



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 10, 2026

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

RE: Project Number(s) SL39894016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 12, 2026, 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.

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 . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

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

pursuant to this survey:

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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>

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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.

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,

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

Kelly Thorson, Supervisor

State Evaluation Team

Email: Kelly.Thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304			
(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: SL39894016-0 On June 8, 2026, through June 10, 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 five residents; five 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.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
0 470	Continued From page 1 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 ensure the registered nurse (RN) reviewed the staffing plan at least twice per year. 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	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304			
(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
0 470	Continued From page 2 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 five residents, with a current census of five residents. The licensee's undated Direct Care Staffing Plan indicated clinical nurse supervisor (CNS)-A had developed and implemented the written staffing plan to include two staff per shift. The staffing plan lacked documentation it had been reviewed at least twice per year. On June 8, 2026, at 1:30 p.m., licensed assisted living director/registered nurse (LALD/RN)-B stated some of the residents require two staff for transfers, so the staffing ratio is always two staff working and this has not changed, but he was unaware the staffing plan needed to be reviewed twice annually. The licensee's Staffing policy, dated March 22, 2024, indicated the staffing plan is based on an evaluation of the appropriateness of the staffing levels in the facility and is reviewed at least twice a year. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
0 510	Continued From page 3	0 510			
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 maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control, by not cleaning shared equipment for one of one employee (unlicensed personnel (ULP)-D). This had the potential to affect all 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 of the residents). The findings include: ULP-D had a hire date of June 4, 2025. ULP-D's record contained documentation the employee	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
0 510	Continued From page 4 had been trained and was competency tested prior to being delegated with resident care. On June 10, 2026, during continuous observation from 8:15 a.m., through 9:10 a.m., the surveyor observed ULP-D take vital signs with shared equipment for two residents (R1 and R6). ULP-D took the blood pressure cuff out of the medication cart and obtained R6's blood pressure. Without sanitizing the blood pressure cuff, placed it back into the medication cart. ULP-D then proceeded to push the medication cart to R1's bedroom, opened the cart and retrieved the same blood pressure cuff. Without sanitizing the blood pressure cuff, he obtained R1's blood pressure. On June 10, 2026, at 9:45 a.m., licensed assisted living director/registered nurse (LALD/RN)-B stated medical equipment should always be cleaned after each use and in between residents and if the equipment was not cleaned this would be an infection control breach. The Licensee's Infection Control policy, dated March 22, 2024, indicated, standard precautions include equipment used for resident care is properly cleaned and reprocessed. The Centers for Disease Control (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated April 12, 2024, indicated reprocessing of reusable medical equipment instructions were to clean and reprocess (disinfect or sterilize) reusable medical equipment (e.g. blood pressure cuffs) prior to use on another patient or when soiled. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
0 510	Continued From page 5 days	0 510			
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 interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for three of three residents (R1, R2 and R5). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: R1 R1 was admitted to the licensee on December	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
0 630	Continued From page 6 10, 2025, with diagnoses which included bipolar disorder, antisocial personality disorder, acute kidney failure and type two (2) diabetes mellitus. R1's IAPP dated May 4, 2026, indicated R1 was at risk to be abused and included statements of specific measures to be taken to minimize the risk of abuse to that person. R2 R2 was admitted to the licensee on February 12, 2026, with diagnoses which included type two (2) diabetes mellitus, chronic kidney disease stage three (3) requiring renal dialysis, essential hypertension and adjustment disorder with anxiety. R2's IAPP dated May 30, 2026, indicated R2 was at risk to be abused and included statements of specific measures to be taken to minimize the risk of abuse to that person. R5, R5's was admitted to the licensee on September 6, 2023, with diagnoses which included chronic respiratory failure with hypoxia, type two (2) diabetes mellitus, bed confinement status with inability to walk and total dependence on cares and depression. R5's IAPP dated December 21, 2025, indicated R5 was at risk to be abused by others, has no known risk to abuse themselves and included statements of specific measures to be taken to minimize the risk of abuse to that person. R1, R2, and R5's IAPP's all lacked the risk to abuse others and measures to be taken to minimize the risk of other vulnerable adults.	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
0 630	Continued From page 7 On June 9, 2026, at 9:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-B stated he agreed the IAPP for R2 was missing the risk to abuse others and specific measures to be taken to minimize the risk of other vulnerable adults. LALD/RN-B stated he must have missed this when completing the assessment because he thinks it is in the other resident's IAPP's. On June 10, 2026, at 10:45 a.m., LALD/RN-B stated the IAPP for R1 is missing the risk to abuse others and specific measures to be taken to minimize the risk of other vulnerable adults. On June 10, 2026, at 2:15 p.m., LALD/RN-B stated R5's IAPP is missing the risk to abuse others and specific measures to be taken to minimize the risk of other vulnerable adults and this would be the case for all residents he will need to update them. The licensee's Vulnerable Adult Policy, dated March 22, 2024, indicated an individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living services are provided. - The plan shall contain an individualized assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults; - The plan shall contain the resident's risk of abusing other vulnerable adults; - The plan shall contain statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults; and - The plan will be implemented immediately and evaluated at each supervisory visit or more frequently, if necessary.	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304			
(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
0 630	Continued From page 8 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 9, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7)	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304			
(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
0 775	Continued From page 9 days	0 775			
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
0 790	Continued From page 10 Environment Inspection Report (PEIR) dated July 9, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
0 800	Continued From page 11 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 9, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. 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	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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 12 least once per year. (f) Evacuation drills are required for staff 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 ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 9, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01060	Continued From page 13	01060			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01060	Continued From page 14 returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (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 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: R2 was admitted to the licensee on February 12, 2026, with diagnoses which included type two (2) diabetes mellitus, chronic kidney disease stage three (3) requiring renal dialysis, essential hypertension and adjustment disorder with anxiety. R2's record indicated R2 was hospitalized on May 7, 2026, through May 15, 2026, for osteomyelitis. R2's record lacked a written notice provided to R2 which included: - the reason for relocation; - the name and contact information for the	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01060	Continued From page 15 location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. - this notice must be delivered as soon as practicable to: - the resident, legal representative, and designate representative; - the resident's case manager; and - notify Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. On June 9, 2026, at 1:30 p.m., licensed assisted living director/registered nurse (LALD/RN)-B stated he was unaware of the emergency relocation notifications requirement and was not aware the case manager needed to be notified or if the resident was out of the facility for more than four days the Ombudsman also needed to be notified. LALD/RN-B stated he has not been doing emergency relocation notifications for any of the residents because he was unaware of this requirement No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304			
