Electronically Delivered

February 20, 2025

Licensee
Serenity Assisted Living & Memory Care
1251 3rd Avenue Northwest
Dilworth, MN 56529

RE: Project Number(s) SL34017016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 14, 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,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34017	A. BUILDING: _____ B. WING _____	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY ASSISTED LIVING & MEM	1251 3RD AVENUE NW DILWORTH, MN 56529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34017016-0 On January 13, 2025, through January 14, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 12 residents; 12 receiving services under the Assisted Living Facility with Dementia Care 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.	

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0 480	Continued From page 1	0 480		
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 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;	0 480		

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0 480	Continued From page 2 (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 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 14, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. 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	0 485		

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0 485	Continued From page 4 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 13, 2025, at 9:13 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided residents three meals per day, and the licensee did not require a resident to include and pay for meals in the resident contract that the resident did not want. On page 13 of the undated Assisted Living with Dementia Care Contract, Attachment A: Services Included in the Base Rent, Section D: Meals and Nutrition: indicated three nutritional meals served daily and snacks with option for private pay residents to choose 2 (two) meals per day for a reduced fee. The licensee's undated Meal Plan addendum indicated to choose one of the following options: -I (resident) choose to keep the 3 (three) meals plus 3pm [sic] snack every day (included in base rate); -I (resident) choose to opt out of the full meal plan for a discount. You (resident) must select which 2 (two) meals you (resident) will choose each day. I (resident) must designate which two meals every day; or -Meal Plan not applicable; Resident is on waivered services. Resident assisted living contract addendums lacked an option for private pay residents to opt out of payment for two or all meals residents would not want. Resident assisted living contract addendums lacked options for residents who did	0 485		

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0 485	Continued From page 5 not pay for services privately to opt out of one, two, or all meals residents would not want. On January 14, 2025, at 12:01 p.m., agent (A)-J stated the same assisted living contract, and addendums were used for all residents. A-J further stated the licensee only allowed an option for residents to opt out of one meal per day for a reduced cost. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated December 13, 2024, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced	0 510		

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0 510	Continued From page 6 by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for two of three employees (unlicensed personnel (ULP)-G, ULP-H) 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on January 13, 2025, at 9:09 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. ULP-G On January 14, 2025, at 6:48 a.m., the surveyor observed ULP-G complete a scheduled blood glucose check for R3. ULP-G completed hand hygiene, applied gloves, completed R3's blood glucose check, and removed gloves. The surveyor did not observe ULP-G complete hand hygiene. ULP-G applied a new pair of gloves, administered R3's inhaler, applied a topical gel to R3, and removed gloves. The surveyor did not observe ULP-G complete hand hygiene. ULP-G applied a new pair of gloves, administered R3's insulin, applied a pain patch to R3, removed gloves, and documented on R3's electronic	0 510		

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0 510	Continued From page 7 medication administration record (EMAR). The surveyor did not observe ULP-G complete hand hygiene. On January 14, 2025, at 8:16 a.m., ULP-G stated ULP-G usually carried hand sanitizer in ULP-G's pocket to complete hand hygiene in between glove changes, however, ULP-G stated ULP-G had picked up the morning shift for another staff and had forgot to bring ULP-G's hand sanitizer with. ULP-H On January 14, 2025, at 7:55 a.m., the surveyor observed ULP-H wash hands with soap and water for eight seconds in R6's room. ULP-H completed scheduled morning medication administration for R6, documented on R6's EMAR, and left R6's room. ULP-H entered the licensee's kitchen and proceeded to wash hands with soap and water for four seconds. On January 14, 2025, at 8:24 a.m., ULP-H stated ULP-H was trained to wash ULP-H's hands for at least 15 to 20 seconds with soap and water. ULP-H further stated "Sorry, I did not do that (wash hands) for long enough." On January 14, 2025, at 9:33 a.m., clinical nurse supervisor (CNS)-B stated ULPs were trained to complete hand hygiene before and after the use of gloves. CNS-B further stated ULPs were trained to wash hands with soap and water for approximately 20 seconds, while singing the "ABC song," and the licensee completed annual audits of hand hygiene with each employee. The licensee's 8.07 Gloves policy dated August 1, 2021, indicated after employee's removed gloves to rewash hands.	0 510		

