Electronically Delivered

October 10, 2024

Licensee
Oaks
2201 7th Avenue North
Anoka, MN 55303

RE: Project Number(s) SL20534015

Dear Licensee:

On September 9, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 18, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-92900

HHH

Electronically Delivered

July 16, 2024

Licensee
Oaks
2201 7th Avenue North
Anoka, MN 55303

RE: Project Number(s) SL20534015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 18, 2024, 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 . . ."

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

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

The correction order documentation should include the following:

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

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

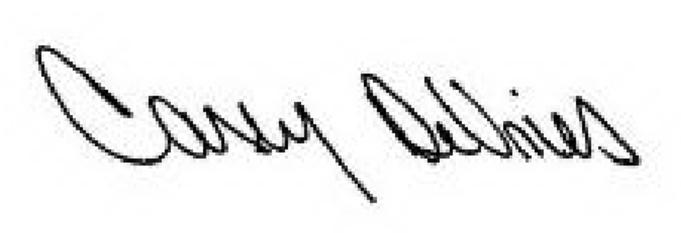
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20534	A. BUILDING: _____ B. WING _____	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS	2201 7TH AVENUE NORTH ANOKA, MN 55303

(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: SL20534015-0 On June 17, 2024, through June 18, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 8 residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 17, 2024, for the specific Minnesota Food Code deficiencies. The Inspection Report was provided to the licensee on June 18, 2024. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	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	0 510		

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0 510	Continued From page 2 nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with acceptable food contamination code when licensed assisted living director (LALD)-D shared their partially eaten food with a resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: Minnesota Administrative Rules, Contaminated Food rule 4626.0445, published on January 2, 2019, indicated, "Food that is contaminated by food employees, consumers, or other persons through contact with hands, bodily discharges, including nasal or oral discharges, or other means must be discarded."	0 510		

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0 510	Continued From page 3 LALD-D was hired on January 6, 2020, to perform administrative duties for the licensee. On June 17, 2024, at 1:35 p.m., the surveyor observed LALD-D eating their lunch which included macaroni and cheese in a round plastic storage container. LALD-D was observed using a fork and and repeatedly dipping it into the macaroni between bites. LALD-D finished approximately half of the container of macaroni before offering the leftover quantity to R4. R4 accepted the offer; LALD-D went to get R4 a clean fork. The surveyor observed R4 eating LALD-D's leftover macaroni. On June 17, 2024, at 2:00 p.m., LALD-D stated they probably should not have shared their partially eaten food with R4. LALD-D stated it feels so much like a family at the facility and wanted to share what they were not going to finish eating. LALD-D stated in hind sight, they should not have shared their partially eaten food and will not do it again in the future. LALD-D stated they understood the infection control risks sharing food posed for resident safety. The licensee's 8.01 Infection Control Policy dated April 25, 2023, indicated, ""Droplet precautions" refers to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions." It further indicated, ""Standard Precautions": infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Standard precautions is based on the principle that all blood, body fluids, secretions, excretions except sweat, regardless of whether they contain visible blood, non-intact skin, and mucous membranes may contain	0 510		

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0 510	Continued From page 4 transmissible infectious agents." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required orientation training documentation was included	0 650		

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0 650	Continued From page 5 in employee records for one of two employees (clinical nurse supervisor (CNS)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: CNS-A was hired on August 6, 2014, to provide oversight to ULPs and direct cares for residents. On June 17 and 18, 2024, the surveyor observed CNS-A performing their duties, interacting with staff and residents throughout the survey. CNS-A's employee record lacked required documentation for the following orientation topics: -overview of assisted living statutes; -handling of resident complaints, reporting complaints, where to report; and -consumer advocacy services. On June 17, 2024, at 12:17 p.m., licensed assisted living director (LALD)-E stated they were unable to locate required orientation training documents for CNS-A. LALD-E stated CNS-A had completed the required orientation topics but their main office staff could not find the documentation. On June 17, 2024, at 1:10 p.m., CNS-A stated they did complete the required orientation training topics.	0 650		

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0 650	Continued From page 6 The licensee's 5.10 Training Records policy last updated on September 26, 2023, indicated, "[licensee] will maintain a record of staff training and competency required." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	0 800		

