Office of
Ombudsman for
Long-Term Care

2019 Annual Report

Covering federal program year:

October 1, 2018-September 30, 2019

This page intentionally left blank.

Dear Citizens of Minnesota;

I am honored to present the 2019 Annual Report of the Minnesota Long-Term Care Ombudsman Program. Our program, which is authorized by the federal Older Americans Act and MN Statute 256.9742, is charged with resolving problems and advocating for the rights of people who receive long-term care services and supports. The Office of Ombudsman for Long-Term Care (OOLTC) is a program of the Minnesota Board on Aging.

A few annual reports back I wrote about critical issues that needed immediate attention in order to improve quality of life for people receiving long-term care services and supports. The issues included elder abuse, lack of proper Ombudsman staff to fulfill our commitment to high quality service, and lack of proper legislation to protect our most vulnerable citizens.

This report reflects progress. I am proud of the work accomplished. The OOLTC proposed and received an increase in funding to provide additional full-time ombudsman positions. With additional staff, OOLTC is able to provide additional services to more residents, provide more education, and conduct many other important activities that improve quality of life and quality of care for residents.

The OOTLC was among a group of stakeholders who remained steadfast in effecting positive change in Minnesota's long-term care system. Stakeholders including the OOLTC met throughout the 2019 Legislative session ultimately leading to the passage of the Elder Care and Vulnerable Adult Protection Act of 2019. This new law provides much needed consumer protections, includes the right to conduct electronic monitoring in long-term care settings, and adds Assisted Living Licensure which substantially changes the current dual contract system.

I am proud of our Certified Volunteer Ombudsmen (COVs). I thank each and every one. COVs dedicate time and talent to expanding our presence. COVs help to accomplish the mission of advocating for the health, safety, welfare, and civil rights of Minnesota's nursing home, assisted living, and adult family care home residents.

Our work is not finished. Many systemic issues remain: fighting ageism, addressing the imbalance of inclusion and equity inherent in our health care system, assuring everyone has equal access to living in the least restrictive environment, and protecting individual rights against abuse and retaliation.

The foundation of our work as Long-Term Care Ombudsmen and as a society is the inherent worth and dignity of each person along with the fundamental right to be treated and respected as an individual with unique interests, perspectives, and circumstances.

Although this report covers the time period of 10/01/18 – 09/30/19; it is issued during the COVID-19 pandemic. Currently Minnesota is under a declared state of emergency due to COVID-19. The COVID-19 pandemic has created enormous pressure on the entire health care system. Possibly the most tragic impact has been on the younger and older people in long term care residential settings. Nursing homes and assisted livings are experiencing the greatest loss of life. My heart goes out to all who have suffered loss.

Cheryl Hennen

Introduction to the OOLTC

Office of Ombudsman for Long-Term Care Basics

What is the mission of the OOLTC?

Enhancing the quality of life and quality of service for consumers of long-term care through advocacy, education and empowerment.

Who does the OOLTC serve?

- 27,978 Minnesota residents living in 363 licensed nursing homes around the state
- 92,413 Minnesotans residing in 7,426 other adult care homes, such as board and care, housing with services, assisted living, customized living, or adult foster care
- Adults receiving licensed home care services
- Medicare beneficiaries with hospital access or discharge concerns
- Anyone seeking information about long-term care services

What authority does the OOLTC have?

Ombudsman have authority to do their work from many sources:

- 42 U.S.C. § 3058g, Older Americans Act (OAA) Ombudsman Program
- Minn. Stat. § 256.9742, Minnesota ombudsman statute
- Minnesota Board on Aging
- Administration for Community Living/ Administration on Aging for Ombudsman program compliance

How does the OOLTC help?

By providing information and consultation about:

- Consumer rights
- Service options
- Facility regulations

Investigating and resolving complaints about:

- Quality of care or services
- Quality of life
- Rights violations
- Access to services
- Service termination
- Discharge or eviction
- Public benefit programs
- Working with service providers to promote a culture of person-directed living
- Identifying issues and advocating for change

The work of the Office of Ombudsman for Long-Term Care is a program of the Minnesota Board on Aging that is provided free-of-charge to Minnesotans statewide.