(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
01060	Continued From page 16 (21) days	01060			
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two unlicensed personnel (unlicensed personnel (ULP)-C). 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	01330			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01330	Continued From page 17 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: ULP-C was hired by the licensee on March 23, 2026, to provide assisted living services. ULP-C's employee record lacked documentation of the completion of the following required competency evaluations: - care and use of hearing aids; - reading and recording temperature, pulse, and respirations of the resident; and - safe transfer techniques and ambulation. On June 10, 2026, at 3:55 p.m., licensed assisted living director/registered nurse (LALD/RN)-B stated he agreed ULP-C is missing the competency evaluations for care and use of hearing aids, vital signs, and safe transfer techniques and these must have been missed when completing the training paperwork for ULP-C. The licensee's Staff Competency policy, dated March 22, 2024, indicated unlicensed personnel may not work for licensee until they have successfully passed the written test and demonstration competency evaluation. The following topics must be completed by a practical skills test: - appropriate and safe techniques in personal hygiene and grooming, including bathing, hair care, oral hygiene, care and use of hearing aids, dressing and toileting; - safe transfer techniques and ambulation; and - reading and recording temperature, pulse and respirations.	01330			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01330	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330			
01530 SS=E	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01530	Continued From page 19 paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct care staff received the required two (2) hours of initial training on mental illness and de-escalation topics within 160 hours of start date for two of two employees (unlicensed personnel (ULP)-C and ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On June 8, 2026, at 10:30 a.m., clinical nurse supervisor (CNS-)-A and licensed assisted living director/registered nurse (LALD/RN)-B both stated there are three (3) shifts a day that are eight (8) hours each.	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01530	Continued From page 20 ULP-C ULP-C was hired by the licensee on March 23, 2026, to provide assisted living services. The licensee's work schedule dated June 1, 2026, through June 14, 2026, indicated ULP-C worked four (4) eight (8) hour shifts each week. ULP-C's personnel record lacked the required two hours of mental illness and de-escalation training within 160 hours of working for the licensee. ULP-D On June 10, 2026, during continuous observation from 8:15 a.m., through 9:10 a.m., the surveyor observed ULP-D administer medication's and take vital signs for two residents (R1 and R6). ULP-D was hired by the licensee on June 4, 2025, to provide assisted living services. The licensee's work schedule dated June 1, 2026, through June 14, 2026, indicated ULP-D worked four (6) eight (8) hour shifts each week. ULP-D's personnel record indicated ULP-D had completed one and a half (1.5) hours of mental illness and de-escalation training. ULP-D's personnel record lacked the required two hours of mental illness and de-escalation training within 160 hours of working for the licensee. On June 10, 2026, at 3:55 p.m., LALD/RN-B verified ULP-C did not have any mental illness training and ULP-D only has a hour and a half (1.5) of mental illness training and this would be the case for several staff because they are in the	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01530	Continued From page 21 process of having the staff work on completing this training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01620	Continued From page 22 Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for one of three residents (R5). 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:	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01620	Continued From page 23 R5 was admitted to the licensee on September 6, 2023, with diagnoses which included chronic respiratory failure with hypoxia, type two (2) diabetes mellitus, bed confinement status with inability to walk and total dependence on cares and depression. R5's Service Plan dated October 14, 2024, indicated R5 received assistance with bathing, bedmaking, continuous positive air pressure (CPAP) assistance, cleaning, dressing, respiratory equipment care, grooming, incontinence care, laundry, behavior management, meal assistance, medication administration, repositioning, blood glucose monitoring, vital sign monitoring, wheelchair assistance and transfer assistance. R5's medical record included ongoing assessment dated December 21, 2025. R5's record lacked the following ongoing 90-day assessment which was due to be completed on March 21, 2026. On June 10, 2026, at 2:25 p.m., licensed assisted living director/registered nurse (LALD/RN)-B stated the last assessment completed for R5 was the December 21, 2025, assessment and another assessment should have been completed in March, but it was missed so he will complete it today. The licensee's Assessment and Reassessment policy dated March 22, 2024, indicated an ongoing resident reassessment must be conducted by a registered nurse (RN) and cannot exceed 90 days from the last date of assessment.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304			
(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
01620	Continued From page 24 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to complete and ensure the service plan included a resident or resident representative's signature to document agreement on the services to be provided within 14 days of admission for one of three residents	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01640	Continued From page 25 (R1). This practice resulted in a level two 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 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 June 10, 2026, at 8:40 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications, monitor blood glucose, obtain a blood pressure reading and a pulse for R1. R1 was admitted to the licensee on December 10, 2025, with diagnoses which included bipolar disorder, antisocial personality disorder, acute kidney failure and type two (2) diabetes mellitus. R1's service plan lacked a resident or resident representative signature to document agreement on the services to be provided. On June 10, 2026, at 10:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-B stated they do not have a signed service plan for R1 because he forgot to send the service plan to R1's representative when the other paperwork was sent and signed at admission. The licensee's Service Plan policy dated March 22, 2024, indicated beginning with the date assisted living services are first provided, a Service plan is developed for the resident based	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01640	Continued From page 26 on an agreement with the resident/responsible party and on the assessed needs identified in the comprehensive assessment. The Service plan will be finalized no later than 14 days after the date Home Care Services are first provided, if not already completed. The initial Service plan and any revisions are signed by a representative from licensee and the resident or resident representative, indicating agreement with the services to be provided. No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01650	Continued From page 27 identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the correct required content for three of three residents (R2, R5 and R6). 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: R2 R2 was admitted to the licensee on February 12, 2026, with diagnoses which included type two (2) diabetes mellitus, chronic kidney disease stage three (3) requiring renal dialysis, essential hypertension and adjustment disorder with anxiety. R2's Service Plan signed February 12, 2026, indicated R2 received assistance with bathing, bedmaking, cleaning, dressing, equipment care, grooming, incontinence care, laundry, behavior	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304			
(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
01650	Continued From page 28 management, meal tray, medication administration, med set up, oxygen delivery, blood glucose monitoring, vital sign monitoring, safety checks, transfer assistance and wound care. R5 R5's was admitted to the licensee on September 6, 2023, with diagnoses which included chronic respiratory failure with hypoxia, type two (2) diabetes mellitus, bed confinement status with inability to walk and total dependence on cares and depression. R5's Service Plan signed October 14, 2024, indicated R5 received assistance with bathing, bedmaking, continuous positive air pressure (CPAP) assistance, cleaning, dressing, respiratory equipment care, grooming, incontinence care, laundry, behavior management, meal assistance, medication administration, repositioning, blood glucose monitoring, vital sign monitoring, wheelchair assistance and transfer assistance. R6 On June 10, 2026, 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications, monitor blood glucose, obtain a blood pressure reading and a pulse for R6. R6 was admitted to the licensee on January 4, 2024, with diagnoses which included schizophrenia, type two (2) diabetes mellitus and chronic obstructive pulmonary disease (COPD). R6's Service Plan signed January 8, 2024, indicated R6 received assistance with bathing, bedmaking, cleaning, grooming, laundry,	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304			
