Electronically Delivered

August 28, 2025

Licensee
Big Hearts Home Care Inc
1130 14th Avenue Southeast
Minneapolis, MN 55414

RE: Project Number(s) SL35604016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 16, 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 . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20;
Level 5: a fine of $5,000 per violation, in addtion to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

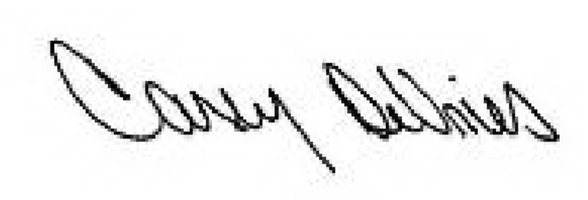
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVrise, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 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
	35604	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG HEARTS HOME CARE INC	1130 14TH AVENUE SE MINNEAPOLIS, MN 55414

(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: SL35604016-0 On July 14, 2025, through July 16, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents, all of whom received services under the 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 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food	0 480		

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0 480	Continued From page 1 must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean	0 480		

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0 480	Continued From page 2 and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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 July 14, 2025, 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		

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0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for three of three employees (unlicensed personnel (ULP)-A, ULP-B, and clinical nurse supervisor (CNS)-C). 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	0 650		

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0 650	Continued From page 4 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 of the residents). The findings include: ULP-A ULP-A was hired on April 6, 2024, to provide direct care to residents. ULP-A's employee record included a performance evaluation dated July 14, 2025, completed during the survey. ULP-A's employee record lacked an annual performance review completed in timely manner. ULP-B ULP-B was hired on May 14, 2024, to provide direct care to residents. ULP-B's employee record lacked the following: - annual performance review. CNS-C CNS-C was hired on January 15, 2021, to provide oversight to employees and to provide nursing care to residents. CNS-C'S employee record lacked the following - annual performance review; - required orientation; and - training in dementia. On July 14, 2025, at 1:58 p.m., via email, licensed assisted living director (LALD)-D provided a Staff Performance Evaluation for ULP-A. ULP-A's performance evaluation indicated the performance evaluation was completed by LALD-D on July 14, 2025, at 1:54	0 650		

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0 650	Continued From page 5 p.m. On July 14, 2025, at 2:05 p.m., LALD-D stated ULP-B and CNS-C did not have performance evaluations completed. On July 14, 2025, at 2:13 p.m., LALD-D stated CNS-C used a different Relias (learning software) for their training. LALD stated CNS-C provided a PDF file containing their training record, but it got lost. LALD-D further stated they did not print the PDF and put it in CNS-C's employee record. The licensee's undated 4.05 Employee Records policy, read: " 1. Employee records for each person will include: o Evidence of current professional licensure, registration or certificate, if required o Records of all training and in-service education required and/or provided including record of competency testing as required o Current signed job description, which includes qualifications, responsibilities, and identification of supervisors, if any o Documentation of annual performance reviews that identify areas of improvement needed and training needs o For individuals providing Assisted Living services, verification that required health screenings for Tuberculosis (TB) have taken place and the dates of those screenings. (Recommended to keep medical information in a separate employee medical file) o Documentation of a competed criminal background study o Evidence that a reference check has been completed o Verification of completed orientation and annual training and competency testing as	0 650		

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0 650	Continued From page 6 required". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of three employees (clinical nurse supervisor (CNS)-C).	0 660		

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0 660	Continued From page 7 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: CNS-C was hired on January 15, 2021, to provide oversight to employees and to provide nursing care to residents. CNS-C's employee record included a Baseline TB Screening Tool for Health Care Workers (HCWs) dated April 23, 2021, (98 days after CNS-C's hire date) with a completed health history and baseline TB symptom screening for CNS-C. CNS-C's employee record also included Imaging Report a negative chest x ray result dated May 26, 2023, (861 days after CNS-C's hire date). The Imaging Report indicated CNS-C had a positive TB QuantiFERON in 2021 (did not indicated the exact date). CNS-C's employee record did not contain the QuantiFERON results mentioned above. On July 15, 2025, at 12:06 p.m., CNS-C stated their expectation for completing the TB screening was to complete it before the employee's start date, and symptom screening was done yearly for all employees. CNS-C stated they did not have an answer for why their TB screening was not completed before their hire date. The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated	0 660		

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0 660	Continued From page 8 May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. The Minnesota Department of Health document titled Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, indicated baseline TB screening is required for all health care workers. Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test (IGRA). An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. The licensee's undated 4.05 Employee Records policy, indicated for individuals providing Assisted Living services, verification that required health screenings for Tuberculosis (TB) have taken place and the dates of those screenings. (Recommended to keep medical information in a separate employee medical file). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 680	Continued From page 9	0 680		
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 interview and record review, the licensee failed to maintain an emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. 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	0 680		

