Office of Ombudsman for Long-Term Care

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Governor's work group request for comment

Introduction:
Governor Mark Dayton has called for AARP to lead a work group to address concerns of abuse to seniors and improve state oversight of Minnesota's senior care facilities. Governor Dayton requests guidance for state leaders to focus on the needs of seniors who are cared for in nursing home and assisted living settings. Recommendations of the work group will inform legislative proposals ahead of 2018 Legislative Session

The landscape of Long-Term services for individuals who need long-term services and supports is rapidly changing. Many people live in residential settings other than nursing homes. These include board and care homes, assisted living, and other types of residential care communities such as Housing with Service/Assisted Living in MN (known by various names under other state laws). While the number of beds and facilities in nursing homes is relatively stagnant, the growth of capacity in these other settings is steadily increasing.

Long-Term Care Ombudsman (LTCO) programs around the country report that there are at least 58,777 of these facilities, with capacity for nearly 1.3 million residents.

Housing with Services/Assisted living (HWS/AL) facilities are the most rapidly growing source of residential care for the elderly around the country. In response to senior's preference for more home-like settings and privacy than are found in many traditional nursing homes, the residential care market has increased substantially in recent years. The idealized image is a person receiving only necessary care and services in a home-like environment while retaining dignity and autonomy however this determination has been made without distinguishing between different varieties of assisted living. There is no federal definition of assisted living but is defined state by state which allows for considerable variation.

HWS/AL facilities market to maximize dignity, privacy, and independence. These adult residential living setting are designed to be home-like and are not regulated as stringent as nursing homes. The opportunity for tenants to "age in place" with the availability of increased services as physical and/or mental conditions change. The most compelling policy arguments might be drawn from individual experiences. Many residents enter assisted living environments with expectations (justified or not) that the HWS/AL will be home for the rest of their lives. They develop friendships and relationships with other people on that basis, and the residence becomes their whole world.

HWS/AL facilities promise a new model of long-term care; one that may at times blur the distinction for consumers between nursing homes and community-based care; especially HWS/AL with memory care units.

The strengths of HWS/AL facilities may create an environment that places some tenants at increased risk for abuse and neglect. Specifically, those tenants diagnosed with dementia, advanced dementia, and mental health issues. The challenge of cognitive impairments in conjunction with minimal regulations and oversight, low staff ratios, minimal staff training, and high staff turnover puts many vulnerable adults at risk of abuse.

Recommendation: High staff turnover, low staffing, and lack of proper staff training related to abuse contributes to high risk of elder abuse. A diverse stakeholder group of government agencies, advocacy groups, people who receive long-term care services, nonprofit organizations representing minorities, providers, law enforcement, court systems, etc. should be established to set proper training standards, work to develop and implement proper training tools to prevent elder abuse.

Long-Term Care Ombudsman (LTCO):" Who are they and what is their role?

The LTCO Program was established as part of the Older Americans Act in 1978 and is administered by the U.S. Administration on Aging (AoA). LTCO programs solve resident/tenant problems. Residents and tenants themselves are the largest group who request Ombudsmen assistance in resolving complaints. Resolving the vast majority of these complaints to the satisfaction of the resident has resulted in improved quality of life and quality of care for many people of our countries long-term care facilities.

Many refer to the phrase "an ounce of prevention" in regards to the work of Ombudsmen because the work of advocates often times prevents problems or reduces problems from escalating.

Ombudsmen are charged with advocating for individual residents rights by identifying, investigating, and resolving complaints that adversely affect their health, safety, welfare, or rights—a function known as individual advocacy. We are also required to carry out broader functions through systems advocacy by representing the interests of residents before governmental agencies, seeking administrative and legal remedies to protect their rights, and monitoring the implementation of laws and regulations affecting residents.

Ombudsmen complement efforts of federal and state agencies who, under statute and/ or regulation, are required to protect, regulate, review and enforce quality of care.

