Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201156782M
Compliance #: HL201121300C

Date Concluded: March 11, 2025

Name, Address, and County of Licensee Investigated:
Rakhma Joy Home
123 So Wheeler St
St Paul, MN 55105
Ramsey County

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

Evaluator's Name: James Larson, 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 alleged perpetrator neglected the resident when they failed to provide physical safety and implement fall precautions after the resident had an apparent seizure. The resident fell and required hospitalization for a fractured ankle.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Due to conflicting accounts of the incident, there was not a preponderance of evidence to support that neglect occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, facility incident reports, personnel files, and related facility policy and procedures. The investigator toured the facility and observed staff interactions and provision of care.

The resident resided in an assisted living facility. The resident's diagnoses included dementia, total blindness, and diabetes. The resident's service plan included hourly safety checks, medication administration, laundry, housekeeping, and meal reminders. The resident's assessment indicated she was blind although alert, responsive, orientated to person, place, and time. The resident had a history of falls with injury and was able to ambulate independently with hand holding assistance when needed for guidance.

A review of the complaint documents indicated that on the morning of the incident staff was assisting the resident from her apartment to the common area bathroom when it was reported that the resident appeared to have a seizure. The incident report indicated the staff assisted the resident to a nearby table and had the resident sit down. The resident began having pain in her ankle and lower leg and was unable to bear weight. Additional facility staff observed swelling and bruising around the resident's ankle and contacted the on-call nurse for instruction that led to the resident being transported by ambulance to a local hospital. The resident was admitted and required surgery to repair a fractured (broken) ankle.

During an interview, the staff member working at the time of the incident stated that while using a gait belt to assist the resident to walk from the common area bathroom back to her apartment, the resident suddenly began repeatedly flinching and appeared to exhibit seizure activity. The staff member denied that the resident fell or lost balance and recalled that he was able to seat her at a nearby kitchen table. Attempts to assist the resident from the kitchenette back to her apartment failed due to her not being able to walk or bear weight and she was transported to a local hospital and required hospitalization for a fractured ankle.

During an interview, a nurse who was on call the morning of the incident stated she was notified by phone about the incident and staff stated that as he was assisting the resident from the common second floor bathroom back to her room she experienced what he described as a possible seizure. When asked what he observed, the staff stated the resident was not responding to verbal commands, was drooling, and shaking her upper extremities for a period of approximately twenty seconds. The nurse stated that she was not aware of the resident having any seizure activity or falls prior to this incident.

During an interview, a nurse stated that on the morning of the incident after assessing the resident for injuries, she was unable to obtain information from the resident due to her own disease process and inability to communicate effectively. When she spoke to staff and inquired about what had happened, she stated that the information received was very vague and it was unclear how the injury occurred.

During an interview, an unlicensed staff member familiar with the resident stated that when she arrived at the facility for her shift minutes after the incident occurred, she observed the resident seated at the table in the common area. When she asked what had happened, she was

told that the resident may have had a seizure and fell. The unlicensed staff member was not aware of the resident ever having a fall or seizure prior to the incident.

During an interview, when asked about the injury or events leading up to the reported fall, the resident was not able to recount details surrounding the incident.

During an interview, a family member stated that she was not aware of the resident ever having a seizure prior to the incident. The family member stated she was made aware of the incident by the facility and had no concerns with the care provided by 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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility completed an internal investigation into the incident.

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
	20115	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAKHMA JOY HOME	123 SOUTH WHEELER SAINT PAUL, MN 55105

(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 February 13, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL201121300C/#HL201156782M. No correction orders are issued.	0 000		