Ombudsman Staff

Central Office Staff	Title
Cheryl Hennen	State Long-Term Care Ombudsman
Genevieve Gaboriault	Deputy Ombudsman
Aisha Elmquist	Policy Specialist
Dana Manteufel	Volunteer Coordinator
Patty Odlaug	Intake Specialist
Dave Hill	Project Manager
Jane Brink	Self-Advocacy Specialist

Regional Ombudsman	Region served
Heather Anderson	Northwestern Minnesota
Maisie Blaine	Northeastern Minnesota
Tiffany Carlson	Central Minnesota—St. Cloud area
Dave Christianson	South Central Minnesota
Lori Goetz	Southeastern Metro area
Sylvia Hasara	Southwestern Minnesota
Ann Holme	West Central Minnesota
Jamie Kunst	Central Minnesota—Mankato area
Kristen Rice	Hennepin County communities
Sally Schoephoerster	North Suburban Metro area
Emma Shepard	Northern Metro region
Brian Stamschror	Southeastern Minnesota
Dan Tupy	Central Minnesota—Brainerd area
Paula Wieczorek	Ramsey County communities
Jane Wolff	Southwestern Metro Area

Trusted

Many staff have been dedicated to serving residents for 15 or more years. Some staff are new this program year. All OOLTC staff are highly trained and effective advocates whom residents can trust.

2019 Federal Year Program Statistics

October 1, 2018-September 30, 2019—By the Numbers

4009 COMPLAINTS RESOLVED

Complaint: A concern brought to the ombudsman for investigation and action by or on behalf of one or more residents of a long-term care facility relating to health, safety, welfare or rights of a resident. One or more complaints constitute a case.

Complaints were slightly reduced from 2018's high mark:

2018 Complaints = 4264

2017 Complaints = 3318

2016 Complaints = 2928

2015 Complaints = 1949

1794 CASES OPENED

1794 Cases were opened and 1472 Cases were Closed in the program year.

Case: Each inquiry brought to, or initiated by, the ombudsman on behalf of a resident or group of residents involving one or more complaints which requires opening a case and includes ombudsman investigation, strategy to resolve, and follow-up.

Case numbers have steadily grown:

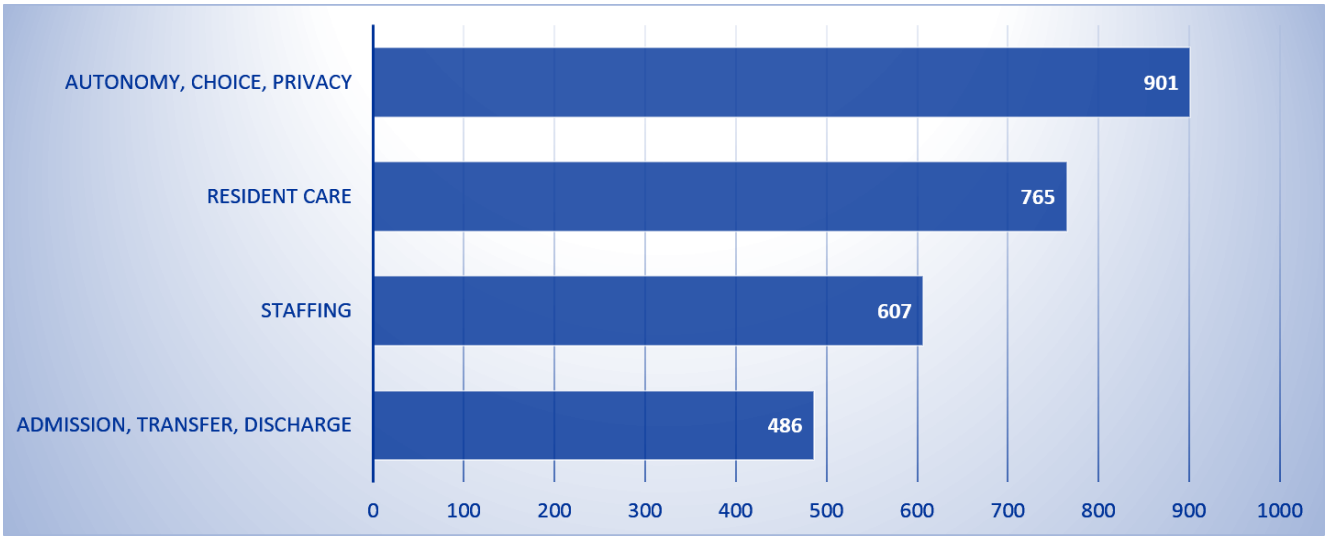
2018 Closed Cases = 1467

2017 Closed Cases = 1359

2016 Closed Cases = 1155

2015 Closed Cases = 1152

4 Highest Complaint Categories



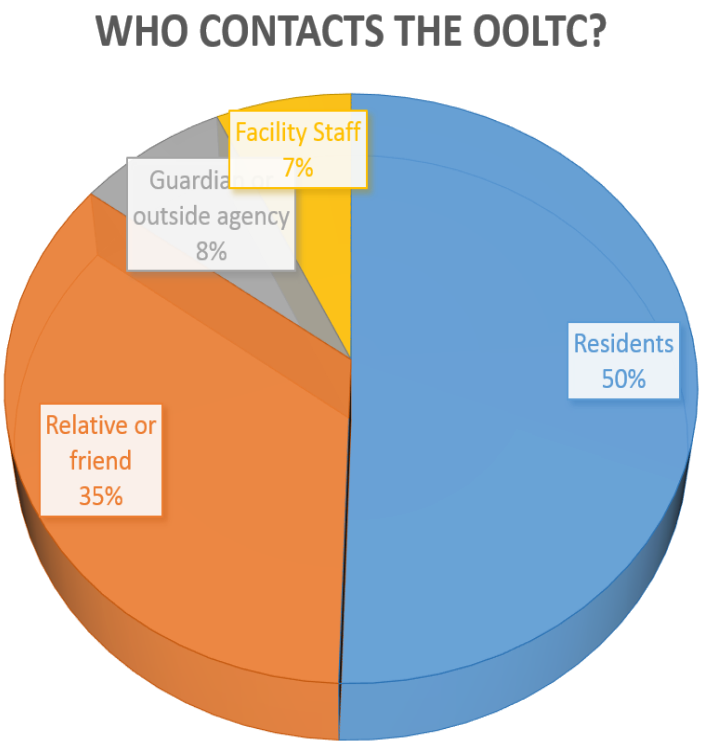
Numbers Tell the Story

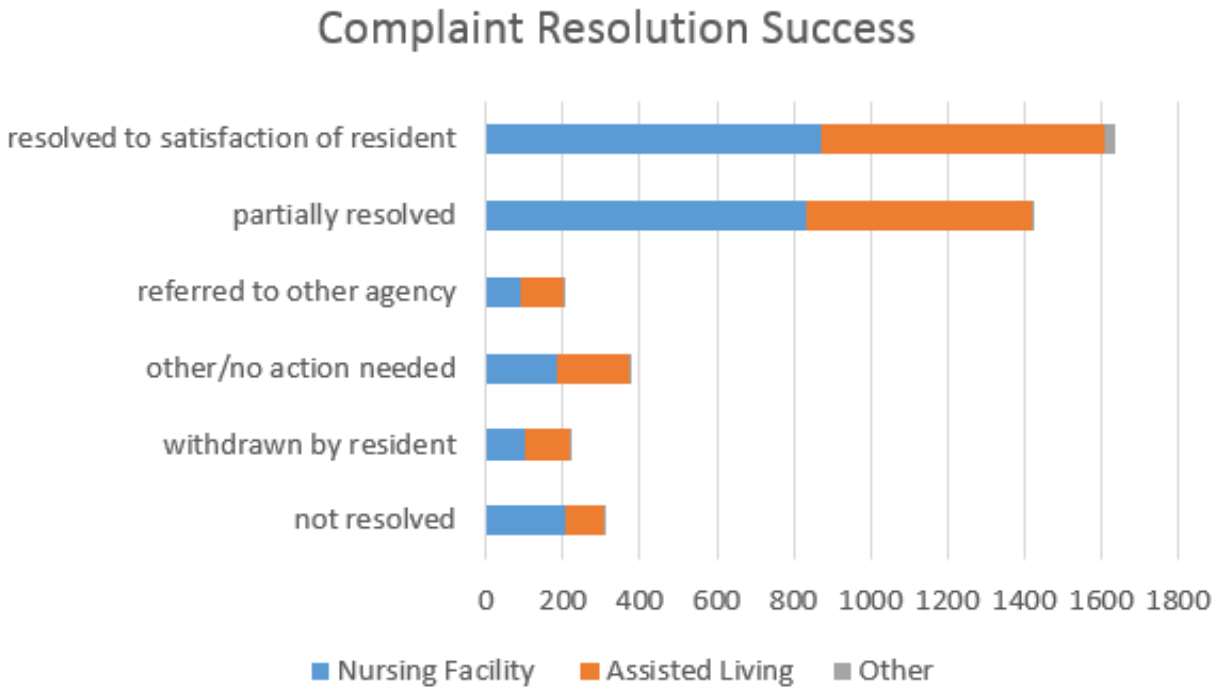
The OOLTC completed 10,000+ Activities in the 2019 Program Year

Activities are tasks that can be part of an intake, case, or a stand-alone activity

Complaint investigation and consultations are primary activities

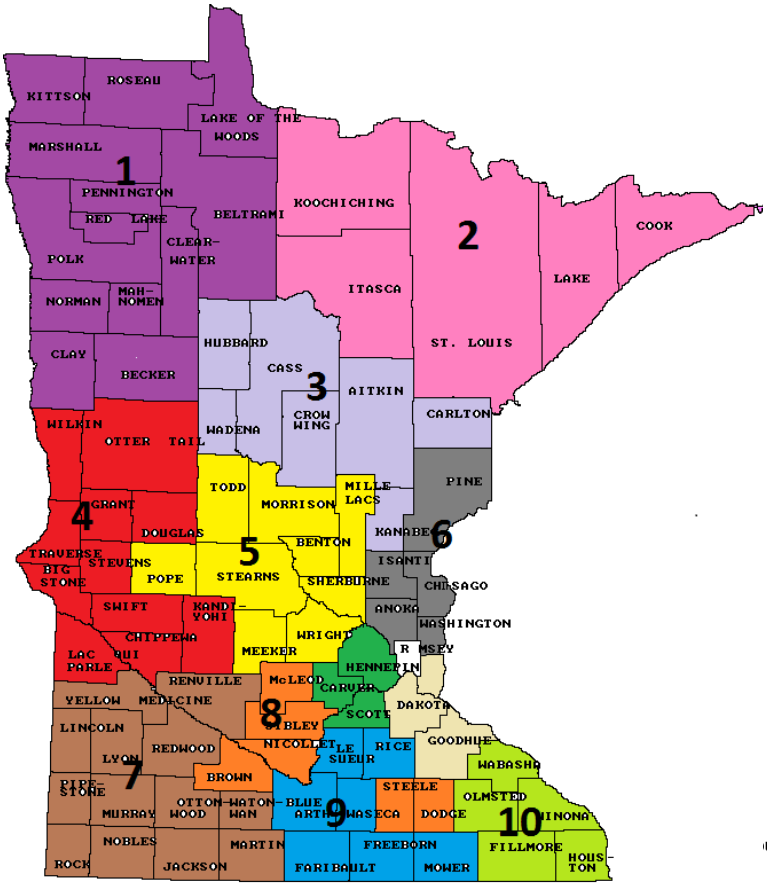
- Information and consultation to individuals: 5878 separate activities
- Consultation to facilities (providing information and technical assistance, often by telephone): 3067 separate activities
- Participation in facility surveys: 480 surveys
- Work with Resident and Family Councils: 459 meetings/contacts
- Community education: 77 sessions
- Trainings for facility staff: 83 sessions





The Role of the Regional Ombudsman (RO)

The Regional Ombudsman (also known as local ombudsman) is the OOLTC local staff who advocates alongside residents to solve problems and concerns.



10 ROs in Greater MN

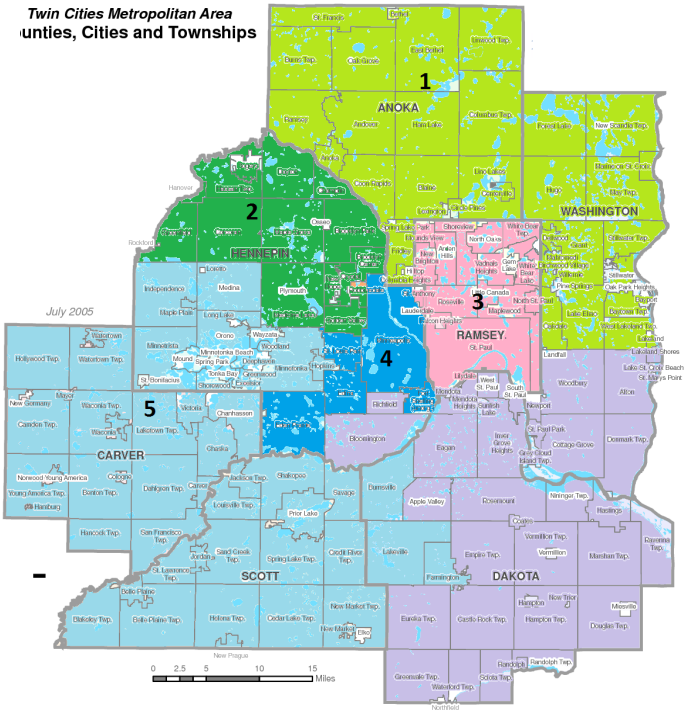
RO regions are determined by many factors including the number of nursing homes and beds, the number of assisted living facilities and beds, and the location of regional offices.

