Electronically Delivered

August 19, 2026

Licensee
Oaks
2201 7th Avenue North
Anoka, MN 55303

RE: Project Number(s) SL20534016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 17, 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.

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

STATE CORRECTION ORDERS

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

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 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. 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,

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

KKM

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 _____	07/17/2026

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: SL20534016-0 On July 13, 2026, through July, 15, 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 resident(s); all of whom were receiving services under the assisted living facility license.	0 000		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;	0 680		

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0 680	Continued From page 1 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required contents. This had the potential to affect all five residents, staff and visitors to 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's EP plan dated January 30, 2026, lacked the following:	0 680		

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0 680	Continued From page 2 -A method for tracking staff during an evacuation -A Hazard Vulnerability Analysis (HVA) During an interview on July 13, 2026 at 1:30 p.m., assisted living director in residence (ALDIR)-C stated the licensee did not have a process for tracking staff during an evacuation and was unsure where to find a HVA. During an interview on July 14, 2026 at 8:15 a.m., ALDIR-C provided an undated printed HVA which did not include the licensee name or location. ALDIR-C stated she printed it at the parent company office the previous day and stated it should have been placed in the EP binder when it was reviewed in January 2026. The licensee's policies for disaster planning and emergency preparedness dated January 30, 2026, included the plan would be printed and based off an assisted living-based and community-based risk assessment which utilized an all-hazards approach. The plan would include evacuation, sheltering in place, relocation sites and staff assignments in the event of a disaster or emergency. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=D	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall	0 700		

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0 700	Continued From page 3 establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private for one of five 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: On July 14, 2026, at 8:21 a.m., the surveyor observed unlicensed personnel (ULP)-B complete a medication pass for R5 and then leaving the medication administration record (MAR) binder open to R5's medication record, ULP-B walked to another part of the facility to provide cares to another resident. At 8:23 a.m., licensed practical nurse (LPN)-C closed the MAR binder. On July 14, 2026, at 11:36 a.m., surveyor observed ULP-B give insulin to R4. ULP-B wrote in MAR, and then left the MAR open on the table and went into another room of the facility. There were two residents and one staff in the common area with the MAR.	0 700		

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0 700	Continued From page 4 On July 14, 2026, at 12:04 p.m., ULP-B stated, "We are trained to keep their information confidential. I should have closed the book, I forgot." The licensee's 2.35 Resident Record-Access & Storage policy, dated June 6, 2022, indicated, "Resident records will be kept confidential and locked in a secured area where only authorized staff of [Licensee] will have access. Records will be readily available to employees and contractors authorized to access the records at [Licensee]." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
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	0 775		

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0 775	Continued From page 5 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 14, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
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	0 800		

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0 800	Continued From page 6 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 14, 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.	0 810		

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0 810	Continued From page 7 (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill 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 14, 2026, for the specific violations related the	0 810		

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0 810	Continued From page 8 physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 14, 2026 at 11:30 a.m., unlicensed personnel (ULP)-B unlocked the medication refrigerator located in a common room to remove pre-drawn insulin for resident (R4). ULP-B replaced lock on medication refrigerator, but did	01880		

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01880	Continued From page 9 not engage lock. ULP-B left common room with medication refrigerator unlocked with two residents and one staff person in the common room. ULP-B placed pre-drawn insulin syringes on dresser in R4's room and left the room to get a pair of gloves for administration of medication. ULP-B closed R4's door upon exit with insulin left in room unattended. Upon return, ULP-B administered medication and returned the unused pre-drawn insulin syringes to the medication refrigerator. Medication refrigerator had been locked while ULP-B was out of the common room administering insulin. During interview on July 14, 2026 at 1:40 p.m., licensed practical nurse (LPN)-F stated she locked the medication refrigerator where pre-drawn insulin syringes were stored because she noticed it was left unlocked and unattended. During interview on July 14, 2026 at 2:15 p.m., clinical nurse supervisor (CNS)-D stated all medications should be in a locked room or refrigerator whenever the staff person is not in direct eyesight of the medications. CNS-D stated medications should not have been left in a resident's room unattended and should have been brought with the staff if they had to leave the room. Medication refrigerator had medication for two residents which included: -Lantus insulin bottles -Novolog insulin bottles -Pre-drawn up syringes of Lantus insulin and NovoLog insulin -Ozempic injection -Trulicity injections Licensee policy for medication storage dated	01880		

