



*Protecting, Maintaining and Improving the Health of All Minnesotans*

## NOTICE OF REMOVAL OF CONDITIONS ON PROVISIONAL LICENSE - LICENSE GRANTED

Electronic Delivery

May 29, 2024

Licensee

Oakland Assisted Living LLC  
17838 Oakland Drive Northeast  
Ham Lake, MN 55304

RE: Initial License Number 411495  
Health Facility Identification Number (HFID) 39894  
Project Number(s) SL39894015

Dear Licensee:

On May 15, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed January 31, 2024. The follow-up survey found the facility to be in substantial compliance. **Based on these findings, the condition(s) on the license were removed effective May 29, 2024.**

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

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

Sincerely,

A handwritten signature in black ink that reads 'Maria King'.

Maria King, RN  
**Division Director**

**Minnesota Department of Health**  
**Health Regulation Division**

HHH





*Protecting, Maintaining and Improving the Health of All Minnesotans*

## NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

February 29, 2024

Licensee

Oakland Assisted Living LLC  
17838 Oakland Drive Northeast  
Ham Lake, MN 55304

RE: Provisional Conditional License Number 411495  
Health Facility Identification Number (HFID) 39894  
Project Number(s) SL39894015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 31, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b), MDH is issuing a 90-day conditional provisional license due to expire on **May 29, 2024**.

### STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state 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 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.



Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to provisional licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$3,500.00. **MDH is not imposing these fines against your provisional license at this time.**

**St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - \$3,000.00**

**St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00**

#### **DOCUMENTATION OF ACTION TO COMPLY**

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional 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. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is



substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

To submit a reconsideration request, please visit:

To submit a reconsideration request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

**CONDITIONAL LICENSE ISSUED:**

MDH will issue Oakland Assisted Living LLC a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Oakland Assisted Living LLC is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.
- b. **No new admissions:** Oakland Assisted Living LLC will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the “no new admissions” condition. Oakland Assisted Living LLC must provide the Department:
  - i. A list of the names and birthdates of any individuals Oakland Assisted Living LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.
  - ii. A list of all current residents by location including:
    - 1. Name and birthdate of each resident
    - 2. Physical location of each resident
    - 3. Current payment source for services
    - 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
    - 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Oakland Assisted Living LLC will contract with an RN to provide consultation concerning all resident(s) to whom Oakland Assisted Living LLC provides provisional licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services



from Oakland Assisted Living LLC. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH.

The RN must not have any affiliation with Oakland Assisted Living LLC and MDH must review the RN's credentials and approve the selection. Oakland Assisted Living LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Oakland Assisted Living LLC in an effort to help Oakland Assisted Living LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Oakland Assisted Living LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

- d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Oakland Assisted Living LLC and the RN consultant about a change. Each report will be electronically submitted to Casey DeVries, Survey Supervisor, State Evaluation Team, Health Regulation Division, at [casey.devries@state.mn.us](mailto:casey.devries@state.mn.us). Casey DeVries can be reached at 651-201-5917 (office) with questions about reports. The content of the reports will include information such as:
- i. Progress towards correction of orders;
  - ii. Observations of staff delivering assisted living services and the level of competency observed;
  - iii. Conversations with residents and family members about satisfaction with assisted living services;
  - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
  - v. Overall impressions about the quality of the assisted living services delivered;
  - vi. Overall impressions about the dignity with which the residents and their family members are treated;
  - vii. Concerns; and
  - viii. Any other information requested by the Department or considered important by the RN consultant(s).
- e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Oakland Assisted Living LLC to correct the violations cited during the survey as well as to determine the overall practice of Oakland Assisted Living LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced



monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.

- f. Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- g. Corrective Action Plan:** Oakland Assisted Living LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
  - i. A statement of the concern
  - ii. A description of what will happen to correct the concern
  - iii. A target date for when each correction will be complete
  - iv. Who is responsible to make sure it happens
  - v. Current status of correction work
  - vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

**RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:**

MDH will determine if Oakland Assisted Living LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Oakland Assisted Living LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from Oakland Assisted Living LLC's assisted living facility provisional license, and Oakland Assisted Living LLC will correct violations identified during the survey to come into substantial compliance. If MDH determines Oakland Assisted Living LLC is not in substantial compliance, MDH may take additional enforcement action against Oakland Assisted Living LLC, including placement of additional conditions, issuing an extension to the conditional provisional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

**REQUEST FOR RECONSIDERATION:**

Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. To submit a reconsideration request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

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 Casey DeVries directly at: 651-201-5917.

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, flowing style.

