Electronically Delivered

October 23, 2025

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

RE: Project Number(s) SL34879016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 23, 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 . . ."

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. 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,

Renee L Anderson

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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34879	A. BUILDING: _____ B. WING _____	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENDIPITOUS LIVING	103 ROBIE STREET WEST SAINT PAUL, MN 55107

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	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: SL34879016-0 On September 22, 2025, through September 23, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 3 residents, all of whom were receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at	0 470		

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0 470	Continued From page 1 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 interview, and record review, the licensee failed to review their staffing plan two times annually to evaluate the appropriateness of staffing levels in the facility to met the scheduled and reasonably foreseeable unscheduled needs of 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	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 the potential to affect a large portion or all of the residents). The findings include: On September 22, 2025, at 10:15 a.m., during an entrance conference, owner/housing manager (O/HM)-A stated leadership discussed staffing needs regularly but they did not document their review. O/HM-A further stated they were not aware the review needed to be documented. The licensee's undated Minimum Assisted Living Facility Requirements policy, indicated a staffing plan would be developed to ensure the licensee had sufficient staffing at all times. The policy lacked an indication how often the plan would be reviewed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
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	0 480		

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

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0 480	Continued From page 4 (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 23, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality	0 580		

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0 580	Continued From page 5 management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size of the facility and relevant to the type of services provided. 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 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: The licensee lacked documentation of quality management activities to evaluate quality of care. On September 22, 2025, at 12:30 p.m., stated they had regular meetings to discuss everything happening at the facility, but they had not been	0 580		

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0 580	Continued From page 6 documenting quality management activity and they were not aware of the requirement. The licensee's undated Quality Management Program policy indicated the licensee would monitor organizational trends related to safety and resident care in order to address unsafe clinical practices. The policy further indicated documentation of quality management activity would be maintained for at least two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 660		

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0 660	Continued From page 7 licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including completing a facility TB risk assessment annually. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee's facility TB risk assessment, dated September 15, 2022, indicated the facility was low risk. The licensee lacked documentation a facility TB risk assessment had been completed annually. On September 22, 2025, at 1:00 p.m., owner/housing manager (O/HM)-A stated he was not sure if a facility TB risk assessment was completed for 2025, and they did not know a risk assessment needed to be done annually. The Minnesota Department of Health (MDH) Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Settings Licensed by MDH, dated June 2024, indicated a TB facility risk assessment should be performed annually.	0 660		

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0 660	Continued From page 8 The licensee's undated Tuberculosis Prevention and Screening Plan policy indicated the licensee would follow the recommended precautions related to TB prevention as identified by MDH. The policy lacked an indication a facility risk assessment would be conducted annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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.	0 680		

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0 680	Continued From page 9 (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all required content as defined in Centers for Medicare and Medicaid Services (CMS) Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee's undated EP plan lacked evidence of the following required content: - documentation the EP plan was reviewed annually - facility hazard risk assessment - documentation of two emergency preparedness exercises (an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise. On September 29, 2025, at 12:00 p.m., owner/housing manager (O/HM)-A stated the EP	0 680		

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0 680	Continued From page 10 plan had not been updated or reviewed and they had not conducted the required annual drills. O/HM-A stated they were not aware of the requirements for the annual drills, and they had recently purchased a new manual and were in the process of updating it. The licensee's undated Emergency Preparedness policy indicated the licensee would have an identified plan in place to assure the safety and well-being of its residents and staff during periods of an emergency. The plan lacked an indication of how often the plan would be reviewed or that staff would participate in an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 and interview, the licensee failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to	0 775		

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0 775	Continued From page 11 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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 23, 2025, from approximately 9:05 a.m. to 10:10 a.m., the surveyor toured the facility with owner/house manager (O/HM)-A. During the tour the surveyor observed the following: There was a significant amount of discarded cigarette butts in the front lawn and in landscaping near the house. There was also a half-smoked cigarette laying on top of the mailbox, leaning against the house near the front entry door. There was a provided receptacle for smoking materials, but many discarded smoking materials were not properly disposed of. All smoking materials must be disposed of in proper manner to prevent fire risk. Existing cigarette butts on lawn should be removed and lawn maintained free of cigarettes or other smoking materials. A significant amount of lint had accumulated behind the clothes dryer. Lint should be removed and area maintained clear of lint to prevent fire risk.	0 775		

