



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 5, 2024

Licensee

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

RE: Project Number(s) SL35604015

Dear Licensee:

On December 19, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on October 5, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 5, 2023 survey.

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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on October 5, 2023, found not corrected at the time of the December 19, 2023, follow-up survey and/or subject to penalty assessment are as follows:

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

0810 - Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on December 19, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. 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.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

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 the MDH 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>

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:

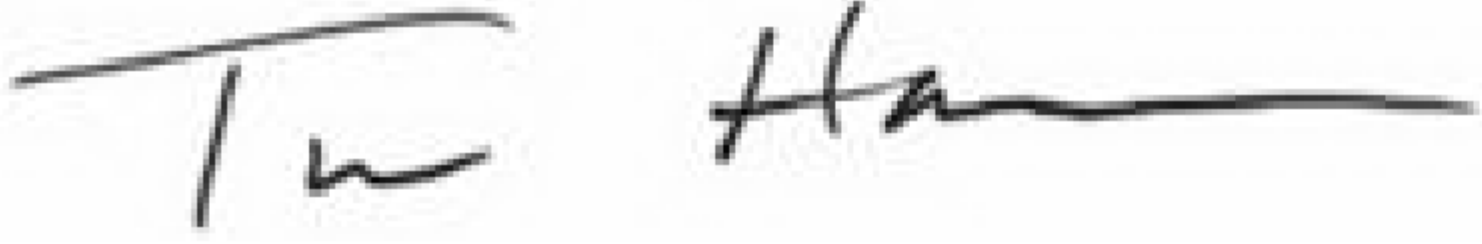
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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.

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Hanna". The signature is written in a cursive, flowing style with a horizontal line extending from the end.

Tim Hanna, Supervisor

Engineering Services

Email: Tim.Hanna@state.mn.us

Telephone: 507-208-8982 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35604	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/19/2023
NAME OF PROVIDER OR SUPPLIER BIG HEARTS HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL35604015-1 On December 19, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 5, 2023. At the time of the survey, there were 3 residents: 3 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced	{0 480}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 by: No further action required	{0 480}			
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (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: No further action required.	{0 650}			
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	{0 660}			

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{0 660}	Continued From page 2 program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action required.	{0 660}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses 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	{0 680}			

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{0 680}	Continued From page 3 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: No further action required.	{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	{0 780}			

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{0 780}	Continued From page 4 existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On December 19, 2023, at 10:30 a.m., survey staff toured the facility with the unlicensed personnel (ULP)-B. Survey staff tested the smoke alarms throughout the home. It was observed that there was no smoke alarm in the hallway outside bedrooms #1 and #2 and found that the smoke alarms in the following locations did not sound when the test button was pressed: 1. Bedroom #3 2. Dining Room 3. Bedroom #4 It was observed that half of the smoke alarms in the facility were interconnected and the other half did not work. These deficient conditions were	{0 780}			

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{0 780}	Continued From page 5 visually verified by ULP-B accompanying on the tour. During interview, ULP-B stated that they had installed all new smoke alarms, but she did not know why the above listed locations did not work. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	{0 780}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	{0 810}			

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{0 810}	Continued From page 6 training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. 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 and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 19, 2023, unlicensed personnel (ULP)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "9.06 Fire Policy", undated, failed to include the following:	{0 810}			

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{0 810}	Continued From page 7 The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on December 19, 2023, at 1:00 p.m., ULP-B stated she did not know if there was a more updated policy on site. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING	{0 810}			

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{0 810}	Continued From page 8 Record review indicated the licensee failed to provide evacuation training to residents at least once per year. ULP-B was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. ULP-B was unable to provide documentation showing any training provided or training scheduled for a future date for staff since the date of the last survey. During an interview on December 19, 2023, at 1:00 p.m., ULP-B stated she was not aware of any training planned for the fire safety and evacuation plans. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. ULP-B was unable to provide documentation showing any evacuation drills completed since the date of the last survey. During an interview on December 19, 2023, at 1:00 p.m., ULP-B stated she was not aware of any evacuation drills that were completed or planned since the date of the last survey. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	{0 810}			
{01500} SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training	{01500}			

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{01500}	Continued From page 9 for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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	{01500}			

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{01500}	Continued From page 10 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the 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, 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: No further action required.	{01500}			
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to	{01530}			

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{01530}	Continued From page 11 dementia care 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 employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: No further action required.	{01530}			
{01940} SS=D	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; (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	{01940}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35604	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/19/2023
NAME OF PROVIDER OR SUPPLIER BIG HEARTS HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 12 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: No further action required.	{01940}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 31, 2023

Licensee

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

RE: Project Number(s) SL35604015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 5, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The 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 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of

abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. 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 the MDH 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.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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 MDH 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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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.

