Electronically Delivered

July 1, 2025

Licensee
Cerenity Care Center - Marian of St Paul
200 Earl Street
Saint Paul, MN 55106

RE: Project Number(s) SL35970016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 13, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L Anderson

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35970	A. BUILDING: _____ B. WING _____	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - MARIAN OF ST PA	200 EARL STREET SAINT PAUL, MN 55106

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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35970016-0 On May 12, 2025, through May 13, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 21 residents; 21 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure direct care staff performed adequate hand hygiene (HH) for one of three employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired December 2, 2024, and provided direct care services to residents. On May 13, 2025, during a continuous observation from 7:25 a.m., through 7:45 a.m.,	0 510		

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0 510	Continued From page 2 the surveyor observed ULP-D assist R4 with personal morning cares. ULP-D knocked and entered R4's apartment. R4 was awake lying supine in her bed. ULP-D donned gloves, and assisted R4 with a standby assist transfer from the bed to the bathroom toilet using R4's two wheeled walker. ULP-D assisted R4 with removing a soiled brief, dressing, and toileting including peri cares. After completing peri cares, without removing gloves and performing HH, ULP-D handed R4 her toothbrush for oral care, and then without changing gloves and performing HH, touched R4's bathroom cabinet and combed residents hair. Next, without changing gloves and performing HH, assisted R4 with her shoes. Next, ULP-D doffed the soiled gloves and, without performing HH, ULP-D escorted R4 to the main dining area, touched the dining room table, pushed in R4's chair to the table. Finally, ULP-D went to the kitchen sink and completed hand hygiene with soap and water for ten seconds. ULP-D dried her hands off with paper towels. ULP-D verbalized she received training on infection control and proper handwashing and glove changes, upon hire and at other times. On May 13, 2025, at 7:52 a.m., clinical nurse supervisor (CNS)-B stated staff were trained, upon hire and annually, to wash their hands for at least twenty seconds between cares and residents. CNS-B verbalized she planned to follow up with additional employee education on infection control and handwashing. The Centers for Disease Control and Prevention (CDC) guidance, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, revised November 29, 2022, indicated standard precautions were to be used to care for all	0 510		

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0 510	Continued From page 3 patients in all settings to include HH, and noted, "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices c. Before moving from work on a soiled body site to a clean body site on the same patient d. After touching a patient or the patient's immediate environment e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal." The licensee's Use of Gloves policy dated March 3, 2022, indicated "Procedure: 1. Wash Hands 2. Apply gloves to both hands 3. Complete task. If gloves become torn or heavily soiled and additional tasks must be performed for the client, then change the gloves (washing hands before putting on new gloves before starting the next task. 4. Place any contaminated materials in proper receptacle - such as biohazardous waste for wound care dressings. 5. Remove gloves by grasping cuff of one glove and pulling it off, turning it inside out. With ungloved hand tuck finger inside cuff of remaining glove and pull off, turning inside out with first glove inside the second glove. 6. Dispose of used gloves in proper receptacle - biohazardous if they have contaminated material on them. 7. Rewash hands." The licensee's Hand Hygiene policy dated March 3, 2022, indicated, "1. When Hands Should be	0 510		

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0 510	Continued From page 4 Washed. Hand washing shall be performed between client cares and whenever direct physical contact with a client takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: a. Before and after direct contact with a client b. If moving from a contaminated-body site to a clean-body site during client care c. After contact with environmental surfaces or equipment in the immediate vicinity of the client d. After removing gloves or gowns e. Before eating and after using a restroom." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be	0 810		

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0 810	Continued From page 5 readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to provide the required training for staff. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 12, 2025, environmental services director (ESD)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. TRAINING:	0 810		

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0 810	Continued From page 6 The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee's training records indicated that staff training was being done annually. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=D	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. (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 obtain a cleared Department of Human Services (DHS) background study, associated with the licensee's health facility identification number (HFID) for two of eight employees (resident services director (RSD)-G, housekeeper (H)-I).	01290		

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01290	Continued From page 7 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On May 12, 2025, at 11:40 a.m., director of housing (DH)-A stated RSD-G was currently employed by the licensee, and performed duties including placing service schedules and service assignments into the residents' medical records. DH-A stated H-I provided housekeeping assistance for the licensee's residents. RSD-G RSD-G was hired January 13, 2025, and provided scheduling and services to the residents. RSD-G's employee record contained documentation of a cleared DHS background study form dated February 26, 2025. The background study was not affiliated with the current HFID, but indicated license number "354". RSD-G's employee record lacked evidence the licensee ensured a cleared background study was obtained, affiliated with the surveyed assisted living license, HFID 35970. The licensee's DHS NETStudy roster for HFID 35970, provided May 12, 2025, did not include RSD-G. On May 13, 2025, at 9:45 a.m., director of housing (DH)-A provided an updated DHS background study clearance form for RSD-G,	01290		

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01290	Continued From page 8 affiliated with the licensee HFID 35970, dated May 12, 2025, during the survey. H-I H-I was hired May 22, 2024, and provided direct services to the residents. H-I's employee record contained documentation of a cleared DHS background study form dated May 16, 2024. The background study was not affiliated with the current HFID, but indicated license number "354". H-I's employee record lacked evidence the licensee ensured a cleared background study was obtained, affiliated with the surveyed assisted living license, HFID 35970. On May 13, 2025, at 9:27 a.m., DH-A provided an email from the human resources business partner (HR)-J stating they were still working to get more information from NetStudy for H-I. The email stated, "I have called the state and they are not available to take any calls right now. I am assuming due to the NetStudy portal update as of this morning, they are backlogged. I will reach out via email and keep you posted on their response." On May 13, 2025, at 9:38 a.m., DH-A stated RSD-G and H-I on the DHS NetStudy background study roster were affiliated only to the licensee's other facilities, and those employees were being updated and affiliated with HFID 35970, during the survey. The licensee's Personnel policy dated March 3, 2022, indicated the personnel records for each employee will include documentation of a completed background study. No further information provided.	01290		

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01290	Continued From page 9 TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure.	01470		

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01470	Continued From page 10 (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to include all required content for one of two employees (registered nurse (RN)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01470		

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01470	Continued From page 11 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-C had a hire date of September 14, 2023, within the employer's skilled care department located in the same building. RN-C transferred to the licensee's assisted living care area with license number HFID 35970 as of March 13, 2025. On May 12, 2025, between 12:30 p.m., and 1:00 p.m., the surveyor observed RN-C provide nursing services to the licensee's residents. RN-C's employee record lacked documentation RN-C completed the following required orientation to Assisted Living topics before providing services: -an overview of the appropriate Assisted Living statutes; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure.	01470		

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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
01470	Continued From page 12 On May 13, 2025, at 9:38 a.m., director of housing (DH)-A stated, RN-C was not assigned the full training content by the licensee's human resource department when she transferred to the licensee's secure care area. DH-A verbalized RN-C was missing some of the required initial orientation content. DH-A stated they were in the process of getting the required courses assigned for RN-C. The licensee's Staff Orientation on Dementia Care policy copyright 2022, indicated, " 2. At minimum, orientation must include the following topics: a. An overview of Minnesota's assisted living law b. An introduction and review of agency policies and procedures related to the provision of assisted living services c. Emergency and disaster training -Handling of emergencies and use of emergency services -Emergency and disaster preparedness plan -Procedures to use in handling various emergency situation d. Employee Right to Know e. The assisted living bill of rights and staff responsibilities to ensuring the exercise and protection of those rights f. Infection control -Bloodborne pathogens -Maintaining a clean and safe environment -TB prevention and control -Basic infection control g. HIPAA / Privacy Practices h. Employee job description i. Organizational chart and roles of staff within the facility j. Principles of person-centered planning and service delivery and how they apply to direct support services	01470		

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	35970	A. BUILDING: _____ B. WING _____	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01470	Continued From page 13 k. Types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and providers scope of licensure l. Maltreatment of vulnerable adults m. How to report maltreatment of vulnerable adults n. How to report a crime -Complaint process -Handling resident complaints -The organization's system for receiving and responding to complaints, -Where and how to report complaints -Contact information for the Office of Health Facility Complaints -Contact information for the Office of the Ombudsman for long-term care -Contact information for the Office of the Ombudsman for Mental Health and Disabilities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the	01540		

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01540	Continued From page 14 requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees had completed at least eight (8) hours of initial dementia training for supervisors of direct care staff within 80 working hours of the employment start date for one of two employees (registered nurse (RN)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 held an Assisted Living with Dementia Care Facility license as of August 1, 2021. RN-C had a hire date of September 14, 2023, within the employer's skilled care department located in the same building. RN-C transferred to the licensee's assisted living care area with license number HFID 35970 as of March 13, 2025.	01540		

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01540	Continued From page 15 On May 12, 2025, between 12:30 p.m., and 1:00 p.m., the surveyor observed RN-C provide nursing services to the licensee's residents. RN-C's employee record included 3.5 hours of dementia training completed within 18 months before RN-C's hire date with the licensee, March 13, 2025. RN-C's record lacked documentation of 4.5 of the required eight hours within 80 working hours of the employment start date for supervisors of direct care staff. On May 13, 2025, at 9:38 a.m., director of housing (DH)-A stated, RN-C was not assigned the full training content by the licensee's human resource department when she transferred to the licensee's secure care area. DH-A verbalized RN-C was missing some hours of dementia training completed in the required time frame. The licensee's Dementia Training policy copyright 2021, included, "1. If the assisted living site has a Dementia/Memory care license for residents with Alzheimer's disease or other dementias, all employees of the Assisted Living community must meet the following training requirements: a. Supervisors of direct care staff must have at least eight (8) hours of initial training within 120 working hours of employment start date. b. For assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource	01540		

