DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 29, 2025

Licensee
Cerenity Residence on Humboldt
514 Humboldt Avenue
Saint Paul, MN 55107

RE: Project Number SL30462016

Dear Licensee:

On September 30, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on July 30, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

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

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Electronically Delivered

September 15, 2025

Licensee
Cerenity Residence on Humboldt
514 Humboldt Avenue
Saint Paul, MN 55107

RE: Project Number(s) SL30462016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 30, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

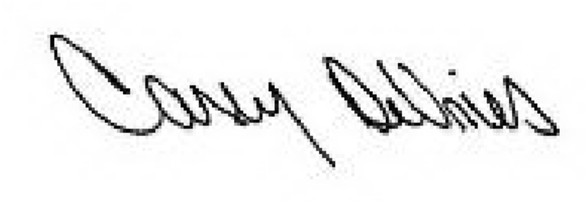
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30462	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY RESIDENCE ON HUMBOLDT	514 HUMBOLDT AVENUE SAINT PAUL, MN 55107

(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: SL30462016-0 On July 28, 2025, through July 30, 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 were 71 residents; 71 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on July 28, 2025, issued for SL30462016-0, tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	0 480		

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 29, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 29, 2025, from approximately 10:35 a.m. to 2:10 p.m., the surveyor toured the facility with resident services director (RSD)-A, licensed assisted living director (LALD)-D, environmental services director (ESD)-N and support environmental services (SES)-O. During the tour, the surveyor observed the following deficient conditions: A marked egress door from the boiler room was	0 775		

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0 775	Continued From page 4 blocked by stored equipment and machines which prevented the door from opening properly from the egress side. The floor where the equipment was stored was marked with yellow tape to indicate it should be kept clear, but materials had accumulated obstructing the door. ESD-N moved a floor machine out of the way to permit the door to open during survey. Gates to the rear courtyard were locked with a chain and padlock that prevented exit along a marked exit route. The supplied locks should be removed, and egress should not be obstructed to avoid risk of injury during an emergency and allow proper exit from the building. ESD-N stated that the gate should not be locked and expressed concern, indicating that the lock would be cut off and removed, and gates maintained free of obstruction. A cart with equipment stacked on it was stored in front of the fire department connection (FDC) on the exterior of the building, obstructing the connection and limiting access. The FDC should be maintained free of obstruction to permit fire department access during emergency. ESD-N acknowledged the cart and indicated it should be moved and that it is not usually stored in that location. Smoking materials were improperly disposed of, and discarded cigarettes were observed on the ground in the rear of the facility near the smoking receptacle. Smoking materials should be disposed of in an appropriate manner to avoid risk of fire. The clothes dryer in the third-floor laundry room and main level laundry room had a significant accumulation of lint near the dryer ventilation.	0 775		

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0 775	Continued From page 5 Accumulated dryer lint may pose a fire hazard and should be removed, and dryer ventilation maintained such that it does not contribute to lint buildup. Emergency exit signs did not function properly when tested to disconnect them from their primary power source. Emergency exit signs near the third floor South stairwell, on the third floor near the memory care entry door, on the third floor near the memory care restrooms, on third floor near North stairwell, on first floor in North stairwell near exit door, on the main floor in the North side men's restroom, and on the main floor near the kitchen delivery door were found not to have adequate auxiliary power to illuminate signage when tested. ESD-N stated that emergency exit signs were not connected to generator system and provided logs of monthly testing of signs by facility staff. Exit signs should be maintained to continue illumination during emergency situation with loss of power in order to remain visible and direct occupants out of the facility. Heat detectors what were not longer in use and no longer functional were present in offices and linen closets throughout the facility on all floors. ESD-N confirmed that these detectors were remnants of a previous fire alarm system and that they are no longer functional. Any fire safety equipment or devices that give the appearance of fire safety devices that are not functional should be removed to not give the false semblance of security and protection. An access panel in the ceiling surrounding a sprinkler head in the third-floor memory care bathroom was missing and left a gap in the ceiling around sprinkler head and escutcheon.	0 775		