(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
01650	Continued From page 29 behavior management, meal reminder, medication administration, medication set up, monitor vital signs, safety checks and socialization. R2, R5 and R6's service plans included the following required content: -a description of the services to be provided and the frequency of each service, according to the residents' current assessment and resident preferences; and -the identification of staff or categories of staff who will provide the services. R2, R5 and R6's service plans lacked the following required content: - the fees for service -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On June 9, 2026, at 9:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-B	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01650	Continued From page 30 stated he agrees the service plan is missing some of the required information after reviewing the statute and he did not realize this information was required on the service plan and will need to have these items added to the service plan. The licensee's Service Plan policy dated March 22, 2024, indicated the service plan would include: a. A description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party; b. The fees for services and the frequency of each service, according to the resident's current review or assessment and resident preferences; c. The identification of the staff or categories of staff who will provide the services; d. The schedule and methods of monitoring reviews or assessments of the resident; e. The schedule and method of monitoring staff providing services; f. A contingency plan that includes the following: i. Action to be taken if the scheduled service cannot be provided; ii. Information and method for a resident or resident's representative to contact the facility; iii. Names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition; iv. The identification of and information as to who has the authority to sign for the resident in an emergency; v. Circumstances in which emergency medical services are not to be summoned and declarations made by the resident related to health care directives. No further information was provided.	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01650	Continued From page 31	01650			
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days				
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01730	Continued From page 32 as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individualized medication management plan with the required content for two of two residents (R1 and 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, 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: R1 On June 10, 2026, at 8:40 a.m., the surveyor observed unlicensed personnel (ULP)-D crush medications for R1, place them in applesauce and administer them to R1. ULP-D stated R1 cannot swallow well, so they crush the medications and put them in applesauce. ULP-D stated the instructions to crush the medications	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01730	Continued From page 33 for R1 are not on the MAR. On June 10, 2026, at 8:45 a.m., licensed assisted living director/registered nurse (LALD/RN)-B stated the specific instructions are not on the medication administration record (MAR), he has contacted the provider to get an order to crush medications and staff know to crush the medications and give them with applesauce because he has told them to do so. R1 was admitted to the licensee on December 10, 2025, with diagnoses which included bipolar disorder, antisocial personality disorder, acute kidney failure and type two (2) diabetes mellitus. R1's Service Plan dated December 10, 2025, indicated R1 received services which included medication administration. R1's Individualized Medication Management Plans completed on May 4, 2026, lacked the following required content: - documentation of specific resident instructions relating to the administration of medications. R2 R2 was admitted to the licensee on February 12, 2026, with diagnoses which included type two (2) diabetes mellitus, chronic kidney disease stage three (3) requiring renal dialysis, essential hypertension and adjustment disorder with anxiety. R2's Service Plan signed February 12, 2026, indicated R2 received assistance which included medication administration. R2's Individualized Medication Management Plans completed on May 30, 2026, lacked the	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01730	Continued From page 34 following required content: - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. On June 9, 2026, at 2:00 p.m., LALD/RN-B stated he agreed R2's medication management plan was missing when to notify a nurse when a problem arises, he will need to add this to R2's plan as it must have been missed. On June 10,2026, at 9:45 a.m., LALD/RN-B stated the specific instructions for R1 to crush the medications is missing from the medication management plans, this would be the case for several residents and will need to review all the medication management plans and make sure they meet the requirements. The licensee's Service Plan for Medication Management policy dated March 22, 2024, indicated the written medication management plan includes the following provisions: - plans for staff notifying the licensed health professional when/if a problem with medication management services arises; and - any resident-specific requirements related to documenting medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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 35 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for two of two residents (R1 and R6) who received medication management 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on June 8, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director/registered nurse (LALD/RN)-B both stated they provided medication management services to all five residents at the facility.	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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 36 R1 R1 was admitted to the licensee on December 10, 2025, with diagnoses which included bipolar disorder, antisocial personality disorder, acute kidney failure and type two (2) diabetes mellitus. R1's Service Plan dated December 10, 2025, indicated R1 received services which included medication administration. R1's June 2026 Medication Administration Record (MAR) indicated R1 was scheduled medications at 8:00 a.m., which included: - carbidopa/levodopa 25-100 milligrams (mg) tablet - take one tablet daily by mouth three times a day for Parkinson's disease; - divalproex 250 mg tablet - Give 250 mg by mouth two times a day for bipolar disorder; - insulin aspart sliding scale 70-149 =0; 150-199=2; 200-249=4; 250-299=6; 300-349=8, 350-399=10; 400+ call MD - inject subcutaneously three times a day per sliding scale before meals; and - sertraline 100 mg tablet - take one and one half tablets by mouth daily. R6 R6 was admitted to the licensee on January 4, 2024, with diagnoses which included schizophrenia, type two (2) diabetes mellitus and chronic obstructive pulmonary disease (COPD). R6's Service Plan signed January 8, 2024, indicated R6 received services which included medication administration. R6's June MAR indicated R6 was scheduled medications at 8:00 a.m., which included: - Breo Ellipita 100 microgram (mcg)/25 mcg inhaler for - inhale one puff by mouth daily for	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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 37 COPD; - Jardiance 10 mg - take one tablet 10 mg by mouth daily for type two diabetes; and - Metformin ER 500 mg - take two tablets (1,000 mg) by mouth twice a day with meals for type two diabetes. On June 10, 2026, during continuous observation from 8:15 a.m., through 9:10 a.m., the surveyor observed unlicensed personnel (ULP)-D administer two oral medications and one inhaler to R6. ULP-D had R6 rinse his mouth with water and spit it out into a kidney basin after using the inhaler. ULP-D stated the MAR does not indicate to have the resident rinse their mouth after each use, but he knows to do this. ULP-D prepared R1's medications, ULP-D took the tablets and placed them in a pill crusher and the one capsule he opened and poured the contents into the pill crusher. ULP-D stated R1 cannot swallow well, and they give him his medications crushed and with some food like applesauce. ULP-D stated the instructions to crush the medications for R1 are not on the MAR. On June 10, 2026, at 8:45 a.m., licensed assisted living director/registered nurse (LALD/RN)-B stated the instructions to crush the medications are not on the MAR, he has contacted the provider to get an order to crush the medications and staff know to crush the medications because he has told them to do so. On June 10, 2026, at 9:45 a.m., LALD/RN-B stated the specific instructions for R6 to rinse mouth after the use of the inhaler and the specific instructions for R1 to crush medications and mix into applesauce are not on the MAR's, this would be the case for several of resident's and he will need to review all of the MAR's to make sure they	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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 38 meet they have specific instructions if needed. The licensee's Medication Administration policy dated March 22, 2024, indicated the registered nurse may delegate medication administration to an unlicensed staff member according to the following protocol. -the registered nurse has prepared written instructions for the home health aide in the proper methods to administer medications with respects to each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01760	Continued From page 39 were transcribed as prescribed for two of two residents (R1 and 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, 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: R1 On June 10, 2026, at 8:40 a.m., the surveyor observed unlicensed personnel (ULP)-D administer morning medications to R1. R1 was admitted to the licensee on December 10, 2025, with diagnoses which included bipolar disorder, antisocial