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0 680	Continued From page 10 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 licensee's Emergency Preparedness Plan revised on March 22, 2024, lacked evidence of the following required contents: - quarterly review of the missing resident plan. On July 14, 2025, at 11:40 a.m., licensed assisted living director (LALD)-D stated the missing resident plan was reviewed every year with the EPP. The licensee's emergency Preparedness plan annual reviewed/revised section indicated the EPP was reviewed on June 1, 2024, and June 1, 2025. On July 15, 2025, at 10:39 a.m., clinical nurse supervisor (CNS)-C stated the missing resident policy was reviewed every six months. The licensee's 2.28 Missing Resident policy dated February 1, 2024, indicated the missing resident policy and any individual resident plans that pertain to elopement will be reviewed at least quarterly, and all changes will be documented. Minnesota Administrative Rule 4659.0110, Subpart 4 dated August 11, 2021, indicated the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan.	0 680		

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0 680	Continued From page 11 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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BIG HEARTS HOME CARE INC	1130 14TH AVENUE SE MINNEAPOLIS, MN 55414

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0 780	Continued From page 12 by: Based on observation and interview, the licensee failed to provide smoke alarms that were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. 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: INTERCONNECTION/POWER SOURCE On July 15, 2025, from 10:30 a.m. to 1:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-D. During the tour, the surveyor observed: Hard-wired smoke alarms between upper, lower and basement levels was not interconnected. Facility using separate battery powered system for interconnection. Facility should maintain one system; hard-wired alarms shall be maintained in the facility and must be interconnected throughout. Smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility During a facility tour on July 15, 2025, at 12:30 p.m., LALD-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2)	0 780		

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0 780	Continued From page 13 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) 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.	0 810		

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0 810	Continued From page 14 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: July 15, 2025, from 10:30 a.m. to 1:30 p.m., with LALD-D; provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Policy", revised date 10-11-23, failed to include the following: STAFF ACTIONS: 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). The provided FSEP was from a third-party provider and had not been updated to the specific facility. RESIDENT ACTIONS:	0 810		

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0 810	Continued From page 15 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. UNIQUE AND UNUSUAL RESIDENT NEEDS: The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP does not include instructions on how to use or what do in the loss of power/internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. Electronic care plan only showed 3 of the 5 residents evacuation status. On July 15, 2025, at 12:30 p.m., LALD-D 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		
0 950 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	0 950		

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0 950	Continued From page 16 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 by: Based on interview and record review, the licensee failed to include the required statutory language giving residents the right to identify a designated representative on its own separate page for two of two residents (R1, 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 the potential to affect a large portion or all the residents). The findings include: R1's Assisted Living Contract was signed on August 1, 2024.	0 950		

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0 950	Continued From page 17 R2's Assisted Living Contract was signed on August 1, 2024. R1 and R2's assisted living contract did not include the required statutory notice language about designated representative on a document separate from the contract. On July 15, 2025, at 12:46 p.m., licensed assisted living director (LALD)-D stated they used the same assisted living contract form for all residents. LALD-D stated they were aware of the required statutory notice language about designated representative. LALD-D stated they used a new and updated version of an assisted living contract form that they bought recently for all residents; they did not know why the required content was not included in the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting	01470		

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01470	Continued From page 18 Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies,	01470		

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01470	Continued From page 19 assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff completed an orientation to assisted living facility licensing requirements and regulations before providing services for three of three employees (unlicensed personnel (ULP)-A, ULP-B, clinical nurse supervisor (CNS)-C). 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 the potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was hired on April 6, 2024, to provide direct care to residents. ULP-A's employee record lacked the following: - overview of Assisted Living statutes. ULP-B ULP-B was hired on May 14, 2024, to provide direct care to residents.	01470		

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01470	Continued From page 20 ULP-B's employee record lacked the following - overview of Assisted Living statutes. CNS-C CNS-C was hired on January 15, 2021, to provide oversight to employees and to provide nursing care to residents. CNS-C's employee record lacked the following: - overview of Assisted Living statutes; - review of provider's policies and procedures; - handing of resident complaints, reporting of complaints, where to report; - consumer advocacy services; and - review of types of Assisted Living services the employee will provide and provider's scope of license. On July 14, 2025, at 2:13 p.m., LALD-D stated CNS-C uses a different Relias (learning software) from another job for their training. LALD-D stated they did not assign trainings to CNS-C as CNS-C did not want to repeat the courses they had already completed. On July 16, 2025, 12:30 p.m., LALD-D stated they had assigned the above-mentioned trainings to both ULPs but the ULPs did not complete it. The licensee's undated 5.01 Orientation of Staff and Supervisors and Content policy indicated Orientation must be completed once for each staff person and is not transferable to another home care provider. 1. All employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. 2. The materials and/or type of training (i.e. video, lecture, reading, etc.) will be documented for compliance.	01470		

