Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL20103026M
Compliance #: HL20103027C

Date Concluded: September 23, 2020

Name, Address, and County of Licensee Investigated:

Rakhma Inc
4953 Aldrich Avenue South
Minneapolis, MN 55419
Hennepin County

Name, Address, and County of Housing with Services location:

Rakhma Grace Home
5126 Mayview Road
Minnetonka, MN 55345
Hennepin County

Facility Type: Home Care Provider

Investigator's Name:
Shannan Stoltz, RN Special Investigator
Paul Spencer, RN Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
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.

Allegation(s):
It is alleged: The facility failed to keep Client #1 free from sexual abuse when Client #2 fondled Client #1.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment of Client #1 when the facility failed to keep Client #1 free from sexual abuse. The facility was aware of previous incidents where Client #2 had engaged in possibly inappropriate contact with other clients, and had documented the need for additional precautions, but failed to implement adequate measures to protect the two clients from the nonconsensual sexual contact.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation also included an onsite visit for observations, review of medical records, and review of facility policies and procedures.

Client #1's diagnoses included Alzheimer dementia, paranoia, and depression. Client #1's medical record indicated she was on hospice, wheelchair-bound, immobile, and non-verbal. Client #1's medical record further indicated she was unable to identify potentially dangerous situations or to deal with verbally/physically aggressive persons.

Client #2's diagnoses included, but were not limited to, dementia, delusions, and insomnia. Client #2's service plan indicated Client #2 received medication administration, verbal cues for personal cares, and daily behavioral monitoring for verbal outbursts. Client #2's care plan indicated he may act out sexually with female residents, and consequently needed supervision and room checks every 30 minutes to ensure he had not taken a female resident to his room.

Client #2's medical records indicated he had a history of sexually abusing, and was likely to seek or cooperate in an abusive situation. Records further indicated all interactions with other female residents "will be closely monitored," however, there was no specification as to what "closely monitored" entailed. The facility also implemented additional checks for Client #2 approximately one month prior to the incident with Client #1.

On the day of the incident, Client #1 was sitting in the living room in her wheelchair, when a staff member walked in to the room and observed Client #2 fondling Client #1's breasts.

During an interview, a staff member stated he walked into the facility's living room and observed Client #1's shirt pulled up, and her breasts being fondled by Client #2. During this same interview, the staff member stated Client #1 is helpless, non-verbal, and cannot protect herself.

During an interview, the registered nurse (RN) stated Client #1 would not have been able to remove herself from situations.

Client #2's progress notes likewise indicated staff found Client #2 in the living room on the date of the incident, with his hands up Client #1's shirt, fondling her breasts. Other progress notes indicated that on a previous occasion, Client #2 took another female resident into his room, and locked the door.

During an interview with RN-B, she stated the facility placed Client #2 on 30-minute checks related to his inappropriate behavior with female clients. During this same interview, RN-B stated Client #2 was involved in a third incident with a female resident, at Client #2's last facility, but there was limited information about that situation.

Client #2's medical record indicated the facility immediately moved him out of the facility, after the occurrence with Client #1.

In conclusion, neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No; both clients are cognitively impaired.
Family/Responsible Party interviewed: Yes for Client #1, No for Client #2.
Alleged Perpetrator interviewed: N/A.

Action taken by facility:
Client #2 was transferred to another facility.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

Or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding.

cc:
The Office of Ombudsman for Long-Term Care
Hennepin County Attorney
Minnetonka City Attorney
Minnetonka Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20103	A. BUILDING: _____ B. WING _____	C 08/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAKHMA PEACE HOME	4953 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55419

(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****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to an investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On August 13, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL20103027C/#HL20103026M. At the time of the investigation, there were six (6) clients receiving services under the comprehensive license. The following correction order is issued/orders are issued for #HL20103027C/#HL20103026M, tag identification 0265, 0325, and 0865.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care 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. 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 144A.474 SUBDIVISION 11 (b)(1)(2)	
0 265 SS=G	144A.44, Subd. 1(a)(2) Up-To-Date Plan/Accepted Standards Practice Subdivision 1.Statement of rights. (a) A client who	0 265		

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0 265	Continued From page 1 receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (2) receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide care according to accepted health care standards, for 2 of 2 clients (C1, C2) reviewed, when (C2) inappropriately touched C1. The facility had previous documented C2's history of inappropriate or sexual interactions with clients, but failed to ensure the clients were protected from a further such interaction, which then occurred. This practice resulted in a level three violation (a violation that harmed a client'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). Issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: C1's medical record was reviewed. C1's medical diagnoses included, but were not limited to, Alzheimer dementia, paranoia, and depression. C1's service plan dated March 12, 2019,	0 265		

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0 265	Continued From page 2 indicated C1 received medication administration, and assistance of one with personal cares and dressing. C1's service plan dated March 12, 2019, at 1:40 pm, indicated C1 was to have 1:1 staffing every day for am and pm shift. The service plan further indicated staff would walk with C1 in-house when necessary and keep C1 from getting into unsafe situations. C1's progress notes dated November 26, 2019, at 12:52 pm, indicated that C1 was admitted to hospice but did not state a reason. C1's progress note dated July 22, 2020, at 8:57 pm, indicated a report made to the state disclosed a staff member observed C2 touch C1's breasts. C1's Individual Abuse Prevention Assessment and Plan, dated July 30, 2020, indicated C1 was immobile, non-verbal, and unable to identify potentially dangerous situations or to deal with verbally/physically aggressive persons. This document further indicated the facility would check on C1 every 60 minutes. C1's care plan dated August 14, 2020, indicated C1's ambulation and transfer status changed on November 20, 2019, and that C1 does not walk due to declining health. C1's care plan further indicated the requirement of 1-2 staff for transfers, the use of a gait belt, and that C1 has a Broda chair. During an interview on August 14, 2020, at 12:40 pm, registered nurse (RN)-B stated C1 was admitted to hospice on November 26, 2019, related to a decline in health, and had been in a	0 265		

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0 265	Continued From page 3 wheelchair for approximately one year. RN-B further stated she was not at the facility when the incident occurred, but C1 would not have been able to remove herself from the situation. Related to protections put in place for C1 after this incident, RN-B stated the plan was that someone should always be in the living room with C1, but this was not in writing. During an interview on August 14, 2020, at 2:10 pm, unlicensed personnel (ULP)-A stated that on July 22, 2020, sometime between 5:15 pm and 6:00 pm, he walked into the living room of facility and observed C2 hunched over C1 as C1 sat in her wheelchair. ULP-A "shouted hey!" at C2 and C2 hurriedly walked away from C1 to a nearby sofa, and sat down. Per ULP-A, C1's shirt was pulled up and her breasts were exposed. ULP-A further advised this was his second day on the job, but he was already suspicious of C2's behavior around other clients because when ULP-A would walk into a room, C2 was "always walking away from one of the females (clients) in the wheelchairs." ULP-A went on to say C1 is helpless and non-verbal, receives complete cares, and cannot protect herself. During an interview on August 19, 2020, at 2:40 pm, C1's family member (FM)-D stated the facility advised him C1 was receiving 1:1 care, relayed to him in March 2020, during an annual meeting. During a second interview with RN-B on September 4, 2020, at 11:50 am, RN-B stated the facility does have an updated service plan for C1, created post-hospice admission, but it is unsigned. Request made for the updated service plan during this conversation, but facility did not provided it.	0 265		

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0 265	Continued From page 4 C2's medical record was reviewed. C2's medical diagnoses included dementia, delusions, and insomnia. C2's service plan dated September 20, 2017, indicated C2 received medication administration, verbal cues for personal cares, and daily behavioral monitoring for verbal outbursts. C2's progress notes, dated March 2, 2020, at 8:56 pm, indicated C2 transferred in to his current living facility. C2's progress notes, dated March 21, 2020, at 3:04 pm, indicated C2 took an ambulatory female resident (unknown name) into his room, and locked the door. C2's Care Plan, dated June 15, 2020, indicated C2 "may act out sexually with female residents. Needs supervision and room checks every 30 minutes to see if anyone is with him in his room." C2 lacked an updated service plan notating C2's 30-minute checks for his inappropriate behavior with female residents. C2's Individual Abuse Prevention Assessment and Plan, dated June 28, 2020, indicated C2 had a history of sexually abusing, and was likely to seek or cooperate in an abusive situation. This document further indicated, "All interactions with other female residents will be closely monitored", however, there is no specification of what "closely monitored" entailed. C2's progress notes, dated July 23, 2020, at 8:51 am, recorded a late entry for July 21, 2020 at 6:00 pm, which indicated staff found C2 found in the living room, with his (C2) hands up another	0 265		

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0 265	Continued From page 5 resident's (C1) shirt, and fondling her breasts. During an interview on August 14, 2020, at 12:40 pm, RN-B stated the facility placed C2 on 30-minute checks related to inappropriate behavior C2 displayed with female clients. During this same interview, RN-B stated C2 was involved in a third incident with a female resident, at C2's last facility, but there was limited information about that situation. During an interview on August 14, 2020, at 2:29 pm, site director (SD)-C stated C1 receives full cares from staff, is non-verbal, and wheelchair bound. C2 is independent with the exception of medication administration. SD-C further stated that on July 21, 2020, she was near the living room but did not witness the incident between C2 and C1. SD-C recalled that as she walked up the stairs she heard ULP-A loudly exclaim something, so she walked into the living room where ULP-A was located, along with C2 and C1. SD-C stated that ULP-A immediately advised her that he had witnessed C2 fondling C1's breasts. The facility-provided document titled Policy 4.09 Service Plans, dated August 8, 2015, indicated a service plan must be revised based on the results of required client monitoring and/or reassessments, then must be entered into a client's record. The policy further stated service plans are required, but care plans are not, and care plans cannot replace the required service plan. TIME PERIOD FOR CORRECTION: IMMEDIATE.	0 265		