personality disorder, acute kidney failure and type two (2) diabetes mellitus. R1's Service Plan dated December 10, 2025, indicated R1 received services which included medication administration. R1's signed provider orders dated January 21, 2026, included orders for the following: - hydroxyzine HCL 10 milligrams (mg) - take one tablet by mouth every six hours if needed for anxiety or itching; - hyoscyamine sulfate 0.125 mg - place one-two tablets on the tongue every four hours if needed for bladder spasms/copious secretions; - lorazepam 0.5 mg tablets - take one-two tablets by mouth as needed for anxiety or agitation; - morphine concentrate 20mg/milliliter (mL) -	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01760	Continued From page 40 Take 0.25-.05mL by mouth every four hours if needed for pain/shortness of breath. R1's Medication Administration Record (MAR) dated June 2026 lacked the dosage amount or indicated the incorrect dosage amount for the following medications: - hydroxyzine HCL - administer one tablet by mouth every six hours as needed for anxiety or itching, no dosage indicated; - hyoscyamine sulfate - Administer one-two tablets on the tongue every four hours as needed for bladder spasms/copious secretions, no dosage indicated; - lorazepam - Administer one-two tablets by mouth every four hours as needed for anxiety or agitation, no dosage indicated; and - morphine sulfate - Administer 0.25 -0.5 mg by mouth every four hours as needed for pain, incorrect dosage. On June 10, 2026, at 11:00 a.m., licensed assisted living director/registered nurse (LALD/RN)-B stated he agrees there are missing dosages in the MAR, there should not be ranges for the unlicensed personnel to determine and the morphine dosage is currently incorrect in R1's MAR. LALD/RN-B stated none of these medications have been given, as they are new hospice medications and the MAR's will need to be changed immediately to reflect the correct dosage. LALD/RN-B stated after seeing these discrepancies he will need to review the MAR's for all the resident's to make sure there are no discrepancies. R2 R2 was admitted to the licensee on February 12, 2026, with diagnoses which included type two (2) diabetes mellitus, chronic kidney disease stage	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01760	Continued From page 41 three (3) requiring renal dialysis, essential hypertension and adjustment disorder with anxiety. R2's Service Plan signed February 12, 2026, indicated R2 received assistance which included medication administration. R2's signed provider orders dated April 28, 2026, included orders for the following: - hydroxyzine 50 mg capsule - take one capsule by mouth every eight hours if needed for anxiety; and - sennosides 8.6 mg tablet - take one-two tablets by mouth two times daily if needed for constipation. R2's Medication Administration Record (MAR) dated June 2026 lacked the following medications: - hydroxyzine 50 mg capsule - take one capsule by mouth every eight hours if needed for anxiety; and - sennosides 8.6 mg tablet - take one-two tablets by mouth two times daily if needed for constipation. On June 9, 2026, at 2:00 p.m., LALD/RN-B stated he agrees the hydroxyzine and senna are not on the MAR, this would be considered a medication error and would be the responsibility of the nurse to make sure the medications were on the MAR. The licensee's Medication Orders policy, dated March 22, 2024, indicated the licensee will administer medications as prescribed by the authorized prescriber and in accordance with all the rights defined in the Assisted Living Bill of Rights and in the Health Insurance Portability and Accountability Act. When a written or electronic	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304			
(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
01760	Continued From page 42 prescription is received, it must be communicated to the registered nurse in charge and recorded or placed into the resident's clinical record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R1 and 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, 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 the residents). The findings include: During the entrance conference on June 8, 2026,	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01770	Continued From page 43 at 10:30 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director/registered nurse (LALD/RN)-B both stated they provided medication management services to all five residents at the facility. R1 On June 10, 2026, at 8:40 a.m., the surveyor observed unlicensed personnel (ULP)-D administer morning medications to R1. R1 was admitted to the licensee on December 10, 2025, with diagnoses which included bipolar disorder, antisocial personality disorder, acute kidney failure and type two (2) diabetes mellitus. R1's Service Plan dated December 10, 2025, indicated R1 received services which included medication administration and medication set up. R1's record contained a progress note dated March 4, 2026, which indicated, weekly pill organizer refilled through March 10, 2026, HS (at bedtime). On June 9, 2026, at 1:40 p.m., licensed assisted living director/registered nurse (LALD/RN)-B stated he currently completes a task in the electronic charting system that indicates he completes the medication set up every Sunday. LALD/RN-B stated he agrees the documentation for R1 is missing the dates, names, dosage, time to be administered and route are missing from the medication set up documentation and will need to document this a different way to meet the requirements. R2 R2 was admitted to the licensee on February 12, 2026, with diagnoses which included type two (2)	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01770	Continued From page 44 diabetes mellitus, chronic kidney disease stage three (3) requiring renal dialysis, essential hypertension and adjustment disorder with anxiety. R2's Service Plan signed February 12, 2026, indicated R2 received assistance which included medication administration and medication set up. R1 and R2's records both lacked medication set up documentation to include the dates, name of medication, quantity of dose, times to be administered and route of administration. On June 10, 2026, at 10:45 a.m., LALD/RN-B stated he completes medication set ups weekly for all of the residents and he documents the medication set ups by completing the task in the electronic computer system so this would not meet the documentation requirements for medication set up. The licensee's Medication Documentation policy dated March 22, 2024, indicated the licensee will document medication set up according to the following: - date of medication set up; - name of medication; - quantity of dose; - times to be administered; route of administration; and - name/title of person completing medications set up. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304			
(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
01820	Continued From page 45	01820			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the licensee managed for two of two residents (R1 and R5). 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 the residents). The findings include: R1 On June 10, 2026, at 8:40 a.m., the surveyor observed unlicensed personnel (ULP)-D administer morning medications to R1. R1 was admitted to the licensee on December 10, 2025, with diagnoses which included bipolar disorder, antisocial personality disorder, acute kidney failure and type two (2) diabetes mellitus. R1's Service Plan dated December 10, 2025, indicated R1 received services which included	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01820	Continued From page 46 medication administration. R1's medication administration record (MAR) dated March 2026, included the following as needed (PRN) medications: - acetaminophen - insert one suppository rectally every six hours as needed for fever or pain; - cerave moisturizing cream - apply to affected area s topically as needed for dermatitis; - haloperidol - administer 0.5-1milliliter (mL) by mouth every 30 minutes up to three doses for severe delirium; - hydrocortisone acetate - apply a small amount topically to affected area once a day for itching; - hydroxyzine HCL 25 milligram (mg) - take one tablet by mouth three times a day as needed for anxiety; - hydroxyzine HCL -administer one tablet by mouth every six hours as needed for anxiety or itching; - hyoscyamine sulfate - administer one-two tablets on the tongue every four hours as need for bladder spasams/copious secretions; - ipratropium-albuterol - inhale one vial orally every six hours as needed for cough/wheezing; - lorazepam - administer one-two tablets by mouth every four hours as needed for anxiety or agitation; - morphine sulfate - administer 0.25-0.5 mg by mouth every four hours as needed for pain; - naloxone - administer 0.4mg IM, you can administer additional doses two-three minutes until emergency medical assistance arrives; - nystatin powder - apply to affected area twice a day; - ondansetron 4mg tablet - take one tablet by mouth every six hours as needed for nausea; - onelax - administer one suppository rectally as needed for constipation; - prochlorperazine - administer one tablet by	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01820	Continued From page 47 mouth every 12 hours as needed for nausea and vomiting; - senna 8.6 mg - administer two tablets by mouth as needed if no bowel movement in three days; and - trazadone 50 mg tablet - take one tablet by mouth every night at bedtime as needed. R1's records lacked signed physician's orders for the following medications: - acetaminophen - insert one suppository rectally every six hours as needed for fever or pain; - hydroxyzine HCL 25 mg - take one tablet by mouth three times a day as needed for anxiety; - naloxone - administer 0.4mg intramuscularly (IM), you can administer additional doses two-three minutes until emergency medical assistance arrives; - ondansetron 4mg tablet - take one tablet by mouth every six hours as needed for nausea; - onelax - administer one suppository rectally as needed for constipation; - prochlorperazine - administer one tablet by mouth every 12 hours as needed for nausea and vomiting; and - trazadone 50 mg tablet - take one tablet by mouth every night at bedtime as needed. On June 10, 2026, at 11:00 a.m., licensed assisted living director/registered nurse (LALD/RN)-B stated he is missing signed orders for several of R1's medications and this is because he thought you could use after visit or discharge summaries as orders, but realizes he needs signed provider orders and will need to contact the provider to get signed orders for all of R1's medications. R5 R5's was admitted to the licensee on September	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01820	Continued From page 48 6, 2023, with diagnoses which included chronic respiratory failure with hypoxia, type two (2) diabetes mellitus, bed confinement status with inability to walk and total dependence on cares and depression. R5's Service Plan signed October 14, 2024, indicated R5 received services which included medication administration. R5's MAR dated June 2026, included the following medications: - Arnuity Ellipta 100 microgram (mcg) - inhale one puff by mouth once daily for asthma; - Eliquis 5 mg tablet - take one tablet by mouth two times a day for blood clots; - Fluticasone 50 mcg - place two sprays into both nostrils daily for allergy symptoms; - Gabapentin 300 mg capsule - take one capsule by mouth twice a day for neuropathy (nerve pain); - lantus solostar 100 units/mL ijection - inject 40 units subcutaneously daily for diabetes; - levetiracetam 250 mg tablet - take one tablet by mouth twice a day for anti seizure; - metformin 500 mg ER tablet - Take two tablets by mouth every morning with a meal for diabetes; - Pramipexole 1 mg tablet - take one tablet by mouth once daily for restless legs; - simvastatin 10 mg tablet - take one tabletby mouth daily at bedtime for high cholesterol; - spironolactone 50 mg tablet - take one tablet by mouth daily to reduce fluid retention; - torsemide 20 mg tablet - take four tablets by mouth every morning to reduce fluid retention; - Ozempic 2mg/dose- Inject 2 mg subcutaneously weekly for diabetes; - quetiapine 200 mg tablet - take one tablet by mouth at bedtime for major depressive disorder; - acetaminophen 500 mg tablet - take one tablet by mouth four times a day as needed for pain;	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304			
(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
01820	Continued From page 49 and - hydromorphone 2 mg tablet - take one to two tablets by mouth twice a day as needed for pain. R5's records lacked signed physician's orders for any of the medications listed on the MAR. On June 10, 2026, at 2:15 p.m., LALD/RN-B stated he does not have signed orders for any of R5's medications but he has already contacted the provider to get signed orders. LALD/RN-B stated he would be missing some signed orders for all of the residents because he had been using after visit summaries (AVS) as orders and they are not signed so he will need to do an audit and make sure all residents have signed orders for all medications. The licensee's Prescriber's Orders policy dated March 22, 2024, indicated written orders from an authorized prescriber will be obtained for all medications and treatments with which the assisted living facility assist residents, including over the counter medications. All orders must be signed and dated by the prescriber. If the prescriber omitted a date, the facility will date the order when received from the prescriber. Medication orders will include the name of the medication, dosage, and directions for use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01880	Continued From page 50 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 the refrigerator storing medications maintained an acceptable temperature and medications were stored according to manufacturer's recommended temperature. In addition, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had the potential to affect all residents in the facility. 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: During the entrance conference on June 8, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director/registered nurse (LALD/RN)-B both stated they provided medication management services to all five residents at the facility. On June 10, 2026, during continuous observation from 8:15 a.m., through 9:10 a.m., the surveyor observed unlicensed personnel (ULP)-D administer two oral medications and one inhaler	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01880	Continued From page 51 to R6. ULP-D unlocked the medication cart, took out an unlabeled inhaler and two medication cards. ULP-D punched out the medications into a medication cup and placed the medication cards on top of the medication cart. ULP-D administered the medications to R6 and then placed the inhaler on top of the medication cart, without putting the medications back into the cart or locking the cart, ULP-D left the room to go into the bathroom to wash hands. ULP-D returned to the room and placed the medications back into the unlocked medication cart and rolled the cart to R1's bedroom. ULP-D left R1's bedroom without locking the cart and went to the bathroom to wash his hands and apply gloves. ULP-D returned to the bedroom and proceeded to take vital signs, blood glucose, and administer medications to R1. ULP-D then rolled the medication cart into the common/office area of the facility and proceeded to chart on the computer, without locking the cart ULP-D left the room to go into the kitchen. On June 10, 2026, at 9:30 a.m., LALD/RN-B approached the medication cart, opened the cart and looked at a medication, closed the cart and locked it. On June 10, 2026, at 9:45 a.m., LALD/RN-B stated ULP-D should not have left medication cards unsecured on top of the medication cart and left the room to go wash hands. LALD/RN-B stated that staff should always lock the medication cart before leaving the room. LALD/RN-B agreed ULP-D did not lock the medication cart before leaving the room to go into the kitchen and he locked the cart when he realized it was unlocked. On June 10, 2026, at 10:10 a.m., the surveyor	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304			
(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
01880	Continued From page 52 observed the locked medication room with LALD/RN-B and noted a medication refrigerator. The refrigerator contained four (4) Ozempic pens (injectable diabetic medication), twelve (12) Lantus pens (long acting insulin), and three (3) Humalog pens (fast acting insulin). The refrigerator also contained two thermometers, one that read 36° Fahrenheit (F) and the other that ready 28° F. LALD/RN-B confirmed the 28° F temperature reading. LALD/RN-B stated the reading was so cold because this thermometer was located right beside the freezer portion of the refrigerator but agreed the Humalog pens were also stored in the same area and more than likely have been out of temperature range. LALD/RN-B stated they used to keep a written temperature log daily, but they do not have a current log and the staff must not be doing the log any longer. The manufacturer's instructions for Ozempic dated June 2026, indicated store the unused pens in the refrigerator between 36° and 46° F. Do not freeze. The manufacturer's instructions for Lantus, last reviewed August 2022, indicated before opening, store unopened pens in a refrigerator between 36° and 46° F. Do not allow Lantus to freeze. Do not put Lantus in a freezer or next to a freezer pack. If you see frost or ice crystals in your Lantus solution, throw it away. The manufacturer's instructions Humalog, revised May 2025, indicated store unused pens in the refrigerator at 36° and 46° F. Do not freeze your insulin. Do not use if it has been frozen.	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304			
(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
01880	Continued From page 53 The licensee's Storage/Control of Medications policy dated March 22, 2024, indicated When licensee is providing storage of medications outside of the residents private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications. Medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separated from foods. Temperature is maintained at 35 to 40°. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=F	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 ensure time sensitive medications included the opened or expired date for one of three residents (R6) and failed to keep a medication in its original container bearing the original prescription label for three of three residents (R2, R5 and R6). This practice resulted in a level two violation (a	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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 54 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: R2 R2 was admitted to the licensee on February 12, 2026, with diagnoses which included type two (2) diabetes mellitus, chronic kidney disease stage three (3) requiring renal dialysis, essential hypertension and adjustment disorder with anxiety. R2's Service Plan signed February 12, 2026, indicated R2 received assistance which included medication administration and medication set up. R5 R5's was admitted to the licensee on September 6, 2023, with diagnoses which included chronic respiratory failure with hypoxia, type two (2) diabetes mellitus, bed confinement status with inability to walk and total dependence on cares and depression. R5's Service Plan signed October 14, 2024, indicated R5 received services which included medication administration. R6 R6 was admitted to the licensee on January 4, 2024, with diagnoses which included schizophrenia, type two (2) diabetes mellitus and chronic obstructive pulmonary disease (COPD).	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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 55 R6's Service Plan signed January 8, 2024, indicated R6 received services which included medication administration. On June 10, 2026, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-D administer an unlabeled inhaler to R6. ULP-D agreed the inhaler was not labeled with R6's name or prescription label but knows it is R6's because it is in R6's section. On June 10, 2026, at 9:45 a.m., the surveyor observed the medication cart with licensed assisted living director/registered nurse (LALD/RN)-B and observed the following: - R2's insulin lispro (Humalog) 100 unit/milliliter (mL) pen (fast acting insulin) lacked a prescription label; - R2's Lantus 100unit/mL pen (long acting insulin) lacked a prescription label; - R2's albuterol 108 micrograms (mcg) inhaler lacked a prescription label; - R5's Ozempic 8 milligrams (mg) /3mL pen (injectable diabetic medication) lacked a prescription label; - R5's Lantus 100unit/mL pen (long acting insulin) lacked a prescription label; - R5's Arnuity Ellipta 100 mcg inhaler lacked a prescription label; and - R6's Breo Ellipita 4mg inhaler lacked a prescription label. On June 10, 2026, at 9:45 a.m., LALD/RN-B confirmed R6's inhaler did not have an open date and the other medications did not have a name or prescription label on them but they should, and this is due to the original box for the inhalers was thrown away and the pens come out of a box that has a prescription label on them. LALD/RN-B	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304			
(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 56 agreed it is the nurse's responsibility to make sure all medications are labeled properly. The manufacturer's instructions for Breo Ellipita inhaler revised May 2023, indicated safely throw away Breo Ellipita in the trash six (6) weeks after you open the tray or when the counter reads "0", whichever comes first. Write the date you open the tray on the label. The licensee's Storage/Control of Medications policy, dated March 22, 2024, indicated Prescription drugs, prior to being set up for immediate or later administration, must be kept in the original container(s) in which they were dispensed by the pharmacy bearing the original prescription label with legible information. The medication is labeled completely and legibly. The medication label should contain the following: - prescription number and name of medication; - strength and quantity; - expiration date for time dated drugs; - directions for use; - resident's name; - prescriber's name; - date issued; and - name and address of licensed pharmacy issuing the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01940	Continued From page 57 services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304			
(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
01940	Continued From page 58 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: On June 10, 2026, at 8:40 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications, monitor blood glucose, obtain blood pressure reading and a pulse for R1. R1 was admitted to the licensee on December 10, 2025, with diagnoses which included bipolar disorder, antisocial personality disorder, acute kidney failure and type two (2) diabetes mellitus. R1's Service Plan dated December 10, 2025, indicated R1 received assistance with blood glucose monitoring. R1's undated Treatment Plan did not indicate R1 was receiving treatments or therapies to include blood glucose monitoring or oxygen management. The treatment and therapy plan lacked the following requirements regarding these treatments or therapies: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures For notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment or therapy	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01940	Continued From page 59 services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On June 10, 2026, at 10:40 a.m., licensed assisted living director/registered nurse (LALD/RN)-B stated the treatment plan for R1 was missing the oxygen management because it was only as needed so he did not think a treatment plan was needed. LALD/RN-B stated the blood glucose monitoring was not on the treatment plan because he did not realize blood glucose monitoring was a treatment but now that he realizes it is a treatment he will update the treatment plans, LALD/RN-B stated this would be the case for all the resident's that received blood glucose monitoring or other treatments. The licensee's Treatment & Therapy Management Plan policy dated March 22, 2024, indicated The RN or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: - type of service to be provided; - procedures for documenting treatments or therapies; - procedures for monitoring treatment or therapies to prevent possible complications or adverse reactions; - identification of treatment or therapy tasks delegated to unlicensed personnel; - procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service.	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01940	Continued From page 60 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident 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 record; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prior to delegating nursing tasks of treatment administration, unlicensed personnel (ULP) were trained in the proper methods to perform wound care and orthotic braces and the ULP had demonstrated competency back to the registered nurse (RN) for two of two unlicensed personnel (ULP-C and	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304			
(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
01950	Continued From page 61 ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: During the entrance conference on June 8, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director/registered nurse (LALD/RN)-B both stated they provided treatment management services to include wound care and orthotic braces. ULP-C was hired on March 23, 2026, to provide direct care services to residents. ULP-D was hired on June 4, 2025, to provide direct care services to residents. ULP-C and ULP-D's employee records lacked evidence that ULP-C and ULP-D had demonstrated competency back to the RN for wound care or orthotic braces. On June 10, 2026, at 3:55 p.m., licensed assisted living director/registered nurse (LALD/RN)-B these employees did not have competency evaluations for wound care and orthotic braces and he is not sure why they are missing but will need to do an audit of all the employee records to make sure all the employees have the required competencies.	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
01950	Continued From page 62 The licensee's Delegation of Assisted Living Tasks dated March 22, 2024, indicated The clinician may delegate procedures according to the following: - the clinician instructed the home health aide and proper methods to perform the procedure with respect to each resident; - the clinician provided the home health aide with written instructions specific to the resident; - the home health aide demonstrated to the clinician competence in the procedure; - the procedure is documented in the resident's clinical record; and - the home health aides competence is documented in his/her personnel file. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards related to hospital-style bed rails for two of two resident (R1 and R2) and with secure oxygen tank storage for	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
02310	Continued From page 63 two of three residents (R1 and R5). 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: HOSPITAL BED RAILS R1 On June 8, 2026, at 11:15 a.m., during a tour of the facility, the surveyor observed R1's bed rails attached to their hospital bed and unsecured oxygen tanks stored in the closet. R1 was admitted to the licensee on December 10, 2025, with diagnoses which included bipolar disorder, antisocial personality disorder, acute kidney failure and type two (2) diabetes mellitus. R1's Service Plan dated December 10, 2025, indicated R1 received assistance with bathing, dressing, grooming, incontinence care, housekeeping, laundry, meal assistance, medication administration, medication setup, repositioning, blood glucose monitoring, vital sign monitoring, safety check, socialization and transfer assistance. R1's Bed Safety Assessment dated May 4, 2026, included: - an assessment was completed; - measurements were completed and documented; and	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304			
(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
02310	Continued From page 64 - the rails were FDA complaint. R1's assessment lacked: - the risk vs. benefit were discussed and documented with the resident. R2 On June 8, 2026, at 11:15 a.m., during a tour of the facility, the surveyor observed R2's bed rails attached to their hospital bed. R2 was admitted to the licensee on February 12, 2026, with diagnoses which included type two (2) diabetes mellitus, chronic kidney disease stage three (3) requiring renal dialysis, essential hypertension and adjustment disorder with anxiety. R2's Service Plan signed February 12, 2026, indicated R2 received assistance with bathing, bedmaking, cleaning, dressing, equipment care, grooming, incontinence care, laundry, behavior management, meal tray, medication administration, med set up, oxygen delivery, blood glucose monitoring, vital sign monitoring, safety checks, transfer assistance and wound care. R2's Bed Safety Assessment dated May 30, 2026, included: - an assessment was completed; and - measurements were completed and documented. R2's assessment lacked: - the rails were FDA complaint; and - the risk vs. benefit were discussed and documented with the resident. On June 9, 2026, at 9:30 a.m., licensed assisted	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
