



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 11, 2023

Licensee
Serendipitous Living
103 Robie Street West
Saint Paul, MN 55107

RE: Project Number(s) SL34879015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 14, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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.

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

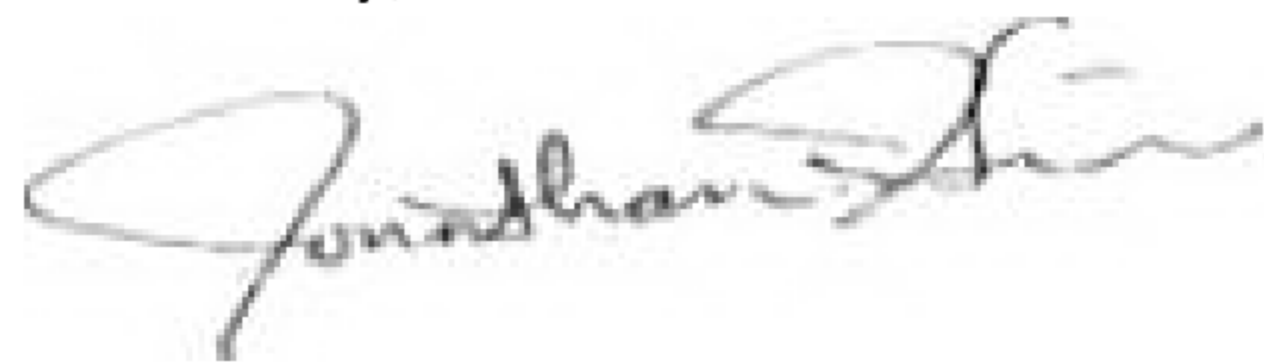
Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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,