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0 775	Continued From page 12 O/HM-A acknowledged the noted deficiencies during the tour and expressed that they would correct the deficiencies. 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 13 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. 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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 23, 2025, from approximately 9:05 a.m. to 10:10 a.m., the surveyor toured the facility with owner/house manager (O/HM)-A. During the tour the surveyor observed the following: A hardwired smoke alarm mount was present in the upper-level bedroom hallway without an attached hardwired smoke alarm. Hardwired smoke alarm mounts must be maintained with operable hardwired smoke alarm. O/HM-A tested smoke alarms by activating alarms in resident room 2, resident room 3 and upper-level bedroom hallway. Smoke alarms provided in resident room 1, upper-level bedroom hallway and lower-level bedroom hallway were not interconnected when tested by O/MH-A. Smoke alarms must maintain power supply and all smoke alarms in the facility must be interconnected such that the activation of any	0 780		

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0 780	Continued From page 14 alarm causes all alarms to sound. The hardwired plate outside of upper-level bedrooms must be equipped with functional hardwired smoke alarm that interconnects with all other alarms in the facility. O/HM-A acknowledged requirements for smoke alarms. During the facility tour interview on September 23, 2025, O/HM-A verified the above-listed observations while accompanying on the tour, and expressed that they would ensure interconnection and correct the deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	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 repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.	0 800		

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0 800	Continued From page 15 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 23, 2025, from approximately 9:05 a.m. to 10:10 a.m., the surveyor toured the facility with owner/house manager (O/HM)-A. During the tour the surveyor observed the following: The front concrete steps to the house were degraded and cracked with loose pieces of concrete. The steps should be repaired and maintained in proper condition to avoid trip and fall hazard. The retaining wall along the front sidewalk was cracked and showed evidence of spalling. The retaining wall should be repaired and maintained. The exit door at the top of the basement stairs was not weathertight in the door frame, with visible gaps in between the door and the frame. The door should be maintained weathertight and in good condition. The window ledge under the egress window in resident room 3 was damaged. There was a significant dent in the windowsill and exposed metal bracket. The damage should be repaired and maintained n proper state of repair.	0 800		

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0 800	Continued From page 16 A portion of carpeting was missing in the doorway threshold of resident room 3. The hole in the carpet may be a tripping hazard and should be repaired. During the facility tour interview on September 23, 2025, O/HM-A verified the above-listed observations while accompanying on the tour, and expressed that they would ensure interconnection and correct the deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
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	0 810		

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0 810	Continued From page 17 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 develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, 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: On September 23, 2025, at approximately 9:45 a.m., owner/house manager (O/HM)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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0 810	Continued From page 18 The licensee FSEP failed to include the following: The FSEP failed to include the location and number of resident rooms. Facility maps and documents did not number or otherwise identify resident rooms, and no such designators were located on or near the resident room doors making it difficult to identify specific rooms. Maps of the upper level were present mounted on the walls, but there was no map for the lower level. The maps also marked the garage as an emergency exit for a fire, however the garage should not be used as a marked emergency exit route as it is an area of higher hazard and may not be safe during fire emergency. The FSEP failed to include appropriate employee actions to take during a fire or similar emergency. O/HM-A stated that they are in the process of transitioning plans and showed the surveyor newly acquired documents that will reportedly be developed into employee procedures for evacuation. The FSEP failed to identify specific fire protection actions for residents. There was no section in the provided documents that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. Fire procedures must be provided for residents. O/HM-A stated that they are in the process of transitioning plans and showed the surveyor newly acquired documents that will reportedly be developed into resident procedures for evacuation. The FSEP failed to identify unique resident needs for evacuation or movement during fire or similar emergency. O/HM-A stated that they were in the	0 810		