Rick Michals, J.D.  
**Interim Assistant Division Director**

**Minnesota Department of Health**  
**Health Regulation Division**

HHH



Minnesota Department of Health

|                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                              |
|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>39894                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | (X3) DATE SURVEY COMPLETED<br><br>01/31/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>OAKLAND ASSISTED LIVING LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br>17838 OAKLAND DRIVE NORTHEAST<br>HAM LAKE, MN 55304 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 000                                                           | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING<br/>CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section<br/>144G.08 to 144G.95, these correction orders are<br/>issued pursuant to a survey.</p> <p>Determination of whether violations are corrected<br/>requires compliance with all requirements<br/>provided at the Statute number indicated below.<br/>When Minnesota Statute contains several items,<br/>failure to comply with any of the items will be<br/>considered lack of compliance.</p> <p>INITIAL COMMENTS:<br/>SL39894015-0</p> <p>On January 29, 2024, through January 31, 2024,<br/>the Minnesota Department of Health conducted a<br/>full survey at the above provider, and the<br/>following correction orders are issued. At the time<br/>of the survey, there were four residents; four<br/>receiving services under the Assisted Living<br/>license.</p> <p>An immediate correction order was identified on<br/>January 30, 2024, issued for SL39894015-0, tag<br/>identification 0470.</p> <p>On January 31, 2024, the immediacy of<br/>correction order 0470 was removed, however<br/>non-compliance remained, and the scope and<br/>level remained unchanged.</p> | 0 000                                                                                        | <p>Minnesota Department of Health is<br/>documenting the State Correction Orders<br/>using federal software. Tag numbers have<br/>been assigned to Minnesota State<br/>Statutes for Assisted Living License<br/>Providers. The assigned tag number<br/>appears in the far-left column entitled "ID<br/>Prefix Tag." The state Statute number and<br/>the corresponding text of the state Statute<br/>out of compliance is listed in the<br/>"Summary Statement of Deficiencies"<br/>column. This column also includes the<br/>findings which are in violation of the state<br/>requirement after the statement, "This<br/>Minnesota requirement is not met as<br/>evidenced by." Following the surveyors'<br/>findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF<br/>THE FOURTH COLUMN WHICH<br/>STATES,"PROVIDER'S PLAN OF<br/>CORRECTION." THIS APPLIES TO<br/>FEDERAL DEFICIENCIES ONLY. THIS<br/>WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO<br/>SUBMIT A PLAN OF CORRECTION FOR<br/>VIOLATIONS OF MINNESOTA STATE<br/>STATUTES.</p> <p>The letter in the left column is used for<br/>tracking purposes and reflects the scope<br/>and level issued pursuant to 144G.31<br/>subd. 1, 2, and 3.</p> |  |                                              |
| 0 470<br>SS=I                                                   | 144G.41 Subdivision 1 Minimum requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 0 470                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                              |

