Electronically Delivered

March 3, 2025

Licensee
Oak House LLC
10038 215th Avenue Northwest
Elk River, MN 55330

RE: Project Number(s) SL32155016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 24, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32155	A. BUILDING: _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HOUSE LLC	10038 215TH AVENUE NW ELK RIVER, MN 55330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32155016-0 On January 21, 2025, through January 22, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were seven resident(s); seven receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480		

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0 480	Continued From page 2 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 21, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to develop an all-hazards risk assessment emergency preparedness program	0 680		

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0 680	Continued From page 4 and plan to include Appendix Z required elements. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 the residents). The findings include: The licensee's undated emergency preparedness plan (EPP), lacked the required content: - a developed facility risk assessment; - contact information for federal, state, tribal, local EP staff, state licensing and certification agency, or the ombudsman for long term care; - method for sharing information from the emergency plan with residents and their families/representatives; and - evidence of conducted exercises to test the EP at least twice per year. On January 21, 2025 at 3:00 p.m., clinical nurse supervisor (CNS)-A stated they were missing some of the required aspects of the EPP due to being in the process of updating it had not completed an EPP drill yet for the facility. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. A disaster drill is conducted at the	0 680		

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0 680	Continued From page 5 residence at least annually. Results of the drill will be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code Rules, Chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 22, 2025, at 10:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-B, director of maintenance (DM)-D, and clinical nurse supervisor (CNS)-A. During the tour, the surveyor observed the following:	0 775		

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0 775	Continued From page 6 1. Burnt cigarettes had been disposed of on the floor in the garage and inside a pot filled with soil on the back deck of the facility. Improper disposal of burnt smoking materials creates a fire hazard. 2. The door leading into the attached garage was labeled as an exit on the posted floor plans. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room. 3. The basement door leading to the exterior of the facility was labeled as an exit on the posted floor plans. The path leading from this door to the public right of way was covered with ice. Exterior egress paths are required to be maintained free of ice. 4. The egress window was obstructed by a portable greenhouse in occupied resident room 7. The window blind obstructed the egress window is occupied resident room 5. This window blind would not fully open to provide unobstructed exiting. Egress windows must be maintained free of obstruction. 5. In the basement laundry room, a cover plate was not installed on the electrical panel and a cover was not installed on an electrial wall outlet behind the clothes dryer. In the garage, there were unused and uncovered openings in the electrical panel. In the basement mechanical room, uncapped wires were observed, and covers were not installed on a wall outlet and wall switch. There was an open electrical outlet box with capped wires on the front exterior of the facility. Electrical panel openings, outlet boxes, outlets, and switches must be properly covered to protect the building occupants from electrical hazards. 6. Two power strips were daisy-chained together in occupied resident room 3, creating a fire hazard. 7. A green extension cord was used in the office	0 775		

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0 775	Continued From page 7 to supply power to office equipment. An extension cord was used in the basement laundry room to supply power to the clothes washing machine. An extension cord was used in occupied resident room 5 to suppy power to personal electronics. Extension cords must not be used as a substitute for permanent wiring. During the facility tour interview on January 22, 2025, LALD-B, DM-D, and CNS-A verified the above listed physical environment observations. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 22, 2025, at 10:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-B and director of maintenance (DM)-D. During the tour, the surveyor observed the following: 1. When the basement smoke alarms were tested, none of the smoke alarms on the main floor were actuated. 2. When the main floor smoke alarms were tested, none of the basement smoke alarms were actuated. 3. When the smoke alarms on the main floor were tested, the smoke alarm installed outside the sleeping area for bedrooms 1, 2, and 3, was not actuated. The dwelling unit smoke alarms were not interconnected as required by statute. During the facility tour interview on January 22,	0 780		

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0 780	Continued From page 9 2025, LALD-B and DM-D verified the above listed smoke alarm observations. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 800		

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0 800	Continued From page 10 On January 22, 2025, at 10:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-B, director of maintenance (DM)-D, and clinical nurse supervisor (CNS)-A. During the tour, the surveyor observed the following: 1. There were water stained ceiling tiles in several locations in the basement. 2. The light fixture in the basement laundry room area was loose. 3. The knob was missing for the door used to access the basement laundry room. 4. Sections of drywall were unfinished in the main floor laundry room. 5. There was a dead mouse in a trap on the floor in the area directly outside the basement laundry room. 6. The ceiling finish was peeling above the shower in the main floor bathroom and in the front foyer. 7. Occupied resident room 7: - Mouse droppings were observed along the window sill. - There was condensation on the window and along the window trim. - The knob was missing on the closet door. - The cover for the ceiling light fixture was missing. 8. Occupied resident room 6: - Two light fixtures were not working. During the facility tour interview, LALD-B stated the bulbs were bad and the fixtures worked. - One side of the bifold closet was off the track. - Two ceiling tiles were missing in the closet. 9. The door trim was chipped for occupied resident room 3. 10. Shared resident basement bathroom: - The access panel cover was missing. - The heat vent cover was loose. - One ceiling tile was missing.	0 800		

