



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

August 18, 2025

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

RE: Project Number(s) SL20115016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 25, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

### **STATE CORRECTION ORDERS**

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

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

### **DOCUMENTATION OF ACTION TO COMPLY**

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

The correction order documentation should include the following:

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

### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

To submit a reconsideration request, please visit:

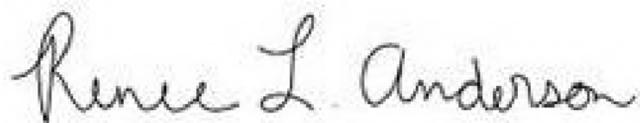
**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at [susan.winkelmann@state.mn.us](mailto:susan.winkelmann@state.mn.us) or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Renee Anderson, Supervisor

State Evaluation Team

Email: [Renee.L.Anderson@state.mn.us](mailto:Renee.L.Anderson@state.mn.us)

Telephone: 651-201-5871 Fax: 1-866-890-9290

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/25/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>RAKHMA JOY HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>123 SOUTH WHEELER SAINT PAUL, MN 55105</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	<p><b>Initial Comments</b></p> <p><b>***ATTENTION***</b></p> <p><b>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b></p> <p><b>SL20115016-0</b></p> <p>On June 23, 2025, through June 25, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were eight residents; eight receiving services under the Assisted Living Facility with Dementia Care license.</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p><b>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.</b></p> <p><b>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.</b></p>	
0 775 SS=I	<p><b>144G.45 Subd. 2. (a) Fire protection and physical environment</b></p> <p>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p>	0 775		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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0 775	<p>Continued From page 1</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide resident sleeping rooms with egress windows in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511 and failed to comply with door locking requirements by not supplying proper locking in accordance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. Egress windows in the facility failed to meet the minimum window opening requirement to comply with state standard for egress. This had the potential to affect residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>On February June 23, 2025, from approximately 12:15 p.m. to 2:35 p.m., the surveyor toured the facility with licensed executive director (ED)-A, and director of maintenance (DM)-C. During the tour, the surveyor asked DM-C to open the windows in the resident sleeping rooms for measurement and the surveyor measured the openable area of the windows. The noncompliant measurements were as follows:</p> <p><b>OCCUPIED SLEEPING ROOMS:</b></p>	0 775		
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0 775	<p>Continued From page 2</p> <p>Resident sleeping room 1: One window measuring 27 inches clear width, 23 inches clear height, and 621 square inches total openable area.</p> <p>Resident sleeping room 2: One window measuring 25 inches clear width, 23 inches clear height, and 575 square inches total openable area.</p> <p>Resident sleeping room 3: One window measuring 25 inches clear width, 23.5 inches clear height, and 587.5 square inches total openable area.</p> <p>Resident sleeping room 4: One window measuring 25 inches clear width, 23 inches clear height, and 575 square inches total openable area.</p> <p>Resident sleeping room 5: One window measuring 27 inches clear width, 23.5 inches clear height, and 634.5 square inches total openable area.</p> <p>Resident sleeping room 7: One window measuring 25 inches clear width, 21.5 inches clear height, and 537.5 square inches total openable area.</p> <p>Resident sleeping room 8: One window measuring 25 inches clear width, 22 inches clear height, and 550 square inches total openable area.</p> <p>UNOCCUPIED SLEEPING ROOMS:</p> <p>Resident sleeping room 6: One window measuring 25.5 inches clear width, 23.5 inches clear height, and 599.25 square inches total</p>	0 775		

