Electronically Delivered

September 9, 2022

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

RE: Project Number(s) SL32155015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 23, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

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

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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. The Department of Health 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 (a)(5)(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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500

The total amount you are assessed is $500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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.

A state licensing 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. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

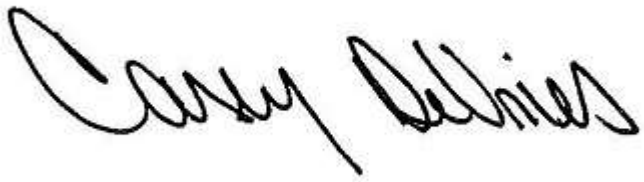
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: Fax: 651-215-9697

PMB

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 _____	08/23/2022

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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders have been issued pursuant to a survey. Determination of whether a violation has been 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: SL32155015-0 On August 22, 2022, through August 23, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders were issued. At the time of the survey, there were seven residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a staffing plan to determine staffing levels to meet the needs of all residents and to ensure the plan was implemented and posted as required. This had the potential to affect all seven residents, staff and visitors. This practice resulted in a level two violation (a	0 470		

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0 470	Continued From page 2 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: The licensee held an assisted living license and was licensed for a capacity of seven residents, with a current census of seven residents. During the facility tour on August 22, 2022, at approximately 12:53 p.m., clinical nurse supervisor (CNS)-B confirmed the licensee employed two licensed personnel and five unlicensed personnel at the survey location. CNS-B stated she wrote the staff schedule every two weeks. CNS-B stated there was no "matrix or plan", scheduling was based on one unlicensed personnel per shift and during the day shifts, nursing would be on-site. On August 23, 2022, at approximately 11:00 a.m., CNS-B stated, "we will get that done in all of our houses". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 3 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all seven residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 22, 2022, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (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. (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. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to COVID-19 when the licensee failed to ensure staff wore recommended personal protective equipment while working in the facility. Additionally, licensee failed to ensure staff screened for COVID-19 prior to working their scheduled shifts and failed to conduct COVID-19 screening of visitors. The deficient practice had the potential to affect all residents, employees and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 510		

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0 510	Continued From page 5 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). Findings include: EYE PROTECTION/SCREENING/FACE MASK On August 22, 2022, at 10:30 a.m., a surveyor from the Minnesota Department of Health (MDH) entered the facility and was greeted by clinical nurse supervisor (CNS)-B and licensed practical nurse (LPN)-D. CNS-B and LPN-D wore medical grade face masks and lacked the use of protective eyewear. The licensee's staff failed to screen the surveyor for COVID-19 upon entry. CNS-B On August 22, 2022, throughout the day between the hours of 10:30 a.m., to 4:30 p.m., the surveyor observed CNS-B interact with staff and residents wearing only a medical grade mask and no protective eyewear. LPN-D On August 22, 2022, throughout the day between the hours of 10:30 a.m., to 4:30 p.m., the surveyor observed LPN-D interact with staff and residents wearing only a medical grade mask and no protective eyewear. LALD-A (Licensed assisted living director) On August 22, 2022, at approximately 11:55 a.m., the surveyor observed LALD-A enter the facility and approach CNS-B and LPN-D for a conversation. LALD-A lacked the use of protective eyewear or a face mask.	0 510		

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0 510	Continued From page 6 ULP-C (unlicensed personnel) On August 23, 2022, at 7:50 a.m., the surveyor observed ULP-C administer R1's morning medications. ULP-C wore a medical grade facial mask and no protective eyewear. The surveyor asked what instructions the licensee had provide to staff for the use of protective eyewear and if staff were instructed to utilize protective eyewear when in the facility. ULP-C stated, "nope, not since I've been here, that's about a year in October." STAFF AND VISITOR COVID-19 SCREENING On August 22, 2022, at approximately 11:40 a.m., the surveyor observed a family member speaking with CNS-B on the main floor commons area. Ashort time later, CNS-B stated to the surveyor the family member "is a sister to one of our residents downstairs and uses the downstairs door to enter" and confirmed family members who enter through the downstairs entrance door do not COVID-19 screen. ULP-C On August 23, 2022, at 7:50 a.m., the surveyor observed ULP-C administer R1's morning medications. ULP-C wore a medical grade facial mask and lacked the use of protective eyewear. The surveyor asked what instructions the licensee had given to staff to conduct COVID-19 screening. ULP-C stated staff had not been COVID-19 screening, "since about wintertime." On August 23, 2022, at approximately 8:04 a.m., the surveyor requested to review the licensee's COVID-19 staff and visitor screening logs. CNS-B provided a document titled Visitor Covid-19 Screening/Sign in. The one-page document	0 510		