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 470                                                                  | <p>Continued From page 1</p> <p>(11) develop and implement a staffing plan for determining its staffing level that:</p> <p>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;</p> <p>(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</p> <p>(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;</p> <p>(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:</p> <p>(i) awake;</p> <p>(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;</p> <p>(iii) capable of communicating with residents;</p> <p>(iv) capable of providing or summoning the appropriate assistance; and</p> <p>(v) capable of following directions;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan to meet the scheduled and reasonably foreseeable unscheduled needs of the residents. This had the potential to affect all residents.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety,</p> | 0 470                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 470                                                                  | <p>Continued From page 2</p> <p>not including serious injury, impairment, or death, or a violation that has the potential to lead to 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).</p> <p>The findings include:</p> <p>On January 29, 2024, at 10:00 a.m., during the entrance conference, license assisted living director (LALD)-B stated the licensee only had four staff members in total and were currently working on hiring more staff.</p> <p>R2 was admitted to the licensee on September 6, 2023.</p> <p>R2's diagnosis included morbid obesity, essential hypertension, generalized anxiety disorder, chronic respiratory failure with hypoxia, unspecified atrial fibrillation, personal history of pulmonary embolism, bed confinement status, adult failure to thrive, and type 2 diabetes mellitus.</p> <p>R2's most current 90-day assessment dated December 5, 2023, indicated R2 required extensive two-person transfer with a Hoyer lift (mechanical lift used to transfer a person that is unable to bear weight).</p> <p>The licensee's staff schedule dated January 29, 2024, through February 4, 2024, indicated that there was only one staff member scheduled to work overnight from 11:00 p.m. to 7:00 a.m.</p> <p>On January 30, 2024, at 1:16 p.m., LALB-B stated that three of four current residents were all</p> | 0 470                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                 |                                                                                                                          |                          |                                              |
|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>39894 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>01/31/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>OAKLAND ASSISTED LIVING LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>17838 OAKLAND DRIVE NORTHEAST<br>HAM LAKE, MN 55304                             |                          |                                              |
| (X4) ID<br>PREFIX<br>TAG                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                              |
| 0 470                                                           | <p>Continued From page 3</p> <p>extensive two-person lifts. LALD-B stated that in the event of a resident needing to get out of bed when only one staff member was scheduled, both clinical nurse supervisor (CNS)-A and LALD-B lived only seven minutes from the facility and were on call 24-hours a day. LALD-B stated that in the event of an emergency evacuation, staff were to call 911 for assistance with evacuation, and then call for assistance from LALD-B and CNS-A.</p> <p>The licensee's 4.06 Staffing &amp; Scheduling policy dated March 30, 2023, indicated: "The clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct care-staff to meet the residents' needs 24-hours a day, seven days a week. The clinical nurse supervisor must ensure that staffing levels are adequate to address the following:</p> <ul style="list-style-type: none"><li>a. Each resident's needs, as identified in the residents' service plan and assisted living contract.</li><li>b. Each resident's acuity level, as determined by the most recent assessment or individualized review.</li><li>c. The ability of staff to meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises."<p>TIME PERIOD FOR CORRECTION: Immediate</p><p>On January 31, 2024, the immediacy of correction order 0470 was removed, however non-compliance remained, and the scope and level remained unchanged.</p></li></ul> | 0 470                                                           |                                                                                                                          |                          |                                              |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                      |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 480                                                                  | Continued From page 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 0 480                                                                                                |                                                                                                                          |  |                                                     |
| 0 480<br>SS=F                                                          | <b>144G.41 Subd 1 (13) (i) (B) Minimum requirements</b><br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br>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).<br>The findings include:<br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 29, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480                                                                                                |                                                                                                                          |  |                                                     |
| 0 510<br>SS=F                                                          | <b>144G.41 Subd. 3 Infection control program</b><br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 0 510                                                                                                |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 510                                                                  | <p>Continued From page 5</p> <p>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.</p> <p>(c) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for hand hygiene. This had the potential to affect all of the licensee's residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>On January 30, 2024, at 8:26, the surveyor observed licensed assisted living director (LALD)-B complete hand hygiene and put on a clean pair of gloves to administer medications to R2. LALD-B administered a topical ointment on R2, and then was observed removing soiled gloves, and without completing hand hygiene put on another clean pair of gloves.</p> | 0 510                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 510                                                                  | <p>Continued From page 6</p> <p>On January 30, 2024, at 8:40 a.m., the surveyor observed LALD-B return to the medication room while wearing the same gloves. LALD-B then set up medications for R3. While setting up the medications, LALD-B touched their face while wearing the same gloves.</p> <p>On January 30, 2024, 8:55 a.m., the surveyor observed LALD-B enter R3's room, and without completing hand hygiene or changing gloves, administer medications to R3.</p> <p>On January 30, 2024, at 9:03 a.m., the surveyor observed LALD-B remove the soiled gloves. LALD-B did not perform hand hygiene after removing the gloves.</p> <p>On January 31, 2024, at 11:52 a.m., clinical nurse supervisor (CNS)-A stated that all staff were expected to complete hand hygiene before and after all cares on residents and in between glove changes.