Electronically Delivered

September 17, 2025

Licensee
Cerenity Residence - Marian of St. Paul
225 Frank Street
Saint Paul, MN 55106

RE: Project Number(s) SL21947016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 6, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21947	A. BUILDING: _____ B. WING _____	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY RESIDENCE - MARIAN OF	225 FRANK STREET SAINT PAUL, MN 55106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL #21947016-0 On August 4, 2025, through August 6, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 97 residents, 63 of whom were receiving services under the provider's Assisted Living license.	0 000	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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter	0 480		

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0 480	Continued From page 1 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part	0 480		

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

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01620	Continued From page 3	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620		

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01620	Continued From page 4 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. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident monitoring and reassessment including a reassessment no more than 14 calendar days from the start of services for one of four residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted February 17, 2025. R2's service plan, dated March 14, 2025, indicated R2 received services including assistance with medication management and	01620		

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01620	Continued From page 5 administration. On July 5, 2025, at 7:43 a.m., the surveyor observed unlicensed personnel (ULP)-C assisting R2 with medication administration. R2's record included two initial comprehensive nursing assessments, dated February 17, 2025. One assessment was finalized at 11:24 a.m., indicating a "care level" of "2", and the other assessment was finalized at 2:25 p.m., and indicated "care level" of "3." A subsequent RN reassessment was completed March 6, 2025 (3 days past the 14-day due date). On August 6, 2025, at 12:49 p.m., regional registered nurse (RN)-F stated R2's initial and 14-day assessments were completed the same day. RN-F stated because of the change in care level, they considered the second assessment completed on February 17, 2025, to be the 14-day assessment. The licensee's Initial and On-going Assessments of Residents policy, reviewed April 22, 2024, indicated the RN would conduct a monitoring and reassessment no more than 14 days after the initiation of assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01870 SS=D	144G.71 Subd. 18 Medications provided by resident or family me When the assisted living facility is aware of any medications or dietary supplements that are	01870		

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01870	Continued From page 6 being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the resident record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure security and accountability for the overall management, control, and disposition of over-the-counter (OTC) medications for one of four residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's service plan, dated March 14, 2025, indicated R2 received services including assistance with medication administration. On August 5, 2025, at 7:43 a.m., the surveyor observed unlicensed personnel (ULP)-C assisting R2 with medication administration. The surveyor observed one bottle of TUMS ultra strength antacid, a box containing Alka seltzer tablets, and two separate eye drop containers sitting on R2's dining table. ULP-C stated R2 was able to self-administer the eye drops. On August 5, 2025, at 9:35 a.m., R2 stated he took two TUMS every night as a "precaution," and	01870		

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01870	Continued From page 7 when he felt "the need." R2 further stated if the TUMS were not effective, staff could give him a pill that goes under his tongue. R2's RN Medication Management Assessment, dated June 25, 2025, indicated R2 was able to self-administer medicated lotions and eye drops, but lacked documentation that R2 could self-administer TUMS or Alka seltzer. A progress note dated July 11, 2025, at 6:17 a.m., indicated R2 had heart burn and an upset stomach. The note indicated R2 did not have TUMS available and was given ondansetron (dissolvable pill taken under the tongue and used for upset stomach). On July 5, 2025, at 2:30 p.m., RN-B stated all medication the resident is self-administering, including OTC medications, should be documented. RN-B further stated sometimes the resident, or family will bring in a medication and "we don't know about it." On July 6, 2025, at 2:33 p.m., regional registered nurse (RN)-F stated R2 did not have a prescriber order for TUMS or Alka seltzer. The licensee's Initial and On-going Assessments of Residents policy, reviewed April 22, 2024, indicated a comprehensive nursing assessment would be conducted no less than every 90-days and the assessment would include a review of all medications including OTC medications. The policy further indicated the RN would review how medications would be administered. The licensee's Medication and Treatment Orders-Receiving, Implementing, Renewal and RE-ordering policy, reviewed April 22, 2024,	01870		

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01870	Continued From page 8 indicated prescribed and non-prescribed medications would require a prescription from a health care provider. The policy further indicated when medications are provided by residents or family members or if the associates become aware of any medications or dietary supplements that are being used by a resident and are not included in the assessment for medication management services, they will contact the RN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01870		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for one of four residents (R3) with medication management services. 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).	01880		

