



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 10, 2025

Licensee
Serenity Living Residential Inc
7527 Bloomington Avenue South
Richfield, MN 55423

RE: Project Number(s) SL40424015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on September 4, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health 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 Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40424	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER SERENITY LIVING RESIDENTIAL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7527 BLOOMINGTON AVE SOUTH RICHFIELD, MN 55423			
(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: SL40424015-0 On September 2, 2025, through September 4, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following orders are issued. At the time of the survey, there was one resident; the resident was receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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

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

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. In addition, the licensee failed to ensure the missing resident policy was reviewed quarterly as required under section 4659.0110.	0 680			

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0 680	Continued From page 4 This had the potential to affect all current 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP lacked evidence it was reviewed annually, and lacked the following required content: -take an all-hazards approach, including emerging infectious diseases, as applicable: -consider hazards like care related emergencies, equipment/utility failures, interruptions in communications/cyber-attacks, loss of all or portion of a facility, interruption to normal supply of essential resources and medical supplies, -consider duration of interruptions -arrangements/contracts to re-establish utility services -policies and procedures (P/P) for securing pharmaceutical supplies, and sewage/waste disposal. -comprehensive communication plan to include means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee, -consider how would coordinate with other health care facilities, as well as community on a whole	0 680			

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0 680	Continued From page 5 during emergency or disaster -develop strategies for addressing facility & community-based risks (i.e.: staffing surges/shortages, back-up plans): -P/P in relation to an 1135 waiver, -P/P for tracking of staff and residents -P/P included handling medical documents, -P/P included handling and use of volunteers, -P/P for long term care family notifications, and -P/P to address: system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records -documentation of two emergency preparedness exercises (an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise). The licensee's missing resident plan, dated March 24, 2025, lacked evidence it was reviewed quarterly, as required. On September 3, 2025, at 1:00 p.m., licensed assistant living director (LALD)-A stated the licensee developed the EPP as a team. LALD-A stated the licensee "did as much as we could" but would reach out for resources to get a comprehensive plan in order to be compliant and would update the EPP on an annual basis. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

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0 775	Continued From page 6	0 775			
0 775 SS=D	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On September 2, 2025, at 11:15 a.m., the surveyor toured the facility with supervisor (S)-D. During the facility tour, the surveyor observed the following: - After multiple attempts, the screen on the egress window in unoccupied resident sleeping room #1 could not be removed by S-C. When screens are installed on egress windows, the screen shall be releasable or removable from the inside without the use of a key, tool, special knowledge, or force greater than that required for the normal operation of the escape and rescue opening. Egress windows are required to be maintained clear of obstructions that would	0 775			

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0 775	Continued From page 7 prevent immediate and full use of the window in the event of a fire or similar emergency. - An extension cord was used to supply power in the basement living room, creating a fire hazard. During the facility tour interview, S-D verified the above listed observations. TIME PERIOD FOR CORRECTION: Two (2) days	0 775			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	0 810			

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0 810	Continued From page 8 least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content and provide required drill documentation. 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 the potential to affect a large portion or all of the residents). The findings include: On September 2, 2025, supervisor (S)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. On September 2, 2025, at 11:15 a.m., the surveyor toured the facility with S-D. During the facility tour, the surveyor observed the following: - A room number identifier was not posted at the door for resident sleeping room 4. During the facility tour interview, S-D verified this room	0 810			

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0 810	Continued From page 9 identifier was missing. The numbers installed at resident room doors are required to correspond with resident room number labels on the FSEP floor plan to provide efficient communication for exiting in the event of a fire or similar emergency. - A fire extinguisher was installed on the wall in the main floor living room. The posted FSEP exit floor plan did not label this fire extinguisher location. Portable fire extinguisher locations must be accurately identified on FSEP floor plans. During the facility tour interview, S-D verified the fire extinguisher location. FIRE SAFETY AND EVACUATION PLAN Record review of the available documentation indicated the licensee failed to develop the FSEP with site specific procedures for the assisted living facility and the building occupants. The FSEP included a fire safety policy dated March 24, 2025, that was a template from a third party provider. Pull fire alarms were inaccurately referenced. The FSEP 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 employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) acronym. The FSEP failed to include fire safety and evacuation instructions for residents evident by limited directions for residents to stoop or crawl to avoid smoke. The FSEP included standard resident evacuation procedures, but failed to provide site specific procedures for resident movement and evacuation or relocation during a fire or similar emergency evident by a lack of these procedures	0 810			

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0 810	Continued From page 10 in the plan. During an interview on September 2, 2025, at 12:35 p.m., S-D verified the FSEP had not been developed with site specific procedures. DRILLS Record review indicated the licensee failed to include required documentation on the evacuation fire drill reports for employees evident by a review of monthly fire drill logs lacking the simulated conditions and the time or shift of the drill. The simulated conditions and time or shift of a fire drill shall be recorded in order to assess the effectiveness of the emergency procedures. During an interview on September 2, 2025, at 12:35 p.m., S-D verified the fire drill records were lacking required information. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 950 SS=C	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	0 950			