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0 800	Continued From page 7 a large portion or all of the residents). Findings include: On a facility tour on June 17, 2024, at 11:00 a.m., with maintenance (M)-G, the surveyor made the following observations of facility disrepair: The drywall wall covering was missing on the left wall facing the clothes washing machine. During the tour M-G, stated the drywall was not re-installed after the new shower was installed. There was no trim installed on the metal door frames of resident room number 1 and 2 exposing sharp edges of metal around the perimeter of the door frame. The window crank handle was broken and missing the knob on the emergency escape and rescue window in resident room number 3, the window does open as required. The doorstop was broken, door hardware damaged and door latch strike plate was missing on resident room number 3 door. The light fixture globe/ covers were missing on the light in the hallway next to the basement kitchen and in the closet in the basement next to the stairway. Light fixture covers are required to be maintained and installed according to manufactures instructions and listings. The air conditioning condensate drain hose was to short and leaking water on top of the faucet and behind the sink in the closet in the basement next to the stairs. The condensate drain water is required to be discharged into the sink and held in place, so the water goes into the drain.	0 800		

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0 800	Continued From page 8 The carpet on the basement stairs is dirty and has ground in dirt from foot traffic and lack of regular cleaning. During a facility tour on June 17, 2024, at 11:45 p.m., M-G, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 820		

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0 820	Continued From page 9 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on June 17, 2024, at 12:20 p.m., with maintenance (M)-G, the following distinct hazards were observed: The window well for the emergency escape and rescue opening in resident room number 7 measured 29.5 inches in width and 41.5 inches in length and 8.5 square inches in total horizontal floor area. Emergency escape and rescue opening window area wells are required to have at least 9 square feet horizontal total floor area and a minimum dimension of 36 inches. There was a plastic container next to the building on the back patio with used cigarette butts discarded in it. There was also used cigarette butts discarded next to the driveway at the front of the garage. There was an appropriate cigarette butt disposal container located near the back patio. Used cigarette butts are required to be discarded in the appropriate disposal container in accordance with the facility smoking policy. There was carpet installed on the walls in the corridor upstairs near resident rooms 1, 2 and 3. Interior wall finish materials are required to meet specific surface burning a smoke developed characteristics. These deficient conditions were visually verified by M-G accompanying on the tour.	0 820		

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0 820	Continued From page 10 TIME PERIOD FOR CORRECTION: Two (2) days.	0 820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor the temperature of their medication storage refrigerator to ensure medications were stored according to manufacturer directions for five of five resident (R2, R3, R4, R5, R6) with refrigerated medications. 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: R2 R2 was admitted to the licensee on August 30, 2019, and had a diagnosis of type two diabetes. R2's Client Service Plan dated December 27, 2023, indicated R2 received medication	01880		

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01880	Continued From page 11 administration with sliding scale insulin (insulin dose adjustments based on BG results) administration. R2's Med-Pass medication administration record (MAR) for June 2024, indicated R2 took the following medication: -Lantus 100 units (u)/milliliter (ml), give 54 u subcutaneously (SQ) daily for diabetes; and -Trulicity 100 u/ml 3.0 milligram (mg)/0.5 ml Pen, one time weekly on Wednesdays for diabetes. On June 18, 2024, the surveyor observed unlicensed personnel (ULP)-B administer R2's medications. R3 R3 was admitted to the licensee on September 28, 2023, and had a diagnosis of chronic kidney disease (CKD). R3's Client Service Plan dated June 4, 2024, indicated R3 received medication administration. R3's Med-Pass MAR for June 2024, indicated R3 took the following medication: -patiromer calcium sorbitex (Veltassa) 16.8 gram (g) packet mix, take one packet in liquid by mouth (PO) once daily, take with lunch three hours apart from morning medications, for hyperkalemia, "Keep in med fridge". R4 R4 was admitted to the licensee on August 14, 2017, and had a diagnosis of type two diabetes. R4's Client Service Plan dated May 14, 2024, indicated R4 received medication administration which included SQ injections.	01880		