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,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35604	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2023
NAME OF PROVIDER OR SUPPLIER BIG HEARTS HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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: SL35604015 On October 3, 2023, through October 5, 2023, 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 four (4) active residents received services under the Assisted Living license. On October 3, 2023, at approximately 6:05 p.m. an immediate order was issued for 0820. At the time of exit, the immediacy was removed, however noncompliance will remain at the same scope and level.	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 Provider. 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 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35604	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2023
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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated october 03, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure,	0 650			

Minnesota Department of Health

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0 650	Continued From page 2 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 the employee record contained the required content to include an annual performance evaluation for one of one registered nurse ((RN)-A). 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: RN-A was hired January 15, 2021, to provide	0 650		

Minnesota Department of Health

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0 650	Continued From page 3 direct cares for the residents of the facility. RN-A's employee record lacked evidence of documentation of a subsequent annual performance review that identified areas of improvement needed and training needs. On October 3, 2023, at 2:30 p.m., licensed assisted living director (LALD)-C stated they are aware of the required annul performance evaluations, but are behind on the annual performance evaluations. The licensee's 4.05 Employee Records policy revised dated August 01, 2023, indicated the personnel record for each person would include annul performance evaluations which identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=D	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	0 660			

Minnesota Department of Health

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0 660	Continued From page 4 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) when the licensee failed to ensure a two-step tuberculin skin test (TST) or other blood test was completed upon hire for one of two employees (unlicensed personnel (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, 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: The facility TB risk assessment dated July 1, 2023, indicated the facility was at a low risk for TB transmission. ULP-B was hired January 10, 2023, and provided direct care services to licensee residents. ULP-B's record lacked documentation ULP-B completed a two-step TST or other blood test and TB history and symptoms screening completed	0 660			

Minnesota Department of Health

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0 660	Continued From page 5 by the licensee upon hire. On October 4, 2023, at 2:50 p.m., licensed assisted living director (LALD)-C confirmed ULP-B's employee record included a TB screening dated July 11, 2022, and a chest x-ray completed on July 11, 2022, (more than 90 days prior to hire). LALD-C acknowledge ULP-B's record lacked TB history and symptom screen and negative IGRA (serum blood test) or TST dated within 90 days before hire. The Minnesota Department of Health (MDH) guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." The licensee's 8.16 Tuberculosis Screening policy revised date August 1, 2023, indicated baseline screenings at time of hire for all healthcare personnel would be completed by the licensee. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB	0 660			

Minnesota Department of Health

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0 660	Continued From page 6 Screening Tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses 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	0 680			

Minnesota Department of Health

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0 680	Continued From page 7 allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. The licensee failed to maintain testing and maintenance records for the emergency generator. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On October 04, 2023, at approximately 11:30 a.m., licensed assisted living director (LALD)-C provided the licensee's written emergency disaster plan. The licensee's plan lacked the following required content: -an assessment of the at risk population's needs; -a process for emergency preparedness (EPS) cooperation with state and local EPS officials/organizations; -procedure for tracking residents and staff; -an evacuation plan to include staff responsibilities during an evacuation; -a plan for how the facility would provide a means to shelter in place for residents, staff and	0 680			

Minnesota Department of Health

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0 680	Continued From page 8 volunteers; -development of emergency staffing strategies to include volunteers; -contact information for federal, state, regional EPS staff, state licensing and certification agency and Office of the State Long Term Care Ombudsman; and -primary and alternative means of communicating with facility staff, federal, state, tribal, regional and local emergency management agencies. On October 5, 2023, at 12:00 p.m., licensed assisted living director (LALD)-C confirmed he believed the licensee had all required components of the EPP developed; however, during further discussion, LALD-C acknowledged some areas could be more developed. The licensee's 9.01 Emergency Preparedness Plan policy revised date August 1, 2023, indicated "Licensee's emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach. Key elements of the plan include four primary components: 1. Risk assessment and planning 2. Policies and procedures 3. A communication plan 4. Staff training and exercises/drills." No additional 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	0 780		

Minnesota Department of Health

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0 780	Continued From page 9 (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 by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 780		