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0 775	Continued From page 6 The ceiling around fire safety devices such as sprinkler heads should be maintained to ensure proper activation of devices and limit spread of smoke and fire above the sprinkler head. Multiplug adapters were in use in resident room 306, and resident room 221. These devices weren't rated for continuous use and may pose a risk of fire. ESD-N and SES-O indicated the devices would be removed and replaced with approved devices. Fire caulk was deteriorated and missing from penetration around conduit in the library closet near resident room 208. ESD-N confirmed that the caulking was missing and indicated it would be replaced via a rated means. On July 29, 2025, the surveyor explained to ESD-N, SES-O and LALD-D the requirements for maintaining egress routes and complying with requirements of Minnesota state fire code. ESD-N, SES-O and LALD-D stated they understood requirements and would make appropriate changes. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
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.	0 800		

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0 800	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. 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 the potential to affect a large portion or all of the residents). The findings include: On July 29, 2025, from approximately 10:35 a.m. to 2:10 p.m., the surveyor toured the facility with resident services director (RSD)-A, licensed assisted living director (LALD)-D, environmental services director (ESD)-N and support environmental services (SES)-O. During the tour, the surveyor observed the following deficient conditions: The lock to the unit door of resident room 332 was not properly functional. Supplied lock should be maintained in proper order and functional condition. Electrical panels in the third-floor memory care area hallway had signage which indicated they	0 800		

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0 800	Continued From page 8 were supposed to be locked, but locking devices did not function properly. The closet door near the business office had fallen off the track and was leaning precariously against the wall. The closet door should be securely attached to the closet assembly to mitigate risk of it falling on potentially injuring someone. Ceiling drop tiles in the chapel were damaged and missing. ESD-N indicated that there had been a water leak and that tiles would be replaced. Ceiling drop tiles in the lower-level hallway on the North side of the building were damaged and bent, with some tiles missing. The retaining wall near the front entry of the property is damaged and leaning which poses a risk of falling over. The retaining wall should be maintained in safe condition. During the facility tour interview on July 29, 2025, LALD-D and ESD-N verified the above listed physical environment observation while accompanying on the tour. 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: (1) location and number of resident sleeping rooms;	0 810		

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0 810	Continued From page 9 (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 required content and provide required training and documentation. 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	0 810		

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0 810	Continued From page 10 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 July 29, 2025, at approximately 1:25 p.m., resident services director (RSD)-A, licensed assisted living director (LALD)-D, environmental services director (ESD)-N and provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training. The licensee FSEP failed to include the following: The FSEP did not include fire procedures for residents. The FSEP should include plans for residents to follow during fire emergency. The FSEP did not include any documentation of trainings provided to residents on evacuation. Trainings should be made available to residents at least once a year. RSD-A indicated that plans are in place for such trainings to begin. The FSEP did not include any documentation of trainings provided to staff on the FSEP. LALD-D stated that this training occurred annually online. Staff should receive training on the FSEP upon hire and at least twice a year thereafter and trainings should be specific to the FSEP and facility. During the record review and interview on April 1, 2025, LALD-D verified the above listed documents were absent from the FSEP. LALD-D stated that they understood requirements and	0 810		

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0 810	Continued From page 11 would supplement the existing FSEP with missing information and documents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=I	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 observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of one employee (unlicensed personnel (ULP)-H). Additionally, licensee failed to ensure a non-employee (hair stylist (HS)-K) had a cleared background study before providing services to residents. This resulted in an immediate correction order issued on July 28, 2025.	01290		

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01290	Continued From page 12 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The finding include: EXPIRED COVID BACKGROUND CHECK On July 29, 2025, at 11:35 a.m., the surveyor received the licensee's NETStudy 2.0 roster (web-based system used to submit background study requests to the Department of Human Services (DHS)). ULP-H was identified as an employee. ULP-H was hired on December 28, 2021, and provided direct cares and services to residents. The licensee's schedule dated July 1, 2025, through July 28, 2025, indicated ULP-H was scheduled to work 11 shifts. ULP-H's background study affiliated to HFID 30426, indicated "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022, on the NETStudy 2.0 website. On July 28, 2025, 1:51 p.m., human resources manager (HRM)-I stated ULP-H did not have a cleared background study and should not be providing direct care services. HRM-I stated ULP-H would need to be removed from all scheduled shifts until the background study is completed. HRM-I stated they were unsure why	01290		

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01290	Continued From page 13 the study was not completed. NON-EMPLOYEE PROVIDING COSMETOLOGY SERVICES TO RESIDENTS WITHOUT A VALID BACKGROUND STUDY. On July 28, 2025, at 11:08 a.m., during a facility tour, in the lower level, the surveyor observed a small room with a printed notice that stated, "Minnesota Board of Cosmetology, Cosmetologist Salon Manager - [hair stylist (HS)-K]; status: active, license number [number listed], license expiration date July 31, 2028." On July 28, 2025, at 11:08 a.m., licensed assisted living director (LALD)-D stated HS-K was not an employee of the assisted living facility but rented the space from the licensee. On July 29, 2025, at 12:59 p.m., HRM-I stated HS-K had been at the facility once. HRM-I stated they worked 10 hours to see if HS-K was liked by the residents. HRM-I stated if HS-K was, "a good fit", they planned to proceed with a background check. On July 29, 2025, at 1:04 p.m., activities director (AD)-L stated HS-K was at the facility on Monday July 10, 2025. AD-L stated they would bring residents to the salon and only stay for a few minutes. AD-L stated they did not stay with residents, and they were left alone with HS-K with no other staff member present. On July 29, 2025, at 1:29 p.m., LALD-D stated they was no contract between the licensee and HS-K. On July 29, 2025, at 2:22 p.m., HRM-I stated their process was to perform a background study on	01290		

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01290	Continued From page 14 anyone providing care or services to residents. HRM-I stated they currently did not have a cleared background study for HS-K. HRM-I stated HS-K should not have been left unsupervised, and an employee should have been with HS-K the entire time they were at the facility. On July 29, 2025, at 2:45 p.m., LALD-D stated all staff required a completed background study. LALD-D stated the human resource department manages the background studies for employees. On July 29, 2025, at 3:45 p.m., LALD-D stated they did not intend to complete a formal contract or least agreement with HS-K. LALD-D stated HS-K would receive payment directly from residents. LALD-D stated if they decided HS-K would be at the facility on a permanent basis, they would have HS-K attend licensee's volunteer training, including some topics on orientation to the facility, and the emergency preparedness plan. LALD-D stated they had planned for HS-K to be at the facility once per month and increase that if there was demand from residents. LALD-D stated HS-K was only going to perform services for residents. The licensee's Background Check policy with a revision date of November 20, 2024, indicated any volunteers, students/interns, temporary staff, agency staff and independent contractors will require a completed background study. The Minnesota Department of Health Emergency Background Studies End website dated July 7, 2024, indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid. Individuals who only had an emergency study must have a fully compliant, fingerprint-based	01290		

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01290	Continued From page 15 background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
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	01730		

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01730	Continued From page 16 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. (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 interview and record review, the	01730		

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01730	Continued From page 17 licensee failed to develop and maintain a current individualized medication management record to include all required content for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the assisted living facility May 18, 2025, and began receiving assisted living services. R1's diagnoses included malignant neoplasm of the bladder (bladder cancer), type 2 diabetes (disease process that causes blood sugars to go unregulated), hyperlipidemia (high cholesterol), insomnia (difficultly sleeping), hypertension (high blood pressure), pain in right and left knees, unsteadiness on feet, and localized edema (swelling), depression. R1's Service Plan with Schedule dated June 10, 2025, indicated R1 received assistance with medication management. R1's Medication Management Assessment dated June 10, 2025, lacked the following information: - identification of medication management tasks that may be delegated to unlicensed personnel and;	01730		