Jonathan Hill, Supervisor

State Evaluation Team

Email: jonathan.hill@state.mn.us

Telephone: 651-201-3993 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS: SL34879015-0</p> <p>On November 13, 2023, through November 14, 2023, 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 three (3) active residents, all of whom received services under the Assisted Living license.</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' findings is the Time Period for Correction.</p> <p>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.</p> <p>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 pursuant to 144G.31 Subd. 1, 2 and 3.</p>	
0 470 SS=F	<p>144G.41 Subdivision 1 Minimum requirements</p> <p>(11) develop and implement a staffing plan for determining its staffing level that:</p> <p>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of</p>	0 470		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 470	<p>Continued From page 1</p> <p>staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents; and failed to ensure the staffing schedule was posted as required. This had the potential to affect all residents, staff, and visitors.</p> <p>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</p>	0 470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 470	<p>Continued From page 2</p> <p>problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>The licensee held an assisted living license. The facility was licensed for a capacity of four and had a current census of three residents</p> <p>On November 13, 2023, at 10:05 a.m., the family room/common area was observed to lack a posted staffing schedule.</p> <p>During the entrance conference on November 13, 2023, at 10:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-B stated the licensee had not developed a staffing plan or posted a staff schedule.</p> <p>No further information was provided.</p> <p>TIME PERIOD OF CORRECTION: Seven (7) days</p>	0 470		
0 480 SS=F	<p>144G.41 Subd 1 (13) (i) (B) Minimum requirements</p> <p>(13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and</p> <p>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</p>	0 480		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 480	<p>Continued From page 3</p> <p>Food Code.</p> <p>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).</p> <p>The findings include:</p> <p>Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 13, 2023, for the specific Minnesota Food code deficiencies.</p> <p>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.</p>	0 480		
0 550 SS=F	<p>144G.41 Subd. 7 Resident grievances; reporting maltreatment</p> <p>All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility</p>	0 550		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 550	<p>Continued From page 4</p> <p>Complaints at the Minnesota Department of Health.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure, including the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect all residents receiving assisted living services.</p> <p>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).</p> <p>The findings include:</p> <p>On November 13, 2023, at 10:05 a.m., the family room/common area was observed to lack a posted grievance procedure with the required facility contacts, and grievance posting information.</p> <p>On November 14, 2023, at 9:00 a.m., licensed assisted living director/registered nurse (LALD/RN)-B stated, when there was a complaint, a resident would let a staff member know. The staff would inform the nurse who would follow up on the complaint. In addition, LALD/RN-B stated they did not have the grievance/complaint procedure posted in the facility that included the facility contact</p>	0 550		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 550	<p>Continued From page 5</p> <p>information, and he was not aware the grievance/complaint procedure was required to be posted.</p> <p>The facility's undated Grievance Policy lacked language regarding posting the required grievance information noted above.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 550		
0 640 SS=F	<p>144G.42 Subd. 7 Posting information for reporting suspected c</p> <p>The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:</p> <ul style="list-style-type: none"> (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. <p>This MN Requirement is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the licensee failed to post the required information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) as required. This had the potential to affect all residents, staff, and visitors.</p>	0 640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 640	<p>Continued From page 6</p> <p>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).</p> <p>The findings include:</p> <p>The licensee failed to post information and the reporting number for MAARC to report suspected maltreatment of a vulnerable adult under section 626.557.</p> <p>On November 13, 2023, at 12:00 p.m., the facility entry and common areas were observed to lack the required posting of the information and reporting number for MAARC. At the time of the observation, licensed assisted living director/registered nurse (LALD/RN)-B stated the MAARC information was not posted.</p> <p>The undated Posting Information for Reporting Crimes or Maltreatment indicated the facility would post the contact information for emergency services and the MAARC hotline for abuse in areas of a common nature. The procedure identified emergency service and MAARC hotline number will be posted in the following areas: "1. In common areas and near any available telephone. 2. Notices will be available in all languages applicable to the facilities residents and staff."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One</p>	0 640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 640	Continued From page 7 (21) days	0 640		
0 650 SS=F	<p>144G.42 Subd. 8 Employee records</p> <p>(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:</p> <p>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;</p> <p>(2) records of orientation, required annual training and infection control training, and competency evaluations;</p> <p>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;</p> <p>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;</p> <p>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and</p> <p>(6) documentation of the background study as required under section 144.057.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of one employee (unlicensed personnel (ULP)-C).</p> <p>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</p>	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 650	<p>Continued From page 8</p> <p>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).</p> <p>The findings include:</p> <p>ULP-C was hired June 1, 2018, to provide direct care and services to the facility's residents.</p> <p>On November 14, 2023, at 10:30 a.m., ULP-C was observed to administer medications to R1.</p> <p>ULP-C's record lacked the following:</p> <ul style="list-style-type: none"> - a current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; - documentation of annual performance reviews that identified areas of improvement needed and training needs. <p>On November 14, 2023, at 9:40 a.m. licensed assisted living director/registered nurse (LALD/RN)-B stated ULP-C's record lacked a job description and annual performance review, and stated this was the same for all employees.</p> <p>The licensee's undated Employee Record policy, indicated each employee record would have documentation of an employee job description and annual review as required.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 660	Continued From page 9	0 660		
0 660 SS=F	<p>144G.42 Subd. 9 Tuberculosis prevention and control</p> <p>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.</p> <p>(b) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening for one of one employees unlicensed personnel (ULP)-B. This had the potential to affect all residents, staff and visitors of the facility.</p> <p>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</p>	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 660	<p>Continued From page 10</p> <p>failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On November 13, 2023, at 1:45 p.m., licensed assisted living director/registered nurse (LALD/RN)-B provided a facility TB risk assessment for a different facility dated September 15, 2022.</p> <p>ULP-C was hired June 1, 2018, to provide direct care and services to the facility's residents.</p> <p>ULP-C's employee record contained a negative Chest X-Ray dated March 28, 2019; however, ULP-C's employee record lacked evidence of the following:</p> <ul style="list-style-type: none"> - TB history and symptom screening <p>On November 14, 2023, at 9:40 a.m. LALD/RN-B stated ULP-C's employee record was missing the above listed content.</p> <p>The licensee's undated Tuberculosis Prevention and Screening Plan policy, indicated staff would include, "Assessing for current symptoms of active TB disease" and would be tested for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test. The policy lacked language for screening TB history. The policy and procedure further indicated the licensee would complete a facility risk assessment every two years or sooner when appropriate.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
--------------------	--	---------------	---	--------------------

0 680 SS=F	<p>144G.42 Subd. 10 Disaster planning and emergency preparedness</p> <p>(a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post an emergency disaster plan prominently, and have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or</p>	0 680		
---------------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 680	<p>Continued From page 12</p> <p>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).</p> <p>The findings include:</p> <p>EMERGENCY PLAN POSTED On November 13, 2023, at 10:00 a.m., during the facility tour with licensed assisted living director/registered nurse (LALD/RN)-B, the facility was observed to lack posting of signage and/or information regarding the licensee's emergency disaster or preparedness plan. LALD/RN-B stated the plan was not posted prominently and they were aware of the requirement.</p> <p>EMERGENCY PREPAREDNESS PLAN (EPP) CONTENT The licensee's undated Emergency Preparedness plan lacked the following:</p> <ul style="list-style-type: none"> - establish and maintain a comprehensive EPP, reviewed/updated annually; - how they would coordinate with other health care facilities and community during an emergency or disaster (natural, man-made, facility, etc.), reviewed/updated annually - documented date of reviews and updates - community risk assessment with documentation - consider duration of interruptions - arrangements/contracts to re-establish utility services - develop strategies for addressing community-based risks (evacuation plans, staffing/shortage, back-up plans) - an assessment of at-risk population's needs including maintaining independence, 	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 680	<p>Continued From page 13</p> <p>communication, transportation, supervision, and medical care</p> <ul style="list-style-type: none"> - must identify which staff would assume specific roles in another's absence through succession planning and delegation of authority - a qualified person who was authorized, in writing, to act in the absence of the administrator - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response - develop and implement EP policies/procedures and review/update annually - develop/implement EP policies and procedures to address evacuation and shelter in place for staff and residents which must include: <ul style="list-style-type: none"> - alternate sources of energy to maintain temperature, safety and sanitary storage of provisions - alternate sources of energy to fire detection, extinguishing, alarms systems; - a tracking system used to document locations of residents, staff, and relocation of staff - develop policies and procedures to address safe evacuation from the facility including: <ul style="list-style-type: none"> - needs of evacuees - staff responsibilities - transportation - alternate communication means - develop policy and procedures for shelter in place for residents, staff and volunteers who remain at the facility - develop policy and procedures to address: <ul style="list-style-type: none"> - systems of medical documentation that preserve resident information - protects confidentiality - secures/maintains availability of records - develop policy and procedures must address use of volunteers including process and role for integration - develop policy and procedures which address 	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 680	<p>Continued From page 14</p> <p>development and arrangements with other facilities or providers to receive residents in the event continuity of services cannot be provided</p> <ul style="list-style-type: none"> - develop a written communication plan and review/update annually <ul style="list-style-type: none"> - communication plan must include all the following names/contact information: <ul style="list-style-type: none"> - entities providing services under agreement - residents' physicians - volunteers - communication plan must include contact information for: <ul style="list-style-type: none"> - other sources of assistance - communication plan must include: <ul style="list-style-type: none"> - means to provide information about facility occupancy - and ability to provide assistance - authority having jurisdiction - incident Command Center - or designee - communication plan must include a method for sharing information from emergency plan - must develop and maintain EP training and testing program, review/update annually - must conduct exercises to test the EP plan at least twice per year including unannounced staff drills using the EP - must implement emergency and standby power systems based on their EP; and - if part of a healthcare system consisting of separately certified healthcare facilities and elects to have a unified and integrated EP, they may choose to participate. <p>On November 14, 2023, at 10:00 a.m., LALD/RN-B stated the licensee's current EP plan did not include the above content. LALD/RN-B further stated he was aware of all the required content, and was working on the plan content.</p>	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 680	Continued From page 15 The licensee's Emergency Preparedness policy, undated, indicated the licensee would have an identified plan in place to assure the safety and well-being of clients and staff during periods of an emergency disaster that disrupts services. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 690 SS=D	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in the resident record were authenticated by the name and title of the person making the entry for one of one resident record (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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:	0 690		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 690	<p>Continued From page 16</p> <p>R-1 diagnosis included schizophrenia (a mental health disorder).</p> <p>R1's undated Daily Resident Log, signed by employees unlicensed personnel (ULP)-C and licensed assisted living director/registered nurse (LALD/RN)- B on October 11, 2023, lacked authentication of the person making the entry. The Daily Resident log listed the following task assigned every shift:</p> <ul style="list-style-type: none"> -Bathing -Dressing -Toileting -Wash hair -Mouth care -Style hair -Apply lotion -Nail care -Housekeeping -Transportation <p>On November 14, 2023, at 9:50 a.m., LALD/RN-B stated each employee placed a check mark in the category when they completed a task. LALD/RN-B stated the Daily Task Log could not be authenticated by tasks completed or times completed by the ULP's.</p> <p>The licensee's undated Resident Records policy, indicated all entries into the clinical record would be legible, permanently recorded in ink, dated, and authenticated with the name and title of the person making the entry.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 690		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 780	Continued From page 17	0 780		
0 780 SS=F	<p>144G.45 Subd. 2 (a) (1) Fire protection and physical environment</p> <p>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>(1) for dwellings or sleeping units, as defined in the State Fire Code:</p> <ul style="list-style-type: none"> (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents and staff.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or</p>	0 780		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 780	<p>Continued From page 18</p> <p>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).</p> <p>The findings include:</p> <p>On November 13, 2023, at 11:00 a.m., survey staff toured the home with unlicensed personnel (ULP)-A. During the tour, survey staff observed the following:</p> <ol style="list-style-type: none"> 1. When smoke alarms were tested in the hallways, the bedroom smoke alarms were not activated. 2. When smoke alarms were tested in the resident bedrooms, none of the other smoke alarms in the dwelling unit were activated. The smoke alarms installed in the bedrooms and outside each sleeping area were not all interconnected. <p>This deficient condition was verified during the facility tour by ULP-A in an interview with survey staff.</p> <p>During an interview on November 14, 2023, at 2:00 p.m., ULP-C explained the licensee was not aware of these smoke alarm requirements and requested that the statute requirements be emailed.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment	0 790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
--------------------	--	---------------	---	--------------------

