

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL308205263M  
**Compliance #:** HL308208972C

**Date Concluded:** November 1, 2023

**Name, Address, and County of Licensee**

**Investigated:**

Whittier Place  
2401 first Avenue South  
Minneapolis, MN 55404  
Hennepin County

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

**Evaluator's Name:** Holly German  
Special Investigator

**Finding:** Not Substantiated

**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 supervise resident #1 and resident #2 when resident #2 requested sexual favors from resident #1.

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was not substantiated. The facility had adequate staffing to provide proper supervision of the residents. The facility investigated the incident timely, and resident #2 no longer resided at the facility.

The investigator conducted interviews with facility staff members, including administrative staff, a family member, and residents. The investigation included review of resident's medical records, staff schedules, facility incident reports, and facility policies. The investigator toured the facility and observed staff interactions with residents.

Resident #1 resided in an assisted living facility. Resident #2's diagnoses included major depressive disorder, post-traumatic stress disorder (PTSD), schizoaffective disorder, obsessive compulsive disorder, and attention deficit hyperactivity disorder (ADHD). Resident #1's service plan included assistance with housekeeping, laundry, meals, and appointment scheduling and transportation. Resident #1's assessment indicated she was alert and oriented to person, place and time and was independent with her activities of daily living.

Resident #2 resided in an assisted living facility. Resident #2's diagnosis included delusional disorder and anxiety disorder. Resident #2's service plan included assistance with meals, housekeeping, laundry, and reminders with grooming and bathing. Resident #2's assessment indicated he was alert and orientated to person, place and time and was independent with his activities of daily living.

On the day of the incident, resident #1 and resident #2 were having friendly conversation in resident #2's room. Resident #2 followed resident #1 to her room where he grabbed her buttocks and tried to kiss her. Resident #1 did not approve of these gestures and texted her friend, resident #3, to come and help her. Resident #3 entered the room and told resident #2 to leave the room, which he refused to do. An argument ensued between resident #2 and resident #3 in the hallway where staff became aware of the argument and intervened. The residents were separated. Frequent safety checks were performed and resident #1 was offered more scheduled visits from her care team. Staff offered a counselor to resident #1, which she declined. Resident #2 discharged from the facility.

During an interview, an administrative staff member stated the facility staffs three to four unlicensed personnel (ULP) for day and evening shifts, and two to three ULP on overnight shifts. She stated per their licensure, they are only required to have one. She stated the residents do not have a call system in their rooms or on their bodies. Each hallway has a phone with directions on how to call 911 or staff. All residents have a master key to access any of the four campus buildings and staff perform safety rounds once every shift.

During an interview, a resident stated he can call staff on the phone when needs to, but sometimes he needs to go find them in the other buildings.

During an interview, multiple residents stated they felt the staff were easily available to them if they needed them. They stated they felt safe at the facility.

During an interview, a family member stated she was satisfied with how the facility handled the incident.

Resident #1 declined to be interviewed.

Resident #2 was not able to be reached for interview.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

**“Not Substantiated” means:**

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

**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:** Yes.

**Alleged Perpetrator interviewed:** Not Applicable.

**Action taken by facility:**

The facility completed an internal investigation and reported the incident.

**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

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30820</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/26/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WHITTIER PLACE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2405 1ST AVENUE SOUTH MINNEAPOLIS, MN 55404</b>
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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
0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>*****REVISED*****</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># HL308208972C /# HL308205263M</p> <p>On September 26, 2023, 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 78 residents receiving services under the provider's Assisted Living license.</p> <p>Upon reconsideration, the correction order issued for #HL308208972C /#HL308205263M, tag identification 460 has been rescinded. No correction orders are issued.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p>	

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