</p> <p>The licensee's Gloves policy dated March 30, 2024, indicated that gloves must be worn whenever there may be direct contact between any employee and contaminated objects or as instructed. The policies included procedure included the following:</p> <ol style="list-style-type: none"><li>1. Wash hands</li><li>2. Apply gloves to both hands</li><li>3. Remove contaminated materials</li><li>4. Place materials in proper receptacle</li><li>5. Remove gloves by grasping cuff of one glove and pulling it off, turning it inside out. With ungloved hand tuck finger inside cuff of remaining glove and pull off, turning inside out.</li><li>6. Dispose used gloves in proper receptacle.</li><li>7. Rewash hands.</li></ol> | 0 510                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                      |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>39894</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 510                                                                  | Continued From page 7<br><br>The Centers for Disease Control's (CDC), "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" dated November 29, 2022, under section 5a.1-2 read:<br>1.) Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations.<br>2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications:<br>a.) Immediately before touching a patient;<br>b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices;<br>c.) Before moving from work on a soiled body site to a clean body site on the same patient;<br>d.) After touching a patient or the patient's immediate environment;<br>e.) After contact with blood, body fluids or contaminated surfaces; and<br>f.) Immediately after glove removal.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510                                                                                                |                                                                                                                          |  |                                                        |
| 0 550<br>SS=F                                                          | 144G.41 Subd. 7 Resident grievances; reporting maltreatment<br><br>All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 0 550                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 550                                                                  | <p>Continued From page 8</p> <p>for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all five residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On January 29, 2024, at approximately 11:35 a.m., during a facility tour, the surveyor observed the licensee's postings board located at the main entrance of the facility. The postings board lacked the required posting of the grievance procedure.</p> <p>On January 31, 2024, at approximately 11:52 a.m., clinical nurse supervisor (CNS)-A verified the common areas lacked a grievance procedure posting with required content. CNS-A stated that the information is provided to residents upon</p> | 0 550                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 550                                                                  | Continued From page 9<br><br>admission, but that the provided form lacked contact information for the licensed assisted living director (LALD).<br><br>The licensee's undated 2.10 Complaint/ Grievance Posting policy indicated the following:<br>"Oakland Assisted Living LLC will post, in a conspicuous place, information about our complaint/ grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances."<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days                                                                                                                                                                                   | 0 550                                                                  |                                                                                                                          |  |                                                     |
| 0 630<br>SS=F                                                          | 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma<br><br>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include | 0 630                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 630                                                                  | <p>Continued From page 10</p> <p>the required content for two of two residents (R2, R3).</p> <p>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).</p> <p>The findings include:</p> <p>R2<br/>R2 was admitted to the licensee for assisted living services September 6, 2023.</p> <p>R2's diagnosis included morbid obesity, essential hypertension, generalized anxiety disorder, chronic respiratory failure with hypoxia, unspecified atrial fibrillation, personal history of pulmonary embolism, bed confinement status, adult failure to thrive, and type 2 diabetes with diabetic nephropathy.</p> <p>R2's Service Plan dated September 17, 2023, indicated R2 received services including bathing assistance, housekeeping, laundry, medication set-up, medication management, and assistance with transfers.</p> <p>R2's 90 Day assessment dated December 5, 2023, under the vulnerability section, indicated R2 was at risk of being abused by others however, lacked an individualized abuse prevention plan to include:</p> <p>- the person's susceptibility to abuse by another</p> | 0 630                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 630                                                                  | <p>Continued From page 11</p> <p>individual, including other vulnerable adults;</p> <p>R3</p> <p>R3 was admitted to the licensee for assisted living services October 17, 2023.</p> <p>R3's diagnosis included Type 2 Diabetes with diabetic chronic kidney disease, morbid obesity, unspecified atrial fibrillation, acute respiratory failure, muscle weakness, dysphagia, heart failure, and chronic sleep apnea.</p> <p>R3's Service Plan, dated October 17, 2023, indicated C4 received services including activity assistance, catheter care, housekeeping, medication administration, safety checks, and transfer assistance.</p> <p>R3's 90 day assessment dated January 17, 2024, under the vulnerability section, indicated R3 was at risk of being abused by others however, lacked an individualized abuse prevention plan to include:</p> <p>- statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.</p> <p>On January 31, 2024, at 11:52 a.m., clinical nurse supervisor (CNS)-A confirmed they or the licensed assisted living director (LALD)-B were responsible for completing the individual abuse prevention plans for residents residing within the facility. CNS-A stated that they were unaware that these components were not included in the resident IAPPs.</p> <p>The licensee's 6.05 Individual Abuse Prevention Plan policy, dated March 30, 2023, indicated the</p> | 0 630                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                      |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 630                                                                  | Continued From page 12<br><br>following:<br>"The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including:<br>- other vulnerable adults<br>- the person's risk of abusing other vulnerable adults, and<br>- statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days                                                                                                                                                                                                                                                                                                                                                                    | 0 630                                                                                                |                                                                                                                          |  |                                                     |
| 0 680<br>SS=F                                                          | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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 | 0 680                                                                                                |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 680                                                                  | <p>Continued From page 13</p> <p>received emergency and disaster training are allowed to work only when trained staff are also working on site.<br/>(c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>On January 30, 2024, at 12:40 p.m., the surveyor requested the licensee's emergency preparedness plan (EPP) for review. The surveyor observed the licensed assisted living director retrieve the licensee's EPP from the locked medication room.</p> <p>The licensee's written EPP lacked evidence of the following required content:<br/>- A risk assessment that considered hazards like care related emergencies, equipment/utility failures, interruptions in communications/cyber-attacks, loss of all or portion of a facility, interruption to normal supply</p> | 0 680                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 680                                                                  | <p>Continued From page 14</p> <p>of essential resources and medical supplies;<br/>-EPP contained an uncompleted template.</p> <p>- Subsistence Needs for Staff and Patients;<br/>-EPP contained an uncompleted template.</p> <p>- Development of Communication Plan;<br/>- EPP contained a partially completed template.</p> <p>- Emergency Official Contact Information;<br/>- EPP contained an uncompleted template.</p> <p>- Primary/Alternate Means for Communication;<br/>- EPP contained an uncompleted template.</p> <p>- Sharing Information on Occupancy/Needs;<br/>- EPP contained an uncompleted incident command structure template.</p> <p>The licensee's undated 2.01 Policies &amp; Procedures Overview (0-009) indicated that (licensee) shall maintain an Emergency Plan describing our all-hazards approach to emergency management. The Emergency Plan guidelines will be developed and made widely available to all staff. This plan will be maintained in accordance to state and federal guidelines will be reviewed and updated annually. The Emergency Plan is Incident Command System (ICS) compliant.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 0 680                                                                  |                                                                                                                          |  |                                                     |
| 0 810<br>SS=F                                                          | <p>144G.45 Subd. 2 (b)-(f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:</p> <p>(1) location and number of resident sleeping</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 0 810                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 810                                                                  | <p>Continued From page 15</p> <p>rooms;</p> <p>(2) employee actions to be taken in the event of a fire or similar emergency;</p> <p>(3) fire protection procedures necessary for residents; and</p> <p>(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.</p> <p>(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.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or</p> | 0 810                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 810                                                                  | <p>Continued From page 16</p> <p>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).</p> <p>The findings include:</p> <p>On January 30, 2024, the licensee provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility.</p> <p><b>FIRE SAFETY AND EVACUATION PLAN</b></p> <p>The FSEP included a 9.06 Fire Safety policy dated March 30, 2023. This policy was a template and had not been developed for use at this facility.</p> <p>The fire safety policy included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The policy inappropriately referenced smoke compartment doors, fire sprinklers, doors on magnetic holders, and pull fire alarms. The employee actions for fire were limited to the acronym RACE (Remove, Alarm, Confine, and Extinguish or Evacuate).</p> <p>The fire safety policy failed to include specific fire protection procedures necessary for residents evident by limited instructions directing employees to remove tenants from immediate danger by evacuating those closest to the fire and moving outwards. No additional fire protection procedures for residents were included.</p> | 0 810                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 810                                                                  | Continued From page 17<br><br>The fire safety policy directs employees to evacuate residents from the building but failed to include information on where residents should relocate to in the event of a fire.<br><br>The fire safety policy failed to provide specific procedures for resident movement and evacuation during a fire or similar emergency including the unique needs of residents evident by a lack of these procedures in the plan.<br><br>During an interview on January 30, 2024, at 3:00 p.m. clinical nurse supervisor (CNS)-A verified the plan was based on a template and stated the licensee would revise the FSEP.                                                                                                                                                                                                                                                                                   | 0 810                                                                  |                                                                                                                          |  |                                                     |
| 01650<br>SS=F                                                          | 144G.70 Subd. 4 (f) Service plan, implementation and revisions to<br><br>(f) The service plan must include:<br>(1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;<br>(2) the identification of staff or categories of staff who will provide the services;<br>(3) the schedule and methods of monitoring assessments of the resident;<br>(4) the schedule and methods of monitoring staff providing services; and<br>(5) a contingency plan that includes:<br>(i) the action to be taken if the scheduled service cannot be provided;<br>(ii) information and a method to contact the facility;<br>(iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including | 01650                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01650                                                                  | <p>Continued From page 18</p> <p>identification of and information as to who has authority to sign for the resident in an emergency; and<br/>(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review the licensee failed to ensure the service plan contained all required content for two of two residents (R2, R3).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R2<br/>R2 was admitted to the licensee for assisted living services September 6, 2023.</p> <p>R2's Service Plan dated September 17, 2023, indicated R2 received services including bathing assistance, housekeeping, laundry, medication set-up, medication management, and assistance with transfers.</p> <p>R3<br/>R3 was admitted to the licensee for assisted</p> | 01650                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01650                                                                  | <p>Continued From page 19</p> <p>living services October 17, 2023.</p> <p>R3's Service Plan, dated October 17, 2023, indicated C4 received services including activity assistance, catheter care, housekeeping, medication administration, safety checks, and transfer assistance.</p> <p>R2 and R3's service plans lacked the following content:</p> <ul style="list-style-type: none"><li>- the schedule and methods of monitoring reviews or assessments of the resident;</li><li>- the schedule and methods of monitoring staff providing services;</li><li>- actions to be taken if scheduled services cannot be provided;</li><li>- circumstances in which emergency services are not to be summoned; and</li><li>- the names and contact information of person the resident wishes to have notified in an emergency.