0 790	<p>Continued From page 19</p> <p>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;</p> <p>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide and maintain portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>On November 13, 2023, at 11:00 a.m., survey staff toured the home with unlicensed personnel (ULP)-A. During the tour, survey staff observed the following:</p> <p>1. The two portable fire extinguishers provided were rated 1-A:10BC (size). ULP-A stated during</p>	0 790		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 790	<p>Continued From page 20</p> <p>the tour that these two fire extinguishers had been newly purchased.</p> <p>2. Tags or labels were not attached to the portable fire extinguisher showing that monthly fire extinguisher inspections were completed. Fire extinguisher inspections must be conducted every month to ensure that each extinguisher is in its designated place, that it has not been tampered with, and that there is no obvious physical damage or condition that would interfere with its use or operation.</p> <p>3. The basement fire extinguisher was stored on a wall ledge. Fire extinguishers must be properly installed to prevent them from being moved or damaged.</p> <p>During an interview on November 14, 2023, at 2:00 p.m., ULP-C explained the licensee was not aware of these requirements for the fire extinguishers and requested that the statute requirements be emailed.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 790		
0 800 SS=F	<p>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</p> <p>(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.</p>	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 800	<p>Continued From page 21</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>On November 13, 2023, at 11:00 a.m., survey staff toured the home with unlicensed personnel (ULP)-A. During the tour, survey staff observed the following:</p> <ol style="list-style-type: none"> 1. A smoldering burnt cigarette had been improperly disposed of on the wood steps for the front door of the home. 2. Burnt used cigarettes had been improperly disposed of on top of a table and in an uncovered ceramic container stored on this table near the front door of the home. <p>During an interview on November 14, 2023, at 2:00 p.m., ULP-C stated the licensee would work on ensuring that burnt used cigarettes would be disposed of properly in the future.</p>	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 800	Continued From page 22 TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	<p>144G.45 Subd. 2 (b)-(f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:</p> <ul style="list-style-type: none"> (1) location and number of resident sleeping rooms; (2) employee 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. <p>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(f) Evacuation drills are required for employees 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.</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
--------------------	--	---------------	---	--------------------