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01540	Continued From page 16 and assist if issues arise c. Staff who do not provide direct care must have at least four (4) hours of dementia training within 160 hours of employment start date." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced	01620		

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01620	Continued From page 17 by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, no more than 14 days after start of services for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 12, 2025, at 10:10 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee completed nursing assessments upon admission, within 14 days of admission, every 90 days, and with a change in condition. R2 was admitted on August 6, 2024. R2's service plan, effective March 25, 2025, indicated R2 received services including assistance with housekeeping, laundry, meals, dressing, grooming, toileting, bathing, compression socks, transfers, safety checks, and medication administration. On May 12, 2025, at 1:10 p.m., the surveyor observed ULP-D provide safety check services for R2.	01620		

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01620	Continued From page 18 R2's medical record included an initial Resident Evaluation, dated August 6, 2024, on the admission date, and a subsequent nursing assessment dated August 27, 2024, greater than 14 days after start of services. On May 13, 2025, at 1:28 p.m., regional director of housing services (RDHS)-F stated R2's 14-day assessment was completed late. The licensee's Initial and On-going Assessments of Residents policy, reviewed May 3, 2022, indicated, "A. Initial Nursing Assessment 1. A RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. Initial assessment completed before services started c. 14-day assessment: completed up to 14-days after start of services d. Ongoing assessment: completed periodically but no less than every 90-days e. Change in resident condition." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated	01890		

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01890	Continued From page 19 drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include an original prescription label with legible information and expired found in one of two medication carts. 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: On May 12, 2025, at 12:30 p.m., the surveyor observed the two medication carts, located in the dining room area, with unlicensed personnel (ULP)-D. The top drawer of the unlabeled medication cart closest to the window, included an unlabeled tube of Salonpas 4% (percent) lidocaine (for pain relief) cream with an expiration date of May 2023. ULP-D stated she was not sure why the cream was in the medication cart and did not know who this was used for. ULP-D verbalized she planned to update the nurse. On May 12, 2025, at 12:47 p.m., registered nurse (RN)-C stated she did not know who the Salonpas lidocaine cream belonged to. RN-C verbalized she transferred employment to the assisted living a couple of months ago and stated she was responsible to monitor the medication carts and was aware she needed to focus more	01890		

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01890	Continued From page 20 on the routine monitoring of the medication cart. On May 12, 2025, at 12:58 p.m., clinical nurse supervisor (CNS)-B stated all medications including over the counter medications should be labeled and the cream should have been discarded since the medication was expired. The manufacturer's instructions for Salonpas 4% lidocaine cream website dated 2014-2025, under frequently asked questions indicated, "The shelf-life of Salonpas® products are 2 to 3 years from the production date. The expiration date is on the box of each product." The licensee's Storage of Medications policy copyright 2021, indicated, "2. b. Until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. c. An over-the-counter drug must be kept in the original labeled container from the pharmacy or manufacturer." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that	02040		

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02040	Continued From page 21 has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability 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 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). Findings include: A record review of available documentation and interview were conducted May 12, 2025, with environmental services director (ESD)-E, on the hazard vulnerability assessment (HVA) for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a	02040		

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02040	Continued From page 22 hazard vulnerability assessment with mitigation factors on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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

Cerenity Care Center- Marian
200 Earl Street
St Paul, MN 55106
Ramsey County
Parcel:

Phone:

License Info

License: HFID 35970

Risk:
License:
Expires on:
CFPM: CRYSTAL ROSENBLOOM
CFPM #: 90993; Exp: 04/30/2027

Inspection Info

Report Number: F8058251018
Inspection Type: Full - Single
Date: 5/12/2025 Time: 3:43:46 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

HRD INSPECTOR DEDE HINNENDAEL

WALK IN:
LETTUCE 41
WATERMELON 41
CHICKEN 40
CHEESE 40

MASHED POTATOES - HOT HOLDING - 172

SANI BUCKET - ACID - 700 MLL

DISH MACHINE - 171
DISH MACHINE 2 - 165
DISH MACHINE 3 - 179

COOLER 2 - MILK 40

COOLER 3 - MILK - 41

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 F8058251018 from 5/12/2025

CRYSTAL ROSENBLOOM
PIC

Aaron Gertz,
Public Health Sanitarian 3

651-201-4516
aaron.gertz@state.mn.us

Minnesota (MDH) Version
EH Manager; RPT: F8058251018

Food Establishment Inspection Report

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

No. of Risk Factor/Intervention/Violations	0	Date: 5/12/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 3:43:46 PM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Cerenity Care Center- Marian	200 Earl Street	St Paul, MN	55106	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 35970		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	IN	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	IN	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
	Safe Food and Water			
30	IN	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
	Food Temperature Control			
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN	Plant food properly cooked for hot holding		
35	N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
	Food Identification			
37		Food properly labeled; original container		
	Prevention of Food Contamination			
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
	Proper Use of Utensils			
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
	Utensils, Equipment and Vending			
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
	Physical Facilities			
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature)

Follow-up: No Follow-up Date: