Electronically Delivered

June 5, 2025

Licensee
Serenity Living Center
1204 Oakview Drive
Dilworth, MN 56529

RE: Project Number(s) SL29276016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 29, 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 . . ."

IMPOSITION OF FINES

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

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

§ 144G.20.

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 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
	29276	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING CENTER	1204 OAKVIEW DRIVE DILWORTH, MN 56529

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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: SL29276016-0 On April 28, 2025, through April 29, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 34 residents; 34 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of three residents (R8). 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: During the entrance conference on April 28, 2025, at 10:05 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R8's diagnoses included diabetes and	0 630		

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0 630	Continued From page 2 hypertension (HTN-high blood pressure). R8's Service Plan (Waiver)- Addendum to Contract dated, December 16, 2024, indicated R8 received medication assistance, blood glucose checks, vital sign monitoring, bathing, housekeeping, and laundry. On April 29, 2025, at 8:06 a.m., the surveyor observed unlicensed personnel (ULP)-E provide scheduled morning medication administration to R8. R8's resident record contained an Assessment dated March 10, 2025. R8's Assessment included a vulnerability section, which indicated R8 was not at risk to be abused. R8's resident record lacked R8's risk to abuse others and R8's risk for self-abuse. On April 29, 2025, at 2:41 p.m., CNS-B stated R8's assessment was not fully completed to include all required content of R8's IAPP. CNS-B further stated R8's assessment was one of the first assessments registered nurse (RN)-C had completed and RN-C had missed checking the boxes for R8's risk for abusing others and R8's risk for self-abuse. The licensee's 6.05 IAPP policy dated August 1, 2021, indicated the resident's IAPP will contain risk of abusing other vulnerable adults and risk for self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 775	Continued From page 3	0 775		
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 comply with the requirements of the Minnesota State Fire Code. 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). Findings include: On a facility tour on April 29, 2025, from 10:15 a.m. to 11:45 a.m., with licensed assisted living director (LALD)-A, director of maintenance (DM)-G, and human resources (HR)-D, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: FIRE-RESISTANT RATED DOOR MAINTENANCE There were several doors propped open throughout the facility with devices that did not	0 775		

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0 775	Continued From page 4 release the door to close automatically upon activation of the fire alarm or sprinkler system. The door was missing from the fire-resistant rated door frame opening between the commercial kitchen and the exit corridor. It was explained that fire resistant rated doors are required to be maintained as automatically closing and latching to prevent the spread of smoke and fire to the exit corridor in the event of a fire or similar emergency. It was also explained that required fire-resistant rated door are required to be maintained in place and automatically closing as designed and installed at the time of construction approval. CARBON MONOXIDE DETECTION/ ALARMS There was one carbon monoxide detector installed and tied into the building fire alarm system near the gas fireplace next to the commercial kitchen. There was no other carbon monoxide detectors observed throughout the facility. There was not carbon monoxide alarms installed within ten feet of all sleeping rooms within the facility. Carbon monoxide detection and or alarm systems are required to be installed to notify the building occupants of the presence of carbon monoxide. Carbon monoxide alarms and detections systems in existing buildings are required to be installed in accordance with MSFC in Minnesota Rules Chapter 7511.	0 775		

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0 775	Continued From page 5 EXIT EMERGENCY LIGHT MAINTENANCE The combination emergency light/ exit signs in the corridor outside resident sleeping room 165 and 157 were tested by pushing the test button and did not operate as designed to provided emergency backup power to the light. It was explained the emergency lighting and exit signs are required to be provided with backup power to light the exit sign at all times and provide emergency light to the exit path in the event of a power outage. During the facility tour LALD-A, DM-G, and HR-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
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	0 810		

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0 810	Continued From page 6 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, make the plan readily available, provide required training and drills. 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 April 29, 2025, at 9:25 a.m., licensed assisted living director (LALD)-A, and human resources	0 810		

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0 810	Continued From page 7 (HR)-D, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP dated, failed to include the following: The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. The available FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident individualized unique needs for evacuation. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. The individual resident unique needs for evacuation are required to be readily available to all staff, at all times within the facility, for use in responding to a fire or similar emergency. During an interview on April 29, 2025, at 9:35 a.m., LALD-A, stated the provided FSEP did not include procedures for residents in the event of a fire or similar emergency or individual resident evacuation status unique needs for evacuation. DRILLS Record review of the available documentation indicated the licensee failed to conduct	0 810		

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0 810	Continued From page 8 evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation fire evacuation drills were completed as a training session in August and December of 2024 only. During an interview on April 29, 2025, at 9:35 a.m., LALD-A, stated the fire drill documentation was for training provided and only twice during 2024 in August and December. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement	01060		

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01060	Continued From page 9 that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01060		

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01060	Continued From page 10 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: During the entrance conference on April 28, 2025, at 10:05 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. The licensee's Discharged Resident/Client Roster dated April 28, 2025, indicated R1 was admitted to the facility on November 22, 2023, and was discharged to a skilled nursing facility on January 21, 2025. R1's diagnoses included congestive heart failure (CHF) and osteoarthritis. R1's Service Plan (Waiver)- Addendum to Contract dated October 8, 2024, indicated R1 received medication assistance, bathing, behavior monitoring, housekeeping, and laundry. R1's Resident Notes-One Resident included the following entries: -December 23, 2024, R1 was admitted to the hospital. -January 2, 2025, R1 was discharged from the hospital to a TCU (transitional care unit at a skilled nursing facility (SNF)). -January 21, 2025, R1's family decided to have R1 stay at the SNF due to R1 needing a higher level of care. R1's Med (medication) Admin (administration) Summary- Actual- Month dated December 2024,	01060		

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01060	Continued From page 11 indicated R1 was hospitalized December 23, 2024, through January 21, 2025. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On April 28, 2025, at 2:13 p.m., CNS-B stated CNS-B was unable to locate the emergency relocation documentation for R1. CNS-B further stated the licensee was aware of the emergency relocation requirement and would document the information in the resident notes, however, R1 was admitted to the hospital over the holidays and the licensee must have missed completing the emergency relocation documentation. The licensee's 1.23 Emergency Relocation policy dated August 1, 2021, indicated in the event of an emergency relocation, (licensee name) will provide a written notice to the resident, legal representative, designated representative,	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29276	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING CENTER	1204 OAKVIEW DRIVE DILWORTH, MN 56529

(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
01060	Continued From page 12 resident's case manager, if applicable, and the OOLTC (if the resident has not returned to the facility within four days) that contains, at a minimum: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the OOLTC; -If known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.	01640		

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SERENITY LIVING CENTER	1204 OAKVIEW DRIVE DILWORTH, MN 56529

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01640	Continued From page 13 (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a resident or resident's representative signature and a licensee signature or other authentication by the licensee to document agreement on the services to be provided for one of three residents (R5). This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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: During the entrance conference on April 28, 2025, at 10:05 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. On April 29, 2025, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-F complete scheduled morning medication administration to R5.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SERENITY LIVING CENTER	1204 OAKVIEW DRIVE DILWORTH, MN 56529

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01640	Continued From page 14 R5's Service Plan (Waiver)- Addendum to Contract printed April 29, 2025, indicated R5's services included medication assistance, TED/Compression stockings, dressing assistance, and vital sign monitoring. R5's service plan lacked a resident signature and a licensee signature or other authentication by the licensee to document agreement on the services to be provided. On April 29, 2025, at 2:43 p.m., the surveyor reviewed R5's electronic medical record and service plans with CNS-B and registered nurse (RN)-C. CNS-B stated R5's service plan was updated on January 22, 2025, to reflect change of services R5 was receiving, however, CNS-B stated the licensee must have missed having R5 and a licensee representative sign R5's updated service plan. CNS-B further stated any time a resident service plan had modification, the licensee had the resident, and a representative of the licensee sign the updated service plan. The licensee's 6.08 Service Plan policy dated August 1, 2022, indicated the service plan and any revision shall include a signature or other authentication by (licensee name) and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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01750	Continued From page 15	01750		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) documented resident-specific instructions for medications for one of three residents (R8) whose medication administration was delegated to unlicensed personnel (ULP). 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: During the entrance conference on April 28, 2025, at 10:09 a.m., clinical nurse supervisor (CNS)-B	01750		