Minnesota Department of Health

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0 780	Continued From page 10 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). Findings include: On October 3, 2023, approximately from 11:45 a.m. to 12:15 p.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-C. It was observed that the smoke alarms throughout the home were not interconnected with each other so the actuation of one alarm would cause all alarms to operate. This deficient condition was visually verified by LALD-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall	0 810		

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0 810	Continued From page 11 receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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). Findings include:	0 810			

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0 810	Continued From page 12 A record review and interview were conducted on October 6, 2023, at approximately 2:45 p.m. with the licensed assisted living director (LALD)-C on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. During interview, LALD-C verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, LALD-C verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for the relocation of residents but did not specify how to move or	0 810			

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0 810	Continued From page 13 evacuate residents or identify the unique and unusual needs of the residents. During interview, LALD-C verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, LALD-C stated they doing training upon hire and then annually after that. LALD-C verified the licensee did not have any additional documentation on training employees. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. During interview, LALD-C stated that the facility did not have documentation on offering resident training on the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. During interview, LALD-C verified that there were no documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment	0 820			

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0 820	Continued From page 14 (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms #3, #2, and #1 with the minimum window opening meeting the minimum state standard for egress. This affected all occupied resident bedrooms #3, #2 and #1. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 03, 2023, approximately from 1:30 p.m. to 2:30 p.m., survey staff toured the facility	0 820	This immediate correction order identified on October 03, 2023, has had the immediacy lifted as of October 04, 2023, by assigning a fire watch for the facility. This was confirmed by the licensee via email and approved by evaluation supervisor.		

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0 820	Continued From page 15 with the licensed assisted living director (LALD)-C. At approximately 1:35 p.m., survey staff asked LALD-C to open the window in occupied resident bedroom #1 on the ground floor for measurement. LALD-C opened the window and measured the clear opening to be 20 inches in height and 24 inches in width with a total openable area of 480 square inches. The window did not meet the minimum requirements for total openable area. At approximately 1:45 p.m., survey staff asked LALD-C to open the window in occupied resident bedroom #2 on the ground floor for measurement. LALD-C opened the window and measured the clear opening to be 19 inches in height and 22.5 inches in width with a total openable area of 427.5 square inches. The window did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. At approximately 1:45 p.m., survey staff asked LALD-C to open the window in occupied resident bedroom #3 on the lower floor for measurement. LALD-C opened the window and measured the clear opening to be 33.75 inches in height and 16.5 inches in width with a total openable area of 557 square inches. The opening was obstructed by the windowpane due to how the crank hardware and arm moved the window. In the closed position the clear width measured 20 inches, but when opened the clear opening width was reduced significantly. The window did not meet the minimum requirements for opening width and did not meet the minimum requirements for total openable area.	0 820			

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0 820	Continued From page 16 Survey staff explained to LALD-C that at least one window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD-C verbally confirmed the findings. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. On October 03, 2023, at approximately 2:45 p.m., survey staff explained to LALD-C that an immediate correction order was issued for the above finding. LALD-C acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control	01500		

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01500	Continued From page 17 standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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 challenges it poses to communication; (2) the 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, assistive listening devices, hearing aids, visual	01500			

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01500	Continued From page 18 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 employees received at least eight hours of annual training for each 12 months of employment for one of two employees (registered nurse (RN)-A). 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: RN-A was hired January 15, 2021, and provided direct cares for the residents of the facility. RN-A's employee training records indicated RN-A had completed zero hours of annual training, thus lacked evidence RN-A had successfully completed at least eight (8) hours of annual training as required in the following areas: -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -training on reporting of maltreatment of vulnerable adults under section 626.557; -Review of provider's policies and procedures -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;	01500			

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01500	Continued From page 19 and -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. On October 03, 2023, at 2:50 p.m., licensed assisted living director (LALD)-C stated all staff have assigned annual training through the online program EduCare, but LALD-C stated RN-A's record lacked evidence that annual training had been successfully completed. The licensee's 5.06 Annual Required Staff Training policy revised date August 1, 2023, indicated "All staff that perform direct care services at [Licensee] will complete at least eight (8) hours of annual training for each 12 months of employment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed	01530			

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01530	Continued From page 20 at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care 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 employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia 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 all staff received eight hours of initial dementia care training within the first 120 working hours of employment for supervisors of direct care staff and within the first 160 working hours of employment for direct care employees as required for two of two employees (registered nurse (RN)-A, unlicensed personnel (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:	01530		