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01730	Continued From page 18 - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. R2 R2 was admitted to the assisted living facility September 28, 2023, and began receiving assisted living services. R2's diagnoses included alcohol abuse, cerebral infarction (brain tissue that has died), hypertension (high blood pressure), gastro-esophageal reflux disease (stomach acid travels up from the stomach), hyperlipidemia (high cholesterol), major depressive disorder, arthritis (inflammation of the joints), osteoarthritis (damage to the cartilage at the end of bones), tobacco use, and sequelae of unspecified cerebrovascular disease (long-term effects following a stroke). R2's Service Plan dated July 18, 2025, indicated R2 received assistance with medication management. R2's Medication Management Assessment dated June 10, 2025, lacked the following information: - identification of medication management tasks that may be delegated to unlicensed personnel and; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. R3 R3 was admitted to the assisted living facility September 28, 2023, and began receiving assisted living services.	01730		

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01730	Continued From page 19 R3's diagnoses included dementia, cyst on the kidney (abnormal growth), pterygium of both eyes (Cancerous growth), insomnia, hyperglycemia (high blood glucose), chronic kidney disease, muscle weakness, hypertension, cerebral infarction (brain stroke), Type 2 diabetes, hyperlipidemia, and hypokalemia (low potassium). R3's Service Plan dated July 18, 2025, indicated R2 received assistance with medication management. R3's Medication Management Assessment dated July 16, 2025, lacked the following information: - identification of medication management tasks that may be delegated to unlicensed personnel and; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. On July 30, 2025, at 11:37 a.m., clinical nurse supervisor (CNS)-C stated they were responsible for the medication management plans. CNS-C stated the used a template in the electronic medical record (EMAR) to create the medication management plan and believed the medication management plans were compliant. The licensee's Medication Management policy dated 2022, indicated the medication management plan would contain the above information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01730		

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01730	Continued From page 20 days	01730		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to correctly label medication after removing from the refrigerator for temperature sensitive medications. Additionally, the licensee failed to store prescription medication securely to permit only authorized personnel to have access, and the licensee failed to correctly monitor refrigeratortemperatures for temperature sensitive medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: INSULIN INJECTION PEN NOT LABELED WITH AN OPEN DATE On July 28, 2025, at 9:44 a.m., regional director	01880		

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01880	Continued From page 21 of nursing (RDON)-E stated clinical nurse supervisor (CNS)-C was not working at the facility that day (during the survey), and they would be providing coverage. On July 28, 2025, at 10:54 a.m., on the third floor of the four-story assisted living facility with dementia care (ALFDC), in the secured unit was a medication cart. In one of the drawers was an Insulin Glargine insulin injection pen (a device for injecting medication into a person) for R3. There were 60 units (u) remaining in the pen. There was no opened date labeled on the insulin injection pen. On July 28, 2025, at 10:56 a.m., ULP-O stated they were trained to label the pen with an open date when it was opened. ULP-O stated they were trained to contact the nurse if there was no open date on the insulin injection pen. ULP-O stated they were unaware and unsure why it was not labeled. On July 28, 2025, at 11:00 a.m., regional director of nursing (RDON)-E stated staff were trained to label the insulin injection pen with an open date. RDON-E stated staff were trained to contact a registered nurse (RN) if there was no open date on the insulin injection pen. RDON-E stated they were unsure why there was no open date. The manufacturer's instruction for Lantus/Insulin Glargine dated 2024 indicated insulin should be discarded after 28 days later after removal from the refrigerator. The manufactures guidelines dated 2024 indicated a new Lantus/Insulin Glargine indicated the medication was dispensed containing 300 units.	01880		