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0 810	Continued From page 19 process of transitioning plans and would identify and record unique resident needs in the facility FSEP. Record review indicated the licensee failed to provide and document adequate training to employees on the FSEP upon hire and at least twice per year. Staff was unable to provide documentation showing adequate trainings were provided for employee training on the fire safety and evacuation plan. No documents were available of staff training. No documents were available of resident training. O/HM-A indicated training will be implemented and documented. Staff should be training on the FSEP upon hire and at least twice a year thereafter. Record review indicated the licensee failed to provide and document adequate training to residents on actions to take during a fire or evacuation. No documents were available of resident training. O/HM-A indicated training will be implemented and documented. Residents should be offered training at least annually. Record review indicated that the licensee failed to provide and document any evacuation drills within the last year. No records were available for drills conducted in 2024 or prior to the survey in 2025. The last recorded drill provided by O/HM-A was from 3/28/23. O/HM-A provided recently created documents and showed plans to conduct a drill on 10/3/25 at 11am. O/HM-B showed efforts to create new FSEP documents and implement fire drills that were previously not occurring. The surveyor explained requirements for drills. Evacuation drills must occur at least once every other month and at least twice per year per shift.	0 810		

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0 810	Continued From page 20 During an interview on September 23, 2025, at approximately 10:00 a.m., the surveyor explained the requirements for employee trainings, evacuation drills and FSEP documentation. O/HM-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.	01440		

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01440	Continued From page 21 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee (unlicensed personnel (ULP)-C). 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: ULP-C was hired January 20, 2025, and provided direct cares for the licensee's residents. On September 23, 2025, at 7:30 a.m., the surveyor observed ULP-C assisting R2 with medication administration. ULP-C's record lacked documentation the RN conducted direct supervision of the ULP performing a delegated task within 30 days of performing the task. On September 22, 2025, at 1:45 p.m., clinical nurse supervisor (CNS)-B stated the 30-day supervision for ULP-C had been done, but it had not been documented. CNS-B stated they did not realize it should have been documented.	01440		

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01440	Continued From page 22 The licensee's undated Delegation and Supervision of Staff policy indicated supervision of unlicensed personnel would be conducted within 30 calendar days after the individual begins working for the licensee and first performs delegated tasks. The policy further indicated all supervisory visits and competency evaluations would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until	01530		

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01530	Continued From page 23 this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff completed the required amount of dementia care training, in the required time frame for one of one employees (unlicensed personnel (ULP)-C). 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:	01530		

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01530	Continued From page 24 ULP-C was hired January 20, 2025, to provide direct care services for the licensee's residents. On September 23, 2025, at 7:30 a.m., the surveyor observed ULP-C assisting R2 with medication administration. ULP-C's employee record lacked documentation they had completed the required 8 hours of initial dementia care training within 160 hours of working. On September 22, 2025, at 12:50 p.m., owner/house manager (O/HM)-A stated ULP-C had not completed all eight hours of the required training. O/HM further stated he did not realize a total of eight hours of training was required. The licensee's undated Dementia Care Training policy indicated direct care staff would complete eight hours of initial dementia care training within120 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	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	01620		

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SERENDIPITOUS LIVING	103 ROBIE STREET WEST SAINT PAUL, MN 55107

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01620	Continued From page 25 prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be 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	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34879	A. BUILDING: _____ B. WING _____	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENDIPITOUS LIVING	103 ROBIE STREET WEST SAINT PAUL, MN 55107

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 26 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 ongoing comprehensive reassessments using the uniform assessment tool at an interval not to exceed 90 days for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R2's client care plan, dated July 23, 2025, indicated R2 received services including assistance with medication administration. On September 23, 2025, at 7:30 a.m., the surveyor observed unlicensed personnel (ULP)-C assisting R2 with medication administration. R2's record included a nursing assessment, dated July 23, 2024. The assessment did not utilize a uniform assessment tool addressing the required elements as identified in MN Rules 4652.0150 Subp.2, A to N. R2's record lacked a subsequent comprehensive	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34879	A. BUILDING: _____ B. WING _____	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENDIPITOUS LIVING	103 ROBIE STREET WEST SAINT PAUL, MN 55107