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01880	Continued From page 9 The findings include: R3's service plan dated October 16, 2024, indicated R3 received assistance with medication management and administration. On August 5, 2025, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-D assist R3 with medication administration. On a table in R3's living room, the surveyor observed two tubes of diclofenac sodium 1% gel (used for mild pain), and one tube of lidocaine 3% cream (for mild pain). The surveyor further observed a bottle of melatonin (to assist with sleep) 5 milligrams (mg) located on the end table next to R3's reclining chair. ULP-D stated R3 does not self-administer the medications, and she will ring for assistance when she wants them applied. A prescriber order dated June 25, 2025, indicated R3 was prescribed diclofenac 1% gel, apply to right knee four times daily as needed. A prescriber order dated July 14, 2025, indicated R3 was prescribed lidocaine 3% cream, apply a thin layer topically to right hip three times daily as needed (PRN); and melatonin 5 mg, take one tablet by mouth at bedtime. R3's medication administration record (MAR) for July and August 2025, indicated R3 was assisted with administration of the following medications July 1, 2025 through August 4, 2025: -melatonin 5 mg, take one tablet by mouth at bedtime, -diclofenac sodium gel; 1 %; 4 g to both legs and 2g to lower back, "Four Times A Day - PRN", and	01880		

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01880	Continued From page 10 -lidocaine topical cream 3% apply thin layer on left hip three times a day as needed. R3's Medication Management Assessment, dated July 1, 2025, indicated staff administer all R3's medications. The assessment further indicated R3's medications were kept "locked up" and the nurse did a medication check weekly. On July 5, 2025, at 2:30 p.m., clinical nurse supervisor (CNS)-B stated all medications should be kept in the locked medication cabinet in the resident's room, unless the resident had been assessed to be able to self-administer medications. CNS-B stated she was not sure why medications would have been left out. The licensee's Storage of Medications policy revised August 1, 2024, indicated "the RN may identify the need for secured storage of the medications within the resident's private living space because of the resident's cognitive status, concerns about medication diversion or other concerns. When secured storage of the medications is necessary, the RN will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in	01890		

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01890	Continued From page 11 the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure time sensitive medications were dated when opened and contained an original prescription label with legible information for one of 4 residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2's service plan, dated March 14, 2025, indicated R2 received services including assistance with medication management and administration. R2's Medication Management Assessment, dated June 25, 2025, indicated R2 was able to safely self-administer eye drops. The assessment further indicated the licensed nurse was responsible for managing all R2's medications. On August 5, 2025, at 7:43 a.m., the surveyor observed unlicensed personnel (ULP)-C assisting R2 with medication administration. The surveyor	01890		

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CERENITY RESIDENCE - MARIAN OF	225 FRANK STREET SAINT PAUL, MN 55106

(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
01890	Continued From page 12 observed two separate eye drop bottles sitting on R2's dining table. One bottle had a purple top with a note written on it, "AM" and "PM," and the other a teal blue top with "PM" written on it. The bottles lacked any further legible information, including when the bottles were opened. ULP-C stated the bottles were R2's eye drops, and she did not do anything with them because R2 was able to self-administer them. On July 5, 2025, at 9:35 a.m., R2 stated he self-administered his eye drops, but he was not able to name the medications in the bottles. R2 stated he took them for "whatever I need for my eyes." An article from the American Academy of Ophthalmology, titled Know Your Drops by Color, dated June 20, 2022, indicated the lid color for the eye drop Brimonidine 0.2% was purple and the lid color for Latanoprost 0.005% was teal green. A provider's order dated January 8, 2025, indicated R2's medications included the following: -brimonidine Tartrate 0.2% solution, one drop to both eyes twice a day; and -latanoprost 0.005% solution, one drop in each eye at bedtime. On July 5, 2025, at 2:30 p.m., clinical nurse supervisor (CNS)-B stated time sensitive medications the facility managed should be dated once they are opened and she was not sure why the eye drops were not. The manufacturer's prescribing information for the use of Latanoprost, revised August 2011, indicated once the bottle was opened for use it could be stored at room temperature for six	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21947	A. BUILDING: _____ B. WING _____	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY RESIDENCE - MARIAN OF	225 FRANK STREET SAINT PAUL, MN 55106

(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
01890	Continued From page 13 weeks. The licensee's Storage of Medications policy, revised August 1, 2024, indicated until medications were set up for immediate or later administration by a nurse, the drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. The policy further indicated medication provided to the resident by an authorized prescriber must be kept in its original container bearing the original label with legible directions for use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

CERENITY RESIDENCE MARIAN OF S
225 FRANK STREET
St Paul, MN 55106
Ramsey County
Parcel:

Phone:

License Info

License: HFID 21947

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

Inspection Info

Report Number: F1039251078
Inspection Type: Full - Single
Date: 8/6/2025 Time: 11:00:00
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 5
Delivery: Emailed

