Addressing Elder Abuse in Minnesota Long-Term Care Settings

Public Policy Actions Necessary to Prevent and Deter Abuse

January 29, 2018

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Executive Summary

Elder abuse is intolerable and an affront to human rights. While years in the making, the scale and gravity of this crisis began to take shape for policymakers during the 2017 legislative session when the Office of Health Facility Complaints ("OHFC") at the Minnesota Department of Health ("MDH") reported a 600% increase in maltreatment reports since 2010 and an ability to investigate only 1% of the 20,791 reports from providers and 10% of the 3,491 reports from individuals.[1]

The magnitude of the crisis was revealed further in the Minneapolis Star Tribune's shocking and sobering series ("Left to Suffer," November 2017) that described a broken system of care and regulatory oversight that has failed to protect Minnesota's older and vulnerable adults[2] from horrific abuse[3] in nursing homes and housing with services and assisted living settings (HWS/AL").[4]

In response, Governor Dayton asked AARP Minnesota to convene a Consumer Workgroup and named the following other organizations to the group: Alzheimer's Association, Minnesota Elder Justice Center, Elder Voice Family Advocates, and Mid-Minnesota Legal Aid. The group's charge was to develop recommendations to improve the care and safety of older and vulnerable Minnesotans in nursing homes and assisted living and to submit a report to the Governor by January 26, 2018. AARP requested an extension and submitted this report on January 29, 2018.

The Consumer Workgroup recommendations call for far-reaching policy and agency practice changes to prevent and deter abuse. The recommendations reflect the experiences of our organizations and a belief that older and vulnerable adults and their families should be at the center of any reform. They further reflect and incorporate feedback the group received from victims, family members, experts, providers, direct care workers, and advocates who responded to the request to convey their concerns and offer recommendations.

The problems in the regulatory system demand immediate and dramatic fixes. We recognize the joint steps already taken by the Minnesota Department of Human Services and the

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[1] *See* FY18-19 Biennium Budget Plan from OHFC.

[2] For the purposes of this report, we use the term "older and vulnerable adults" to generally mean those who are advanced in age and receiving services from a licensed health care provider, particularly in a nursing home or in assisted living. The term "vulnerable adult" is given the meaning as defined in the Vulnerable Adult Act. *See* Minn. Stat. § 626.5572, subd. 21.

[3] For the purposes of this report, we use the term "abuse" generically to include "abuse," "neglect," and "financial exploitation" as those terms are defined in the Vulnerable Adult Act. *See* Minn. Stat. § 626.5572, subds. 2,17, and 9, respectively.

[4] In Minnesota, regulation of residential settings that offer or allow a spectrum of needed care and services is confusing to the public and, most importantly, to older and vulnerable adults, and their families and advocates. Under the convoluted statutory construct in Minnesota, the commonly known term "assisted living" is actually a subset of the broader residential setting called "housing with services," a term few recognize or understand. In this report, we use the term "assisted living" or the abbreviation "HWS/AL" interchangeably to describe residential settings into which older and vulnerable adults move that are registered under Chapter 144D of Minnesota Statutes or have assisted living "title protection" under Chapter 144G of Minnesota Statutes.

Minnesota Department of Health (MDH) to address the backlog of complaints. Regulatory oversight is a critical element in ensuring appropriate care for older and vulnerable adults. The public needs assurance that the Minnesota Department of Health is enforcing state laws and administrative regulations. The Consumer Workgroup has examined where public regulation and enforcement have failed in their mission and recommends measures that improve both the licensing function of the MDH's Health Regulation Division and the investigative function of the OHFC.

However, regulatory agency reform does not provide the entire answer. An equally important response to the crisis entails giving older and vulnerable adults – and their families[5] – stronger consumer protection tools. Consequently, many of our recommendations are designed to strengthen and expand rights and address the sizable imbalance of power, knowledge, understanding, and sophistication between older and vulnerable adults who need care and those entities that provide that care. A significant number of our recommendations address gaps in rights and their enforcement.

Further, the exponential growth of HWS/AL and Memory Care units demands an overhaul of definitions, requirements, and consumer protections. Today, many older Minnesotans living in such residential settings have more complex care needs – including dementia – than when assisted living options first became available more than two decades ago.

Demographics show that this vulnerable population is expected to continue to rise over the next decade, placing greater demand and pressure on this already faltering system.[6] Comparatively few protections exist for vulnerable adults in these settings, although the frailty of residents in the HWS/AL setting often closely resembles that of people living in licensed nursing facilities.

Minnesota is an outlier in comparison to other states when it comes to regulation of assisted living. All other states require licensure or similar public oversight for these settings.[7] The Consumer Workgroup calls for Assisted Living licensure and Dementia Care Certification to establish clear and necessary standards of care and services.

Many of the comments we received expressed concerns about insufficient staffing levels in both nursing homes and assisted living settings. Research shows that understaffing contributes

[5] For the purposes of this report, we use the term "family" or "families" to include, broadly, those who represent and advocate on behalf of the older or vulnerable adult on the basis of kinship. We recognize that legal definitions and restrictions affect the basis and extent of families' authorities to act in place of the older or vulnerable adult in specific situations.

[6] *See, e.g.,* Minnesota State Demographic Center, *Aging* (stating that the 285,000 "Minnesotans turning 65 in this decade will be greater than the past four decades combined" and that, by 2030, "more than 1 in 5 Minnesotans will be an older adult"); at https://mn.gov/admin/demography/data-by-topic/aging/.

[7] *See* Paula Carder, Janet O'Keeffe, and Christine O'Keeff, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Compendium of Residential Care and Assisted Living Regulations and Policy: 2015 Edition* (2015); at https://aspe.hhs.gov/basic-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition#states

to serious care-related violations, including abuse and neglect.[8] Undeniably, staffing issues must be addressed. While there are ongoing efforts to address complex staffing issues, this issue must be addressed as part of the AL Licensure Stakeholder process as well. Stakeholders must be creative and cooperative and develop private/public incentives to improve staffing levels, retain today's dedicated caregivers, and find ways to recruit, train, and support future caregivers.

Summary of Key Action Recommendations:

The Consumer Workgroup's recommendations are divided into four key action areas:

- **Strengthen and Expand Rights of Older and Vulnerable Adults and Their Families**
  To address the significant power and knowledge imbalance, the State must strengthen and expand the rights of older and vulnerable adults and their families. These rights include allowing access to reports of allegations of abuse; establishing stronger anti-retaliation laws for vulnerable adults and their families; enacting new laws that give victims the same rights to appeal a maltreatment finding as perpetrators have; clarifying a resident's right to place a camera or electronic monitoring device[9] in the room[10]; and providing better access to information to assist consumers to assert and vindicate their rights.

- **Enhance Criminal and Civil Enforcement of Rights**
  To enforce these rights, the State must strengthen the Criminal Code to allow prosecutors to charge perpetrators of abuse with a gross misdemeanor for terrorizing assaults that do not result in physical injuries. Under current law, prosecutors are unable to bring that charge in the absence of demonstrable bodily harm. Further, because there is no statutory right for vulnerable adults and their families to enforce their rights in court and, where appropriate, receive compensation for rights that are violated, the Consumer Workgroup recommends establishing a private right of action for the violation of the vital rights granted under Minnesota law.

- **Develop New Licensure Frameworks for Assisted Living and Dementia Care Across Residential Settings**
  To address the complexity and confusion in the market today, the State must develop an AL license designed to create clear standards for providers and older and vulnerable adults alike. Input from a broad stakeholder group will be needed to develop standards for staffing, training, admission and discharge[11] criteria, as well as definitions of and certification for dementia care and protections to preserve access for individuals who rely on the Elderly Waiver Program. We propose immediate institution of termination appeal

[8] See, e.g., the federal Elder Justice Roadmap and collateral research to support the connection between understaffing and preventable abuse, at https://centerjd.org/content/fact-sheet-epidemic-nursing-home-abuse-and-neglect.

[9] For the purposes of this report, we use the term "camera" broadly to include other electronic monitoring devices. Such devices may include video camera, web-based camera, devices with one or two-way communication, devices with audio and/or video, devices that record or stream images and/or sound over the internet or cell phone signals, or other systems that utilize technology as a means of communication or to monitor care needs.

[10] For the purposes of this report, the term "room" is used in the context of camera placement to mean the private living space of the resident.

[11] For the purposes of this report, the term "discharge" generally refers to no longer residing in a nursing home while the term "termination" generally refers to no longer receiving housing and/or health care services in HWS/AL. The terms may be used interchangeably in this report, depending on the circumstances.

rights, and new protections against arbitrary discharge. Displacement is traumatic for older and vulnerable adults who suddenly find themselves homeless, including those who rely on the Elderly Waiver Program to pay for care.

- **Improve MDH Licensing Regulation, OHFC Enforcement and Investigative Process, and MAARC Reporting**
  To restore confidence in our regulatory system, MDH and OHFC must use existing licensing and other authority to order corrections for violations and employ an effective investigative process that holds abusers accountable, including the use of fines. With respect to Home Care licensing inspections, the three-year cycle must be shortened, and to accomplish those more frequent inspections, adequate staffing is necessary. Further, we encourage the use of a wide array of tools to combat violations, including provisional licenses and increased fines in the HWS/AL settings. Also there must be continued efforts to improve the reporting system for vulnerable adults, families, and mandated reporters to the Minnesota Adult Abuse Reporting Center ("MAARC")

In sum, Minnesotans deserve a system that provides optimal care and services, and maximum protection against abuse. Elder abuse is not an inevitable consequence of the system of care and services provided by nursing homes, HWS/AL, or home care providers. Our recommendations focus on both prevention of and responses to older and vulnerable adult abuse.

We thank Governor Dayton for the opportunity to develop and present these recommendations and recognize the many lawmakers, consumers, care workers and providers who also have been working to improve Minnesota's long-term care system. Addressing the tragedy of elder abuse in this system is a shared Minnesota value. We urge lawmakers and regulators to take swift action to enact these recommendations.

The information contained in this Executive Summary and Report represents the collaborative discussion of the Governor's Consumer Workgroup and does not represent the views, platform or agenda of any individual organization on the Consumer Workgroup.

About this Report

Elder Abuse Consumer Workgroup Charge

Governor Dayton's letter of November 30, 2017 asking AARP to convene a Consumer Workgroup requested guidance for state leaders focused on the needs of seniors who are cared for in nursing home and assisted living settings, including:

Protecting the rights of residents and families and connect them to resources

- Review the current state and federal regulatory, licensing, compliance, and enforcement requirements, and recommend changes if these requirements are insufficient to deter potential abuse and protect seniors and families from retaliation from providers.
- Clarify and strengthen the statutory definitions of memory care, assisted living, and housing with services so consumers and families can make informed decisions on proper placement for seniors.
- Recommend changes to current law to ensure that family members are informed about how to report suspected abuse and neglect, including the Minnesota Vulnerable Adults Reporting Center and the Ombudsman for Long Term Care.

Improving communication with family members and law enforcement about allegations of abuse

- Recommend changes to current law to remove barriers and improve communication with family members when there is alleged abuse, including the complaints and investigations processes within the Office of Health Facility Complaints and self-reports from providers.
- Recommend changes to current law to ensure proper reporting to law enforcement about potential abuse.

Elder Abuse Consumer Workgroup Process

The Consumer Workgroup met frequently to discuss and develop recommendations that call for far-reaching policy and agency practice changes to prevent and deter abuse. To garner input from the public and other interested stakeholders, we developed and a distributed a survey based on the questions posed to us by Governor Dayton to workgroup members and the organizations, providers and individuals who contacted us.

We received more than 100 survey responses and more stories of elder abuse. A summary of responses to the survey and stories are attached in the appendix of this report along with the names of organizations and individuals who contacted us. Upon request, AARP can make available the full survey responses.

Organization of this Report

Given the breadth of issues facing older and vulnerable adults, organization of this report presented challenges. The broad scope and level of detail that the Workgroup was able to achieve for the recommendations in this report in a relatively short amount of time are both a testament to the intricate knowledge of those on the Workgroup but also to the magnitude of the crisis. For readability, and given the level of detail, this report is divided into two main sections: 1) Background of the Problems and Summary of Recommendations; and 2) Recommendations with Statutory Changes Needed. Each of the sections is broken down into the four action areas for reform listed in the Executive Summary. The Workgroup trusts that this organizational structure allows for readability of complex issues followed by fine-tuned recommendations and statutes.

Consumer Workgroup Participants

AARP
Mary Jo George
Maureen O'Connell

Alzheimer's Association Minnesota-North Dakota Chapter
Beth McMullen

Elder Voice Family Advocates
Kris Sundberg
Jean Peters
Suzy Scheller

Mid-Minnesota Legal Aid
Ron Elwood
Genevieve Gaboriault

Minnesota Elder Justice Center
Amanda Vickstrom
Iris Freeman

STRENGTHEN AND EXPAND RIGHTS OF VULNERABLE ADULTS AND THEIR FAMILIES

BACKGROUND

Critical Gaps and Inequalities Exist in Current Law

Critical gaps and inequalities exist in current laws designed to safeguard Minnesota's older and vulnerable adults from abuse and to provide other vital consumer rights. These gaps exist despite the fact that there are many laws already on the books designed to protect older and vulnerable adults -- including, but not limited to, the Health Care Bill of Rights, the Home Care Bill of Rights, and the Minnesota Vulnerable Adult Act.

First, distressingly, as the system is set up, families – and those who care about and are responsible for the well-being of older and vulnerable adults in residential settings – are often completely in the dark that abuse, neglect, maltreatment, or violation of rights is occurring. Under current law, neither the victim nor the family has a right to know about the filing and content of reports of abuse.

Second, under current law, not all older and vulnerable adults who receive care at home or reside in nursing homes, boarding care homes, or in Housing with Services/Assisted Living (HWS/AL) settings, have the same rights. The Health Care Bill of Rights today does not apply to persons residing in HWS/AL settings. In most cases, it should not matter whether the older or vulnerable adult lives and receives care and services in a nursing home, a boarding care home, in HWS/AL, or at home. Most likely because these laws were stacked on top of one another over time, rights that should apply universally to all apply only to some. In addition, where a right does exist, it is often limited and insufficiently clear and protective.

Third, certain essential and longstanding rights, such as the expressed right of an older or vulnerable adults to place a camera or electronic monitoring device in their rooms, are unclear or absent from existing bills of rights. The Health Care Bill of Rights should be updated to include the right to place a camera and electronic monitoring devices both for abuse detection and for communication and make certain all other rights are clear and unequivocal.