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0 775	<p>Continued From page 3</p> <p>openable area.</p> <p>The windows in resident sleeping rooms 1,2, 3, 4, 5, 6, 7 and 8 did not meet the minimum requirements for total openable area. 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.</p> <p>DM-C and ED-A stated that they were aware of the size requirements for windows and that the facility was not compliant and thus had implemented a fire watch as a temporary measure to mitigate risk to residents. ED-A indicated that an approved sprinkler system and fire alarm system will be installed and that permits will be pulled for such installation.</p> <p>The front door of the facility was equipped with a locking mechanism at the very top of the door frame, approximately 80 inches from the ground, which is not permitted as is mounted too high from the floor and requires special knowledge or ability to readily open in event of fire or other emergency evacuation.</p> <p>The rear door is marked and indicated as an emergency egress component and requires a number be entered into a keypad to allow egress. This keypad lock requires special knowledge and is not proper to accommodate egress. All doors that are components of the egress system for the building must comply with egress requirements.</p> <p>The fence surrounding the property had two gates, each requiring a key to unlock the gates and egress to the public right of way. These gates necessitate special tools and knowledge to</p>	0 775		

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0 775	<p>Continued From page 4</p> <p>egress and would delay or limit egress in the event of an emergency. Egress from the facility was obstructed with improper locking on doors and gates. Components of egress must not include locks at improper heights or locks requiring special knowledge, effort or tools. DM-C and ED-A confirmed that there was no fire alarm system or sprinkler system available at the facility.</p> <p>On February 23, 2025, the surveyor explained to DM-C and ED-A the requirements for egress, locking and egress windows as well as the findings from the survey. ED-A stated they understood the requirements for egress windows and would immediately start the process of gaining compliance. ED-A mentioned that the facility has plans to install sprinkler system and fire alarm system. The surveyor directed facility staff to pull appropriate permits required for any intended repairs and provide means of correction for undersized egress windows.</p> <p>Extension cords were utilized as a substitute for permanent wiring to power multiple devices in the upper-level living room including the television, electric fireplace and other electronics. Extension cords should not be used in lieu of permanent wiring as they may pose risk of fire.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	0 775		
0 780 SS=E	<p>144G.45 Subd. 2 (a) (1) Fire protection and physical environment</p> <p>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p>	0 780		

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0 780	<p>Continued From page 5</p> <p>(1) for dwellings or sleeping units, as defined in the State Fire Code:</p> <ul style="list-style-type: none"> <li>(i) provide smoke alarms in each room used for sleeping purposes;</li> <li>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;</li> <li>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;</li> <li>(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</li> <li>(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;</li> </ul> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors.</p> <p>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 an pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has</p>	0 780		
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0 780	<p>Continued From page 6</p> <p>occurred repeatedly; but is not found to be pervasive).</p> <p>The findings include:</p> <p>On February June 23, 2025, from approximately 12:15 p.m. to 2:35 p.m., the surveyor toured the facility with executive director (ED)-A, and director of maintenance (DM)-C and observed the following:</p> <p>When tested, smoke alarms provided in resident room 6, and in several common areas were not interconnected such that activation of one alarm activates all alarms. Smoke alarms were tested by DM-C. During testing it was found that smoke alarms in resident room 6, upper-level near bathroom, lower-level near bathroom, rear stairwell and in the basement did not sound with the activation of other alarms. These alarms must be interconnected so activation of one alarm activates all alarms within the facility.</p> <p>During the facility tour and interview on June 23, 2025, DM-C and ED-A verified the above listed smoke alarms were not properly interconnected and indicated that the alarms would be repaired or replaced and maintained as interconnected.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	0 780		
0 810 SS=F	<p>144G.45 Subd. 2 (b-f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:</p> <p>(1) location and number of resident sleeping</p>	0 810		

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0 810	<p>Continued From page 7</p> <p>rooms;</p> <p>(2) staff actions to be taken in the event of a fire or similar emergency;</p> <p>(3) fire protection procedures necessary for residents; and</p> <p>(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.</p> <p>(c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>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 required content. This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or</p>	0 810		