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0 325	Continued From page 6	0 325		
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interviews, and document review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 was neglected. Findings include: On September 23, 2020, the Minnesota Department of Health (NDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with an incident which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No Plan of Correction (PoC) required. Please refer to the maltreatment public report for details.	
0 865 SS=E	144A.4791, Subd. 9(a-e) Service Plan, Implementation & Revisions Subd. 9.Service plan, implementation, and revisions to service plan. (a) No later than 14 days after the date that home care services are first provided, a home care provider shall finalize	0 865		

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0 865	Continued From page 7 a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care. (c) The home care provider must implement and provide all services required by the current service plan. (d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable. (e) Staff providing home care 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 a signed current service plan was instituted for 2 of 2 clients (C1, C2), upon record review. C1 was admitted to hospice for a higher level of care, yet C1's service plan did not reflect this. C2 moved to current facility, from another facility within same licensee, yet the facility failed to update C2's service plan to reflect the new name and address. This practice resulted in a level two violation (a violation that did not harm a client's health or	0 865		

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0 865	Continued From page 8 safety but had the potential to have harmed a client's health or safety), and was issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: C1's medical record was reviewed. C1's medical diagnoses included, but were not limited to, Alzheimer dementia, paranoia, and depression. C1's service plan dated March 12, 2019, indicated C1 received medication administration, and assistance of one with personal cares and dressing. C1's service plan further indicated C1 was independent with transfers and ambulation, to include stairs. C1's service plan dated March 12, 2019, at 1:40 pm, indicated C1 was to have 1:1 staffing every day for am and pm shift. The service plan further indicated staff would walk with C1 in house when necessary and keep C1 from getting into unsafe situations. C1's progress notes dated November 26, 2019, at 12:52 pm, indicated C1was admitted to hospice but did not state a reason. C1's care plan dated August 14, 2020, indicated C1's ambulation and transfer status changed on November 20, 2019, and that C1 does not walk due to declining health. C1's care plan further indicated the requirement of 1-2 staff for transfers, the use of a gait belt, and that C1 has a Broda chair. During an interview on August 14, 2020, at 12:40	0 865		

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0 865	Continued From page 9 pm, registered nurse (RN)-B confirmed C1 admitted to hospice on November 26, 2019, related to a decline in health, the only service plan for C1 is dated March 12, 2019, and that C1 does not have an updated service plan reflecting C1's admission to hospice. RN-B further stated C1 has been in a wheelchair for a year, and has not had a 1:1 since that time. During an interview on August 19, 2020, at 2:40 pm, C1's family member (FM)-D stated the facility advised him C1 was receiving 1:1 care. Per FM-D, the facility relayed this information in March 2020, during an annual meeting with the facility. C1's medical record lacked an updated service plan with post-hospice admittance information, to illustrate C1's change in condition and ambulation status. During an interview on September 4, 2020, at 11:50 am, RN-B stated the facility does have an updated, but unsigned, service plan for C1 created post-hospice admission. This updated service plan was requested from the facility, but not provided. C2's medical record was reviewed. C2's medical diagnoses included dementia, delusions, and insomnia. C2's service plan dated September 20, 2017, indicated C2 received medication administration, verbal que's for personal cares, and daily behavioral monitoring for verbal outbursts. C2's service plan rindicated a facility address different from the facility where C2 currently resides. C2's progress notes dated March 2, 2020 at 8:56	0 865		

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0 865	Continued From page 10 pm, indicated C2 moved to his current residence from a facility located in another city. During an interview on August 14, 2020, at 12:40 pm, RN-B stated C2 moved to current residence in March 2020. RN-B further stated the facility placed C2 on 30-minute checks related to inappropriate behavior C2 was displaying with female clients. C2's medical record lacked an updated service plan notating C2's current physical address, as well as the 30-minute safety checks. The facility-provided document titled Policy 4.09 Service Plans, dated August 8, 2015, indicated a service plan must be revised based on the results of required client monitoring and/or reassessments, then must be entered into a client's record. The policy further stated service plans are required, but care plans are not, and care plans cannot replace the required service plan. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 865		