 2025. On September 10, 2025, at 10:35 a.m., licensed assisted living director (LALD)-D stated R1's service log should not have missing documentation. LALD-D stated there should not have been any missing service administration documentation. LALD-D stated there should	0 730		

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0 730	Continued From page 13 always be something documented even if the resident declines the service. The licensee's Service Plan policy dated December 15, 2023, indicated, "[Licensee] will implement and provide all services required by the current service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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, 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 14 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: September 9, 2025, at approximately 12:00 p.m., survey staff toured the facility with licensed assisted living director (LALD)-D. The following was observed. GENERAL MAINTENANCE: The main level closet door was off the track and laying over. This has the potential to injury staff and residents. There was a hole in the front entry way which appeared to be made by the entry door handle. In the garage there appeared to be water damaged sheet rock over the service door into the facility. On September 9, 2025, LALD-D stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) 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:	0 810		

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0 810	Continued From page 15 (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 develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 16 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 9, 2025, at approximately 12:00 p.m., the surveyor observed the fire evacuation diagrams did not include the identification of the bedroom and the bedrooms were not individually identified. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. On September 9, 2025, at approximately 12:00 p.m., the surveyor observed the fire safety and evacuation plan was not located in a central location for all staff accessibility. LALD-D stated they took the FSEP plan home and would email a full version. On September 9, 2025, licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following:	0 810		

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0 810	Continued From page 17 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. On September 9, 2025, LALD-D stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy from a third-party provider that was not specific to the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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 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	01640		

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01640	Continued From page 18 Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain a resident or resident representative's signature documenting agreement on the services to be provided when a change was made to services and the service plan for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on April 3, 2025. R1's Service Plan signed on April 3, 2025, indicated R1 received services for manage behavior for agitation, manage behavior for anxiety, manage symptoms of paranoia, safety	01640		

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01640	Continued From page 19 checks, activity assistance, appointment reminders, bathing reminders, bed making, deep room clean, grooming, housekeeping and incontinence care, linen changes, garbage removal, and shopping assistance. R1's Service Plan printed on September 9, 2025, unsigned, indicated R1 received additional services which were not on R1's signed service plan from April 3, 2025. R1 was receiving the following services without a signed service agreement or plan: -manage behavior physical aggression; -manage behavior property destruction; -manage behavior verbal aggression; -medication reminders; and -safety checks completed by administration. On September 10, 2025, at 10:35 a.m., licensed assisted living director (LALD)-D stated the service plan printed during the survey (September 9, 2025) did include additional services which were not included on R1's signed service plan from April 3, 2025. LALD-D stated they were aware of the requirement and forgot to get a new one signed. The licensee's Service Plan policy dated December 15, 2023, indicated, "The initial service plan and any revisions are signed by a representative from [Licensee] and the resident or resident's representative, indicating agreement with the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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01730	Continued From page 20	01730		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.	01730		

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01730	Continued From page 21 (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure updated medication orders were received and reviewed by the nurse as indicated by the individualized medication management plan for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on April 3, 2025. R1's Service Plan dated April 3, 2025, indicated R1 received services for behavior management, safety checks, appointment reminders, bathing reminders, bed making, deep room clean, grooming, housekeeping, and incontinence care. R1's 90 Day Assessment dated July 3, 2025,	01730		

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01730	Continued From page 22 included an individualized medication management assessment and indicated facility staff would provide the following medication management: -staff will provide verbal prompts to take medications; -staff to coordinate medication reorders and safe keeping of medications; and -coordinate medication orders with pharmacy. On September 9, 2025, at 9:03 a.m., R1 stated they managed their own medication. R1 said they would never allow the facility to touch their medications. On September 9, 2025, at 11:42 a.m., clinical nurse supervisor (CNS)-A stated they did not know if R1 was taking their medication. CNS-A stated R1 refused to allow them to manage their medications. CNS-A stated they were not managing medications for R1 including coordinating orders, storing, or ordering medications. CNS-A stated they were only providing R1 with reminders to take their medication. The surveyor explained the assessments conducted by them, CNS-A, indicated they were providing verbal prompts, coordinating medication reorders, safe keeping of medications and coordinating medication order with the pharmacy; CNS-A stated they would need to review the assessments as they had not done anything to manage R1's medication. On September 9, 2025, at 11:55 a.m., licensed assisted living director (LALD)-D stated they assessed R1 to need medication management services and wanted to manage them for safety reasons. LALD-D stated the individualized medication management plan in the	01730		