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0 810	<p>Continued From page 8</p> <p>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).</p> <p>The findings include:</p> <p>On June 23, 2025, at approximately 2:10 p.m..., licensed assisted living director (LALD)-B, executive director (ED)-A and director of maintenance (DM)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.</p> <p>The licensee FSEP failed to include the following:</p> <p>The FSEP failed to identify specific fire protection actions for residents. There was no section in the provided documents that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.</p> <p>The FSEP also mentioned use of an air horn to alert occupants during emergency, but did not indicate location of the airhorn nor information on how it was to be used.</p> <p>No generator logs were provided to the surveyor during the survey and DM-C indicated that logs are not being collected and maintained. The generator for the facility is part of the FSEP plans for emergency power supply and should be maintained in proper working order.</p> <p>Record review indicated the licensee failed to provide and document adequate training to</p>	0 810		
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0 810	<p>Continued From page 9</p> <p>employees on the FSEP upon hire and at least twice per year. Staff was unable to provide documentation showing adequate trainings were provided for employee training on the fire safety and evacuation plan. ED-A stated that employees are trained once per year via educare. Employees should be provided training upon hire and at least twice a year thereafter and trainings should be specific to the facility and FSEP plans.</p> <p>Records were provided for fire drills conducted at the facility on 1-21-25, 11-21-24 and 9-26-24. No further records of fire drills were available. Fire drills should be conducted and recorded at least once every other month and at least twice per shift per year.</p> <p>During an interview on June 23, 2025, at approximately 2:30 p.m., the surveyor explained the requirements for employee trainings, resident trainings, fire drills, and FSEP documentation. LALD-B and ED-A stated they understood the requirements.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 810		



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

## Food & Beverage Inspection Report

Page: 1

Establishment Info	License Info	Inspection Info
Rakhma Joy Home 123 South Wheeler St Paul, MN 55105 Ramsey County Parcel:  Phone:	License: HFID 20115  Risk: License: Expires on: CFPM: Erin Armstrong CFPM #: 56529; Exp: 3/6/2028	Report Number: F7994251051 Inspection Type: Full - Single Date: 6/23/2025 Time: 10:49:25 AM Duration: minutes Announced Inspection: <u>Total Priority 1 Orders: 1</u> <u>Total Priority 2 Orders: 0</u> <u>Total Priority 3 Orders: 0</u> <u>Delivery:</u>

**! New Order: 4-700 Sanitizing Equipment and Utensils**

4-703.11B      *Priority Level: Priority 1    CFP#: 16*

*MN Rule 4626.0905B* Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

COMMENT: NO CURRENT DISHWASHER TEMP LOG WAS FOUND ON SITE. PROVIDE A PICTURE OF THE ON SITE THERMOMETER AFTER THE NEXT SANITIZING CYCLE.

*Comply By: 6/23/2025      Originally Issued On: 6/23/2025*

## Food & Beverage General Comment

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOOR IS VINYL, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, LAMINATE COUNTER TOPS AND SMOOTH PAINTED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

TEMPERATURES

MILK 41

EGG 38

FRUIT 38

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

I acknowledge receipt of the Metro District Office inspection report number F7994251051 from 6/23/2025

*Crystal Elva*

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Establishment Representative

Crystal Elva, REHS, MS, BS  
Public Health Sanitarian 3  
651-201-3981  
crystal.elva@state.mn.us

# Food Establishment Inspection Report

Metro District Office Minnesota Department of Health 625 Robert St N, PO BOX 64975 St Paul, MN 55164	No. of Risk Factor/Intervention/Violations	1	Date: 6/23/2025
	No. of Repeat Risk Factor/Intervention/Violations		Time: 10:49:25 AM
	Score (optional)		Dur: min
Establishment: Rakhma Joy Home	Address: 123 South Wheeler	City/State: St Paul, MN	Zip: 55105
License/Permit #: HFID 20115	Permit Holder:	Purpose of Inspection: Full	Est. Type: Risk Category:

## FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item		Mark "X" in appropriate box for COS and/or R	
IN=in compliance    OUT=not in compliance    N/O=not observed    N/A=not applicable		COS=corrected on-site during inspection    R=repeat violation	