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01880	Continued From page 12 R4's Med-Pass MAR for June 2024, indicated R4 took the following medication: -epinephrine injection auto-injector 0.3 mg, four pens; use as needed (PRN) for allergic reaction, bee allergy, "In Med Fridge". R5 R5 was admitted to the licensee on February 27, 2023, and had a diagnosis of type two diabetes. R5's Client Service Plan dated January 23, 2024, indicated R5 received medication administration which included SQ injections with sliding scale insulin for diabetes. R5's Med-Pass MAR for June 2024, indicated R5 took the following medication: -Novolog (insulin aspart) 10 ml vial, inject at mealtimes and bedtime per sliding scale for BG 70-149 no insulin, 2 u for BG 150-199, 4 u for BG 200-249, 6 u for BG 250-299, 8 u for BG 300-349, 10 u for BG 350-399, 12 u for BG 400 or great and call nurse for diabetes; and -Ozempic (semaglutide) injection, inject 2 mg SQ weekly on Monday for diabetes. R6 R6 was admitted to the licensee on September 11, 2019, and had a diagnosis of multiple sclerosis (MS). R6's Client Service Plan dated May 14, 2024, indicated R6 received medication administration which included SQ injections. R6's Med-Pass MAR for June 2024, indicated R6 took the following medication: -Glatiramer Acetate injection 40 mg/ml, inject 1 ml SQ on Monday/Wednesday/Friday at 8:00 a.m. for MS.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20534	A. BUILDING: _____ B. WING _____	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS	2201 7TH AVENUE NORTH ANOKA, MN 55303

(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 13 On June 18, 2024, at 9:00 a.m., the surveyor observed the locked medication refrigerator with clinical nurse supervisor (CNS)-A in the kitchen. A blue sign was taped to the front of the medication refrigerator which indicated, "Please remember to document Med Fridge Temp twice daily :)" The round classic thermometer inside the refrigerator read 32 degrees Fahrenheit (F). The refrigerator contained the following medications: -R2 Lantus 100 u/ml vial, give 54 u SQ daily, three vials; -R2 Trulicity 100 u/ml 3.0 mg/0.5 ml Pen, one time weekly on Wednesdays, seven single dose injector pens; -R3 Veltassa 16.8 g pack quantity 30; mix one packet in liquid then take PO daily, take with lunch three hours apart from morning medications; -R4 Amneal epinephrine injection auto-injector 0.3 mg, four pens; use as needed (PRN) for allergic reaction, bee allergy; -R4 Tresiba FlexTouch (insulin degludec) injection 100 u/ml prefilled pen, one FlexTouch pen; inject 28 u once daily; -R5 Novolog (insulin aspart) 10 ml vial, inject at mealtimes and bedtime per sliding scale; -R5 Ozempic (semaglutide) injection prefilled pens 8 mg/3 ml, inject 2 mg SQ weekly; -R6 Glatiramer Acetate injection 40 mg/ml, inject 1 ml SQ on Monday/Wednesday/Friday at 8:00 a.m., 12 single-dose prefilled syringes. The licensee's Medication Refrigerator temperature log form for June 2024, indicated the refrigerator temperature, "Safe Zone is between 36-46 degrees F." The temperature log form had four columns to be filled in for date, time, temperature and staff signature. The June refrigerator temperature log was below 36	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20534	A. BUILDING: _____ B. WING _____	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS	2201 7TH AVENUE NORTH ANOKA, MN 55303

(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 14 degrees F on the following dates: -June 1, 2, 4, 6-8, 10, 11, 13-15, 17, and 18; on seven of these days the temperature was below freezing with a low of 26 degrees F. On June 18, 2024, at 9:25 a.m., CNS-A stated the medication refrigerator temperature should be between 36 and 46 degrees F. CNS-A stated they switched to only checking the medication refrigerator's temperature to one time per day. Licensed practical nurse (LPN)-F stated anyone was allowed to check the medication refrigerator temperature. LPN-F stated they signed off on today's (June 18, 2024) temperature which was 29 degrees F and took no action to correct the low temperature. LPN-F stated, in general, actions to correct low temperatures were not documented. CNS-A stated no actions had been taken for any of the temperatures outside of the acceptable range of 36 to 46 degrees F on the June refrigerator temperature log. The surveyor observed the medication refrigerator a second time with licensed assisted living director (LALD)-D and CNS-A and inspected the freezer shelf. The freezer shelf was covered with a thick layer of ice which was directly above the medications and thermometer. Manufacturer instructions for Lantus, last revised on June 2023, indicated store unused Lantus in a refrigerator between 36-46 degrees F; discard if Lantus has been frozen. Manufacturer instructions for Trulicity , last revised April 2023, indicated to store pens in the refrigerator between 36 and 46 degrees F; do not freeze and if the pen has been frozen, throw the pen away and use a new pen. You may store your pen at room temperature for a total of 14 days.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20534	A. BUILDING: _____ B. WING _____	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS	2201 7TH AVENUE NORTH ANOKA, MN 55303

