Electronically Delivered

February 14, 2025

Licensee
Rakhma Grace Home
5126 Mayview Road
Minnetonka, MN 55345

RE: Project Number(s) SL20102016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 8, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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 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.

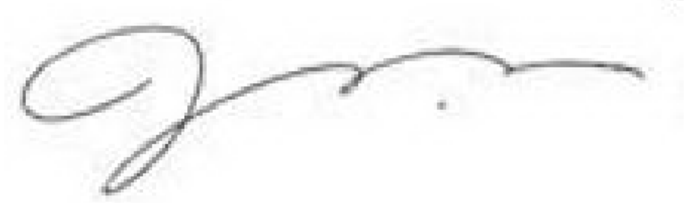
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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 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,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20102	A. BUILDING: _____ B. WING _____	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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	Initial Comments 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: SL20102016-0 On January 6, 2025, through January 8, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were eight (8) resident(s); 8 receiving services under the Assisted Living Facility 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 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 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 evaluators ' 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 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 6, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included maintaining a current Facility TB Risk Assessment and baseline history and symptom screening for two of two employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 660		

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0 660	Continued From page 4 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Facility TB Risk Assessment dated August 4, 2023, indicated the facility was a low risk setting for TB transmission. The licensee lacked a Facility TB Risk Assessment completed in 2024 and did not include current information. ULP-C ULP-C was hired on June 6, 2024, and began providing assisted living services. ULP-C's employee record included a negative QuantiFERON Gold TB Test dated November 25, 2024. ULP-C's employee record lacked a TB history and symptom screening. ULP-D ULP-D was hired on June 26, 2024, and began providing assisted living services. ULP-D's employee record included a QuantiFERON Gold TB test dated July 3, 2024. ULP-D's employee record lacked a TB history and symptom screening. On January 6, 2025, at approximately 2:30 p.m., licensed assisted living director (LALD)-A stated they were behind on completing the Facility TB Risk Assessment Worksheet.	0 660		

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0 660	Continued From page 5 On January 7, 2025, at approximately 12:42 p.m., LALD-A stated TB history and symptom screening was not completed for ULP-C and ULP-D. LALD-A stated director of nursing (DON)-F had mistakenly assumed a TB screening and history were not needed if the TB test was negative. The Minnesota Department of Health (MDH) guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, read "an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a IGRA (a 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 undated Tuberculosis and Staff Training policy indicated the licensee would establish and maintain a TB prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 6 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 interconnected smoke alarms throughout the facility. 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 the potential to affect a large portion or all of the residents).	0 780		

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0 780	Continued From page 7 The findings include: On a facility tour on January 8, 2025, from 10:00 a.m. to 11:55 a.m., with area licensed assisted living director (LALD)-A and maintenance director (M)-G, the surveyor observed the following: Smoke alarms were tested by M-G pushing test button on smoke alarm in upper-level hallway. During testing of alarms not all alarms properly functioned to sound including the alarms in resident room 11, resident room 13, resident room 8, resident room 9, resident room 7, and resident room 10. Further testing was carried out and M-G activated test function of a smoke alarm on the main level and it was noted that the smoke alarms in resident room 2, resident room 5 and resident room 6 did not sound. Smoke alarms are not properly interconnected. M-G acknowledged lack of interconnection between alarms and provided information regarding a permit for a new fire alarm system and interconnected smoke alarms that they have submitted. During the facility tour on January 8, 2025 M-G and LALD-A verified the above listed fire protection and physical environment observations while 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	0 810		

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0 810	Continued From page 8 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. 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 and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 9 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 January 8, 2025, at approximately 11:25 a.m. licensed assisted living director (LALD)-A and maintenance director (M)-G provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP did not include location and number of resident rooms. Floor plans were provided in the facility, but were not included in the FSEP documents, and plans designated garage as a marked egress route. The garage may not be used as a primary route as marked egress routes may not pass through an area of higher hazard such as the garage. The FSEP did not include documentation of employee training. Employees must receive training on FSEP upon hire and twice a year thereafter. FSEP did not include record of adequate fire drills for facility. Only two fire evacuation drills were documented in the past year, however evacuation frills are required twice per year per shift at a rate not less than a drill every other month.	0 810		

