Electronically Delivered

June 26, 2024

Licensee
A Future Goals Inc
14331 Ebony Lane
Apple Valley, MN 55124

RE: Project Number(s) SL39744015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on May 29, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health 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. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance 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
Per 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 residents/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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

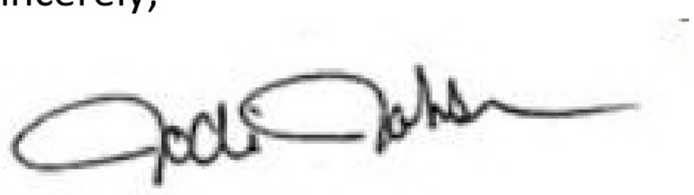
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39744	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A FUTURE GOALS	14331 EBONY LN APPLE VALLEY, MN 55124

(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: SL39744015 On May 28, 2024, through May 29, 2024, the Minnesota Department of Health conducted an intial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents receiving services under the provider's provisional Assisted Living 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 28, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact	0 550		

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0 550	Continued From page 2 information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place information about the facility's grievance procedure with the required content. This had the potential to affect all the licensee's current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a client'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: On May 28, 2024, at 2:47 p.m. the surveyor toured the facility with licensed assisted living director in residency/unlicensed personnel (LALDIR/ULP)-A. The licensee posted on a bulletin board on the main floor common area the facility's grievance procedure; however, the grievance procedure lacked an e-mail contact	0 550		

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0 550	Continued From page 3 information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, or any information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). On May 28, 2024, at 3:17 p.m. LALDIR/ULP-A stated the required posting for the grievance procedure lacked the content as listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
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.	0 660		

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0 660	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: The findings include: The licensee's TB Risk Assessment dated August 8, 2024, indicated a low risk level. ULP-C had a hire date of April 24, 2024, to provide direct care services to residents. On May 29, 2024, at 9:20 a.m. the surveyor observed ULP-C assist R3 transfer from the wheelchair to car. ULP-C's record contained a history and symptom screening and one-step negative TST dated as read on April 18, 2024.	0 660		

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0 660	Continued From page 5 On May 28, 2024, at 4:00 p.m. licensed assisted living director in residency/unlicensed personnel (LALDIR/ULP)-A stated ULP-C was instructed to do a one-step TST by LALDIR/ULP-A. LALDIR/ULP-A stated she didn't know that employees were to have a two-step TST. The licensee's Tuberculosis screening policy dated August 8, 2023, indicated new staff will have an IGRA blood test or a two-step TST conducted with results documented on the Baseline TB screening tool for HCW's. The Minnesota Department of Health (MDH) guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 680		

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0 680	Continued From page 6 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 have a written emergency preparedness (EP) plan with all of the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all residents receiving services under the assisted living license, 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	0 680		

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0 680	Continued From page 7 has affected or has the potential to affect a large portion or all of the residents). The findings include: During the initial tour on May 28, 2024, at 2:47 p.m. the facility's layout included one building with two resident rooms, kitchen, living room, dining room located on the main level, and two resident rooms, living room located on the lower level. There was no evidence of signage posted or information regarding the licensee's emergency plan. The licensee lacked a plan to include the following required content: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for EP cooperation and collaboration with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility); - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies including surge planning and use of volunteers; - the facility's role in providing care and treatment at alternative sites; - a communication plan that included: - arrangement with other facilities;	0 680		

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0 680	Continued From page 8 - names and contact information for staff, resident physicians, other facilities, volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents - a means to provide information regarding the facility's needs, and the ability to provide assistance to include information about their occupancy; -a method of sharing information from the emergency plan with residents and their families; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On May 29, 2024, at 3:06 p.m. licensed assisted living director in residency/unlicensed personnel (LALDIR/ULP)-A stated the licensee had not fully developed and implemented the facility's emergency preparedness plan/program. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, indicated the licensee would have in place an effective and compliant Emergency Preparedness Plan. The intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." No further information was provided.	0 680		

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0 680	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee 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) Employees 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 employees 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.	0 810		

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0 810	Continued From page 10 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. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 29, 2024, the licensed assisted living director in residency/unlicensed personnel (LALDIR/ULP)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "9.06 Fire Policy", dated 08/01/2023, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments.	0 810		

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0 810	Continued From page 11 The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on May 29, 2024, at 2:30 p.m., LALDIR-A stated they had not had an opportunity to update the policy to make it site specific. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. LALDIR-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous	0 910		

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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
0 910	Continued From page 12 place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have the licensee's health facility identification (HFID) number listed on the contract as required for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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: R2's Resident Agreement signed October 11, 2023, failed to identify the licensee's HFID. On May 29, 2024, at 1:36 p.m. licensed assisted living director in residency (LALDIR)-A stated the contract needed to be updated. The contract would be the same for all residents and it should have included the HFID.	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39744	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A FUTURE GOALS	14331 EBONY LN APPLE VALLEY, MN 55124

(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
0 910	Continued From page 13 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced	0 950		

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	39744	A. BUILDING: _____ B. WING _____	05/29/2024

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0 950	Continued From page 14 by: Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for right to a designated representative with the required verbiage on a document separate from the contract for one of one resident (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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 the residents). The findings include: R2's Assisted Living Contract dated October 11, 2023, lacked the required notice to designate a representative. R2's records lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On May 29, 2024, at 1:36 p.m. licensed assisted	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 950	Continued From page 15 living director in residency/unlicensed personnel (LALDIR/ULP)-A stated the contract needed to be updated. The contract would be the same for all residents and it should have included all required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
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 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:	01640		

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	39744	A. BUILDING: _____ B. WING _____	05/29/2024

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01640	Continued From page 16 Based on observation, interview, and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident to document agreement on the services to be provided 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: R2's Service Plan dated August 9, 2023, lacked a signature or other authentication by the resident documenting agreement on the services to be provided. On May 29, 2024, at 8:26 a.m. licensed assisted living director in residency/unlicensed personnel (LALDIR/ULP)-A was observed to administer morning medications to R2. On May 29, 2024, at 1:29 p.m. LALDIR/ULP-A stated the service plan had been developed on August 9, 2023, and stated it lacked a signature by the resident as required. The licensee's Service Plan policy dated August 1, 2023, indicated the initial service plan and any revisions are signed by a representative from licensee and the resident or resident's representative, indicating agreement with the services to be provided.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01640	Continued From page 17 No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label and included the date opened of a time-sensitive drug 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: R2 was admitted on August 8, 2023, with diagnoses that included diabetes.	01890		

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01890	Continued From page 18 R2's service plan dated August 9, 2023, indicated R2 received assistance with medication management. R2's provider's order dated April 20, 2024, included: -Novolog Pen; inject 0-10 units subcutaneous three times daily with meals. If blood glucose (BG) is under 100 give nothing; if BG 100-250 give six units subcutaneous, if BG is over 250 give 10 units subcutaneous. On May 29, 2024, at 8:26 a.m. the surveyor observed licensed assisted living director in residency/unlicensed personnel (LALDIR/ULP)-A obtain a Novolog insulin pen out of medication fridge. LALDIR/ULP-A applied a needle to the insulin pen, obtained medications and an alcohol wipe and entered R2's room. LALDIR/ULP-A washed their hands and applied gloves. LALDIR/ULP-A obtained blood sugar with Freestyle Libre 2 and resulted at 159. LALDIR/ULP-A stated the sliding scale dose to be given was 6 units. LALDIR/ULP-A primed the insulin pen, cleansed an area on the stomach with alcohol, dialed the Novolog insulin pen to 6 units, and R2 administered insulin per self. LALDIR/ULP-A removed their gloves, washed their hands, and documented. The surveyor noted R2's Novolog insulin pen did not include a current original pharmacy label or an opened date. On May 29, 2024, at 9:09 a.m. LALDIR/ULP-A stated the pharmacy did not provide a label for each individual insulin pen and a label was not kept with the opened insulin pens. At the same time, clinical nurse supervisor (CNS)-B further stated insulin pens should be dated when opened.	01890		

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01890	Continued From page 19 The manufacturer's instructions for Novolog Flex Pen dated June 2021, indicated the pen should be discarded after 28 days. The licensee's Medication Storage policy dated August 8, 2023, indicated medications will be stored consistent with manufacturer's recommendations. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *05/28/24*
Time: 12:55:19
Report: 1018241082

Food and Beverage Establishment Inspection Report

Location:
A Future Goals Inc
14331 Ebony Lane
Apple Valley, MN55124
Dakota County, 19

Establishment Info:
ID #: 0042678
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #: 9522201967
ID #:

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

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW EGGS OBSERVED TO BE STORED OVER READY TO EAT FOODS IN THE FRIDGE. CORRECTED ON SITE.

Corrected on Site

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

ESTABLISHMENT STATED THEY DO COOL AND REHEAT SOME FOOD ITEMS IN THE FACILITY. DISCUSSED WITH MANAGER TO BEGIN DOING SAME DAY FOOD SERVICE ONLY.

Comply By: 05/28/24

Surface and Equipment Sanitizers

Hot Water: = at 170 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *05/28/24*
Time: 12:55:19
Report: 1018241082
A Future Goals Inc

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding/ FRIDGE
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

INSPECTION CONDUCTED WITH JENN PANITZKE (MDH) PRESENT

DISHWASHER OBSERVED TO HAVE SANITIZE FUNCTION AVAILABLE.

FLOORS, WALLS, AND CEILINGS OBSERVED TO BE IN GOOD CONDITION.

EQUIPMENT AND PHYSICAL FACILITIES OBSERVED TO BE IN GOOD CONDITION.

SEPARATE SINK AVAILABLE FOR SEPARATE HAND WASHING AND FOOD PREP.

DISCUSSED EMPLOYEE ILLNESS REPORTING, VIEWED ILLNESS LOG AND DISCUSSED PEST CONTROL SERVICES.

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 1018241082 of 05/28/24.

Certified Food Protection Manager: SALMA A BARKAD

Certification Number: FM120853 Expires: 11/21/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
SALMA A BARKAD
MANAGER

Signed: _____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us