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SERENITY LIVING CENTER	1204 OAKVIEW DRIVE DILWORTH, MN 56529

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01750	Continued From page 16 stated the licensee provided medication management services to residents at the facility. CNS-B further stated ULPs had one hour before and one hour scheduled administration times to administer resident medications. R8's diagnoses included diabetes, hypertension (HTN-high blood pressure), and Alzheimer's. R8's Service Plan (Waiver)- Addendum to Contract dated December 16, 2024, indicated R8 received medication assistance. R8's prescriber orders dated April 20, 2025, included an order for levothyroxine 100 micrograms (mcg) by mouth every morning. R8's Med (medication) Admin (administration) Summary dated March 2025, and April 2025, respectively, indicated levothyroxine was scheduled to be administered at 8:00 a.m. daily. R8's other scheduled morning medications were listed for administration at 9:00 a.m. On April 29, 2025, at 8:06 a.m., the surveyor observed ULP-E conduct a scheduled morning medication pass for R8. ULP-E compared the prescription label with R8's electronic medication administration record (EMAR) for R8's levothyroxine scheduled at 8:00 a.m. and ULP-E proceeded to compare prescription labels to R8's EMAR for all scheduled 9:00 a.m. medications. ULP-E administered R8's levothyroxine with R8's scheduled 9:00 a.m. medications, and R8 proceeded to eat breakfast in R8's room. Immediately following the observation, ULP-E stated ULPs had one hour before and one hour after scheduled medication administration times to administer resident medications.	01750		

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01750	Continued From page 17 R8's record lacked resident specific instructions for the administration of levothyroxine to be administered on an empty stomach with no other medications 30 to 60 minutes prior to food consumption. On April 29, 2025, at 2:35 p.m., RN-C stated R8's EMAR lacked specific instructions for ULPs to follow for the administration of levothyroxine to ensure 30 to 60 minutes had passed prior to administration of other scheduled medications. RN-C further stated normally ULPs would not administer scheduled 8:00 a.m. medications and 9:00 a.m. medications together. The manufacturer's instructions for levothyroxine dated August 2022, indicated to take levothyroxine on an empty stomach one-half to one hour before breakfast. The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2021, indicated the medication management record will be current and would include 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	01890		

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01890	Continued From page 18 immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications in three of six locked medication cabinets located in resident rooms (R4, R5, R6). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on April 28, 2025, at 10:09 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R4 On April 29, 2025, at 6:41 a.m., the surveyor reviewed R4's locked medication cabinet with unlicensed personnel (ULP)-F and observed R4's opened bottle of calcium carbonate with an expiration date of June 2024. ULP-F stated R4's calcium carbonate was not a scheduled medication for R4, however, R4 had used the	01890		

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01890	Continued From page 19 calcium carbonate on an as needed (PRN) basis. R5 On April 29, 2025, at 7:00 a.m., the surveyor reviewed R5's locked medication cabinet with ULP-F and observed 18 vials of Systane eye drops 0.7 milliliters (mL) with an expiration date of April 2023. ULP-F stated the nurse was responsible to monitor for expired medications in resident's locked medication cabinets. R6 On April 29, 2025, at 7:13 a.m., the surveyor reviewed R6's locked medication cabinet with ULP-H and observed four boxes of Aspercreme Lidocaine 4% patches with an expiration date of September 2024. ULP-H stated R6 had not recently used any Aspercreme Lidocaine 4% patches, and the nurse checked the resident's medication cabinets monthly for expired medications. On April 29, 2025, at 10:39 a.m., registered nurse (RN)-C stated RN-C had audited some of the resident's medication cabinets and removed expired medications, however, RN-C had not completed an audit for all residents at the facility. On April 29, 2025, at 2:31 p.m., CNS-B stated the nurse was responsible to monitor for expired medications in the resident's locked medication cabinets. The licensee's 7.23 Medication Disposal policy dated July 23, 2024, indicated medications that have expired or been discontinued by a provider will be disposed of at time of notice via hazardous waste container. No further information was provided.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 20 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02320 SS=D	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, the licensee failed to ensure the steps of the medication administration process was followed for one of three employees (unlicensed personnel (ULP)-E) observed administering 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 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: During the entrance conference on April 28, 2025, at 10:09 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320	Continued From page 21 management services to residents at the facility. R8's diagnoses included diabetes, hypertension (HTN-high blood pressure), and Alzheimer's. R8's Service Plan (Waiver)- Addendum to Contract dated December 16, 2024, indicated R8 received medication assistance. R8's prescriber orders dated April 15, 2025, included an order for Fluticasone Propionate 50 micrograms (mcg)/actuation (act) instill one spray in each nostril once daily. R8's Med (medication) Admin (administration) Summary dated March 2025, and April 2025, respectively, indicated Fluticasone 50 mcg/act instill one spray in each nostril once daily. On April 29, 2025, at 8:06 a.m., the surveyor observed ULP-E conduct a scheduled morning medication pass for R8. ULP-E compared the prescription label to R8's electronic medication administration record (EMAR), shook the Fluticasone bottle, handed R8 the Fluticasone nasal spray for self-administration, R8 administered three sprays of Fluticasone into each nostril, and R8 handed the Fluticasone nasal spray back to ULP-E. The surveyor did not observe ULP-E verbalize to R8 to only complete one spray into each nostril. On April 29, 2025, at 8:14 a.m., ULP-E stated R8 had always self-administered more than one spray of Fluticasone into each nostril. ULP-E further stated ULP-E used to remind R8 to only administer one spray of Fluticasone into each nostril, however, R8 would administer an additional one or two sprays into each nostril.	02320		