</li></ul> <p>On January 31, 2024, at 11:52 a.m., clinical nurse supervisor (CNS)-A stated they were aware that the missing information was supposed to be included in service plans and would ensure that going forward, all service plans have this information included.</p> <p>The licensees 6.08 Service Plan policy dated March 30, 2023, indicated that service plans will include the following:</p> <ul style="list-style-type: none"><li>"- A schedule and method for the next planned assessment or monitoring</li><li>- A schedule and method for the next planned monitoring of staff providing services</li><li>- A contingency plan that includes:</li><li>- Actions [licensee] will take if scheduled services cannot be provided</li><li>- Information regarding how the resident can</li></ul> | 01650                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01650                                                                  | Continued From page 20<br><br>contact [Name of AL]<br>- The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition<br>- Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency<br>- How the facility will support documented resident health care directive decisions, if any - including circumstances when emergency medical services are not to be summoned."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days                                                                                                                                                                                       | 01650                                                                  |                                                                                                                          |  |                                                     |
| 01760<br>SS=F                                                          | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record | 01760                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01760                                                                  | <p>Continued From page 21</p> <p>review, the licensee failed to ensure medications were administered per provider's orders for one of two residents (R2).</p> <p>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).</p> <p>The findings include:</p> <p>R2's diagnosis included morbid obesity, essential hypertension, generalized anxiety disorder, chronic respiratory failure with hypoxia, unspecified atrial fibrillation, personal history of pulmonary embolism, bed confinement status, adult failure to thrive, and type 2 diabetes with diabetic nephropathy.</p> <p>R2's Service Plan dated September 17, 2023, indicated R2 received services including bathing assistance, housekeeping, laundry, medication set-up, medication management, medication administration and assistance with transfers.</p> <p>R2's physician order signed October 18, 2023, included diclofenac sodium gel one percent (%) (used to relieve joint pain) one gram (gm) to the affected area externally four times daily.</p> <p>On January 29, 2023, at 8:26 a.m., surveyor observed LALD-B place an unmeasured amount of diclofenac sodium gel 1% directly onto their gloved hand and rub the gel onto both of R2's knees.</p> | 01760                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01760                                                                  | <p>Continued From page 22</p> <p>LALD-B held an active Registered Nurse (RN) licensure with an expiration date of April 30, 2024, and was responsible for some of the training of staff working within the facility.</p> <p>On January 29, 2023, at 8:40 a.m., the surveyor inquired how diclofenac sodium 1% was measured. LALD-B stated that he measured the amount to administer by putting two drops of gel into their gloved hand to measure the amount. The surveyor asked whether the manufacturer provided dosing card is utilized when measuring out the correct dose of this medication, LALD-B stated that they did not recall receive a dosing card when receiving this medication from the pharmacy.</p> <p>The licensee's 7.42 Topical Application of Medication &amp; Treatments policy dated March 30, 2023, indicated the following:<br/>"Medications always need to be administered according to the "6 Rights."<br/>- Right person<br/>- Right medication<br/>- Right time<br/>- Right route (i.e., by mouth, eye drops, to the skin)<br/>- Right dose (i.e., how many milligrams, drops)<br/>- Right chart/record to document that the medication was taken"</p> <p>The manufacturers instructions indicated that the dosing card should always be used to measure out the correct dose of Diclofenac Sodium Topical Gel 1%, and not to apply more than 16 grams to any single joint of the lower body.</p> <p>No further information provided.</p> | 01760                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01760                                                                  | Continued From page 23                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 01760                                                                  |                                                                                                                          |  |                                                     |
|                                                                        | TIME PERIOD FOR CORRECTION: Seven (7) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        |                                                                                                                          |  |                                                     |
| 01880<br>SS=D                                                          | <b>144G.71 Subd. 19 Storage of medications</b><br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to store all medications in a securely locked location for one of four residents (R2).<br><br>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).<br><br>The findings include:<br><br>R2's diagnosis included morbid obesity, essential hypertension, generalized anxiety disorder, chronic respiratory failure with hypoxia, unspecified atrial fibrillation, personal history of pulmonary embolism, bed confinement status, adult failure to thrive, and type 2 diabetes with diabetic nephropathy.<br><br>R2's Service Plan dated September 17, 2023, | 01880                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>39894</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>01/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAKLAND ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17838 OAKLAND DRIVE NORTHEAST<br/>HAM LAKE, MN 55304</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01880                                                                  | <p>Continued From page 24</p> <p>indicated R2 received services including bathing assistance, housekeeping, laundry, medication set-up, medication management, medication administration and assistance with transfers.</p> <p>R2's Master Care Plan dated January 29, 2024, indicated that all R2s medications were to be securely stored.</p> <p>On January 30, 2024, at approximately 8:26 a.m., the surveyor observed licensed assisted living director (LALD)-B retrieve diclofenac gel 1% (used to relieve joint pain) from a small unsecured floor cabinet inside of R2's room. LALD-B then applied the medication to R2 and was observed placing the medication back into the unsecured floor cabinet.</p> <p>On January 31, 2024, at approximately 11:52 a.m., clinical nurse supervisor (CNS)-A verified that R2's medication management plan indicated that all medications were to be stored securely.</p> <p>The licensee's 7.11 Medication Storage policy dated March 30, 2023, indicated that medications will be stored consistent with each residents' medication management plan and service plan.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 01880                                                                  |                                                                                                                          |  |                                                     |



