Electronically Delivered

January 26, 2026

Licensee
Oakland Park Communities Inc
123 Baken Street
Thief River Falls, MN 56701

RE: Project Number(s) SL40268015

Dear Licensee:

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.

The Minnesota Department of Health completed an initial survey on January 7, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance 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
Per 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 residents/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 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 the Department of Health within 15 calendar days of the correction order receipt date.

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

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

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40268	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES INC	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40268015-0 On January 5, 2026, through January 7, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the Provisional 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (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; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 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 6, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 630		

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0 630	Continued From page 4 During the entrance conference on January 5, 2026, at 3:48 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements. R2 R2's diagnoses included diabetes, hypertension (HTN-high blood pressure), and chronic kidney disease. R2's Addendum to Contract- Private- MN (Minnesota) (service plan) dated January 5, 2026, indicated R2's services included medication administration, blood glucose cheeks, assistance with showering, and housekeeping. On January 6, 2026, at 6:58 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R2's scheduled morning medication. R2's IAPP dated December 26, 2025, indicated under the Safety section, R2 was not at risk of elopement. R2's record lacked R2's susceptibility to abuse by another individual, including other vulnerable adults, and R2's risk of abusing other vulnerable adults. On January 7, 2026, at 11:46 a.m., the surveyor received an email (electronic mail) from LALD/CNS-A. The email had written LALD/CNS-A looked over all of R2's record and it looks like it may be my (LALD/CNS-A) error. I (LALD/CNS-A) missed clicking the box for that area. The safety assessment said that it was all completed (11/11) (all 11 areas were assessed) so I (LALD/CNS-A) opened up a new assessment and there is no box check in the vulnerability	0 630		

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0 630	Continued From page 5 section so I (CNS/LALD-A) completed that (vulnerability section) [sic]. R3 R3's diagnoses included diabetes and HTN. R3's Addendum to Contract- Private- MN (Minnesota) (service plan) dated January 5, 2026, indicated R3's services included medication administration, blood glucose checks, assistance with bathing and dressing, and housekeeping. On January 6, 2026, at 7:07 a.m., the surveyor observed ULP-C administer R3's scheduled morning medication. R3's IAPP dated January 3, 2026, indicated R3 was at risk to be abused and R3 was not at risk to abuse themselves. R3's record lacked R3's risk of abusing other vulnerable adults. R4 R4's diagnoses included iron deficiency and polyneuropathy (weakness or numbness in the hands and feet). R4's Addendum to Contract- Private- MN (Minnesota) (service plan) dated January 5, 2026, indicated R3's services included medication administration, catheter care, ostomy care, and assistance with bathing, grooming, dressing, and housekeeping. On January 6, 2026, at 8:42 a.m., the surveyor observed ULP-C administer R4's scheduled morning medication. R4's IAPP dated November 11, 2025, indicated R4 was at risk to be abused and R4 was not at risk to abuse themselves. R4's record lacked	0 630		

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0 630	Continued From page 6 R4's risk of abusing other vulnerable adults. On January 7, 2026, at 1:00 p.m., LALD/CNS-A stated R3 and R4 were both assessed for risk of abusing others, however, the resident's IAPPs do not include the risk for abusing others listed unless the resident had a potential risk to abuse others. The licensee's 6.05 IAPP policy dated August 3, 2025, indicated the IAPP will contain an individualized review or assessment of the person's (resident's) susceptibility to abuse by another individual, including: other vulnerable adults, the person's (resident'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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency	0 650		

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0 650	Continued From page 7 evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for one of two employees (registered nurse (RN)-B). 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). The findings include: On January 5, 2026, at 12:52 p.m., the surveyor entered the assisted living facility to initiate the survey. RN-B stated RN-B was helping licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A today (January 5, 2026) while LALD/CNS-A was out of town and would provide the surveyor documentation. RN-B further stated	0 650		

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0 650	Continued From page 8 RN-B was a little familiar with assisted living regulations. During the entrance conference on January 5, 2026, at 4:05 p.m., LALD/CNS-A stated the licensee was aware of the required contents in the employee record. RN-B was hired on May 21, 2021, for the management company of the licensee, and had begun providing assisted living services and supervision of staff and residents for the assisted living facility as needed effective July 29, 2025. RN-B's employee record contained a 32-page undated Dementia Care Competency presentation, which RN-B taught to new employees of the licensee. RN-B's employee record lacked documentation of eight hours of dementia training, two hours of mental illness and de-escalation training, and a job description. On January 6, 2026, at 9:56 a.m., LALD/CNS-A stated RN-B's record will be lacking some documentation the surveyor requested to review. On January 6, 2026, at 1:02 p.m., LALD/CNS-A emailed (electronic mail) the surveyor, which indicated LALD/CNS-A emailed all information the licensee had for RN-B's record. On January 6, 2026, at 2:29 p.m., LALD/CNS-A stated LALD/CNS-A was unable to locate a job description for RN-B. LALD/CNS-A further stated RN-B had taught dementia and mental illness training to new employees, however, RN-B's record lacked documentation of RN-B's training. RN-B stated RN-B had completed dementia,	0 650		

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0 650	Continued From page 9 mental illness, and de-escalation training from various trainings, and RN-B would look for copies of the trainings to provide to the surveyor. The surveyor did not receive any additional documentation from the licensee. The licensee's 4.05 Employee Records policy dated August 3, 2025, indicated employee records will include records of all training and in-service education required, and current signed job description, which includes qualifications, responsibilities, and identification of supervisors, if any. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person	0 650		

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0 650	Continued From page 10 successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's	01460		

