Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356015322M
Compliance #: HL356012244C

Date Concluded: November 10, 2025

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Michele Larson, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 the resident when facility staff failed to provide adequate supervision and monitoring which resulted in multiple emergency room visits due to illicit drug use and alcohol intoxication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to provide supervision in accordance with the resident's care plan and failed to develop and implement new resident specific interventions to ensure the resident's safety. Despite known safety vulnerabilities and identified patterns of unsafe behavior the resident was at the emergency department seven times within a one month related to drug overdoses and alcohol intoxication. In addition, the resident had sexual behaviors that resulted in the resident sexually assaulting a staff member.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement and a member from the resident's interdisciplinary team. The investigation included review of resident records, facility documentation, personnel files, staff schedules, emergency department record, law enforcement reports, and related facility policies and procedures. At the time of the onsite investigation, the investigator observed the facility and interactions between staff and residents.

The resident resided in a small, assisted living facility situated nearby four other small facilities owned by facility leadership. The resident's diagnoses included schizophrenia (chronic mental health condition characterized by persistent disturbances in thought, perception, and behavior), polysubstance use disorder (addicted to more than one illicit drug and alcohol). The resident's care plan included but was not limited to 1:1 supervision while smoking, assistance with medications including antipsychotics, and behavior management. The resident's assessment indicated he was oriented to person, place, and time, had a history of substance abuse and behaviors including sexual behaviors. The resident's Individual Abuse Prevention Plan indicated the resident was vulnerable to being abused and abusing others. The resident's history included sexual advances towards female residents and staff. Interventions included increased supervision and monitoring, vigilance, and knowing the resident's whereabouts at all times to ensure the resident and other vulnerable adult's safety.

Review of the resident's medical records indicated over the course of a month the resident had several incidents that included being found lying face down on the ground and having an altered mental status. The resident was seen in the hospital six times for intoxication and admitted to using methamphetamines, PCP, and K2. Medical records indicated the resident would be provided time to sober up and then was discharged back to the facility.

The resident's record lacked evidence the resident's medical provider or interdisciplinary team members were updated regarding the resident's multiple incidents. The resident's record lacked evidence that new interventions were put in place after each incident.

An incident report indicated the resident attempted to sexually assault a female staff member. The resident locked the front door, turned off the lights, grabbed the female staff person from behind and took her walkie talkie, preventing her from calling for help. The female staff member freed herself and ran out the front door to another facility owned by leadership. The resident the incident occurred.

Facility documentation lacked evidence the facility put in new interventions after the incident and female staff continued to be scheduled during the night shift.

During an interview with law enforcement, indicated over a span of several years law enforcement responded to multiple calls at the facility regarding the resident and voiced concerns about the quality of care the resident received from the facility.

During an interview, a staff member stated the resident needed to be watched but sometimes he would leave the facility and there wasn't anyone to monitor him while he was out on the streets. A staff member stated the resident needed to be monitored and it needed to be reported to a facility nurse if the resident was intoxicated and vital signs obtained. A staff member stated the resident did make sexual comments towards female staff and female staff continued to work at the facility.

During an interview, the resident's interdisciplinary team member stated the facility told them the resident required constant supervision but there were less staff scheduled during weekends and the facility did not have resources for additional staff. The interdisciplinary team member stated they were concerned with the resident's safety.

During an interview, facility leadership stated the resident targeted people who were unable to stand up for themselves, stating the female unlicensed staff member was not "stern enough."

In conclusion, neglect is 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 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: No. Attempted
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: A few weeks after the resident's incidents the facility discharged a resident from one of their other facilities on the same block as the resident's facility to a different facility owned by a different company. The former resident was suspected of providing drugs to the resident and others.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Champlin City Attorney
Champlin Police Department

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 09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC - CILLA H	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 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: #HL356012244C/#HL356015322M and #HL356016222C On September 17, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were five residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL356012244C/#HL356015322M, tag identification 1600, 2360.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 evaluators' 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 144G.31 SUBDIVISION 1-3.	

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01600	Continued From page 1	01600		
01600 SS=J	144G.70 Subdivision 1 Acceptance of residents An assisted living facility may not accept a person as a resident unless the facility has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the assisted living contract. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to ensure staff had the sufficient qualifications, competency, and numbers to adequately provide the services agreed to in the assisted living contract prior to admission for one of five residents (R1) who had a history of mental health disorders, elopements, substance abuse, and drug overdoses. This practice resulted in a level four violation (a violation harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On September 17, 2025, at 9:30 a.m., the investigator arrived at the licensee's facility to initiate the onsite investigation. During an entrance conference, registered nurse, (RN)-F stated the licensee had five facilities situated within close proximity to each other. RN-F stated R1's facility was a duplex which currently had five residents. RN-F stated staff-resident ratio was 1:4 and based on current census there was one	01600		