Unanswered calls for help, improper medication administration, discharge or eviction without proper notice, lack of respect and dignity for residents, unsafe buildings or equipment—these are just some of the complaints made by some of the 2.5 million residents of nursing and other residential care facilities to state and local long-term care Ombudsmen across the country.

States Unit on Aging (SUA), in Minnesota this is the MN Board on Aging, are required to ensure a fulltime State Long-Term Care Ombudsman responsible for statewide advocacy services. The Ombudsman for Long-Term Care is a program of the MN Board on Aging. The SUA must ensure that

Ombudsmen have access to residents and their medical and social records if the resident or his or her legal representative grants permission or if it is necessary to investigate a complaint when the resident is unable to grant permission, as well as access to facility administrative records and policies.

SUA must ensure that Ombudsmen are independent and have the freedom to carry out their consumer advocacy role. Long-term Care Ombudsman programs must be separate from agencies that administer funding or services, agencies that regulate, license, or certify long-term care services and from associations of long-term care facilities.

The MN Office of Ombudsman for Long-Term Care is administratively placed within the MN Department of Human Services (DHS) however in order to be in compliance with Federal Regulation, must identify as separate from DHS to avoid conflict of interest.

Request for Input:

I. **What state and federal regulatory licensing, compliance, and enforcement requirements, do you recommend be changed to deter potential abuse and protect seniors and families from retaliation from providers?**

Expanded choice for consumers of long-term care services to live in the least restrictive environment, is one of the most important developments in long-term care policy over the past fifteen years. Prior to that time, nursing home care was virtually synonymous with long-term care, and consumers felt consigned to nursing homes when they could no longer live independently. Now, however, in-home care is much more available, and assisted living facilities are full of residents who in the past would have been living in nursing homes. The movement away from nursing homes, however, should not be made at the expense of consumer protections. Those protections are just as essential for in-home care (included in assisted living care) as they have proven to be for nursing home care.

Regulation of assisted living providers can differ dramatically from state to state, and also from facility to facility within the same state. (More than 20 names are used across the United States to describe the concept.) As some consumers have noted, “If you’ve seen one assisted living facility you have seen one”.

It is not surprising that the mixture of residents with complex diagnosis and lower standards or regulation and oversight is leading to the horror stories that pop up in news media, not exclusive to MN, across the country. Assisted living standards must be raised so that residents are ensured proper consumer protections and quality of care is sustainable.

Currently HWS/AL lacks proper consumer protections particularly for people who require care in memory care units due to advanced dementia and/or diagnosed mental illness. Ombudsmen client complaint work indicates increase in advocacy service for people with advanced dementia and/or mental illness especially when they are issued 10 day notice of termination of Home Care Services with no right to due process or to appeal the decision. The most common reason for home care providers to terminate services is no longer able to meet resident needs.

Current Home Care statute requires a provider to issue a 10 day notice with no consumer right to appeal. This creates further concern for the person because HWS/AL is governed by Landlord Tenant Law; requires 30 eviction notice. The person is put at risk of losing required home care services, more likely to receive an eviction notice with the possibility of no home care services during the 30 day eviction period, and experience additional challenges such as transfer trauma and worsening of condition should relocation be necessary. In most cases the person is transferred to a hospital psychiatric ward for assessment/treatment and notified from the provider they are not allowed to return to their home because needs cannot be met. A forced move from an HWS/AL can in itself be a significant demoralizing factor with harmful effects on a person's health and well-being.

Recommendation: Create appeal rights for people who receive home care services when issued provider-initiated service termination notice. During the appeal period the provider must continue home care services until an administrative law judge decision is rendered.

