



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 8, 2024

Licensee
Enhance Living Inc.
1377 Searle Street
Saint Paul, MN 55130

RE: Project Number(s) SL35136015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 13, 2024, 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,



Renne Anderson, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35136	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER ENHANCE LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1377 SEARLE STREET SAINT PAUL, MN 55130		
(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: SL35136015-0 On June 10, 2024, through June 13, 2024, 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 received 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.		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according	0 480			

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

TITLE

(X6) DATE

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0 480	Continued From page 1 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and 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 June 10, 2024, 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			
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure,	0 650			

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0 650	Continued From page 2 registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of two employees (clinical nurse supervisor (CNS)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: CNS-D was hired on February 15, 2022.	0 650			

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0 650	Continued From page 3 CNS-D'S employee record lacked documentation of an annual performance review. On June 11, 2024, at 9:00 a.m., licensed assisted living director (LALD)-B stated CNS-D did not have record of a performance review in their employee file. On June 11, 2024, at 9:10 a.m., CNS-D stated she had not had an annual performance review completed and believed it was an oversight because she was a supervisor. The licensee's 4.35 Employee Evaluation policy dated August 1, 2021, indicated "all staff of [the licensee] will be given an employee evaluation at least annually." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
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	0 680			

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0 680	Continued From page 4 (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness (EP) plan with all the required content. 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 potential to affect a large portion or all of the residents). The findings include: The licensee's EP manual, last reviewed August 2022, lacked the following required content: -EP policies/procedures review/updated annually; -transfer agreements and/or contracts with other facilities/providers to receive residents in the event of evacuation or other limitations that would impact the continuity of services;	0 680			

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0 680	Continued From page 5 -develop policy and procedures to address: - use of volunteers, including the process/role for integration; - role of the [licensee] under a waiver declared by the secretary in accordance with section 1135; - provision of subsistence needs for staff and residents to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems); -a written communication plan reviewed/updated annually; and -EP testing requirements including an annual full-scale exercise or individual facility-based functional exercise. On June 10, 2024, at 2:00 p.m., the surveyor reviewed the licensee's EP plan with owner/manager (OM)-A. OM-A stated the licensee's EP plan was missing the above required content. The licensee's 9.01 Emergency Preparedness policy dated August 1, 2021, indicated the EP plan would include all the required elements of appendix Z and would be reviewed/updated annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire	0 790			

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0 790	Continued From page 6 Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and 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) 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 a facility tour on June 12, 2024, at 11:45 a.m., with unlicensed personnel (ULP)-C, it was observed that the required fire extinguisher was not mounted as required and was sitting on the floor near the back door in the kitchen. At least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility.	0 790			

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0 790	Continued From page 7 Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During interview on June 12, 2024, at 11:55 a.m., ULP-C, verified this deficient finding. TIME PERIOD FOR CORRECTION: Two (2) days.	0 790			
0 800 SS=D	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 maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to affect a limited number of residents, staff, and visitors.	0 800			

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0 800	Continued From page 8 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). Findings include: On a facility tour on June 12, 2024, at 12:00 p.m., with unlicensed personnel (ULP)-C, the surveyor made the following observations of facility hazards and disrepair: The bathroom ventilation fan in the basement was making loud noise and is in need of repair. The room number was missing from resident room door of room number 4 as identified on the evacuation floor plan map. The resident room numbers are required to be maintained in place to identify the room number for direction to occupants during a fire or similar emergency. During a facility tour on June 12, 2024, at 12:05 p.m., ULP-C, verified the above listed observations while accompanying on the tour. 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:	0 810			

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0 810	Continued From page 9 (1) location and number of resident sleeping rooms; (2) employee 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) Employees 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 employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. 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, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors.	0 810			

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0 810	Continued From page 10 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 June 12, 2024, at 12:05 p.m., owner/manager (OM)-A and unlicensed personnel (ULP)-C, 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 The licensee provided FSEP, failed to include the following: The location and number of resident sleeping rooms was not accurate on the evacuation floor plan for resident room number 3 and the office. The two rooms were switched on the floor plan from what was identified on the door of the room. The FSEP did not identify specific fire protection actions for residents evident by not providing procedures for residents to take in the event of a fire or similar emergency in writing in the FSEP. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The licensee failed to include	0 810			

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0 810	Continued From page 11 resident evacuation status/ unique needs for evacuation for each resident in writing and available at all times in the FSEP. During an interview on June 12, 2024, at 12:10 p.m., OM-A, and ULP-C, stated the floor plans were not accurate in the location and number of resident room 3 and the office. During the same interview OM-A, and ULP-C, stated procedures for residents in the event of a fire or similar emergency and resident evacuation status was not available in writing in the FSEP. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by not providing documentation the required training was completed by employees. Record review indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing documentation resident training was offered as required. During an interview on June 12, 2024, at 12:15 p.m., OM-A, and ULP-C, stated documentation was not available for training of employees and residents. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation drills were completed in September 2023, January 2024, and May 2024	0 810			

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0 810	Continued From page 12 but not in the required sequence. During an interview on June 12, 2024, at 12:15 a.m., OM-A, and ULP-C, stated documentation was not available in the required sequence for evacuation drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35136	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER ENHANCE LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1377 SEARLE STREET SAINT PAUL, MN 55130		
(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
01470	Continued From page 13 Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received orientation to include all required content for two of two employees (unlicensed personnel (ULP)-C and clinical nurse supervisor (CNS)-D). 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	01470			