ROs are responsible for handling all of the complaints for long-term care (LTC) residents who reside within their geographic region. ROs also provide education to LTC providers, community education in their region, and support for their local resident councils and family councils.

5 ROs in the Twin Cities

Population density is another factor for how regions are determined. The metro ROs have much smaller service areas by square mileage than greater MN ROs. Metro ROs served at least 10,000 residents in each region.

ROs around the state work closely with each other to share ideas and new case trends.



OOLTC Helps Resident Stay in his Nursing Home

Case Highlight #1

A Regional Ombudsman (RO) worked with a male resident of a nursing home who was threatened with involuntary discharge. The client has a court-appointed guardian to help him make decisions about his cares and his living situation. The resident lived at a nursing home in rural Minnesota with extensive care needs including tube feeding, one-on-one assistance with transfers, and assistance with walking. The nursing home issued a notice of involuntary discharge stating that they could not meet his needs. Primarily, the concern was that he was not aware of his limitations and had many falls when he would try to stand or walk independently. The resident and his guardian agreed there were some valid concerns but wanted him to stay in his current home and improve his care there.

The involuntary discharge notice stated that the resident would be transferred to a residential group home. However, the residential group home that was listed on the notice could not accept the resident. When the RO tried to negotiate with the facility and requested that the involuntary discharge notice be rescinded, the facility refused. They suggested that it was good enough to find a location later. The RO felt this was a clear violation of law. How can the resident have safe discharge planning if he does not know where he will be moved?

The RO assisted the resident's guardian to file an appeal of the intent to discharge. The resident was allowed to stay in the facility pending the appeal. The RO skillfully pleaded the resident's case at the administrative hearing. The RO highlighted many issues where the facility had a duty to keep trying to care for the resident.

The judge ruled very clearly in favor of the resident based on a flawed discharge notice. The discharge notice must include an appropriate discharge location that will accept the resident. The facility cannot assist with discharge planning if there is no safe discharge location identified. The resident cannot prepare for an appeal hearing on the appropriateness of the discharge location if the receiving location is not included in the notice itself. The judge ruled that a facility that lists a discharge location that cannot accept the resident has to withdraw that discharge notice and start again. Involuntary discharge notices frequently do not have a discharge location listed. This persuasive decision will be helpful for many residents to obtain more time to work with facilities and ROs to stay in their current home or to more carefully plan their move.

In this program year, the OOLTC assisted 155 nursing home residents with involuntary discharge cases.

There are only six reasons allowed under federal law for a nursing home to be able to discharge a resident. Strong federal nursing home laws are vital tools used by OOLTC staff to help residents remain in their nursing homes.

Collaboration to Ensure Residents Feel Safe

Case Highlight #2

In 2019, an unwanted visitor entered a nursing home which resulted in an incident with the potential for harm to residents. This was quite unsettling to staff and residents in what had formerly felt like a safe space. Staff took immediate action to stop the situation and law enforcement was quickly involved. The facility is a large facility with many unlocked entry doors. These unlocked entry doors had been convenient for residents and visitors but appeared to be a security threat after this unwanted visitor event. As an immediate safety step the facility implemented a temporary plan to lock doors at 5 PM after which all visitors entered with assistance from facility staff.

The RO was contacted and asked for input and collaboration on plans to assure that all residents, families, and staff were included in assuring residents' rights to a safe environment and to be free from maltreatment were respected.

This is a large nursing home which holds resident council meetings in each of its neighborhoods. At the meetings the incident that occurred was discussed. Staff messaged that resident's safety is of the utmost importance. Residents were reminded to inform staff ASAP if they feel unsafe, fearful or feel mistreated by another resident, staff member, family member, visitor or someone they don't know. The following questions were asked of residents at the neighborhood meetings – with a "hands" count:

1. Do you feel safe here? Yes = 63 No = 1 No Response = 17
2. Are you comfortable with the temporary measure of locking the doors at 5pm? Yes = 58 No = 0 No Response = 22
3. Do you understand your rights re: freedom from abuse? Yes = 55 No = 0 No Response = 26
4. Are you in agreement that a safety committee can implement a security plan for the facility? Yes = 58 No = 0 No Response = 23

Following these neighborhood resident council meetings, a Safety Committee group met comprised of resident and family representatives, facility team members, local law enforcement, and the Regional Ombudsman. That Safety Committee reviewed the incident, reviewed the temporary safety plan and locked door status, reviewed quotes for the security systems procurement with pre-approval from the Board of Directors for purchase of cameras and equipment based on Committee recommendations. The Safety Committee also agreed that the residents' input was important on how to move forward. They decided to have residents, their representatives, and staff complete surveys regarding what would work best to secure the property.