Retaliation

Laws and Statutes:

A. Laws exist to protect people from retaliation. The question is what enforcement barriers exist and is change needed to current laws in order to improve consumer protections?
   a. 1987 Federal Nursing Home Reform Law requires each nursing home to care for its residents in a manner that promotes and enhances the quality of life of each resident, ensuring dignity, choice, and self-determination. Resident Rights include the right to complain and present grievances to staff or any other person, without fear of reprisal and with prompt efforts by the facility to resolve those grievances

   b. Per MN Home Care Bill of Rights; People who receive Home Care Services have the right to be treated with courtesy and respect, and to have their property treated with respect. People have the right to complain about services that are provided, or fail to be provided. People have the right to assert these rights personally, or have them asserted by the client's representative or by anyone on behalf of the client, without retaliation. A provider must protect and promote these rights.

   c. MN Ombudsman Statute; 256.9742 DUTIES AND POWERS OF THE OFFICE. Subd. 6. Prohibition against discrimination or retaliation.
      i. (a) No entity shall take discriminatory, disciplinary, or retaliatory action against the ombudsman, representative of the office, or a client, or guardian or family member of a client, for filing in good faith a complaint with or providing information to the ombudsman or representative of the office. A person who violates this subdivision or who aids, abets, invites, compels, or coerces another to do so is guilty of a misdemeanor.

ii. (b) There shall be a rebuttable presumption that any adverse action, as defined below, within 90 days of report, is discriminatory, disciplinary, or retaliatory. For the purpose of this paragraph, the term "adverse action" refers to action taken by the entity involved in a report against the person making the report or the person with respect to whom the report was made because of the report, and includes, but is not limited to: (1) discharge or transfer from a facility; 2) termination of service; (3) restriction or prohibition of access to the facility or its residents; (4) discharge from or termination of employment; (5) demotion or reduction in remuneration for services; and (6) any restriction of rights set forth in section 144.651, 144A.44, or 144A.751.

The MN Long-Term Care Ombudsman Program is in need of adequate legal counsel representation in order to pursue legal charges when violation of Subd.6 is substantiated. To meet this need the Ombudsman Program must be adequately staffed to establish effective working relationships with legal counsel resources such as; Attorney General Office, Legal Aid, and explore opportunities of possible pro-bono interest within the Elder Bar Associations.

Recommendation (s):

- Support additional funding to increase Ombudsman staff to include fulfilling adequate legal counsel. Adequate legal counsel is needed to support not only the operation of the ombudsman program and its goals and objectives but to also pursue “administrative, legal, and other remedies to protect health, welfare, and rights of residents to include the right to be free from retaliation.

- Propose legislative changes to applicable Statutes; add provisions that allow for civil or criminal charges when retaliation is substantiated.

Staff Training:

Retaliation and the fear of retaliation is a reality in any supportive housing situation. Because retaliation can be either egregious or subtle, many forms of retaliation may not even be recognized by residents, family or staff.

While there are regulations in place which allow the people to report abuse, many people, due to their physical or mental condition and because of their dependence on caregivers, many do not feel empowered to report. In some cases it is the family member who is fearful that, if reporting an incident, the resident might be asked to leave the facility and that it would be up to them to find a new place for their family member to live.

More rigorous training about retaliation is needed for direct-care staff. Connecticut, Kansas, Massachusetts, New Jersey, North Carolina and Washington require either an hourly minimum for training and/or a passing score on a state-developed competency examination.

Providers need to be encouraged to develop best practices that support a pro-active approach with respect to retaliation issues. These include, but are not limited to, adopting a “no tolerance” policy regarding fear of retaliation and encouraging formation of internal committees to provide a meaningful and interactive in-service to staff and residents specific to this issue.

Recommendations:

- The Ombudsmen Program can serve as a referral resource for residents and staff for complaints of actual retaliation and fear of retaliation.

- The Ombudsman Program can provide and/or support continuing education to facility staff, residents, and families to define retaliation and explain procedures for reporting and responding to complaints.

- When facility staff receive reports of retaliation, plans to prevent should be part of the care plan and routinely monitored.

II. **How would you strengthen statutory definitions of memory care assisted living, and housing with services so consumers and families can make informed decisions on proper placement for senior? Do you think licensure for Assisted Living Facilities make sense?**

In theory, residents of assisted living facilities are, on average, less frail than most people in nursing homes. However, there is a fuzzy line between nursing homes and some types of residential care facilities; the levels of impairment of some residents in HWS/AL facilities are similar to those of people living in nursing homes, and dementia is common in both settings.