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01470	Continued From page 21 3. The orientation must contain the following topics: - An overview of the appropriate Assisted Living statutes and rules - An introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person - Handling of emergencies and use of emergency services - Compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) - The assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person - Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints - Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services - A review of the types of assisted living services the employee will be providing and the facility's category of licensure - The staff person's job description upon hire and whenever there is a change to the job description that changes the nature of the job or how the job is to be performed - The facility's organization chart and the roles of staff within the facility, and the services	01470		

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01470	Continued From page 22 offered by the facility as identified in the uniform checklist disclosure of services - The identification of incidents of maltreatment as defined under Minnesota Statutes, section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia, menta All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff completed two hours of initial mental illness and de-escalation training within 160 hours of providing direct care to residents for one of three employees (clinical nurse supervisor (CNS)-C). 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	01490		

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01490	Continued From page 23 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: CNS-C was hired on January 15, 2021, to provide oversight to employees and to provide nursing care to residents. CNS-C's employee record lacked documentation of mental illness and de-escalation training. On July 15, 2025, at 2:53 p.m., assisted living director (LALD-D) stated they had assigned the training to all employees, but they did not know if all employees had completed the training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01490		
01530 SS=E	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness	01530		

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01530	Continued From page 24 and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of three employees (unlicensed personnel (ULP)-A, ULP-B) received at least eight hours of initial dementia care training within 160 working hours of their employment start date, and two hours of additional dementia training for each 12 months of employment. This practice resulted in a level two violation (a	01530		

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01530	Continued From page 25 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-A ULP-A was hired on April 6, 2024, to provide direct care to residents. ULP-A's employee record included a Relias (online training platform) transcript which indicated ULP-A had 5.75 hours of dementia training completed October 20, 2024, through October 28, 2024, and 3.5 hours of dementia training May 23, 2025, through June 2, 2025. ULP-A's employee record lacked 2.25 hours of dementia training completed within 160 working hours of their employment start date. ULP-B ULP-B was hired on May 14, 2024, to provide direct care to residents. ULP-B's employee record included a Relias transcript which indicated ULP-B had 6.5 hours of dementia training completed September 16, 2024, through September 27, 2024. ULP-B's employee record lacked 1.5 hours of dementia training completed within 160 working hours of their employment start date, and 2 hours of additional dementia training for each 12	01530		

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	35604	A. BUILDING: _____ B. WING _____	07/16/2025

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01530	Continued From page 26 months of employment. On July 16, 2025, at approximately 11:15 a.m., licensed assisted living director (LALD)-D stated ULP-A and ULP-B had worked more than 160 hours by their anniversary dates. LALD-D stated ULP-A was a part time employee and worked three shifts a week and ULP-B was a full-time employee and worked 5 days a week. On July 16, 2025, at approximately 11:50 a.m., LALD-D stated they were aware of the requirement for providing eight hours of initial dementia training to direct care employees. LALD-D stated they did assign eight hours of dementia training to both ULPs but the ULPs only completed part of the training. On July 16, 2025, at 12:20 p.m., LALD-D stated all employees were expected to complete additional four hours of dementia training annually, a month before their employment anniversary date. The licensee's undated 5.03 Dementia Training policy indicated direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date; and all staff will complete two (2) hours of additional training for each 12 months of work thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will	01790		

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01790	Continued From page 27 (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the	01790		

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01790	Continued From page 28 medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for two of two employees (ULP-A, ULP- B). 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 of the residents). The findings include:	01790		

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01790	Continued From page 29 ULP-A ULP-A was hired on April 6, 2024, to provide direct care to residents. On July 15, 2025, at 8:54 a.m., the surveyor observed ULP-A administer medication to R3. ULP-B ULP-B was hired on May 14, 2024, to provide direct care to residents. ULP-A and ULP-B's employee record lacked documentation of training and competencies for unplanned time away when the RN is not available. On July 15, 2025, at 12:24 p.m., ULP-A stated they did not remember if they were trained on dispensing medication for residents when they had to leave the facility unexpectedly. ULP-A stated they did not have to dispense medication for leave of absence in the past. ULP-A stated they would call the nurse and the manager if a resident had to leave unexpectedly. On July 15, 2025, at 12:28 p.m., clinical nurse supervisor (CNS)-C stated the ULPs were trained and could dispense medication for a resident who was going on unplanned times away but usually licensed assisted living director (LALD)-D provided medication for a resident who was going on unplanned times away. CNS-C further stated they did not have documentation to indicate LALD-D or other ULPs were trained on unplanned times away medication administration, but asserted LALD-D knew how to administer medication. CNS-C stated they did not train ULP-A.	01790		