0 810	<p>Continued From page 23</p> <p>This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop fire safety and evacuation plans with the required elements; failed to provide the required employee and resident training on fire safety and evacuation; and failed to complete the required employee evacuation drills. 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 potential to affect a large portion or all of the residents). The findings include: On November 13, 2023, at 11:00 a.m., survey staff toured the home with unlicensed personnel (ULP)-A. During the tour, survey staff observed that resident bedroom 3 was located in the basement. ULP-A confirmed the basement bedroom location during the tour interview with survey staff. On November 14, 2023, ULP-A provided documents on the fire safety and evacuation plans (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLANS The FSEP, undated, indicated the emergency evacuation floor plan failed to identify bedroom 3 in the basement. This floor plan also identified the office as bedroom 3 on the main floor. The location of resident sleeping rooms was not accurately identified on the emergency evacuation floor plan. The FSEP included limited employee procedures,</p>	0 810		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 810	<p>Continued From page 24</p> <p>and failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The actions in this plan directed employees to call 911 and then proceed to the nearest exit.</p> <p>The FSEP did not include fire protection procedures for residents. The plan was limited to letting 911 know that vulnerable adults are in the home.</p> <p>The FSEP did not include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including individualized unique needs of residents.</p> <p>Additionally, the fire procedures were blank in the undated emergency preparedness plan.</p> <p>During an interview on November 14, 2023, at 2:00 p.m., ULP-C verified these deficiencies of the plan.</p> <p>TRAINING</p> <p>Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation. Staff emergency training records were provided showing that 4 out of 6 employees had received training once in the past year. No additional training records were provided.</p> <p>Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year as evident by the lack of training documentation.</p> <p>During an interview on November 14, 2023, at 2:00 p.m., ULP-C explained residents had been trained, but this had not been documented.</p> <p>DRILLS</p> <p>Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by fire drill reports</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 810	Continued From page 25 lacking the required frequency. Fire drill reports were dated 08/21/2022 and 01/18/2023, no time or shift was recorded on these drill records. The person conducting the drills was recorded but the names of the employees who participated were not included. Additionally, the fire drill frequency specified on the drill logs was every 6 months. During an interview on November 14, 2023, at 2:00 p.m., ULP-C verified the deficiencies with conducting drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=F	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident	0 950		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 950	<p>Continued From page 26</p> <p>must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the following verbatim notice to identify a designated representative for one of one resident (R1).</p> <p>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).</p> <p>The findings include:</p> <p>R1's diagnoses schizophrenia (a mental health disorder).</p> <p>R1's service plan dated October 11, 2023, indicated R1 received services which included medication administration and assistance with bathing, grooming and dressing.</p> <p>On November 14, 2023, at 9:40 a.m., licensed assisted living director/registered nurse (LALD/RN)-B stated the assisted living contracts lacked a statute statement from statute 144.50 subd. 3 with the required verbatim 'right to designate a representative for certain purposes'</p>	0 950		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 950	<p>Continued From page 27</p> <p>in separate page in the contract. The contract also lacked a space for the name and contact information of the designated representative and a box for R1 to initial if they declined to name a designated representative. LALD/RN-B stated he was unaware that this was a requirement.</p> <p>The licensee lacked a policy regarding the designated representatives requirements.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 950		
0 970 SS=C	<p>144G.50 Subd. 5 Waivers of liability prohibited</p> <p>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident.</p> <p>This practice resulted in a level one 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 a</p>	0 970		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
0 970	<p>Continued From page 28</p> <p>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).</p> <p>The findings include:</p> <p>During the entrance conference on November 13, 2023, at 10:00 a.m., a copy of the facility's assisted living contract was requested.</p> <p>The licensee's Assisted Living Contract included an indemnification clause which indicated "Resident here by releases Serendipitous Living from liability for any act or omission of an Serendipitous Living employees that may be harmful to resident and that arises from the provision of services to resident pursuant to this agreement, including those acts or omissions that arise from an employee's negligence."</p> <p>On November 14, 2023, at 10:20 a.m., licensed assisted living director (LALD)-B confirmed the assisted living contract contained the above content, and stated the same contract was utilized for all residents who resided at the facility.</p> <p>The licensee's undated Assisted Living Contract Suggested Table of Contents document lacked information regarding the facilities liability or indemnification content of the assisted living contract provided to licensee residents.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 970		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
01290	Continued From page 29	01290		
01290 SS=F	<p>144G.60 Subdivision 1 Background studies required</p> <p>(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.</p> <p>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.</p> <p>(c) Termination of an employee 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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living facility (ALF) license for one of one employees (unlicensed personnel (ULP)-C. This had the potential to affect all residents living in the facility.</p> <p>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).</p> <p>The findings include:</p>	01290		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
01290	<p>Continued From page 30</p> <p>ULP-C was hired on June 1, 2018, to provide direct care and services to the facility's residents.</p> <p>ULP-C's employee record contained a Background Study Clearance dated May 16, 2019, from another licensee owned facility. However, the background study was not affiliated with the facility's license.</p> <p>On November 14, 2023, at 9:35 a.m., licensed assisted living director/registered nurse (LALD/RN)-B stated ULP-C had worked at another licensee owned facility and therefore did not believe ULP-C, or any employee, was required to have a background study affiliated with the current ALF.</p> <p>The licensee's undated Employee Record policy, indicated each employee record would have documentation of a background study and fingerprints as required.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	01290		
