DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308203623M **Date Concluded:** January 17, 2023
Compliance #: HL308205936C

Name, Address, and County of Licensee Investigated:
Whittier Place
2405 1st Avenue South
Minneapolis, MN 55404
Hennepin County

Facility Type: Assisted Living Facility (ALF) **Evaluator's Name:** Peggy Boeck, RN
Special Investigator

Finding: Substantiated, individual responsibility

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 coerced and then forced a resident to engage in sexual acts, under threat of violence.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP sought out the resident outside of work, coerced her to engage in sexual acts, and then threatened harm if she told anyone. The investigation identified evidence which corroborated the resident's account of events.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of medical records, the resident's phone and text logs, facility

documents, policies, and procedures related to code of conduct, and maltreatment of vulnerable adults.

The resident lived in an assisted living facility. The resident's diagnoses included autism spectrum disorder and bipolar disorder. The resident's service plan included medication administration and activities. The resident's abuse prevention plan indicated the resident had a history of abuse by others and directed staff to set healthy boundaries with the resident.

The AP's personnel file indicated facility training provided to the AP included prevention of maltreatment to vulnerable adults, boundaries, and mental health education. The AP's file indicated the AP's job description included coordinating weekly and monthly events for all residents and taking residents on one-to-one activities in the community. The AP's scheduled work hours were from 7:00 a.m. to 3:00 p.m.

Facility documentation indicated the AP provided one outing with the resident and had several more scheduled. There was no documentation by the AP that indicated he provided one-to-one activities with other residents.

A law enforcement report indicated the resident reported a sexual assault. At the time of the report, officers noted the resident was fearful. The report indicated the AP called the resident several days earlier and drove the resident to complete some errands. On the way back in the facility vehicle, the AP demanded a sexual act. The resident reported that after 5:00 p.m. on the day of the report the AP asked to meet the resident several blocks from the facility. The resident met the AP and they walked to several locations where the AP made the resident perform sexual acts under threats of harm. The resident gave law enforcement information about specific locations where this occurred.

After the resident gave the report, law enforcement transported the resident to the hospital where the resident underwent a sexual assault examination and evidence collection.

During a tandem interview with law enforcement, the resident stated the AP had contacted the resident in the evening by text and then a phone call. (The investigator reviewed evidence of a text which the AP sent to the resident after 5:00 p.m. indicating the resident knew it was the AP and to call the AP back for a "one-on-one, if you know what I mean"). The resident reported she met with the AP and walked with the AP to specific locations where he made her engage in sexual acts. The resident stated she eventually was able to leave and then began walking to find a bus to get home. The resident stated she received a text from the AP while she was on the bus indicating the AP was coming to pick her up, so she called police after she arrived back at the facility. The investigator viewed evidence of texts from the AP to the resident that were after 11:00 p.m. indicating the AP was coming to the resident.

During an interview with law enforcement, the AP confirmed he was at two of the locations the resident identified, but stated he was not with the resident.

During an interview, the AP provided conflicting information concerning interactions with the resident, the text messages he sent to the resident, his whereabouts, and timelines during the alleged incident. The AP abruptly ended the interview when the investigator asked clarifying questions.

In conclusion abuse 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.

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.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: No, resident was her own guardian and declined to have family interviewed.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The AP no longer works at the facility.

Action taken by the Minnesota Department of Health:
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

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
Minneapolis City Attorney
Minneapolis Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30820	A. BUILDING: ______ B. WING ______	C 12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITTIER PLACE	**2405 1ST AVENUE SOUTH MINNEAPOLIS, MN 55404**

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL308205936C/#HL308203623M/#HL308203086M/#HL308205081C On November 22, through November 23, 2022, 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 16 residents receiving services under the provider's Assisted Living license. The following immediate correction orders are issued for #HL308205936C/#HL308203623M, tag identification 0620, 1290, and 3000. The immediacy was removed on December 8, 2022, from tags 0620, 1290, and 3000. Non-compliance remains at a scope and severity of a F.	0 000	The Minnesota Department of Health documents the State Licensing 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	