Minnesota Department of Health

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01470	Continued From page 14 cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CNS-D and ULP-C were hired February 15, 2022, and September 15, 2023, respectively, to provide direct care services for the licensee's residents. On June 10, 2024, at 11:00 a.m., ULP-C was observed assisting R2 with medication administration. ULP-C's employee record lacked documentation the following orientation topics were completed prior to providing assisted living services: -an overview of the appropriate Assisted Living statutes 144G and rules; and -consumer advocacy services CNS-D's employee record lacked documentation the following orientation topics were completed prior to providing assisted living services: -consumer advocacy services; and -principles of person-centered planning/service delivery. On June 11, 2024, at 9:10 a.m., licensed assisted living director (LALD)-B stated some of the required content for orientation had not been completed and they were "just missed." The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated, "All staff of [licensee] providing and supervising direct services must complete an orientation to Assisted Living facility licensing	01470			

Minnesota Department of Health

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01470	Continued From page 15 requirements and regulations before providing assisted living services to residents. The policy further indicated the orientation would include all the required topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care 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 employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;	01530			

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01530	Continued From page 16 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame in accordance with 144G.64 for one of two employees (clinical nurse supervisor (CNS)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CNS-D was hired on February 15, 2022, to provide direct care services for the licensee's residents. CNS-D's record lacked documentation they completed at least eight hours of initial dementia care training on required topics within 120 working hours, including: -an explanation of Alzheimer's disease and other dementia; -assistance with activities of daily living; -problem solving with challenging behaviors; -communication skills; and -person-centered planning and service delivery. On June 11, 2024, at 9:10 a.m., CNS-D stated the above dementia care training had not been assigned at the time of orientation and was	01530			

Minnesota Department of Health

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01530	Continued From page 17 "missed." The licensee's 5.03 Dementia Training dated August 1, 2021, indicated supervisors of direct care staff would have eight (8) hours of dementia training within 120 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01530			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640			

Minnesota Department of Health

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01640	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). R1 was admitted on December 23, 2021. R1's service plan dated June 11, 2024, indicated R1 received services to include medication management, bathing, and dressing, but lacked authentication by the facility and the resident (or resident's representative). On June 11, 2024, at 8:00 a.m., unlicensed personnel (ULP)-C was observed to assist R1 with medication administration. On June 11, 2024, at 11:00 a.m., owner/manager (OM)-A stated the licensee did not get signatures on any residents' service plans, and the lack of authentication was an oversight. The licensee's 6.08 Service Plan policy dated June 1, 2023, indicated the service plan and any revisions would include a signature or other authentication by the licensee. and by the	01640			

Minnesota Department of Health

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01640	Continued From page 19 resident, or resident's representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			



Minnesota Department Of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: 06/10/24
Time: 12:00:42
Report: 1050241114

Food and Beverage Establishment Inspection Report

Page 1

Location:

Enhance Living Inc
1377 Searle Street
St Paul, MN55130
Ramsey County, 62

Establishment Info:

ID #: 0037548
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514478430
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1)

**** Priority 1 ****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

OBSERVED CARTONS OF EGGS STORED OVER READY TO EAT FOODS IN THE REFRIGERATOR. DISCUSSED REMOVING AND UTILIZING A SEPARATE DRAWER. COMPLY WITH RULE ABOVE.

Comply By: 06/11/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

FACILITY DOES NOT HAVE A CURRENT CFPM OR SERVSAFE CERTIFIED INDIVIDUAL ON SITE. DISCUSSED THE PROCESS TO SECURE AND PROVIDED VIA EMAIL. COMPLY WITH RULE ABOVE.

Comply By: 08/12/24

Surface and Equipment Sanitizers

Hot Water: = at 180F Degrees Fahrenheit

Location: DISHWASHER

Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: 06/10/24
Time: 12:00:42
Report: 1050241114
Enhance Living Inc

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Cold Holding/ GARLIC BREAD
Temperature: -2F Degrees Fahrenheit - Location: FREEZER
Violation Issued: No

Process/Item: Cold Holding/ MILK
Temperature: 40F Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

Inspection was completed with Brandi and Natosha and MDH Andrew Spaulding. Tammy Carlson was the lead Health Regulation Division Nurse Evaluator. Facility had zero residents on site at time of inspection. Meals are prepared on site. This establishment has a residential kitchen. Food must be prepared for same day service only.

The kitchen has wood cabinets with a hollow base and tile flooring. All found to be in good condition. Designated high temp dishwasher is currently in use test strips were verified 6/10/24.

Discussed the following:

- Employee illness policy and logging requirements
- Hand Washing
- Glove-use and bare hand contact
- Food storage and preventing cross contamination
- Date marking
- Vomit clean up procedures
- Restrictions concerning serving a highly susceptible population

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

I acknowledge receipt of the Minnesota Department Of Health inspection report number 1050241114 of 06/10/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Brandi Rogalla
Owner

Signed: _____

Andrew Spaulding
Public Health Sanitarian 2
FPLS Metro
651-201-5298
andrew.spaulding@state.mn.us