02310	Continued From page 65 living director/registered nurse (LALD/RN)-B stated he agreed R2's bed rail assessment is missing if the bed rail is FDA compliant and also the risk vs. benefit discussion documentation and this might be the case for all the residents that have bed rails. On June 10, 2026, at 10:55 a.m., LALD/RN-B stated the bed rail assessment for R1 is missing the risk vs. benefit discussion documentation and this would be the case for all residents because he did not realize this was a requirement. The licensee's Side Rail Use policy dated March 22, 2024, indicated before implementing side rails for a resident, the RN will conduct a side rail assessment that includes the following: - Level of mobility, including bed mobility - Ability to transfer in and out of bed without assistance - Vision - Level of consciousness - Level of cognition - Physical health status - Presence of orthostatic hypotension - Incontinence - Pain - Uncontrolled body movement The RN will consider the resident and/or resident's representative's request for side rails during the evaluation. Results of the side rail assessment will be documented in the clinical record. The RN will discuss with the resident/resident's representative alternatives to the use of side rails. A physical therapy evaluation may be obtained, as appropriate. If the need for side rails is indicated and the resident/family agree to their use, the RN will provide education related to side rails: - Risks and benefits of the side rails will be	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
02310	Continued From page 66 discussed - If the manufacturer cannot be determined, this risk will be discussed with the resident and/or resident's representative or responsible party. The RN will document the purpose of the side rails, the education provided and the discussion with the resident/resident's representative(s) regarding the risks and benefits of the side rails as well as the preferences of the resident. The resident/resident's representative will co-sign the document agreeing to the benefits and risks of the side rails. The RN is responsible to ensure that the side rails in use are of a safe design and properly maintained. Portable side rails will be used consistent with the manufacturer's recommendations. The RN will verify that the side rails meet FDA guidelines and follow the manufacturer's recommendations related to the following: - The side rails, mattress and bed frame are compatible - The side rails are appropriate for the age, size and weight of the resident - The side rails are securely installed or attached to the bedframe according to the manufacturer's recommendations for the particular bed frame and side rails used - The manufacturer's guidelines should be accessible - As indicated, additional information will be obtained from the Consumer Product Safety Commission (CSPC) related toe side rails and any recalls The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 17, 2026, indicated, the nurse must abide by accepted health care standards, and the FDA	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
02310	Continued From page 67 requirements related to the safety of bedrails is one of those accepted standards. Best practice for documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail - Measurements - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks) - The resident's preferences - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements SECURE OXYGEN TANK STORAGE R5 On June 8, 2026, at 11:15 a.m., during a tour of the facility, the surveyor observed two unsecured oxygen tanks in the common/office area of the facility and R5's bedroom with several unsecured oxygen tanks in the closet. R5's was admitted to the licensee on September 6, 2023, with diagnoses which included chronic respiratory failure with hypoxia, type two (2) diabetes mellitus, bed confinement status with inability to walk and total dependence on cares and depression. R5's Service Plan dated October 14, 2024, indicated R5 received assistance with respiratory equipment care, oxygen delivery, grooming, incontinence care, laundry, behavior management, meal assistance, medication administration, repositioning, blood glucose monitoring, vital sign monitoring, wheelchair assistance and transfer assistance.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304			
(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
02310	Continued From page 68 On June 9, 2026, at 2:30 p.m., LALD/RN-B stated the two portable oxygen tanks in the common/office area and the tanks stored in R1 and R5's bedrooms are not stored in racks. LALD/RN-B stated he did not realize oxygen tanks needed to be stored in racks, but realizes this now and will contact the oxygen supply company to get racks for the tanks. The MDH Oxygen Cylinder Storage Requirements dated April 16, 2020, indicated based on the National Fire Protection Association, Standard 99 (NFPA 99), Health Care Facilities Code, noted a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
02320	Continued From page 69 review, the licensee failed to ensure the steps of the medication administration process were followed for one of one employee (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: During the entrance conference on June 8, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director/registered nurse (LALD/RN)-B both stated they provided medication management services to all five residents at the facility. On June 10, 2026, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-D administer two oral medications and one inhaler to R6. ULP-D used a paper copy of the medication administration record (MAR) instead of the computer system where the medication administration would be charted. ULP-D looked at the paper MAR one time to verify the names of the medications and unlocked the medication cart and took out an unlabeled inhaler and two medication cards. ULP-D punched out the medications from the cards into a medication cup and handed the cup and the inhaler to R6. ULP-D completed the medication administration and placed the medications back into the medication cart. ULP-D stated he does not know what the six	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
02320	Continued From page 70 rights and three checks of medication administration is and he was trained by the nurse. ULP-D stated he normally uses the computer to verify the medications but used the paper MAR today because the surveyor was observing him. ULP-D stated he charts the medications later in the computer after he finishes all the resident medication passes and always does the charting this way. On June 10, 2026, at 8:45 a.m., the surveyor observed ULP-D administer medications, monitor blood glucose and take vitals for R1. ULP-D used the paper MAR to verify the names of the medications one time and opened the medication cart and took out three medication cards. ULP-D took the tablets and placed them in a pill crusher and the one capsule he opened and poured the contents into the pill crusher. ULP-D stated R1 cannot swallow well, and they give him his medications crushed and with some food like applesauce. ULP-D stated the instructions to crush the medications for R1 are not on the MAR. ULP-D completed the medication administration and rolled the medication cart into the common/office area of the facility and started charting medications for all the residents. On June 10, 2026, at 9:45 a.m., LALD/RN-B stated he agreed ULP-D did not follow proper procedure for medication administration and should be completing the six right and three checks when administering medications. LALD/RN-B stated ULP-D should also be charting the medications in the computer as soon as the medication administration is completed and not charting later. The licensee's Delegation of Assisted Living Tasks policy dated March 22, 2024, indicated the	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304			
(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
02320	Continued From page 71 clinician (Registered Nurse or licensed health professional) is responsible for appropriately delegating tasks to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks in accordance with the appropriate Minnesota Practice Act. The licensee's Medication Administration policy dated March 22, 2024, indicated, Residents of [Licensee] are entitled to the safe administration of medications by qualified personnel according to a written Medication Management Plan. All staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to: - purpose - dosage - route - frequency - instructions related to the medication and specific to the residents, as appropriate - side effects - resident allergies to medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			
02430 SS=F	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when	02430			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304		
(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
02430	Continued From page 72 personal records are requested by any outside party. (b) Residents have the right to access their own records. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure residents' personal health and medical information was kept private. This had the potential to affect all residents residing at the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 8, 2026, at 10:00 a.m., the surveyor arrived at the facility was taken into a common/office area of the facility that contained a table where the surveyor was advised to set up workstation. The surveyor observed a dry erase board attached to the wall of the room located behind a desk, the board indicated each resident name with room numbers, allergies, appointments, diet information, and treatment information. On June 9, 2026, at 2:30p.m., licensed assisted living director/registered nurse (LALD/RN)-B stated the dry erase board with resident information should not be posted on the wall of	02430			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER OAKLAND ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17838 OAKLAND DRIVE NORTHEAST HAM LAKE, MN 55304			
(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
02430	Continued From page 73 the common room for anyone to see and is a Health Information Privacy Protection Act (HIAPPA) violation. The Minnesota Bill of Rights dated January 1, 2026, indicated residents have the right to have personal, financial, health, and medial information private. The licensee's Resident Confidentiality policy, dated March 22, 2024, indicated all resident information including personal, financial and medical data would be kept confidential. The policy indicated all employees shall adhere to the Assisted Living Bill of Rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02430			