01620 SS=F	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.</p> <p>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
01620	<p>Continued From page 31</p> <p>9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.</p> <p>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed and/or documented a comprehensive assessment to include required areas of assessment per Assisted Living Facilities: Minnesota Rules Chapter 4659, for one of one resident (R1).</p> <p>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).</p> <p>The findings include:</p> <p>R1's diagnoses included schizophrenia a mental health disorder.</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
01620	<p>Continued From page 32</p> <p>R1's service plan dated October 11, 2023, indicated R1 received assistance with bathing, dressing, toileting, transfers, and medication management.</p> <p>R1's last two assessments were requested. Licensed assisted living director (LALD)/RN-B provided a pre-admission Care Plan Review Assessment dated September 18, 2023, and stated a 14-day assessment was not completed for R1. The assessments did not include per Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Uniform Assessment Tool, the components required in subpart 2, section A, 1-3.</p> <p>On November 14, 2023, at 11:00 a.m., licensed assisted living director (LALD)/RN-B stated the resident's care plans were reviewed every 90 days and he would complete a full comprehensive assessment if a change of condition occurred. LALD/RN-B reviewed the required criteria for the Uniform Assessment Tool and verified the 14-day, 90-day and change of condition assessments did not contain the required content for any of the residents. LALD/RN-B also confirmed that a 14 day assessment was not completed for any client.</p> <p>The licensee's undated Comprehensive Assessment policy, indicated the RN would conduct a comprehensive assessment upon admission and reviewed and revised every 90 days and the assessment would include the following:</p> <ul style="list-style-type: none"> - Client evaluation - Vulnerability assessment - Medication profile - Home health aide care plan 	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
01620	<p>Continued From page 33</p> <ul style="list-style-type: none"> - Emergency information - Fall risk assessment - Mental status assessment - Home safety checklist - Medication management plan <p>The Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Uniform Assessment Tool indicated:</p> <ul style="list-style-type: none"> - Subpart 1. Definition. For purposed of this part, "Uniform Assessment Tool" means an assessment tool that meets the requirements of this part and is used by a licensee to comprehensively evaluate a resident's or prospective resident's physical, mental, and cognitive needs - Subp. 2. Assessment tool elements. Each facility must develop a uniform assessment tool. The facility may use any acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart. A uniform assessment tool must address the following: <ul style="list-style-type: none"> A. the resident's personal lifestyle preferences, including: <ul style="list-style-type: none"> (1) sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; (2) spiritual and cultural preferences; and (3) advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order or "physician/provider orders for life-sustaining treatment: order. <p>No further information was provided.</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
01620	Continued From page 34 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01790 SS=F	<p>144G.71 Subd. 10 Medication management for residents who will</p> <p>(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;</p> <p>(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and</p> <p>(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.</p> <p>(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:</p> <p>(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and</p> <p>(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:</p> <p>(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;</p> <p>(ii) how the container or containers must be labeled;</p>	01790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
01790	<p>Continued From page 35</p> <p>(iii) written information about the medications to be provided;</p> <p>(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;</p> <p>(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;</p> <p>(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and</p> <p>(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for one of one employee (ULP-C).</p> <p>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</p>	01790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
01790	<p>Continued From page 36</p> <p>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).</p> <p>The findings include:</p> <p>ULP-C was hired on June 1, 2018, to provide direct care and services to the licensee residents.</p> <p>ULP-C's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available.</p> <p>On November 14, 2023, at 10:35 a.m., licensed assisted living director (LALD)/RN-B stated all ULP's were trained, and competency tested on providing medications to residents for unplanned time away but stated the licensee lacked documentation of the training or competencies.</p> <p>The licensee's undated Staff Requirements policy, indicated before performing delegated tasks, ULP's would complete training of that task and demonstrate competency either with an oral or written exam and would perform a practical skills test of the task with the RN.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01790		
01910 SS=F	<p>144G.71 Subd. 22 Disposition of medications</p> <p>(a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer</p>	01910		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
01910	<p>Continued From page 37</p> <p>part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.</p> <p>(b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.</p> <p>(c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document the disposition of the medications in the resident's record, for one of one resident (R2).</p> <p>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).</p> <p>The findings include:</p> <p>R2 was admitted to the licensee on February 14, 2020, and discharged on August 28, 2023.</p>	01910		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SERENDIPITOUS LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ROBIE STREET WEST 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
01910	<p>Continued From page 38</p> <p>R2's discharge summary dated August 28, 2023, indicated all prescribed medications were sent with R2's case manager at the time of discharge.</p> <p>R2's record lacked a medication disposition record at the time of discharge to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.</p> <p>On November 14, 2023, at 9:15 a.m., licensed assisted living director/registered nurse (LALD/RN)-B stated he was unaware of this requirement.</p> <p>The licensee's undated Resident Record policy, indicated the resident record would include a discharge summary and related documentation would be maintained for all residents.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01910		