Additionally, many stories we heard were from families that felt they were subject to deceptive marketing or alleged "bait and switch" practices after admission. There are no prohibitions against these practices in laws governing HWS/AL, and the one reference to it in the nursing home statutes has no associated enforcement right for the older or vulnerable adult, or for his or her family or advocate. All too often they report being given misleading information prior to, at, and after admission – or not receiving important information at all. For example, some of the misinformation is related to the nature and level of care offered; whether the older and vulnerable adult will have to move or share a room; or whether they will receive inferior services if forced to relocate if they switch from private pay to public pay are only some of the reported concerns.

Fourth, older and vulnerable adults and their families need stronger protections against retaliation for asserting rights, filing grievances or otherwise complaining about care or services. Further, the law should delineate the types of behaviors that constitute retaliation. Under current law, there is no meaningful protection against retaliation when either the older or vulnerable adult or a family member reports maltreatment or other violations of rights. It is essential that Minnesota law provide protection against retaliation.

Finally, the statutes and rules governing the provision of care and services to older and vulnerable adults, as well as to all persons with physical, developmental, or mental disabilities, are a tangled maze of confusion, rife with inconsistency, ambiguity, and cross-references to repealed statutes or rules. They cry out for harmonization, reorganization, consolidation, and recodification.

In this section, we outline the gaps in the current law regarding the rights of older and vulnerable adults and their families as well as point out where they need to be strengthened and expanded. In the next section, under criminal and civil enforcement, we outline new protections that are necessary to enforce these rights.

SUMMARY OF RECOMMENDATIONS

The Consumer Workgroup makes a set of recommendations to strengthen and expand the rights of older and vulnerable adults and their families, including adding the right to know about abuse; affirming the right to placement of a camera or electronic monitoring device in the room; enacting stronger anti-retaliation laws for vulnerable adults and their families; ensuring that, where appropriate, older and vulnerable adults all have the same rights and protections, regardless of the residential care setting in which they live; and ensuring that the services marketed are provided as promised and purported.

A. The Right to Know About Abuse

Disclosure of information in maltreatment/abuse reports must be allowable to the victim and those acting on their behalf. The state law should also be amended to mirror federal law by allowing release of medical records to authorized agents after the death of an older or vulnerable adult.

B. Affirming the Right to Placement of a Camera and Electronic Monitoring Device[12]

Technology plays an integral role in the lives of older and vulnerable adults and often operates as an important tool in their quality of life and connection to their support system beyond the care setting. Older and vulnerable adults need the explicit right to allow for use of a camera or other electronic monitoring device in their own room. The Workgroup recommends that such a right be added to the Health Care Bill of Rights.

[12] For further information on this topic, see Minnesota Elder Justice Center, *Residential Care and Services Electronic Monitoring Work Group Final Report* (January 16, 2017) (presented to the Legislature pursuant to 2016 Minn. Laws, ch. 179, s. 39); available at http://www.health.state.mn.us/divs/fpc/rcworkgroup/finalreport.pdf.

C. Addressing Retaliation

Minnesota law needs to be clear and provide meaningful protection against retaliation when either the older or vulnerable adult or a family member reports maltreatment or other violations of rights. Certain acts that are currently not defined as "retaliatory" under the Vulnerable Adult Act should be added, including, among others, restriction of use of or access to amenities or services; termination of services or lease agreement; sudden increase in costs for services not already contemplated at the time of the maltreatment report; and deprivation of technology, communication, or electronic monitoring devices.

D. Ensuring Equal Rights and Expanding Rights

Currently, there is one Bill of Rights (the "Health Care Bill of Rights")[13] for older and vulnerable adults who live in nursing homes and boarding care homes, and another Bill of Rights (the "Home Care Bill of Rights")[14] for older and vulnerable adults who receive home care or live and receive services in a HWS/AL setting. As currently constituted, important and relevant rights granted in one Bill of Rights are not granted in the other, and vice-versa. There is no reason why older and vulnerable adults, regardless of the setting in which they live, should not be entitled to the same rights.

Moreover, there are significant gaps in both these Bills of Rights. Additional rights are needed. For example, while an older or vulnerable adult has the right to appeal a discharge from a nursing home, an older or vulnerable adult living in a HWS/AL or home care setting has no comparable right to appeal a termination of a lease or services. Finally, with one narrow exception, older and vulnerable adults can be asked or required to waive any or all of their rights. Waivers of rights generally is problematic, but it is especially worrisome in this setting because the people these rights are meant for are our most vulnerable. These rights should never be waivable. Laws already exist to allow necessary exceptions when the safety of the person or others is at stake. No further limitation of these rights should be allowed.

E. Identifying and Prohibiting Deceptive Marketing and Business Practices

Laws must be strengthened to specifically prohibit deceptive marketing and business practices across all care settings including HWS/AL. In addition, older and vulnerable adults and their families must have the statutory right to enforce these laws.

F. Making Sense of Our Confusing Laws Governing Care and Services to Vulnerable Minnesotans

Currently, the statutes governing the provision of care and services to persons receiving home care services, assisted living clients, and persons residing in nursing homes, boarding care homes, housing with services establishments, and residential facilities – as well as persons with physical, developmental, functional, or mental, functional impairments receiving services – are in varying degrees confusing, overlapping, redundant, inconsistent, ambiguous, and extremely difficult to navigate.

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[13] Minn. Stat. § 144.651 (providing rights for residents in nursing homes and boarding care homes, among other facilities).

[14] Minn. Stat. § 144A.44 (providing rights for persons receiving home care). The "Assisted Living Addendum" extends, with one exception, those rights to assisted living clients. *See* Minn. Stat. § 144A.441.

Further, there are five separate "Bills of Rights" that provide the same or similar rights to (and impose the same or similar provider responsibilities regarding) different types of recipients of the same or similar care and services.[15] They cry out for harmonization, reorganization, consolidation, and recodification.

In addition, the Uniform Consumer Information Guide – which was designed to provide a clear statement of promised services and provide an apples-to-apples comparison among competing providers – is not adequately fulfilling those originally intended purposes. It requires updating and editing for clarity.

Finally, while there are already legal requirements for providers to post and inform older and vulnerable adults about where to report suspected abuse, the reality is that this information cannot be fully absorbed during the complex admissions process. A separate mailing - developed by an independent victim services organization – should be distributed to new residents and their families no later than a month after move-in.

[15] *See* Health Care Bill of Rights (Minn. Stat. § 144.651); Home Care Bill of Rights (Minn. Stat. § 144A.44); the Assisted Living Addendum (Minn. Stat. § 144A.441); Hospice Bill of Rights (Minn. Stat. § 144A.751); and Patient Rights (Minn. Stat. § 144.292).

CRIMINAL AND CIVIL ENFORCEMENT

BACKGROUND

Criminal Enforcement: Prosecutors Need More Tools to Hold Abusers Accountable

Minnesota's criminal code does not allow prosecutors to charge perpetrators of abuse in the fourth degree with a gross misdemeanor if the older or vulnerable adult does not experience "demonstrable bodily harm." As a result, when an older or vulnerable adult is assaulted and terrorized by threats or other physical abuse where the legal standard cannot be met, prosecutors' hands are tied, and it is impossible for equally egregious – but less physically manifest – abuses and harms to be punished. The criminal code needs to be strengthened to give prosecutors the ability to charge assaults against older and vulnerable adults as gross misdemeanors.

Further, policymakers and prosecutors should undertake a thorough review of statutes enumerating crimes against vulnerable adults in other portions of the Criminal Code that apply in vulnerable adult cases. For example, the definition of criminal abuse of a vulnerable adult has limited application to aversive and deprivation procedures in a licensed facility or to sexual contact by a facility caregiver. Alternatives include expanding the definition of criminal abuse of a vulnerable adult to encompass a broader range of physical and sexual assault and/or prosecuting any sexual assault of a vulnerable adult under the sections of law governing sexual assault generally.

Civil Enforcement: Older and Vulnerable Adults Need a Statutory Right to Judicial Enforcement of Their Rights

There is a critical gap in Minnesota's civil statutes that for the most part leaves older and vulnerable adults, and their families and advocates, without a realistic avenue to obtain justice, redress, and compensation in a court of law for physical or other harms inflicted by abuse perpetrated or for other violations of the rights granted under the statutes. In many other sections of Minnesota law where vital rights are violated, or serious harms are inflicted, victims are statutorily empowered to seek the help of the courts to enforce their rights and receive compensation and their legal fees if they prevail. Without this statutory authority, all the critical rights provided for older and vulnerable adults are merely paper rights.

Currently, the right to civil enforcement is minimally mentioned in the Health Care Bill of Rights – and that right is severely limited. Since it resides in the Health Care Bill of Rights, it is available only to older and vulnerable adults residing in nursing homes, boarding care homes, and limited other settings. It appears further restricted to only those persons with guardians or conservators. Critically, this right does not even exist in the Home Care Bill of Rights and thus does not extend to older and vulnerable adults living in HWS/AL settings.

The narrow private enforcement right in the Health Care Bill of Rights is not at all helpful to the victim or the victim's family since there is no teeth to the law, and no right to compensation for wrongs included. And since the populations for whom these rights are intended are often

older and vulnerable adults with limited and rapidly diminishing financial resources, without inclusion of legal fees, few can afford lawyers to help them fight for their rights and justice.

Moreover, where a family can afford a lawyer to go to court when a perpetrator causes physical injuries to a vulnerable adult, if the older or vulnerable adult victim dies while the case is in progress, the case effectively dies with her or him; families get no closure or relief. This limitation provides a disincentive for perpetrators to resolve matters while the older and vulnerable adult is alive and sends the wrong message.

Older and vulnerable adults and their families cannot rely solely on the providers themselves or on government agency oversight, especially in the HWS/AL setting, where regulatory agency authority and oversight is statutorily and otherwise weak or nonexistent. Even if the public enforcement system were optimal, there is still no existing meaningful right for older and vulnerable adults and families to enforce their rights and receive compensation for harms done. Civil remedies must be strengthened.

Finally, there is an anomaly in the law that gives perpetrators of abuse greater appeal rights than victims of abuse of a maltreatment finding. Under current law, a perpetrator has the right to appeal an administrative finding of maltreatment to either an administrative tribunal or to district court, but the victim does not have that same right when the lead investigative agency does not find maltreatment. The victim's only appeal is back to the same agency that made the finding with which the victim disagrees in the first place. Only a paper review is conducted by a Maltreatment Review Panel composed, nearly exclusively, of lead investigative agency representatives. It is illogical that perpetrators have greater rights and access to our courts than older and vulnerable adult victims.

SUMMARY OF RECOMMENDATIONS

Criminal Enforcement

A. Strengthen Criminal Code to Hold Perpetrators of Assault Accountable
Prosecutors must be given additional authority to file a gross misdemeanor charge against a perpetrator committing assault in the fourth degree against a vulnerable adult without needing to prove "demonstrable bodily harm" when the assault was committed with the "intent to cause fear in another of imminent bodily harm or death."

B. Review the Criminal Code with Respect to Crimes Against Vulnerable Adults
The Criminal Code sections that address crimes against vulnerable adults should be reviewed to evaluate whether definitions of criminal abuse and neglect should be updated and whether some or all sexual assault crimes against vulnerable adults should be prosecuted, with enhancement for vulnerability.

Civil Enforcement

A. Allow Older and Vulnerable Adults to Go to Court to Enforce Their Rights
Older and vulnerable adults and their families and advocates need a statutory right to obtain redress and compensation for harms inflicted by the violation of consumer rights granted under Minnesota law, including but not limited to, rights contained in the Health Care Bill of Rights and the Home Care Bill of Rights.

B. Give Family Members and Others Advocates Authority to Enforce Rights Granted to Older and Vulnerable Adults
Currently, enforcement of the Health Care Bill of Rights is severely limited – appearing to extend to only those persons with guardians or conservators. Nowhere else in law are family and advocates given statutory authority to enforce the rights of older and vulnerable adults on their behalf.

C. Allow Court Actions Involving Abuse to Proceed After Death of the Vulnerable Adult Plaintiff
Families or an advocate should be able to proceed to the conclusion of the case, without limitations, on behalf of the deceased victim of abuse.

D. Give Victims of Abuse the Same Appeal Rights to Challenge a Maltreatment Finding
Victims of abuse should have the same rights as perpetrators of abuse to judicial appeal of an administrative determination of maltreatment.

NEW LICENSING FRAMEWORK FOR ASSISTED LIVING & DEMENTIA CARE

BACKGROUND

Regulation Not Keeping Up with Complex Care Needs of Residents

There has been an exponential growth in facilities in Minnesota called Housing with Services (HWS) or Assisted Living (AL). Approximately 60,000 elders[16] currently live in AL compared to fewer than 28,000 living in nursing homes.[17] In 2014, 58% of residents in AL were over age 85 and 39% had dementia.[18] In addition, the medical needs of those living in AL have steadily increased and are more complex.

Today, Minnesota does not currently license HWS/AL residential settings, making us an outlier compared to all other states. Instead, Minnesota regulates housing services separately from home care services and does not license the HWS/AL residential setting as a whole. The state requires a registration for "Housing with Services Establishments" and separately licenses home care providers who provide services to residents in these settings. However, the registration has no connection with or carries no authority over the home care provider(s) operating within the building.

Further complicating this scheme is that an HWS can call itself "assisted living" using title protection under Chapter 144G of Minnesota Statutes as long as it complies with other requirements, such as 24/7 awake staff. Not all HWS seek AL title protection and again the title protection does not provide a framework for oversight of the residential care setting. See graph 1 on page 17.

This complicated structure means older adults must enter into two contracts – one for the building/services and one for the home care services – each with important differences[19] that

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[16] *See,* Minnesota Department of Health, *Regulation and Oversight of Long Term Care* (2017) (reporting 1,474 HWS registrations and 1,144 Assisted Living designations); at http://www.senate.mn/committees/2017-2018/3087_ Committee_on_Aging_and_Long-Term_Care_Policy/MDH%20Long%20Term%20Care%20 Provider%20Licensing% 20and%20Regulation.pdf; Minnesota Board on Aging, *Legislative Report - Housing with Services Assisted Living Medical Assistance Study* (2013) (reporting 970 Assisted Living designations; at www.mnaging.org/en/ News%20Archive/2013/MA-Study.aspx); Minnesota Housing Finance Agency, *Housing for Minnesota's Aging Population* (2010) (reporting 57,261 AL residents); at www.mnhousing.gov/ idc/groups/secure/ documents/admin/mhfa_010262.pdf; Minnesota House of Representatives, *Information Brief: Assisted Living/Housing with Services in Minnesota* (2001) (reporting 643 HWS registrations); at www.house.leg.state. mn.us/hrd/pubs/asstlvg.pdf.

[17] Charlene Harrington, Helen Carrillo, and Rachel Garfield, Henry J. Kaiser Family Foundation, *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2015* (finding 25,542 occupied beds in in Certified Nursing Facilities in Minnesota in 2015); at https://www.kff.org/medicaid/report/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2015/.

[18] National Center for Assisted Living, *Minnesota: Fast Facts – State Profile for Assisted Living;* at https://www.ahcancal.org/ncal/facts/Pages/State-Data.aspx.

[19] Home care services in the HWS setting can be terminated with 10-day notice while AL clients are given a 30-day notice. Even 30 days is an insufficient amount of time to find new services for many AL clients, let alone 10 days.

creates confusion for older and vulnerable adults in understanding what entity has overall responsibility for their care and causes significant disruptions in care.

The two-contract system provides two means to remove a vulnerable adult from their care setting – through termination of housing or termination of home care services. Older and vulnerable adults in residential settings can face traumatic and health-threatening impacts when forced to move. Today, there are few protections when they are terminated from housing or home care services. Older and vulnerable adults have no appeal rights[20] and there is no requirement for providers to assist with discharge planning. These protections exist for nursing home residents and we believe these protections should apply equally to older and vulnerable adults across all settings.

Several other problems exist with the current system. Minnesota does not define minimum standards for dementia care in statute, whether in what is commonly called a "memory care" unit or in another long-term care setting. This lack of definition results in differing standards of care across settings, such as nursing homes and HWS/AL. The lack of definition is making it difficult for vulnerable adults and their families to make informed decisions. Minnesota only requires the disclosure of practices related to dementia care in a facility, and there is little or no regulation of that disclosure, let alone the practices outlined in the disclosure. Also, while training guidelines are required for those facilities offering dementia care, there is no measure of competency to determine if staff understands the curriculum. Those with dementia are among our most vulnerable and often cannot articulate when they are being harmed or their needs are not being met.

In addition, there are no minimum staffing requirements in HWS/AL settings that take into account the acuity level of residents beyond concepts of "sufficient numbers" under Minnesota law. Without clear standards it is difficult for consumers to understand what services are available and whether such services will meet their needs.

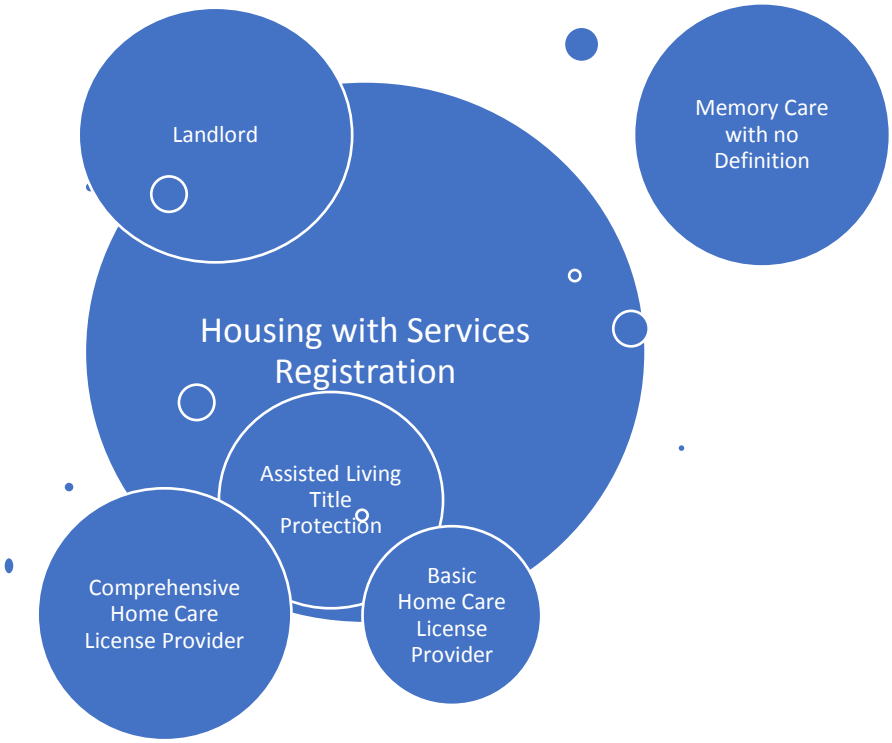
Finally, problems exist for vulnerable adults who have spent their life savings and then must enroll in the Elderly Waiver (EW) Program, Minnesota's Medicaid program. EW recipients are often no longer able to either keep their private room or are terminated altogether from HWS/AL settings. More protections are needed beyond disclosure of whether the setting accepts persons on the EW program. Additionally, given the significant confusion in the EW benefit process, more training and greater collaboration among county, providers, and the vulnerable adult or his or her family member is necessary.

Given the complexity of care needs of the frail elderly living in HWS/AL settings, it is time to recognize that these "clients" are not merely tenants, but rather older and vulnerable adults that cannot simply find a new apartment. Therefore, we call for major systemic changes in how we regulate these settings including the development of Assisted Living Licensure, Certification of Dementia Care as well as some immediate protections for vulnerable adults in these settings today.

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[20] If the HWS/AL wishes to formally evict the resident, housing court can become a venue for opposing the eviction from housing, but arguably not the termination of home care services.

Graph 1. Current framework of HWS and AL Title Protection that separates housing from and home care services creating a confusing regulatory scheme.



SUMMARY OF RECOMMENDATIONS

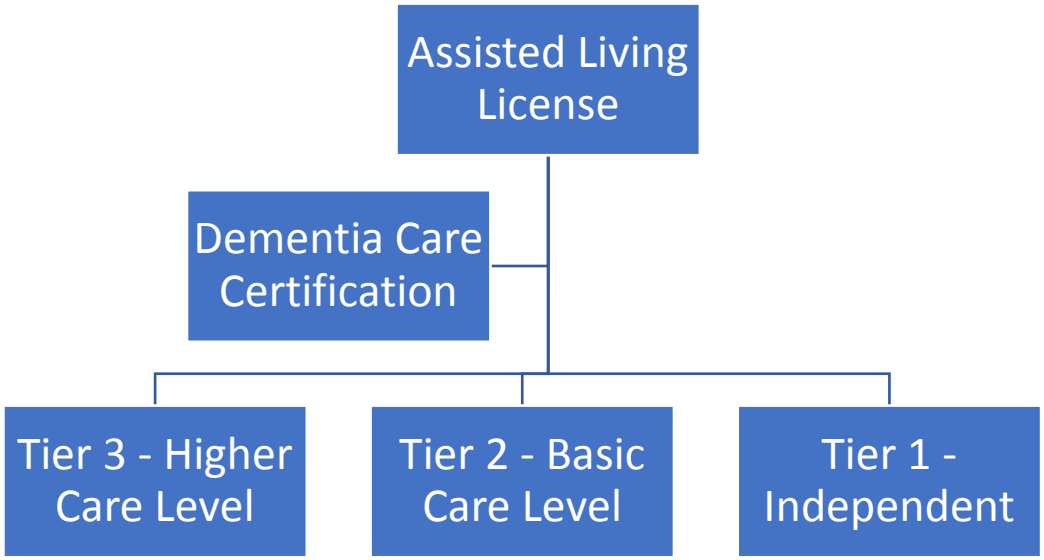
A. ***New Assisted Living Licensure Framework***
Direct the Commissioner of Health to create a new assisted living license during the 2018 legislative session to be implemented by January 1, 2020, with details of the license to be developed by a stakeholder group that includes significant consumer input. The main goal of licensing the AL residential setting is to join both housing and home care services under one license structure. The new licensing structure must recognize that landlord- tenant law under Chapter 504B still applies and additional standards that are currently outlined in law, in addition to new standards as discussed in this report. See graph 2 below for an illustration of the new framework.

B. ***New Dementia Care Certification***
Direct the Commissioner of Health to create a new Dementia Care Certification, including for Dementia Care Units, during the 2018 legislative session to be implemented by January 1, 2020 as part of the AL licensure development process. The details of the certification will be developed by the stakeholder group referenced above. The goal of the certification is to identify minimum safety and quality of service standards for dementia special care, including dementia training, assessment, care planning, therapeutic activities,

and physical design/environment.

C. ***Improved Staffing Levels Required***
Current staffing requirements are not sufficient to ensure that proper levels of staff are available and adequately trained to care for residents with complex needs, especially on nights and weekends. Stakeholders must be creative and cooperative as well as and develop private/public incentives to improve staffing levels, retain today's dedicated caregivers, and find ways to recruit, train, and support future caregivers.

Graph 2: Recommended new AL and Dementia Care License Framework.



D. ***Immediate Protections for Vulnerable Adults Needed in HWS/AL***

Create a Termination of Appeal Right for Residents in HWS/AL
Allow residents of HWS/AL to appeal terminations of housing and/or home care services to the Minnesota Office of Administrative Hearings, similar to the appeal rights available to nursing home residents.

Prevent HWS/AL from Redefining Statutory Terms in Admission Contracts
Establish that HWS/AL admission contracts cannot redefine the terms, including "responsible party," that are already defined under current law.

Immediate Needs for Elderly Waiver (EW) Vulnerable Adults
Immediate needs include protections of elders on EW by requiring the HWS/AL to accept EW residents after a period of private pay and establishing training and/or education for providers and residents (or their families) on the process of applying for EW benefits, focusing on greater collaboration between the county, the resident, and the provider to avoid gaps in payment for long-term care services.

IMPROVE MDH LICENSING, OHFC ENFORCEMENT AND OHFC INVESTIGATION PROCESS, AND MAARC REPORTING PROCESS

BACKGROUND:

Current Licensing & OHFC Investigations Laws are Not Being Adequately Enforced

Under current law, the Minnesota Department of Health has two units to carry out its mission to protect vulnerable adults: the Office of Health Facility Complaints (OHFC) and the Health Regulation Licensing Division. Minnesota law and rules enable numerous actions MDH can take when violations are found in either a licensing survey or complaint investigation. A unique opportunity presents itself now, with so much public attention to these issues, to reevaluate the effectiveness of correction orders, time periods for correction, re-inspection, the schedules of fines for both nursing facilities and home care providers, the adequacy of those fines, and other available means for penalizing violations (e.g. receivership, placement of a monitor).

During the 2017 legislative session, OHFC revealed a substantial need for additional resources to handle the dramatic rise in maltreatment reports. OHFC reported a 600% increase in maltreatment reports since 2010 and an ability to investigate only 1% of the 20,791 reports from providers and 10% of the 3,491 reports from individuals.[21] We recognize that steps are being taken to improve OHFC's processes, including: task force and engagement work done in the fall of 2017; the current work being done in conjunction with the Department of Human Services; and potential solutions that will be in the Office of Legislative Auditor's report due in early 2018. Therefore, our recommendations reflect recognition of the work already underway while acknowledging that more must be done.

MDH should be expected to meet standards and statutory timelines for inspections and investigations. The process under which OHFC must perform investigations of maltreatment complaints is largely prescribed by law but is not being followed. The current rate of OHFC investigating family reports is woefully unacceptable. Moreover, continued improvements in reporting practices and enforcement policies are needed to hold perpetrators of maltreatment in facility settings accountable.

The current regulatory process is split between nursing homes on the one hand and Housing with Services (HWS) and assisted living (AL) settings on the other. OHFC for example, does not provide on-going monitoring for compliance for HWS/AL. Moreover, the fines for maltreatment in HWS/AL are generally believed to be less than the fines in nursing homes. While, both OHFC and MDH Licensing currently have the authority to issue fines for substantiated maltreatment, resident right violations, and violations of certain provisions in the Vulnerable Adults Act, such authority is not being utilized. Currently the maximum penalty for the most egregious harm or death of an older or vulnerable adult in HWS/AL is $5,000. We believe this is not significant enough to deter poor care. Vulnerable adults are entitled to equal protection from maltreatment regardless of their care setting.

[21] *See* FY18-19 Biennium Budget Plan from OHFC.

In light of the potential rollbacks in federal nursing home standards and enforcement, it is imperative that MDH use the tools afforded by state law, except in cases where the federal law is stronger or supersedes. Given the fact that there are no federal requirements for home care services in HWS/AL (with the exception of Medicare certified providers), our state laws are fundamental safeguards but differ substantially from federal laws and are inadequate.

Further, with so much attention on lack of response and deficient enforcement at OHFC, we also encourage MDH to engage in reform from the MDH licensing side. Surveys of MDH licensed facilities are meant to identify deficiencies sooner and prevent abuse from occurring in the first place. MDH has only surveyed approximately 205 licensed-only home care providers each year, although there are currently 1,200 providers.

To be meaningful and effective, these surveys must be completed routinely, and in the case of home care licensees, more frequently than every three years. Many home care providers have not received surveys even on the three-year cycle.

Another problem is that MDH interprets the law to require it to allow facilities time to correct violations before it can issue a fine. MDH believes that it lacks the authority to issue fines unless it first provides an "opportunity to correct," rendering its oversight less effective. Minnesota law should be changed to eliminate the "opportunity to correct" in cases of sexual assault, serious harm, or maltreatment that results in death, where "correction" is not possible, and should be accompanied by an immediate fine.

In addition, more can be done with current law regarding abuse prevention plans under the Vulnerable Adult Act,[22] including expanding the plan requirements to HWS/AL residential settings. MDH should be directed to evaluate compliance with these plans during all surveys and maltreatment complaint investigations.

Law Enforcement Does Not Receive Timely Reports of Suspected Criminal Maltreatment

Currently, law enforcement experiences delays in receiving report referrals from OHFC. Criminal investigations must be conducted as quickly as possible to assure that interviews are timely, crime scenes are preserved, and evidence remains fresh. Solid investigative information is required for a referral for prosecution. Similarly, the likelihood of a case being prosecuted requires solid information to justify criminal charges. In a related matter, law enforcement receives community complaints concerning a vulnerable adult directly and may fail to report that to the MAARC so that emergency protective services can be provided as needed.

Enhancements to MAARC Needed

As to reporting, the Minnesota Adult Abuse Reporting Center (MAARC) was designed to be a single common point of entry (reporting center) for all reports of suspected maltreatment.

We were encouraged to hear Acting MDH Commissioner Pollock report on January 24, 2018 to the Committee on Aging and Long-Term Care Policy that MDH has received federal

[22] Specifically, Minn. Stat. § 626.557, subd. 14.

approval to have MAARC serve as the single reporting line for MDH-licensed providers. This approval should eliminate the dual-reporting structure that was creating unnecessary burden on providers and OHFC.

We also encourage clarification in the law requiring providers to inform their staff of the ability to report directly to MAARC on their own, without fear of retaliation. Families must be encouraged to report only to MAARC and not separately to OHFC, with OHFC assisting the family in transferring initial reports to MAARC.