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01530	Continued From page 21 RN-A RN-A was hired January 15, 2021, to provide direct cares for the residents of the facility. RN-A's employee record indicated RN-A completed zero hours of dementia training, thus did not contain documentation RN-A completed the initial eight hours of training required related to dementia care, within 120 working hours of RN-A's employment start date. ULP-B ULP-B started employment on January 10, 2023, to provide direct cares for the residents of the facility. ULP-B's employee record indicated ULP-B completed zero hours of dementia training, thus did not contain documentation ULP-B completed the initial eight hours of training required related to dementia care, within 160 working hours of ULP-B's employment start date. On October 5, 2023, at 12:50 p.m., licensed assisted living director (LALD)-C stated all staff have assigned dementia training through the online program EduCare, but LALD-C verified RN-A's and ULP-B's records lacked evidence that the required eight (8) hours of dementia care training were completed within the required time frame. The licensee's 5.03 Dementia Training policy revised date August 1, 2023, indicated supervisors of direct care staff must have eight (8) hours of initial dementia care training within the first 120 working hours of employment and direct care employees must have eight (8) hours of initial dementia care training within the first 160 hours of employment.	01530			

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01530	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			
01940 SS=D	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; (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.	01940			

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01940	Continued From page 23 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a treatment management plan to include all required content for one of one resident (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 admitted to the licensee on August 18, 2020. R1's diagnoses included but were not limited to COPD (chronic obstructive pulmonary disease). R1's Service Plan dated September 20, 2023, indicated R1 received oxygen assistance three (3) times per day. R1's Oxygen prescriber order dated November 14, 2022, indicated " Please provide patient with O2 [oxygen] portability at 2 LPM [liters per minute] via nasal cannula with activity and 3 LPM via nasal cannula at night." R1's record lacked an individualized treatment and therapy plan that included the following required content: (1) a statement of the type of specific services that would be provided; (2) documentation of specific resident instructions	01940			

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NAME OF PROVIDER OR SUPPLIER BIG HEARTS HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 24 relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that would be delegated to unlicensed personnel (ULP); (4) procedures for notifying a registered nurse (RN) or appropriate licensed health professional when a problem arose 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. On October 4, 2023, at 9:15 a.m., unlicensed personnel (ULP)-C was observed checking R1's oxygen saturation. ULP-C stated there were no resident specific instructions relating to the oxygen, but staff were trained to notify to nurse if oxygen is below 90. Also, ULP-C stated R1 managed oxygen and required reminders if oxygen is below 90. On October 4, 2023, at 9:30 a.m., R1 was observed in her room with oxygen and R1 reported staff monitor her oxygen saturation and if it was below 90, will remind her to use oxygen. R1 stated she managed oxygen and used during activity and at night. On October 4, 2023, at 11:00 a.m., registered nurse (RN)-D and licensed assisted living director (LALD)-C acknowledged R1's record lacked an individualized treatment and therapy plan that included the required content. LALD-C and RN-D acknowledged R1's service plan indicated R1 received oxygen assistance 3 times per day but lacked resident specific instructions relating to the	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35604	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2023
NAME OF PROVIDER OR SUPPLIER BIG HEARTS HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 25 oxygen. The licensee's 7.05 Treatment & Therapy Management Plan policy revised date August 1, 2023, indicated " [Licensee] will develop and maintain individualized treatment and therapy management record for each resident which must contain all the required content." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			

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Location:

Big Hearts Home Care Inc.
1130 14th Ave SE
Minneapolis, MN 55414
Hennepin County, 27

Establishment Info:

ID #: N035604
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

3-500D Microbial Control: disposition of food

3-501.18A **** Priority 1 ****

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

OPEN GALLON OF MILK HAD A EXPIRATION DATE OF 10/2/23. THE GALLON OF MILK WAS ALREADY EXPIRED AND STAFF DISCARDED GALLON OF MILK DURING INSPECTION. CORRECTED ON-SITE.

Comply By: 10/03/23

2-500 Responding to contamination events

2-501.11 **** Priority 2 ****

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

ESTABLISHMENT DOES NOT HAVE PROCEDURES FOR STAFF TO CLEAN-UP VOMITING/FECAL ACCIDENTS. INFORMATION SENT WITH REPORT. MAKE SURE TO TRAIN EMPLOYEES ON HOW TO PROPERLY CLEAN-UP VOMIT OR FECAL ACCIDENTS.

