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 #: HL308203086M
Compliance #: HL308205081C

Date Concluded: January 17, 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: Inconclusive

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 facility neglected a resident when they failed to administer a resident's antipsychotic medication for three weeks. The resident experienced increased symptoms.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The facility had a system in place to ensure that unlicensed staff reordered medications in a timely manner, and a process for actions if a medication was not received in an expected time frame (which was undefined) but did not designate who was expected to call the pharmacy or when. An unlicensed staff reordered the medication per the policy. The resident's insurance required a prior authorization from the resident's physician, but the pharmacy did not communicate this to the facility or family. The resident experienced symptoms but did not require hospitalization and returned to baseline when the facility restarted the medication.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the family, pharmacy, and reviewed pharmacy records. The investigation included review of resident records, medication administration policies and procedures related to medication administration, and medication reordering.

The resident lived in an assisted living facility due to mental health diagnoses. The resident's service plan included assistance with medication management. The resident's medication management services document indicated trained staff dispensed, administered, documented, and ordered medications as needed through the pharmacy.

A resident progress note indicated a family member contacted the facility for a regular update and expressed concern that the resident was experiencing mental health symptoms. The family member questioned whether the resident took his anti-psychotic medication. The facility reviewed the resident's medication administration record and discovered that the resident's antipsychotic medication had been on order for several weeks. An unlicensed staff contacted the pharmacy to resolve the situation.

During an interview the unlicensed staff person stated they called the pharmacy to ask about the resident's medication and why the pharmacy had not sent it. The unlicensed staff stated the pharmacy indicated they had waited for prior authorization from the resident's doctor, but the facility/family could pay out of pocket, and they would send the medication. The unlicensed staff stated the family paid for the medication and the pharmacy sent it.

During an interview, a family member stated the facility kept in regular contact about how the resident was doing. The family member stated during a phone call a client coordinator informed her that the resident did not receive his antipsychotic medication for almost three weeks. The family member stated the facility figured out that although staff had reordered the medication, there was an issue with a prior authorization required from the doctor. The family member stated the resident had some symptoms of paranoia, hearing things, and agitation but did not require hospitalization. The family member stated the resident returned to his normal when the facility restarted the medication, and family had no concerns about the care the resident received at the facility.

During an interview, the resident stated the staff took care of his medications. He stated he hoped to soon live independently and control his own medication administration and ordering.

In conclusion neglect is inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility provided education to staff on the reordering of medications policy/procedure.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

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 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.	0 620		

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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 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	01290		

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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	03000		

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

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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		