Minnesota Department of Health
 Environmental Health, FPLS
 P.O. Box 64975
 St. Paul, MN 55164-0975
 651-201-4500

Type: Full
 Date: 11/13/23
 Time: 11:50:00
 Report: 103923168

Food and Beverage Establishment Inspection Report

Page 1

Location:

Serendipitous Living
 103 Robie Street West
 St Paul, MN55107
 Ramsey County, 62

Establishment Info:

ID #: 0038999
 Risk:
 Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514149040
 ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

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

3-302.11A(1) ** Priority 1 **

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

SHELL EGGS STORED OVER PRODUCE IN REFRIGERATOR. PERSON-IN-CHARGE MOVED EGGS TO COMPLY WITH ABOVE. CORRECTED ON SITE. STACKING ORDER GUIDANCE DOCUMENT SENT WITH REPORT.

Corrected on Site

Surface and Equipment Sanitizers

Rinse Temp: = at >170 Degrees Fahrenheit
 Location: DISH WASHING MACHINE
 Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
 Temperature: 39 Degrees Fahrenheit - Location: COLD HOLD REFRIGERATOR
 Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	0	0

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Angel Woehler

The establishment has a residential kitchen and should serve food for same-day service only.

Type: Full
Date: 11/13/23
Time: 11:50:00
Report: 103923168
Serendipitous Living

Food and Beverage Establishment Inspection Report

The kitchen has wood cabinets with hollow base, tile and grout floor, painted walls and ceiling and quartz countertops.

The kitchen finishes and surfaces are clean and well maintained.

The kitchen refrigerator/freezer are of residential grade.

A 2-compartment sink is present in kitchen. 1 compartment is designated for hand washing only.

A residential dish machine is located in the kitchen which achieves a utensil surface temperature greater than 170 degrees F. The dishwashing machine should always be run with the sanitize cycle.

A supply of single-use gloves is present in kitchen.

A probe-type food thermometer is present in kitchen. Alcohol wipes must be used to sanitize probe.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, orders on report.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 103923168 of 11/13/23.

Certified Food Protection Manager Rothana T. Seney

Certification Number: FM111325 Expires: 06/04/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Rothana T. Seney
Person-in-charge

Signed: _____

Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us