Electronically Delivered

June 3, 2026

Licensee
Ostrander Assisted Living
309 Minnesota Street
Ostrander, MN 55961

RE: Project Number(s) SL30336016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 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 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

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. 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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 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
	30336	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSTRANDER ASSISTED LIVING	309 MINNESOTA STREET OSTRANDER, MN 55961

(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: SL30336016-0 On May 11, 2026, through May 12, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents; zero receiving services under the Assisted Living Facility license. 1290: An immediate order was issued on May 11, 2026, at a level 3/Widespread (I). The licensee took action on May 11, 2026; however, the scope and level remain at I.	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.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (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 ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R1). Furthermore, the licensee failed to update an IAPP to accurately reflect known vulnerabilities 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1 received services under the licensee's assisted living license from January 30, 2026, through March 6, 2026, with diagnoses including myelodysplastic syndrome (bone marrow	0 630		

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0 630	Continued From page 2 produces abnormal blood cells that fail to mature properly, leading to anemia, chronic infections, and bleeding problems), chronic obstructive pulmonary disease (COPD-chronic lung disease), and a recent right hip fracture. R1's record included a care plan dated January 30, 2026, that indicated she received services including supervision with showering and daily assistance with bilateral lower extremity compression wraps for swelling. R1's record lacked a signed Service Plan/Agreement to include the services the licensee provided. R1's record lacked an IAPP with the required content to include 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. On May 12, 2026, at 12:25 p.m., clinical nurse supervisor (CNS)-A stated R1 received services from January 30, 2026, to March 6, 2026, and further stated a hard copy IAPP was developed at the time of her admission for respite services; however, she could not find the hard copy chart following R1's discharge and the IAPP didn't appear to have been uploaded to the licensee's electronic medical record (EMR) system. R2 R2 was admitted to the assisted living facility on January 18, 2021, with diagnoses including	0 630		

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0 630	Continued From page 3 Wernicke's encephalopathy (life-threatening neurological condition caused by a thiamine (vitamin B1) deficiency. It can lead to symptoms such as lack of muscle coordination, irregular eye movements, and confusion). R2's signed housing contract dated July 30, 2021, indicated the licensee provided only housing services for R2. On April 9, 2026, the licensee filed a Minnesota Adult Abuse Reporting Center (MAARC) report regarding an incident on April 8, 2026, where R2 had gone to a local bar, became intoxicated and fell. He had another fall that day in the facility. The MAARC report indicated R2's alcohol consumption posed a risk to his health. The report also indicated the licensee's action taken was that R2 was to notify the licensee when he was going to the bar so that they could "keep an eye out for him and go get him if needed." R2's IAPP dated March 6, 2026, indicated R2 had vulnerabilities and interventions including: -financial exploitation with an intervention including the licensee's business office staff assistance with his checkbook and writing checks -self-abuse-with the note of "alcohol abuse"-no interventions -vulnerable with safe ambulation with/without assistive devices with an intervention of uses a cane with reflective tape -vulnerable to range of motion limitations and pain with note of bilateral knee arthritis-no interventions -vulnerable with vision with note "legally blind, sees shadows"- no interventions -vulnerable to use of telephone with intervention of "staff help to dial the number" -vulnerable to alcohol and substance abuse with	0 630		

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0 630	Continued From page 4 note "walks to bars uptown" R2's IAPP also indicated both: -resident does not have the risk of maltreatment requiring interventions; and -there are signs of maltreatment which have been or are being reported with the comment "alcohol consumption" The licensee failed to update R2's IAPP to include interventions following his fall at the bar on April 8, 2026. Furthermore, the licensee failed to implement interventions for his known vulnerabilities of self-abuse with his alcohol consumption, and vulnerabilities with his poor vision and ambulation safety. Finally, R2's IAPP did not clearly/accurately depict his risk of maltreatment. On May 12, 2026, at 12:25 p.m., CNS-A stated R2's IAPP had not been updated to depict accurate information regarding his vulnerabilities and lacked interventions for his known self-abuse. The licensee's undated, Individual Vulnerable Adult policy indicated an individual abuse prevention plan is developed for each assisted living resident. - Assisted living residents who receive nursing services will have an individual abuse prevention plan based upon the nursing assessment. - Assisted living residents who do not receive nursing services - Will have an individual abuse prevention plan based upon a review of information available to the assisted living staff - Will have an individual abuse prevention plan created that will be developed by a staff - The individual abuse prevention plan will include:	0 630		

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0 630	Continued From page 5 a. Individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults b. The resident ' s risk of abusing other vulnerable adults c. Specific measures to minimize the risk of abuse to that person and other vulnerable adults. d. Measure to minimize the risk of self-abuse, if applicable No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a	0 660		

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0 660	Continued From page 6 tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening at the time of hire for one of one employee (unlicensed personnel (ULP)-G). 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 TB Risk Assessment Worksheet for Health Care settings dated April 27, 2026, indicated the licensee was a low-risk health care setting. ULP-G's employee record indicated a hire date of May 7, 2024, to provide direct care services to the licensee's residents. ULP-G's employee file included an undated, Work Clearance letter that indicated ULP-G had a positive QuantiFERON Gold blood test dated April 5, 2024, and a normal chest X-ray dated April 17, 2024. ULP-G's employee file lacked a TB symptom screening as required. On May 12, 2026, at 2:00 p.m., clinical nurse supervisor (CNS)-A stated she was unable to find	0 660		

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0 660	Continued From page 7 a completed TB symptom screening in ULP-G's employee record. She further stated ULP-G had not completed an annual symptom screening with a known positive QuantiFERON test. The licensee's undated, TB Prevention and Control policy indicated upon hire all staff are screened for active signs of TB using the Baseline TB Screening Tool provided by the MN Department of Health or a similar tool with all required information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 810 SS=E	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.	0 810		

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0 810	Continued From page 8 (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, record review, and interview, 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 12, 2026, for the specific violations related the physical environment under Minnesota Statute	0 810		

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0 810	Continued From page 9 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was current, affiliated, and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS) with the assisted living with dementia care license for two of 27 employees (housekeeping supervisor (HS)-D, dietary aide (DA)-E). This had the potential to affect all residents residing in the facility. This resulted in an immediate correction order issued on May 11, 2026.	01290		

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01290	Continued From page 10 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 11, 2026, at 12:30 p.m., the surveyor received the licensee's NETStudy 2.0 roster for health facility identification (HFID)-30336, and the licensee's current employee roster as printed on May 11, 2026. HS-D HS-D had a hire date of January 17, 2011, and currently serves as the licensee's housekeeping supervisor. The licensee's NETStudy 2.0 roster printed May 11, 2026, did not indicate an active background study for HS-D. On May 11, 2026, at 2:30 p.m., business office manager (BOM)-C referenced NETStudy 2.0 on the computer and could not locate HS-D with an active background study with HFID 30336 nor with the "sister" skilled nursing facility (HFID 922) that shares employees. BOM-C further stated HS-D was a current employee between both facilities and would not have been under direct supervision while working in the licensee's facility. DA-E DA-E had a hire date of May 13, 1985, as a	01290		

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01290	Continued From page 11 dietary aide. The licensee's NETStudy 2.0 roster printed May 11, 2026, did not indicate an active background study for DA-E. On May 11, 2026, at 2.32 p.m., BOM-C referenced NETStudy 2.0 on the computer and could not locate DA-E with an active background study with HFID 30336, nor with HFID 922. BOM-C further stated DA-E was a current employee between both facilities and would not have been under direct supervision while working in the licensee's facility. The licensee's undated, Background Checks policy indicated all employees; as well as contractors, and regularly scheduled volunteers of the facility with direct resident contact will undergo a background study through OHS. Only those with satisfactory results will continue to work with the facility and its residents. Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. All employees must pass a background study and all contractors or volunteers with direct resident contact are required to have a background study. "Direct contact" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the program. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took immediate action to mitigate risk; however, the scope and level remain at l.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30336	A. BUILDING: _____ B. WING _____	05/12/2026

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01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct supervision of one of one unlicensed personnel (ULP-G) performing delegated tasks was provided by the registered nurse (RN) within 30 calendar days after the date on which the individuals began working for the licensee. 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	01440		

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01440	Continued From page 13 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: ULP-G's employee record indicated a hire date of May 7, 2024, to provide direct care services to the licensee's residents. ULP-G's employee file indicated she held a certified nursing assistant (CNA) certificate with an expiration date of May 30, 2026. ULP-G's employee file lacked evidence that the licensee's registered nurse (RN) completed a 30-day supervisory observation. On May 12, 2026, at 2:00 p.m., clinical nurse supervisor (CNS)-A stated she was not the nursing director at the time of ULP-G's hire and was not able to find record of any RN providing direct supervision of ULP-G performing delegated tasks. She further stated the licensee only hired CNAs and shared staff between both the assisted living facility (ALF) and the skilled nursing facility (SNF), was not aware of the requirement and had not completed any 30-day RN supervision evaluations for newly hired ULPs since she started. The licensee's undated Supervision of Licensed and Unlicensed Personnel policy indicated supervision of ULPs by an RN will be direct supervision of the staff performing a delegated task(s) within 30 calendar days after the staff member begins working and first performs the delegated resident tasks.	01440		

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01440	Continued From page 14 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01530 SS=F	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		

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	30336	A. BUILDING: _____ B. WING _____	05/12/2026

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OSTRANDER ASSISTED LIVING	309 MINNESOTA STREET OSTRANDER, MN 55961

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01530	Continued From page 15 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 interview and record review, the licensee failed to ensure one of one direct care staff (unlicensed personnel (ULP)-G) received the required two hours of initial training on mental illness and de-escalation topics within 160 hours of start date. 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: ULP-G's employee record indicated a hire date of May 7, 2024, to provide direct care services to the licensee's residents. ULP-G's employee training transcript indicated she lacked the required two hours of initial mental health training within 160 hours of work, to include the following training topics:	01530		

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01530	Continued From page 16 - recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor related disorders, personality and psychotic disorders, substance use disorder, and substance misuse - de-escalation techniques and communication; and - crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines. On May 12, 2026, at 1:30 p.m., business office manager (BOM)-C stated she assigned staff training and was not aware of the mental health training or the required training topics. BOM-C further stated ULP-G had worked greater than 160 hours since her hire date and no employee would have completed the required mental health training. The licensee's undated, Assisted Living and Dementia, Mental Illness, and De-escalation training policy indicated all assisted living staff will receive required training on dementia, mental illness and de-escalation during orientation and annually lacked the required mental health training topics. Mental illness and de-escalation technique topics will include: 1. Recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor related disorders, personality and psychotic disorders, substance use disorder, and substance misuse 2. de-escalation techniques and communication; and 3. crisis resolution and suicide prevention, including procedures for contacting county crisis	01530		

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01530	Continued From page 17 response teams and 988 suicide and crisis lifelines No further information provided. Direct-care staff will complete: 1. a minimum of 8 hours of initial training on dementia care topics and 2 hours of initial training on mental illness and de-escalation topics and initial training will be completed within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	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;	01620		

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01620	Continued From page 18 (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 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, the licensee failed to ensure the registered nurse (RN) completed a 14-day assessment 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 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	01620		

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01620	Continued From page 19 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 May 11, 2026, at 11:30 a.m. during entrance conference, clinical nurse supervisor (CNS)-A stated she completed RN assessments for residents on the day of admission, every 90 days and with a change in condition. R1 received services under the licensee's assisted living license from January 30, 2026, through March 6, 2026, with diagnoses including myelodysplastic syndrome (bone marrow produces abnormal blood cells that fail to mature properly, leading to anemia, chronic infections, and bleeding problems), chronic obstructive pulmonary disease (COPD-chronic lung disease), and a recent right hip fracture. R1's record lacked a signed service plan/service agreement. R1's record included a care plan dated January 30, 2026, that indicated she received services including supervision with showering and daily assistance with bilateral lower extremity compression wraps for swelling. R1's record included one RN assessment dated January 30, 2026, (on the day of R1's admission). The licensee failed to ensure the registered nurse (RN) completed R1's 14-day assessment within the required timeframe (due February 13, 2026). On May 12, 2026, at 12:25 p.m. CNS-A stated she was not aware of the required assessment to	01620		

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01620	Continued From page 20 be completed 14 days following a resident's admission. She further stated she had not completed a 14-day assessment for any resident receiving services from the licensee. The licensee's undated, Initial and Ongoing Assessments of Residents policy indicated an RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90 days d. Change in resident condition resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. 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	01640		

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	30336	A. BUILDING: _____ B. WING _____	05/12/2026

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01640	Continued From page 21 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 interview and record review, the licensee failed to ensure a written service plan was revised and signed by the resident or resident representative to reflect the services provided 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 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 received services under the licensee's assisted living license from January 30, 2026, through March 6, 2026, with diagnoses including myelodysplastic syndrome (bone marrow	01640		

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01640	Continued From page 22 produces abnormal blood cells that fail to mature properly, leading to anemia, chronic infections, and bleeding problems), chronic obstructive pulmonary disease (COPD-chronic lung disease), and a recent right hip fracture. R1's record included a care plan dated January 30, 2026, that indicated she received services including supervision with showering and daily assistance with bilateral lower extremity compression wraps for swelling. R1's electronic medical record (EMR) included a task record dated February 2026, which indicated "resident needs extensive assistance with compression wraps, meal attendance, quantity of meal eaten, assistance with dressing, and assistance/supervision with showering". R1's record lacked a signed Service Plan/Agreement to include the services the licensee provided. On May 12, 2026, at 12:40 p.m., clinical nurse supervisor (CNS)-A stated R1 was a resident from January 2026, until March 6, 2026, as a respite resident and received services including compression stocking application (when the resident allowed) and supervision with showering. CNS-A provided the surveyor with a blank paper version of the licensee's Service Agreement and stated R1 had signed a paper copy of the licensee's Service Agreement, but it had not been uploaded to the licensee's EMR. CNS-A stated she was unable to locate R1's paper chart, which likely included the signed Service Agreement. The licensee's undated, Contents of Service Plans indicated a finalized service plan will be completed no later than 14 calendar days after	01640		

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01640	Continued From page 23 initiation of services. Service plans and any revisions to services plans will have a signature or other authentication by the facility and by the resident. Other authentication could be emailed with confirmation accepting terms of a service agreement or other method deemed appropriate by the assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01650 SS=D	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 identification of and information as to who has authority to sign for the resident in an emergency; and	01650		

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01650	Continued From page 24 (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 interview, and record review, the licensee failed to ensure the service plan included 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 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 received services under the licensee's assisted living license from January 30, 2026, through March 6, 2026, with diagnoses including myelodysplastic syndrome (bone marrow produces abnormal blood cells that fail to mature properly, leading to anemia, chronic infections, and bleeding problems), chronic obstructive pulmonary disease (COPD-chronic lung disease), and a recent right hip fracture. R1's record included a care plan dated January 30, 2026, that indicated she received services including supervision with showering and daily assistance with bilateral lower extremity compression wraps for swelling.	01650		

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01650	Continued From page 25 R1's electronic medical record (EMR) included a task record dated February 2026, which indicated "resident needs extensive assistance with compression wraps, meal attendance, quantity of meal eaten, assistance with dressing, and assistance/supervision with showering". R1's record lacked a signed Service Plan/Agreement to include the services the licensee provided. R1's Service Plan lacked the following: - a description of the services to be provided, the fees for services, and the frequency of each service, according to the residents' current assessment and resident preferences - the schedule and methods of monitoring staff providing services; - information and a method to contact the facility; - the names and contact information of people 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; and - 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 May 12, 2026, at 12:40 p.m., clinical nurse supervisor (CNS)-A stated R1 was a resident from January 2026, until March 6, 2026, as a respite resident and received services including compression stocking application (when the resident allowed) and supervision with showering. CNS-A provided the surveyor with a blank paper version of the licensee's Service Agreement and stated R1 had signed a paper copy of the licensee's Service Agreement, but it had not been	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30336	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSTRANDER ASSISTED LIVING	309 MINNESOTA STREET OSTRANDER, MN 55961

(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 26 uploaded to the licensee's EMR. CNS-A stated she was unable to locate R1's paper chart which likely included the signed Service Agreement. The licensee's undated, Contents of the Service Plan policy indicated contents of the service plan will include: a. A description of the services provided b. Fees for services c. Frequency of each service according to resident assessment and resident preferences d. Schedule and methods of monitoring assessments e. Schedule and methods of monitoring staff providing services f. Contingency plan g. A contingency plan that includes: i. Action taken if the scheduled service cannot be provided ii. Information and method to contact the facility iii. Names and contact information of people the resident wishes to have notified in an emergency iv. Names and contact information of people the resident wishes to have notified if there is a significant adverse change in the residents' condition v. Identification of and information on who has authority to sign for the resident in an emergency vi. Circumstances in which emergency medical services are not to be summoned vii. The service plan and revisions will be entered into the resident record No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30336	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSTRANDER ASSISTED LIVING	309 MINNESOTA STREET OSTRANDER, MN 55961

