*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL340263689M
**Compliance #:** HL340263537C

**Date Concluded:** October 19, 2026

**Name, Address, and County of Licensee Investigated:**
Gabby Home Care
1512 Pennsylvania Ave. North
Champlin, MN 55316
Hennepin County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Heather Beigel, RN
Special Investigator

**Finding:** Substantiated, facility and individual 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 alleged perpetrator (AP) neglected the resident when the AP failed to notify a nurse after the resident fell and sustained an injury. Resulting in a delay of care, as the resident later went to the hospital and required surgical intervention.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was substantiated. The facility and the AP were responsible for the maltreatment. The resident had multiple falls with injury and the facility failed to investigate the cause, reassess the resident and implement new fall interventions after each fall. The AP failed to report the fall to the nurse which resulted in delay of medical interventions.

The resident resided in an assisted living facility. The residents' diagnoses included traumatic brain injury (damage to the brain caused by force), bipolar-schizoaffective disorder (psychotic symptoms and extreme mood swings) and alcohol use disorder. The resident's service plan

included assistance with medication administration, grooming, toileting and transfers. The resident had a walker and wheelchair but often did not use them. The resident's assessment states that she has altered mental status, impaired judgment, reduced safety, history of eloping from the facility and walking unsafely along busy streets.

The incident reports indicated with in the two months prior to the incident the resident had five falls. One fall leading to serious injury and requiring the emergency services to be called. Following the injury the facility failed to complete an investigation, change of condition assessment and new fall interventions. Three of the five falls occurred when the resident was unsupervised outside. The facility failed to notify the physician and did not implement new interventions, increasing the residents' risk for future falls and injury. The assessment stated the resident was to have every fifteen-minute safety checks while intoxicated, however the facility failed to implement the safety checks on the resident's service plan.

The facility's internal investigation indicated the day of the incident the resident fell around 9:53 pm in the bathroom the AP assisted resident up off the floor and onto the toilet. The AP left the facility to obtain help from a neighboring facility. Staff #1 came to the facility with the AP and provided grooming assistance then both the AP and staff #1 assisted the resident into bed. Staff #1 went back to her facility. At 10:01 pm the resident was heard on facility video footage stating that her arm was hurting. At 10:03 pm the resident stated that she wanted to get out of bed and requested help. The resident continued to cry loudly and moan. The AP went into the resident's room and asked why she was crying. The resident responded that she was hurting. The AP left the room and the resident continued to cry.  At 11:13 pm staff #2 arrived for the night shift. Staff #2 heard the resident crying and yelling upon entering the facility. Staff #2 asked the AP why the resident was crying and yelling. The AP stated that she was drinking and fell. Staff #2 and the AP went into the resident's room. The resident stated her arm hurt and said help me. Staff #2 called the nurse who instructed him to call 911. Staff #2 called 911 and the resident was taken to the hospital. The resident required surgical intervention and returned to the facility.

The AP's training record indicated he received training on fall protocol, documentation and reporting changes in resident's condition.

During the interview, the nurse stated the resident had increased falls when she was drinking alcohol and could be resistive to assistance. The care team met and decided to spread out the residents' monthly income, so all the money was not spent immediately on alcohol. The resident was to be checked on every fifteen minutes while intoxicated. The facility's policy was that unlicensed staff were required to call the nurse to report a fall and complete an incident report.

During the interview with the AP, he stated that the resident was outside drinking and it took two other staff members from nearby facilities to get the resident into the facility. The resident was put into bed, shortly after she called for assistance and the AP found the resident on the

floor next to her bed. The AP assisted her up and to the bathroom. The resident told the AP to wait outside the door. The AP did not call the nurse or fill out an incident report for the first fall. The AP heard commotion in the bathroom and realized the resident had fallen again. The AP helped the resident up off the floor and back on to the toilet. The resident requested a female caregiver, so the AP left the facility to go next door and get help. Staff #1 came to the facility, was not told about the falls and assisted the resident with grooming. Both staff #1 and the AP walked the resident to bed. The AP stated he did not call the nurse after the second fall because he was tired from working the day shift and did not think the resident was hurt. The AP acknowledged that it was the facilities policy to call the nurse after a fall and fill out an incident report.

During the interview with staff #1 she stated she was in the facility for a few minutes to help the resident with grooming. She was not told the resident had fallen. The resident did not complain of pain while staff #1 was in the house. Staff #1 states if a resident falls the nurse should be called, the nurse will direct staff on what to do next and staff fill out an incident report.

During the interview, staff #2 stated upon walking into the facility to work the night shift he could hear the resident yelling from her room. Staff #2 asked the AP why the resident was yelling and if she had fallen. The AP said she was drunk. Both staff #2 and the AP went into the resident's room; staff #2 called the nurse who instructed him to call 911.

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**: No, declined.
**Family/Responsible Party interviewed**: No, declined.
**Alleged Perpetrator interviewed**: Yes.

**Action taken by facility:**

Nursing staff re-educated staff on immediate post-fall procedures and change in condition reporting.

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

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 |
|---|---|---|---|
| | 34026 | A. BUILDING: _____ B. WING _____ | C 09/01/2026 |

| 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<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL340263537C/#HL340263689M<br><br>On September 1, 2026, 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 2 residents receiving services under the provider's Assisted Living license.<br><br>The following correction order is issued for #HL340263537C/#HL340263689M , tag identification 2360. | 0 000 | 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 0 000 | Continued From page 1 | 0 000 | ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment.<br><br>Findings include:<br><br>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and an individual person were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. | 02360 | | |