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01880	Continued From page 15 Manufacturer instructions for Veltassa 16.8 g dated December 2016, indicated it should be refrigerated, you can store it at room temperature for up to three months. Manufacturer instructions for Amneal Pharmaceuticals Epinephrine injector, last revised in March 2021, indicated to store at room temperature between 68 to 77 degrees F. Do not store in the refrigerator or freezer. Manufacturer instructions for Tresiba FlexTouch (insulin degludec), found on the box in the refrigerator, indicated to keep in a cold place until first use, store at 36 to 46 degrees F; do not freeze. Manufacturer instructions for Novolog (insulin aspart), last revised in March 2023, indicated to store unused vials in the refrigerator at 36-46 degrees F; do not freeze and do not use if it has been frozen. Manufacturer instructions for Ozempic pens, last revised September 2023, indicated to store unused pens in the refrigerator at 36-46 degrees F; do not freeze and do not use if it has been frozen. Manufacturer instructions for glatiramer acetate injection, last revised January 2024, indicated to store in the refrigerator at 36-46 degrees F; do not freeze and discard if it is frozen. The licensee's 7.11 Medication Storage policy dated April 24, 2023, indicated: "-Medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen) -Medication storage refrigerator temperatures will	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01880	Continued From page 16 be checked daily by staff. The findings will be documented, if the temperature is not in the ideal temperature range as documented on the temperature log staff will notify either the house or on call nurse for further direction. The nurse will notify maintenance as needed." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *06/17/24*
Time: 09:51:31
Report: 1029241186

Food and Beverage Establishment Inspection Report

Location:

The Oaks
2201 7th Avenue North
Anoka, MN55303
Anoka County, 02

Establishment Info:

ID #: 0038518
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7637128363
ID #:

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

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

SOME EQUIPMENT AND UTENSILS HANDWASHED AND AIR-DRIED WITHOUT SANITIZING. CORRECTED DURING INSPECTION. ITEMS PLACED IN DISHWASHER WITH SANITIZE CYCLE. INSTRUCTED REP TO DISCONTINUE PRACTICE.

Comply By: 06/17/24

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

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

NO MEANS OF TESTING SANITIZING TEMPERATURE IN DISHWASHER. INSTRUCTED REP TO OBTAIN MEANS OF TESTING HIGH TEMPERATURE SUCH AS THERMAL STICKERS OR A MIN/MAX THERMOMETER.

Comply By: 06/25/24

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

HANDWASHING SINK USED FOR DISHES. INSTRUCTED REP TO ONLY USE FOR HANDWASHING.

Comply By: 06/17/24

4-900 Protecting Clean Items

4-903.11B

MN Rule 4626.0955B Store all clean equipment and utensils in a self-draining position that permits air drying, and covered or inverted.

UTENSILS AND EQUIPMENT DRYING ON ABSORBENT CLOTH. CORRECTED DURING INSPECTION. INSTRUCTED REP TO NOT USE ABSORBENT MATERIAL FOR AIR DRYING.

Comply By: 06/17/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

LAMINATE COVERING MDF IN CABINETRY PARTIALLY OR ENTIRELY MISSING. INSTRUCTED REP TO REPAIR OR REPLACE.

Comply By: 06/28/24

Surface and Equipment Sanitizers

QUATERNARY AMMONIUM: = 400 PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

HOT WATER: = at ~158 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: DOWNSTAIRS REFRIGERATOR
Violation Issued: No

Process/Item: MILK
Temperature: 40 Degrees Fahrenheit - Location: UPSTAIRS REFRIGERATOR
Violation Issued: No

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

Discussed employee illness procedures, vomit/fecal matter cleanup, common reportable foodborne illness pathogens and common signs of foodborne illness, datemarking, delivery and holding temperatures, same day service and exclusion of raw or undercooked animal proteins for highly susceptible populations. Dishwasher is NSF/ANSI Standard 184 with a SaniRinse option. Manual indicated a final rinse temperature of 156°F. Establishment without means to test high temperature. A thermal sticker was provided which indicated a temperature that exceeded 150°F and approached 160°F. All identified issues discussed with representatives throughout the inspection.

CFPM certificate expires in few days on June 22nd. Establishment was instructed to ensure a CFPM is employed by having the current CFPM renew prior to expiration or by having a different staff member obtain a CFPM certificate.

Type: Full
Date: *06/17/24*
Time: 09:51:31
Report: 1029241186
The Oaks

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1029241186 of 06/17/24.

Certified Food Protection Manager: NICOLE ALDES

Certification Number: FM107381 Expires: 06/22/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
NICOLE ALDES
LALD

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