Residents of assisted living facilities who receive services paid by Medicaid home and community-based waiver funds must meet the state’s definition for nursing home functional eligibility, but these settings are not subject to federal regulatory requirements.

Assisted Living Standards must be strengthened. Recent newspaper stories illustrate the substandard care that too frequently is observed in HWS/AL facilities. Serious problems often are caused by a dangerous combination; vulnerable physically or mentally disabled residents with significant health care problems, diagnosis of advanced dementia, and cared for most often by staff with minimal knowledge, skill, training, and proper oversight. The management and staff of HWS/AL facilities often do not have adequate experience or expertise in providing health care, even for relatively routine health care such as the management and administration of medication.

MN Assisted Living Regulation

Reference: 2017 Assisted Living State Regulatory Review (National Center for Assisted Living)

Minnesota does not license assisted living as a distinct category. Assisted living is a definition requiring a Housing with Services registration and a comprehensive home care license. Alternatively, a provider that has a housing with services registration may contract with a separate, arranged home care agency that has a comprehensive home care license. Housing with Services establishments can also have a basic home care license to provide non-medical services, however, this license would not meet the definition of assisted living.

Staffing Requirements In order to use the term assisted living, Housing with Services establishments are required to have a person available 24 hours a day, seven days a week, who is responsible for responding to the requests of assisted living clients for assistance with health or safety needs, unless they meet the criteria for exemption for awake-staff described in MN Statute 144G.03 Subdivision 3. In addition, the licensed home care agency providing the health care services must provide all services agreed to in the client's signed service plan. There are no mandated staffing ratios.

Admission and Retention Policy
A person or entity offering assisted living may determine which services it will provide and may offer assisted living to all or only some of the residents of a housing with services establishment. Housing with services establishments and home care providers are not required to offer or continue to provide services under a service agreement or service plan to prospective or current residents if they determine that they cannot meet their needs.

In 1995, the legislature separated housing from services, requiring an establishment to provide health-related services through a licensed home care agency. Minnesota then created a registration category called Housing with Services that applies to establishments that provide sleeping accommodations to adult residents and one or more health-related services or two or more supportive services.

HWS/AL must be defined in a meaningful way and governed by standards that guarantee a reasonable level of quality. Standards should address the types of care provided, staffing levels, staff training, fire standards, and other important issues. The setting of standards should not be left to a facility's admission contract. It is unreasonable to expect an elderly individual in need of long-term care to negotiate the standards that the facility will follow.

In general HWS/AL providers set the range of services they will offer. Some providers offer only the minimum services required for licensure – meals plus limited supervision and assistance with routine activities of daily living. Others may serve residents with significant needs, including those with severe dementia and those whose care needs could justify nursing home care. Still others offer services somewhere between the two extremes, carving out certain services that they choose not to provide.

Recommendation: Establish levels of service to inform consumers and ensure staff are adequately trained and proper consumer protections are in place. Minnesota should consider establishing levels

of Assisted Living Licensure. A more effective system is to license assisted living at more than one level, with levels defined by the type and severity of the physical and mental conditions of residents that the assisted living facility is prepared to accommodate. Such a system is used successfully by other states. Idaho and Maryland have established three levels of licensure based on services offered. Arkansas, Florida, Mississippi, and Utah each have two levels.

The most significant distinction between levels is in the health care provided. In Arkansas and Maryland, for example, Level I facilities are not permitted to administer medications; in Arkansas, only Level II facilities may house or provide services to residents whose medical needs would qualify them for nursing home care. Level-of-service licensure provides information that consumers otherwise would lack. By informing consumers what conditions a facility is or is not licensed to accommodate, a level-of-service system allows the consumer to choose a facility from the desired licensure category and, in deciding among facilities, to compare “apples with apples.” Level-of-service licensure also allows states to establish appropriate standards for staffing levels and staff qualifications, special care or services, participation by health care professionals, and fire safety.

