Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356014423M
Compliance #: HL356017439C

Date Concluded: April 26, 2023

Name, Address, and County of Licensee Investigated:
Gabby Care Homes LLC Cilla House
1500 Pennsylvania Avenue North
Champlin, MN 55316
Hennepin County

Facility Type: Assisted Living Facility (ALF)

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 alleged perpetrator (AP) abused a resident when the AP punched the resident in the back, the head, and kicked the resident out of the facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. There is no evidence to support the AP abused the resident. At the time of the incident, police were contacted, and the resident was charged with assault.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical record, police reports, personnel files, and facility policies and procedures. At the time of the onsite visit, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included traumatic brain injury, major depressive disorder, and intermittent explosive disorder. The resident's care plan included assistance with medication management, supervision for showers, and behavioral support. The resident's assessment indicated the resident had history of verbal and physical aggression.

According to resident progress notes, the resident used racial statements, spit on the AP, and refused to take his medications during the AP's shift. The next day the resident was aggressive towards the AP, which led to the AP calling the police.

According to the police report, the AP called and said they were "attacked" by the resident. Dispatch then received a call from the resident who stated the AP pushed and punched him. The police report indicated police went to the facility and took statements from the resident and the AP. The resident was charged with assault for attacking and spitting on the AP.

During an interview, the resident stated at the time of the incident he had walked away, and the AP punched him in the back three times. He called police, but when they arrived, the police did not speak to him. The resident denied sustaining any bruising or injuries. The resident said one week after the incident occurred, the AP locked him out of the neighboring facility when he was trying to visit his friends.

During an interview, the AP denied punching the resident. The AP said the resident yelled racial slurs and spit on the AP when the AP attempted to redirect him. Facility management spoke with the resident, and he apologized to the AP. The next day, when he attempted to give the resident medications, he became agitated and yelled at the AP. The resident hit the AP, "smashed" his phone from his hand and the AP called police. One week later the resident was still upset with the AP and chased the AP upon entrance to a neighboring facility. The AP ran into the facility and locked the door. The resident banged on the door and broke the door.

During investigative interviews, multiple administrative staff indicated the resident was triggered by staff redirection and would hold grudges when staff stopped him from going to neighboring facilities. Staff were educated and re-trained on interventions, de-escalation techniques, and when to contact police if a resident became aggressive. Administrative staff held a meeting to address concerns with the resident and his care team following the incident. The resident did not report he was hit by the AP to any administrative staff.

During an interview, the resident's family member said the resident did not tell them he was punched by the AP. The family member indicated they were satisfied with the communication and care provided by the facility.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility completed an internal investigation and interviewed all parties. The facility completed an individualized abuse prevention plan which identified the resident’s vulnerabilities and interventions to help manage behaviors. The facility communicated regularly with the resident’s case manager and guardian to discuss care and behavior management.

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
	35601	A. BUILDING: _____ B. WING _____	C 03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC - CILLA HOUSE	1500 PENNSYLVANIA AVENUE NORTH CHAMPLIN, MN 55316

(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****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint 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 March 24, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL356017439C/#HL356014423M. No correction orders are issued.	0 000		