Type: Full  
Date: 01/29/24  
Time: 12:00:38  
Report: 1029241017

## Food and Beverage Establishment Inspection Report

Page 1

**Location:**

Oakland Assisted Living LLC  
17838 Oakland Drive NE  
Ham Lake, MN55304  
Anoka County, 02

**Establishment Info:**

ID #: 0042377  
Risk:  
Announced Inspection: Yes

**License Categories:**

Expires on: 12/31/24

**Operator:**

Phone #:  
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.

### 2-200 Employee Health

#### 2-201.11C

**\*\* Priority 1 \*\***

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.

NO EMPLOYEE ILLNESS LOG. ILLNESS LOG OBTAINED FROM MDH WEBSITE AND PRINTED DURING INSPECTION.

Comply By: 01/31/24

### 3-500C Microbial Control: date marking

#### 3-501.17A

**\*\* Priority 2 \*\***

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

DATE MARKING ABSENT ON DELI MEATS. CORRECTED DURING INSPECTION.

Comply By: 01/31/24

### Surface and Equipment Sanitizers

HOT WATER: = at 160 Degrees Fahrenheit  
Location: DISHWASHER - TEMP STICKER  
Violation Issued: No

### Food and Equipment Temperatures



Type: Full  
Date: 01/29/24  
Time: 12:00:38  
Report: 1029241017  
Oakland Assisted Living LLC

# Food and Beverage Establishment Inspection Report

Page 2

Process/Item: SLICED TURKEY

Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: No

Process/Item: SHREDDED CHEESE

Temperature: 35 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: No

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

Inspection conducted with Faith Sapit, Nurse Manager, and Nicodemus Naimodu, LALD and CFPM. Identified issues were addressed with Faith and/or Nicodemus throughout the inspection.

Topics discussed with Faith and Nicodemus included employee illness exclusion and reporting procedures, common contagious foodborne illness pathogens (e.g., salmonella, shigella, Shiga toxin-producing E. coli, hepatitis A virus, and norovirus), sanitizing by heat and by chemical, hygienic practices (e.g., handwashing, barehand contact with ready to eat foods, glove use), datemarking, highly susceptible populations, and general food safety practices (e.g., holding temperatures at or below 41°F and 135°F or above for TCS foods). Establishment's kitchen was non-commercial in nature with smooth painted walls and ceiling, laminate countertops, wood/composite-wood drawers and cabinetry, and pergo-esque flooring. Kitchen was in good condition.

Identified issues conveyed to Zachary Morth, RN, Nursing Evaluator, following the inspection.

**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 1029241017 of 01/29/24.

Certified Food Protection Manager: NICODEMUS W. NAIMODU

Certification Number: FM117253 Expires: 05/23/26

**Inspection report reviewed with person in charge and emailed.**

Signed: \_\_\_\_\_

FAITH SAPIT  
NURSE MANAGER

Signed: Trevor McCliment

Trevor McCliment  
Public Health Sanitarian  
Metro District Office  
651-201-3957  
trevor.mccliment@state.mn.us