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01790	Continued From page 30 The licensee's undated 7.10 Medication Management -Planned and Unplanned Time Away policy read, "For unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or properly trained and competency tested unlicensed personnel may give the resident or resident's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven (7) calendar days with the following requirements: 1. The resident, or the resident's representative, must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances. 2. The medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. 3. The resident or resident's representative must be provided in writing the facility's contact information in case they have questions. 4. The process must be properly documented in the MAR and resident record including documenting the date the medications were given to the resident or the resident's representative and who received the medications, the person who gave the medications to the resident, the number of medications that were given to the resident, and other required information. For unplanned resident time away when a pharmacist or licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: 1. The registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents.	01790		

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01790	Continued From page 31 2. The registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: a. the type of container or containers to be used for the medications appropriate to the provider's medication system b. how the container or containers must be labeled c. the written information about the medications to be given to the resident or resident's representative d. how the unlicensed staff must document in the resident's record that medications have been given to the resident or the resident's representative, including documenting the date the medications were given to the resident or the resident's representative and who received the medications, the person who gave the medications to the resident, the number of medications that were given to the resident, and other required information e. how the registered nurse shall be notified that medications have been given to the resident or resident's representative and whether the registered nurse needs to be contacted before the medications are given to the resident or the resident's representative f. a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel g. how the unlicensed staff must document in the resident's record any unused mediations that are returned to the provider, including the name of each medication and the doses of each returned medication."	01790		

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01790	Continued From page 32 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01870 SS=D	144G.71 Subd. 18 Medications provided by resident or family me When the assisted living facility is aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the resident record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were included in the assessment for medication management or documented in the resident record for medication or dietary supplement the resident was self-administering for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on August 18, 2020. R1's diagnoses included chronic	01870		

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01870	Continued From page 33 obstructive pulmonary disease, hypertension, hypothyroidism, anxiety, benign tumor of brain, chest pain, seizure disorder, lung nodule, neuropathy, and major depressive disorder. R1's Service Plan (Waiver)- Addendum to Contract dated August 25, 2024, indicated R1 received services for ambulation, grooming, housekeeping, laundry, linen change, manage behavior, manage symptoms, meal assistance, medication administration, shopping assistance, skin care, and transportation assistance. On July 15, 2025, at 12:51 p.m., the surveyor observed the following medications in R1's room: - Tylenol extra strength 500 milligram(mg); and - Prilosec (omeprazole) delayed tablet 20mg. R1's medication administration record (MAR) dated July 2025, indicated R1 took Prilosec (omeprazole) delayed tablet 20mg twice a day. R1's MAR did not indicate R1 was taking Tylenol extra strength 500mg. R1's signed Provider Orders dated February 13, 2025, indicated R1 had an order for omeprazole 20mg delayed release capsules, take 1 capsule by mouth twice daily. R1's individualized medication management plan (IMMP) dated May 27, 2025, indicated R1 could not self-administer. The IMMP indicated all medication would be secured in a central storage in a locked room. On July 15, 2025, at 12:59 p.m., clinical nurse supervisor (CNS)-C stated R1 was not able to self-administer any medication. CNS-C stated they were not aware R1 had the above-mentioned medications in their room.	01870		

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01870	Continued From page 34 CNS-C stated R1 did not have an order for Tylenol and no order for Prilosec on an as needed basis. CNS-C stated they had gone in R1's room last week but did not see any medication in R1's room. On July 15, 2025, at 1:02 p.m., unlicensed personnel (ULP)-A stated they knew R1 had the above-mentioned medications in their room. ULP-A stated R1 took Tylenol for pain and the Prilosec for acid reflux occasionally. On July 16, 2025, at 11:08 a.m., R1 stated she had been self-administering the Tylenol for pain and the Prilosec for acid reflux, "emergency medicine". The licensee's undated 7.11 Medication Storage policy indicated when medications are managed and stored by the licensee, medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01870		
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.	01890		

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01890	Continued From page 35 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a medication was labeled with the resident's name for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on August 18, 2020. R1's diagnoses included chronic obstructive pulmonary disease, hypertension, hypothyroidism, anxiety, benign tumor of brain, chest pain, seizure disorder, lung nodule, neuropathy, and major depressive disorder. R1's Service Plan (Waiver)- Addendum to Contract dated August 25, 2024, indicated R1 received services for ambulation, grooming, housekeeping, laundry, linen change, manage behavior, manage symptoms, meal assistance, medication administration, shopping assistance, skin care, and transportation assistance. On July 15, 2025, at 11:00 a.m., the surveyor observed the medication cabinet and observed R1's insulin aspart protamine and insulin aspart injectable suspension mix70/30, 100unit/ milliliter (ML) flex pen opened on July 14, 2025, without an identifying name label.	01890		

