Addressing Elder Abuse in Minnesota Long-Term Care Settings

Public Policy Actions Necessary to Prevent and Deter Abuse

January 29, 2018

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.