Level-of-service licensure may promote affordability in HWS/AL. It may limit the operating costs for facilities that choose not to offer more complex services. It also can limit expenses for private-pay consumers with fewer care needs, by allowing them the option of selecting (and paying for) a facility that offers only a lower level of service.

State Long-Term Care Ombudsman agree the Federal Government should take an active role in assuring that Assisted Living Residents receive quality care. The federal government has jurisdiction over numerous important aspects of assisted living, and federal funding is responsible for a significant percentage of assisted living care. In addition, the health and safety of vulnerable assisted living residents is a pressing concern.

Need for improved Disclosure Statements to better inform Consumers and their families.

States have an interest in protecting and informing consumers. Older adults and their families need information to guide their choice of available residential care settings. States may require settings to provide consumer information, typically in a document called a disclosure statement that consumers may use to "comparison shop" based on facilities' services, rates, staffing, and other policies. States should require providers to provide a disclosure statement that clearly identifies under what circumstances a person may be discharged or no longer meet care criteria and how fees may be changed well in advance to create opportunity for informed choice.

Currently, providers of assisted living services must “make available” information consistent with the contents of a model information guide, called The Uniform Consumer Information Guide. These guides should detail the cost of services, packages and fees levied by the provider. These guides are required to be updated every year, but they are not routinely seen or accessed by consumer or potential residents of assisted living settings. Providers should be required to affirmatively disclose their Uniform Consumer Information Guide to prospective resident/tenants and provide updated guides to existing residents. The Department of Health should be given additional resources and enforcement authority to ensure that consumers have access to current and accurate information about fees and services.

Currently, providers of memory care services must disclose the following prior to executing a housing and service agreement (This disclosure is called a Disclosure of Special Care Status):

- The providers overall philosophy on caring for people with dementias
- The process for assessing and updating service plans
- Criteria for deciding who is appropriate for memory care units
- Security features of the physical plant
- Staffing credentials and training specific to dementia
- Type and frequency of activities
- Availability of family support programs
- That a 30 day notice will be provided prior to changes in the fee schedule

Recommendation: Amend current statute to provide additional information to consumers, including policies and procedures related to service and housing termination, appeal rights for provider initiated service termination (if they were created), and staffing goals (e.g. how many direct care workers are on the unit, how many licensed staff, and how often they are available). Align current disclosure requirements and streamline enforcement mechanisms for proper disclosure. (Reference 2016 Ombudsman Annual Report)

III. **What are recommended 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?**

MN Office of Ombudsman recommends increased funding for MN Adult Abuse Reporting Center or MAARC. Funding to be used to increase staff and fund a statewide public awareness campaign in regards to reporting.

Ombudsman Reporting Responsibilities:

Both the Older Americans Act and Ombudsman Federal Regulation prohibit reporting of resident-identifying information without the resident's consent. By logical extension, this precludes mandated reporting of suspected abuse which discloses such information.

Congress has indicated its intent for the Ombudsman program to be a safe, person-centered place for residents to bring their concerns. Residents can be assured that their information will not be disclosed without their consent, the consent of the resident representative, or court order. (OAA Section 712(d)(2)(B)). Intent of Congress was and remains for the Ombudsman program to be a safe, person-centered place for residents to bring concerns. Residents can be assured their info will not be disclosed without their consent, consent of legal representative or court order.

Ombudsman program policies and procedures must exclude the Ombudsman and representatives of the Office from abuse reporting requirements when such reporting would disclose identifying information of a complainant or resident without appropriate consent or court order. (45 CFR 1327.11(e)(3)).

The Ombudsman program is designed to represent the interest of the resident (and not necessarily the interest of the state) in order to support the resident to make informed decisions about the disclosure of his or her own information. Residents may be concerned about retaliation if their concern is known or have other reasons why they do not want the Ombudsman program to disclose their information.