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01880	Continued From page 10 February 11, 2026, included medications must be in a securely locked and substantially constructed compartment and permit only authorized personnel to have access. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee established a facility Client Handbook that used language which limited the rights for one of one resident (R2). This had the potential to affect all residents residing within 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:	02290		

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02290	Continued From page 11 On July 13, 2026, at 2:15 p.m., while reviewing R2's resident file, the surveyor observed the licensee's Client Handbook. The Client Handbook read, "Alcohol and illegal drugs are prohibited for use on [licensee] property for any reason." as well as, "You are allowed to receive deliveries. WPAL may inspect packages for illegal substances and weapons." The Client Handbook also addressed, "Food is not allowed to be stored in rooms." as well as, "Clients must always wear socially appropriate clothing when outside of their rooms. Socially appropriate clothing may be defined as: -Appropriately fitting tops (example: shirts) and bottoms (example: shorts, pants, skirts) -Tops and bottoms that cover personal areas; undergarments are appropriately colored to be concealed and covered -Shoes, slippers, socks, or other footwear (sic)" On July 14, 2026, at 12:17 p.m., assisted living director in residance (ALDIR)-C stated, "We use that contract and house rules for all the residents, We are an alcohol free site so nobody is allowed alcohol, the food in room rule, that one is taken case by case because some people we do but if there are mice or other issues or if someone has high blood sugars and we can't control then we don't let them have food in their room. As for the packages, well, that would be another case-by-case basis, because we have had clients that we have had issues with, so we have it written in there to cover us so that we can inspect their packages as we need to. We require all residents when they come out of their rooms that they are properly dressed, it is very much a hygienic issue, so they must wear proper clothing, but if a guy wants to have his shirt off in his room behind closed doors he can."	02290		

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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
02290	Continued From page 12 On July 14, 2026, at 12:32 p.m., ALDIR-C stated,"I double checked with my boss and it is a case-by-case situation. We go through what they are not agreeing to in the client hand book and see if we can fix it or agree to change the rules and if not, like with the alcohol, we are a no alcohol facility so if they can't agree to that, than we may choose not to move them in." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02290		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Oaks ALF
2201 7th Ave N
Anoka, MN 55303
Anoka County
Parcel:

Phone:

License Info

License: HFID 20534

Risk:
License:
Expires on:
CFPM: BERINDA ANN STANLEY
CFPM #: FM68059; Exp: 03/08/2029

Inspection Info

Report Number: F8087261129
Inspection Type: Full - Single
Date: 7/14/2026 Time: 3:30 PM
Duration: 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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF HRD NURSE EVALUATOR TESA BROWN.

THE FOLLOWING OBSERVATIONS WERE MADE:

CEILING: POPCORN - NON COMPLIANT
FLOORS: LINOLEUM - NON COMPLIANT
COUNTERTOPS: QUARTZ - COMPLIANT
CABINETS: WOOD - NON COMPLIANT
REFRIGERATOR/FREEZER: UNKNOWN
DISHWASHER: WHIRLPOOL
STOVE/RANGE: AMANA
MICROWAVE: WHIRLPOOL
HAND WASHING SINK: YES - LEFT SIDE OF 2-BIN STAINLESS STEEL KITCHEN SINK

NON COMPLIANT CEILING, FLOOR, AND CABINETS ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION. TEMPERATURE STICKERS USED TO ENSURE UTENSIL SURFACE TEMPERATURES REACH 165.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

INSPECTION REPORT EMAILED TO FACILITY AND HRD NURSE SURVEYOR.

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 Metro District Office inspection report number F8087261129 from 7/14/2026

John Boettcher

BERINDA ANN STANLEY
CFPM

John Boettcher,
Public Health Sanitarian 3
651-201-5076
john.boettcher@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

Oaks ALF
Anoka
County/Group: Anoka County

Inspection Info

Report Number: F8087261129
Inspection Type: Full
Date: 7/14/2026
Time: 3:30 PM

Equipment Temperature: **Product/Item/Unit:** AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Freezer at 3 Degrees F.
Comment: DINING ROOM FREEZER
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Cooler at 38 Degrees F.
Comment: DINING ROOM FRIDGE
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** YOGURT**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment: DINING ROOM FRIDGE
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 39 Degrees F.
Comment: DINING ROOM FRIDGE
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** CHEESE**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment: DINING ROOM FRIDGE
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Freezer at -2 Degrees F.
Comment: MAIN KITCHEN FREEZER
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Cooler at 38 Degrees F.
Comment: MAIN KITCHEN FRIDGE
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment: MAIN KITCHEN FRIDGE
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** DELI MEAT**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 37 Degrees F.
Comment: MAIN KITCHEN FRIDGE
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** CHEESE**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 39 Degrees F.
Comment: MAIN KITCHEN FRIDGE
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL20534016	**Date:** 7/14/2026
Facility Name: Oaks	
Facility Address: 2201 7th Ave N, Anoka, MN 55303	