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0 810	Continued From page 10 During the record review and interview on January 8 2025 LALD-A verified the above listed documents were absent from the FSEP. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and	01060		

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01060	Continued From page 11 designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation lasting more than four days for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R2 was admitted on February 22, 2024, and began receiving assisted living services. R2's record included a signed Service Plan Agreement dated October 4, 2024, indicating	01060		

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01060	Continued From page 12 R2's services included assistance with dressing and grooming, medication administration, behavior management, and catheter care. R2's record included a progress note dated September 28, 2024, indicating R2 was transported to the hospital. The progress notes indicated R2 returned from the hospital on October 3, 2024. R2's record lacked evidence of a written notice provided to the resident, the residents' legal representative, designated representative, and OOLTC that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. On January 6, 2025, at approximately 1:15 p.m., clinical nurse supervisor (CNS)-B stated they had forgotten to send an emergency relocation notice for R2. The licensee's 4.16 Contract Termination Policy dated July 30, 2021, read: "B. In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20102	A. BUILDING: _____ B. WING _____	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAKHMA GRACE HOME	5126 MAYVIEW ROAD MINNETONKA, MN 55345

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01060	Continued From page 13 location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility will provide contact information for the agency to which the resident may submit an appeal." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
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 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.	01640		

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	20102	A. BUILDING: _____ B. WING _____	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAKHMA GRACE HOME	5126 MAYVIEW ROAD MINNETONKA, MN 55345

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01640	Continued From page 14 (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 revised service plans were authenticated by the resident or resident's representative for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R2 was admitted on February 22, 2024, and began receiving assisted living services. R2's record included a Service Plan Agreement signed October 4, 2024, indicating R2's services included assistance with dressing and grooming, catheter care, medication management and administration and behavior management. R2's Service Plan Agreement, unsigned, dated January 6, 2024, indicated the following services had been changed:	01640		

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	20102	A. BUILDING: _____ B. WING _____	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAKHMA GRACE HOME	5126 MAYVIEW ROAD MINNETONKA, MN 55345

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01640	Continued From page 15 -hourly safety checks had been added to the service plan; -coordination of catheter care had been removed from the service plan; -medication storage information had been added to the service plan; and -wandering; frequent redirection had been removed from the service plan. R2's service plan lacked authentication or signature from the residents or their designated representatives. On January 7, 2025, at approximately 3:30 p.m., clinical nurse supervisor (CNS)-B stated they were unaware service plans required authentication if services change regardless of pricing changes. The licensee's 4.09 Service Plans policy revised August 5, 2021, indicated service plans and any revisions to service plans would have a signature or other authentication by the facility and by the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's	02110		

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	20102	A. BUILDING: _____ B. WING _____	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAKHMA GRACE HOME	5126 MAYVIEW ROAD MINNETONKA, MN 55345

(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
02110	Continued From page 16 values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living facility with dementia care developed and implemented the required policies and procedures for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20102	A. BUILDING: _____ B. WING _____	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAKHMA GRACE HOME	5126 MAYVIEW ROAD MINNETONKA, MN 55345

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02110	Continued From page 17 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: R2 R2 was admitted on February 22, 2024, and began receiving assisted living services. R2's record included a Service Plan Agreement signed October 4, 2024, indicating R2's services included assistance with dressing and grooming, catheter care, medication management and administration and behavior management. R3 R3 was admitted on August 13, 1999, under the licensee's former comprehensive home care license and began receiving assisted living services on August 1, 2021. R3's record included a Service Plan Agreement signed July 9, 2023, indicating R3's services included assistance with dressing, grooming, and dining, medication administration, and behavior management. R2 and R3's records lacked evidence of documentation for receipt of required policies and procedures to be provided at the time of resident move-in to the facility. On January 6, 2025, at approximately 1:45 p.m., licensed assisted living director (LALD)-A provided the licensee's admission packet with a Dementia Disclosure Statement document.	02110		