MAARC also does not have the capability to allow individuals to provide or upload critical evidence, including photos and recordings, when filing a complaint. We strongly believe the MAARC reporting system must be upgraded to allow for the submission of documentation from complainants and providers. Currently, vital records, photographs and videos remain undocumented in many cases. This evidence is critical to spur and support prosecution of perpetrators. In addition, reporters of maltreatment currently must request follow-up information about the disposition of the report; instead, we believe an automatic follow-up communication to the reporter should be the standard procedure.

In sum, enforcement authority must be strengthened through licensing, in OHFC for better triage and investigation of allegations, and in the corrective measures taken to hold perpetrators accountable. As a corollary, improvements in the abuse and maltreatment reporting processes at OHFC and MAARC will respond to the expressed needs of vulnerable adults, families and providers.

SUMMARY OF RECOMMENDATIONS

A. ***Improve MDH Licensing Inspections/Correction Orders/Fine***
Every three years for a survey for home care providers operating in an HWS/AL setting is too infrequent to allow course corrections for the provider and to allow MDH to monitor the care provided to older and vulnerable adults. Surveys should be conducted every year. The department must have the staff resources and a clear mandate to require compliance when these home care providers are first licensed as well as the duty to survey home care providers more frequently, particularly when violations are found.

B. ***Strengthen and Equalize MDH Enforcement Capacity in Nursing Facilities and HWS/AL***
We call particular attention to the efficacy of plans for correction and time periods for correction prior to the imposition of a fine. These processes should be comparable whether the provider is a home care licensee in HWS or a nursing facility. Furthermore, correction orders, plans, and time periods may be suitable for some violations; however, in cases of sexual assault, serious harm, or maltreatment that results in death, correction orders should be accompanied by an immediate fine. We encourage MDH to, at a minimum, double the penalties for all levels of home care violations from the current structure of $0-$5,000. Currently the maximum penalty for the most egregious harm or death of an older or vulnerable adult is $5,000.

C. ***Ensure Provider Compliance with Abuse Prevention Plans in Nursing Facilities & HWS/AL.***

MDH must evaluate compliance with the Vulnerable Adult Act, in all licensing surveys and maltreatment complaint investigations of entities that serve older and vulnerable adults. Further, MDH must order corrective action for noncompliance, using the authority to fine facilities and services for failing to correct.[23]

An additional problem is that the term "facility" does not include Housing with Services/Assisted Living, despite their residential nature. Therefore, the establishments are not required to have a facility-wide abuse prevention plan. Homelike settings are no less likely to have hazards (e.g. location beside a body of water) than institutional settings.

D. ***Accelerate Reports to Law Enforcement***

We recommend amending Minnesota laws (reporting mandates, timeframes) to clarify which is the lead agency when cases in an MDH licensed facility involve an alleged crime (law enforcement) or adult protective services (APS) are needed by the victim. Clarifying mutual reporting responsibilities is essential to the effective resolution of cases and establishing best practices. In addition, training and notifications should be done for lead agencies and law enforcement on these clarified expectations.

E. ***Improve OHFC investigative Timelines and Require Higher Investigation Rates***

Measurable outcomes should be developed to ensure a higher investigation rate and interventions when such rates fall below established guidelines. In addition, it is crucial that all required investigation timelines established by MDH under the Vulnerable Adult Act are met. Additional resources are needed to continue to meet required timelines.

F. ***Improve OHFC Communications to Families***

Response times and guidelines for relaying information to families and advocates should be added to Minnesota law. The investigator should contact the vulnerable adult's family for an introduction within five days after initiation of an investigation and communicate with the family at a minimum every three weeks throughout the investigation. Communication should not be extended from OHFC to a family who is a suspected perpetrator of the abuse.

Also, it is necessary to enforce stricter guidelines surrounding final notification of the investigation to assure the family member does not receive the results of the investigation later than the facility or perpetrator under the Vulnerable Adult Act.[24] Finally, consumers and families need tools to help them as they search for a home care facility. They deserve a dedicated website, easy to search, which displays the current and historical investigative reports of abuse specific to each facility.

The opportunity to add additional reports of abuse and neglect for the same victim in the same facility to a case already in the process of investigation should be allowed. In addition, multiple reports for the same vulnerable adult and/or the same facility for better tracking of maltreatment data should be cross-referenced.

[23] *See* Minn. R. 4658.0193 (reporting maltreatment of vulnerable adults; fines)
[24] *See* Minn. Stat. §626.557, subd. 9c(f).

G. ***Improve Central Reporting of Maltreatment to MAARC***

The recent approval by the Centers for Medicare and Medicaid (CMS) allowing providers to report to MAARC should be implemented as quickly as possible by MDH to strengthen MAARC as the single common entry point for all reports. Families should be directed to report directly to MAARC as well as all mandated reporters including staff. Also, the MAARC intake process much be changed to allow for document and file uploads.

Recommendations with Statutory Changes Needed

STRENGTHEN AND EXPAND RIGHTS OF OLDER AND VULNERABLE ADULTS AND THEIR FAMILIES

A. *Establishing the Right to Know About Reports of Abuse*

1. **Allow Disclosure of Reports and Records.**
   Disclosure of information in maltreatment/abuse reports must be allowable to the victim and those acting on their behalf. The state law should also be amended to mirror federal law and allow release of medical records to authorized agents after the death of an older or vulnerable adult.
   Amend the Health Care Bill of Rights (Minn. Stat. § 144.651)
   Amend the Vulnerable Adult Act (Minn. Stat. § 626.557)
   Amend the Medical Records Act (Minn. Stat. § 144.291)

B. *Clarifying the Right to Place a Camera and Electronic Monitoring Device in Rooms*

1. **For Abuse Detection.** Abuse detection tools should be enhanced by making clear the right to place cameras and electronic monitoring devices in rooms.
   Amend Health Care Bill of Rights (Minn. Stat. § 144.651)

2. **For communication.** The Health Care Bill of Rights should be updated to include the right to obtain and pay privately for Internet service (if not included), not only to use a web camera or electronic monitoring device, but also to enable remote contact with family and friends, and to facilitate other healthy social and commercial interaction.
   Amend Health Care Bill of Rights (Minn. Stat. § 144.651)

C. *Addressing Retaliation*

1. **Protect Older and Vulnerable Adults and Their Families from Retaliation for Reporting Abuse, Filing Grievances, or Asserting Rights**
   - Certain acts that are currently not defined as "retaliatory" under the Vulnerable Adult Act should be added, including, among others, restriction of use of or access to amenities or services; termination of services or lease agreement; sudden increase in costs for services not already contemplated at the time of the maltreatment report; and deprivation of technology, communication, or electronic monitoring devices.
   - Minnesota law needs to be clear that older and vulnerable adults and their families may report abuse without fear of retaliation.
     Amend Health Care Bill of Rights (Minn. Stat. § 144.651)
     Amend Vulnerable Adult Act (Minn. Stat. § 626.557)

D. *Ensuring Equal Rights for All and Expanding Resident Rights*

1. **Extend the Protections of the Health Care Bill of Rights to Persons Residing in HWS/AL**

   Persons residing in nursing homes, boarding care homes, housing with services establishments, and assisted living ought to, where applicable, have the same protections. The Health Care Bill of Rights does not apply to persons residing in HWS/AL. It should.

   Amend Health Care Bill of Rights (Minn. Stat. § 144.651)

2. **Ensure Consistency of Health Care Bill of Rights and the Home Care Bill of Rights**
   The relevant rights granted under the Health Care Bill of Rights and the Home Care Bill of Rights should be the same. They are not. For example, the rights to trained and competent staff and to advance notice of changes in charges or services are not available for residents in nursing homes and boarding care homes. They should be.

   Amend Health Care Bill of Rights (Minn. Stat. § 144.651)
   Amend Home Care Bill of Rights (Minn. Stat. § 144A.44)

3. **Establish the Right to Appeal Termination of Housing or Services in HWS/AL**
   For an older or vulnerable adult, a discharge from a nursing home or boarding care home, or a termination of a lease or services in HWS/AL, is traumatic and health-threatening. But, while a process exists to appeal a nursing home or boarding care home discharge, there is no similar opportunity under statute to challenge a termination of housing or services in an HWS/AL setting. Older and vulnerable adults residing in those settings deserve the same rights as those living in nursing homes and boarding care homes as to such appeals.

   Amend Chapter 144D (Housing with Services Establishments)

4. **Enhance Protections to Ensure a Safe Transfer in HWS/AL Settings**
   Because of the traumatic and health-threatening impacts of being forced to move when in need of care, ensuring the least traumatic transfer possible should be everyone's goal and responsibility. Currently, while older and vulnerable adults moving from a nursing home or boarding care home are entitled to a statutorily required safe discharge plan, there is no comparable right for an older or vulnerable adult forced to move from his or her HWS/AL residence. A safe discharge plan is necessary in the HWS/AL setting.

   Amend Chapter 144D (Housing with Services Establishments)

5. **Prohibit Waiver of Rights**
   No older or vulnerable adult should be asked or required to waive any rights they are given under law as condition of stay or services or for any other reason.

   Amend Health Care Bill of Rights (Minn. Stat. § 144.651)
   Amend Home Care Bill of Rights (Minn. Stat. § 144A.44)

E. <u>Identifying and Prohibiting Deceptive Marketing and Business Practices</u>

1. **Enumerate and Prohibit Specific Deceptive Practices**

Laws specific to the provision of care and services to older and vulnerable adults should be strengthened to include explicit protection against, and definitions of, deceptive marketing and business practices.

Amend Health Care Bill of Rights (Minn. Stat. § 144.651)
Amend Home Care Bill of Rights (Minn. Stat. § 144A.44)

2. **Make the Additional Fine for Consumer Fraud Committed Against Older Adults and Persons with Disabilities Apply to Fraud Committed Against Vulnerable Adults**
Perpetrators who commit fraud against vulnerable adults should be subject to the same additional fine to which they are currently subject for committing fraud against older adults and persons with disabilities.

Amend Consumer Fraud Act (Minn. Stat. § 325F.71)

F. Making Sense Out of Our Confusing Health Care Laws

1. **Create a Resource List to Be Provided Separately from Admission Documents**
While there are already legal requirements for providers to post and inform older and vulnerable adults about where to report suspected abuse, the reality is that this information cannot be fully absorbed during the complex admissions process. A separate mailing -- developed by an independent victim services organization – should be distributed to new residents and their families no later than a month after move-in. Content should include explanation of the pertinent rights with clear directions about where to get help with problems and what to expect in the process.

Amend Health Care Bill of Rights (Minn. Stat. § 144.651)
Amend Home Care Bill of Rights (Minn. Stat. § 144A.44)

2. **Ensure Older and Vulnerable Adults Receive the Uniform Consumer Information Guide**
The Uniform Consumer Information Guide was developed and required by lawmakers to be made available to older and vulnerable adults to help them understand their rights and comparison shop among potential residential settings. Many prefer paper copies, but they only made available through a link to an electronic copy. Older and vulnerable adults and their families should have the right to have a paper copy. Further, the Legislature should direct MDH to update and clarify the required content.

Amend Minn. Stat. § 144D.08 (Housing with Services)
Amend Minn. Stat. § 144G.06 (Assisted Living)

3. **Harmonize, Reorganize, Consolidate, and Recodify Statutes Governing Care and Services Provided to Vulnerable Minnesotans**
The Revisor of Statutes, in consultation with stakeholders including industry and consumer advocates, should be directed to recodify the statutes that govern consumer rights and provider responsibilities for health care consumers to ensure consistency of rights and language, address ambiguities, and update cross-references to repealed laws and rules.

ENHANCE CRIMINAL AND CIVIL ENFORCEMENT OF RIGHTS

Criminal Enforcement

A. *Strengthen Criminal Code to Hold Perpetrators of Assault Accountable*
Prosecutors must be given the authority to file a gross misdemeanor charge against a perpetrator committing assault of a vulnerable adult in the fourth degree, without needing to prove "demonstrable bodily harm" when the assault was committed with the "intent to cause fear in another of imminent bodily harm or death."[25]

Amend the Criminal Code (Minn. Stat. § 609.2231)

B. *Review and Assess the Criminal Code with Respect to Crimes Against Vulnerable Adults*
Policymakers should undertake a review of the Criminal Code sections that address crimes against vulnerable adults to evaluate whether definitions of criminal abuse and neglect should be updated and whether some or all sexual assault crimes against vulnerable adults should be prosecuted, with enhancement for vulnerability, under the sections of criminal law that govern those crimes generally.

Review the Criminal Code (in particular Minn. Stat. §§ 609.232, 609.2325, and 609.233)

Civil Enforcement

A. *Allow Older and Vulnerable Adults to Go to Court to Enforce Their Rights*
Neither older and vulnerable adults nor their families and advocates have adequate tools under current law to enforce their rights and protections in a court of law. They need a statutory right to obtain redress and compensation for harms inflicted by the violation of consumer rights granted under Minnesota law, including but not limited to, the Health Care Bill of Rights and the Home Care Bill of Rights.

Amend Health Care Bill of Rights (Minn. Stat. § 144.651)
Amend Home Care Bill of Rights (Minn. Stat. § 144A.44)
Amend Chapter 144D (Housing with Services)

B. *Give Family Members and Other Advocates the Explicit Statutory Authority to Enforce Rights Granted to Older and Vulnerable Adults*
Currently, enforcement of the Health Care Bill of Rights is severely limited – appearing to extend to only those persons with guardians or conservators. Nowhere else in law are family and advocates given statutory authority to enforce the rights of older and vulnerable adults on their behalf. They should have that right.

Amend Health Care Bill of Rights (Minn. Stat. § 144.651)
Amend Home Care Bill of Rights (Minn. Stat. § 144A.44)

C. *Allow Court Actions Involving Abuse to Proceed After Death of the Vulnerable Adult Plaintiff*
Under current law, in cases involving physical injuries to a vulnerable adult from abuse, if the victim dies before conclusion of the claim, the claim is severely limited and effectively ends. Families should be able to proceed to the conclusion of the case, without such limitations, on

[25] See definition of assault in Minn. Stat § 602.224 subd.1

behalf of the deceased victim. Such limitations that occur when the victim dies creates a disincentive for perpetrators to resolve matters while victim is alive and send the wrong message to our older and vulnerable adults.

Amend Minn. Stat. § 573.02

D. *Give Victims the Same Appeal Rights to Challenge a Maltreatment Finding*

Victims of abuse should have the same rights as perpetrators of abuse to appeal an administrative determination of maltreatment. Currently, victims can only appeal to the lead investigative agency and obtain paper review by the Maltreatment Review Panel. They are denied independent administrative hearings or access to district court, while perpetrators have both. Victims should have the same right to judicial appeal that perpetrators now have.

Amend Minn. Stat. § 256.045

NEW LICENSING FRAMEWORKS FOR ASSISTED LIVING AND DEMENTIA CARE ACROSS RESIDENTIAL SETTINGS

The Consumer Workgroup recommends a new assisted living license framework and a dementia care certification. The Consumer Workgroup also recommends immediate changes in HWS/AL.