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01890	Continued From page 36 On July 15, 2025, at 11:13 a.m., clinical nurse supervisor (CNS)-C stated the insulin pen was for R1 and stated the pharmacy sent the insulin pen without a name label. The licensee's undated 7.36 insulin policy read, "1. Medications always need to be administered according to the "6 Rights" o Right person o Right medication o Right time o Right route (i.e., by mouth, eye drop, to the skin) o Right dose (i.e., how many milligrams, drops) o Right chart/record to document that the medication was taken 2. Some important tips to remember when assisting residents with self-administered insulin medications are: A. Always know what medications you are giving, what effect they have, and what their side effects are. If you are not sure about any medications, check your medication reference manual and/or call the nurse. B. Medications should be set up, given to the individual, and documented by the same staff member. Do not give out medications that another person has set up. C. To avoid confusion, it is best to give the medications as quickly as possible after they are set up. Set up the medications for one person, give them to the person, and document that they were given before you set up the medications for the next person. D. Always wash your hands before setting up medications and at any time during the process if your hands have been contaminated. (See hand washing procedure) E. Compare the information of the MAR with the	01890		

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01890	Continued From page 37 label on the medication container. The following information should be in all the places: o Resident name o Name of the medication o The strength and dosage of the medication o The route o The time that the medication is to be given o Any special instructions F. If you cannot read the label, or if the MAR and the label do not all say the same thing, stop and call the nurse for instructions. The directions on the label and the MAR should be the same. 3. Read the label and compare it with the information on the MAR three (3) times to make sure that you haven't made a mistake." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration;	01940		

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01940	Continued From page 38 (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a current treatment or therapy management plan to include all required content for two of two residents (R1, R2) who received blood glucose monitoring and oxygen therapy. 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 of the residents). The findings include: R1 R1 was admitted to the licensee on August 18, 2020. R1's diagnoses included chronic obstructive pulmonary disease, hypertension,	01940		

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01940	Continued From page 39 hypothyroidism, anxiety, benign tumor of brain, chest pain, seizure disorder, lung nodule, neuropathy, and major depressive disorder. R1's Service Plan (Waiver)- Addendum to Contract dated August 25, 2024, indicated R1 received services for ambulation, grooming, housekeeping, laundry, linen change, manage behavior, manage symptoms, meal assistance, medication administration, shopping assistance, skin care, and transportation assistance. R1's prescriber order dated November 14, 2022, indicated R1 required 2 liters of oxygen per minute (LPM) via nasal cannula with activity and 3 LPM via nasal cannula at night. R1's signed prescriber order dated June 12, 2025, indicated "test blood glucose levels daily". R1's Service Recap Summary - Month for the month of July 2025, indicated direction to staff for recording blood glucose twice daily. The service recap summary indicated staff were checking R1's blood glucose twice daily. R1's record lacked specific instruction related to blood glucose monitoring. R1's Individualized Treatment and Therapy Plan (ITTP) as of July 15, 2025, indicated a treatment and therapy plan for oxygen delivery. R1's ITTP read, "ULP - Oxygen delivery as ordered: Resident is on Oxygen when napping and at night, HHA will check and remind resident to put it on. Notify RN if: its less 90%. RN - Check with the client for SOB, Educate the the [SIC] client to report SOB and check the setting and tank tube for malfunction, Review the Oxygen saturation for the past one week every Monday". R1's ITTP did not indicate R1's blood glucose monitoring plan,	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35604	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG HEARTS HOME CARE INC	1130 14TH AVENUE SE MINNEAPOLIS, MN 55414

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 40 and the ITTP lacked procedures for notifying a registered nurse or appropriate health professional when a problem arises with blood glucose monitoring. On July 15, 2025, at 12:53 p.m., the surveyor observed R1's oxygen concentrator dialed to 5 LPM delivering 5 liters of oxygen to R1 via nasal canula while R1 was resting in bed. On July 15, 2025, at 12:54 p.m., unlicensed personnel (ULP)-A stated they did help R1 by turning the oxygen concentrator on and to put the cannula on R1. ULP-A stated they believed R1 was supposed to be on 3 or 4 LPM of oxygen; ULP-A stated they received direction from R1 for how many liters of oxygen to deliver, and they dialed it to the number R1 wanted. ULP-A stated they also check R1's oxygen saturation. R2 R2 was admitted to the licensee on August 18, 2020. R2's diagnoses included bilateral lower extremity edema diabetic, major depressive disorder, chronic systolic congestive heart failure, and chronic venous insufficiency. R2's Service Plan (Waiver)- Addendum to Contract dated August 25, 2024, indicated R2 received services for dressing, grooming, housekeeping, laundry, linen change, manage behavior, meal assistance, medication administration, shopping assistance, skin care, and transportation assistance. R2's signed prescriber order dated April 3, 2023, indicated R2 required 2 liters of oxygen per minute (LPM) via nasal cannula. R2's ITTP as of July 15, 2025, was blank and did	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35604	A. BUILDING: _____ B. WING _____	07/16/2025

