



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 31, 2023

Licensee
Rakhma Joy Home
123 South Wheeler
Saint Paul, MN 55105

RE: Project Number(s) SL20115015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 9, 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.

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions 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

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

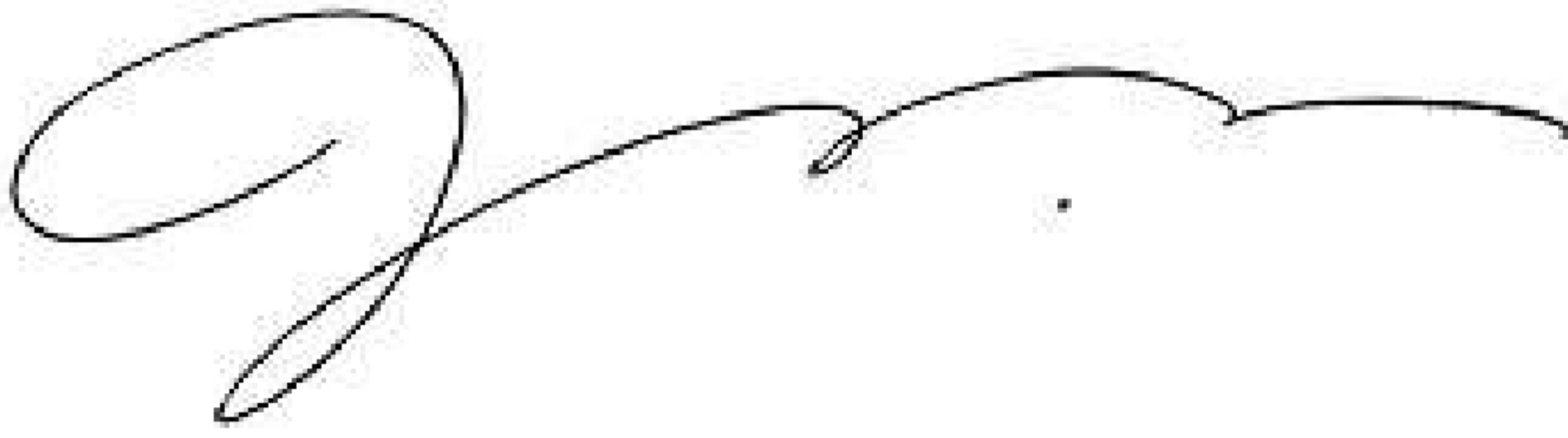
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85 East Seventh Place
St. Paul, MN 55164-0970

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,

A handwritten signature in black ink, appearing to read 'Jess Schoenecker', with a large loop at the start and a horizontal flourish extending to the right.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20115	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/09/2023
NAME OF PROVIDER OR SUPPLIER RAKHMA JOY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 123 SOUTH WHEELER SAINT PAUL, MN 55105		
(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: SL20115015 On August 7, 2023, through August 9, 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 were nine (9) active residents, all of whom received services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care License 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

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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 August 8, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another	0 630			

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0 630	Continued From page 2 individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed 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 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: R1 was admitted October 4, 2022. R1's service plan with effective date July 16, 2023, indicated R1 received services for assistance with medication administration, bathing, assistance with activities of daily living (ADLs), dressing and grooming, transfers, and toileting assistance. R1's record included a Master Assessment dated July 23, 2023. R1's record lacked an IAPP to include the	0 630			

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0 630	Continued From page 3 person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On August 08, 2022, at 2:07 p.m. director of nursing (DON)-A stated the Master Assessment was the vulnerability assessment for R1, and most of the residents, and was intended to serve as the IAPP but lacked required content. The licensee's 1.45 Individual Abuse Prevention Plans policy dated July 16, 2021, indicated the following; 1. An individual abuse prevention plan is developed for each assisted living resident based upon the nursing assessment. 2. The individual abuse prevention plan will include: a. Individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults b. The resident's risk of abusing other vulnerable adults c. Specific measures to minimize the risk of abuse to that person and other vulnerable adults. d. Measure to minimize the risk of self-abuse, if applicable 3. Abuse prevention plans will be completed by day-1 of an initial assessment. 4. Abuse prevention plans will be reviewed every 90-days and revised as needed. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			

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0 780	Continued From page 4	0 780			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that 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	0 780			

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0 780	Continued From page 5 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 August 9, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Maintenance (M)-G, Operations Director (OP)-D, and Interim Executive Director (ED)-C. During the facility tour, it was observed that the sleeping rooms that were equipped with smoke alarms were not interconnected with the other smoke alarms in the dwelling unit, so the actuation of one alarm would cause all alarms to operate. These deficient conditions were visually verified by M-G, OP-D and, ED-C accompanying the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800			

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0 800	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. 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 August 9, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Maintenance (M)-G, Operations Director (OP)-D, and Interim Executive Director (ED)-C. During the facility tour, survey staff observed the following: In the living room, it was observed that there were cracked plasters and brown stains on the sheetrock ceiling with evidence of water damage from the leaked roof. In resident room 8, it was observed that the ceiling plaster was bubbled with brown stains from the leaked roof. During the interview, M-G stated that the roof had been replaced and the ceiling needed to be repaired. In resident room 4, it was observed that the glass in a window was cracked.	0 800			

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0 800	Continued From page 7 This deficient condition was visually verified by M-G, OP-D, and ED-C accompanying the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	0 810			