A. *New Assisted Living License Framework*

1. Commit to a New Assisted Living License during the 2018 Legislative Session

A. Create a new assisted living license during the 2018 legislative session to be implemented by January 1, 2020, with details of the license to be developed by a stakeholder group that includes significant consumer input. The Consumer Workgroup recommends a new AL license framework be developed with a main goal of licensing the AL residential setting, including both housing and health care services, recognizing that landlord-tenant law under Chapter 504B still applies but that there are additional housing needs for the AL residential setting.

B. Replace "title protection" under Chapter 144G with an "assisted living license," separate and distinct from a basic or comprehensive home care license under Chapter 144A. Essentially home care licensure under Chapter 144A would remain intact as applied to care for clients in their own home.

C. Remove the "housing with services" registration concept under Chapter 144D from any association with AL and relocate any necessary or helpful HWS framework related to AL in new AL licensure under Chapter 144G.

2. Issues to be Addressed by Stakeholders Licensure Process

A. Confirm Responsibility for Coordination of Care

Confirm in law that the HWS/AL is responsible for the overall coordination of care among medical providers, based on the needs of the resident, including carrying out any medical orders.

Amend Minn. Stat. §§ 144A.4791 & 144A.4795

B. Clarify When the Residents Needs are Beyond the Scope of Care

Establish a brighter line for both residents and providers to know when the needs of a resident are beyond the scope of practice of the HWS/AL, mirroring the responsibilities of Home Care Providers as a basis for the definition. [26]

Amend Minn. Stat. § 144A.4791

C. Protections for Elderly Waiver Recipients

- Establish standards to meet the federal Home and Community Based Service requirements to preserve access for individuals who rely on the Elderly Waiver Program.
- That EW benefits do not cover housing costs under the current structure, including a discussion of Group Residential Housing benefits for housing.
- Designate at least 10% of beds for residents receiving EW benefits and notify residents of this requirement.

[26] *See* Minn. Stat. § 144A.4791, subd. 4.

- Investigate whether the current EW benefit program for AL residents meets the needs of EW beneficiaries, including under the new AL licensure framework.

  Amend Chapter 144D (HWS)

  Consult Minn. Stat. § 256B

D. Increase Training for Those Providing Services in HWS/AL

- Review recently implemented dementia training laws for efficacy.
- Improve training for all care providers employed by a facility or program and who are involved in the delivery of care, as well as those who have regular contact with, persons with Alzheimer's disease or related dementias, including training on behavioral approaches.

  Amend Minn. Stat. § 144D.065 (HWS)

  Amend Minn. Stat. §§ 144A.4795 & 144A.4796 (Home Care)

  Amend Minn. Stat. § 144.6503 (Nursing Facility)

  Amend Minn. Stat. § 144A.61 (Nursing Assistant)
- Require training for owners, financial officers, administrators, and management on the Minnesota Vulnerable Adult Act and best practices in standard of long-term care.

  Amend Minn. Stat. § 144A.472
- Require training for all staff and management in best practices for courteous treatment of residents, resolution of conflict, and collaboration between the residents and their families.

  Amend Minn. Stat. § 144A.4796

E. Establish New Notice and Financial Requirements

- Promptly provide a written notification to residents of a change in ownership or management, including contact information.
- Provide written notice to the resident under what conditions the contract may be amended.
- Prohibit charges for community fees, activity fees, or other fees that are not classified as rent or health care services charges, unless otherwise allowed under law.
- Prohibit relocation of a resident within the facility without proper notice and resident consent, even if going on EW.
- Notify residents of their right to request a reasonable accommodation for their disability, including for disability related behaviors.

  Amend Chapter 144D (HWS)

  Amend Minn. Stat. § 144A.472

F. Establish Resident and Family Councils

Ensure creation of resident and/or family councils in HWS/AL settings with the input from the Ombudsman for Long Term Care, based on similar rights found in the Health Care Bill of Rights and provisions in Minn. Stat. §144A.33.

Amend Chapter 144D (HWS)

G. Create a License for AL Administrators

Create a license for AL Executive Directors/Administrators of assisted living, in consultation with the Minnesota Board of Examiners for Nursing Home Administrators.

B. New Dementia Care Certification

Commit to Create a Dementia Care Certification

The certification should:

- Apply across residential setting (i.e. nursing home, HWS/AL, or home care), with increased requirements for those providers operating a Dementia Care Unit within their residential setting.
- Meet minimum standards based on best practice recommendations for dementia care, like those developed by the Alzheimer's Association.
- Establish one place in statute to identify minimum safety and quality of service standards for dementia special care, including dementia training, assessment, care planning, therapeutic activities, and physical design/environment by combining concepts from current law governing improper disclosure, dementia training in nursing facilities and HWS/AL, and home care provider responsibilities. [27]
- Develop comprehensive dementia care training including evaluation of competency of the individual worker, continuing education, portability for workers across employers, minimum standards for trainers. Training curriculum should incorporate principles of person-centered dementia care including thorough knowledge of the person, their abilities and needs; advancement of optimal functioning and a high quality of life; and use of problem solving approaches to care. Training should be culturally competent, both for the provider and the care recipient.
- Grant authority to MDH to monitor and enforce such certification for compliance.

C. Improved Staffing Levels Required Through the Stakeholder Process

Create more detailed staffing guidelines and best practices based on acuity level and number of residents, specifically taking into account nights and weekends. Staffing requirements under state law (Minn. Stat. § 144A.4795) and federal law (42 CFR §483.30) should be consulted when setting such guidelines.

Amend Minn. Stat. § 144A.4795

D. Immediate Protections Needed in HWS/AL

1. Create an Appeal Right for Terminations

Create an appeal right for residents in HWS/AL to appeal termination of housing and/or services to the Minnesota Office of Administrative Hearings, similar to the appeal rights available to nursing home residents under Minn. Stat. §144A.135.

Amend Chapter 144D (HWS)

[27] *See* Minn. Stat. § 325F.72 (improper disclosure); Minn. Stat. §§ 144.6503 (dementia training in nursing facilities); 144D.065 (dementia training in HWS/AL); and Minn. Stat. §§ 144.4791 and 144A.4796 (home care provider responsibilities).

2. Add Requirements to Termination of Lease and/or Services in HWS/AL

- Limit the reasons for termination of lease or health care services to non-payment or breach of contract; allow the resident 30 days from termination to cure the breach.
- Include at minimum the following in a detailed written notice of termination: the reason for termination, time period to cure any breach, date of termination, and appeal process.
- Assist the resident in developing a discharge plan to a safe location, including giving the receiving provider sufficient information for continuity of care and offering names to the resident of other providers and HWS/AL facilities.
- Return any refunds, fees, money or property to the resident as well as provide a final account statement within 30 days of discharge.

Amend Minn. Stat. § 144D.09

3. Require a Minimum of 30-Day Notice for Termination

Currently there are two minimum notice requirements for termination of housing and services (30 days for assisted living and 10 days for health care services). Require a minimum of 30-day notice for termination of either housing or health care services in the HWS/AL environment.

Amend Home Care Bill of Rights (Minn. Stat. § 144A.44)

4. Address Improvements in Elderly Waiver

Establish training and/or education for providers and residents (or their families) on the process of applying for EW benefits, focusing on greater collaboration between the county, the resident, and the provider to avoid gaps in payment for long-term care services. The training should, at minimum, include the following:

- That a MnChoices assessment is required prior to becoming eligible for EW;
- That EW payments do not include three months of retroactive benefits;
- That if EW benefits are not approved within 60 days of the MnChoices assessment, the resident must undergo another MnChoices assessment prior to becoming eligible for EW.

5. Prevent HWS/AL from Redefining Statutory Terms in their Admission Contracts

Establish that HWS/AL admission contracts cannot redefine the terms, including "responsible party," that are already defined under Minn. Stat. § 144.6501.

Amend Chapter 144D (HWS)

IMPROVE MDH LICENSING REGULATION, OHFC ENFORCEMENT AND INVESTIGATIVE PROCESS, AND MAARC REPORTING

A. *Improve MDH Licensing for Inspections Correction Orders/Fines*

1. **Increase Frequency of Surveys from Every Three Years to Annually**
   Surveys should be every year. The change to annually would require a significant commitment by MDH, but the ramifications of not doing so places older and vulnerable adults at unjustifiable risk.
   Amend Minn. Stat. §144A.474

2. **Remove the Requirement to Provide An "Opportunity to Correct" Before Issuing a Fine**
   MDH interprets the law to require it to allow facilities time to correct violations before it can issue a fine for a violation. MDH believes that its lack of authority under statute to issue fines unless it first provides an "opportunity to correct" not only makes it oversight less effective, but also reduces the effectiveness of fines.

3. **Impose Fine if New Violation Identified in Follow Up Survey**
   For providers that have Level 3 or Level 4 violations, as provided under Minn. Stat. § 144A.474, if a new violation is identified on a follow-up survey, a fine may be immediately imposed during the follow-up survey or during any subsequent survey.

4. **Require Assisted Living Entities to Submit Written Plan of Correction**
   Current practices of allowing providers to develop a "plan of correction" in residential settings should require that the plan is submitted to the department and on file. HWS/AL entities and home care providers should be required to submit a written plan of correction to MDH.
   Amend Minn. Stat. §144A.474

5. **Increase Home Care Fines**
   Fines under home care licensing statutes should be increased to deter violations.
   Amend Minn. Stat. §144A.474

B. *Strengthen and Equalize OHFC Fines and Penalties*

OHFC currently has the authority to issue fines for substantiated maltreatment, resident right violations, and violations of certain provisions in the Vulnerable Adults Act, but such authority is not being utilized. Also, some fines and penalties are not significant enough to be a deterrent for home care providers.

1. **Use Current Authority Enforce fines for Violations of Resident Rights and the Vulnerable Adults Act**
   Both OHFC and MDH's Health Regulation Division have authority to issue fines for violations of resident rights, the Vulnerable Adults Act, and other violations under Minnesota Rules. [28] Such authority needs to be utilized as intended to deter violations.

[28] *See* Minn. Stat. § 144A.53, subd. 1(f) and Minn. R. 4664.0014.

2. **Clarify OFHC Authority to Issue Fines for a Variety of Violations**.
   Clarify OHFC's statutory authority to issue fines under Minnesota law for substantiated maltreatment, and to issue correction orders and assess civil fines.[29] A facility or home's refusal to cooperate in providing lawfully requested information may also be grounds for a correction order.

3. **Increase Penalties for Violations by Home Care Providers.**
   We encourage MDH to, at a minimum, double the penalties for all levels of home care violations from the current structure of $0-$5,000. Currently the maximum penalty for the most egregious harm or death of an older or vulnerable adult is $5,000. We believe this is not significant enough to deter poor care.
   Amend Minn. Stat. §144A.474

C. Enforcement of Abuse Prevention Plans - Under the Vulnerable Adult Act

1. **Direct Compliance and Correction Action Related to Abuse Prevention Plans**
   MDH should also be directed to require a corrective action for noncompliance and use its regulatory authority to fine facilities and services for failing to correct noncompliance with abuse prevention plans.[30]

2. **Increase Fines for Failure to Comply with Abuse Prevention Plans**
   Fines for compliance failures regarding the establishment and enforcement of ongoing written abuse prevention plans, as required under the Vulnerable Adult Act, should be increased from its current level of $100.[31]

3. **Change the Definition of Facilities to Include HWS/AL Settings**
   HWS/AL Settings should also be required to have an Abuse Prevention Plan for the physical plant.
   Amend the Vulnerable Adult Act (Minn. Stat. § 626.557 or Minn. Stat. § 626.5572)

D. Accelerate Reports to Law Enforcement and Improve Law Enforcement Response where Crimes are Suspected

Amend Minnesota laws to clarify which is the lead agency when cases involve an alleged crime, whether law enforcement or protective services; clarify mutual reporting responsibilities from OHFC to law enforcement and vice versa, and notify and train lead agencies and law enforcement on clarified expectations.
Amend the Vulnerable Adult Act (Minn. Stat. § 626.557)

[29] See Minn. Stat. §§ 144.653, subd. 6; 144A.45; 144A.53, subd. 1(f); 626.557 – 626.5573; and Minn. R. 4664.0014.
[30] *See* Minn. R. 4658.0193 (reporting maltreatment of vulnerable adults; fines)
[31] *See* Minn. Stat. § 626.557, subd. 14 (abuse prevention plans).

E. Improve OHFC investigative Timelines

Measurable outcomes should be developed to ensure a higher investigation rate and interventions when such rates fall below established guidelines. It is crucial that all required investigation timelines established by MDH under the Vulnerable Adult Act are met, including:

a. Immediate reporting to law enforcement in appropriate cases;[32]
b. In the nursing home context, reporting within two hours when the abuse results in serious bodily injury[33] to comply with federal law;
c. Assignment to the lead investigative agency with two working days;[34]
d. Communication the initial disposition of the report to the reporter within five days;[35]
e. Completion of the final disposition of the investigation with 60 calendar days;[36]
f. Completion of the public investigation memorandum within ten days of disposition.[37]

F. *Increase Communication to Families During the Investigation*

1. Allow Disclosure of Reports and Records

Older and vulnerable adults and their trusted family members should have the right to learn the details of suspected maltreatment. Disclosure of information in maltreatment/abuse reports received by MAARC must be allowable to the victim and those acting on their behalf, except in cases where those acting on their behalf is the suspected perpetrator of abuse.

Amend the Vulnerable Adult Act (Minn. Stat. § 626.557)

2. Add Response Times and Guidelines for Relaying Information to Families and Advocates

The investigator should contact the vulnerable adult's family for an introduction within five days after initiation of an investigation and communicate at a minimum every three weeks throughout the investigation. This recommendation does not extend to contacting a family member who is the alleged abuser.

Amend the Vulnerable Adult Act (Minn. Stat. § 626.557)

3. Provide Investigator Contact Information

The appropriate family member or designated victim representative should be provided with contact information for the OHFC investigator, as well as additional contact information for other OHFC personnel as needed, resources and appeal rights.