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0 510	Continued From page 8 The licensee's 8.09 Hand Washing policy dated August 1, 2021, indicated to wet hands and wrists, apply soap over hands and wrists working into a generous lather by scrubbing vigorously for at least 20 seconds, rinse hands and wrists under running water, and pat dry with a paper towel. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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 9 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, 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 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). Findings include: On January 15, 2025, at 10:10 a.m., survey staff toured the facility with director of maintenance (DM)-I and it was observed that the emergency exit door, in the sunroom, went out to the courtyard which did not have the snow removed, this removes a safe means of egress during a fire or similar emergency. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. These emergency exit doors were identified with overhead exit signs and are included in the facility's evacuation plan.	0 780		

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0 780	Continued From page 10 DM-I verbally confirmed survey staff observation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
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 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	0 810		

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0 810	Continued From page 11 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 the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 15, 2025, at 11:40 a.m., agent (A)-J, licensed assisted living director (LALD)-A and director of maintenance (DM)-I provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: Failed to provide the FSEP (fire safety and evacuation plan) for employee actions to take in the event of a fire or similar emergency. A-J stated the FSEP was an electronic document which all of the employees had access to but was unable to provide these documents at the time of	0 810		

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(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 the survey. Failed to provide the FSEP (fire safety and evacuation plan) for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan Should include instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. A-J stated training was done upon hire and twice per year but no documentation of this was provided. The licensee failed to provide evacuation training to residents at least once per year. A-J lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34017	A. BUILDING: _____ B. WING _____	01/14/2025

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SERENITY ASSISTED LIVING & MEM	1251 3RD AVENUE NW DILWORTH, MN 56529

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01770	Continued From page 13 by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R4). 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: During the entrance conference on January 13, 2025, at 9:12 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R4's diagnoses included late onset Alzheimer's dementia without behavioral disturbances, osteoporosis (weak bones), and depression. R4's service plan dated October 2, 2024, indicated R4 received medication set-up one day per week by a licensed practical nurse (LPN). R4's prescriber orders dated December 16, 2024, included the following orders: -Buspirone (antianxiety) 10 milligrams (mg) twice daily; -Caltrate 600 D (supplement) one tablet daily; -celecoxib (for pain) 200 mg twice daily; -Donepezil (for dementia) 10 mg daily; -gabapentin (for pain) 200 mg twice daily; -gabapentin 300 mg daily; -melatonin (sleep aid) 5 mg daily;	01770		

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	34017	A. BUILDING: _____ B. WING _____	01/14/2025

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01770	Continued From page 14 -Memantine HCL (for dementia) 10 mg twice daily; -omeprazole (for acid reflux) 20 mg daily; -sertraline (antidepressant) 50 mg daily; -Trazodone (antianxiety) 25 mg daily; -Trazodone 50 mg daily; and -Trazodone 75 mg daily. R4's record contained documentation of a medication set up completed by a LPN on December 30, 2024, at 11:46 a.m., however, R4's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, name of the medication, quantity of dose, times to be administered, and route of administration. On January 13, 2025, at 1:56 p.m., CNS-B stated the LPN completed medication set ups every 28 days for some residents and compared all resident medications to the resident's electronic medication administration record (EMAR) during each medication set up. On January 14, 2025, at 8:59 a.m., CNS-B stated the licensee did not document each specific medication during a resident's medication set up and the licensee was not aware of all the required documentation for a medication set up. CNS-B further stated resident medication set ups completed by the LPN were all documented the same in RTasks (electronic medical record software). The licensee's 7.09 Medication Management-Medication Set Up Policy [sic] policy dated August 1, 2024, indicated the LN (licensed nurse) setting up the medications will verify each medication for correct strength, dose, and time using individuals (residents) EMAR, and med (medication) set up	01770		

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	34017	A. BUILDING: _____ B. WING _____	01/14/2025

