Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL360119423M
Compliance #: HL360118522C

Date Concluded: April 7, 2025

Name, Address, and County of Licensee Investigated:
Gabby Care
1513 Pennsylvania Avenue North
Champlin, MN 55316
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, 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 assaulted a resident, which resulted in the resident sustaining a bloody nose.

Investigative Findings and Conclusion:
The Minnesota Department of Health (MDH) determined abuse was not substantiated. The resident and the AP had a misunderstanding about a community trip and the resident, who was disappointed, took away the AP's phone. In the process of trying to retrieve his phone the AP's fingernail scraped the resident's nose, causing bleeding. The AP did not swing at or punch the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The investigation included review of the resident record, facility internal investigation, facility

incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed surveillance video of the incident.

The resident lived in an assisted living facility. The resident's diagnoses included schizoaffective disorder, attention-deficit hyperactivity disorder, and post-traumatic stress disorder. The resident's service plan included assistance with agitation, anxiety, aggression, and medication administration. The resident's assessment indicated he was independent with activities of daily living and used the facility for transportation.

An incident report indicated the resident usually got a ride to visit his dad on Fridays, but one Monday the resident went to the office and asked the AP to drive him to his dad's. The AP declined to give the ride as he was working in the office and the resident became upset. The report indicated the resident became verbally aggressive, banged on a desk and grabbed a walkie talkie. The report indicated the resident then moved closer to the AP, grabbed his phone and headed toward the exit. The report indicated the AP attempted to retrieve the phone as the resident attempted to exit. The report indicated the facility surveillance video was reviewed, and the AP was seen grabbing the resident's jacket to prevent him from leaving with the AP's phone.

The MDH investigator obtained and reviewed the video of the incident. The video had no sound. The resident knocked on the office door and the AP opened the door to talk to the resident. The resident pushed past the AP, entered the office, and sat on a chair. The AP sat in another chair while they talked. The resident pounded his hand on a desk and scooted his chair close to the AP and grabbed a walkie talkie. The AP did not move, and they continued to talk. The resident jumped up and grabbed the AP's phone which the AP was holding. The resident attempted to go out the open door. There was a scuffle while they both held onto the phone. The AP grabbed the resident's jacket and they both fell to the floor. The AP and the resident got up off the floor and the resident sat in a chair. The resident gave the AP the walkie talkie and his phone back, but due to his continued agitation, the AP called the police.

During an interview, the AP stated the resident became quickly agitated on the day of the incident. The AP stated he was trying to arrange a ride for the resident, but the resident thought he was intentionally taking his time about it. The AP stated the resident was upset, banged his fist on a desk, took a walkie talkie and then took his phone. The AP stated he tried to get his phone away from the resident and did grab the resident's jacket but denied striking him. The AP stated the incident was over quickly and the resident apologized for grabbing his phone. The AP stated his fingernail ripped during the incident and the resident got blood on his nose.

During an interview, the resident stated he was frustrated when the AP told him he did not have a ride set up for him. The resident stated he felt the AP was argumentative and when the resident did not get the answer he wanted, he took the walkie talkie and the AP's phone. The resident stated they did not really fight, the AP just tried to get the phone and walkie talkie. The resident stated he and the AP get along fine.

During an interview, a family member stated she thought highly of the staff at the facility, but they were often reactive and instead needed to be proactive with the resident's behaviors. The family member stated she wished the staff would call COPE (the mobile crisis response team) and use them rather than wait and call her after something is already happening. The family member stated the staff could use more training on medications but also noted the resident was doing better.

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; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

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

Action taken by facility:
The AP received job counseling and retraining on de-escalation techniques with an emphasis on avoiding power struggles. The facility reviewed the policy on Vulnerable Adults with the AP. The facility updated the resident's service plan to ensure future transportation requests were properly communicated. The facility arranged for another staff to transport the resident to his dad's house later that day.

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
	36011	A. BUILDING: _____ B. WING _____	C 03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC - FAITH'S HOUSE	1513 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 On March 18, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL360118522C/#HL360119423M. No correction orders are issued.	0 000		