The primary responsibility of the LTCOP is to investigate and resolve complaints on behalf of residents, but the LTCO program is unique in that its goal is to resolve the complaint to the "satisfaction of the resident or complainant" as opposed to seeking to "substantiate" a complaint by gathering evidence to prove the allegation occurred. This difference means that the Ombudsman program does not have the same standard of evidence required for complaint investigation and resolution as other entities, such as Adult Protective Services, state survey agency and law enforcement. The investigation by other entities seeks evidence to demonstrate that laws or regulations were broken.

Since the Ombudsman's primary goal is to resolve complaints to the satisfaction of the resident, the LTCO seeks resolution "on behalf of a resident regardless of whether violation of any law or regulation is at issue. When an Ombudsman program receives any complaint (including, but not limited to, an abuse-related complaint), it investigates solely for the purpose of gathering necessary information to resolve the complaint to the resident's satisfaction. It does not investigate in order to officially determine whether any law or regulation has been violated or for purposes of taking official protective, regulatory, or enforcement action. The goal of the investigation is to resolve the complaint to the resident's satisfaction, but not to substantiate whether the abuse or other allegation occurred.

The Ombudsman seeks the permission of the resident and/or the resident representative to report abuse or neglect. The Ombudsman may also assist a resident and/or the resident representative to make a report to the proper lead investigative agency.

Recommendation: Ombudsman provide in-service training upon request to better inform people about Ombudsman role in reporting suspected abuse or neglect.

IV. Are there other barriers you think need to be addressed to improve the care of older Minnesotans residing in nursing homes and assisted living facilities?

<u>HWS/AL:</u>

Ombudsman learn from people living in HWS/AL facilities when eviction notice is issued the notice may not be legal. HWS/AL providers need to be held accountable to follow landlord/tenant laws to ensure if an eviction notice is issued a full rental period plus at least a day's notice must be given before they are allowed to evict anyone or require people to randomly move to a different room within the HWS/AL or to a shared room within a few days' notice.

Nursing Homes:

The Health and Human Services inspector general's office using investigative data identified 134 cases in which hospital emergency room records indicated possible sexual or physical abuse, or neglect, of nursing home residents. The incidents spanned a two-year period from 2015-2016.

Illinois had the largest number of incidents overall, with 17. It was followed by Michigan (13), Texas (9), and California (8). Minnesota had 3 cases. In 38 of the total cases (28 percent), investigators could find no evidence in hospital records that the incident had been reported to local law enforcement, despite a federal law requiring prompt reporting by nursing homes, as well as similar state and local requirements. Of the 38 unreported cases, 31 involved alleged or suspected rape or sexual abuse, about 4 out of 5.

Recommendation: Partner with Law enforcement, courts, and prosecutors, to provide staff with proper training of what not to do when abuse/neglect is discovered. For example; in the case of alleged rape this is a crime scene, how should the staff respond.

Reporting:

Nursing home employees do not always understand what is meant by immediate reporting. Section 1150B of the Social Security Act (the Act)4 requires covered individuals in federally funded long-term care facilities to report immediately any reasonable suspicion of a crime committed against a resident of that facility. Those reports must be submitted to at least one law enforcement agency (with jurisdiction where the facility is located) and the Survey Agency. Improved training on VA reporting and mandated reporting is needed.

Conclusion:

I positively recognize the efforts of the members of the Governor's Workgroup and applaud Governor Dayton for publically recognizing the importance of protecting our most vulnerable citizens from abuse and neglect. I remain committed to assist the Governor and workgroup members in any way possible moving forward.

The most important recommendation I make is a Legislative initiative that will establish a task force/workgroup to continue the work that needs to be done. The workgroup will bring forward recommendations and again I applaud the accomplishments operating within a short time frame.

I envision the task force or workgroup; comprised of people invested in protecting vulnerable adults within government, law enforcement, court systems, community members, consumers and families, etc. This task force may establish subcommittees to take a "deeper dive" into what needs to change inclusive of minorities.

Respectfully Submitted by:
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