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02320	Continued From page 22 On April 29, 2025, at 2:34 p.m., CNS-B stated ULPs were trained to follow the instructions on a resident's EMAR when administering medications. CNS-B further stated ULP-E should have instructed R8 to only administer one spray into each nostril and report to the registered nurse (RN) for any additional sprays R8 requested. The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2021, indicated the medication management record will be current and would include 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

SERENITY ASSISTED LIVING
1204 OAKVIEW DRIVE
DILWORTH, MN 56529
Parcel:

Phone:

License Info

License: HFID 29276

Risk:
License:
Expires on:
CFPM: Denise Tollefson
CFPM #: 67300; Exp: 6/5/2025

Inspection Info

Report Number: F7935251001
Inspection Type: Full - Single
Date: 4/29/2025 Time: 10:01:33 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

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 Fergus Falls District Office inspection report number F7935251001 from 4/29/2025

Rebecca Tonneson

Establishment Representative

Rebecca Tonneson, RS
Public Health Sanitarian Supervisor
218-332-5142
rebecca.tonneson@state.mn.us

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

Temperature Observations/Recordings

Establishment Info

SERENITY ASSISTED LIVING
DILWORTH
County/Group:

Inspection Info

Report Number: F7935251001
Inspection Type: Full
Date: 4/29/2025
Time: 10:01:33 AM

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Ground Hamburger**; Temperature Process:** Cooking
Location: Oven at 205 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Norlake**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Walk In **; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

Sanitizer Observations/Recordings

Establishment Info

SERENITY ASSISTED LIVING
DILWORTH
County/Group:

Inspection Info

Report Number: F7935251001
Inspection Type: Full
Date: 4/29/2025
Time: 10:01:33 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Manual Mix
Location: Wiping Cloth Bucket **Equal To** 200 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Dispenser
Location: Dishwashing Area **Equal To** 400 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** High Temp Dishwasher
Location: Dishwashing Area **Equal To** 164 Degrees F.
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F7935251001

Food Establishment Inspection Report

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

No. of Risk Factor/Intervention/Violations	0	Date: 4/29/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:01:33 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
SERENITY ASSISTED LIVING	1204 OAKVIEW DRIVE	DILWORTH, MN	56529	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 29276		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	IN	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	IN	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) [redacted]

Follow-up: No Follow-up Date:

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

SERENITY ASSISTED LIVING
1204 OAKVIEW DRIVE
DILWORTH, MN 56529
Parcel:

Phone:

License Info

License: HFID 29276

Risk:
License:
Expires on:
CFPM: Denise Tollefson
CFPM #: 67300; Exp: 6/5/2025

Inspection Info

Report Number: F7935251001
Inspection Type: Full - Single
Date: 4/29/2025 Time: 10:01:33 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

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 Fergus Falls District Office inspection report number F7935251001 from 4/29/2025

Establishment Representative

Rebecca Tonneson

Rebecca Tonneson, RS
Public Health Sanitarian Supervisor
218-332-5142
rebecca.tonneson@state.mn.us

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

Temperature Observations/Recordings

Establishment Info

SERENITY ASSISTED LIVING
DILWORTH
County/Group:

Inspection Info

Report Number: F7935251001
Inspection Type: Full
Date: 4/29/2025
Time: 10:01:33 AM

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Ground Hamburger**; Temperature Process:** Cooking
Location: Oven at 205 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Norlake**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Walk In **; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

Sanitizer Observations/Recordings

Establishment Info

SERENITY ASSISTED LIVING
DILWORTH
County/Group:

Inspection Info

Report Number: F7935251001
Inspection Type: Full
Date: 4/29/2025
Time: 10:01:33 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Manual Mix
Location: Wiping Cloth Bucket **Equal To** 200 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Dispenser
Location: Dishwashing Area **Equal To** 400 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** High Temp Dishwasher
Location: Dishwashing Area **Equal To** 164 Degrees F.
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F7935251001

Food Establishment Inspection Report

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

No. of Risk Factor/Intervention/Violations	0	Date: 4/29/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:01:33 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
SERENITY ASSISTED LIVING	1204 OAKVIEW DRIVE	DILWORTH, MN	56529	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 29276		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			
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Person in Charge (signature)

Inspector (signature) [redacted]

Follow-up: No Follow-up Date: