Electronically Delivered

October 30, 2024

Licensee
Mighty Love Home Care Inc
1529 Pennsylvania Avenue North
Champlin, MN 55316

RE: Project Number(s) SL39961015

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 October 22, 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.

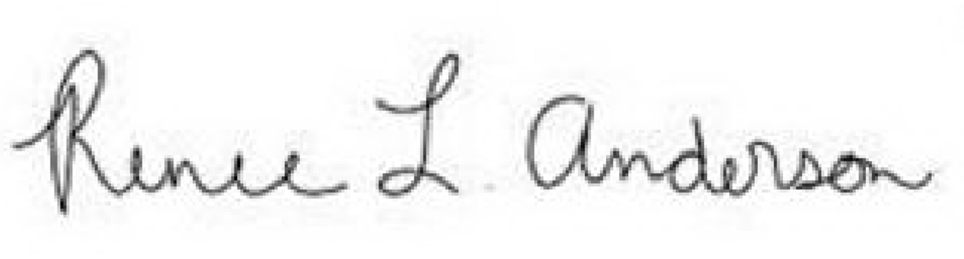
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 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
	39961	A. BUILDING: _____ B. WING _____	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIGHTY LOVE HOME CARE INC	1529 PENNSYLVANIA AVENUE NORTH CHAMPLIN, MN 55316

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL39961015-0 On October 21, 2024, through October 22, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four (4) residents; four 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 License 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 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 surveyors' 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 October 21, 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		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 2 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 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 baseline testing for two of two employees (owner (O)-A, unlicensed personnel (ULP)-D). 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: The facility TB risk assessment dated December 1, 2023, indicated the facility was a low risk	0 660		

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0 660	Continued From page 3 setting for TB transmission. O-A was hired July 10, 2023, and provided direct cares for residents of the facility. On October 22, 2024, at 8:30 a.m., O-A was observed preparing and administering oral medications to R1. O-A's employee record included a TB history and symptom screening form completed, June 30, 2023, and a negative first-step TST (tuberculin skin test) result, dated October 16, 2022, which was greater than 90 days prior to hire date. O-A's employee record lacked documentation of second-step TST or TB blood test results. ULP-D was hired March 15, 2024, and provided direct cares for residents of the facility. ULP-D's employee record included a TB history and symptom screening form completed September 20, 2024, which was greater than 90 days prior to hire date. ULP-D's record lacked documentation of a baseline two-step TST or TB blood test. On October 22, 2024, at 11:07 a.m., O-A stated employee symptom screening was completed by licensee every 6 months and TB blood tests were completed upon hire. O-A further stated his record lacked a second TST and indicated licensee's consultant informed him that the requirement was staff only needed a one-step TST. O-A stated the clinic he received his first TST never indicated he would need to return to the clinic within 1-3 weeks after the first-step, to receive the second-step TST. The Regulations for Tuberculosis Control in	0 660		

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0 660	Continued From page 4 Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. The licensee's Tuberculosis Screening/Prevention policy, dated October 13, 2023, indicated the licensee would observe the recommended precautions related to TB prevention as identified by the CDC and the MDH. Furthermore, the policy indicated screening would be conducted as follows: 1. New staff would be screened for active signs of TB. 2. New staff would have an IGRA blood test, or a two-step TST conducted, with results documented in employee 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 5 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 interview and record review, the licensee failed to have a written emergency disaster plan with all required content that was reviewed/updated annually. 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) 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:	0 680		

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0 680	Continued From page 6 The licensee's emergency preparedness (EP) plan, dated April 2024, 2022, lacked documentation of annual review, and the following required content: -development of all policies/procedures, based on assessment; and additional policies for: -handling and use of volunteers; -arrangement with other facilities (including sister facilities); -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. On October 21, 2024, at 12:08 p.m., EP plan was reviewed with owner (O)-A and licensed assisted living director (LALD)-B. O-A stated he and LALD-B had talked about licensee's EP plan during their last Quality Assurance meeting and were aware the EP binder had lacked the information noted above. O-A further stated he and LALD-B had been working on implementation of the required information. The licensee's Emergency Preparedness policy, dated October 13, 2023, indicated the licensee would have an identified plan in place that would assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services, as referenced in the Center for Medicare Service (CMS) State Operations Manual Appendix Z. Furthermore, the EP plan would include the following: -development of all policies/procedures, based on assessment; and additional policies for: -handling and use of volunteers; -arrangement with other facilities (including sister facilities); -EP training and testing program;	0 680		

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0 680	Continued From page 7 -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced	0 780		

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0 780	Continued From page 8 by: Based on observation and interview, the licensee failed to keep the facility in compliance with the Minnesota Fire Code. The deficient condition had the ability to affect all staff 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, 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 facility tour with clinical nurse supervisor (CNS)-C and owner (O)-A on October 22, 2024, between 8:50 a.m. and 10:15 a.m., the following deficient conditions were observed: ELECTRICAL: The surveyor observed that the electrical receptacle in the lower-level office was recessed in the wall and was missing its cover. The surveyor explained to CNS-C and O-A that all the electrical receptacles shall be maintained and a cover provided. SMOKING: The designated smoking area is in front of the garage. There was not an approved receptacle for the residents and employees to dispose of the cigarette butts present at time of survey. The surveyor explained to the CNS-C and O-A that an approved receptacle shall be provided for	0 780		

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0 780	Continued From page 9 the disposal of the cigarette butts. The deficient conditions were visually verified by CNS-C and O-A, accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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	0 810		

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0 810	Continued From page 10 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 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: A record review and interview were conducted on October 22, 2024, at approximately 10:00 a.m., with clinical nurse supervisor (CNS)-C and owner (O)-A on the fire safety and evacuation plan for the facility. During record review, CNS-C and O-A stated they did not have a signed contract with a transportation company to move residents to another one of their facilities if the facility needed to be evacuated, nor did they have signed agreements with the facility they planned to move the residents to in case an evacuation was required.	0 810		

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0 810	Continued From page 11 The surveyor explained to CNS-C and O-A that a written signed agreement shall be in place with a transportation company and the facility they plan to move the residents to in case an evacuation is required and it shall be updated annually. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) 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. (d) 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. (e) 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:	01620		

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	39961	A. BUILDING: _____ B. WING _____	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIGHTY LOVE HOME CARE INC	1529 PENNSYLVANIA AVENUE NORTH CHAMPLIN, MN 55316

(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
01620	Continued From page 12 Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of one resident (R1). 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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted March 28, 2024, and had diagnoses to include quadriplegia, type 2 diabetes mellitus, obesity, hypertension, and mild cognitive impairment. R1's record included documentation of an initial comprehensive nursing assessment completed March 28, 2024, a 14-day reassessment dated April 11, 2024, and a 90-day reassessment dated June 28, 2024. R1's record lacked any further reassessments. On October 21, 2024, at 10:20 a.m., during entrance conference, clinical nurse supervisor (CNS)-C indicated licensee would complete a pre-admission assessment, initial comprehensive assessment, a 14-day reassessment, a 90-day reassessment, and change in condition assessments as necessary. On October 22, 2024, at 12:54 p.m., CNS-B	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39961	A. BUILDING: _____ B. WING _____	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIGHTY LOVE HOME CARE INC	1529 PENNSYLVANIA AVENUE NORTH CHAMPLIN, MN 55316

(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
01620	Continued From page 13 stated no further 90-day reassessments were documented in R1's record. CNS-B further stated, R1 had been a high risk for skin breakdown, therefore, frequent skin assessments had been completed by the RN and documented in R1's progress notes. Licensee's Assessment and Reassessment policy dated October 13, 2023, indicated the RN would conduct a comprehensive assessment upon admission, a reassessment no more than 14 days after the initiation of services, and ongoing reassessments would not exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
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;	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39961	A. BUILDING: _____ B. WING _____	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIGHTY LOVE HOME CARE INC	1529 PENNSYLVANIA AVENUE NORTH CHAMPLIN, MN 55316

(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 14 (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 (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 observation, interview and record review, the licensee failed to ensure the service plan included all required content for one of two residents (R1). 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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's service plan dated March 28, 2024, indicated R1 received services including assistance with medication administration, blood glucose testing, bathing, transferring, dressing, grooming/hygiene, toileting/incontinence management, mobility assistance, meal preparation, and homemaking.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39961	A. BUILDING: _____ B. WING _____	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIGHTY LOVE HOME CARE INC	1529 PENNSYLVANIA AVENUE NORTH CHAMPLIN, MN 55316

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01650	Continued From page 15 On October 22, 2024, at 8:30 a.m., the surveyor observed owner (O)-A preparing and administering oral medications to R1. R1's service plan dated March 28, 2024, lacked a contingency plan to include: -actions to be taken if the scheduled service could not be provided; -the names and contact information of persons the resident wished to have notified in an emergency or if there was a significant adverse change in the resident's condition, including identification of and information as to who had authority to sign for the resident in an emergency; -the identification of and information as to who had the authority to sign for the resident in an emergency; and -circumstances in which emergency medical services are not to be summoned, and declarations made by the resident related to health care directives. On October 22, 2024, at 12 p.m., clinical nurse supervisor (CNS)-C stated R1's service plan lacked the required information noted above. CNS-C further stated licensee was aware of the required service plan content, printed all R1's service plan content; however, was unable to locate the completed document in R1's medical record. The licensee's Service Plan policy dated October 13, 2023, indicated an individualized service plan would be implemented for all resident, beginning with the date assisted living services were first provided, and the initial service plan and any revisions would be signed by a representative from [licensee] and the resident or resident's representative, indicating agreement with the services to be provided, the identification of the	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01650	Continued From page 16 staff or categories of staff who would provide the services, and a contingency plan that includes the following: -actions to be taken if the scheduled service could not be provided; -the names and contact information of persons the resident wished to have notified in an emergency or if there was a significant adverse change in the resident's condition, including identification of and information as to who had authority to sign for the resident in an emergency; -the identification of and information as to who had the authority to sign for the resident in an emergency; and -circumstances in which emergency medical services are not to be summoned, and declarations made by the resident related to health care directives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

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

Type: Full
Date: *10/21/24*
Time: 15:39:16
Report: 8041241207

Food and Beverage Establishment Inspection Report

Location:
Mighty Love Home Care Inc
1529 Pennsylvania Ave N
Champlin, MN55316
Hennepin County, 27

Establishment Info:
ID #: 0043686
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
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.

3-500A Microbial Control: cooling

3-501.14A ***** Priority 1 *****

MN Rule 4626.0385A Cool cooked TCS food: 1. within 2 hours from 135 degrees F (57 degrees C) to 70 degrees F (21 degrees C); and 2. within a total of 6 hours from 135 degrees F (57 degrees C) to 41 degrees F (5 degrees C) or less.

RICE IN THE REFRIGERATOR MEASURED 93F AFTER 2 HOURS COOLING. RICE WAS DISCARDED DURING INSPECTION. DISCUSSED APPROVED COOLING METHODS AND LIMITATIONS ON COOLING AT THIS FACILITY.

Comply By: 10/21/24

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO TEMPERATURE INDICTOR ON SITE TO MEASURE THE UTENSIL SURFACE TEMPERATURE IN THE DISHWASHER. THERMAL STRIP PROVIDED DURING INSPECTION.

Comply By: 10/28/24

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 IS SAVING SOME LEFTOVERS SUCH AS SALISBURY STEAK AND COOKING AND COOLING RICE FOR A FUTURE MEAL. DISCUSSED SAME-DAY SERVICE REQUIREMENT FOR RESIDENTIAL KITCHENS.

Comply By: 10/21/24

Type: Full
Date: *10/21/24*
Time: 15:39:16
Report: 8041241207
Mighty Love Home Care Inc

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Cooling
Temperature: 93 Degrees Fahrenheit - Location: SAMSUNG REFRIGERATOR: RICE (2 HOURS COOLING)
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: SAMSUNG REFRIGERATOR: HAM
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: SAMSUNG REFRIGERATOR: MILK
Violation Issued: No

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

Inspection was completed with Joseph Owusu-Ansah and Cynthia Asumea. Rhonda Makela was the lead Health Regulation Division Nurse Evaluator. Facility had four residents on site at time of inspection.

This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has wood cabinets with a hollow base, solid surface countertop and vinyl flooring.

Establishment has a Samsung dishwasher that has a sani rinse/high temp cycle and achieved a temp at least 160F for sanitizing dishes.

Discussed the following:
- Employee illness policy and logging requirements
- Handwashing
- Glove-use and bare hand contact
- Pest control
- Food storage and preventing cross contamination
- Date marking
- Restrictions concerning serving a highly susceptible population
- Vomit clean up process

Type: Full
Date: *10/21/24*
Time: 15:39:16
Report: 8041241207
Mighty Love Home Care Inc

Food and Beverage Establishment Inspection Report

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 8041241207 of 10/21/24.

Certified Food Protection Manager: Cynthia Asumea

Certification Number: fm120351 Expires: 11/27/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Joseph Owusu-Ansah
Owner

Signed: Sarah Conboy
Sarah Conboy
Public Health San. Supervisor
651-201-3984
sarah.conboy@state.mn.us