Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL360118846M
Compliance #: HL360116450C

Date Concluded: January 16, 2024

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Abuse-Substantiated, Individual responsibility
Neglect-Not Substantiated

Nature of Visit:
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 provided alcohol to the resident and had sexual contact with the resident.
It is also alleged the facility neglected the resident when the resident ingested pills received from a peer who lived across the street.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP gave alcohol to the resident, who was under the legal drinking age. There was a preponderance of evidence in audio/video recording of the incident the AP had sexual contact with the resident.

The Minnesota Department of Health determined neglect was not substantiated. The facility supervised the resident with one-to-one staffing. The resident's hospital records indicated the

resident told them she took Benadryl to get high, however, the resident had no signs or symptoms of ingestion.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted county workers, the resident's guardian, and law enforcement. The investigation included review of medical records, facility documents, police reports, and hospital records. The investigator also viewed video recorded inside the facility vehicle during the incident.

The resident lived in an assisted living facility. The resident's diagnoses included schizophrenia, borderline intellectual disability, and post-traumatic stress disorder. The resident's service plan included assistance with choosing weather appropriate clothing, meals, transportation, medication administration, and behavior management. The resident had no peers living in the home (the owners had four other assisted living homes on the same property) and received constant one to one supervision due to a history of elopement and behaviors. The resident's care plan, developed with the resident's county team, included extensive staff interventions for behaviors and mental health symptoms.

A facility internal investigation report indicated a staff member called an administrative staff to report concerns the resident was under the influence of alcohol. The administrative staff provided direction to the staff and received no additional calls back. The next day the administrative staff reviewed video recorded of the inside of the facility vehicle. The report indicated the resident's one to one staff (the AP) took the resident on an outing in the facility vehicle. The report indicated surveillance cameras from the vehicle provided video/audio of conversations and locations of the AP and the resident. The AP drove the resident to a liquor store, the staff's home, and a park. The report indicated the video showed the AP bought alcohol and gave it to the resident who drank it while in the vehicle. The report indicated the video showed the AP and the resident engaged in sexually focused conversation while driving around for an hour, until the vehicle stopped at a park. The video stopped when the AP turned off the vehicle. Approximately 15 minutes later the video restarted, and the resident is heard saying "it was a good day with you even though we didn't mean to do what we did." The report indicated the facility called law enforcement and sent the resident to the hospital for an examination.

During an interview, a staff member stated he took over from the AP as the resident's one-to-one on the evening of the incident. The staff member stated the resident appeared drunk, with difficulty standing and laughing more than usual, so he contacted an administrator.

During an interview an administrative staff stated he reviewed video from inside the van the day after the incident to figure out what had gone on. The administrative staff stated based on what he saw on the video, he called police, and the police came to the facility. The administrative staff stated police interviewed the resident and took the resident's clothing as evidence.

During an interview, another staff stated she spoke with the resident the day after the incident. The resident told the staff the AP bought her alcohol, and they had sex.

During an interview, the AP initially stated he drove with the resident to Mc Donald's, to his house to get his phone charger, and back to the facility for a total of 20 minutes. The AP stated the resident asked him to buy her some alcohol, but he told her no. When confronted by the investigator with the content of the audio/video recording, the AP changed his recollection of events several times. The AP denied he provided the resident with alcohol and denied he had sexual contact with the resident.

The facility provided training to the AP on prevention of maltreatment of vulnerable adults, boundaries, the resident's vulnerabilities/service plan/interventions, and the facility code of conduct.

During an interview with law enforcement, an officer indicated charges were pending.

The resident declined to interview.

In conclusion abuse in substantiated, neglect is not 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.

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.

"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: Declined
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The AP is no longer employed by the facility.
The facility increased the staffing for the resident to two staff.
The resident discharged to a new facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

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
	36011	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC - FAITH'S	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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction orders is 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: #HL360116450C/ #HL360118846M On December 18, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were no residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL360116450C/#HL360118846M, tag identification 2360.	0 000		
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.	02360		

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02360	Continued From page 1 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 an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	