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01600	Continued From page 2 staff person scheduled per shift, including overnight shifts. R1's record was reviewed. R1 was admitted to the licensee's facility on February 3, 2020. R1's diagnoses included but were not limited to schizophrenia, polysubstance use disorder, and antisocial personality disorder. R1's history included sexually inappropriate behaviors with staff and residents. In addition, R1's history included ongoing abuse of illegal drugs and alcohol. R1's record indicated he received personal care reminders and assistance with medication administration, safety checks, behaviors, housekeeping, and laundry R1's court records indicated R1 was under a continual civil commitment (involuntary treatment when a person is considered a danger to themselves or others due to a severe mental illness) since 2016. Court records indicated if R1 was not involuntarily committed he would likely attempt to physically harm himself or others or fail to provide himself with necessary food, clothing, shelter, and medical care. R1's care plan dated May 23, 2025, indicated R1 received assistance with medication administration and behaviors, including verbal aggression, agitation, and hallucinations. R1's assessment dated May 23, 2025, indicated R1 was at risk to be abused. Staff would monitor R1's safety as well as the safety of others. R1 was at risk to abuse others due to his history of sexual advances towards female residents and staff. Staff would provide increased supervision,	01600		

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01600	Continued From page 3 vigilance, and close monitoring of R1. Because of R1's history and continuing use of drugs and alcohol, licensee staff were to know the whereabouts of R1 at all times and ensure R1 did not have drugs or contraband in his possession. In addition, R1 was assessed as unsafe to smoke unsupervised and required 1:1 staff supervision while smoking. R1 wandered in and out of the residential area. Staff were to ensure they were aware of R1's whereabouts at all times. R1's Individual Abuse Prevention Plan (IAPP) dated July 1, 2025, indicated R1 was vulnerable to impaired judgement due to mental illness and whenever he used drugs and alcohol. Staff were to encourage R1 to abstain from alcohol and drug consumption and call 911 when R1 demonstrated signs of impairment. R1's history of sexual inappropriateness included exposing himself in public, inappropriately grabbing and touching staff, and sexual assault. The licensee indicated allegations of sexual assault serious and would promptly be reported to law enforcement and licensee management. It was the licensee policy to ensure the safety and well-being of all residents, indicting sexual assault was egregious and would not be tolerated. Preventative measures included staff education and training on their rights and protection to recognize, identify, and report sexual assault. Staff would closely monitor R1's interaction with others. R1 wandered. Interventions included staff would know R1's whereabouts at all times. R1's incident report dated July 12, 2025, at 12:15 a.m., indicated R1 was found unresponsive lying on his stomach face down in the grass. Staff	01600		

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01600	Continued From page 4 were unable to see if R1 sustained any injuries. Law enforcement arrived administered oxygen to R1 through a nasal cannula. The resident was transported to the hospital. The incident report indicated there were no witnesses. R1's incident report dated July 14, 2025, at 6:35 a.m., indicated R1 attempted to sexually assault unlicensed personnel (ULP)-E near the end of ULP-E's overnight shift. ULP-E indicated R1 wanted to kiss ULP-E, but ULP-E redirected R1. R1 then turned off facility lights, locked the front door, grabbed ULP-E from behind, and took ULP-E's walkie talkie to prevent ULP-E from calling for help. ULP-E freed herself from R1 and ran across the street to another licensee facility where ULP-C worked. R1 admitted to ULP-C the incident occurred. RN-G arrived at the facility and told ULP-E indicated law enforcement would not be called since the "raping was not yet done." Review of July 2025 through September 2025 staff schedules indicated after R1's attempted sexual assault the licensee continued to schedule ULP-E and other female ULP to work alone during overnight shifts at R1's facility. In addition, R1's record lacked documentation the licensee immediately implemented new interventions related to the incident. Review of five unlicensed personnel files lacked evidence they received sexual assault training. R1's record indicated July 25, 2025, R1 was found unconscious on the doorstep of the facility. R1 told hospital staff he drank alcohol and injested cannabis to kill himself. R1's law enforcement report (#25017552), dated	01600		

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01600	Continued From page 5 July 26, 2025, at 10:01 p.m., indicated law enforcement responded to a call where R1 was found lying in the roadway. R1 was conscious but unable to verbally respond to questions. R1 vomited on himself and was incontinent due to intoxication. R1 agreed to be transported to the hospital. A law enforcement report (#25018491) dated August 6, 2025, at 1:37 p.m., indicated facility staff found R1 unconscious but breathing on the front steps. Staff reported they were unaware of what happened or what substances R1 took. Law enforcement monitored R1 until EMS arrived and transported R1 to the hospital. R1's hospital record dated August 6, 2025, indicated R1 presented to the emergency department with altered mental status (AMS) after R1 stated he smoked K2. The hospital social worker was involved due to multiple reports of other residents involved. EMS staff noted the licensee allowed residents to smoke and do certain drugs. R1's incident report dated August 11, 2025, at 5:15 p.m., indicated R1 lost his balance and fell while walking alone towards a busy roadway with significant traffic. A vehicle almost struck R1. There were no staff witnesses. R1's law enforcement report, (#25018977), dated August 11, 2025, at 5:17 p.m., indicated law enforcement were dispatched to a road ditch where R1 was found due to smoking marijuana and "K2" (potent, synthetic marijuana with psychotic effects). Law enforcement monitored R1 until paramedics arrived and transported R1 to the hospital. There were no staff witnesses.	01600		

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01600	Continued From page 6 R1's ambulance report dated August 11, 2025, at 5:27 p.m., indicated R1 reported issues with getting "weed" and alcohol into the facility. R1 told EMS he smoked K2 and drank alcohol prior to the incident. R1 was previously seen in the emergency department on August 6, 2025, for similar substance abuse issues. R1's incident report dated August 14, 2025, at 7:00 p.m., indicated a passerby in a vehicle called law enforcement after they observed R1 in a ditch. The ambulance report indicated staff reported R1 laid in the ditch for approximately 40 minutes. R1 was sent to the hospital for evaluation. Staff were unaware what happened prior to R1 being found. R1's hospital record dated August 14, 2025, indicated R1 was recently seen multiple times for similar incidents. During an interview with ED staff, RN-G told ED staff R1 appeared to be under the influence of K2 again since R1's behaviors were similar to previous episodes. When asked by hospital staff, RN-G indicated he had no concerns about the licensee's ability to keep R1 and others safe. R1's record lacked documentation R1's medical provider or mental health case manager (MHCM)-B were updated regarding R1's multiple incidents of R1's ED visits, and drug and alcohol intoxication. R1's IAPP lacked documentation the licensee immediately updated R1's IAPP with interventions after each incident. In addition, In addition, R1's IAPP interventions were not followed through by licensee staff, including 1:1	01600		

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01600	Continued From page 7 staff supervision at all times when R1 smoked outside. R1's medical record lacked documentation R1 was assessed after each incident by a licensee nurse. Furthermore, although requested by the investigator, the licensee was unable to provide documentation they submitted Minnesota Adult Abuse Reporting Center (MAARC) reports for R1's incidents. During an interview on September 12, 2025, at 8:50 a.m., law enforcement (LE)-A questioned the level of care R1 received at the facility. LE-A stated law enforcement were frequently called to R1 and other four licensee's facilities several times per week stating the number of calls increased the past several years. During an interview on October 15, 2025, at 1:00 p.m., using a language interpreter, ULP-E stated R1 like to smoke and used drugs and asked residents for drugs. ULP-E stated she was traumatized after R1 attempted to sexually assault her, stating she still remained traumatized whenever she saw R1. ULP-E stated RN-G told her he could not call 911 because the act (sexual assault) was not followed through by R1. ULP-E stated she after the incident she was told by a facility manager that for now she would not be scheduled at R1's facility. ULP-E stated she no longer worked at R1's facility but did work at other licensee's facilities on the block, stating R1 would show up while she worked. ULP-E stated, "I was shaking, traumatized. I didn't know what to do. I was so scared." During an interview on October 15, 2025, at 3:00 p.m., RN-F stated one ULP worked per shift and	01600		

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01600	Continued From page 8 were responsible for the residents who lived in both sides of the duplex. RN-F stated the licensee's residents all had similar mental health diagnoses, and stated R1 and another resident in the duplex were currently under a civil commitment. During an interview on October 16, 2025, at 8:27 a.m., RN-G stated he completed MAARC reports for R1 but did not save any case numbers for the completed MAARC reports. RN-G stated staff were not retrained after ULP-E's incident stating he only spoke to ULP-E after the incident. RN-G stated ULP-E was not stern enough stating R1 targeted staff who were unable to stand up for themselves. RN-G stated since ULP-E explained R1 did not put his hands on her he felt no need to call 911 stating in the past the licensee did call law enforcement after R1 touched a female staff member after he followed her downstairs to the laundry room stating, "It was a pretty scary incident. Really scary." The licensee policy titled Acceptance of Residents dated August 1, 2021, indicated the licensee would only accept a resident if the facility had staff sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in each resident's Assisted Living Contract and with the scope of the licensee's disclosed services. The licensee policy titled Staffing & Scheduling, dated August 1, 2021, indicated the clinical nurse supervisor must ensure staffing levels were adequate to address each resident's needs as identified in the resident's service, each resident's acuity level as determined by the resident's most recent assessment, the ability to	01600		

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01600	Continued From page 9 timely meet the resident's scheduled and reasonably foreseeable unscheduled needs. TIME PERIOD TO CORRECT: Seven (7) days.	01600		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		