Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL33762001M **Date Concluded:** December 6, 2021
Compliance #: HL33762002C

Name, Address, and County of Licensee Investigated:
Adapta
2020 5th Street SW
Rochester, MN 55902
Olmsted County

Facility Type: Assisted Living Facility (ALF) **Evaluator's Name:** Shannan Stoltz, 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.

Allegation(s):
It is alleged: the alleged perpetrator (AP) financially exploited the resident when the AP stole the resident's medications.

Investigative Findings and Conclusion:
Financial exploitation was substantiated. The AP was responsible for the maltreatment. A full card of medication went missing during the AP's shift, during which only AP had access to the medication cart. During that time the medications went missing, the surveillance footage showed the AP taking something from the medication cart, placing it in a bag, carrying the bag outside, and accessing his vehicle. It is consequently more likely than not that the AP diverted the medication.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included an onsite visit for observation of medication administration procedure and surveillance video footage. The investigation also included review of medical records, and review of facility policies and procedures.

The resident's medical record was reviewed. The resident's diagnoses included anxiety, depression, and attention deficit hyperactive disorder (ADHD). The resident's signed service plan indicated he received services for medication management, behavior monitoring for substance abuse, and housekeeping.

Records indicated the resident moved into the facility in 2021. During the admission process, the facility's registered nurse checked-in all of the resident's medications, which were on a total of 12 medication cards (med-cards). Medications included gabapentin, and the 30-day supply was packaged on three different med-cards, prescribed for 8:00 am, 2:00 pm, and 8:00 pm. Each med-card had a different colored sticker (orange, yellow, green) to differentiate the scheduled administration times. The resident's prior facility, however, had not administered the gabapentin in accordance with the prescribed times of the med-cards, but instead administered all gabapentin off the 8:00 am (orange-sticker) card, which was half full at the resident's admission to the current facility. The two other gabapentin med-cards: 2:00 pm (yellow sticker), and 8:00 pm (green sticker), were unused and full.

The facility kept all of their residents' medications in a locked medication cart (med-cart), in a locked medication room (med-room), to include this resident's gabapentin. The med-room is approximately 6 feet long by 3 feet wide, with one door. Mounted above the door is a surveillance camera which points towards the med-cart. The surveillance footage is time-stamped, in high-quality color, and is saved to computer hard drives outside the med-room. The facility utilized a computer program that once all medications are input to the system, it sends an alert to the facility's registered nurse to reorder due to low supply.

Facility policy dictated that the scheduled medication passer (med-passer) for the shift is the staff member who held the keys to the med-room and the med-cart. The staff schedule indicated that the day the resident moved in, the AP was the med-passer, and therefore the staff member who held the keys to the med-room and med-cart.

Facility-provided surveillance footage, time-stamped and dated, showed the AP in the med-room the evening the gabapentin was stolen. The surveillance footage showed the resident's med-cards in a small basket on top of the med-cart, and some med-cards on the counter, next to the med-cart. The surveillance footage showed the AP and the following events (notated in 24-hour time):
19:43:52: The AP stood at the counter and utilized a phone calculator for one minute.
19:44:52: The AP put down the cellphone and took two steps back towards med-cart.
19:44:54: The AP picked up the gabapentin med-card.
19:45:06: The AP turned and took two steps away from the med-cart while glancing up, then turned around a full 360 degrees and looked up at camera again. The AP then turned toward the counter, looked up and down the counter (as if looking for something), then raised both hands.
19:45:25: The AP closed the med-room door.
19:45:32: The AP opened the med-room door, then left the room.
19:51:11: The AP stood in front of med-cart. The AP placed the resident's med-cards back into the basket, and then appeared to count the med-cards.
19:51:24: The AP placed the basket of med-cards on the counter. The gabapentin card is viewed as the first med-card in the basket.

19:51:34: The AP turned and stepped over to drawer where he removed a new, small, clear-plastic, empty garbage bag, approximately one gallon in size. He then stepped back to the med-cart as he opened the new garbage bag.
19:52:04: The AP opened the middle drawer of med-cart and grabbed the medication basket from the counter and placed the basket into the middle drawer.
19:52:09: The AP reached with his right hand into the middle drawer, while his left hand held the new, empty garbage bag.
19:52:13: The AP reached with his left hand for the used, small, clear-plastic garbage bag (that is in a garbage can attached to the left side of med-cart) and pulled the used bag out of the can.
19:52:22: The AP held the used garbage bag in his left hand, while his right hand reached into the med-cart's open middle drawer, and pulled something out of the drawer. The AP had his back to camera so full-view of his hands are blocked. He then put the object into the used garbage bag, tied it up, then placed the bag on the countertop.
19:52:43: The AP closed the middle drawer and put the new, small, clear-plastic, empty garbage bag into the garbage can.
19:53:26: The AP replaced the garbage can back onto the side of the med-cart.
19:53:30: The AP lifted the used garbage bag off the counter with two hands, held the bag up against his stomach with two hands, then left the med-room. The contents of the used garbage bag were possibly a clear plastic water bottle {16 oz}, a small paper cup, and a few pieces of papers. The contents of the bag did not appear to be heavy enough to warrant a two-hand hold of the bag.
19:53:32: The hallway camera showed AP leave the med-room, and walk-up the hallway with the used garbage bag in his left hand.
19:57:00: The next camera view showed the AP outside the facility walking towards his car. It is dark, and the video quality is poor.
19:57:16: The AP's lights on the AP's vehicle flash twice.
19:57:25: The lights on the AP's vehicle flash three times.
19:57:52: The AP walked away from his vehicle, as the lights flash once.
20:21:00: The video footage showed the AP in the med-room again where he stood at the counter in front of the med-cart. He held and looked at different med-cards, shuffled med-cards around in the basket, stared at medications on the counter, moved a couple of them around, then stared at the counter for nine seconds.
20:21:38: The AP stared into the camera for four seconds, stared at counter for nine seconds, then video cut off.

During an interview, the facility's registered nurse (RN) stated that the computer's medication software alerted her to the low supply of the resident's gabapentin. The RN stated she knew a low supply could not be correct as the resident was admitted to the facility with almost a full month's supply, so she counted the resident's medications and found that one entire gabapentin med-card was missing. The RN then alerted the executive director, who tasked the human resource manager (HR) and the office manager to view video all the way back to when the resident was first admitted to the facility.

During an interview with HR, she stated she watched surveillance video of the med-room, for the day the resident admitted to the facility, from the 3:00 pm hour to the 11:00 pm hour. HR stated that while viewing the footage, she counted 12 med-cards in the resident's basket, which included three gabapentin med-cards (each with a different colored sticker). HR stated two of the gabapentin med-

cards were full, and one gabapentin med-card was half-full. HR stated this 12 med-card count was at the beginning of AP's shift as the med-passer. HR stated she also viewed surveillance video of the end of AP's shift, and there were only 11 med-cards in the resident's basket. HR stated the full gabapentin med-card with the yellow sticker, was missing from the resident's basket. HR stated the AP was the only staff member who had access to the locked med-cart during the time between those two counts.

During an interview, the office manager stated she watched surveillance video from the day the resident was admitted to the facility. The office manager stated she observed the 3:00 pm shift-change medication count between the day shift med-passer, and the evening shift med-passer (the AP), at which point the resident had 12 med-cards in his basket, three of which held large, orange pills, and each med-card had a different colored sticker across the top. However, when she watched the shift change medication count between the AP and the midnight staff person, there were only 11 med-cards in the resident's basket. OM stated she then watched the medication count between the midnight shift and next shift, and again only counted 11 med-cards. The operations manager stated she watched the med-card counts between these three staff members several times, including in slow motion, and concluded one of the full med-cards, with the "big, orange pills", went missing.

The AP was contacted and declined to respond to any questions.

The two other staff member medication passers were contacted but stated they did not know anything about missing medications.

In conclusion, financial exploitation 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.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means: …
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: N/A.
Alleged Perpetrator interviewed: No; hung up on when contacted via phone.

Action taken by facility:
AP is no longer employed by the facility.
The facility covered the cost of replacement medication, so the resident did not miss any doses of medication.

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
Olmsted County Attorney
Rochester City Attorney
Rochester Police Department, Report# 21-44611
Nurse Aide Registry, DHS

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33762	A. BUILDING: ______ B. WING ______	C 11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAPTA	**2020 5TH STREET SW ROCHESTER, MN 55902**

(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: HL33762001M / HL33762002C On November 19, 2021, 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 18 clients receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL33762001M, HL33762002C, tag identification 2360.	0 000	Minnesota Department of Health is documenting 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 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. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	Continued From page 1 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: Based on observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was financially exploited. Findings include: On December 6, 2021, the Minnesota Department of Health (MDH) issued a determination that financial exploitation occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	