Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL360124883M
Compliance #: HL360121070C

Date Concluded: October 22, 2025

Name, Address, and County of Licensee Investigated:
Gabby Care Homes Sam's House
1306 West River Road
Champlin, MN 55316
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, 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 staff failed to supervise and implement safety interventions for a resident with a known drug and alcohol abuse history. The resident overdosed on drugs and was treated in the hospital. The resident later became unresponsive after getting intoxicated and was evaluated by emergency medical services.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident had at least three overdoses where police were contacted. Two of the overdoses the resident was at a sister facility across the street from where the resident lived. The facility failed to ensure the resident had appropriate supervision and failed to implement safety interventions after each overdose. Facility management were not aware a 911 call had been made for one of the overdoses.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, the case worker, and the primary care provider. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed resident activities at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included post-traumatic stress disorder (PTSD), unspecified psychosis, and alcohol use disorder. The resident's service plan included assistance with three times per day behavior management services for alcoholism, anxiety, verbal aggression, and a safety check. The resident's assessment indicated that due to the resident's continued use of drugs and alcohol and lack of insight and poor weighing of advice, the resident was at risk of self-abuse, especially through consistent alcohol consumption. Interventions included encouraging the resident to not use alcohol and monitor for signs of alcohol consumption. Staff were to notify the nurse and document if the resident consumed alcohol. Staff were to call 911 if the resident had any shortness of breath, confusion, unresponsiveness, or injury related to drug or alcohol use. Staff were to keep educating the resident and encouraging him to seek chemical dependency therapy. The resident was to be reminded of the facility rules and the possible consequences that may result from consuming alcohol in the facility. Staff were to monitor his alcohol use and ensure he wasn't buying or sharing alcohol with other residents or trying to borrow money from other residents to buy drugs or alcohol. The resident had a history of purchasing marijuana from the community and bringing it back to the facility to share with other residents. The resident had impaired judgment related to psychosis and when he consumed alcohol or drugs. Staff were to monitor the resident's behaviors and intervene as per training. Staff were to monitor the resident, keep other residents safe, and document and report the usage and sharing of alcohol. Staff were to monitor the resident's whereabouts.

Facility documentation indicated the resident was noted to be intoxicated, drinking alcohol or smoking marijuana several times per week. Facility documentation lacked evidence the nurse was notified of every instance. The resident would frequently go to a sister facility owned by the licensee that was across the street and use marijuana and drink alcohol, returning to the facility under the influence.

Facility documentation indicated the resident went to the garage of the facility and came back 15 minutes later crawling and asking for help. When the resident went unconscious, 911 was called. The resident was taken to the hospital and returned a few hours later. A police report indicated the resident showed signs of significant drug impairment and was taken to the hospital and "area residents had witnessed party [the resident] falling repeatedly before crawling back inside his residence. Plain view marijuana pipe and plain view drug pipe were observed in party's bedroom on bedside nightstand." Two facility managers were interviewed and both stated there was no 911 call made on the date the incident occurred. The resident's record lacked documentation from a nurse that they were notified of the incident, and no

interventions were put in place after it was determined the resident had drug paraphernalia in his room. Management provided a copy of an after-visit summary from a hospital for the date of this incident which indicated the resident was seen in the emergency room for drug abuse and agitation.

Facility records lacked documentation of anything occurring on the date the incident occurred, approximately a month after incident one happened. A police report indicated officers were called for a possible overdose at a facility operated by the licensee that was across the street. The resident was found sitting on the ground vomiting uncontrollably and sweating profusely. The resident was not able to speak full sentences and had a difficult time getting up on his own. Officers spoke with facility staff who speculated the resident had smoked K2. Facility staff told a police officer they had 4 or 5 overdoses within a short period of time, and they believed someone in the facility or associated with the facility was supplying residents with illicit substances. Hospital records indicated the resident was brought to the emergency room and after being evaluated was discharged back to the facility. A partially completed incident report indicated a nurse was notified; however, the nurse failed to assess the resident or identify any interventions.

Facility records indicated about two weeks later, the resident returned to the facility drunk and staggering and was brought in by his friends and requested to take a shower but was unable to stand alone. Facility documentation indicated the resident was in the hospital for the last part of the shift. A police report indicated they were contacted after staff found the resident in and out of consciousness shivering on the front step and that staff thought he may have taken K2. The resident was taken to the hospital. Facility records lacked documentation the nurse was notified, and the nurse failed to assess the resident or identify any interventions.