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0 510	Continued From page 7	0 510		

included 13 names and dated back to July 7, 2021. CNS-B confirmed that licensee had not been COVID-19 screening staff prior to work shifts and stated, "no, we don't do that" when asked by the surveyor if staff self-screening was being monitored, and "staff know not to come to work if they aren't feeling well." CNS-B was unable to provide the surveyor with any staff COVID-19 screening documentation.

On August 23, 2022, at approximately 10:00 a.m., the surveyor confirmed with CNS-B and LPN-D the link to the Centers for Disease Control and Prevention (CDC) website for knowledge of community transmission levels and required personal protective equipment (PPE) use. CNS-B stated "yes, we are familiar with the COVID-19 Tracker site, and I listen in to the meetings."

The licensee's COVID-19 Infection Control Policies and Procedures policy dated 2020, indicated all staff would be screened when reporting for work for a fever equal to or over 100F, acute respiratory symptoms, including cough, SOB, sore throat, loss of taste or smell, muscle aches and chills.

The Minnesota Department of Health (MDH) COVID-19 PPE and Source Control Grids for Congregate Care Settings by Community Transmission Levels dated April 7, 2022, indicated with high community transmission levels, protective eyewear and medical grade masks were to be worn by staff to prevent unseen spread of COVID-19 in a facility. The guidance recommended eye protection when staff were in resident care areas. On August 23, 2022, at approximately 10:00 a.m., the surveyor and CNS-B confirmed the Centers for Disease Control and Prevention (CDC) county tracker

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0 510	Continued From page 8 indicated covid transmission levels were high within the county the facility is located. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all seven 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	0 550		

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0 550	Continued From page 9 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 August 22, 2022, during the facility tour at approximately 12:53 p.m., the surveyor observed facility common areas and noted the lack of required posting of the licensee's information related to reporting suspected maltreatment to MAARC. In addition, there was no posting of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, or any information for reporting suspected maltreatment to MAARC. On August 23, 2022, at approximately 11:15 a.m., clinical nurse supervisor (CNS)-B confirmed the content noted above was not posted as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent	0 580		

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0 580	Continued From page 10	0 580		

services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to maintain documentation of a quality management activity. This had the potential to affect all seven residents receiving assisted living services.

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:

On August 22, 2022, at approximately 11:30 a.m., the surveyor requested documentation of the licensee's quality management activity. Clinical nurse supervisor (CNS)-B stated, "I'm not going to have that" and added that management would review different topics each week, however, CNS-B "wouldn't have the documentation piece of that."

The licensee's Quality Management Plan policy dated August 1, 2021, indicated the licensee would maintain and update quality improvement projects as needed, but not less than annually. Additionally, the policy indicated documentation of

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(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
0 580	Continued From page 11 quality improvement activities would be retained in the agency files for two years and made available to the Minnesota Department of Health (MDH) at the time of a survey, investigation or renewal upon request. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information to include: (1) Posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; and (2) Posting information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. This had	0 640		

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	32155	A. BUILDING: _____ B. WING _____	08/23/2022

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0 640	Continued From page 12 the potential to affect all current 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: The licensee lacked a posting of the 911 emergency number in common areas and near telephones provided by the assisted living and the information for reporting suspected maltreatment to MAARC. On August 22, 2022, at approximately 12:53 p.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-B and observed the common areas lacked the required posting for the 911 emergency number and the reporting number for MAARC. On August 23, 2022, at approximately 11:20 a.m., CNS-B confirmed the 911 emergency number was not posted on or near the telephone located in the main area and the contact information or reporting number for MAARC was not posted in a conspicuous manner. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		