Comply By: 10/10/23

3-500C Microbial Control: date marking

3-501.17B **** Priority 2 ****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

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OPEN CONTAINER OF CREAM CHEESE AND OPEN GALLON OF MILK IN THE WHIRLPOOL REFRIGERATOR WERE FOUND WITHOUT A DATE MARK. DISCUSSED DATE MARKING WITH STAFF. THE GALLON OF MILK WAS EXPIRED AND WAS DISCARDED. STAFF WILL DATE MARK THE CREAM CHEESE CONTAINER.

Comply By: 10/03/23

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN HIGH TEMPERATURE DISH MACHINE. PROVIDE. THERMOLABELS LEFT ON-SITE.

Comply By: 10/10/23

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF CHLORINE. PROVIDE.

Comply By: 10/10/23

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ** Priority 2 **

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

ESTABLISHMENT HAS A TWO COMPARTMENT SINK IN THE KITCHEN. NOT VERY CLEAR WHICH SIDE WAS DESIGNATED AS THE HANDWASHING SINK. STAFF DESIGNATED THE RIGHT SIDE COMPARTMENT AS THE HANDWASHING SINK DURING INSPECTION. SEE COMMENTS.

Comply By: 10/03/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111C ** Priority 2 **

MN Rule 4626.1565C Use approved trapping devices or other means of pest control when pests are found.

MICE DROPPINGS FOUND IN THE DRY STORAGE ROOM UNDER STORAGE RACK AND ALONG WALL. PER CONVERSATION WITH MANAGER, THEY HAVE ROVE PEST CONTROL AND THEY WILL CONTACT THEM TO DO A ROUTINE INSPECTION. MAKE SURE TO USE APPROVED TRAPPING DEVICES.

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3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

TWO CONTAINERS OF BBQ SAUCE, A BOX OF POPCORN, AND SACK OF RICE FOUND STORED DIRECTLY ON THE FLOOR IN THE DRY STORAGE ROOM. STORE ANY FOOD AT LEAST 6 INCHES ABOVE THE FLOOR AS DESCRIBED IN RULE ABOVE. STAFF WILL MOVE FOOD UP TO A STORAGE SHELF.

Comply By: 10/03/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

THE WOOD CABINETS IN THE KITCHEN ARE NO LONGER SEALED AND THE RAW WOOD IS VISIBLE. PAINT OR SEAL THE WOOD CABINETS SO THEY ARE SMOOTH AND EASILY CLEANABLE.

Comply By: 10/24/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

FLOUR AND MICE DROPPINGS FOUND UNDER STORAGE RACK AND ALONG THE BACK WALL IN THE BASEMENT DRY STORAGE ROOM. CLEAN AND SANITIZE STORAGE ROOM FLOOR. DISCUSSED WITH STAFF TO PREVENT HARBORAGE CONDITIONS OF PESTS.

Comply By: 10/03/23

Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 40 Degrees Fahrenheit - Location: MILK - WHIRLPOOL REFRIGERATOR

Violation Issued: No

Process/Item: Cold Holding

Temperature: 41 Degrees Fahrenheit - Location: CREAM CHEESE - WHIRLPOOL REFRIGERATOR

Violation Issued: No

Process/Item: Cold Holding

Temperature: 40 Degrees Fahrenheit - Location: INDIVIDUAL CUP OF YOGURT - WHIRLPOOL REFRIGERATOR

Violation Issued: No

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Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		1	6	3

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH MANAGER, AHMED FARAH, HOME CARE AID, LAYLA MOHAMED AND HEALTH REGULATION DIVISION NURSE EVALUATOR SAFIA HASSAN.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 4 CLIENTS AND THE FACILITY CAN HAVE UP TO 5 CLIENTS.

PER CONVERSATION WITH LAYLA, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

CONTINUATION OF MN Rule 4626.1110AB

THAT COMPARTMENT IS ONLY GOING TO BE USED TO WASH HANDS. STAFF WILL PLACE THE HANDWASHING SIGNAGE ON THE RIGHT SIDE COMPARTMENT. CORRECTED ON-SITE.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, VINYL FLOORING, PAINTED DRYWALL AND LAMINATE COUNTERTOPS. EQUIPMENT AND PHYSICAL FACILITIES WILL BE MONITORED AT FUTURE INSPECTIONS.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021231297 of 10/03/23.

Certified Food Protection Manager: AHMED A. FARAH

Certification Number: FM111970 Expires: 02/11/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

LAYLA MOHAMED
HOME CARE AID

Signed: _____

Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us