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0 800	Continued From page 11 During the facility tour interview on January 22, 2025, LALD-B, DM-D, and CNS-A verified the above listed physical environment observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill	0 810		

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0 810	Continued From page 12 every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop and maintain a fire safety and evacuation plan with the required content, make the plan readily available, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 22, 2025, clinical nurse supervisor (CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The fire safety and evacuation plan (FSEP) was not located in a central location for all staff accessibility. CNS-A stated during an interview on January 22, 2025, at 12:30 p.m., that the FSEP was located inside a locked cabinet in the med room. The licensee FSEP failed to identify the location and number of all resident sleeping rooms. On January 22, 2025, at 10:00 a.m., the surveyor toured the facility with licensed assisted living	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32155	A. BUILDING: _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HOUSE LLC	10038 215TH AVENUE NW ELK RIVER, MN 55330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 13 director (LALD)-B and director of maintenance (DM)-D. During the tour, the surveyor observed the following: The posted FSEP floor plans did not label all the resident sleeping rooms in the basement as verbally identified by LALD-B during the facility tour interview. The floor plan for the main level of the facility labeled one room as both a bedroom and staff office. The location of the staff office, dining room, and bedroom 3 were not accurate. LALD-B verbally identified resident sleeping rooms 3 and 5 during the tour. The surveyor observed room identifiers were not posted on or at these resident sleeping room doors. Resident sleeping room identifiers are required to be posted and included on the FSEP floor plan. Resident sleeping rooms must be accurately identified to provide efficient communication for exiting in the event of a fire or similar emergency. Record review indicated the licensee FSEP was not developed and maintained for the facility location. The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE (Remove, Alarm, Confine, and Extinguish or Evacuate) acronym. The FSEP inaccurately referenced smoke compartments and pull fire alarms. The FSEP inappropriately directs the building occupants to evacuate through the attached garage. The FSEP inappropriately directs the building occupants to only evacuate the entire building upon orders from the administration or fire department in a building that did not have any fire resistant construction or life safety systems. The FSEP failed to identify fire protection procedures necessary for residents. The procedures were limited to directing residents to	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32155	A. BUILDING: _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HOUSE LLC	10038 215TH AVENUE NW ELK RIVER, MN 55330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 14 stoop or crawl to avoid smoke. The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents evident by a lack of these procedures in the plan. One resident was identified as a level 2 and required assistance in an emergency. Procedures for this resident were not included in the plan. The FSEP shall be developed and maintained to provide efficient communication for exiting in the event of a fire or similar emergency. During an interview, on January 22, 2025, at 12:30 p.m., CNS-A verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year evident by the lack of training documentation. Training records were requested by the surveyor but not provided. During an interview on January 22, 2025, at 12:30 p.m., CNS-A verified the employee FSEP training requirements were not met. Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of training documentation. Training records were requested by the surveyor but not provided. During an interview on January 22, 2025, at 12:30 p.m., CNS-A verified the resident training requirements were not met. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by fire drill logs lacking the required frequency and documentation. Six fire drills were recorded in 2024, completed in March, May, July, September, November, and December. The date of these drills and the	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32155	A. BUILDING: _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HOUSE LLC	10038 215TH AVENUE NW ELK RIVER, MN 55330