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0 950	Continued From page 11 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 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included the resident's designated representative, or indication the resident declined to designate a representative, for one of one resident (R1). 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 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: R1's service plan, signed March 28, 2025, indicated R1 received services to include assistance with medication set-up and reminders,	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40424	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER SERENITY LIVING RESIDENTIAL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7527 BLOOMINGTON AVE SOUTH RICHFIELD, MN 55423			
(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	Continued From page 12 hair care, bathing assistance and meal preparation assistance, as well as housekeeping and laundry services. R1's Resident Agreement, signed March 28, 2025, included the designated representative form, which was blank. The agreement lacked indication the resident declined to name a designated representative. On September 3, 29, 2025, at 1:00 p.m., licensed assisted living director (LALD)-A stated the licensee was not aware the contract must indicate when the resident declined to designate a representative. LALD-A further explained the same contract was used for all residents but would correct the situation by having all current and future residents sign a new contract with the required content of regarding a resident's wish to decline to designate a representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date.	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40424	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER SERENITY LIVING RESIDENTIAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7527 BLOOMINGTON AVE SOUTH RICHFIELD, MN 55423		
(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
01530	Continued From page 13 Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct care staff received the required 2 hours of initial training on mental illness and de-escalation topics within 160 hours of start date for two of two employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C).	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40424	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER SERENITY LIVING RESIDENTIAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7527 BLOOMINGTON AVE SOUTH RICHFIELD, MN 55423		
(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
01530	Continued From page 14 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 the potential to affect a large portion or all of the residents). The findings include: CNS-B was hired June 22, 2023, and provided management of the day-to-day operations, supervision of staff, and direct cares and services for residents of the facility. ULP-C was hired June 22, 2023, and provided direct care and services to residents of the facility. CNS-B and ULP-B's employee records lacked documentation they completed the required 2 hours of initial training on mental illness and de-escalation topics within 160 hours of start date, effective July 1, 2025. On September 3, 2025, at 1:00 p.m., LALD-A stated the licensee was unaware of the required 2 hours of initial training on mental illness and de-escalation topics within 160 hours of start date for all direct-care staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			



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

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Establishment Info	License Info	Inspection Info
SERENITY LIVING RESIDENTIAL IN 7527 BLOOMINGTON AVENUE SOUTH Richfield, MN 55423 Hennepin County Parcel: Phone:	License: HFID 40424 Risk: License: Expires on: CFPM: CFPM #: ; Exp:	Report Number: F1018251062 Inspection Type: Full - Single Date: 9/2/2025 Time: 8:47:48 AM Duration: minutes Announced Inspection: <u>Total Priority 1 Orders: 1</u> <u>Total Priority 2 Orders: 0</u> <u>Total Priority 3 Orders: 1</u> <u>Delivery:</u>

New Order: 2-100 Supervision

2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: Establishment was unable to produce a certified food protection manager certificate at the time of inspection.
Comply with rule.
Comply By: 9/2/2025 Originally Issued On: 9/2/2025

! New Order: 2-200 Employee Health

2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: Establishment does not currently have an illness log for recording instances of illness in food employees. Illness log sent with report.
Comply By: 9/2/2025 Originally Issued On: 9/2/2025

Food & Beverage General Comment

Establishment is a residential home with residential equipment.

All food is prepared for same day service.

Establishment has a dishwasher with sanitize function available. Test strip indicated that appropriate temperature was achieved during cycle.

Kitchen has a two-basin sink with one basin for hand washing and one basin for food prep.

Floors, walls, and ceilings were observed to be in good condition at the time of inspection.

Equipment and physical facilities were observed to be in good condition.

Establishment has a needle point thermometer for measuring food temperatures.

Discussed pest control, and employee illness policy.

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 F1018251062 from 9/2/2025

Keti Sima
Manager



Rebecca Prestwood, REHS
Public Health Sanitarian 3
651-201-3777
rebecca.prestwood@state.mn.us



Metro District Office
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St Paul, MN 55164

Temperature Observations/Recordings

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Establishment Info

SERENITY LIVING RESIDENTIAL IN
Richfield
County/Group: Hennepin County

Inspection Info

Report Number: F1018251062
Inspection Type: Full
Date: 9/2/2025
Time: 8:47:48 AM

Food Temperature: **Product/Item/Unit:** Turkey; **Temperature Process:** Cold-Holding

Location: Cooler at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Tuna; **Temperature Process:** Cold-Holding

Location: Cooler at 41 Degrees F.

Comment:

Violation Issued?: No



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Sanitizer Observations/Recordings

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Establishment Info	Inspection Info
SERENITY LIVING RESIDENTIAL IN	Report Number: F1018251062
Richfield	Inspection Type: Full
County/Group: Hennepin County	Date: 9/2/2025
	Time: 8:47:48 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Equal To** 160 Degrees F.

Comment:

Violation Issued?: No