The results of the security survey given to the residents was as follows:

- Doors locking at 6pm in winter and 7pm in summer – 25.4% of votes
- Doors locking at 7pm in winter and 8pm in summer – 74.6% of votes

The process concluded the installation of new security systems as agreed to by the Safety Committee. Lock times changed after the installation according to the resident vote. Letters were sent to families/ resident representatives and staff members informing them of the security measures. And because needs can change, the Neighborhood Resident Councils will vote annually on the door lock times. This collaborative process was an opportunity for residents, families, staff, Ombudsman, and others to work together to assure an inclusive plan to address resident safety concerns. The extra efforts to ensure that the voices of residents and their families are recognized and integrated into creating facility policy promotes the rights of all residents to a safe environment.

Enhanced Support for Residents

Two Special Projects within the OOLTC

Self-Advocacy Project:

Voicing concerns and standing up for yourself when you live in a nursing home can be scary at times. Residents may be afraid to give their opinion or ask for help because they are frightened that they will be labeled a "complainer". They may also be afraid that the people who care for them will treat them differently or even hurt them. The OOLTC, in partnership with the Community Supports Administration - Moving Home Minnesota Team, developed a self-advocacy curriculum for resident councils and people receiving supports in nursing homes. The curriculum consists of modules of topics that residents felt would be most beneficial to help them advocate for themselves. The modules are: 'Resident Self-Advocacy - What is Important to You', 'Exercising Your Rights', 'Person-Centered Care', 'Voicing Grievances', 'Awareness of Abuse', 'Understanding Retaliation', and 'Ombudsman Program is Here for You'. The OOLTC's Self-Advocacy Specialist provides these modules directly to the residents at a series of special resident council meetings over weeks or months. At the completion of the training everyone is presented with a certificate of completion and is celebrated for their accomplishment.

The kick off of the curriculum was at an area-wide Resident Council Event on August 9, 2018 and consisted of 41 individuals representing 10 nursing homes in west-central Minnesota. The next steps were to bring the training to people around Minnesota who receive long-term care supports. The groups were prioritized by residents who requested the training, residents who participated in the development of the training, Federal Special Focus Facilities, and nursing homes who received low scores on the Minnesota Nursing Home Report Card Quality of Life Survey. From August 9, 2018 to December 31, 2019 90 training modules were presented to 1,325 people. This training is available for nursing home resident councils and groups by Regional Ombudsman and Certified Ombudsman Volunteers.

Elder Abuse Video Project:

Sexual abuse in nursing homes is a nationwide problem that has received media attention in the past few years. Unfortunately, these crimes have occurred in Minnesota facilities. The Minnesota Civil Money Penalty Committee with approval from CMS released funds to train on this subject of nursing home sexual abuse. The training will focus on preventing, identifying and responding to sexual abuse in nursing homes with the provision of follow up care. This has been a team effort from the Minnesota Department of Humans Services- Nursing Home Rates and Policy division and the Minnesota OOLTC. Nationwide there has been no extensive training on the subject of sexual abuse in nursing homes so Minnesota is leading the way on this initiative.

We began on October 4th, 2018 gathering information and making contacts with experts in various fields who can shed light on this subject. In 2019 we contracted a videography company and a training and development and graphic design firm. We also secured eleven experts who agreed to share knowledge and be interviewed on camera. We consulted with all eleven experts and filmed interviews with six of these participants in 2019. Our graphic design firm created the design and theme for the training which is Detect Elder Abuse & Respond (DEAR Caregiver). The final training will be a professionally edited video with full color booklets that will guide the participants and facilitators through the material. The plan is to release this training to all of Minnesota's nursing homes in late 2020. This OOLTC developed video will become part of available trainings for all staff at Minnesota's 363 skilled nursing facilities.