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01880	Continued From page 22 UNSECURED MEDICATIONS On July 29, 2025, at 7:47 a.m., on the first level of the ALFDC, the surveyor entered the nurse office that was unlocked. There was a small refrigerator that contained the following medications: 6 full Insulin Aspart injection pens (a device to inject insulin), 1 full insulin Glargine injection pen, 6 full Lantus insulin injection pens, 10 full Novolin Flex insulin injection pens and 3 boxes containing full latanoprost eye drops. There were no staff present in the nurse office and the medications were unsecured. On July 29, 2025, at 8:04 a.m., CNS-C stated staff were trained to lock the door when no staff were present. CNS-C stated if the door was unlocked, there was no way to prevent residents from entering the nurse office and removing the medications. CNS-C stated the medications were not as secured as, "I would like them to be." CNS-C stated best practice was the medications should be locked to prevent unauthorized accessed. REFRIGERATOR TEMPERATURES NOT LOGGED On July 28, 2025, at 11:08 a.m., on the side of the medication refrigerator where the insulin was stored, the surveyor observed a document titled Daily Refrigerator Temperature Log dated July 2025. The document had four columns labeled, "date, time temp was taken, temperature, initial." The following dates were missing the temperature recording: 2, 3, 4, 5, 6, 8, 9, 12, 13, 15, 16, 19, 20, 26, and 27. On July 28, 2025, at 11:09 a.m., registered nurse	01880		

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01880	Continued From page 23 (RN)-J stated there was no nursing staff that worked on the weekend. RN-J stated those checks were missed. RN-J stated without checking the refrigerator temperatures there was no way to determine if the temperature was within required range. On July 30, 2025, at 11:20 a.m., CNS-C stated the nursing staff were responsible for the temperature checks during the week and unlicensed personnel (ULP) were responsible for the temperature checks on the weekend. CNS-C stated they were unsure why the temperature checks were missed. The manufacturer's instruction for Lantus/Insulin Glargine dated 2024 recommended unopened insulin pens should be refrigerated at a temperature of 36 degrees Fahrenheit (F) to 46 degrees F until opened or expired. The manufacturer's instruction for Insulin Aspart Novolog Flex dated April 2025 recommended unopened insulin pens should be refrigerated at a temperature of 36 degrees F to 46 degrees F until opened or expired. The United States Food and Drug Administration (FDA) datasheet for Latanoprost dated August recommended unopened medication should be refrigerated at a temperature of 36 degrees F to 46 degrees F until opened or expired. The licensee's Storage of undated Medications policy indicated the registered nurse would determine appropriate storage based on the resident's assessments and would ensure medications were stored under proper temperature controls.	01880		

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01880	Continued From page 24 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, licensee failed to ensure unlicensed personnel followed appropriate infection control practices and failed to ensure a sharps container was replaced when required. 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: DID NOT WIPE DOWN GLUCOSE MONITOR On July 30, 2025, at 7:17 a.m., the surveyor observed unlicensed personnel (ULP)-M remove	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30462	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY RESIDENCE ON HUMBOLDT	514 HUMBOLDT AVENUE SAINT PAUL, MN 55107

(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
02320	Continued From page 25 a blood glucose monitor (a device that measures blood sugars) from a medication cart. ULP-M placed a blood glucose test strip into the blood glucose monitor, used a lancet (a device that is used to punch a hole in the skin to produce a drop of blood) on R3, placed the strip onto the blood drop and obtained the reading. ULP-M removed the used blood glucose strip and placed it into the sharps container. Without wiping down the blood glucose machine, ULP-M placed it back into the drawer of the medication cart. On July 30, 2025, at 7:49 a.m., ULP-M stated they were trained to wipe down the blood glucose machine after each use and forgot to wipe it down. On July 30, 2025, at 11:23 a.m., clinical nurse supervisor (CNS)-C stated staff were trained to wipe down the blood glucose machine after each use. CNS-C stated ULP-M should have wiped the blood glucose machine after each use and they would have to retrain staff. SHARPS CONTAINER PAST FILL LINE On July 29, 2025, at 9:09 a.m., on the first level of the four-story assisted living facility with dementia care (ALFDC), the surveyor observed a sharps container attached to a medication cart. There were several lancets above the fill line of the container. On July 30, 2025, at 7:32 a.m., ULP-M stated they were trained to replace the sharps container when it was at the fill line. On July 30, 2025, at 11:18 a.m., CNS-C stated sharps containers should be changed out when they were three-quarters full or when they reach	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30462	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
02320	Continued From page 26 capacity which was indicated by the fill line on the container. CNS-C stated staff should have changed the sharps container. The Center for Disease Control (CDC) Disinfection of Healthcare Equipment dated November 28, 2023, recommended using bleach or alcohol for cleaning reusable equipment. The United States Food and Drug Administration (FDA) Sharps Disposal Containers dated April 28, 2021, recommended when the content of the container reaches the fill line (approximately three-quarters full), the sharps container should be replaced. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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 Residence on Humboldt
514 Humboldt Ave
St Paul, MN 55107
Ramsey County
Parcel:

