

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308209545M
Compliance #: HL308207419C

Date Concluded: May 16, 2024

Name, Address, and County of Licensee

Investigated:

Whitter Place
2401 1st Avenue South
Minneapolis, MN 55404
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:

Katie Germann, 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 to provide supervision to the resident who had a history of using illegal drugs. The facility found the resident deceased in her room from a drug overdose.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility was aware of the residents' unsafe behaviors, history of drug use, and prior drug overdoses. The facility failed to ensure interventions were developed and/ or implemented to ensure the residents safety. The resident was missing for approximately 32 hours when staff unlocked the resident's room to look for the resident. The resident was laying on the floor, deceased. The residents cause of death was a fentanyl (narcotic pain medication) and methamphetamine (a narcotic stimulant) overdose.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigation included review of medical records, hospital records, medical examiner report, staff training, and facility policies and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder, bipolar disorder, substance-exacerbated psychotic disorder, anti-social personality disorder, and anxiety. The resident's service plan included assistance with appointments, socialization, and medication management. The resident's assessment indicated the resident had a history of illegal drug use and overdose.

A facility investigation of the incident indicated the resident had not been seen by facility staff for three eight-hour shifts. Facility staff made the decision to file a missing person report with the police. When the police arrived at the facility, a facility staff member went into the resident's room and found the resident lying on the floor next to her bed with tinfoil next to her face. The police officer contacted the medical examiner.

A medical examiner report indicated facility staff told the medical examiner the resident had a drug overdose one month prior. The report indicated the resident was found lying on the floor with a piece of tinfoil near her face and partially under one of her arms, as well as a box of matches and a pen. The report indicated the resident passed away of a fentanyl and methamphetamine overdose.

The residents abuse prevention plan dated two months prior to the incident indicated the resident had a history of substance abuse with alcohol, marijuana, methamphetamine, and fentanyl. The plan directed staff to monitor the resident for any relapse and offer redirection or contact emergency medical crisis team if necessary. The plan indicated staff would support the resident in building healthy relationships with people who support her sobriety.

The resident's care tracking sheet indicated the resident was not observed by facility staff for four, eight-hour shifts prior to finding the resident deceased. The care tracking sheet directed staff to immediately seek to determine the resident's whereabouts if the resident had not been observed during the current or the past two shifts.

During an interview, the facility administrator stated the resident had a drug overdose one month prior to her death from the drug overdose. The administrator stated the plan to prevent another overdose included updating the residents abuse prevention plan and adding extra safety checks. The administrator stated prior to the resident's death, the staff did check on the resident in her room, however, they did not see the resident laying on the floor because she was laying behind a dresser. The administrator stated the resident frequently left the facility so staff waited a longer for the resident to show up before contacting the supervisor or police.

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, deceased.

Family/Responsible Party interviewed: No, unable to contact.

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

The facility filed a report with the Minnesota Adult Abuse Reporting Center.

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
Minneapolis City Attorney
Minneapolis Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/17/2024
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NAME OF PROVIDER OR SUPPLIER WHITTIER PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2405 1ST AVENUE SOUTH MINNEAPOLIS, MN 55404
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(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
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL308207419C/#HL308209545M</p> <p>On April 17, 2024, 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 66 residents receiving services under the provider's Assisted Living license.</p> <p>The following correction order is issued for #HL308207419C/#HL308209545M, tag identification 2360.</p>	0 000	<p style="font-size: 2em; transform: rotate(-45deg); opacity: 0.5;">Reconsideration Request Received</p>	
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p>	02360		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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02360	<p>Continued From page 1</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>Please refer to the public maltreatment report for details.</p> <p>No plan of correction is required for this tag.</p>	02360	<p style="font-size: 2em; transform: rotate(-45deg); opacity: 0.5;">Reconsideration Request Received</p>	