Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308205167M
Compliance #: HL308208885C

Date Concluded: March 31, 2023

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), a facility staff, abused a resident when the AP had sex with the resident on several occasions.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP engaged in sexual contact with a resident. The AP was provided training on maltreatment of vulnerable adults, ethical conduct, and appropriate boundaries. The training identified the facility did not permit any romantic or sexual involvement between a staff member and a resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the AP's personnel file and texts sent by the AP to the resident. Also, the investigator observed staff interactions with residents.

The resident lived in an assisted living facility with diagnoses including autism, depression, and post-traumatic stress disorder. The resident's service plan included assistance with medication administration, mental health management of anxiety, agitation, and self-injurious behaviors. The resident's individual abuse prevention plan indicated the resident was susceptible to sexual abuse.

During an interview, a manager stated a staff reported to her the resident had a crush on the AP. The manager stated she met with the AP to ask about the AP's interaction with the resident. The AP told the manager they texted outside of work hours, offering support to the resident and to ensure the resident that others cared. The manager stated they discussed appropriate boundaries, and the AP told her the texting would not continue.

The manager stated a few days later she heard concerns from several staff who reported observing the resident and AP holding hands, laughing, giggling together, and whispering. The manager stated the facility placed the AP on leave and began an investigation. The manager stated she interviewed the resident who confirmed having a sexual relationship with the AP.

During an interview, a staff stated she and several co-workers had concerns about the interactions between the AP and the resident. The staff stated she observed them playing, joking, and laughing in a manner that lacked a professional tone. The staff stated she spoke with the resident, who told her the resident and AP had a physical relationship, had spent a night together in a hotel, as well as in the facility. The staff reported the information to the manager.

A review of text messages between the AP and the resident confirmed sexual contact, and that the AP created a story to "lie our way out of this."

The resident declined to interview.

The AP declined to interview.

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:
(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: No, declined.
Family/Responsible Party interviewed: No, per the vulnerable adult.
Alleged Perpetrator interviewed: No, declined.

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

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

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

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 03/21/2023

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 ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order is issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL308208885C/#HL308205167M On March 21, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 69 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL308208885C/#HL308205167M, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	