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0 810	Continued From page 8 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 a fire safety and evacuation plan with the required elements; failed to provide a maintained fire safety and evacuation plan that showed the location and number of resident rooms; failed to provide a fire protection procedures necessary for residents; failed to provide required employee training on fire safety and evacuation and failed to conduct required evacuation drills every other month. 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: An interview and record review were conducted on August 9, 2023, at approximately 12:00 p.m. with the Maintenance (M)-G, Operations Director (OP)-D, and Interim Executive Director (ED)-C on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. On the facility tour with the M-G, OP-D, and ED-C	0 810			

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0 810	Continued From page 9 on August 9, 2023, at approximately 10:00 a.m., it was observed that the fire safety and evacuation plan did not show the location and number of resident rooms. It was also observed that the posted fire safety plan and evacuation plan did not identify the location of exits and exit routes. This deficient condition was visually verified by M-G, OP-D, and ED-C accompanying the tour. 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 the interview, OP-D verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that employees did not receive training twice per year after initial hire. During the interview, OP-D stated that the facility provided only one fire safety training in November 2022 and confirmed no further documented training for the staff on the fire safety and evacuation plan as required by statute. 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. Provided documentation indicated that the drills were conducted on 5/23/23 at 6:00 am., 6/13/23 at 1:45 pm., and 6/15/23 at 4:15 pm. with no further drills being documented. M-G verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			

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0 820	Continued From page 10	0 820			
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (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 provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. 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). On August 9, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Maintenance (M)-G, Operations Director (OP)-D, and Interim Executive Director (ED)-C During the	0 820			

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0 820	Continued From page 11 facility tour, survey staff observed the following items: It was observed that both the front and back exit doors that lead to the outside of the building had a lock that required a code to exit. Survey staff verified with M-G and OP-D that the locks were not tied into the building fire alarm system and would not default to an unlocked (fail-safe) position in the event of a fire or other emergency. During the interview, M-G stated that all staff had access to the key for the doors, but residents did not have access to the key and verified the deficient condition. It was also observed that both exit doors were enclosed with chain link yard fences. The front and back yard gates were locked inside and required a key to exit. Survey staff verified with M-G and OP-D that the locks were not tied into the building fire alarm system and would not default to an unlocked (fail-safe) position in the event of a fire or other emergency. This deficient condition was verified by M-G, OP-D, and ED-C accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 820			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20115	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/09/2023
NAME OF PROVIDER OR SUPPLIER RAKHMA JOY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 123 SOUTH WHEELER SAINT PAUL, MN 55105		
(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
01640	Continued From page 12 service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident service plan and any revisions included a signature or other authentication by the resident and the licensee to document the agreement on the services to be provided 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's record included a signed Service Plan Agreement dated February 18, 2022. R1's most recent Service Plan Agreement with effective date	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20115	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/09/2023
NAME OF PROVIDER OR SUPPLIER RAKHMA JOY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 123 SOUTH WHEELER SAINT PAUL, MN 55105			
(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
01640	Continued From page 13 August 8, 2023, lacked a current service plan with signature or authentication by the resident or resident's representative with all current services provided by licensee after addition of services. On August 8, 2023, at 3:10 p.m. director of nursing (DON)-A stated R1's current Service Plan Agreement was not signed by resident or resident's representative. DON- A confirmed the updates were not acknowledged by the resident or resident's representative, by signing the updated Service Plan Agreement. The licensee's 4.09 Service Plans policy dated August 5, 2021, indicated, "Service plans and any revisions to services plans will have a signature or other authentication by the facility and by the resident." No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01640			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20115	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/09/2023
NAME OF PROVIDER OR SUPPLIER RAKHMA JOY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 123 SOUTH WHEELER SAINT PAUL, MN 55105		
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03090	Continued From page 14 the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect the current residents, staff and any visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 7, 2023, at approximately 10:00 a.m., surveyor and survey supervisor entered the facility and at the main entry way there was no signage, as required, to notify visitors of electronic monitoring. On August 7, 2023, at approximately 11:00 a.m., Interim Executive Director (ED)-C acknowledged no electronic monitoring signage was posted at the main entrances to the facility. ED-C stated they had construction recently and it may have removed at that time. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



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

Type: Full
Date: 08/08/23
Time: 08:01:59
Report: 1018231129

Food and Beverage Establishment Inspection Report

Page 1

Location:

Rakhma Joy Home
123 South Wheeler
St Paul, MN55105
Ramsey County, 62

Establishment Info:

ID #: 0039266
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128242345
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.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CERTIFIED FOOD PROTECTION MANAGER ON SITE. COMPLY WITH RULE.

Comply By: 11/01/23

Food and Equipment Temperatures

Process/Item: Cold Holding/ CHEESE

Temperature: 40 Degrees Fahrenheit - Location: KITCHEN FRIDGE

Violation Issued: No

Process/Item: Cold Holding/ AMBIENT

Temperature: 38 Degrees Fahrenheit - Location: UPSTAIRS FRIDGE

Violation Issued: No

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

ESTABLISHMENT HAS 9 RESIDENTS AT THIS TIME.

INSPECTION CONDUCTED WITH SAFIA HASSAN (MDH) PRESENT

PHYSICAL FACILITIES WERE OBSERVED IN GOOD CONDITION.

ALL FOODS ARE MADE FOR SAME DAY SERVICE.

FIRM HAS SEPARATE SINKS FOR HAND WASHING AND FOOD PREP.

Type: Full
Date: 08/08/23
Time: 08:01:59
Report: 1018231129
Rakhma Joy Home

Food and Beverage Establishment Inspection Report

Page 2

DISHWASHER HAS SANITIZE FUNCTION AVAILABLE.

DISCUSSED PEST CONTROL.

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 1018231129 of 08/08/23.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____/____/____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Establishment Representative

Signed: _____

Rebecca Prestwood

Sanitarian 3

6512013777

rebecca.prestwood@state.mn.us