Electronically Delivered

March 12, 2025

Licensee
Options Residential Inc.
12837 Briar Court
Burnsville, MN 55337

RE: Project Number(s) SL27394016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 12, 2025, 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 . . ."

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27394	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIONS RESIDENTIAL INC	12837 BRIAR COURT BURNSVILLE, MN 55337

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0 000	Initial Comments 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: SL27394016-0 On February 10, 2025, through February 12, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 25 residents; four receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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

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0 470	Continued From page 2 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: The licensee held an assisted living license and was licensed for a capacity of 28 residents with a current census of 25 residents. On February 10, 2025, at 2:00 p.m., the licensee's staffing plan was requested. On February 11, 2025, at 11:30 a.m., licensed assisted living director (LALD)-B stated neither she nor clinical nurse supervisor (CNS)-C could find a staffing plan had been completed since 2023. The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the	0 630		

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0 630	Continued From page 3 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 observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1, 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 began receiving assisted living services on April 6, 2022. R1's diagnoses included post-traumatic stress disorder, persistent depressive disorder, and alcohol use disorder. R1's Service Plan-Addendum to Contract dated August 7, 2023, indicated he received services to include medication reminders, bathing reminders,	0 630		

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0 630	Continued From page 4 and mental health/behavior management. On February 10, 2025, at 1:35 p.m., unlicensed personnel (ULP)-D observed R1 to set up his weekly medications and self-administer his morning medication. ULP-D stated R1 preferred for staff to provide him with a daily reminder to take his medications. R1's IAPP (included in his comprehensive assessment) dated February 3, 2025, included his risk for self-abuse, indicated he was not at risk for abusing others including other vulnerable adults; however, R1's IAPP lacked his susceptibility to abuse by others including other vulnerable adults and interventions to minimize his risk for abuse. R2 R2 began receiving assisted living services on January 2, 2018. R2's diagnoses included schizoaffective disorder. R2's Service Plan dated December 6, 2024, included the services of meal assistance, mental health management, transportation assistance, and money management. On February 10, 2025, at 1:30 p.m., licensed assisted living director (LALD)-B stated R2 was currently hospitalized for mental health symptoms and received services from the licensee. R2's IAPP dated November 25, 2024, indicated his inability to be assertive regarding sexual, verbal or physical abuse or financial exploitation, included his history of poor decision making, paranoia and hallucinations; however, R2's IAPP lacked an indication of his susceptibility to abuse	0 630		

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0 630	Continued From page 5 by others including other vulnerable adults and lacked an indication of his risk to abuse others including other vulnerable adults. The licensee failed to properly depict R1 and R2's vulnerability to abuse by others and failed to implement measures to minimize the risk of abuse to R1 and R2. Furthermore, R2's IAPP lacked an indication of his susceptibility to abuse others including other vulnerable adults. On February 11, 2025, at 11:15 a.m., LALD-B stated she was aware of the need to identify the residents' susceptibility to abuse by others including other vulnerable adults; however, R1 and R2's IAPPs both lacked this content and lacked interventions to minimize the risk for abuse by others and R2's risk to abuse others and those interventions. The licensee's Individual Abuse Prevention Plans policy dated August 1, 2021, indicated [licensee name] will develop and implement an individual abuse prevention plan for each vulnerable adult. All residents in an assisted living are categorically considered vulnerable adults. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: i. other vulnerable adults ii. the person's risk of abusing other vulnerable adults, and iii. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. 2. For purposes of the abuse prevention plan, abuse includes self-abuse	0 630		

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0 630	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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 observation, interview, and record review, the licensee failed to develop an all-hazards risk assessment emergency	0 680		

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0 680	Continued From page 7 preparedness (EP) program and plan to include Appendix Z required elements. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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 the residents). The findings include: On February 10, 2025, at 10:00 a.m., the surveyor reviewed the contents of the licensee's EP plan. The licensee lacked the following required information according to Emergency Preparedness: Appendix Z: -a defined relocation location for emergency evacuation/relocation; -communication plan must include contact information for the following: Federal, State, tribal, regional & local EP staff, State Licensing and Certification Agency, MN Office of Ombudsman for LTC -communication plan must include all of the following: method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives -conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility	0 680		

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0 680	Continued From page 8 experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; and -lacked evidence the licensee reviewed the Missing Resident policy/procedure on a quarterly basis as required On February 11, 2025, at 11:30 a.m., licensed assisted living director (LALD)-B stated the licensee had not completed any emergency preparedness exercises over the course of the past two years, and confirmed the above listed missing content for the licensee's EP plan. LALD-B stated she was not aware of the requirement to review the missing resident policy on a quarterly basis and was adding this to the licensee's quality improvement meeting agenda. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=D	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 and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors.	0 775		

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0 775	Continued From page 9 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: During facility tour on February 12, 2025, from 12:30 p.m. to 4:00 p.m., with licensed assisted living director (LALD)-B, assisted living director in residency (ALDIR)-A and maintenance supervisor (MS)-E, windowsill heights were over 48" from the floor. The maximum height from the floor to the windowsill opening shall not exceed 48 inches. Following buildings had windows that measured over 48". 1200- units two, four, five and seven all measured at 49" from the floor. 12845- units three (both bedrooms) measured at 51" and 49.5" and five measured at 50". 12829- unit two measured at 49", seven measured at 50" escape windows with openings up to 52 inches off of the floor may meet the height requirement for existing buildings by securing a step, platform or bed to the wall directly underneath the window. This step, platform or bed shall be no more than 44 inches below the opening and must be strong enough to support the weight of the person. The minimum acceptable width shall be the same as the window opening. The minimum acceptable	0 775		

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0 775	Continued From page 10 depth away from the wall shall be 18 inches. During a facility tour on February 12, 2025, at 2:30 a.m., LALD-B/ ALDIR-A and MS-E, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day.	0 775		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required in Minnesota State Fire Code throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	0 790		

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0 790	Continued From page 11 the residents). The findings include: During facility tour on February 12, 2025, from 12:30 p.m. to 4:00 p.m., with licensed assisted living director (LALD)-B, assisted living director in residency (ALDIR)-A and maintenance supervisor (MS)-E., The portable fire extinguishers throughout the facility were stored in outdoors. Some extinguishers were in boxes and others were not. Extinguishers must be protected from the elements to prevent rust and to ensure operability. On February 12, 2025, at 2:00 p.m., LALD-B/ ALDIR-A and MS-E, verified this deficient finding. TIME PERIOD FOR CORRECTION: Two (2) days.	0 790		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings,	0 800		

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0 800	Continued From page 12 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During facility tour on February 12, 2025, from 12:30 p.m. to 4:00 p.m., with licensed assisted living director (LALD)-B, assisted living director in residency (ALDIR)-A and maintenance supervisor (MS)-E, in building 1200 unit 4 the closet door was off the track and was damaged, the unit was not clean and had several flies on the ceiling and walls, the bathroom and toilet was dirty. On February 12, 2025, at 2:30 a.m., LALD-B/ ALDIR-A and MS-E, verified the above listed observations while accompanying on the tour. LALD-B stated the unit was not in this condition on the Friday before the survey and immediately called staff to come assist the resident in cleaning and maintaining a healthy living environment. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27394	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIONS RESIDENTIAL INC	12837 BRIAR COURT BURNSVILLE, MN 55337

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0 810	Continued From page 13 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at 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 develop the fire safety and evacuation plan with the required content and provide the required training. This	0 810		

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0 810	Continued From page 14 had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During facility tour on February 12, 2025, from 12:30 p.m. to 4:00 p.m., with licensed assisted living director (LALD)-B, assisted living director in residency (ALDIR)-A and maintenance supervisor (MS)-E, surveyor observed the posted evacuation plans lacked identification of resident rooms, and accurate facility layout. Exit plan diagrams must be correctly labeled for staff, residents and visitors to reduce confusion and potential obstructions during egress of a fire or similar emergency. A copy of the facility floor plan should also be in the emergency preparedness binder to aid first responders in search and rescue operations. On February 12, 2025, LALD-B and ALDIR-A provided documents on the fire safety and evacuation plan (FSEP), fire safety training and evacuation drills, for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Site Emergency Preparedness Program", reviewed on 02/10/2025, failed to include the following:	0 810		

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0 810	Continued From page 15 Training: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. Staff does web-based training at the time of hire, and reviews emergency preparedness documentation. LALD-B stated that the previous LALD was not maintaining records or not performing training. No other training documentation was provided. The licensee failed to provide evacuation training to residents at least once per year. LALD-B lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On February 12, 2025, at 2:30 p.m., ALDIR-A and LALD-B stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation;	01060		

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01060	Continued From page 16 (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for	01060		

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01060	Continued From page 17 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 began receiving assisted living services on January 2, 2018. R2's Service Plan dated December 6, 2024, included the services of meal assistance, mental health management, transportation assistance and money management. R2's progress note dated February 6, 2025, indicated R2 was re-hospitalized on February 5, 2025, due to altered mentation and remained at the hospital. R2's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide	01060		

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01060	Continued From page 18 housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R2's records lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On February 10, 2025, at 1:30 p.m. licensed assisted living director (LALD)-B stated R2 was currently hospitalized and had been since February 5, 2025, (five days thus far). LALD-B stated she was not aware of the requirement to complete an emergency relocation notice and to contact the ombudsman when the resident had not returned within four days. On February 11, 2025, at 11:30 a.m., LALD-B stated she had found the required notice/form within R-Tasks (the licensee's electronic medical record documentation system), and sent the notice to the ombudsman on February 10, 2025, after learning about the requirement. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01060		

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

Type: Full
Date: *02/10/25*
Time: 12:30:00
Report: 1043251043

Food and Beverage Establishment Inspection Report

Location:
Options Residential - Briar
12837 Briar Court
Burnsville, MN55337
Dakota County, 19

Establishment Info:
ID #: 0039036
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528956970
ID #:

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

No NEW orders were issued during this inspection.

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

Inspection was completed with Deb Jacobson as the lead Health Regulation Division Nurse Evaluator completing the site survey.

This is an apartment community set up. Residents are responsible for their own grocery shopping, and making their own meals in their apartment. No central kitchen or food service operated on-site by staff. Mom's Meals (or similar) is provided for residents who do not cook.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1043251043 of 02/10/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Jackie Reiter
PIC

Signed: Blia Lor
Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us