☒ **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. 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:

   An extension cord was in use in the front office of the facility to power computers and office equipment. Extension cords should not be used in lieu of permanent wiring.

   An extension cord was in use in resident room 3 to power several devices. Extension cords should not be used in lieu of permanent wiring.

3. Listed single and multiple-station smoke alarms complying with UL 217 shall be installed. [Minn. Stat. 144G.45 subd. 2; MSFC 907.2.10]

   Comments: Smoke alarms installed throughout the facility were not properly listed for use. The surveyor requested documentation, but facility staff were unable to provide documents indicating that the alarms were listed to underwriters laboratory (UL) standard 217. The user manual for the smoke alarms was accessed online and failed to indicate that the alarms complied with UL 217. Properly rated alarms should be installed and maintained.

4. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

   Comments: Battery operated smoke alarms were installed over hardwired smoke alarm mounts. Hardwired smoke alarms must be maintained with the provided power source.

5. 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:

   The egress window in resident room 6 was obstructed by a chair that was stored in front of the window, preventing ready operation of the window. The chair should be moved away from the window, and the window should be maintained free of obstruction.

   The marked exit door in the living room was blocked by a cart that was stored in front of the exit. The path of egress should be maintained free of obstruction.

6. Clothes dryers and their exhaust systems shall be cleaned as necessary to keep lint traps, exhaust ducts, and mechanical and heating components free from excessive lint accumulation. [Minn. Stat. 144G.45 subd. 2; MSFC 304.4]

   Comments: There was a significant amount of lint that had accumulated behind the clothing dryer. The lint should be removed, and the dryer should be maintained free of lint accumulation.

7. Occupancy separation shall be provided in Group I and Group R occupancies. Existing wood lath and plaster in good condition or ½ inch gypsum wallboard is acceptable where one hour occupancy separations are required. [Minn. Stat. 144G.45 subd. 2; MSFC 1105.2]

   Comments: The top of the wall separating the attached garage from the living portion of the facility did not have proper required separation. The top section of the wall in the garage was missing section of drywall at the top which would provide fire separation between the garage and the rest of the facility. The fire separation of the garage wall should be restored and maintained to limit fire spread between the garage and main portion of the building.

☒ **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 window crank on the casement window in the basement common room was broken and did not function properly. The crank was disconnected from the window assembly. The crank hardware should be repaired and maintained in a proper state of repair.

   The bedside table in resident room 5 was missing a handle or knob hardware that had come loose from the drawer. The opening hardware should be reinstalled and maintained in working order.

   The grout along the base of the shower in the basement bathroom was discolored and sullied. The edges along the base of the shower were dirty and not properly maintained. The shower should be cleaned and maintained in a sanitary condition.

   The ceiling paint in the basement bathroom was peeling and flaking. The ceiling should be repaired and maintained in proper condition.

   The window crank on the casement window in the upper-level common room was broken and did not function properly. The crank was disconnected from the window assembly. The crank hardware should be repaired and maintained in a proper state of repair.

   Window screens were missing from the bedroom window in resident room 4. Window screens should be replaced and maintained.

   The floor was damaged and worn in resident room 4. The floor should be repaired and maintained in a safe and smooth manner.

   The handle to the unit door of resident room 4 was damaged and did not function properly. The door handle should be repaired and maintained in operable condition.

   The walls of the facility showed wear and damage throughout. The walls should be repaired and maintained free of damage.

There was a puddle of water behind the washing machine and evidence of a leak. The leaking plumbing should be repaired and maintained in proper working order.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) 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 appropriate employee actions for evacuation. Several conflicting policies were provided to the surveyor during the survey, but the policies were not site-specific. The facility should develop and maintain a site-specific policy for evacuation.

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

   Comments: The licensee failed to provide resident actions for evacuation. No resident actions for evacuation were located in the FSEP. Site-specific resident actions for evacuation should be developed and maintained.