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02110	Continued From page 18 LALD-A indicated document was provided to all residents in lieu of licensee's policies and procedures required to be disclosed to residents prior to move-in. LALD-A stated the information required could be found in either policies or other various documents. On January 7, 2025, at approximately 10:30 a.m., LALD-A stated all the information required was not in a policy format and they were working on getting it corrected. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
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, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors of the licensee. This practice resulted in a level one violation (a	03090		

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03090	Continued From page 19 violation that has not potential to cause more than a minimal impact on the client 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 the clients). The finding include: On January 6, 2025, at 10:00 a.m., upon arrival to the licensee's facility, the surveyor observed a lack of electronic monitoring notice at the entrance of the facility with the required statutory language. On January 6, 2025, at 11:00 a.m., licensed assisted living director (LALD)-A stated the postings containing the required language must have been removed from the entrances. The licensee's 1.42 Electronic Monitoring Policy and Procedure dated March 11, 2021, indicated licensee would 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". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *01/06/25*
Time: 12:00:00
Report: 8041251004

Food and Beverage Establishment Inspection Report

Location:
Rakhma Grace Home
5126 Mayview Road
Minnetonka, MN55345
Hennepin County, 27

Establishment Info:
ID #: 0037572
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.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON SITE. CORRECTED ON SITE. MDH LOG FORM PRINTED FOR USE. EXCLUSION AND LOGGING REQUIREMENTS REVIEWED.

Comply By: 01/06/25

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

FACILITY COOKS THIN MEATS. NO SMALL DIAMETER PROBE THERMOMETER WAS AVAILABLE ON SITE. COMPLY WITH ABOVE RULE.

Comply By: 01/13/25

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 TEMPERATURE INDICATOR FOR MEASURING THE UTENSIL SURFACE TEMPERATURE IN THE DISH MACHINE. OPTIONS DISCUSSED DURING INSPECTION.

Comply By: 01/20/25

2-100 Supervision

2-102.12AMN

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

ISSUED 8/29/22 (REPEAT): NO CERTIFIED FOOD PROTECTION MANAGER. STAFF HAS FOOD SAFETY CERTIFICATE. SUBMIT APPLICATION FOR STATE CFPM CERTIFICATE. APPLICATION LINK SENT WITH REPORT.

Comply By: 01/20/25

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

THE TRUE UPRIGHT COOLER DOOR GASKET IS TORN ON THE BOTTOM.

Comply By: 01/20/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.14A

MN Rule 4626.1530A Maintain clean all intake and exhaust air ducts and change filters so they are not a source of contamination.

BUILD-UP OF GREASE AND DUST OBSERVED ON THE VENTILATION HOOD BAFFLES.

Comply By: 01/13/25

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: upright cooler 1: turkey
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: upright cooler 1: yogurt
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: upright cooler 2: milk
Violation Issued: No

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

Inspection was completed with the food service manager, Jillian Butler. Michelle Winters was the lead Health Regulation Division Nurse Evaluator. Facility had eight residents on site at time of inspection.

This establishment has a commercial kitchen with laminate cabinetry and a separate handwashing sink. Food is prepared for same day service only.

Establishment has a under counter commercial dishwasher that achieved a temp at least 160F for sanitizing dishes.

Discussed the following:

- Employee illness policy and logging requirements
- Handwashing
- Glove-use and bare hand contact
- Pest control
- Food storage and preventing cross contamination
- Date marking
- Restrictions concerning serving a highly susceptible population
- Vomit clean up process
- Upcoming remodel- submit plans to HRD.

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 8041251004 of 01/06/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Jillian Butler
Food Service Manager

Signed:_____
Sarah Conboy
Public Health San. Supervisor
651-201-3984
sarah.conboy@state.mn.us