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01940	Continued From page 41 not indicate R2's oxygen administration and monitoring plan. R2's electronic task list for the licensee's staff dated April 4, 2023, under Respiratory Equipment Care- AM daily order read, "staff will help the client [resident] to put it on and regulate the setting on the oxygen tank when in use and switch off as needed." R2's Service Recap Summary - Month for the month of July 2025, indicated record-oxygen saturation twice daily. R2's record lacked specific instruction related to oxygen administration and monitoring. On July 15, 2025, at 12:54 p.m., clinical nurse supervisor (CNS)-C confirmed there were no clear instructions for the ULPs to follow for R1 and R2's oxygen administration or for R1's blood sugar checks. CNS-C stated the ULPs may not know how many liters of oxygen to deliver. On July 15, 2025, at 1:20 p.m., licensed assisted living director (LALD)-D stated R1 asked the doctor to manage their own oxygen. LALD-D was unable to provide the order from the doctor for R1 to manage their own oxygen. On July 15, 2025, at 1:24 p.m., CNS-C stated there was no assessment completed for R1to determine if they were competent and able to manage their own medication or oxygen delivery. On July 15, 2025, at 1:30 p.m., CNS-C stated they spoke with R1 to find out why they were on 5LPM of oxygen at rest and CNS-C learned that R1 had a new oxygen order. The surveyor overheard CNS-C ask if LALD-D had received the order; LALD-D replied to CNS-C no; they had not	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35604	A. BUILDING: _____ B. WING _____	07/16/2025

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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
01940	Continued From page 42 received a new order. On July 15, 2025, at 1:32 p.m., CNS-C clarified with R1 about the new oxygen order mentioned above and stated R1 received a verbal order from the doctor to increase the oxygen level. On July 15, 2025, at 2:36 p.m., CNS-C stated R2 was managing their own oxygen but there was no assessment completed for R2 to check if R2 was competent and able to manage their own oxygen. On July 15, 2025, at 2:42 p.m., CNS-C stated they did not have an answer for why there was no clear instruction for the ULPs to follow for both residents' treatments and therapies mentioned above. The licensee's undated 7.05 treatment and Therapy Management Plan policy indicated the licensee will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided b. Documentation of specific resident instructions relating to the treatments or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. Any resident-specific requirements relating to documentation of treatment and therapy received f. Verification that all treatment and therapy was administered as prescribed g. Monitoring of treatment or therapy to prevent	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 43 possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure treatments were performed as ordered for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01960	Continued From page 44 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on August 18, 2020. R1's diagnoses included chronic obstructive pulmonary disease, hypertension, hypothyroidism, anxiety, benign tumor of brain, chest pain, seizure disorder, lung nodule, neuropathy, and major depressive disorder. R1's Service Plan (Waiver)- Addendum to Contract dated August 25, 2024, indicated R1 received services for ambulation, grooming, housekeeping, laundry, linen change, manage behavior, manage symptoms, meal assistance, medication administration, shopping assistance, skin care, and transportation assistance. BLOOD GLUCOSE R1's signed prescriber order dated June 12, 2025, indicated "test blood glucose levels daily". R1's Service Recap Summary - Month for the month of July 2025, indicated a direction for staff for recording blood glucose twice daily. The service recap summary indicated staff were checking R1's blood glucose twice daily. R1's record lacked specific instruction related to blood glucose monitoring. R1's service recap summary for recording blood glucose twice daily did not match R1's signed prescriber order for recording blood glucose daily. On July 15, 2025, at 2:21 p.m., clinical nurse supervisor (CNS)-C stated they did not know why the blood glucose order for R1 did not matching	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35604	A. BUILDING: _____ B. WING _____	07/16/2025

