Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308203682M
Compliance #: HL308207068C

Date Concluded: August 18, 2025

Name, Address, and County of Licensee Investigated:
Whittier Place
2401 1st Ave South
Minneapolis, MN 55404
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, RN, BSN, 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 the resident when staff failed to follow the resident's plan of care and as a result the resident was found deceased in his room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. At the time of the resident's death, facility staff were following the resident's plan of care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the mental health case manager and community access disability inclusion (CADI) worker. The investigation included review of the resident records, death record, facility incident reports, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator made an unannounced visit and observed staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included major depression, panic disorder, psychosis, and bipolar disorder. The resident's service plan included assistance with appointments, mental health management, and medication management. The resident's care plan indicated staff were to observe the resident one time each shift and if he could not be found, staff were to notify the on-call supervisor. The resident's history included hearing voices and verbally answering the voices which staff referred to as "internal stimulus". Staff were directed to check with the resident about suicidal ideations two times a day.

The resident's mental health management plan indicated staff were to check in with the resident at each medication pass. The resident's mental health management plan indicated the resident used methamphetamine (additive stimulant) when anxious or depressed.

The resident's medical record indicated one day, unlicensed personnel started their shift and observed the resident one and a half hour after starting their shift. The resident was observed "responding quietly to internal" voices. The resident denied suicidal ideations and continued to respond to internal voices. Approximately five hours later, the unlicensed personnel went to the resident's room to administer medications. The unlicensed personnel knocked at the resident's door three times without a response, the unlicensed personnel entered the resident's room. The unlicensed personnel found the resident unresponsive on the floor and immediately called emergency services. Emergency services arrived at the facility and announced the resident was deceased. Drug paraphernalia and empty bags were found near the resident leading police to suspect a drug overdose.

During an interview, the unlicensed personnel stated the resident did not mention anything about using drugs and she did not witness the resident with drugs during the resident's safety check earlier in the shift. The unlicensed personnel stated if she suspected the resident of using drugs, she would have notified the on-call supervisor for further directions.

During an interview, leadership stated there was interventions in place to help the resident with his mental health and drug use. The interventions included establishing a new psychiatrist, seeking out a higher level of care, conducting care conferences, educating the resident on the dangers of using drugs, using the community outreach for psychiatric emergencies, and using the behavioral crisis response for when the resident needed additional assistance.

During an interview, the resident's mental health case manager stated she had no concerns with how the facility handled the resident's drug use. The facility had interventions to keep the resident engaged and busy. The facility was trying to get the resident to his psychiatrist appointments so that the resident could get better medications for better control of his mental health to hopefully reduce his drug use.

The resident's death record indicated the resident's cause of death was combined drug (fentanyl and methamphetamine) toxicity.

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. The resident was deceased.
Family/Responsible Party interviewed: No. The resident was responsible for self.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
In the months leading up to the resident’s death, the facility was attempting to establish new care with a psychiatrist for medication management. The facility was also attempting to assist the resident with finding a higher level of care somewhere outside of the metro area in hopes to reduce the resident’s access to drugs.

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 08/05/2025

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 On August 5, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL308203682M/#HL308207068C. No correction orders are issued.	0 000		