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01770	Continued From page 15 will be documented in RTasks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
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 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 medications were maintained with the original prescription label for one of four residents (R3). In addition, the licensee failed to monitor for expired medications in one of four locked medication drawers located in resident's rooms (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on January 13,	01890		

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01890	Continued From page 16 2025, at 9:12 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. ORIGINAL PRESCRIPTION LABEL On January 14, 2025, at 6:55 a.m., the surveyor reviewed R3's locked medication drawers with unlicensed personnel (ULP)-G and observed R3's opened Breo Ellipta 200 micrograms (mcg)-25 mcg was not labeled with a prescription label. ULP-G stated R3's Breo Ellipta inhaler use to be stored in the box with the original prescription label, however, the Breo Ellipta box must have been thrown away. On January 14, 2025, at 7:43 a.m., ULP-D stated all resident inhalers were supposed to be stored in the original inhaler box with the original prescription label. EXPIRED MEDICATION On January 14, 2025, at 7:55 a.m., the surveyor reviewed R6's locked medication drawers with ULP-H and observed R6's opened Guaifenesin bottle with an expiration date of October 2024. ULP-H stated the nurse was responsible for checking on expired resident medications each week. On January 14, 2025, at 9:31 a.m., CNS-B stated all medications should be stored bearing the original prescription label or kept in the medication box with the prescription label attached. CNS-B further stated a nurse had checked resident medication drawers every Monday to monitor for expired medications, and ULPs should check for expired medications prior to administration. The licensee's 7.13 Medications- Prescription	01890		

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01890	Continued From page 17 Drugs and Prohibition policy dated August 1, 2021, indicated all prescription drugs administered by (licensee name) must be kept in the original container in which they (medications) were dispensed by the pharmacy bearing the original prescription label with legible information including the expiration. The licensee's 7.11 Controlling and Storing Medications policy dated August 1, 2021, indicated medications will be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the	02040		

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02040	Continued From page 18 physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, 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 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). Findings include: A record review and interview were conducted on January 15, 2025, at 10:43 a.m. with director of maintenance (DM)-I, licensed assisted living director (LALD)-A and agent (A)-J on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, LALD-A, DM-I and A-J stated he understood the requirements of this policy. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

MN Department of Health
Food Pools and Lodging Services
PO Box 64975
St Paul, MN, 55164
218-332-5150

Type: Full
Date: *01/14/25*
Time: 09:59:19
Report: 1042251001

Food and Beverage Establishment Inspection Report

Location:
Serenity Living Center Inc
1125 Oakview Drive
Dilworth, MN56529
Clay County, 14

Establishment Info:
ID #: 0037440
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2184777254
ID #:

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

The following orders were issued during this inspection.

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

Comply By: 01/16/25

6-300 Physical Facility Numbers and Capacities

6-304.11A

MN Rule 4626.1475A Provide sufficient mechanical tempered make-up air and exhaust ventilation to keep rooms free of grease, excessive heat, steam condensation, vapors, obnoxious or disagreeable odors, smoke, and fumes according to State Building and Mechanical codes.

Comply By: 01/16/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: Bucket
Violation Issued: No

Quaternary Ammonia: = 400ppm at Degrees Fahrenheit
Location: Dispenser
Violation Issued: No

Quaternary Ammonia: = at Degrees Fahrenheit
Location:
Violation Issued: No

Food and Equipment Temperatures

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 29.2 Degrees Fahrenheit - Location: Cream
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 31.0 Degrees Fahrenheit - Location: Pie Apple
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 32.7 Degrees Fahrenheit - Location: Cheese
Violation Issued: No

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

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.

2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up to date employee illness log.

3. There should be a Person in Charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.

4. Employees should use spatula, tongs, deli tissue, gloves, or some other approved means to prevent any direct bare hand contact with ready to eat foods.

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

I acknowledge receipt of the MN Department of Health inspection report number 1042251001 of 01/14/25.

Certified Food Protection Manager: Jacob J Luna

Certification Number: FM121659 Expires: 02/01/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Tyler Pyle
Environmental Health Specialist
Fergus Falls Area Office
tyler.pyle@state.mn.us