Volunteers Extend the OOLTC's Reach

Certified Ombudsman Volunteers Serve Statewide

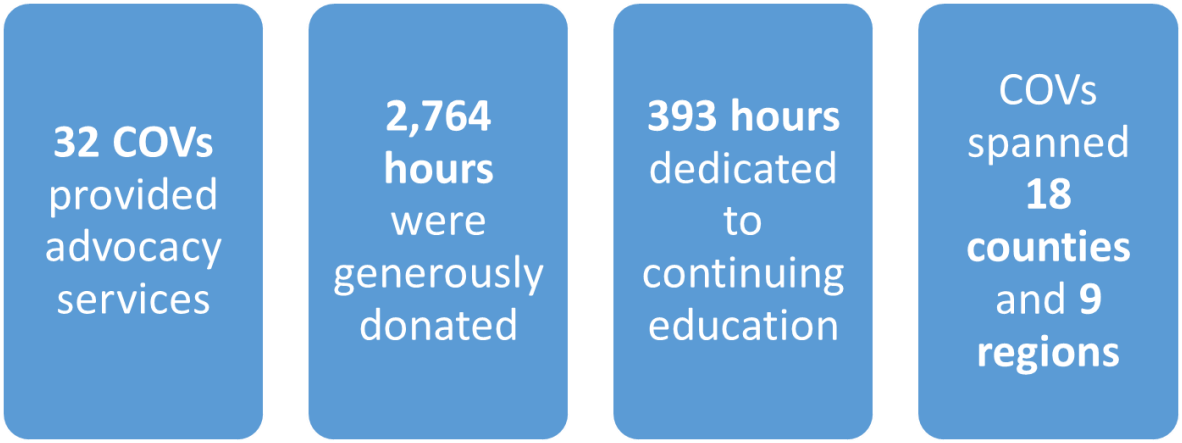
The Certified Ombudsman Volunteer Program is a service of the Office of Ombudsman for Long-Term Care. Certified Ombudsman Volunteers (COVs) complete extensive training, building a foundation that prepares COVs to advocate, empower and educate consumers of long-term care services and supports.

COVs extend the reach of Regional Ombudsmen (ROs) by building trusting relationships with residents and providing a regular presence in assigned facilities.

A few examples of the work done by COVs::

- A resident was upset following the death of a beloved roommate. The COV was able to advocate for the resident to move to a private room.
- COV provided ongoing education at monthly resident council meetings by reviewing a resident right each month.
- A resident in a wheelchair was unable to comfortably reach her clothing in her closet. She repeatedly asked the facility for assistance with no success. After the resident spoke with the COV, the COV was able to successfully advocate for the resident. The facility maintenance staff lowered the closet clothing rod to a desired height.

COV Program At-A-Glance:



COV Highlight:

A Certified Ombudsman Volunteer has been visiting their assigned facility for now the past 6 years. They COV has been a consistent presence for many of the residents residing at this care center which caters to younger disabled individuals that have rehab needs. These residents are often interested in moving to a less restrictive setting once they no longer require the rehab services of this setting. The COV has been able to identify an issue of concern over the past several months: this provider seems to create barriers that keep people in the facility longer than perhaps they need to be. The provider also sees itself as the entity that decides whether or not an individual should even be allowed to try moving out to a less restrictive

placement. The Regional Ombudsman (RO), too, has casework that reflects this situation over the past 16 years. However, the volunteer also identified the fact that this culture persists despite all of the staff changes over the years.

The COV and RO met with the administrator and the social services director to discuss the culture around residents' attempts to move out of the facility. They learned that the provider is actually not often using the programs that the state offers to individuals in care centers to help them move out (relocation services, Moving Home Minnesota, and Return to Community). As a result, those residents who are able to get assistance from the nursing home social workers are only being sent to a couple of places. In particular, one location is close to the Iowa border which is far from residents' family and friends. Residents may not be given all of the information on their rights to use an outside provider to help them relocate.

The RO and COV are actively working with the county to determine how to best advocate for residents of this care center in regards to their right to receive outside assistance in discharge planning. The COV continues to be a strong presence and is speaking to residents interested in relocating and providing them information around residents' rights to utilize outside services and the process that would best allow them to do so.

Certified Ombudsman Volunteers

Gloria Alexander	Jane Kill	Fred Simon
Dorothy Chizek	Kathy Konstant	Jim Sowles
Betty Clark	Pat Loban	Barb Spears
Larry Clausen	Ronna Locketz	Elizabeth Spohr
Sue Halverson	Christine Marcotte	Ruth Steffensen
Rose Hansmeyer	Patricia McCormick	Molly Tackaberry
Charlotte Hanson	Joy Mesia	Pat Westman
Jo Hennen	Joan Nephew	Audrey Wiita
Gary Hennen	Kathy Nornes	Yolanda Williams
Edith Hoyum	Tom Oven	Myrna Yenter
Betty Johnson	Barb Risken	

Certified Ombudsman Volunteers commit to spending at least 6 hours a month visiting residents, attending resident councils, and working with OOLTC staff to empower residents. COVs commit an additional 12 hours of continuing education every year.