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0 680	Continued From page 13	0 680		
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 tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content and post an emergency preparedness plan prominently. This had the potential to affect all seven residents receiving services under the assisted living with dementia care license.	0 680		

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0 680	Continued From page 14 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 August 22, 2022, at approximately 11:20 a.m., the surveyor requested to view the licensee's emergency preparedness plan, which was provided to and later reviewed by the surveyor. The licensee's emergency preparedness plan included a one page posting of the emergency plans for a fire, power outage, violence/terrorism, medical emergency, tornado/severe weather procedure and a hazardous material event. The licensee's plan lacked the following content and/or policies and procedures to address: - a comprehensive program to include man-made disasters, facility based (power, water etc.), infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - the facilities role in providing care and treatment at alternative sites; - the provision of subsistence needs for staff and residents; - a tracking system used to document locations of residents and staff;	0 680		

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0 680	Continued From page 15 - an evacuation plan; - how the facility would provide a means to shelter in place for residents and volunteers; - the medical record documentation system the facility has developed to preserve resident information security and availability of records; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On August 23, 2022, at approximately 11:35 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee had not fully developed and implemented the facility's emergency preparedness plan/program to address Appendix Z. CNS-B stated the copy provided to the surveyor was the complete emergency preparedness plan, however, the plan provided was a generalized template that was not specific to the facility. The licensee's Emergency Plan policy dated August 1, 2021, indicated the facility would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780		

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0 780	Continued From page 16 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms in some of resident's bedrooms. 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 residents). The findings include:	0 780		

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0 780	Continued From page 17 On August 22, 2022, between 1:30 p.m. and 2:30 p.m., survey staff toured the facility with Licensed Practical Nurse (LPN)-E. During the facility tour, survey staff observed the following: 1. There was no smoke alarm provided in the bedroom located by the kitchen and in the bedroom located by the living room. 2. There was no smoke alarm provided in the immediate vicinity of the upstairs bedroom located by the kitchen. 3. Staff could not provide evidence that the smoke alarms were all interconnected. LPN-E verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21)	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 maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the	0 800		

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0 800	Continued From page 18 residents. This had the potential to directly affect some of the 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 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 August 22, 2022, from approximately 1:30 p.m. to 2:30 p.m., survey staff toured the facility with the Licensed Practical Nurse (LPN)-E. During the facility tour, survey staff observed and verified that carpet in one of the resident rooms was torn and coming up between the bathroom and bedroom floor. LPN-E verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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;	0 810		

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0 810	Continued From page 19 (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 810		

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0 810	Continued From page 20 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On August 22, 2022, from approximately 2:30 p.m., the Licensed Practical Nurse (LPN)-E provided documents for review. During the review, survey staff observed the facility fire safety and evacuation plan, and it was noted to lack the following documentation: 1. The schedule and required records on training of employees on proper actions in fire safety and evacuation upon hiring and twice per year with at least one evacuation drill every other month. 2. The schedule and required records on training of residents who can assist in their own evacuation on proper actions to take in the event of a fire including movement, evacuation, and relocation. Must be done at least once per year. On August 22, 2022, at approximately 2:30 p.m., LPN-E was not able to provide the information listed above as requested. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal	0 970		

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0 970	Continued From page 21	0 970		

property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the assisted living agreement did not include language waiving the facility's liability for health, safety or personal property of a resident. This had the potential to affect all residents.