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01960	Continued From page 45 the provider order and stated they were checking to find out what happened. On July 15, 2025, at 2:25 p.m., CNS-C stated R1's record blood glucose order was entered into Rtask (software system) incorrectly and stated it was a transcription error. OXYGEN R1's prescriber order dated November 14, 2022, indicated R1 required 2 liters of oxygen per minute (LPM) via nasal cannula with activity and 3 LPM via nasal cannula at night. On July 15, 2025, at 12:53 p.m., the surveyor observed R1's oxygen concentrator dialed to 5 LPM delivering 5 liters of oxygen to R1 via nasal canula while R1 was resting in bed. On July 15, 2025, at 12:54 p.m., unlicensed personnel (ULP)-A stated they did help R1 by turning the oxygen concentrator on and to put the cannula on R1. ULP-A stated they believed R1 was supposed to be on 3 or 4 LPM of oxygen; ULP-A stated they received direction from R1 for how many liters of oxygen to deliver, and they dialed it to the number R1 wanted. ULP-A stated they also check R1's oxygen saturation. On July 15, 2025, at 12:54 p.m., CNS-C confirmed there were no clear instructions for the ULPs to follow for R1 and oxygen administration. CNS-C stated the ULPs may not know how many liters of oxygen to deliver. On July 15, 2025, at 1:20 p.m., licensed assisted living director (LALD)-D stated R1 asked the doctor to manage their own oxygen. LALD-D was unable to provide the order from the doctor for R1	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01960	Continued From page 46 to manage their own oxygen. On July 15, 2025, at 1:24 p.m., CNS-C stated there was no assessment completed for R1 to determine if they were competent and able to manage their own medication or oxygen delivery. On July 15, 2025, at 1:30 p.m., CNS-C stated they spoke with R1 to find out why they were on 5LPM of oxygen at rest and CNS-C learned that R1 had a new oxygen order. The surveyor overheard CNS-C ask if LALD-D had received the order; LALD-D replied to CNS-C no; they had not received a new order. On July 15, 2025, at 1:32 p.m., CNS-C clarified with R1 about the new oxygen order mentioned above and stated R1 received a verbal order from the doctor to increase the oxygen level. On July 15, 2025, at 2:42 p.m., CNS-C stated they did not have an answer for why there was no clear instruction for the ULPs to follow for the residents' treatments and therapies mentioned above. The licensee's undated 7.05 treatment and Therapy Management Plan policy indicated the licensee will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided b. Documentation of specific resident instructions relating to the treatments or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or	01960		

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01960	Continued From page 47 appropriate licensed health professional when a problem arises with treatments or therapy services e. Any resident-specific requirements relating to documentation of treatment and therapy received f. Verification that all treatment and therapy was administered as prescribed g. Monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescriber's orders were in place for treatments for two of two residents (R1, R2). This practice resulted in a level two violation (a	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 48 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 the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on August 18, 2020. R1's diagnoses included chronic obstructive pulmonary disease, hypertension, hypothyroidism, anxiety, benign tumor of brain, chest pain, seizure disorder, lung nodule, neuropathy, and major depressive disorder. R1's Service Plan (Waiver)- Addendum to Contract dated August 25, 2024, indicated R1 received services for ambulation, grooming, housekeeping, laundry, linen change, manage behavior, manage symptoms, meal assistance, medication administration, shopping assistance, skin care, and transportation assistance. On July 15, 2025, at 12:53 p.m., the surveyor observed R1's oxygen concentrator dialed to 5 LPM delivering 5 liters of oxygen to R1 via nasal canula while R1 was resting in bed. R1's prescriber order dated November 14, 2022, indicated R1 required 2 liters of oxygen per minute (LPM) via nasal cannula with activity and 3 LPM via nasal cannula at night. R1's record lacked a current and renewed prescriber order for oxygen treatment.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 49 R2 R2 was admitted to the licensee on August 18, 2020. R2's diagnoses included bilateral lower extremity edema, diabetic, major depressive disorder, chronic systolic congestive heart failure, and chronic venous insufficiency. R2's Service Plan (Waiver)- Addendum to Contract dated August 25, 2024, indicated R2 received services for dressing, grooming, housekeeping, laundry, linen change, manage behavior, meal assistance, medication administration, shopping assistance, skin care, and transportation assistance. R2's signed prescriber order dated April 3, 2023, indicated R2 required 2 liters of oxygen per minute (LPM) via nasal cannula. R2's electronic task list for the licensee's staff dated April 4, 2023, under Respiratory Equipment Care- AM daily order read, "staff will help the client [resident] to put it on and regulate the setting on the oxygen tank when in use and switch off as needed." R2's Service Recap Summary - Month for the month of July 2025, indicated an order to record-oxygen saturation twice daily and respiratory equipment care daily in the morning. R2's record lacked a current and renewed prescriber order for oxygen treatment. On July 15, 2025, at 1:20 p.m., licensed assisted living director (LALD)-D stated R1 asked the doctor to manage their own oxygen. LALD-D was unable to provide the order from the doctor for R1 to manage their own oxygen.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 50 On July 15, 2025, at 1:30 p.m., CNS-C stated they spoke with R1 to find out why they were on 5LPM of oxygen at rest, and CNS-C learned that R1 had a new oxygen order. CNS-C asked if LALD-D had received the order. LALD-D replied to CNS-C no; they had not received a new order. On July 15, 2025, at 1:32 p.m., CNS-C clarified with R1 about the new oxygen order mentioned above and stated R1 received a verbal order from the doctor to increase the oxygen level. On July 16, 2025, at 12:34 p.m., CNS-C stated prescription renewal for all medication, treatment and therapy was completed every year. CNS-C stated they were not aware that R1 and R2's oxygen orders were outdated. The licensee's undated 7.40 Oxygen policy read, "POLICY: When oxygen is utilized by resident at [the licensee's name] the facility will determine, based on assessment and what is included in the resident Service Plan, if the resident or the facility is responsible for the ordering, refilling, and administration of oxygen. PROCEDURE 1. If [the licensee's name] accepts responsibility for the ordering, refilling, and administration of oxygen, then oxygen shall be managed in the same manner as an ordered medication, including requiring a physician order." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Big Hearts Home Care Inc.
1130 14th Ave SE
Minneapolis, MN 55414
Hennepin County
Parcel:

Phone:

License Info

License: 0042114

Risk:
License: -1
Expires on: 12/31/2023
CFPM: AHMED FARAH
CFPM #: 21524; Exp: 02/12/2028

Inspection Info

Report Number: F1023251055
Inspection Type: Follow-up - Single
Date: 7/21/2025 Time: 1:18:56 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

FOLLOW UP CONDUCTED TO ENSURE SAFE FOOD OPERATIONS.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1023251055 from 7/21/2025

Gregory T Nelson

AHMED FARAH
PERSON IN CHARGE

Greg Nelson,
Public Health Sanitarian 3
651-201-4259
greg.nelson@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

Big Hearts Home Care Inc.
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1023251055
Inspection Type: Follow-up
Date: 7/21/2025
Time: 1:18:56 PM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Refrigerator **#**1 at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: JUICE**; Temperature Process:** Cold-Holding
Location: Refrigerator **#**2 (BASEMENT) at 41 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

Big Hearts Home Care Inc.
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1023251055
Inspection Type: Follow-up
Date: 7/21/2025
Time: 1:18:56 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine (ANSI 184)
Location: **Greater Than** 150 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:**
Location: Kitchen **Equal To** PPM
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Big Hearts Home Care Inc.
1130 14th Ave SE
Minneapolis, MN 55414
Hennepin County
Parcel:

Phone:

License Info

License: 0042114

Risk:
License: -1
Expires on: 12/31/2023
CFPM: AHMED FARAH
CFPM #: 21524; Exp: 02/12/2028

Inspection Info

Report Number: F1023251050
Inspection Type: Full - Single
Date: 7/14/2025 Time: 1:18:39 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 1
Delivery:

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: REISSUED FROM LAST SURVEY. HIGH TEMP DISH WASHER IN USE BUT OPERATOR STATED NO METHOD OF VERIFYING 150dF AVAILABLE ON SITE. ACQUIRE AND USE THIS DEVICE TO ENSURE PATHOGEN DESTRUCTION.
Comply By: 10/04/2023 Originally Issued On: 7/14/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: REISSUED FROM LAST SURVEY. CHLORINE SANITIZER ON SITE BUT NO METHOD TO VERIFY CORRECT CONCENTRATION. ACQUIRE AND USE TEST STRIPS TO ENSURE PATHOGEN DESTRUCTION.
Comply By: 10/04/2023 Originally Issued On: 7/14/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.111ABD *Priority Level: Priority 3 CFP#: 38*
MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.
COMMENT: REISSUED FROM PREVIOUS SURVEY. OBSERVED MOUSE DROPPINGS IN BASEMENT DRY STORAGE ROOMS. OPERATOR MUST CHECK ENTIRE FACILITY FOR MOUSE DROPPINGS REGULARLY, CLEAN ALL MOUSE DROPPINGS WHEN FOUND, SEAL POINTS OF ENTRY ASSOCIATED WITH DROPPINGS, ORGANIZE AREAS THAT HARBOR MICE AS EVIDENCED BY DROPPINGS, AND HAVE PROFESSIONAL PEST CONTROL SERVICES VISIT AS NEEDED.
Comply By: 10/04/2023 Originally Issued On: 7/14/2025

Food & Beverage General Comment

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE

- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- ANSI 184 DISH WASHER
- PEST CONTROL REQUIREMENTS

FOOD SERVICE IS PROVIDED BY FACILITY STAFF. THIS FACILITY DOES NOT HAVE ALL COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1023251050 from 7/14/2025

Gregory T Nelson

AHMED FARAH
PERSON IN CHARGE

Greg Nelson,
Public Health Sanitarian 3
651-201-4259
greg.nelson@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

Big Hearts Home Care Inc.
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1023251050
Inspection Type: Full
Date: 7/14/2025
Time: 1:18:39 PM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Refrigerator **#**1 at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: JUICE**; Temperature Process:** Cold-Holding
Location: Refrigerator **#**2 (BASEMENT) at 41 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

Big Hearts Home Care Inc.
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1023251050
Inspection Type: Full
Date: 7/14/2025
Time: 1:18:39 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine (ANSI 184)
Location: **Greater Than** Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:**
Location: Kitchen **Equal To** PPM
Comment:
Violation Issued?: No