Amend the Vulnerable Adult Act (Minn. Stat. § 626.557)

4. Enforce Timely Distribution of Final Report to Families

It is necessary to enforce stricter guidelines surrounding final notification of the

[32] *See* Minn. Stat. § 626.557, subd. 9(d).
[33] See 24 CFR §483.12 subd. (c)(1).
[34] *See* Minn. Stat. § 626.557, subd. 9a(a)(3).
[35] See Minn. Stat. §626.557, subd. 9c(a).
[36] *See* Minn. Stat. 626.557, subd. 9c(e)
[37] *See* Minn. Stat. §626.557, subd. 9c(f)

investigation to assure the family member does not receive the results of the investigation later than the facility or perpetrator, under the Vulnerable Adult Act.[38]

5. **Require OHFC to Cross-Reference Reports for the Same Victim and Facility**
   The opportunity to add additional reports of abuse and neglect for the same victim in the same facility to a case already in the process of investigation should be allowed. In addition, multiple reports for the same vulnerable adult and/or the same facility for better tracking of maltreatment data should be cross-referenced.
   Amend the Vulnerable Adult Act (Minn. Stat. § 626.557)

6. **Publish Completed Investigations to an Easily Searchable Website**
   Consumers and families need tools to help them as they search for a home care facility. They deserve a dedicated website, easy to search, which displays the current and historical investigative reports of abuse specific to each facility.

G. Improve Central Reporting of Maltreatment to MAARC

1. **Allow for Document and File Uploads to MAARC.**
   In order to allow federally certified providers to submit their five-day internal investigation report required by CMS, as well as for families and reporters to provide critical evidence when making a report, the MAARC intake process must be changed to allow for document and file uploads.
   Amend the Vulnerable Adult Act (Minn. Stat. § 626.557)

2. **Direct all Reporters to MAARC**
   All reporters, including families, should be directed to make their initial report to MAARC and not OHFC.
   Amend the Vulnerable Adult Act (Minn. Stat. § 626.557)

3. **Clarify Ability of Staff to Directly Report Maltreatment**
   Ensure that providers communicate to their staff that they are able to report maltreatment directly to MAARC, without fear of retaliation, and need not rely solely on an internal reporting process.[39]

4. **Define and Enforce Immediate Reporting**
   The term "immediate" should be defined to mean within 24 hours when referring to when a mandated reporter must submit a maltreatment report upon suspecting or having knowledge of abuse. Enforce the strict 24-hour reporting timeline for provider self-reports.[40]

5. **Post MAARC Contact Information.**
   The Health Care Bill of Rights currently states that notice of the grievance procedure to the Office of Health Facility Complaints shall be posted in a conspicuous place. However,

[38] *See* Minn. Stat. §626.557, subd. 9c(f).
[39] *See* Minn. Stat. § 626.557, subd. 4a(d).
[40] *See* 42 CFR §483.12, subd. (c)(1).

given that the central common entry point is currently the MAARC, the contact information for MAARC should be posted for residents to know what number to call to report abuse.

Amend the Health Care Bill of Rights (Minn. Stat. § 144.651, subd.20)

Conclusion

The Elder Abuse Consumer Workgroup respectfully submits this report and offers a comprehensive set of recommendations to address the many problems that undermine the system of care and services provided to older and vulnerable Minnesotans. Our paramount concerns and the heart of our recommendations are these: ensuring that those older and vulnerable adults are protected from abuse; that they have the rights they need and the ability to enforce them fully; and that the system of licensing, reporting, inspection, and public enforcement is effective in fulfilling its statutory and societal obligations.

While we made significant efforts to be comprehensive in our recommendations, we grant that multiple issues affecting older and vulnerable adults could not be addressed in the short timeframe allotted. Nor could we incorporate the entire span of public agencies who share the mission of combatting abuse, caregiver neglect, and financial exploitation in residential long-term care. We certainly recognize and appreciate that the Ombudsman for Long-Term Care and the Minnesota Department of Human Services, particularly Adult Protective Services, are key partners in improving quality of life and services for older and vulnerable adults.

The Workgroup also recognizes that issues discussed in this report may uniquely impact rural and outstate communities, given more limited options for care and workforce, and encourage consideration of these issues when focusing on recommended solutions.

We thank Governor Dayton for giving us the opportunity to develop and present these recommendations, and we recognize the many lawmakers, consumers, care workers, and providers who have been working to improve Minnesota's long-term care system. The Workgroup now looks ahead to working with others to enact legislation in 2018 and commit to the longer-term efforts to bring our recommendations to fruition. Minnesotans deserve a system that provides optimal care and services, and maximum protections against abuse. Addressing the tragedy of elder abuse is a shared Minnesota value. We urge lawmakers and regulators to take swift action to turn these recommendations into laws and into meaningful change.

Appendix

Addressing Elder Abuse in Minnesota in Long-Term Care Settings

Table of Contents

Summary of Survey Responses Submitted to the Elder Abuse Consumer Workgroup

Summary of Stories Received by Consumer Workgroup

Elder Voices Family Advocates—Member Experiences

Summary of Survey Responses

Submitted to the Elder Abuse Consumer Workgroup

Improve Enforcement of Maltreatment Violations through the OHFC and Licensing Regulation through MDH (135 total)

- Hold providers accountable – 13
- State established rating system for facilities – 10
- More frequent reporting/inspections/surprise visits – 26
- Timely investigations – 23
- Penalties assessed for providers on abuse, fraudulent advertising, not reporting – closure, loss of license, fines -26
- Legislative funding for regulation/enforcement – 24
- Post/advertise information on where to report/better info to consumers – 13

Strengthen & Expand Rights of Consumers and Their Families (127 total)

- Allowing cameras – 7
- Prohibit retaliation against residents – 3
- Process to bring case forward when patient has passed away – 1
- Increased public education campaign, hotline to report, etc.) on senior facilities/long-term care – 21
- Family involvement (frequent visits and monitoring)/patient advocates – 14
- Communication regarding complaint process – 26
- Improve access to home care – 4
- Consumer sign off on acknowledgement of rights/reporting process – 27
- More transparency on reports and incidents of abuse/inspection/report cards/consumer feedback – 24

Staffing Issues (74 total)

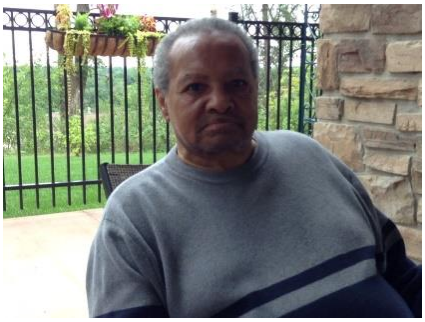
- Staffing shortage/wages/turnover/pay – 20
- Background checks/screening – 13
- No tolerance hiring offenders – 2
- Staff training on proper care/process for reporting abuse – 21
- Change work culture at facilities (i.e people feel safe reporting) – 8
- Timely reporting of abuse by facility staff – 10

AARP® Real Possibilities
Minnesota

Stories Submitted to AARP & Elder Abuse Consumer Workgroup

This document includes stories from families and victims who have shared their personal experiences of maltreatment and abuse to AARP anonymously.





Photos submitted from family members who expereinced maltreatment and abuse within these facilities.

Case 1 – Neglect and Insufficient Care – Moving to a Third Facility

"My father has been in a memory care facility since August 19, 2015. We are now working on moving him to his third facility. We have experienced grave concerns about care and competency in the first two facilities. I also have worked in higher education for the past 10 years. Through this experience I know just how important education is to help our care facilities find qualified and quality team members to serve this fragile and vulnerable population."

Case 2 – Left Wandering in Memory Care and Staff Theft of Valuables; Family Was Not Notified – State ruled unsubstantiated

"My mom escaped and was found outside for an undisclosed amount of time, and I had to follow up on my own for a month to find out what happened, and even then the response was vague and differed from the original explanation.

She had her debit card stolen by a staff member. Other staff told me who it was and that the CNA in question was homeless and staying with another staff member and it was that staff member that turned in the card (she found in her couch) and the CNA in question. The CNA in question admitted that she'd taken it to the Sanctuary staff and was fired immediately. A police report was filed and an elder abuse claim was opened with DHS. 9

months later they found my claim of financial exploitation to be unsubstantiated because the staff member in question said she had the card by accident and never actually used it. Mom's fast decline was met with staff that simply didn't have time for her. The Elderly Waiver she is on to pay for housing and services specifically lists tasks that the staff are to do and in return be compensated for by the State of Minnesota. Consistently for almost three months, my mom was missing meals and was unaccompanied to and from those meals, her medication was given hours later than it was supposed to be given. She was left out of activities and structured social gatherings, and lost in the elevator and walking the halls lost almost the entire time. They were paid to escort her, include her and make her feel safe. None of those things happened. There were doctors' orders for all of the mentioned above tasks that went unfulfilled."

Note: initially her mother was not put into memory care, even after staff advised her to do so. When her mother eventually did move her to memory care facility, she still was left alone wandering and going without meals.

Case 3 – Death after Neglect – Uneducated Staff Abused Resident – Cameras Could Have Proven Abuse

"Our mother was in three different facilities with many problems. Mom was neglected in all three facilities mainly due to a lack of training and/or understanding of Alzheimer's. Our mother was a hardworking person that was a nurse's aid herself for 20 years. The last place she was in was the very facility she worked at. Mom was a true giving person and did not deserve neglect and abuse. Most of which I could not prove, I was accused of having to high of expectations

We did hide one (camera) in mom's room at one point, it was difficult to watch! But if staff knew it was there it would change a lot as time went on I think. Many of our problems would have been witnessed and proven."

Case 4 – Harassed, Abused and Withheld Medication – MDH Investigation Delayed another Year

"I will continue to use my voice to draw attention to the fact elderly residents in the United States are continually being injured and dying. While the governor keeps his finger to his lips, sick old people such as this writer might be able to survive their feelings of anger and rage as they try to reach for handholds in life that may give them one more day, one more day, one more day. And in the meantime, one more old woman is ignored, threatened, physically or sexually assaulted, ridiculed , stolen from, or out and out killed. I asked a registered nurse on staff why it didn't bother her that she is violating the law and she shrugged her shoulders and said "PEOPLE GET OLD AND THEN THEY DIE ! " , AND THEN SHE TURNED HER BACK AND WALKED OUT OF MY ROOM.

I don't intend to die! THERE IS TOO DAMN MUCH LEFT TO DO!"

Note: Marjory has also been featured in the Startribune where an abusive nurse stopped giving her antibiotics that were prescribed to her. "She said she could feel fluid building up again in her lungs, and asked an aide about resuming her mediations. When she got no response, she asked that a nurse call a doctor to renew her prescription. She said the nurse reacted by slamming a phone against her check so hard she nearly passed out. I laid there for 20 minutes, too petrified to move." Last month, Aldrich received a letter form the Health Department informing her that the state's investigation into her case had been delayed until later this year.

Case 5 – Emotionally and Financially Exploited; Facility Denied Family Communication – Complaints Ignored by the State

"My 95 year old grandmother was emotionally and financially exploited over a 4 year period. I would hate to see it happen to other people in the future. I think many of my concerns and complaints were ignored by the state and county agencies that were designed to protect her and others like her.

The nursing home that had a financial interest in my grandmother's care actually did not allow family to speak to her. They set up a password and denied us access to speak to her. I called to talk to my grandmother and they said "do you have the password?" They also did not allow us to take her out for visits!

A system exists but nobody has any authority to enforce the rules. The county agencies I spoke to after filling out complaints did not return calls. They gave zero indication they were doing anything. Our complaints were repeatedly ignored. We later found out licensed healthcare providers (Registered Nurse) made the same complaints we did and they were not contacted by any agency after they reported. These vulnerable adult reports were ignored. This should actually be considered a crime. Agencies that fail to protect vulnerable adults should face criminal liability."

Case 6 – Death after Neglect – OHFC, Ombudsman, Law Enforcement and Multiple Lawyers reported substantiated neglect – No Repercussions to Deter Abuse

"My father was deliberately abused, neglected, and finally killed by his "guardian" and the facility, while the Office of Facility Complaints, ombudsman, law enforcement, and multiple lawyers stood by.

A Special Investigator from Office of Health Facility Complaint reported "substantiated neglect" of my father when she finally showed up February 5, 2017 and yet she left him there to be killed. He died February 11, 2017. She did not even call law enforcement.

The guardian and facility were allowed the power to continue to punish/retaliate against Dad and me whenever I advocated for his wellbeing, not even letting me be with him except for a few hours.

My father was loved. He was a wonderful man who simply wanted to live a quality life with us, the ones who loved him. He needed me and I him."

Case 7 – Insufficient Care and Neglect at Memory Care Facility – No Notification of Incidents to Family

"My dad was sent to the emergency room for complete kidney failure only to find and learn that he had almost 3 liters of urine in his bladder that went up into his chest. He was wheezing and very confused. During his hospital stay, I learned that he was so constipated that he had bile coming from his mouth while having a bowel movement at the same time. He now has a permanent catheter which is causing much pain and anxiety, that leads to him pulling out the catheter and almost bleeding to death several times. He has dementia. The facility he is at now let me know that they didn't have the staff or man power to care for my dad in the manner I expected. I wanted them to treat his sores on his feet at least 3 times a day, he had bed sores on his feet after being there a couple weeks, this is new! I did leave the director a message with no response. I don't want to make it more difficult for my dad, or put him at higher risk of abuse by policing and complaining.

He was sent to the emergency room with the same clothing on from 4 days prior to his emergency room visit. He was so nasty and dirty!

I have been sending a CNA over to help and teach them how to care and treat and meet my dad's needs. I had to act ugly, to gain much needed attention to my personal situation concerning his welfare, care and needs.

I spoke to my father one evening and I asked him "Daddy How Do You Feel?"

His response was "Baby, I Feel Good And I Look Good Too" those words touched my heart, because I sent someone to properly care for him in the manner his is accustomed to, the way I expect him to be cared for and treated."

Case 8 – Death after Poor Staffing – Facility did not Listen to Family Complaints

"My mother's experience with long-term care in a suburb of the Twin Cities consisted of eight years in assisted living, memory care, and, finally, the nursing home. My mother's care was provided by a very reputable non-profit organization, but the best of intentions was no match for the understaffing and high staff turnover which negatively impacted her care and quality-of-life in the nursing home. Our family grew to believe that no one listened to or cared about our concerns regarding the importance of quality-of-life at the end of life."

Case 9 – Decline in Health after Neglect – Family was not contacted after fall or Health Problems

"My Grandfather suffered a stroke after my Grandmother's death. As a result, we had to move him to an assisted living facility. When he went in, he had some difficulty with searching for words and was a little unsteady on his feet. His decline began gradually and then picked up speed. I was concerned about the changes and urged my mother to make an unannounced visit.

We found that my grandfather was being left alone in his room. If he didn't respond when it was time to eat, they just left him there. He had fallen but no calls were made to us when it happened and we likely would not have known if not for the sudden visit. By the time we moved him out of the assisted living, he was wheel chair bound and completely non-verbal. The nursing home worked one on one with him and made some progress, but he never was the same. It breaks my heart to think of people treating seniors in this way."