Facility records indicated about five days later, the resident went to the sister facility across the street and started smoking marijuana around 10:30 p.m. The resident fell so 911 was called but the resident refused to go to the hospital. The resident “came staggering back to his room, at the time of documentation, he was in his room not even knowing himself.” A police report indicated the resident was semi responsive, lying face up on the steps of the sister facility. The resident smelled of alcohol and had vomit on his clothing. Staff reported to police they did not know what happened and were unsure how long the resident had been on the ground. A partially completed incident report indicated the nurse was notified; however, the nurse failed to assess the resident or identify any interventions.

During an interview, the resident’s case manager stated the facility should have been able to implement more interventions based on the reimbursement they were receiving. The case manager stated she was not updated when the overdoses had happened and only found out about them several weeks later. The case manager stated the facility didn’t offer any activities to keep the resident busy and did not provide adequate supervision to keep the resident from overdosing or drinking too much.

During an interview, facility management stated facility staff kept an eye on the resident. Facility management stated facility staff should have been calling to report to the nurse if the resident was intoxicated.

In conclusion, the Minnesota Department of Health determined neglect was 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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

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
Minnesota Board of Nursing
Minnesota Board of Executives for Long Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36012	A. BUILDING: _____ B. WING _____	C 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC - SAM'S H	1306 WEST RIVER ROAD 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: #HL360124883M/#HL360121070C On September 29, 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 three residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL360124883M/#HL360121070C, tag identification 0620, 2310, 2360.	0 000		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section	0 620		

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0 620	Continued From page 1 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause	0 620		

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0 620	Continued From page 2 (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one residents (R1) reviewed for maltreatment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, 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: The licensee failed to immediately report suspected neglect after R1 suffered at least four overdoses where police were called for	0 620		

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0 620	Continued From page 3 assistance. Facility documentation indicated R1 had also eloped several times. R1's diagnoses included post-traumatic stress disorder (PTSD), unspecified psychosis, and alcohol use disorder. R1's service plan dated August 1, 2021, indicated R1 had three times per day behavior management services for alcoholism, anxiety, verbal aggression, and a safety check. R1 admitted to the facility on January 1, 2021. R1's admission assessment indicated R1 had a history of chemical dependency treatment. R1's assessment dated April 30, 2025, indicated that due to R1's continued use of drugs and alcohol and lack of insight and poor weighing of advice, R1 was at risk of self-abuse, especially through consistent alcohol consumption. Interventions included encouraging R1 to not use alcohol and monitor for signs of alcohol consumption. Staff were to notify the nurse and document if R1 consumed alcohol. Staff were to call 911 if R1 had any shortness of breath, confusion, unresponsiveness, or injury related to drug or alcohol use. Staff were to keep educating R1 and encouraging him to seek chemical dependency therapy. R1 was to be reminded of the facility rules and the possible consequences that may result from consuming alcohol in the facility. R1 was noted to have been referred to chemical dependency treatment but had declined to attend treatment. Staff were to monitor his alcohol use and ensure he wasn't buying or sharing alcohol with other residents or trying to borrow money from other residents to buy drugs or alcohol. R1 had a history of purchasing	0 620		

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0 620	Continued From page 4 marijuana from the community and bringing it back to the facility to share with other residents. R1 had impaired judgment related to psychosis and when he consumed alcohol or drugs. Staff were to monitor R1's behaviors and intervene as per training. If behaviors were related to drug or alcohol use, staff were to provide validation of his thoughts and feelings as needed and encourage R1 to verbalize his thoughts and needs. R1 could become agitated if he was redirected from not sharing alcohol with other residents. Staff were to monitor R1, keep other residents safe, and document and report the usage and sharing of alcohol. R1 was noted to have a history of being sexually inappropriate while intoxicated and had been arrested at a park after discussing his penis with a minor while intoxicated. Staff were to monitor R1's whereabouts. R1 could also become verbally aggressive and threatening when drunk and did not like to be redirected by staff. R1 had a history of wandering and had left the facility multiple times unannounced. "Once he left home with another client and ended up in another client's parents' home in Waconia uninvited causing fear and panic. Staff must know where [R1] is at all times." R1 was noted to not have a pattern of wandering, however it was noted in the same section of the assessment that "[R1] wanders frequently from facility. He may not let staff know when he leaves. He ensures that staff are unaware when he leaves. [R1] will not sign out and will not let staff know where he's gone. He at times will not take his phone with him to avoid staff's contacting him. Staff will continue monitoring [R1] and encouraging him to communicate when he wants to leave the facility. R1 had "multiple instances of elopement in the last six months." R1's record lacked documentation of when he eloped or what	0 620		

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0 620	Continued From page 5 happened. Facility documentation indicated on June 22, 2025, when staff arrived, R1 "was sleeping in his room, He woke up after two hours went to gabby garage. He came back after fifteen minutes crawling and asking for help. I called other staff, and we found that his unconscious, we called 911 immediately. They came took him to hospital; he came back at 8pm. He took his medication and meals and now he is sleeping at home and safe." A police report dated June 22, 2025, police were called at 5:10 p.m. for R1 who had crawled back into the house after being outside briefly and then collapsed in his bedroom, going unconscious. R1 was showing signs of "significant drug impairment" and was taken to the hospital. "Area residents had witnessed party [R1] falling repeatedly before crawling back inside his residence. Plain view marijuana pipe and plain view drug pipe were observed in party's [R1] bedroom on bedside nightstand." The licensee failed to report the incident to MAARC. A police report dated July 18, 2025, indicated officers were called at 3:12 p.m. for a possible overdose at a facility owned by the licensee but across the street from the facility R1 lived at. Officers found R1 in the lawn of a sister facility across the street "sitting on the ground vomiting on himself uncontrollably and sweating profusely. It should be noted that I am very familiar with [R1] and speak with him on a regular basis. [R1] was not making full sentences and was difficult to understand. [R1] was having a difficult time holding himself up on his own. Officers had to physically assist [R1] in order for him to remain in	0 620		

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0 620	Continued From page 6 a seated position. All of this is abnormal for his behavior...Officers were directed by staff to a few group home members who were with [R1] earlier in the day. I attempted to speak with them to gather what [R1] might have taken, according to the group home members they either didn't know or speculated that he had smoked K2. It should also be noted that on 6/22/2025 officers were called to assist [R1] who was overdosing and had possibly smoked K2 that day." R1 was taken to the hospital for a suspected overdose. The police report included, "Speaking with the staff, I asked what the group home was doing to stop these overdoses from happening. Staff advised that the clients are free to come and go as they please, which makes it difficult for them to monitor their activities when not at home. I suggested to them that they contact he state department for either recommendations or assistance in the matter. I was advised by staff that they have had 4-5 overdoses within a short period of time and that they believe that someone in the group home or associated with the group home is supplying the clients with illicit substances." The licensee failed to report the incident to MAARC. Hospital records indicated on July 18, 2025, R1 was brought to the emergency room for concerns of altered mental status. It was documented that "Police report K2 common in this group home so unsure if patient ingested anything or not. Patient intermittently combative and argumentative but was too altered and weak to become too severe. Patient covered in emesis...Patient was found on ground in neighborhoods yard. Patient reports drinking "a lot of alcohol" and doing marijuana as well..." Facility documentation indicated on July 30,	0 620		

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0 620	Continued From page 7 2025, R1 returned to the facility drunk and staggering "he was brought by his friends and requested to go take a shower of which he could not stand alone." Notes indicated R1 was in the hospital for the last part of the shift. A police report dated July 30, 2025, indicated police were called at 3:04 p.m. after staff found R1 in and out of consciousness shivering on the front step. Staff reported to dispatch that R1 had possibly taken K2. Police monitored R1 until emergency medical services arrived and transported R1 to the hospital. The licensee failed to report the incident to MAARC. A police report dated August 5, 2025, at 10:06 p.m. indicated officers were "dispatched to one unconscious in front of a group home..." at a facility owned by the licensee but across the street from the facility R1 lived at. Two officers arrived and found R1 lying face up next to the front steps of the home. R1 was "semi-responsive" but did begin responding once a sternum rub was done. R1's speech was heavily slurred and unintelligible as he tried to roll over on the ground. "He had a dazed look in his eyes and appeared unable to form cohesive thoughts or sentences." Officers could smell a "heavy and distinct odor of a consumed alcoholic beverage emanating from his person. I could also smell vomit and found wet spots on his clothing. Staff was gathered around [R1] and stated they did not know what happened, did not witness the event, and were unsure how long [R1] had been spent lying on the ground...Staff was asked if they had observed [R1] drinking or if he has access to alcohol in his bedroom and they were unable to provide a definite denial or confirmation. Staff also stated [R1] had 'been	0 620		