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0 810	Continued From page 15 names of the employees who had participated were not recorded. During an interview on January 22, 2025, at 12:30 p.m., CNS-A verified the evacuation drill frequency was not met and the required drill documentation not recorded. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened-on date for one of one residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on July 11, 2016, under the comprehensive home care licensee	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32155	A. BUILDING: _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HOUSE LLC	10038 215TH AVENUE NW ELK RIVER, MN 55330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 16 and started receiving assisted living services on August 1, 2021. R2's diagnoses included type II diabetes mellitus, schizophrenia, and hepatitis C. R2's prescriber's orders signed June 26, 2024, indicated R2 was prescribed the following: - insulin aspart (Novolog) pen 100 unit/ml (milliliter) inject 14 units subcutaneously once daily before breakfast. If blood sugar is less than 100 inject 12 units subcutaneously. - insulin aspart (Novolog) pen 100 unit/ml (milliliter) inject 10 units subcutaneously once daily before lunch. If blood sugar is less than 100 inject 8 units subcutaneously. - insulin aspart (Novolog) pen 100 unit/ml (milliliter) inject 9 units subcutaneously once daily before supper. If blood sugar is less than 100 inject 7 units subcutaneously. On January 22, 2025, at 9:00 a.m., the surveyor observed the medication cabinets with unlicensed personnel (ULP)-D and confirmed the Novolog pen for R2 did not have an open date marked on the pen. ULP-D stated the staff are supposed to write an open date on the insulin pens when they are opened and used for the first time. On January 22, 2025, at 9:00 a.m., clinical nurse supervisor (CNS)-A stated all insulin pens should have an open date marked on them once they have been opened, staff have been trained to do this but must have forgotten to date the pen. Novolog pen manufacturer instructions dated March 2023, directed the medication should be discarded 28 days after opened. The licensee's Storage/Control of Medications	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32155	A. BUILDING: _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HOUSE LLC	10038 215TH AVENUE NW ELK RIVER, MN 55330

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01890	Continued From page 17 policy dated August 1, 2021, indicated when licensee is providing storage of medications outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. The licensed nurse is responsible for dating time-sensitive medications when opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health
Environmental Health Division
3333 W. Division #212
St. Cloud
320-223-7300

Type: Full
Date: *01/21/25*
Time: 12:05:20
Report: 1041251018

Food and Beverage Establishment Inspection Report

Location:
Oak House Llc
10038 215th Avenue Nw
Elk River, MN55330
Sherburne County, 71

Establishment Info:
ID #: 0038377
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7636076874
ID #:

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

The following orders were issued during this inspection.

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

3-302.11A(1) ***** Priority 1 *****

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

IN THE KITCHEN UPRIGHT COOLER, EGGS WERE STORED ABOVE COTTAGE CHEESE. STORE EGGS BELOW READY TO EAT FOODS.

Comply By: 01/21/25

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

IN THE DINING ROOM UPRIGHT COOLER, CANTALOUPE AND CHOPPED LETTUCE MEASURED 44 AND 43 DEG. F. TURN UNIT COOLER OR REPAIR.

Comply By: 01/21/25

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

AROMA RICE COOKER AND INSTANT POT AIR FRYER ARE NOT APPROVED. REMOVE RICE COOKER AND AIR FRYER.

Comply By: 01/21/25

Type: Full
Date: *01/21/25*
Time: 12:05:20
Report: 1041251018
Oak House Llc

Food and Beverage Establishment Inspection Report

6-200 Physical Facility Design and Construction

6-202.13B

MN Rule 4626.1385B Relocate insect control devices so they are not over food preparation areas or in areas where dead insects or fragments can fall onto exposed food, clean equipment, utensils, linens and unwrapped single-service and single-use articles.

AT TIME OF INSPECTION, FLY SWATTER WAS STORED OVER THE SINK. STORE FLY SWATTER AWAY FROM SINK AREA. THIS WAS COMPLETED DURING INSPECTION

Comply By: 01/21/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: SANITIZING CONTAINER IN SINK
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK IN KITCHEN COOLER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 190 Degrees Fahrenheit - Location: BROWN RICE
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 44 Degrees Fahrenheit - Location: CANTALOUPE IN DINING ROOM COOLER
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 43 Degrees Fahrenheit - Location: CHOPPED LETTUCE IN DINING ROOM COOLER
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK IN DOWNSTAIRS COOLER
Violation Issued: No

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

Type: Full
Date: *01/21/25*
Time: 12:05:20
Report: 1041251018
Oak House Llc

Food and Beverage Establishment Inspection Report

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 1041251018 of 01/21/25.

Certified Food Protection Manager: MELISSA KOOP

Certification Number: 1771 Expires: 09/15/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Linda Heinen

Linda Heinen
Public Health Sanitarian
St. Cloud
320-223-7306
Linda.Heinen@state.mn.us

Report #: 1041251018

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Environmental Health Division
3333 W. Division #212
St. Cloud

No. of RF/PHI Categories Out	2
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 01/21/25
Time In 12:05:20
Time Out

Oak House Llc	Address: 10038 215th Avenue Nw	City/State: Elk River, MN	Zip Code: 55330	Telephone: 7636076874
License/Permit #: 0038377	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
Surpervision							
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 Hygenic 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

			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 labled; original container		
Prevention of Food Contamination				
38	X	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		

			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	X	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:** 01/22/25

Inspector (Signature) Linda Hinen