Case 10 – Abused by Caregiver – Limited Family Contact and Caregiver Threatened Resident to not Report Abuse

"My mother was a vulnerable adult and was abused be her caregiver. She was competent but so afraid of the consequences she refused to report it. She was cut off from all other family contact. The county provided prior notification of any visits which allowed her caregiver to scare her and prepare the home/responses before the visit. Sadly there was no help from any county or state group. She eventually died, most likely from neglect - not getting prompt attention to her health issues."

Case 11- Resident Shares First Hand Experience with Neglect in Facility

"I was in a facility in the Twin Cities for cardiac rehab after open heart surgery. I was only allowed a shower once a week even when I asked for daily showers. I didn't get clean towels & washcloths daily. I had wounds that needed to be cleansed daily, and proper soap wasn't provided, and I got an infection. Other residents had dirty hair, and weren't kept clean when they couldn't care for themselves."

Case 12 – Facility Limits Residents Decision to Use Self-Protection

"I was in a care facility and while sitting in a wheel chair I was getting sleepy. I knew if I fell asleep I would fall to the floor, so I put the body strap around the back of the chair too. They saw it and removed it and gave me a shorter belt that would not reach around the

chair. It should be my decision to protect myself. Let's use common sense. I know they were afraid a possible investigator might see it. I offered to sign a note stating I chose to belt myself in. But the reply was "no"."

Case 13 – Death after Neglect – Only in Facility for Twelve Days

"The facility employs young people with no training to take care of the elderly. My husband was there for 12 days and the intact person I talked to told me that every concern I asked about would be taken care of by the care taker. It was not. He never got a shower, his toilet was always full of feces and his teeth were never fixed so he could eat. We went to pick him up and he was unable to talk, walk or anything. He died a few days later. Bad place."

Case 14 – Family Member Financially Exploits Vulnerable Adult

"In the case of my mother, I checked the facility out myself and asked community leaders what they thought about the place. In this instance, it wasn't the facility staff that caused issues, but her financially-dependent verbally-abusive "boyfriend" (who wanted to take her back home and regain control of her checkbook) and a male client who was a bully at the dinner table. I took care of both situations by addressing the social worker on staff."

Case 15 – Staff within a Facility lists Examples of "Care"/Abuse Witnessed

- Staff repeatedly refused to give a pillow to a patient to elevate her foot. The patient had a pressure wound on her foot and protocol is to elevate the foot to prevent additional pressure.
- Staff refused to give water to patients. When water is provided, it is put in a place where the patient cannot reach it unassisted and there is no assistance. Staff will tell you that they withhold water to reduce the need to toilet. (Multiple Facilities)
- Staff put a patient in a disposable diaper that was far too large for the patient's size. The staff told the family they did that because the larger diaper "held more." The patient was left in the diaper so long he ended up with e-coli.
- Verbal abuse and humiliation of patients with dementia (Multiple Facilities).
- Patient was stripped and put naked on the toilet, handled roughly, doused with water. When the patient behaved badly during this "bath", the staff demanded that the patient's anti-psychotics be increased.

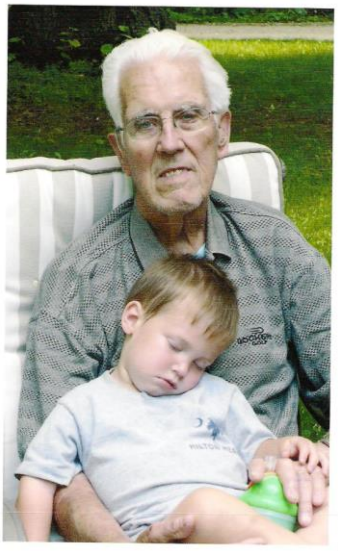
There are regulations and "standards of care" that would suggest that none of these things should happened and yet they are a common occurrence.

elder voice
FAMILY ADVOCATES

Member Experiences - Examples of Abuse and Maltreatment

The following are some of Elder Voice member experiences at various senior living, home care and long-term care facilities. Many members, however, have not felt they could contribute their story in any public manner because of fear of retaliation; legal action they are pursuing; or other family concerns.







These are photos of three family members who suffered from maltreatment and neglect at some of these facilities.

Case 1 – Death after Neglect

After months of concern for the care being given a mother at a memory care facility and numerous care conferences with the provider, the family installed a video camera. Within three days of installing the video camera the family had clear evidence of multiple incidences of gross neglect and abuse including not being fed, given water, cleaned or moved for 16 - 18 hours in a stretch.

The family first reported the abuse and neglect to the Vice President of the organization by showing him the videos. The family was promised that the organization would report themselves to the Minnesota Department of Health (MDH). After two weeks of silence by the facility and MDH, the family suspected the facility self-report was never filed, submitted their own report and sent it certified mail to MDH. Following up with MDH two weeks later the family learned the report had never been reviewed or recorded as being received. The facility continued to ignore emails and phone calls from the family after the video camera documented further neglect of their mother's care which included daily cares and escorts to meals.

Their mother was placed in hospice after significant weight loss that was undetected and/or ignored by the caregivers and the facility. The family made the decision not to use the hospice associated with the facility and went to another hospice provider. Within days of hiring the other hospice provider, an email was received from the executive director threatening continuation of substandard care.

MDH substantiated the complaints filed by the family and the results were published to the Minnesota Department of Health website four months after their mothers' death and almost 7 months after the complaint was initially filed by the family. No documentation of the report, the facility stated they filed was ever discovered.

Case 2 - Amputation of Legs Resulting from Neglect at Skilled Nursing Facility

A member's father lacked proper treatment at a skilled nursing home that resulted in the amputation of both legs below the knee. He was admitted to the hospital for blood sepsis and life-threatening bone infections in both of his feet/calves as a result of pressure wounds that were not properly treated in the skilled nursing care facility.

This case was reported to the Minnesota Department of Health (MDH). It was evident that very little time was spent on finding the truth and the department concluded that maltreatment was unsubstantiated. The finding was then appealed and solid evidence was provided to support the fact that each of the MDH reasons were NOT accurate. The factual evidence, including photos, supported the abuse and neglect.

Case 3 - Death from Untreated Emergency Condition in Assisted Living

This is a case of failure to get adequate medical care for an emergency condition, which resulted in death. The assisted living staff were aware of the emergency condition and the symptoms to look for, yet they did not assess him adequately or call 911 when there were clear signs of serious problems. His stomach was bloated and swollen; he was vomiting and had explosive diarrhea. He screamed for help in the morning and no one did a thing. The daughter came unexpectedly and found her father in extreme pain and in critical condition. 911 was immediately called and he died later that day.

He was in relatively good physical condition before this incident. The state found the assisted living provider was neglectful in their care.

Case 4 - Resident Repeated Attacks, Medication Errors

One of the main reasons my sister and I are so involved in our parents' care at their assisted living facility is because of the many 'misses' – with basic medical care. One example is the administration of the wrong medication or non-administration of a required medication for both our parents.

However, these PALE in comparison to the following events. A resident entered my mother's bedroom, refused to leave and hit her more than 1 time on the head with a plastic bottle. She told me these blows hurt very much.

I thought we should report this incident as an assault and contact the Police Dept. The Director of the facility counseled me against doing so, as it "would be too disruptive". She promised she would take immediate action to stop/prevent the problem from happening again. I found out a few days later, the action was to install a temporary 'companion' with the resident who assaulted my mother, so he could not wander the hallways any more.

He again entered my mother's bedroom. A nurse confirmed he was "very restless last night and entered several other resident's apartments, prior to entering my mother's room." The nurse also told me she locked the doors of the residents' room that the resident had already entered, but did not feel the need to lock my mother and father's room because "I didn't think he would wander that far away from his own room."

After the 2nd event I hired a 'guard,' at my expense, to sit in front of my mother's room, during the evening times when the resident was often wandering and restless (7:30pm – 11:30pm for several days). During the guard's employment with me, there were at least 3 times the guard was required to chase him away from my mother's front door. Another task the guard was responsible for was to make sure the nurses or aides locked my mother's door when they left. There were at least 5 times the nurses or aides forgot to lock the door, and the guard then made sure her door was locked, to prevent a 3rd assault. On Sept 1, 2016, my mother moved away from the facility.

Case 5 - Sexual Assault in Memory Care Facility

In June 2014 a mother with dementia was the victim of sexual assault by another resident at the facility where she had lived. This assault was witnessed by staff and reported to MDH. Even after the report, the perpetrator (who had no diagnosis of cognitive deficit or dementia) was not removed from the facility for 5 days until the family secured a temporary order of restraint.

A maltreatment report was filed with the MDH. However, the family has yet to be informed of any investigation completed by the MDH.

Case 6 – Caregiving Company Authorized by County Appointed Guardian Fails On Many Fronts

Guardianship fraud seems to be absent from the conversation about elder abuse, but third-party, court-appointed guardians have total power over an individual. Though the intent is to protect an

individual and their assets, this process often allows quite the opposite to take place. A ward of a guardian has fewer rights than a criminal. One can be stripped of his or her right to determine their residence, the right to marry, vote or apply for government benefits. The guardian decides where you live, who can see you, and who takes care of you to name just a few.

My 92-year old step-mother lived in her own home with a guardian as overseer. Her actual care was provided by a home health-care company for more than three years. During that time, multiple incidents occurred. One of the worst was when she fell and broke her ankle. She couldn't move around so the caretaker called me (instead of the guardian) to try and find a wheelchair. The caretaker's supervisor said that" since it was Friday, wait until Monday until they could reach a doctor." I went to her house, picked her up and put her in my car and took her to the ER where she was diagnosed with a broken ankle and admitted to the hospital for treatment.

Case 7 - Financial Exploitation

This is a case of the substantiated claim of financial exploitation in 2015/2016. Video evidence of the incident was provided.

The case determination was completed after 3 months. But the information was not available online for many months afterward. The facility was marketing itself as "voted best," yet the data from this substantiated claim and another from the same time period were not made available to the public.

Case 8 - Untreated Broken Leg Led to Recommended Amputation

My mother's experience in the first facility was horrific as it was for many other residents that I saw and witnessed. One of the many things that happened to my mother was that she ended up with a severe urinary tract infection, to the point that she passed out as a result of them not caring properly for her and regularly taking her to the bathroom. When I was helping her in the rest room, she passed out on the toilet. I was holding her up and pulled the cord for a nurse or aid to come in. No one came after several minutes, therefore I called 911. The paramedics arrived came into the room with a gurney and then the nurse and aids came running into the room. As a result, she spent a few days in the hospital. On another occasion, we found that they had shoved a dining room table cloth down the back of her wheelchair to soak up the urine so they wouldn't have to take her to the bathroom. They would leave her pants pulled down and use a sweater or a long shirt to cover her in front. She was only there for 3 months and something horrible happened almost every day. I got her out of there as fast as I could.

Next: we found another assisted living facility and it started out well. It is a family owned place, with the whole family involved, the wife/mother is the nurse there. As time went on, the staff started turning over and one evening, I went to visit my mom and an aid said, "I don't know what's wrong with your mom, she was screaming in pain and wouldn't let anyone touch her. She was pointing at her leg saying it hurts." The aid called the nurse and she told her to put a hot pack on it and they put her to bed. I got there and she was in horrific pain, I called 911 immediately. When she got to the hospital they took an X-ray of her leg, the technician yelled from the back,

"Oh my god!" Her femur (leg), was broken in half. She ended up with a splint from hip to toe. When she went back, hospice came to "manage her pain." They were giving her far too much morphine and I ended up calling 911 again and she ended up back in the hospital because as the ER Doctor stated, "They were giving her far too much morphine, elderly people can't process drugs the way someone younger can, with that amount, she could OD."

I got her out of there and moved her to another facility. They would put her in a lift to move her into her wheel chair and back to bed because her leg was completely broken in half. Every time they did it, her femur started coming out of her knee. I went to see her and found her lying on the bed with a hospital gown just draped over her and blood coming through all the bandages around her knee. It was the bone coming through the skin and now she had an infection. I called 911 again. She was rushed to Fairview Southdale, one of the Orthopedic Doctors who was on duty said, "You should just have her leg amputated, she has dementia, she doesn't know what's going on, it's not going to heal." I basically told him to get out of the room.

In the end, I couldn't imagine putting her in another place after the horror she had already been through. Between my brother, my sister and myself, we brought her home and I did her care until she passed away. It was my biggest mistake to ever entrust any of these places to care for her and it will haunt me until I die. It is my deepest regret. If I can change things so that no one else has to experience the horror and pain that she experienced, I will do it.

Case 9 - Physical and Emotional Abuse at Memory Care Facility

A video in a "state-of-the-art" memory care facility shows this family member being given physical care which was unnecessarily rough and being verbally disrespected. Two complaint reports were filed with MDH. The first one was substantiated and the second one, which showed videos taken with a camera, was not. The facility nurse announced at the last family care conference that the latest filing with MDH had been denied. The family had not heard anything from MDH about this denial. The family then called MDH and they confirmed that the case had been denied. Why did they notify the provider of this denial and ignore the family?

Case 10 - Gross Negligence and Abuse

A family member's mother had fallen at her long-term senior care residence, fracturing her shoulder. It was determined that she should be transferred to another provider that could give the additional care required while recovering from her fracture. Almost no other local providers would accept the mother due to her dementia diagnosis. She was therefore transferred from the hospital to this temporary care center until she could return to her long-term care center.

The cleanliness of the facility was poor. The family often found the mother wearing the same rumpled clothing that she had on the day before. She was not being bathed and on several occasions the family found a meal tray left sitting in front of their mother for several hours. No one had stopped by to pick up the tray or to offer to help her eat—in spite of having a fractured right shoulder that left her unable to manage silverware or cut the food.

When the mother was transferred back to her long-term care center and the nursing staff gave her an exam they noted that her buttock area was enflamed and raw from being left in wet Depends®. They also noted her unclean skin and ordered medication to treat her buttock area. The nursing supervisor informed the daughter that she would be reporting the other senior care center to the MN Department of Health and that she was obligated to do so because of the obvious neglect.

The family also wrote a lengthy complaint and sent that to the MN Department of Health. They were told that the complaint would be investigated. It took one full year to receive the report on the complaint. The MDH investigator said there wasn't sufficient evidence to prove neglect but later noted on the report that there was concern regarding this facility.

Case 11 - Neglect, Abuse Resulting Hospitalizations and Retaliation

My mother was moved into a senior living facility. She was repeatedly admitted to the hospital with urinary tract infections, cuts and bruises over the next months. There were continual serious errors in giving her the medications or never giving them to her. Dietary orders were not followed by the staff. They ignored her and when she was sick or in pain, they often did not give her Tylenol or heart medication. One time she collapsed and was seriously injured because they hadn't been giving her the heart medication. Another time, my mom said that when she was having chest pain they refused to give her any Nitroglycerin. I gave her one. Another time my mom was complaining of tooth pain. When I got her in to the dentist the next day, we found out that she had 3 abscessed teeth. The oral surgeon said that she had been getting poor help with cleaning her teeth.