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0 000	Continued From page 1 Correction orders which were not immediate are issued for #HL308205936C/#HL308203623M, tag identification 2360.	0 000		
0 620 SS=I	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interviews and document reviews, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment of one of one residents (R1) reviewed for maltreatment. Police informed unlicensed personnel (ULP)-G that R1 reported a rape and they were taking R1 to the hospital. ULP-G did not make a report to MAARC but called assistant director (AD)-H. AD-H did not file a MAARC report but called the facility director (D)-C. D-C did not file a MAARC report, but called senior director (SD)- F, who filed a MAARC report approximately 40 hours after the facility was aware of the alleged rape. The failure to implement the facility policy on reporting suspected maltreatment had the potential to affect all 16 residents at the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 620		

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0 620	Continued From page 2 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The licensee was notified of the immediate correction order on November 23, 2022. The immediacy was removed on December 8, 2022. Non-compliance remains at a scope and severity of a F. Findings include: R1 moved into the assisted living facility on October 3, 2022, due to diagnoses including autism spectrum disorder, attention deficit hyperactivity disorder, major depressive disorder, generalized anxiety disorder, social anxiety disorder, and intermittent explosive disorder. R1's service plan dated October 3, 2022, indicated R1 received services from the licensee that included monthly activities, whereabouts checks every shift, housekeeping, laundry, and medication administration. R1's law enforcement report dated November 6, 2022, at 1:00 a.m. indicated R1 called law enforcement to report R1 had been raped. The report indicated the suspect was an employee of the facility who was no longer on site but had the potential to return. R1's observation note dated November 6, 2022, at 2:11 a.m. indicated unlicensed personnel (ULP)-G walked outside and observed police	0 620		

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0 620	Continued From page 3	0 620		

talking to R1. Officers told ULP-G R1 reported being raped and they were taking R1 to the hospital.

During an interview on November 23, 2022, at 1:46 p.m., facility director (D)-C stated she received a call from assistant director (AD)-H on November 6, 2022, informing her of R1's incident. D-C stated she called senior director (SD)-F, who directed D-C to fill out an incident report and contact R1's emergency contact, county worker, and to wait to file a MAARC report, as SD-F wanted to send a report on Monday (November 7, 2022). D-C stated ULP-G did not file a MAARC report, AD-H did not file a MAARC report, and she did not file a MAARC report. D-C stated the facility protocol for filing MAARC reports was to notify the senior director, who conducts an investigation and submits a MAARC report within 24 hours.

During an interview on November 23, 2022, SD-F stated all staff were trained as mandated reporters, and he (SD-F) was typically the central point of contact. SD-F stated if staff were unsure of whether to file a MAARC report, they send the information to SD-F. SD-F acknowledged that ULP-G, AD-H, and D-C should have filed a MAARC report.

The Vulnerable Adult Act Reporting policy (undated) indicated all employees are designated as mandated reporters and if know of or suspect that a vulnerable adult has been maltreated, must report immediately (as soon as possible, but no longer than 24 hours).

TIME PERIOD FOR CORRECTION: Seven (7) days.

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01290	Continued From page 4	01290		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interviews and document review, the licensee failed to complete a background study for one of one staff unlicensed personnel (ULP)-I, reviewed for alleged maltreatment. ULP-I provided independent direct services to residents including one to one off-site activities. This had the potential to affect all 16 residents receiving services from the licensee. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01290		

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01290	Continued From page 5	01290		

Continued From page 5

The licensee was notified of the immediate correction order on November 23, 2022.

The immediacy was removed on December 8, 2022. Non-compliance remains at a scope and severity of a F.

Findings include:

ULP-I's personnel file indicated the licensee hired ULP-I on March 14, 2022, to provide direct care services to residents. ULP-I's file indicated the facility changed his job description to activities coordinator in July, 2022.

A search of the Minnesota Department of Human Services background study website (https://netstudy2.dhs.state.mn.us/Live/Employees/SearchRoster) conducted on November 17, 2022, at 4:26 p.m. indicated the employee roster affiliation for the licensee (HFID #30820) did not include ULP-I.

A search of the Minnesota Department of Human Services background study website (https://netstudy2.dhs.state.mn.us/Live/Employees/SearchRoster) conducted on November 23, 2022, at 8:04 a.m. indicated the licensee requested a background study of ULP-I for the licensee's previous board and lodge providing special services license (HFID #95332) on June 14, 2022. The website indicated ULP-I's "fingerprint time elapsed" and that ULP-I required "Immediate Removal" dated July 30, 2022.

