Electronically Delivered

May 18, 2026

Licensee
Serendipitous Living
7935 Upper 139th Court West
Apple Valley, MN 55124

RE: Project Number(s) SL37368016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 24, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37368	A. BUILDING: _____ B. WING _____	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENDIPITOUS LIVING	7935 UPPER 139TH COURT WEST APPLE VALLEY, MN 55124

(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: SL37368016-0 On April 20, 2026, through April 24, 2026, 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 five residents; five 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of 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; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the staffing plan was evaluated and revised at least twice a year to ensure appropriate staffing levels. This had the potential to affect all residents and employees. 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	0 470		

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0 470	Continued From page 2 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated, Contingency Staffing Plan indicated at least one staff on duty always 24 hours a day, seven days per week, who is responsible for responding to the requests of residents for assistance with health or safety needs. If there is a need for additional help, on duty staff can communicate directly with the owner and co-owners (phone numbers included). On April 20, 2026, at 3:55 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he did not know the staffing plan was required to be reviewed at least twice yearly. On April 21, 2026, at 7:26 a.m., the surveyor observed unlicensed personnel (ULP)-E assisting R4 with breakfast. House manager/unlicensed personnel (HM/ULP)-C was observed prompting R1 to complete morning activities of daily living. HM/ULP-C stated three of the five residents in the home attended adult day care three to four days a week; on those days they always worked with two staff in the morning to assist with getting those residents ready in time for pick-up. On April 21, 2026, at 9:45 a.m., LALD/RN-A stated HM/ULP-C was scheduled on the day shift (along with one other ULP) every Monday through Wednesday with duties including to assist with direct care of residents. In addition, periodically the night shift ULP would stay late (into the	0 470		

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0 470	Continued From page 3 morning shift) to assist the residents who attended adult day care. LALD/RN-A stated the staffing plan did not reflect this. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
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	0 680		

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0 680	Continued From page 4 by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. 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 emergency preparedness plan last reviewed October 1, 2025, lacked the following required content: - Review of the Missing Resident policy quarterly - Emergency prep testing requirements On April 20, 2026, at 3:42 p.m., administrator (A)-B provided the surveyor with a typed sheet of paper from the emergency preparedness binder. The paper indicated on October 9, 2025, a tabletop exercise titled, "Storm with Power Outage" had been conducted. The paper also included the staff participants. A-B stated having no documentation related to how the staff had been trained or an analysis and response related to the training; A-B stated being unaware of the requirement. A-B further stated this was the only documented training they had for emergency preparedness other than fire drills. On April 23, 2026, at 9:57 a.m., licensed assisted	0 680		

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0 680	Continued From page 5 living director/registered nurse (LALD/RN)-A stated the licensee had not been reviewing the Missing Resident policy quarterly and was unaware of the requirement. The licensee's 4.01 Training, Exercises, and Testing policy dated October 1, 2025, indicated: Annually, the licensee's staff will participate in a full-scale exercise that is community-based, or when a community-based exercise is not accessible, an individual, facility-based tabletop exercise. If the facility experiences an actual natural or man-mad emergency that requires activation of the emergency plan, the facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for one year following the onset of the actual event. The facility will also conduct an additional annual exercise that may include, but is not limited to the following: - A second full-scale exercise that is community-based or individual, facility based; or: - A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed message, or prepared questions designed to challenge an emergency plan; or; - A mock disaster drill. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident:	0 730		

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0 730	Continued From page 6 (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service	0 730		

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0 730	Continued From page 7 termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (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 record lacked a discharge summary to include: - course of illnesses - treatments and therapies - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. R2 was admitted to the licensee on September 16, 2021, with diagnoses including seizure disorder and cerebral palsy. R2 was discharged from the facility on September 25, 2025.	0 730		

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0 730	Continued From page 8 On April 20, 2026, at 3:42 p.m., licensed assisted living director/registered nurse (LALD/RN)-A reviewed R2's discharge summary and stated it did not include all required components. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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: Please refer to the document titled, Physical	0 775		

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0 775	Continued From page 9 Environment Inspection Report (PEIR) dated April 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days.	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (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;	0 780		

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0 780	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=A	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and	0 800		

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0 800	Continued From page 11 repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 800		
0 810 SS=I	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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37368	A. BUILDING: _____ B. WING _____	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENDIPITOUS LIVING	7935 UPPER 139TH COURT WEST APPLE VALLEY, MN 55124

(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 12 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 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 ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 810		

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0 810	Continued From page 13 or a violation that had the potential to cause more than minimal harm to the resident) 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced	01290		