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01620	Continued From page 27 assessment. On September 23, 2025, at 11:09 a.m., owner/housing manager (O/HM)-A stated R2's 90-day comprehensive nursing assessment had not been done. O/HM-A stated they had implemented a new comprehensive nursing assessment form while the previous nurse worked for the licensee, but it looked like the information did not get passed along to the new clinical nurse supervisor. O/HM-A further stated they would add this to their "to do" list. On September 23, 2025, at 11:30 a.m., clinical nurse supervisor (CNS)-B stated they had kept documentation of visit notes in the residents' records, but did not document comprehensive 90-day assessments. CNS-B stated they were not aware of the requirement. The licensee undated Assessment - Comprehensive Services policy indicated "ongoing client monitoring and reassessment," would be conducted by the registered nurse at least every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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
103 Robie Street West
St Paul, MN 55107
Ramsey County
Parcel:

Phone:

License Info

License: HFID 34879

Risk:
License:
Expires on:
CFPM: Rothana T. Seng
CFPM #: 13924; Exp: 06/04/2028

Inspection Info

Report Number: F1021251155
Inspection Type: Full - Single
Date: 9/23/2025 Time: 12:07:08 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 2
Delivery: Emailed

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: NO EMPLOYEE ILLNESS LOG ON-SITE. DISCUSSED EMPLOYEE ILLNESS POLICY AND RECORDING WITH STAFF. AN MDH EMPLOYEE ILLNESS LOG SENT WITH REPORT.

Comply By: 9/26/2025 Originally Issued On: 9/23/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT: NO THIN PROBE FOOD THERMOMETER ON-SITE. PROVIDE AS DESCRIBED IN RULE ABOVE. DISCUSSED THERMOMETER PROBE CLEANING AND SANITATION. ESTABLISHMENT ORDERED AND RECEIVED A FOOD THERMOMETER. CORRECTED.

Comply By: 9/26/2025 Originally Issued On: 9/23/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.13A *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.
COMMENT: ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN DISH MACHINE. ESTABLISHMENT PROVIDED THERMOMETER STICKERS AND SENT THE INSPECTOR A PHOTO OF ONE THAT WAS RUN THROUGH THE DISH MACHINE. CORRECTED.
Comply By: 9/26/2025 Originally Issued On: 9/23/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11C *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT: RESIDENTIAL VENTILATION HOOD AND FILTER BELOW THE MICROWAVE CONTAINS ACCUMULATION OF GREASE. CLEAN AND MAINTAIN CLEAN.

Comply By: 9/26/2025 Originally Issued On: 9/23/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: THERE IS A BUILDUP OF DRIED GREASE ON THE CEILING AND WALL ABOVE THE STOVE. THE CEILING ALONG THE KITCHEN WALL AND IN THE DINING AREA HAS ACCUMULATED DUST AND COBWEBS. CLEAN AND MAINTAIN CLEAN.
Comply By: 9/26/2025 Originally Issued On: 9/23/2025

Food & Beverage General Comment

All findings on this report were discussed with Chief Operating Officer (COO)/Administrator, Maysa Sayavongchanh and Health Regulation Division Nurse Evaluator, Tammy Carlson.

This facility is a residential home, and they currently have 3 clients and the facility can accommodate up to 4 clients.

Food is for same-day service. Leftovers are discarded at the end of service.

The kitchen has residential equipment, laminate cabinets and painted drywall. Physical facility items will be monitored during future inspections.

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 F1021251155 from 9/23/2025

Melissa Ramos

Maysa Sayavongchanh

COO/Administrator

Melissa Ramos,
Public Health Sanitarian 3
651-201-4495
melissa.ramos@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
St Paul
County/Group: Ramsey County

Inspection Info

Report Number: F1021251155
Inspection Type: Full
Date: 9/23/2025
Time: 12:07:08 PM

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

Food Temperature: Product/Item/Unit: Raw Chicken **; Temperature Process:** Cold-Holding
Location: Frigidaire Refrigerator at 39 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Frigidaire Refrigerator **; Temperature Process:** Ambient Air
Location: Kitchen at 37 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
St Paul
County/Group: Ramsey County

Inspection Info

Report Number: F1021251155
Inspection Type: Full
Date: 9/23/2025
Time: 12:07:08 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Residential Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment: Staff ran the thermometer sticker and sent inspector a picture on 9/25/25.
Violation Issued?: No