After repeated falls, medication mistakes and numerous other poor care that resulted in several hospitalizations in a year's time, I had a confrontation with the nurse. Soon after that I got a call from my brother stating that mom was acting up and could I go. I was there in 10 minutes. The police arrived because the facility wanted her to be taken out of the facility because of her behavior. The whole time this was happening my mom was calm and quiet. When I took her to a hospital it was found that she had narcotics in her system that were not prescribed to her. Then, when they tried to place her in the geriatric psych unit, they wouldn't take her because she was calm the whole time.

She was returned to the facility because there were no open beds elsewhere. They met with the family and they blamed me for the narcotics and I was not permitted to have any contact with her. Finally, after six months my beautiful mother succumbed to her injuries.

Case 12 - Theft and Pawning of Valuables

Instances were caught on camera showing aides stealing cash and valuables from a mother's room. In working with the police, it was learned they found that the aide took the valuables to sell at a pawn shop. Her case went all the way to the Attorney General. It was substantiated by MDH but the findings were never put on MDH website, so this information is not available to the public.

Case 13 - No Wellness Checks as Guaranteed, Body Left for One Week

An independent living facility that also offered assisted living and nursing home care, told the family that they would do a same day wellness check if the father didn't come to a meal. They didn't do this. His body was not discovered for one week, even though he hadn't been to one meal during that period of time, his newspapers were piling up outside his door and another resident asked them to check on him. The family doesn't know how long he laid there before he died but the condition of his body was horrible.

Assisted Living facilities have limited governmental oversight, therefore there was no recourse for the family to assure that the provider corrected their procedures to prevent this from happening in this facility or another provider facility.

Case 14 - Under Staffing and Pay Lead to Abuse

My Mom suffered neglect during her stay in a nursing home. "I think the issue that needs more attention is the staffing of nursing homes. Both the proper number of staffers but also staff pay. Better pay would mean better staffers.

Case 15 - Disregard for the Dignity of The Elderly and Devaluation of Their Life

I am a baby boomer who saw a parent through various stages of elder "care." My parents are both deceased but I care deeply for those currently facing this epidemic and for all of our future elders. The thing that keeps sticking in my craw is that, if people behaved with decency and respect in the first place, we wouldn't be having to work so hard to legislate it. Where is it written that at a certain age, you should start to be treated like trash?? This includes hospitals. I know it's mostly about administrative and money, but they are so eager to get rid of these old people before they spend too much time and money on them. I'm not the only one where their parent was trashed and let die without consent and before their time.

Case 16 - Neglect and Complaint Received No Follow-up

Mother was an elderly woman with mild dementia and we believed that the facilities' caregivers found it acceptable to neglect her because they didn't believe she had the capacity to relate what happened. Unfortunately, when she did report different episodes to us and demanded answers, the facility discounted her reports saying she was mistaken or confused.

One morning we found her in a wheelchair in the dining room, slumped over her untouched cold food and crying out in pain. The women at the table said she had been sitting there for a long time, crying, and with no one coming to help her eat or give her pain meds. We located a nurse who finally gave her medication and an aide then offered to help feed her.

Another day we came at 10 AM to find her in her darkened room, in bed, still wearing the shirt and bra we had dressed her in the day before. Upon pulling off the blanket, we saw no pants and only a bath towel stuck between her legs soaked in urine! Appalled, we immediately called for help. The aide informed us that she had come in to work at 6 AM but hadn't had time to help her

yet. It was 4 hours later! She had not been seen, offered breakfast, or moved since the night before! During her short stay there, she also developed a decubitus ulcer on her coccyx. Even though we filed a report with the state regarding the neglect, there was no follow up by the facility or state.

Case 17 - Financial Exploitation and Theft, No Government Protections Available

We have evidence that my father's cash assets were mysteriously changing in favor of his attorney-in-fact (AIF). The financial institutions seemed to slam their books shut, and claimed undocumented changes were done "electronically". It's very hard to believe that the 89 year old senior was doing anything electronically.

My father had kept very meticulous, handwritten records. These records were claimed to have been destroyed by the personal representative (P/R), who had also operated as the AIF. All of this was done after he was determined to need help with banking. The power of attorney document on file, at the Credit Union, had a 3rd stipulation stating his AIF could NOT take ownership of any of his property. Yet, as P/R, she walked away with an undisclosed amount of the Elder's assets, including a $96,000 transfer to a "ghost" account. The financial institutions were able to seemingly slam their records shut, and claim the Elderly, vulnerable adult, with Alzheimer's/Dementia was "clear".

I have submitted reports and complaints to several authorities throughout the State of Minnesota, including the Attorney General's office. I have filed 3-4 complaints to Adult Protective Services (APS), to no avail. My latest report was to Consumer Protection to their Elder Abuse task force. From there, the investigator was to be forwarding the information to Adult Protection. I also spoke with Law Enforcement, who was later denied consent for a criminal investigation. Yet, apparently, in Minnesota, the laws are rather archaic, the standards are nearly as low as being able to fog a mirror and/or sign an X (this worked as a loophole, allowing the wrongdoer to walk away with the undisclosed amount of the Elder's cash assets). Aren't "electronic" changes, to elderly vulnerable adult's assets, without supporting documentation, a crime?

Case 18 - Improper Medical Transport Resulted in Severe Trauma, No Investigation

My mother was a victim of abuse from the employees. I have spent countless hours making phone calls and writing letters to plead my case and find resolution to what happened to her before she passed. In desperation I contacted Fox 9 Investigators and Jeff Ballion aired our story on May 2, 2017, 'Ride from hell.'

A few days after hip surgery, she was strapped to a gurney and loaded into a medical transport van for a 36-mile drive back to her nursing home. Because of her dementia, having had anesthesia and being with a stranger she was very scared and confused. She got very agitated and started thrashing around causing serious injury and trauma. It looked like a wild animal had gotten a hold of her hands. That lasted the entire ride and continued at the nursing home. I wanted to be with her, but they never let me know.

Mom never did recover from the ordeal. She passed away two weeks later.

The Department of Health never did an investigation even when other healthcare professionals verified the claims. The health department reviewed the records and determined there were no violations of state or federal regulations, even though they never met with hospital staff or interviewed the driver. Without a state investigation, we will never get a full understanding of what happened to mother.

Case 19 - Poor Hygiene Care

I'm a volunteer in the senior living community in the Twin Cities area. I was asked to leave the facility after cutting a resident's hair. While this was apparently an offense, the real offense was that her hair was matted like a cat's and clearly hadn't been brushed in weeks, if not longer.

I also witnessed nurses admonishing residents for complaining about their treatment. Mind you, the residents often times hardly understood what the nurses were saying!

Case 20 - Staff Neglect Led to Suffering and Painful Death

My mother had advanced Parkinson's and lived for 1 ½ years at a residential assisted living facility. She was mobile with a walker when she moved in, was of very sound mind and excellent hearing. Of course, the disease progressed but she remained quite sharp. She passed away due to aspiration, she was 75.

Unfortunately, the conversations I had with my mother regarding the incidents I personally witnessed or my mother told me about usually ended with her asking me not to say anything because it would just make it worse or that she was worried she would end up in a nursing home.

These are some of the many incidents:

- The facility advertises a specialized home environment and that all staff are fully trained in Parkinson's patients. Many aides I spoke with had never been trained. There was no specialized eating, drinking or personal care items designed for a person with Parkinson's and the bathroom hardly had room for an aide and a resident.

- They also said that an aide was always on the lower level of the house where my mom's room was. That was definitely not true. Many times I would visit and she would be sitting at the table alone trying to eat, her care plan clearly stated she was not to eat unattended due to high risk of choking.

- She was left fully clothed, with her glasses on and dentures still in, lying on top of the covers and the TV and the lights on from about 9:00 pm until the daytime aide came in to get her up for breakfast. Mom said she called out many times, but no one came. She was very cold and had wet herself. The aide did make a report and management said that the night time aide didn't notice anything.

- I came to visit and found my mom in the bathroom on the toilet and she said she had no feeling in her legs because she had been sitting there so long. Again, she called out many times, but no one came. This would happen frequently. The aide's response would be "just go in your Depends and I'll change you, it's easier."

- My husband, son and I witnessed an aide pushing a resident in a wheelchair that had her foot wedged under the wheel, there were no foot rests. The resident was calling out that her foot was stuck and the aide responded, "pick up your feet, I am tired of your games." The resident cannot stand, walk and can hardly sit up straight.

- My mom had hospice care at the end and the day before she died hospice prescribed more pain meds. The facility nurse would not respond to the Hospice or the aide's calls to give approval for the aides to administer the new dosage. The aides were terrified that they would lose their jobs since the facility nurse did not give approval. The facility nurse stopped in 9 hours later, stating he had 24 hours to make a medication change and it didn't matter anyway!

- I was told the day before mom died that she had a large open sore on her back, pain meds would not be given sometimes for an entire day and she had fallen many more times than the staff reported. The few aides that came forward asked me to please speak up, that they did care but didn't want to lose their jobs.

Case 21 – Sexual Abuse in a Nursing Home

My grandfather was a resident in a nursing home. He had been living there for several months when suddenly he didn't want to take a bath. He had always looked forward to a whirlpool bath. I asked him why he didn't want to bath any longer and his response was "sex maniac." Clearly it had been hard for him to report what was going on. My husband and I contacted the administrator once we could identify the person responsible. The administrator was responsive about the situation and had called the individual to come into his office while we were there. The person never showed up for that meeting and never reported back to the nursing home. Hopefully, he's not working in another facility. I have heard talk about a database to track CNA's and nurses, but I don't know if that exists.

Case 22 – Physical Abuse, Cruelty and Theft

An elderly aunt and uncle (she 80 and he in his 90s) were residing in a care facility that included both assisted living in one part of the building and skilled nursing care in another. Their niece, the primary advocate and caregiver lived in another state and made regular, unannounced, visits to see them and check on their care. During a period of three years, the following things were observed:

(1) The aunt could not walk and/or transfer from her wheelchair to her bed without assistance. She had a MRSA infection in her hip from a hip surgery and sitting was painful for her. When she asked to lie down one time, they picked her up and threw her into the bed saying, "there, now you are where you want to be." Both she and her husband were afraid to comment on the abuse because they thought the staff would treat them even worse.

(2) One staff member would ram my uncle, legs first into the wall when she became frustrated with caring for him. This was reported through all the appropriate channels, but by the time an agency actually called the family to follow up on the situation (many months later), he was already dead.
(3) On another occasion, my uncle was taken to a doctor in a van. The wheelchair was not secured and during a quick stop, he toppled over backwards hitting his head on the floor. No action was taken by the staff regarding this injury.
(4) My uncle, early on his stay, was very motivated to walk and asked to receive physical therapy to help him. I repeatedly called the therapist and the facility manager requesting this therapy and offered to pay for the therapy privately. They refused and the doctor told me, "that would be like throwing money at a dead horse." He was confined to a wheelchair sometime after those requests failed.

Because their caretaker lived out of town and couldn't do weekly checks, she hired a private caretaker to visit the facility three times a week to check on and report the status of her aunt and uncle. This regular checking helped to get this couple some special attention; though during the stay there was a continual stream of little incidents.

Why didn't they just move to another facility? They were all full. Their niece had them on a waiting list for all the local facilities, but an opening never arose in four years. The aunt was eventually hospitalized due to the MRSA infection. The last insult was during her transport from the hospital to the hospice facility, her wedding rings vanished from her hand! And, of course, no one knew what happened to them.

Case 23 - Put in Hospice Against Will of Capable Resident

My Dad loved life to the full. He was 91 years young and living at home with my beautiful Mom, then 87, in August of 2016.

My twin sister and I were dedicated to helping them stay in their home, but my niece convinced my Mom to sign a hospice agreement back in about 2015 without consulting my Dad, who was still running errands, paying bills, and playing in the band. My Mom was trying her best to understand all this but what she didn't understand was that Dad could not be admitted to a hospital with this hospice agreement.

Dad ended up being transported to the hospital with pneumonia…my sister and I rushed to the hospital and told the doctors to please care for him…we'd be there in two hours from the Twin Cities to Albert Lea. The doctor said, "We have plenty of drugs to give him"…I said, "I bet you have morphine too." He said, "Yes , we do but he's on hospice so we can't treat him".

Dad said he wanted to be treated and he was signed into hospice. Dad said, "They know I want to live…Why isn't my word good enough." Dad had been released to a nursing home. The person in charge never liked Dad and she said, "I'll give him one chance to rehab and that's it." The administrators came and told her to leave. One of the medical nurses let me look at the records for my Dad and it said, "Wife signed benefit election form for Hospice, due to patient's declining

to sign due to HOH (hard of hearing). They didn't put his hearing aids in and they were laying on table. "Am I supposed to be in pain, but I'm not."

Mom doesn't remember any of these days because she was suffering from a urinary tract infection. So, I prayed with Dad and said I wanted the hospice nurse to check his lungs. She got short with me and said, 'your Dad's dying" and walked out. Adam (my son) can understand if Grandpa dies from CHF, but he can't understand how they would let him die without treating him for pneumonia.

I see no difference between this story and euthanasia…I'll never get over this.

Case 24 - Mental Abuse

I have a mother at a nursing home. I have had to work hard to get people (aides, nurses, nurse managers and directors) to realize that abuse constitutes more than something physical.

1). Mom does not want not go to the bathroom in front of men but she now has men late at nite because the female aide is either not there or is busy - and it takes a long time…..why can't a female nurse help?

This man also told my mother he was a doctor!!!!!!!!! These women are Catholic and have certain modes of modesty that they have followed all their lives - why are they forced to accept this? This is where physical abuse can occur and knowing their maladies can give them assurance that if they have the inclination towards aberrant behavior it probably will not be reported or they can lie. I have repeatedly called the Nurse Manager but she is only there on Monday, Wednesday, and Friday. They never get back to me, even when I leave message.

2). We just got done with a so-called "quarantine" because 3 people came down with flu symptoms and when tested, were positive. They required that all residents will be given the Tamiflu. It did affect Mom and so we discontinued it at day 8. Her frame of mind improved from that missing dose.

They do not let the first floor residents go anywhere - not to Mass, not to the atrium, but they are all expected to sit in their rooms and then go out to be together in small places where they can get sick - no fresh air, no sun exposure.

3). The refrigerators on the 1st floor are always dirty with dried on spills everywhere - I try to keep it spruced when I am there but at $6-8,000 /mo isn't that housekeeping's job? Not to mention the tables in the dining room. There is dried food on the sides, bottom of the table.

While these are no where near the horrible abuses that have happened to others, they are an opening of pandora's box that will lead to more serious abuses. Lincoln said, "you can judge a country by the way it treats it elderly." No abuses should occur at any time.