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Oakland Assisted Living LLC
17838 OAKLAND DRIVE NORTHEAST
Ham Lake, MN 55304
Anoka County
Parcel:

Phone:

License Info

License: HFID 39894

Risk:
License:
Expires on:
CFPM: Nicodemus Wuantai Naimodu
CFPM #: 25381; Exp: 5/23/2029

Inspection Info

Report Number: F1051261153
Inspection Type: Full - Single
Date: 6/8/2026 Time: 11:30:00 AM
Duration: 30 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

MET WITH THE NURSE EVALUATOR, SARABETH REMKER.

DISCUSSED THE FOLLOWING WITH THE MANAGER, FAITH:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES
HANDWASHING & GLOVE USE/DISPOSAL
NOROVIRUS
DATEMARKING & DISPOSITION OF TCS FOOD
PEST CONTROL

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 St Cloud District Office inspection report number F1051261153 from 6/8/2026

Faith
Manager

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Page: 1

Establishment Info

Oakland Assisted Living LLC
Ham Lake
County/Group: Anoka County

Inspection Info

Report Number: F1051261153
Inspection Type: Full
Date: 6/8/2026
Time: 11:30:00 AM

Food Temperature: **Product/Item/Unit:** SLICED HAM; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 41 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL39894016	Date: 6/9/2026
Facility Name: Oakland Assisted Living LLC	
Facility Address: 17838 Oakland Dr. NE, Ham Lake, MN 55304	

☒ TAG IDENTIFICATION: 0775	
SCOPE/ SEVERITY: Level 2; Widespread	TIME PERIOD OF CORRECTION: Seven (7) days

1.

Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2.

A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

Comments: There was a tree growing directly outside of the egress window in resident room 3 which obstructed egress from the window. Vegetation should be cut back to allow access to the egress window and maintained such that the means of egress is not impeded.

3.

A working space of not less than 30 inches in width, 36 inches in depth and 78 inches in height shall be provided in front of electrical service equipment. Where the equipment is wider than 30 inches, the working space shall be not less than the width of the equipment. Storage of materials shall not be located within the designated working space. [Minn. Stat. 144G.45 subd. 2; MSFC 604.3]

Comments: Items were stored around the electrical panel in the garage which prevented ready access to the equipment. Space should be cleared in front of the panel and maintained such that there is an appropriate clearance to access the equipment.

4.

Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with

portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: Equipment in the mechanical room including the water softener was powered by an extension cord which showed signs of wear and damage. Extension cords should not be used in lieu of permanent wiring, and all wiring should be maintained in good condition free of damage.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

-
1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

Comments: The fire extinguishers provided throughout the facility did not have current annual service tags. Service tags indicated the fire extinguishers were last serviced in April 2025. Fire extinguishers also did not have records of monthly staff inspection. Fire extinguishers should receive annual inspection by a licensed contractor and monthly visual inspections by facility staff.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

-
1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are 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. [Minn. Stat. 144G.45 subd.2]

Comments:

The unit door to resident room 5 was damaged. The door should be repaired or replaced and maintained in proper condition.

The flooring in resident room 1 was damaged and peeling up. The flooring should be repaired and maintained in proper condition.

The hallway wall outside of resident room 1 was damaged and had a nail head sticking out where it might catch or snag on someone walking by. The walls should be repaired and maintained in a smooth condition and in a state of good repair.

The bathroom vent in the restroom near resident room 2 was not functional when tested. The vent fan should be restored to proper working order and should be maintained in a state of good repair.

The threshold of the flooring transitioning from resident room 3 to the hallway was peeling up and unstable. The floor should be repaired and maintained in flat and stable condition to prevent a tripping hazard.

An electrical junction box in the garage was not capped and exposed electrical wiring. The junction box should be properly covered to protect wiring.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide a site-specific plan for evacuation and staff actions included information that was not relevant to the building. Several documents were provided in the FSEP that included general information, but the information was not specific and was inaccurate for the facility. Site-specific and accurate employee plans for evacuation should be maintained and stored in a readily accessible location.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide resident procedures for evacuation to the surveyor during the survey. No documented resident procedures were located in the fire safety and evacuation plan (FSEP). Residents should be provided with site-specific procedures for evacuation during fire or similar emergencies.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include 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. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide unique resident needs for evacuation to the surveyor during the survey. Unique resident needs should be documented, and records should be maintained so that they are current and accurate so they may be used in the event of an emergency.

4. 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. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide documentation of resident training on the FSEP to the surveyor during the survey. Residents should be offered training on procedures for evacuation at least once per year.

5. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans (FSEP) upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide documentation of staff training on the FSEP to the surveyor during the survey. Staff should be trained on the FSEP on hire and at least twice per year thereafter.