Compliance Status	COS	R	Description
<b>Supervision</b>			
1	IN		Person in charge present, demonstrate knowledge and performs duties
2	IN		Certified Food Protection Manager
<b>Employee Health</b>			
3	IN		knowledge, responsibilities, and reporting
4	IN		Proper use of restriction and exclusion
5	IN		Response to vomiting, diarrheal events
<b>Good Hygienic Practices</b>			
6	IN		Proper eating, tasting, drinking, tobacco use
7	IN		No discharge from eyes, nose, and mouth
<b>Preventing Contamination by Hands</b>			
8	IN		Hands clean and properly washed
9	IN		No bare hand contact with RTE foods, alternatives
10	IN		Adequate handwashing sinks supplied and access
<b>Approved Source</b>			
11	IN		Food obtained from approved source
12	N/O		Food Received at proper temperature
13	IN		Food in good condition, safe & unadulterated
14	N/A		Records available: shellstock tags, parasite dest.
<b>Protection From Contamination</b>			
15	IN		Food separated and protected
16	OUT		Food-contact surfaces; cleaned & sanitized
17	IN		Proper Disposition of returned, previously served, reconditioned, & unsafe food

Compliance Status	COS	R	Description
<b>Time/Temperature Control for Safety</b>			
18	N/O		Proper cooking time & temperatures
19	N/A		Proper reheating procedures for hot holding
20	N/A		Proper cooling time and temperature
21	N/A		Proper hot holding temperatures
22	IN		Proper cold holding temperatures
23	IN		Proper date marking & disposition
24	N/A		Time as public health control; procedures & record
<b>Consumer Advisory</b>			
25	N/A		Consumer advisory provided for raw or undercooked foods
<b>Highly Susceptible Populations</b>			
26	IN		Pasteurized foods used; prohibited foods not offered
<b>Food/Color Additives and Toxic Substances</b>			
27	N/A		Food additives; approved & properly used
28	N/A		Toxic substances properly identified; stored; used
<b>Conformance with Approved Procedures</b>			
29	N/A		Compliance with variance, specialized processes & HACCP plan

**Risk factors** are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions are control measures to prevent foodborne illness or injury

## GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance    Mark "X" in appropriate box for COS and/or R    COS=corrected on-site during inspection    R=repeat violation

Compliance Status	COS	R	Description
<b>Safe Food and Water</b>			
30	IN		Pasteurized eggs used where required
31			Water & ice from approved source
32	N/A		Variance obtained for specialized processing methods
<b>Food Temperature Control</b>			
33			Proper cooling methods used; adequate equipment for temperature control
34	N/A		Plant food properly cooked for hot holding
35	IN		Approved thawing methods used
36			Thermometers provided & accurate
<b>Food Identification</b>			
37			Food properly labeled; original container
<b>Prevention of Food Contamination</b>			
38			Insects, rodents, & animals not present; no unauthorized person
39			Contamination prevented during food prep, storage, & display
40			Personal cleanliness
41			Wiping cloths: properly used & stored
42			Washing fruits & vegetables

Compliance Status	COS	R	Description
<b>Proper Use of Utensils</b>			
43			In-use utensils; Properly stored
44			Utensils, equipment & linens; properly stored, dried, handled
45			Single-use & single-service articles, properly stored and used
46			Gloves used properly
<b>Utensils, Equipment and Vending</b>			
47			Food & non-food contact surfaces cleanable, properly designed, constructed, & used
48			Warewashing facilities: installed, maintained, used; test strips
49			Non-food contact surfaces clean
<b>Physical Facilities</b>			
50			Hot & cold water available; adequate pressure
51			Plumbing installed; proper backflow devices
52			Sewage & waste water properly disposed
53			Toilet facilities; properly constructed, supplied & cleaned
54			Garbage & refuse properly disposed; facilities maintained
55			Physical facilities installed, maintained & clean
56			Adequate ventilation & lighting; designated areas used
57			Compliance with MCIAA
58			Compliance with licensing and plan review

Person in Charge (signature)  Inspector (signature) <span style="float: right; font-family: cursive; font-size: 1.2em;">Crystal Elva</span>	Follow-up:      Follow-up Date:
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