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01290	Continued From page 14 by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received an affiliation with the assisted living license for one of two employees (unlicensed personnel (ULP)-D). This had the potential to affect all residents. 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: ULP-D was hired on March 28, 2025, to provide direct care and services to the licensee's residents. ULP-D's employee record contained a background study dated February 1, 2025, for a separate location operated by the licensee's owner. ULP-D's employee record lacked evidence the licensee affiliated a background study for their license. On April 20, 2026, at 2:07 p.m., administrator (A)-B stated ULP-D worked at both of the licensee's assisted living facilities; however, ULP-D's background study had not been affiliated with this residence (health facility identification number (HFID) 37368).	01290		

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01290	Continued From page 15 The licensee's undated, Background Screening policy indicated the licensee will conduct background screening so on all applicants once an offer of employment has been offered. All employment offers are contingent upon a clearance of their DHS (Department of Human Services) screening. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
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	01620		

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01620	Continued From page 16 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 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 the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 calendar days from the last assessment, for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01620		

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01620	Continued From page 17 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: R1's diagnoses included schizoaffective disorder, depression, and type II diabetes. R1's Client Care Plan signed February 1, 2025, indicated R1 received services including medication administration, blood glucose monitoring, reminders for activities of daily living, housekeeping, and laundry. On April 21, 2026, at 8:11 a.m., the surveyor observed unlicensed personnel (ULP)-E administering medications to R1. R1's last three assessments were requested. Assessments completed October 23, 2025, November 1, 2025, and February 1, 2026, were provided. 93 days had passed between the October 2025, and February 2026, thus exceeding 90 calendar days. On April 21, 2026, at 12:36 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated R1's February 2026, assessment had not been completed within 90 days as required. The licensee's undated, Acceptance of Residents policy indicated reassessments shall be conducted as needed or no longer than 90 days from the previous assessment. No further information was provided.	01620		

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01620	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included	01650		

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01650	Continued From page 19 the correct required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1's Client Care Plan signed February 1, 2025, indicated R1 received services including medication administration, blood glucose monitoring, reminders for activities of daily living, housekeeping, and laundry. R1's Service Agreement/Plan dated May 30, 2023, indicated resident assessment/evaluation will be completed within five days of admission, 14 days after to finalize the resident evaluation and as needed but not to exceed 90 days from previous assessment. The service plan identified an incorrect schedule and method of monitoring assessments of the resident. On April 21, 2026, at 1:31 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the Service Agreement/Plan and the Client Care Plan went together. When changes were needed in services, the Client Care Plan was updated and signed. LALD/RN-A reviewed R1's Service Agreement/Plan and stated the above required content was incorrect in the service agreement/plan, and reflective of previous home care statutes. LALD/RN-A further stated the same service agreement/plan format was utilized	01650		

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01650	Continued From page 20 for all residents. The licensee's undated, Acceptance of Residents policy indicated the RN will conduct an initial assessment of the resident prior to the resident moving into the facility. All service plan will include the schedule and method of monitoring assessments of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;	01730		

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01730	Continued From page 21 (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for one of one resident(R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	01730		

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01730	Continued From page 22 During the entrance conference on April 20, 2026, at 11:48 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee provided medication management services to their residents. R1's diagnoses included schizoaffective disorder, depression, and type II diabetes mellitus. R1's service plan/client care plan signed February 1, 2025, indicated R1 received services including medication administration. R1's medication administration record (MAR) dated April 2026, two antidepressants, one antipsychotic, one beta-blocker (to treat high blood pressure), three medications to treat diabetes, one for high cholesterol, one iron supplement, and one vitamin supplement. On April 21, 2026, at 8:11 a.m., the surveyor observed unlicensed personnel (ULP)-E administering medications to R1. R1's Medication Management Plan dated January 17, 2024, lacked the following: - procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services. On April 21, 2026, at 12:36 p.m., LALD/RN-A reviewed R1's medication management plan and could not locate evidence of procedures for notifying a registered nurse. LALD/RN-A stated all residents utilize the same medication management plan template. The licensee's undated, Individual Medication	01730		

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01730	Continued From page 23 Management Plan policy indicated: A staff RN will prepare a written medication management plan specific to each resident receiving medication management service. The medication management plan will include the following: 6. Procedures for contact the RN with questions or concerns. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed by one of one unlicensed personnel (ULP)-E observed during medication administration. 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	02320		

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02320	Continued From page 24 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: R3 R3's diagnoses included cerebrovascular accident (CVA-stroke) with left hemiplagia (paralysis), dysphasia (difficulty swallowing), dizziness, and renal insufficiency. R3's service plan/client care plan signed February 1, 2025, indicated R1 received services including medication administration. On April 21, 2026, at 7:41 a.m., the surveyor observed unlicensed personnel (ULP)-E setting up R3's medications for administration. R3's four morning oral medications had been set up by the pharmacy in one blister package. The package listed the name and dosage of each medication on the top of the blister package. ULP-E opened the blister package and poured the four medications into a cup with applesauce without comparing what was listed on the top of the package with R3's medication administration record (MAR). ULP-E administered R3's medication with the applesauce to R3, then proceeded to feed R3 the rest of his breakfast. R1 R1's diagnoses included schizoaffective disorder, depression, and type II diabetes mellitus. R1's service plan/client care plan signed February 1, 2025, indicated R1 received services including medication administration. On April 21, 2026, at 8:11 a.m., the surveyor	02320		