This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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:

R1's Assisted Living Contract dated October 5, 2021, contained a clause indicating the resident would waive the facility's liability as follows:

"Insurance Liability and Release: The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [name of facility] upon request. The resident acknowledges that [name of facility] is not an insurer of the resident's

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0 970	Continued From page 22 person or property. The residents agrees that [name of facility] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [name of facility] or it employees or agents. The resident hereby releases [name of facility] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [name of facility] or its employees or agents." Page 12, first paragraph. On August 22, 2022, at approximately 2:23 p.m., clinical nurse supervisor (CNS)-B confirmed the same assisted living service agreement was used for all residents at the facility. No further information available. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to	01540		

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01540	Continued From page 23 dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-C) received the required amount of dementia care training in the required time frame with records reviewed. 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: The licensee had an assisted living facility license. ULP-C was hired on September 14, 2021, to provide direct care services to licensee's residents. ULP-C's employee record contained documentation ULP-C completed 6.5 hours of initial dementia training upon hire.	01540		

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01540	Continued From page 24 ULP-C's employee record lacked evidence ULP-C completed the required eight (8) hours of training on the specific dementia care topics within 80 working hours of ULP-C's hire date. On August 23, 2022, at approximately 11:35 a.m., clinical nurse supervisor (CNS)-B confirmed ULP-C lacked the required dementia training. CNS-B stated licensee would audit training items at all houses operated by licensee as part of the auditing system put in place by CNS-B. The licensee's Dementia Education policy dated August 1, 2021, indicated direct care staff would complete a minimum of eight hours of initial training on dementia care topics within 160 working hours of the employment start date. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident.	01750		

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01750	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the registered nurse (RN) failed to specify, in writing, specific instructions for one of one resident (R1) for administration of medications. Additionally, unlicensed personnel (ULP)-C failed to prime the insulin pen prior to administration. 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: R1's record lacked evidence the RN specified, in writing, specific instructions for administration of Novolog insulin. R1's service plan dated August 4, 2021, indicated R1 received services which included medication administration. R1's prescriber's orders dated May 2, 2022, included; Tylenol 325 milligram (mg) twice daily (BID); aspirin 81 mg daily; benztropine 1 mg BID; bethanechol chloride 25 mg BID; carvedilol 3.125 mg BID; Chlorhexidine 0.12% mouth rinse BID; Clindamycin 300 mg daily; clonazepam 0.5 mg three times daily (TID); clozapine 100 mg BID; fenofibrate 160 mg daily; finasteride 5 mg daily; fish oil 1000 mg daily; Levemir Flextouch 100	01750		

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 _____	08/23/2022

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
01750	Continued From page 26	01750		

units/ milliliters (u/mL) 52 units at bedtime; lisinopril 5 mg daily; metformin 1000 mg daily; Novolog Flexpen 100u/mL 6 units before breakfast and 10 units before lunch and dinner; omeprazole 20 mg daily; phenytoin extended release 100 mg TID; polyethylene glyco 17 grams (g) daily; rosuvastatin 20 mg daily; Senna-S 8.6mg-50 mg daily; sugar free fiber supplement one teaspoon daily; tamsulosin 0.4 mg daily; viatmin D2 1.25 mg every Thursday; and zeasorb antifungal 2% powder topical BID.

R1's medication administration record (MAR) dated August 2022 instructed ULPs as follows:
- Novolog Flexpen 100/u (daily) inject subcutaneously 6 units before breakfast, 10 units before lunch and dinner; and
- Levemir Flextouch 100/u (daily) inject 52 units at bedtime.

On August 23, 2022, at approximately 7:53 a.m., the surveyor observed ULP-C administer R1's morning medications to include Novolog insulin. ULP-C failed to prime the Lantus insulin pen with 2 units of insulin prior to administration. The surveyor inquired with ULP-C if she had been taught to prime the insulin pen with 2 units of insulin prior to administration. ULP-C stated, " I've never heard of that."

ULP-C's training record dated November 18, 2021, indicated ULP-C had completed insulin pen competency with clinical nurse supervisor (CNS)-B.