Phone:

License Info

License: HFID 30462

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

Inspection Info

Report Number: F1039251071
Inspection Type: Full - Single
Date: 7/29/2025 Time: 10:15:00
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 4
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: NO CURRENT CFPM. PERSON-IN-CHARGE PLANS TO RETAKE SERV-SAFE AND REGISTER AS CFPM. GOOGLE "MDH CFPM" TO FIND MAIN PAGE ON TOPIC.
Comply By: 9/1/2025 Originally Issued On: 7/29/2025

New Order: 6-100 Physical Facility Construction Materials
6-101.11A1 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.
COMMENT: REISSUE FROM PREVIOUS INSPECTION - FLOOR IN DRY STORE ROOM (PREVIOUSLY HELD WALK-IN COOLER/FREEZER) HAS WORN VINYL TILE, BARE CEMENT AND GAP AT FLOOR/WALL JUNCTION. REPLACE WITH APPROVED FLOORING, INCLUDING BASE COVING AT FLOOR/WALL JUNCTION.
Comply By: 12/1/2025 Originally Issued On: 7/29/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.11 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1515 Maintain the physical facilities in good repair.
COMMENT: INSTALLATION OF DUCT WORK FOR NEW DISH MACHINE HAS LEFT HOLE IN CEILING. REPAIR HOLE AND GIVE SMOOTH/DURABLE/EASILY CLEANABLE FINISH.

GROUTING FOR TILE ON DIRTY SIDE OF DISH AREA IS WORN AND DAMAGED. REPAIR GROUT.
Comply By: 9/1/2025 Originally Issued On: 7/29/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: KITCHEN FLOORS AT DISH AREA AND COOK LINE HAVE ACCUMULATED SOILS. TILE WALL AT DIRTY SIDE OF DISH AREA HAS SOILED GROUT. CLEAN AND MAINTAIN CLEAN TO COMPLY WITH ABOVE RULE.
Comply By: 8/8/2025 Originally Issued On: 7/29/2025

Food & Beverage General Comment

MILK - COLD HOLD/BEVERAGE 1-DOOR COOLER - 41 DEGREES F
COOKED TACO MEAT - HOT HOLD/PORTABLE HOT BOX - 170 DEGREES F
COOKED CORN - HOT HOLD/CORNER KITCHEN HOT BOX - 156 DEGREES F
CUT TOMATO - COLD HOLD/4-DOOR REACH-IN COOLER - 40 DEGREES F

AMBIENT - WALK-IN COOLER - 38 DEGREES F
PACKAGED CHEESE - COLD HOLD/WALK-IN COOLER - 38 DEGREES F
FREEZERS - FROZEN

This inspection was completed with the persons-in-charge and reviewed with MDH nurse evaluator Keith Langley.

The kitchen facility and equipment are of commercial grade.

Discussed the following with the person-in-charge: food source, foodborne illness symptoms and exclusion of ill employees, frequencies for equipment cleaning, temperature measurement, sanitizing, menu and food processes, all orders on this report.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1039251071 from 7/29/2025

Justin Klunk
kitchen manager

Aron Goodner,
Public Health Sanitarian 1
651-201-4910
aron.goodner@state.mn.us

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

Sanitizer Observations/Recordings

Establishment Info

Cerenity Residence on Humboldt
St Paul
County/Group: Ramsey County

Inspection Info

Report Number: F1039251071
Inspection Type: Full
Date: 7/29/2025
Time: 10:15:00

Sanitizing Chemical: **Product:** Sink and Surface**; Sanitizing Process:** Dispenser
Location: 3-Comp Sink **Equal To** 700 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Equal To 160 Degrees F.
Comment:
Violation Issued?: No