Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201029702M
Compliance #: HL201029121C

Date Concluded: May 16, 2025

Name, Address, and County of Licensee Investigated:
Rakhma Grace Home
5126 Mayview Road
Minnetonka, MN 55345
Hennepin County

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

Evaluator's Name: Brooke Anderson, RN
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 the resident was found on the ground in his room with his right eye lid swollen shut and a cut above his eyebrow.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell and sustained an injury, when staff found the resident appropriate care was provided and the resident was transported to the hospital for further evaluation

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, hospital records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with dressing, grooming, and ambulation. The resident's assessment indicated the resident had short term memory impairment.

Medical records indicated the day of the incident, facility staff last saw the resident at 1:04 p.m. during a safety check. At 1:44 p.m. facility staff went to the resident's room to administer medications. The resident was found on the ground near a space heater. The resident had swelling on his right eye lid with a cut just above his eyebrow. The facility nurse was notified and 911 was called. The resident was taken to the hospital for evaluation.

The hospital record indicated the resident was treated and returned to the facility.

During an interview, a facility staff member stated after lunch the resident went upstairs to his room. He checked on the resident approximately 45 minutes prior to finding the resident on the ground. When the resident was found, 911 and the facility nurse were notified, and the resident was sent to the hospital for evaluation.

During an interview, a facility nurse stated she was notified when the resident fell, and he was sent to the hospital. The facility nurse investigated and determined facility staff completed a safety check prior to the fall. When the resident returned, he was moved to a first-floor apartment located near a common area so staff could keep a closer eye on him. A facility nurse stated since the resident returned from the hospital he had almost returned to his baseline health status.

During an interview, a family member stated she was not aware of the situation but had no concerns with the care the resident received at the facility.

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, resident's cognition was not intact.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility responded to the resident, called 911 and implemented additional interventions upon the resident's return.

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

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 _____	C 05/07/2025

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
0 000	Initial Comments On May 7, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL201029121C/#HL201029702M. No correction orders are issued.	0 000		