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0 620	Continued From page 8 around' all day, but was apparently unsupervised, as they could provide no details as to how [R1] became so intoxicated." Officers found a small, empty bottle of vodka on the ground nearby. A breath test was given but R1 wasn't able to give a strong enough breath and a reading of 0.066 was displayed after holding the breath test near his mouth. R1 refused care from paramedics and walked to his home and went to bed. The licensee failed to report the incident to MAARC. Records provided by the facility indicated R1 was seen in the emergency room for an overdose on August 6, 2025. On October 21, 2025, at 12:40 p.m., registered nurse (RN)-A stated some of R1's behavior was self neglect and there were incidents that should have been reported. RN-A stated he didn't think R1 had eloped although he would leave the facility during the day. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview, and record review, the	02310		

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02310	Continued From page 9 licensee failed to ensure care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R1) with multiple emergency room visits related to overdoses. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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: R1's diagnoses included post-traumatic stress disorder (PTSD), unspecified psychosis, and alcohol use disorder. R1's service plan dated August 1, 2021, indicated R1 had three times per day behavior management services for alcoholism, anxiety, verbal aggression, and a safety check. R1 admitted to the facility on January 1, 2021. R1's admission assessment indicated R1 had a history of chemical dependency treatment. The licensee's UDALSA dated September 1, 2023, indicated one direct care staff was typically scheduled per shift. While the facility did not have an assisted living with dementia care license, the section for only assisted living with dementia care facilities was filled out. The facility was prepared to manage challenging behaviors and had door alarms and window alarms if care planned for risk of elopements.	02310		

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GABBY CARE HOMES LLC - SAM'S H	1306 WEST RIVER ROAD CHAMPLIN, MN 55316

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02310	Continued From page 10 The licensee's schedule for July 2025 indicated one direct care staff was scheduled per shift with shift times from 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m. Facility documentation indicated R1 had "multiple instances of elopement in the last six months." However, R1's assessment failed to include interventions related to elopements and what the licensee would do to prevent R1 from eloping. R1's assessment dated April 30, 2025, indicated that due to R1's continued use of drugs and alcohol and lack of insight and poor weighing of advice, R1 was at risk of self-abuse, especially through consistent alcohol consumption. Interventions included encouraging R1 to not use alcohol and monitor for signs of alcohol consumption. Staff were to notify the nurse and document if R1 consumed alcohol. Staff were to call 911 if R1 had any shortness of breath, confusion, unresponsiveness, or injury related to drug or alcohol use. Staff were to keep educating R1 and encouraging him to seek chemical dependency therapy. R1 was to be reminded of the facility rules and the possible consequences that may result from consuming alcohol in the facility. R1 was noted to have been referred to chemical dependency treatment but had declined to attend treatment. Staff were to monitor his alcohol use and ensure he wasn't buying or sharing alcohol with other residents or trying to borrow money from other residents to buy drugs or alcohol. R1 had a history of purchasing marijuana from the community and bringing it back to the facility to share with other residents. R1 had impaired judgment related to psychosis and when he consumed alcohol or drugs. Staff	02310		

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02310	Continued From page 11 were to monitor R1's behaviors and intervene as per training. If behaviors were related to drug or alcohol use, staff were to provide validation of his thoughts and feelings as needed and encourage R1 to verbalize his thoughts and needs. R1 could become agitated if he was redirected from not sharing alcohol with other residents. Staff were to monitor R1, keep other residents safe, and document and report the usage and sharing of alcohol. R1 was noted to have a history of being sexually inappropriate while intoxicated and had been arrested at a park after discussing his penis with a minor while intoxicated. Staff were to monitor R1's whereabouts. R1 could also become verbally aggressive and threatening when drunk and did not like to be redirected by staff. R1 had a history of wandering and had left the facility multiple times unannounced. "Once he left home with another client and ended up in another client's parents' home in Waconia uninvited causing fear and panic. Staff must know where [R1] is at all times." R1 was noted to not have a pattern of wandering, however it was noted in the same section of the assessment that "[R1] wanders frequently from facility. He may not let staff know when he leaves. He ensures that staff are unaware when he leaves. [R1] will not sign out and will not let staff know where he's gone. He at times will not take his phone with him to avoid staff's contacting him. Staff will continue monitoring [R1] and encouraging him to communicate when he wants to leave the facility. R1's progress notes contained the following documentation: -June 1, 2025, R1 was "observed to be intoxicated and under the influence of alcohol during the shift. Despite his condition, he consumed his dinner and was administered his	02310		

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02310	Continued From page 12 prescribed medications as scheduled. R1 exhibited wandering behavior throughout the evening but remained nonaggressive and cooperative. He is currently within the facility." -June 2, 2025, R1 was noted to be under the influence of alcohol. -June 3, 2025, R1 returned to the facility around 10:00 p.m., with "a squad of other residents" and was "very dirty and intoxicated..." -June 4, 2025, R1 was "smelling alcohol and weed at the start of shift..." June 5, 2025, R1 "was not home when the shift started at 3pm, He came later on around 4pm he was very drunk and talking very loud, he went straight to his room and took a nap, he woke up very late in the evening and left to other houses across the street chilling with his peers, he came back around 8pm with his peers he went his room, the staff reminded him to eat dinner but declined. R1 swallowed his meds in the presence of the staff, after which he left with [two residents of sister facility], [R1] told me he was going out with [other resident] to look for girlfriend, but he signed out he was going to friends house. At the time of documentation, he was not back." -June 6, 2025, R1 went across the street to visit friends at the sister facility. -June 7, 2025, R1 was "totally drunk" and smoking marijuana in his room. -June 8, 2025, R1 was observed to be drunk. -June 12, 2025, R1 went for a walk and "came back drunk..." -June 13, 2025, R1 went across the street to visit friends at a sister facility. -June 15, 2025, R1 was noted to be drunk. -June 16, 2025, R1 was noted to be drunk. -June 17, 2025, R1 was noted to be "under the influence of alcoholism (sic), that is not able to walk properly."	02310		

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02310	Continued From page 13 -June 18, 2025, R1 was "looking a bit intoxicated talking around and staff could smell alcohol as he was moving around." -June 19, 2025, R1 was not home when the afternoon shift arrived. R1 "came later on around 6pm he was looking drunk, he ate his dinner after which he went to his room, after some time he went to his peers across the street. [R1] came back at 10:15 pm ..." -June 20, 2025, R1 was "drunk and came out staggering to smoke." -June 21, 2025, R1 "looked drunk." -June 22, 2025, when staff arrived, R1 "was sleeping in his room, He woke up after two hours went to gabby garage. He came back after fifteen minutes crawling and asking for help. I called other staff, and we found that his unconscious, we called 911 immediately. They came took him to hospital; he came back at 8pm. He took his medication and meals and now he is sleeping at home and safe." A police report dated June 22, 2025, police were called at 5:10 p.m. for R1 who had crawled back into the house after being outside briefly and then collapsed in his bedroom, going unconscious. R1 was showing signs of "significant drug impairment" and was taken to the hospital. "Area residents had witnessed party [R1] falling repeatedly before crawling back inside his residence. Plain view marijuana pipe and plain view drug pipe were observed in party's [R1] bedroom on bedside nightstand." -June 24, 2025, R1 went across the street to visit with residents at a sister facility. -June 25, 2025, R1 "looked drunk and was smelling alcohol." -June 27, 2025, R1 "enjoyed the day smoking	02310		

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02310	Continued From page 14 and drinking alcohol with other clients across the street. He came to the house and ate meal and then went back to hang out with peers." -June 29, 2025, R1 "exhibited wandering behavior throughout the evening but remained non-aggressive and cooperative. He is currently out of the facility." -July 1, 2025, R1 went across the street to visit other residents at a sister facility. He returned later that evening "drunk looking tired and dirty..." -July 2, 2025, R1 went for a walk and returned to the facility "intoxicated staggering." Another note indicated, "Client was so intoxicated at the start of shift. He was staggering around and having hard time keeping a conversation. staff safely redirected to his room. He slept all day during the shift. He woke up at 8:40 pm ate dinner, took his medications and went back to his room." -July 3, 2025, R1 "woke up at 9am, dressed up and went across the street to hang out with other clients. He came back to the house drunk; he ate lunch and went to his room to take a nap." At 7:33 p.m., registered nurse (RN)- wrote, "Resident noted to be highly inebriated as evidenced by his breath, dilated pupils, loss of balance, slurred speech, confusing and staggering when ambulating. Numerously, staff had to redirect R1 from going to the wrong residence and hand guide him back to his facility. He had numerous near falls while ambulating back to his residence. He verbalized "I gave myself a good dose of vodka." -July 4, 2025, R1 was visiting with other residents at a sister facility across the street. -July 5, 2025, R1 returned to the facility "totally drunk" and "staggering." -July 6, 2025, R1 returned to the house "drunk looking tired and dirty" -July 7, 2025, R1 went for a walk and was noted	02310		

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02310	Continued From page 15 to be drunk and struggling to walk. -July 8, 2025, R1 "exhibited wandering behavior." R1 later went across the street to visit residents at a sister facility. -July 9, 2025, R1 was at a sister facility "all day smoking, drinking, refuse staff redirection." -July 10, 2025, R1 was "drunk on this shift." -July 12, 2025, R1 went to a sister facility across the street and when he returned, he "looked drunk but very strong..." -July 13, 2025, R1 was "either under an influence, either alcohol or smoked something." A staff member wrote, "ChatGPT Log in You said: Make an end of shift note for [R1], a resident who was socializing with other clients at [sister facility], at some point he became under influence and was lying on the ground with slurred speech, the staff was present to ascertain his level of influence, the nurse was informed. He later staggered to the house took his dinner and medications, currently sleeping in his room. ChatGPT said: Sure, here ' s a professional and concise end-of shift note for [R1]: End of Shift Note - [R1] During the shift, [R1] was observed socializing appropriately with other clients in the common area at [sister facility]. At a later point, he appeared to be under the influence; he was found lying on the ground with slurred speech. Staff remained present to assess his condition and ensure safety. The nurse was promptly informed of the situation. [R1] later got up on his own, staggered into the house, and was able to take his dinner and evening medications with supervision. He is currently in his room and appears to be sleeping. Will continue to monitor. Let me know if you'd like this adapted to a specific format or system (e.g., SOAP, DAP, electronic charting, etc.). You said: Add under influence of alcohol or smoked something he	02310		

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02310	Continued From page 16 didn't reveal to the staff ChatGPT said: Certainly, here is the revised version with that detail included: End of Shift Note - [R1] During the shift, [R1] was initially observed socializing appropriately with other clients in the common area at [sister facility]. Later, he appeared to be under the influence of alcohol or possibly a substance he smoked but did not disclose to staff. He was found lying on the ground with slurred speech. Staff remained present to assess his condition and ensure his safety. The nurse was promptly informed of the situation. [R1] eventually got up on his own, staggered into the house, and was able to take his dinner and evening medications with staff supervision. He is currently in his room and appears to be sleeping. Will continue to monitor." -July 15, 2025, R1 was noted to have been drinking alcohol all of the evening shift. -July 16, 2025, R1 was drunk and aggressive to anyone giving him any direction. -July 17, 2025, R1 went for a walk and returned drunk. R1's record lacked documentation of any incidents on July 18, 2025. Hospital records indicated on July 18, 2025; R1 was brought to the emergency room for concerns of altered mental status. It was documented that "Police report K2 common in this group home so unsure if patient ingested anything or not. Patient intermittently combative and argumentative but was too altered and weak to become too severe. Patient covered in emesis...Patient was found on ground in neighborhoods yard. Patient reports drinking "a lot of alcohol" and doing marijuana as well..." R1 was treated in the emergency room	02310		

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02310	Continued From page 17 and returned to the facility the next day. A police report dated July 18, 2025, indicated officers were called at 3:12 p.m. for a possible overdose at a facility owned by the licensee but across the street from the facility R1 lived at. Officers found R1 in the lawn of a sister facility across the street "sitting on the ground vomiting on himself uncontrollably and sweating profusely. It should be noted that I am very familiar with [R1] and speak with him on a regular basis. [R1] was not making full sentences and was difficult to understand. [R1] was having a difficult time holding himself up on his own. Officers had to physically assist [R1] in order for him to remain in a seated position. All of this is abnormal for his behavior...Officers were directed by staff to a few group home members who were with [R1] earlier in the day. I attempted to speak with them to gather what [R1] might have taken, according to the group home members they either didn't know or speculated that he had smoked K2. It should also be noted that on 6/22/2025 officers were called to assist [R1] who was overdosing and had possibly smoked K2 that day." R1 was taken to the hospital for a suspected overdose. The police report included, "Speaking with the staff, I asked what the group home was doing to stop these overdoses from happening. Staff advised that the clients are free to come and go as they please, which makes it difficult for them to monitor their activities when not at home. I suggested to them that they contact he state department for either recommendations or assistance in the matter. I as advised by staff that they have had 4-5 overdoses within a short period of time and that they believe that someone in the group home or associated with the group home is supplying the clients with illicit substances."	02310		

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02310	Continued From page 18 -July 19, 2025, R1 returned to the facility in the afternoon "very drunk and staggering" -July 22, 2025, R1 showed signs of alcohol use. -July 23, 2025, R1 left the house around 10:00 a.m. and returned around 2:00 p.m. drunk and was not able to make it to his facility so he went to the office. R1 was noted to be so drunk. R1 had swelling to his eyebrow that he said happened when he was fighting with a friend. -July 24, 2025, RN-A wrote that he observed R1 was intoxicated as evidenced by slurred speech, loss of balance, smell of alcohol and inability to have a coherent thought process. R1 wanted a ride to cash a check however due to his verbal and aggressive behavior, management declined to transport him to the store. RN- called for emergency services due to R1's aggressive behavior. -July 26, 2025, R1 returned to the facility around 5:00 p.m. drunk and staggering. -July 28, 2025, R1 "...appeared drunk but the staff did not know the substance that he had taken. The staff provided calm and safe environment for the client to have a enough rest and regain. After some time the client gained, ate his dinner and took his medications. The client is in the house, okay and safe." -July 29, 2025, R1 had "intoxicated behaviors" and was "looking very dirty and weak." R1 was so drunk "beyond to knowing what is going on." -July 30, 2025, R1 returned to the facility drunk and staggering "he was brought by his friends and requested to go take a shower of which he could not stand alone." Notes indicated R1 was in the hospital for the last part of the shift. A police report dated July 30, 2025, indicated police were called at 3:04 p.m. after staff found	02310		

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02310	Continued From page 19 R1 in and out of consciousness shivering on the front step. Staff reported to dispatch that R1 had possibly taken K2. Police monitored R1 until emergency medical services arrived and transported R1 to the hospital. -July 31, 2025, R1 "was not home when the shift started at 3pm, the staff saw him outside the street talking so loud and pacing around the road, he came later at around 6pm he was very drunk and staggering, he went to his room taking a nap, peers came in to check on him, the staff directed them, and after some time, he woke up ate dinner and swallowed his bedtime meds in the presence of the staff, [R1] left again to other houses he came back around 9.30pm with his peers closed his door and started smoking weed the staff redirected them and they stopped. At the time of documentation, he was in his room with [other residents] and other peers." -August 2, 2025, R1 went to the facility's garage with other residents and "came back at noon drunk with his peer." -August 3, 2025, R1 was in the garage when evening shift staff arrived and "he was drunk at that time." -August 4, 2025, R1 was "under the influence of alcohol up to the point of not supporting himself..." -August 5, 2025, "When the shift started at 3pm, the staff saw [R1] outside the street talking, he came later at around 4pm he was very drunk and staggering, he went to his room taking a nap, peers came in to check on him, the staff directed him to his room, he woke up declined dinner and swallowed his bedtime meds in the presence of the staff, [R1] left again to other houses he came back around 9pm ,he went to [sister facility] and started smoking weed around 10:30pm he fall	02310		