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02320	Continued From page 25 observed ULP-E setting up R1's medications for administration. R1's six morning oral medications had been set up by the pharmacy in one blister package. The package listed the name and dosage of each medication on the top of the blister package. ULP-E opened the blister package and poured the medications into R1's hand without comparing what was listed on the top of the package with R1's MAR. ULP-E provided orange juice to R1, who took the medications independently once ULP-E had placed them into her hand. ULP-E then threw away the blister package that had contained R1's morning medications, then documented each medication that had been administered. On April 21, 2026, at 8:33 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated staff are trained and expected, to compare the resident's medication label on the blister pack with the orders in the MAR when setting up medications for administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Food & Beverage Inspection Report

Establishment Info

Serendipitous Living
7935 UPPER 139TH COURT WEST
Apple Valley, MN 55124
Dakota County
Parcel:

Phone:

License Info

License: HFID 37368

Risk:
License:
Expires on:
CFPM: Salina Pao Yann
CFPM #: CFPM-16531; Exp: 06/04/2028

Inspection Info

Report Number: F1005261116
Inspection Type: Full - Single
Date: 4/21/2026 Time: 11:30 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

INSPECTION COMPLETED WITH PERSON IN CHARGE AND REVIEWED WITH HRD NURSING EVALUATOR WENDY BUCKHOLZ.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

A THERMOLABEL WAS RUN THROUGH THE DISHWASHER BEFORE INSPECTOR ARRIVED, SHOWING THE DISHWASHER PROVIDED A UTENSIL SURFACE TEMPERATURE OF AT LEAST 180 DEGREES F.

FLOORING IS LAMINATE, CABINETS ARE WOOD WITH HOLLOW BASE AND COUNTERS ARE LAMINATE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 F1005261116 from 4/21/2026

SALINA YANN
PIC

Jessica Davis, REHS
Public Health Sanitarian 3
651-201-3961
jessica.davis@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Serendipitous Living
Apple Valley
County/Group: Dakota County

Inspection Info

Report Number: F1005261116
Inspection Type: Full
Date: 4/21/2026
Time: 11:30 AM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Refrigerator at 34 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: TOFU**; Temperature Process:** Cold-Holding
Location: Refrigerator at 37 Degrees F.
Comment:
Violation Issued?: No

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

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

Sanitizer Observations/Recordings

Establishment Info

Serendipitous Living
Apple Valley
County/Group: Dakota County

Inspection Info

Report Number: F1005261116
Inspection Type: Full
Date: 4/21/2026
Time: 11:30 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** DISHWASHER
Location: Greater Than 180 Degrees F.
Comment: AT LEAST 180 DEGREES F PER THERMOLABEL
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL37368016-0	**Date:** April 22, 2026
Facility Name: SERENDIPITOUS LIVING	
Facility Address: 7935 UPPER 139TH COURT W, APPLE VALLEY, MN 55124	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Two (2) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

   Comments: The existing hardwired smoke alarm in main level bedroom hallway was removed. Existing hardwired smoke alarms are required to be maintained as installed previously and shall be replaced with smoke alarms having the same type of power supply.

3. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

   Comments: Facility didn't have carbon monoxide alarm installed within 10 feet of the three main level bedrooms.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Smoke alarms are provided in each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

   Comments: In the basement common area, the facility had a resident bedroom set-up. The area didn't have a smoke or carbon monoxide alarm.

2. Smoke alarms interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments: Multiple, different battery powered alarms throughout the facility were not interconnected with each other or the hard-wired alarms in the facility.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 1; Isolated **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are 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. [Minn. Stat. 144G.45 subd.2]

   Comments: On the ceiling of resident room #1 there was peeling paint and water stains from previous roof and water damage.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

   Comments: The surveyor observed the evacuation plans lacked accurate identification of resident rooms and layout. Exit plan diagrams must be correctly labeled to reduce confusion for emergency responders and potential obstructions for egress in a fire or similar emergency.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP failed to include standard resident evacuation procedures and failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.

5. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: Administrator (A)-B lacked documentation showing training was completed twice in 2025 for staff on the fire safety and evacuation plan. A-B stated training was taking place during fire drills.

6. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: A-B lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.

7. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: A-B lacked documentation showing evacuation drill details. A-B provided document titled "Fire Drill planning matrix". Documents provided showed drill dates and times with staff names only. A-

B also provided one fire drill report dated 3-6-25, the report lacked details of the drill. Documents provided show drills didn't occur twice per year, per shift. No other information or documentation was provided.