

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL201157364M  
**Compliance #:** HL201152404C

**Date Concluded:** April 11, 2025

## **Name, Address, and County of Licensee**

### **Investigated:**

Rakhma Joy  
123 S Wheeler St  
St Paul MN 550105  
Ramsey County

**Facility Type:** Assisted Living Facility with  
Dementia Care (ALFDC)

**Evaluator's Name:** Maggie Regnier  
Special Investigator

**Finding:** Not Substantiated

### **Nature of Investigation:**

The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

### **Initial Investigation Allegation(s):**

The facility neglected the resident when she ingested hand sanitizer.

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was not substantiated. The facility had hand sanitizer available for staff to use but removed it when they found the resident ingesting the product.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, staff schedules, related facility policy and procedures. Also, the investigator observed staff interaction with other staff, residents and visitors.

The resident resided in an assisted living facility. The resident's diagnoses included cirrhosis of liver, alcohol abuse, liver failure, epilepsy and depression. The resident's service plan included assistance with medication management, meals, and personal daily cares.

A facility incident report indicated staff member(s) observed the resident use hand sanitizer and then put her hand up to her mouth three weeks after moving into the facility. The staff reported the incident to the nurse and the nurse did an assessment. The nurse also called poison control. This document further indicated the resident denied ingesting the hand sanitizer and was offered to be taken to the emergency department for further evaluation, but the resident refused.

During an interview, manager #1 stated the staff had no idea the resident would ingest hand sanitizer but once they were aware of the behavior, the facility leadership directed staff to remove all bottles of hand sanitizer from the facility and staff were issued individual pocket size bottles of hand sanitizer to use when needed. The manager further stated all staff were educated on why this was necessary, to ensure the resident could not ingest the hand sanitizer.

During an interview, manager #2 stated resident was new to the facility, and they were aware of her alcohol abuse history, but they did not know that she would ingest hand sanitizer. Manager #2 further stated that when they were made aware of the issue, the whole team worked together to develop a plan to reduce the risk the resident could misuse hand sanitizer from the facility. Manager #2 stated the team was committed to keep the resident as safe as possible.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

**“Not Substantiated” means:** An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

**Neglect: Minnesota Statutes, section 626.5572, subdivision 17**

“Neglect” means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

**Vulnerable Adult interviewed:** No, unresponsive

**Family/Responsible Party interviewed:** attempted

**Alleged Perpetrator interviewed:** Not Applicable

**Action taken by facility:** The facility immediately assessed the resident, called poison control and offered medical treatment. The facility also limited the hand sanitizer availability within the facility to prevent the resident from accessing any. .

**Action taken by the Minnesota Department of Health:** No further action at this time

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

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>C</b> <b>03/11/2025</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>On March 11, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL201152404C/#HL201157364M. No correction orders are issued.</p>	0 000		

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