A Vulnerable Adult Maltreatment Report dated November 7, 2022, at 5:20 p.m. indicated a resident (R1) reported ULP-I contacted her when he was off work, coerced, and then forced R1 to

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01290	Continued From page 6 engage in sexual acts, under threats of violence. During an interview on November 23, 2022, at 1:46 p.m. facility director (D)-C stated ULP-I worked four days a week as activities coordinator and took residents out on one-to-one outings as part of the activities program. D-C stated ULP-I worked one week-end day providing direct care services to residents. D-C stated the process for background studies is that the director waits to hear about clearance from human resources and then the employee begins orientation. The licensee did not provide a requested background study policy at the time Immediate orders were written. The Background Checks and Sexual Exploitation Release policy (undated) indicated employees who work directly with vulnerable adults would have to pass a background check that is either required by state law or facility policy. The policy further indicated the background checks were specific to the organization and their function, with no exceptions. TIME PERIOD FOR CORRECTION: Seven (7) days.	01290		
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:	02360		

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02360	Continued From page 7 The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	
03000 SS=I	626.557 Subd. 3 Timing of report (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	03000		

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03000	Continued From page 8 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 (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 interviews and document reviews, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment of one of one residents (R1) reviewed for maltreatment. Police informed unlicensed personnel (ULP)-G that R1 reported a rape, and they were taking R1 to the hospital. ULP-G did not make a report to MAARC but called assistant director (AD)-H. AD-H did not file a MAARC report but called the facility director (D)-C. D-C did not file a MAARC report, but called	03000		

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03000	Continued From page 9	03000		

senior director (SD)- F, who filed a MAARC report approximately 40 hours later. The failure to implement the facility policy on reporting suspected maltreatment had the potential to affect all 16 residents at the facility.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The licensee was notified of the immediate correction order on November 23, 2022.

The immediacy was removed on December 8, 2022. Non-compliance remains at a scope and severity of a F.

Findings include:

R1 moved into the assisted living facility on October 3, 2022 due to diagnoses that included autism spectrum disorder, attention deficit hyperactivity disorder, major depressive disorder, generalized anxiety disorder, social anxiety disorder, and intermittent explosive disorder.

R1's service plan dated October 3, 2022, indicated R1 received services from the licensee that included monthly activities, whereabouts checks every shift, housekeeping, laundry, and medication administration.

R1's law enforcement report dated November 6, 2022, at 1:00 a.m. indicated R1 called law

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03000	Continued From page 10 enforcement to report R1 had been raped. The report indicated the suspect was an employee at the facility who was no longer on site but had the potential to return. R1's observation note dated November 6, 2022, at 2:11 am. indicated unlicensed personnel (ULP)-G walked outside and saw police talking to R1. Officers told ULP-G that R1 reported a rape, and they were taking R1 to the hospital. During an interview on November 23, 2022, at 1:46 p.m., facility director (D)-C stated she received a call from assistant director (AD)-H on November 6, 2022, informing her of R1's incident. D-C stated she call senior director (SD)-F, who directed D-C to fill out an incident report and contact R1's emergency contact, county worker, and to wait to file a MAARC report, as SD-F wanted to send a report on Monday (November 7, 2022). D-C stated ULP-G did not file a MAARC report, AD-H did not file a MAARC report, and she did not file a MAARC report. D-C stated the facility protocol for filing MAARC reports was to notify the senior director, who conducts an investigation and submits a MAARC report within 24 hours. During an interview on November 23, 2022, SD-F stated all staff were trained as mandated reporters, and he (SD-F) was typically the central point of contact. SD-F stated if staff were unsure of whether to file a MAARC report, they send the information to SD-F. SD-F acknowledged that ULP-G, AD-H, and D-C should have filed a MAARC report regarding the incident with R1. The facility Vulnerable Adult Act Reporting policy (undated) indicated all employees are designated as mandated reporters and if know of or suspect	03000		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30820	A. BUILDING: ______ B. WING ______	C **12/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITTIER PLACE	**2405 1ST AVENUE SOUTH MINNEAPOLIS, MN 55404**

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03000	Continued From page 11 that a vulnerable adult has been maltreated, must report immediately (as soon as possible, but no longer than 24 hours). TIME PERIOD FOR CORRECTION: Seven (7) days	03000		