Report #: 1029241017

DEPARTMENT OF HEALTH

Minnesota Department of Health

Food, Pools, and Lodging Services

625 Robert Street North

St. Paul

No. of RF/PHI Categories Out

2

Date

01/29/24

No. of Repeat RF/PHI Categories Out

0

Time In

12:00:38

Legal Authority MN Rules Chapter 4626

Time Out

Oakland Assisted Living LLC

Address

17838 Oakland Drive NE

City/State

Ham Lake, MN

Zip Code

55304

Telephone

License/Permit #

0042377

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN=in compliance

OUT= not in compliance

N/O= not observed

N/A= not applicable

COS= corrected on-site during inspection

R= repeat violation

Compliance Status

COS

R

Supervision

1

IN

OUT

PIC knowledgeable; duties & oversight

2

IN

OUT

N/A

Certified food protection manager, duties

Employee Health

3

IN

OUT

Mgmt/Staff;knowledge,responsibilities&reporting

4

IN

OUT

Proper use of reporting, restriction & exclusion

5

IN

OUT

Procedures for responding to vomiting & diarrheal events

Good Hygienic Practices

6

IN

OUT

N/O

Proper eating, tasting, drinking, or tobacco use

7

IN

OUT

N/O

No discharge from eyes, nose, & mouth

Preventing Contamination by Hands

8

IN

OUT

N/O

Hands clean & properly washed

9

IN

OUT

N/A

N/O

No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed

10

IN

OUT

Adequate handwashing sinks supplied/accessible

Approved Source

11

IN

OUT

Food obtained from approved source

12

IN

OUT

N/A

N/O

Food received at proper temperature

13

IN

OUT

Food in good condition, safe, & unadulterated

14

IN

OUT

N/A

N/O

Required records available; shellstock tags, parasite destruction

Protection from Contamination

15

IN

OUT

N/A

N/O

Food separated and protected

16

IN

OUT

N/A

Food contact surfaces: cleaned & sanitized

17

IN

OUT

Proper disposition of returned, previously served, reconditioned, & unsafe food

Compliance Status

COS

R

Time/Temperature Control for Safety

18

IN

OUT

N/A

N/O

Proper cooking time & temperature

19

IN

OUT

N/A

N/O

Proper reheating procedures for hot holding

20

IN

OUT

N/A

N/O

Proper cooling time & temperature

21

IN

OUT

N/A

N/O

Proper hot holding temperatures

22

IN

OUT

N/A

Proper cold holding temperatures

23

IN

OUT

N/A

N/O

Proper date marking & disposition

24

IN

OUT

N/A

N/O

Time as a public health control: procedures & records

Consumer Advisory

25

IN

OUT

N/A

Consumer advisory provided for raw/undercooked food

Highly Susceptible Populations

26

IN

OUT

N/A

Pasteurized foods used; prohibited foods not offered

Food and Color Additives and Toxic Substances

27

IN

OUT

N/A

Food additives: approved & properly used

28

IN

OUT

Toxic substances properly identified, stored, & used

Conformance with Approved Procedures

29

IN

OUT

N/A

Compliance with variance/specialized process/HACCP

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is not in compliance

Mark "X" in appropriate box for COS and/or R

COS= corrected on-site during inspection

R= repeat violation

Compliance Status

COS

R

Safe Food and Water

30

IN

OUT

N/A

Pasteurized eggs used where required

31

Water & ice obtained from an approved source

32

IN

OUT

N/A

Variance obtained for specialized processing methods

Food Temperature Control

33

Proper cooling methods used; adequate equipment for temperature control

34

IN

OUT

N/A

N/O

Plant food properly cooked for hot holding

35

IN

OUT

N/A

N/O

Approved thawing methods used

36

Thermometers provided & accurate

Food Identification

37

Food properly labeled; original container

Prevention of Food Contamination

38

Insects, rodents, & animals not present

39

Contamination prevented during food prep, storage & display

40

Personal cleanliness

41

Wiping cloths: properly used & stored

42

Washing fruits & vegetables

Compliance Status

COS

R

Proper Use of Utensils

43

In-use utensils: properly stored

44

Utensils, equipment & linens: properly stored, dried, & handled

45

Single-use/single service articles: properly stored & used

46

Gloves used properly

Utensil Equipment and Vending

47

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

Warewashing facilities: installed, maintained, & used; test strips

49

Non-food contact surfaces clean

Physical Facilities

50

Hot & cold water available; adequate pressure

51

Plumbing installed; proper backflow devices

52

Sewage & waste water properly disposed

53

Toilet facilities: properly constructed, supplied, & cleaned

54

Garbage & refuse properly disposed; facilities maintained

55

Physical facilities installed, maintained, & clean

56

Adequate ventilation & lighting; designated areas used

57

Compliance with MCIAA

58

Compliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)

Date:

01/31/24

Inspector (Signature)