On August 23, 2022, at approximately 11:10 a.m., CNS-B confirmed R1's record lacked instructions specific to administering R1's Novolog and Levemir insulin medication and stated, "this one is on me, because we use to be home care, the

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 _____	08/23/2022

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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01750	Continued From page 27 staff were not taught to prime the insulin pen with 2 units of insulin before they administered the insulin." The licensee's Medication administration policy dated August 1, 2021, indicated the registered nurse may delegate medication administration to an unlicensed staff member according to protocol. Protocol indicated the registered nurse would prepare written instructions for the unlicensed staff in the proper method to administer medication with respect to each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
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 prescription medications were stored according to the manufacturer's directions and failed to ensure prescription medications were stored in a secured manner allowing only authorized personnel access. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01880		

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 _____	08/23/2022

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OAK HOUSE LLC	10038 215TH AVENUE NW ELK RIVER, MN 55330

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01880	Continued From page 28	01880		

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:

On August 22, 2022, at approximately 1:33 p.m., in the presence of licensed practical nurse (LPN)-E, the surveyor observed a medication refrigerator in the nurse's office. The medication refrigerator lacked a lock to secure medications. The surveyor requested to review the medication refrigerator temperature log and it was provided by clinical nurse supervisor (CNS)-B.

The medication refrigerator contained insulin pens belonging to R1 as follows:
- two unopened Novolog Flexpens 100 units (u)/milliliter (ml); and
- three unopened Levemir Flextouch pens 100 u/ml.

The manufacturer's instructions for Novolog and Levemir insulin pens dated June 2021, indicated unopened pens should be stored in the refrigerator at 36 to 46 degrees Fahrenheit (F) and be discarded if frozen. The refrigerator temperature log contained several readings at or below 32 degrees F on the following days in July and August 2022:
- July 13, 18, 2022; and
- August 18, 2022.

On August 22, 2022, at approximately 1:57 p.m., CNS-B confirmed the refrigerator contained unsecured medications and the temperature log

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01880	Continued From page 29 contained several readings at or below 32 degrees F. The surveyor asked CNS-B if she was aware of the safe range for insulin pen storage in the refrigerator and CNS-B stated, "I would imagine it's not 32 degrees". Additionally, CNS-B stated she would be in contact with maintenance to correct the refrigerator concerns. The licensee's Storage/Control of Medications dated August 1, 2021, indicated all prescription drugs were securely locked in substantially constructed compartments according to the manufacturer's directions and only authorized personnel have access to the stored medications. Medications requiring refrigeration would be clearly labeled and the temperature would be maintained between 35 - 40 degrees. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/22/22*
Time: 14:25:03
Report: 8042221170

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.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

PROVIDE A WAY TO MONITOR THE DISH MACHINE TEMPERATURE AT PLATE LEVEL TO ENSURE PROPER SANITATION (MIN 160F).

Comply By: 08/29/22

4-500 Equipment Maintenance and Operation

4-501.116 ** Priority 2 **

MN Rule 4626.0815 Use the sanitizer test kit or other device to accurately measure the concentration of the sanitizing solution.

PROVIDE QUAT TEST STRIPS TO MONITOR CONCENTRATION OF SANITIZER IN BUCKETS.

Comply By: 08/29/22

2-100 Supervision

2-102.12AMN

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

MS KOOP HAS SERVSAFE. MN CFPM REQUIRED. VISIT WWW.HEALTH.STATE.MN.US FOR MORE INFORMATION

Comply By: 09/26/22

Food and Beverage Establishment Inspection Report

5-100 Water

5-102.14A

MN Rule 4626.1010A Water sample reports must be retained on file in the food establishment in accordance with the requirements specified in chapter 4720.

PROVIDE UP TO DATE WATER SAMPLE REPORTS. LAST REPORT AVAILABLE AT TIME OF INSPECTION WAS FROM 2018.

Comply By: 08/29/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

MOUSE DROPPINGS PRESENT ON UPRIGHT FREEZER IN BASEMENT STORAGE ROOM. ENSURE PROPER PEST CONTROL.

Comply By: 08/26/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: POTATO SALAD
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: SHREDDED LETTUCE
Violation Issued: No

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

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 8042221170 of 08/22/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed: EH
Erin Hodgins
Public Health Sanitarian
651-201-4500
health.foodlodging@state.mn.us