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02310	Continued From page 20 down, AGUTA called 911 who came and started examining him ambulance also came but [R1] refused to go with them came staggering to his room, At the time of documentation, he was in his room not even knowing himself." A police report dated August 5, 2025, at 10:06 p.m. indicated officers were "dispatched to one unconscious in front of a group home..." at a facility owned by the licensee but across the street from the facility R1 lived at. Two officers arrived and found R1 lying face up next to the front steps of the home. R1 was "semi-responsive" but did begin responding once a sternum rub was done. R1's speech was heavily slurred and unintelligible as he tried to roll over on the ground. "He had a dazed look in his eyes and appeared unable to form cohesive thoughts or sentences." Officers could smell a "heavy and distinct odor of a consumed alcoholic beverage emanating from his person. I could also smell vomit and found wet spots on his clothing. Staff was gathered around [R1] and stated they did not know what happened, did not witness the event, and were unsure how long [R1] had been spent lying on the ground...Staff was asked if they had observed [R1] drinking or if he has access to alcohol in his bedroom and they were unable to provide a definite denial or confirmation. Staff also stated [R1] had 'been around' all day, but was apparently unsupervised, as they could provide no details as to how [R1] became so intoxicated." Officers found a small, empty bottle of vodka on the ground nearby. A breath test was given but R1 wasn't able to give a strong enough breath and a reading of 0.066 was displayed after holding the breath test near his mouth. R1 refused care from paramedics and walked to his home and went to bed.	02310		

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02310	Continued From page 21 -August 6, 2025, R1 went across the street to visit a sister facility. He returned that evening "so drunk to an extend that he could hardly walk..." (sic) Records provided by the facility indicated R1 was seen in the emergency room for an overdose on August 6, 2025. -August 8, 2025, R1 was "drinking alcohol across the street. He came back drunk, took his meds and dinner and went to bed." -August 9, 2025, R1 "went across the street to smoke and drink with other clients. He returned to the house drunk..." R1 was seen by his primary care provider on August 19, 2025, to review recent emergency room visits. The primary care provider discussed options for his psychiatrist to prescribe other medications for R1's anxiety and depression. R1's psychiatry appointment that same day was cancelled as R1 was intoxicated and the provider wanted to see R1 when he was sober. On October 1, 2025, at 2:25 p.m., one of R1's case managers (CM)-C stated the facility received a high reimbursement rate and she felt they should have been able to implement more interventions to keep R1 safe. CM-C stated she did not hear much from the facility while R1 was living there, and she was not notified about the overdoses until several weeks after they happened. CM-C stated the facility was barely a room and board and they did not offer any activities to keep R1 busy and did not provide adequate supervision to keep R1 from overdosing or drinking too much. CM-C stated	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36012	A. BUILDING: _____ B. WING _____	C 09/29/2025

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02310	Continued From page 22 she asked the facility why they couldn't get a restraining order on the person who was bringing drugs into the facility or do more to keep drugs out of the facility and the facility never acted. CM-C stated she had told the facility they were getting reimbursed enough for R1's care that they could have hired private security or hired more than one person to work per shift to help supervise R1, but nothing was done. On October 2, 2025, at 12:10 p.m., a nurse from R1's primary care provider's office stated they had not been updated on any overdoses or concerns with R1's care at the facility and they would expect to be updated of those types of events. On October 16, 2025, at 12:36 p.m., RN-B replied to an email of questions sent by the investigator. Documentation of the June 22, 2025, 911 call was requested. RN-B replied, "No 911 call on the 22nd." RN documentation of the July 13th incident was requested, RN-B replied, "No nurse notes but HHA [home health aide/unlicensed personnel] notes." Documentation of the July 18, 2025, incident was requested, RN-B replied, "Incident completed by a manager." Documentation of the July 30, 2025, incident was requested, an after-visit summary from the hospital dated June 22, 2025, August 6, 2025, July 18, 2025, and July 30, 2025, were provided. Documentation of the RN being notified of any instances of R1 being intoxicated was requested but not provided. On October 21, 2025, at 12:45 p.m., RN-A stated R1 had lived at the facility for a few years but the last few months he lived at the facility, R1 had more instances where he was drinking, getting	02310		

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02310	Continued From page 23 intoxicated, and under the influence of unknown substances. RN-A stated facility staff would keep an eye on R1. RN-A stated facility staff should have been calling to report to the nurse if R1 was intoxicated. RN-A confirmed there was no documentation to show the nurse was notified of each instance R1 was showing signs of intoxication. RN-A stated R1 didn't really elope and was not sure why the assessment indicated R1 had a history of elopements. RN-A stated they did the best they could with R1 but as he was getting more intoxicated and unsafe, he needed to move to a more supervised place as the facility was not the best place for him. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	02310		
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 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	02360	No plan of correction required for this tag.	

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02360	Continued From page 24 maltreatment report for details.	02360		