(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 27	01940		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy 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 interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions and	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30336	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSTRANDER ASSISTED LIVING	309 MINNESOTA STREET OSTRANDER, MN 55961

(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 28 documented those instructions in the resident record for one of one resident (R1) with treatments. 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 received services under the licensee's assisted living license from January 30, 2026, through March 6, 2026, with diagnoses including myelodysplastic syndrome (bone marrow produces abnormal blood cells that fail to mature properly, leading to anemia, chronic infections, and bleeding problems), chronic obstructive pulmonary disease (COPD-chronic lung disease), and a recent right hip fracture. R1's record included a care plan dated January 30, 2026, that indicated she received services including supervision with showering and daily assistance with bilateral lower extremity compression wraps for swelling. R1's record lacked a signed Service Plan/Agreement to include the services the licensee provided. R1's signed prescriber's orders dated December 23, 2025, included ace wraps from toes upwards. R1's electronic medical record (EMR) included a	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30336	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01940	Continued From page 29 task record dated February 2026, which indicated "resident needs extensive assistance with compression wraps (9:00 a.m./9:00 p.m.), meal attendance, quantity of meal eaten, assistance with dressing, and assistance/supervision with showering". R1's record lacked individualized instructions for what ULP should monitor for (redness, open skin) when using compression stockings. On May 12, 2026, at 12:45 p.m., clinical nurse supervisor (CNS)-A stated she was not aware of the requirement to include written instructions for the ULP to reference delegated treatments and stated she assumed as certified nurse assistants (CNA), they would already know this information. The licensee's Delegation of Nursing Tasks, Treatments or Therapy Tasks policy dated August 14, 2017, indicated treatments or therapy tasks may be delegated or assigned by a Licensed Health Professional to unlicensed personnel according to the Licensed Health Professional's applicable licensing practice standards. When a treatment or therapy is delegated or assigned to unlicensed personnel, the registered nurse (RN) or authorized Licensed Health Professional must develop written specific instructions for each client and document those instructions in the client's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Ostrander Assisted Living
309 MINNESOTA STREET
Ostrander, MN 55961
Fillmore County
Parcel:

Phone: 507-517-9731
dmcconnell@careinrehab.org

License Info

License: HFID 30336
Dusti McConnell
Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1045261075
Inspection Type: Full - Single
Date: 5/11/2026 Time: 1:31:27 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

Reviewed the food service activities occurring on the Assisted Living side of the firm. Meals are made in a commercial kitchen which serves the nursing home. Meals are preplated in the commercial kitchen and delivered to the residents. The small residential or neighborhood kitchen is utilized by staff and family.

Reviewed the following: Ill employee policy, sanitation, handwashing procedures and no barehand contact with ready to eat foods, discussed biohazardous clean up and the Certified Food Manager licensure process. Firm currently has Dusti who completed the Serv Safe course but has not applied for MN CFPM. Provided web link

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 Rochester District Office inspection report number F1045261075 from 5/11/2026

Dusti McConnell
Food Director

Nicole Hunger,
Public Health Sanitarian 3
507-206-2741
nicole.hunger@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30336016-0	**Date:** May 12, 2026
Facility Name: Ostrander Assisted Living	
Facility Address: 309 Minnesota Street, Ostrander, MN 55961	

☒ **TAG IDENTIFICATION: 0810**

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

1. 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 surveyor requested records for employee fire safety and evacuation plan training completed between May 2025 and May 2026, from the licensee. Record review of the available documentation indicated employees were trained on the FSEP at the time of hire and then annually. Employee training on the FSEP was not completed at the required frequency of twice per year.

2. 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 surveyor requested records for resident training on fire safety and evacuation completed between May 2025 and May 2026, from the licensee. Maintenance supervisor (MS)-F stated residents had received training, but this had not been documented.