Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 14, 2026

Licensee
Big Hearts Home Care Inc
3824 Park Avenue
Minneapolis, MN 55407

RE: Project Number(s) SL42147015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on July 23, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s)

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

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

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42147	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG HEARTS HOME CARE INC	3824 PARK AVENUE MINNEAPOLIS, MN 55407

(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: #SL42147015-0 On July 20, 2026, through July 23, 2026, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there was one resident; one receiving services under the provider's Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing 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 pursuant to 144G.31 Subd. 1, 2 and 3.	
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone	0 730		

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0 730	Continued From page 1 number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and	0 730		

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0 730	Continued From page 2 (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure resident records included documentation of services provided for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R2 was admitted on May 5, 2026. R2's Service Plan signed May 5, 2026, indicated R2 received services including meal assistance, blood glucose monitoring, vital signs check, bed making, dressing, grooming, laundry, behavior management, and medication assistance. On July 21, 2026, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-C assisting R2 with medication administration. R2's Service Recap Summary, dated June 2026, and July 2026, were each identified by licensed assisted living director (LALD)-A as documentation of services the licensee provided for R2. The Service Recap Summary documents	0 730		

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0 730	Continued From page 3 included a line item for each service to be provided by the licensee and a box for every date and time of day where the staff member who completed the service would initial when the service was provided or circle their initials when a service was not provided. If no initials were present in a box, it indicated the service was not provided. R2's Service Recap Summary included boxes with no indication whether services were provided as agreed upon in R2's Service Plan, or that the services were refused, including the following: -June 2: 13 of 43 scheduled services, -June 18: 6 of 43 scheduled services, -June 23: 8 of 43 scheduled services, -June 25: 5 of 43 scheduled services, -June 29: 27 of 43 scheduled services, -July 2: 1 of 43 scheduled services, -July 7: 9 of 43 scheduled services, -July 10: 2 of 43 scheduled services, -July 13: 16 of 43 scheduled services. On July 21, 2026, at 9:45 a.m., LALD-A stated they monitor documented services. LALD-A further stated the ULP should have been documenting completed services, and the empty boxes would indicate the service was not provided. LALD-A stated there might be empty boxes because the ULP had forgotten to provide the documentation, and they would have to educate the ULP on the importance of documenting services provided. The licensee's 2.37 Resident Record - Documentation policy dated December 1, 2025, indicated all services would be documented in the resident's record and when services were not provided, staff would document the reason why and must be reported to meet the resident's needs.	0 730		

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0 730	Continued From page 4 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document administration of medications according to provider orders for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	01760		

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01760	Continued From page 5 affect a large portion or all of the residents). The findings include: R2 was admitted on May 5, 2026. R2's Service Plan signed May 5, 2026, indicated R2 received services including meal assistance, blood glucose monitoring, vital signs check, bed making, dressing, grooming, laundry, behavior management, and medication assistance. On July 21, 2026, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-C assisting R2 with medication administration. R2's medication administration record (MAR), dated June 2026, lacked documentation for the following scheduled medication times: -aspirin (heart attack and stroke preventative) 81 milligrams (mg) at 8:00 a.m., on June 2, 10, 23, 25; -fluoxetine (antidepressant) 40 mg at 8:00 a.m., on June 2, 10, 23, 25; -gabapentin (nerve pain) 300 mg at 8:00 a.m., on June 2, 10, 23, 25; -insulin lispro (fast acting insulin to lower blood sugar) 6 units at 8:00 a.m., on June 2, 10, 23, 25; -insulin lispro 6 units at 1:00 p.m., on June 15; -insulin lispro 6 units at 5:00 p.m., on June 29; -losartan potassium (lower blood pressure and protect kidney function) 12.5 mg at 8:00 a.m., on June 2, 10, 23, 25; -polyethylene glycol powder (laxative) 17 grams at 8:00 a.m., on June 2, 10, 23, 25; -aripiprazole (antidepressant)10 mg at 9:00 p.m., on June 29, and -quetiapine fumarate (antidepressant) 50 mg at 9:00 p.m., on June 29.	01760		

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01760	Continued From page 6 R2's record lacked documentation the medications were administered as prescribed, or the reason why medication administration was not completed as prescribed and any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed. On July 21, 2026, at 9:45 a.m., licensed assisting living director (LALD)-A stated they monitor documentation of medication administration. LALD-A further stated the ULP should have been documenting medication administration, and the empty boxes would indicate the medication was not administered. LALD-A stated there might be empty boxes because the ULP had forgotten to provide the documentation, and they would have to educate the ULP on the importance of documenting medication administration. The licensee's 7.08 Medication Management-Administration and Setup policy dated December 1, 2025, indicated the staff administering medication would document on the MAR by entering their initials under the date and opposite the medication and dose given. The policy further indicated documentation would be done immediately after the task had been performed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health	02320		

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02320	Continued From page 7 care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure unlicensed personnel (ULP)-C followed appropriate medication administration procedures. 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: ULP-C was hired May 15, 2026. ULP-C's record included documentation the employee had been trained and competency tested prior to being delegated medication administration. On July 21, 2026, at 8:10 a.m., the surveyor observed ULP-C assisting R2 with medication administration. ULP-C performed hand hygiene, applied gloves, and prepared R2's medications. ULP-C removed R2's medications from medication packets and placed the medications into a medication cup. ULP-C handed the medication cup to R2 who put the cup to their mouth. The surveyor observed one of the	02320		

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02320	Continued From page 8 medications fall from the cup to the floor. ULP-C bent over to pick up the medication from the floor and R2's swallowed the rest of the medications with water. ULP-C then placed the fallen medication back into the cup and R2 swallowed the medication with water. ULP-C stated they had been trained by the registered nurse on medication administration. On July 21, 2026, at 9:00 a.m., ULP-C stated, they should not have given the dropped medication to R2. ULP-C stated she would normally call the nurse to report a dropped medication, but she was nervous. On July 21, 2026, at 11:00 a.m., licensed assisted living director (LALD)-A stated ULPC should not have given the dropped medication to R2, and instead should have called the nurse. LALD-A stated he would call the nurse. The licensee's 7.07 Medication Loss or Spillage policy dated December 1, 2026, indicated that when a loss or spillage of a medication occurred, a notation would be made in the resident's record explaining the spillage and the actions taken. The policy further indicated a medication error report form would be completed and staff would notify the RN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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
3824 PARK AVENUE
Minneapolis, MN 55407
Hennepin County
Parcel:

Phone:

License Info

License: HFID 42147

Risk:
License:
Expires on:
CFPM: Ahmed Farah
CFPM #: 21524; Exp: 2/11/2028

Inspection Info

Report Number: F1063261180
Inspection Type: Follow-up - Single
Date: 7/23/2026 Time: 2:55:08 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

No inspection was completed. The operator sent a picture over email on 7/22/2026 to confirm dish machine was measuring at a minimum of 160 degrees F per test strip. Order for MN rule 4626.0905B was removed.

UTENSIL SURFACE TEMPERATURE: >160 DEGREES F

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 F1063261180 from 7/23/2026

Ahmed Farah
Program Director

Laura Yang,
Public Health Sanitarian 1
651-201-3581
laura.yang@state.mn.us