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01460	Continued From page 11 category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide staff orientation to assisted living licensing requirements and regulations for one of two employees (registered nurse (RN)-B). This had the potential to affect all three residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: On January 5, 2026, at 12:52 p.m., the surveyor entered the assisted living facility to initiate the survey. RN-B stated RN-B was helping licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A today (January 5, 2026) while LALD/CNS-A was out of town and would provide the surveyor documentation. RN-B further stated RN-B was a little familiar with assisted living regulations. During the entrance conference on January 5, 2026, at 4:05 p.m., LALD/CNS-A stated the	01460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40268	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES INC	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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
01460	Continued From page 12 licensee was aware of the required contents in the employee record. RN-B was hired on May 21, 2021, for the management company of the licensee, and had begun providing assisted living services and supervision of staff and residents for the assisted living facility as needed effective July 29, 2025. RN-B's record contained a Certificate of Completion for the World of Assisted Living completed on February 18, 2022. RN-B's employee record lacked documentation to indicate RN-B completed orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents and supervision of staff. On January 6, 2026, at 2:29 p.m., LALD/CNS-A stated RN-B was hired to fill in for LALD/CNS-A and assist the residents and ULPs as needed in the assisted living facility if LALD/CNS-A was unavailable. LALD/CNS-A further stated LALD/CNS-A did not know the course content for the World of Assisted Living training, however, LALD/CNS-A would request the course content and provide to the surveyor. The surveyor did not receive any further documentation. The licensee's 5.01 Orientation of Staff and Supervisors and Content [sic] policy dated August 3, 2025, indicated all staff of (licensee name) providing and supervising direct services must complete an orientation to Assisted Living [sic] facility licensing requirements and regulations before providing assisted living services to residents. No further information was provided.	01460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40268	A. BUILDING: _____ B. WING _____	01/07/2026

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01460	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01880 SS=F	144G.71 Subd. 19 Storage of medications 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one refrigerator storing medications maintained an acceptable temperature and medications were stored according to manufacturer's recommended temperature. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 5, 2026, at 3:52 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to residents at the facility.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40268	A. BUILDING: _____ B. WING _____	01/07/2026

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01880	Continued From page 14 On January 6, 2026, at 6:47 a.m., the surveyor observed the medication refrigerator, located in the locked staff office, with unlicensed personnel (ULP)-C. ULP-C stated the current temperature was 41 degrees Fahrenheit (F), and ULP-C was not sure how often the medication refrigerator temperature was checked. The medication refrigerator contained five unopened Lantus 100 units/milliliter (mL) insulin pens for R2. On January 6, 2026, at 6:51 a.m., the surveyor requested the last 30 days of the medication refrigerator temperature. LALD/CNS-A stated the licensee did not document the temperature of the medication refrigerator or have an assigned task for ULPs to check the medication refrigerator temperature. LALD/CNS-A further stated the licensee used to have a sign posted on the medication refrigerator to maintain the temperature between 34 degrees F to 42 degrees F, however, the sign must have fallen off the medication refrigerator. The manufacturer's instructions for Lantus dated May 2019, indicated to store unopened Lantus in the refrigerator at 36 degrees F to 46 degrees F. Do not allow Lantus to freeze. The licensee's 7.11 Medication Storage policy dated August 3, 2025, indicated medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Bemidji District Office
Minnesota Department of Health
707 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Oakland Park Communities
123 Baken St
Thief River Falls, MN 56701
Parcel:

Phone:

License Info

License: HFID 40268

Risk:
License:
Expires on:
CFPM: GRACEALIS LOUVON GULIKSON
CFPM #: 55569; Exp: 1/28/2028

Inspection Info

Report Number: F1040261002
Inspection Type: Full - Single
Date: 1/6/2026 Time: 9:21:30 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 1
Delivery:

New Order: 4-200 Equipment Design and Construction
4-201.11GMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: AT TIME OF INSPECTION GALLON OF MILK IS STORED IN FRIDGE FOR MULTIPLE DAYS
Comply By: 1/6/2026 Originally Issued On: 1/6/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT: AT TIME OF INSPECTION NO THERMOMETER AVAILABLE
Comply By: 1/13/2026 Originally Issued On: 1/6/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: AT TIME OF INSPECTION NO TEST STRIPS AVAILABLE FOR CHLORINE SANITIZER
Comply By: 1/6/2026 Originally Issued On: 1/6/2026

Food & Beverage General Comment

ALL FOOD OUTSIDE OF DRINKS AND PEANUT BUTTER SANDWICHES PREPARED AT NURSING HOME AND CARTED OVER, ALL DISHES CLEANED AT NURSING HOME

DISCUSS METHODS TO PREVENT TCS ITEMS BEING STORED IN A DOMESTIC COOLER

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Bemidji District Office inspection report number F1040261002 from 1/6/2026

Establishment Representative

Vania Jeh,
Public Health Sanitarian 1
218-308-2124
vania.jeh@state.mn.us

Bemidji District Office
Minnesota Department of Health
707 5th St NW, Suite A
Bemidji, MN 56601

Temperature Observations/Recordings

Establishment Info

Oakland Park Communities
Thief River Falls
County/Group:

Inspection Info

Report Number: F1040261002
Inspection Type: Full
Date: 1/6/2026
Time: 9:21:30 AM

New Record: Product/Item/Unit: ; Temperature Process:
Location: at Degrees F.
Comment:
Violation Issued?: No

Bemidji District Office
Minnesota Department of Health
707 5th St NW, Suite A
Bemidji, MN 56601

Sanitizer Observations/Recordings

Establishment Info

Oakland Park Communities
Thief River Falls
County/Group:

Inspection Info

Report Number: F1040261002
Inspection Type: Full
Date: 1/6/2026
Time: 9:21:30 AM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Mop Sink **Equal To** PPM
Comment: AT TIME OF INSPECTION BOTTLE NOT OPENED
Violation Issued?: No