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01730	Continued From page 23 above-mentioned 90-day assessment must have been a, "clerical error." LALD-D stated they were only providing reminders to R1 to take their medication. The licensee's Service Plan for Medication Management policy dated December 15, 2023, indicated: "1. The written Medication Management Plan includes the following provisions. a. A statement describing the medication management services to be provided b. A description of the storage of medications based on the resident assessment* and addressing i. Resident preference ii. Risk of diversion iii. Instructions per manufacturer c. Documentation procedures d. Procedures for medication reconciliation* e. Identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered/timely f. Description of medication management tasks to be delegated to unlicensed personnel g. Plans for staff notifying the licensed health professional when/if a problem with medication management services arises h. Any resident-specific requirements related to documenting medication administration, verification that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions." "3. The Medication Management Plan will be kept current and updated with any changes." No further information was provided.	01730		

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01730	Continued From page 24 TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required verbatim notice was posted at the facility main entrance to disclose electronic monitoring activity. 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 9, 2025, at 8:50 a.m., the surveyor approached and entered the facility. The surveyor observed the front door and entry way of the facility which lacked the required video monitoring signage posting. On September 10, 2025, at 10:46 a.m., licensed assisted living director (LALD)-D stated they did	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41385	A. BUILDING: _____ B. WING _____	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING CARE INC	2300 CARVER AVE E SAINT PAUL, 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
03090	Continued From page 25 not have video monitoring signage posted. LALD-D stated they did not have video cameras in the facility and was under the impression they didn't need the posting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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
2449 Shryer Ave E
North St Paul, MN 55109
Ramsey County
Parcel:

Phone:

License Info

License: HFID 41385

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

Inspection Info

Report Number: F1025251145
Inspection Type: Follow-up - Single
Date: 9/11/2025 Time: 8:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

Items on previous report addressed by operator, reported via email as:
Food discarded from downstairs freezer and refrigerator
Refrigerator temperature for downstairs refrigerator adjusted
Sanitizer and soap containers labeled

Verify the temperature in the refrigerator downstairs after adjustment is maintaining TCS foods at or below 41 deg F (discussed using bottle or glass of water with the available TMD during inspection)

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 F1025251145 from 9/11/2025

Establishment Representative

Casey Kipping, MA RS
Public Health Sanitarian 3
651-201-4513
casey.kipping@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Serenity Living Care Inc
North St Paul
County/Group: Ramsey County

Inspection Info

Report Number: F1025251145
Inspection Type: Follow-up
Date: 9/11/2025
Time: 8:00 AM

New Record: Product/Item/Unit: Milk**; Temperature Process:** Cold holding
Location: Upstairs refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: Ambient**; Temperature Process:** Cold holding
Location: Downstairs refrigerator, laundry room at 48 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: Ambient**; Temperature Process:** Cold holding
Location: Downstairs freezer at Degrees F.
Comment: Frozen food not maintained frozen
Violation Issued?: No

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Minnesota Department of Health
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St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

Serenity Living Care Inc
North St Paul
County/Group: Ramsey County

Inspection Info

Report Number: F1025251145
Inspection Type: Follow-up
Date: 9/11/2025
Time: 8:00 AM

New Record: **Product:** Quaternary Ammonia**; Sanitizing Process:**
Location: Container **Equal To**
Comment: 1 tab < 200 PPM
Added 1 more to make 200 PPM solution in 1 gal container
Violation Issued?: No