DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL340268486M
Compliance #: HL340265753C

Date Concluded: March 26, 2024

Name, Address, and County of Licensee Investigated:
Gabby Care Homes
1512 Pennsylvania Avenue North
Champlin, MN 55316
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Katie Germann, 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 resident 1 (R1) and R2 when the facility failed to supervise the residents. R1 and R2 had a physical altercation resulting in hospitalization for R2 with a left-sided closed orbital (bony edges of eye socket) fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. R1 and R2 got into a physical altercation and R2 was sent to the hospital. The residents care plans were being followed at the time of the incident, and neither resident had a history of physical altercations.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff, and residents. The investigator contacted law enforcement. The investigation included review of the police report, hospital records, medical records, employee files, and facility policies and procedures.

R1 resided in an assisted living facility. The resident's diagnoses included major depressive disorder and intermittent explosive disorder. The resident's service plan included assistance with medication management. The resident's assessment indicated the resident is at risk to abuse other people when agitated or under the influence of drugs or alcohol.

R2 resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder. The resident's service plan included assistance with medication management. The resident's assessment indicated the resident has a history of verbal aggression.

A facility investigation indicated R1 and R2 had a physical altercation in a common area of the facility. The staff reported witnessing the altercation when R2 accused R1 of stealing another resident's money. R2 was sitting down outside the facility when approached by R1 who was upset R2 had accused him of theft. There were words exchanged between the two residents and R1 punched several punches into the air. The punches were blocked by R2 who stepped back without throwing any punches. R1 walked away, but continued a verbal exchange with R2, causing R1 to return and throw a few more punches at R2, causing R2 to fall down. Staff intervened and contacted an ambulance. R2 had a bruise on his left eye but refused to be taken to the hospital. Later in the day, R2 reported feeling dizzy. R2 was taken to the hospital by staff and diagnosed with a left-side orbital floor closed fracture. R2 was treated in the emergency room and released with an appointment to follow up with a surgeon.

A police report detailing video footage of the incident indicated R2 was sitting outside the facility garage and R1 approached. R1 and R2 appeared to have a verbal altercation, and R1 began throwing punches with his right-hand closed fist. A staff member came to the scene and R1 went into the garage and R2 walked away. However, R1 turned around, reapproached R2, and pushed him with both hands. R1 punched R2 in the face, R2 fell to the ground, and R1 walked away.

Hospital notes indicated R2 sustained a left-sided orbital floor blowout fracture (break along the floor or inner wall of your eye socket) and would require surgery. R2 was treated and released with a referral for surgery.

When interviewed, the facility nurse stated R1 and R2 have always gotten along, and the altercation was a one-time occurrence. The nurse stated R1 and R2 had never argued prior to this and have had no issues since this incident.

During interview, R1 stated on the day of the incident he went to the store to get something for a friend that also lives at the facility. R1 stated he lost five dollars, so he came back and told the resident he lost her money. R1 stated R2 accused him of stealing the money. R1 stated he told R2 he did not steal the money and R2 got riled up. R1 stated R2 shoved him and in return R1 hit R2. R2 stated he and R1 get along now.

When interviewed, R2 stated R1 went to the store to get something for the other resident, but when he came back to the facility, R1 told her he lost her money. R2 stated he accused R1 of stealing the other resident's money and the argument escalated to R1 punching R2 in the face, knocking R2 to the ground. R2 stated he still interacts with R1, and they have no issues with each other.

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: Not Applicable

Action taken by facility:
The facility contacted the authorities and filed a report to the Minnesota adult abuse reporting center. Interventions were added to the residents' care plans requiring staff supervision of interactions between R1 and R2.

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
	34026	A. BUILDING: _____ B. WING _____	C 02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC	**1512 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 February 28, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL340265753C/ #HL340268486M. No correction orders are issued.	0 000		