

STATE LICENSING COMPLIANCE REPORT

Report #: HL397448860C

Date Concluded: December 26, 2024

Name, Address, and County of Facility

Investigated:

A Future Goals
14331 Ebony Lane
Apple Valley, MN 55124
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Willette Shafer, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39744	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/27/2024
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NAME OF PROVIDER OR SUPPLIER A FUTURE GOALS	STREET ADDRESS, CITY, STATE, ZIP CODE 14331 EBONY LN APPLE VALLEY, MN 55124
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(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>HL397448860C</p> <p>On November 27, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were two residents receiving services under the provider's Assisted Living license.</p> <p>The following correction order is issued for HL397448860C, tag identification 1040.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
01040 SS=D	144G.52 Subd. 7 Notice of contract termination required	01040		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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01040	<p>Continued From page 1</p> <p>(a) A facility terminating a contract must issue a written notice of termination according to this section. The facility must also send a copy of the termination notice to the Office of Ombudsman for Long-Term Care and, for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5.</p> <p>(b) A facility terminating a contract under subdivision 3 or 4 must provide a written termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative.</p> <p>(c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal representative, and designated representative.</p> <p>(d) If a resident moves out of a facility or cancels services received from the facility, nothing in this section prohibits a facility from enforcing against the resident any notice periods with which the resident must comply under the assisted living contract.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to issue a written notice for a termination of contract at least 30 days ahead of the termination, or at least 15 days ahead of an expedited termination for one of one resident, (R1) former resident. R1's contract was terminated without notice after being sent to the hospital. In addition, the licensee failed to provide</p>	01040		

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01040	<p>Continued From page 2</p> <p>a written termination notice to R1 and R1's representative and failed to send a termination notice to the Office of Ombudsman for Long Term Care.</p> <p>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).</p> <p>The findings include:</p> <p>R1's diagnoses included diabetes, amputation of right foot, heart disease, peripheral vascular disease, sepsis, and benign prostatic hyperplasia. R1's care plan dated July 28, 2024, indicated R1 received services including bathing, dressing, grooming, assist of two for transfers, bed mobility, incontinence cares including catheter care, meals, housekeeping, laundry, and medication management. R1 also received wound care to left heel from a home health care wound nurse.</p> <p>R1's pretermination meeting progress notes dated July 22, 2024, indicated R1's physical and mental health declined. R1 needed a mechanical lift and a medical bed. The licensee informed the case manager to find a more suitable placement for the resident.</p> <p>R1's record lacked a written termination notice.</p> <p>R1's hospital record dated September 4, 2024, indicated R1 had a large wound on his left heel for at least six months and despite wound care</p>	01040		

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01040	<p>Continued From page 3</p> <p>three times a week, the wound had worsened. The hospital recommended amputation or debridement but R1 declined procedures. The hospital provider ordered daily dressing changes to left heel wound.</p> <p>R1's progress note dated September 17, 2024, indicated R1 was hospitalized due to worsening left heel wound. The licensee was unable to meet his daily wound care needs. R1 was transferred to a skilled nursing facility.</p> <p>R1's discharge summary dated September 17, 2024, indicated R1 was sent to the hospital and discharged from the hospital to a nursing home for increased level of care and daily wound care.</p> <p>R1's record did not include a written termination notice.</p> <p>On November 27, 2024, at 9:10 a.m., owner (OW)-A said the licensee refused to accept R1 back from his hospital stay as R1 required a greater level of care than the licensee could provide. OW-A said before his hospital stay, a pretermination meeting was conducted and the case manager was informed R1's physical and mental health had declined and R1's service level increased. The licensee was unable to continue to care for R1's increased needs. R1 required a full body mechanical lift as he was a larger person and unable to transfer with two staff. He also had a catheter placed and increased diabetic needs.</p> <p>An email sent by OW-A to MDH evaluator dated November 27, 2024, at 4:39 p.m., indicated OW-A never wrote a termination notice.</p> <p>The licensee's Discharge and Transfer of</p>	01040		

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01040	<p>Continued From page 4</p> <p>Residents policy dated August 8, 2021, indicated a pretermination meeting must be scheduled at least seven days before a notice of termination is issued. The policy failed to include information for the written termination notice and required content.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01040		