New Order: 4-400 Equipment Location and Installation
4-402.11A *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.
COMMENT: CAULK SEALS AT SINK AND DRAINBOARD JUNCTIONS TO WALLS ARE IN BAD REPAIR. REMOVE OLD SEALS AND CLEAN WALLS, THEN RESEAL SINKS AND DRAINBOARDS TO WALLS.
Comply By: 11/1/2025 Originally Issued On: 8/6/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11A *Priority Level: Priority 2 CFP#: 16*
MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.
COMMENT: OBSERVED GRIME ON ICE CONTACT SURFACES OF ICE MACHINES IN MAIN KITCHEN AND DINING AREA. DISCARD ICE, THEN CLEAN AND SANITIZE ALL ICE/WATER CONTACT SURFACES OF MACHINES. CLEAN AT FREQUENCY TO PREVENT SOILS FROM FORMING.
Comply By: 8/6/2025 Originally Issued On: 8/6/2025

New Order: 5-200A Plumbing: approved materials/design
5-201.11B *Priority Level: Priority 3 CFP#: 51*
MN Rule 4626.1040B Maintain the plumbing system in good repair.
COMMENT: OBSERVED LEAK AT MOP FILLING FAUCET FIXTURE. REPAIR LEAK.
Comply By: 8/20/2025 Originally Issued On: 8/6/2025

New Order: 6-200 Physical Facility Design and Construction
6-201.13A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1345A Properly cove and seal the wall/floor junctures to no larger than 1/32 inch (1 millimeter).
COMMENT: BASE COVE NOT PRESENT AT FLOOR/WALL JUNCTION IN PARTS OF MAIN KITCHEN. ESTABLISHMENT SHOULD PLAN TO PROPERLY COVE FLOOR/WALL JUNCTION WHEN KITCHEN FLOOR RENOVATION OCCURS.
Comply By: 8/6/2025 Originally Issued On: 8/6/2025

New Order: 6-200 Physical Facility Design and Construction
6-202.11A *Priority Level: Priority 3 CFP#: 56*
MN Rule 4626.1375A Provide effective shielding, coated or shatter-resistant light bulbs for all light fixtures where there is exposed food, clean equipment, utensils and linens, or unwrapped single-service or single-use articles.
COMMENT: NO COVERING OVER BULBS ON CEILING LIGHT FIXTURE IN MAIN KITCHEN LARGE WALK-FREEZER. COMPLY WITH ABOVE RULE.
Comply By: 9/3/2025 Originally Issued On: 8/6/2025

New Order: 6-300 Physical Facility Numbers and Capacities
6-303.11A *Priority Level: Priority 3 CFP#: 56*
MN Rule 4626.1470A Provide at least 10 foot candles (108 LUX) of light intensity at a distance of 30 inches from the floor in the walk-in refrigeration units, dry food storage areas, and in other areas during periods of cleaning.
COMMENT: INSUFFICIENT LIGHTING IN MAIN KITCHEN LARGE WALK-IN FREEZER. ADD SUFFICIENT LIGHTING.
Comply By: 9/3/2025 Originally Issued On: 8/6/2025

Food & Beverage General Comment

MILK - COLD HOLD, DAIRY WALK-IN COOLER - 40 DEGREES F
AMBIENT - MAIN WALK-IN COOLER - 39 DEGREES F
CHEESE - COLD HOLD, MAIN WALK-IN COOLER - 39 DEGREES F
COOKED BEEF - HOT HOLD, STEAM TABLE - 157 DEGREES F
SOUP - HOT HOLD IN WARMER - 189 DEGREES F
MILK - COLD HOLD, PASS THROUGH COOLER IN SERVICING KITCHEN - 40 DEGREES F
FREEZERS - FROZEN

Inspection conducted as part of HRD survey of assisted living facility let by Tammy Carlson (MDH).

Discussed the following topics with person-in-charge: illness policy for staff, handwashing and glove use, cleaning and sanitizing, food processes, food source, all orders on this report.

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

I acknowledge receipt of the Metro District Office inspection report number F1039251078 from 8/6/2025

Crystal Rosenbloom
person-in-charge

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

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

Sanitizer Observations/Recordings

Establishment Info

CERENITY RESIDENCE MARIAN OF S
St Paul
County/Group: Ramsey County

Inspection Info

Report Number: F1039251078
Inspection Type: Full
Date: 8/6/2025
Time: 11:00:00

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

Sanitizing Chemical: Product: Sink and Surface**; Sanitizing Process:** Wiping Cloth Bucket
Location: Equal To 700 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: Product: Hot Water**; Sanitizing Process:** Dish Machine
Location: MAIN KITCHEN **Greater Than** 160 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Equipment: Product: Hot Water**; Sanitizing Process:** Dish Machine
Location: SERVING KITHCEN **Greater Than** 160 Degrees F.
Comment:
Violation Issued?: No