Recognizing the COVs:

The Office of Ombudsman for Long-Term Care recognized volunteers of the Certified Ombudsman Volunteer program at a July 2019 statewide event in Duluth. Staff and members of the MN Board on Aging were in attendance to share their appreciation.

OOLTC Receives Historic Funding Boost

Additional Funding Will Provide Even Better Service for LTC Consumers

Legislative Funding

The OOLTC was very fortunate to be funded for an increase of 17 Full Time Employees (FTE) as part of the Elder Care and Vulnerable Adult Protection Act of 2019. For years the OOLTC has been stretched thin with a large geographic area and not enough local ombudsman staff. The legislature's focus on elder abuse was an opportunity to explain the importance of our work and need for increased state funding. The state regulators, provider groups, and consumer advocates all agreed that the work of ombudsman is invaluable to advocate alongside residents on individual complaints and also to educate residents and empower residents to advocate for better care and a better quality of life.

As part of the research to request increased funding, it was determined that Minnesota had roughly 1 local ombudsman for every 9000 long-term care residents. OOLTC had one of the worst ratios of ombudsman to long-term care residents in the country. This information coupled with the roughly 400 complaints of elder abuse filed with the state every week made a clear case that we need more staff to better serve the LTC clients in Minnesota. The Minnesota Board on Aging, state senators and representatives, and many others championed our cause. The SLTCO testified to the legislature in spring 2019 in support of increased funding. We were fortunate that the Elder Care and Vulnerable Adult Protection Act recognized our essential place in the community and funded the office for an additional 17 FTEs to be added throughout 2020 and 2021. Ensuring that this funding continues in the future will be a key to success for the OOLTC and our clients.

Staffing Update

There were 14 local ombudsmen serving Minnesota residents when the program year began on 10/1/2018. Two local ombudsmen retired in the winter of 2019 and were replaced with new staff. In addition, one local ombudsman filled a vacancy in the busy southeastern corner of the state. That brought the local ombudsman level to 15 in August 2019. With the new state funding the OOLTC was able to begin hiring for new local ombudsman positions. A new map was drawn that plans for 25 local ombudsmen, 1 SLTCO, 2 deputy SLTCOs, 1 policy person to work on legislation and electronic monitoring, 1 policy person for local policy, 1 volunteer coordinator, 1 data analyst, 3 intake staff, and a variety of other support positions. The program year ended September 30, 2019 with 15 local ombudsman on staff. Hiring continued through late 2019 and 2020 and at the time this report was released there were 23 local ombudsman on staff and more on the way.

This new funding will allow the Regional Ombudsman staff to grow from 14 to 25 in the next program year.

Legislative Advocacy

Legislative Efforts Make Positive Change for LTC Consumers

The hallmark of this 2018-2019 program year for the Minnesota OOLTC was the enactment of a sweeping new law that will positively affect our long-term care clients. The Elder Care and Vulnerable Adult Protection Act of 2019 was signed into law after a relatively short two-year rally to improve long-term care systems and particularly the assisted living system in Minnesota. The OOLTC was an integral part of the creation of this new law. Not only were favorable regulations added to protect residents in assisted living settings, but critical funding increases to the OOLTC were passed as part of the legislative session. Amidst this intense period of growth and change the OOLTC has continued in its strong individual advocacy efforts as well. These and other major issues will be highlighted below.

Legislative Update

In the winter of 2018 there was a tremendous push to redesign the assisted living system in Minnesota. Minnesota historically had a dual-contract system for its roughly 80,000 assisted living residents. The design intended that residents would have a lease with the landlord/owner of the building and would have a separate health care services contract with an arranged home care provider to provide home care services. Assisted living residents were essentially treated as private renters in apartments who happened to be getting separate health care services. Their physical apartments had little to no regulation or inspection other than what would be included in state fire codes and municipal rental license codes. Only the health care services were regulated by the Minnesota Department of Health. This led to instability for residents, confusion on who was responsible for health and safety on site, and a myriad of other problems.

As the population of vulnerable adults living in assisted living has expanded in the past 20 years it became clear that this system of limited regulation was not working anymore. Specific problems included the fact that residents could have their lease terminated with a simple 30 day notice and their home care service contracted terminated with as little as 10 day notice to end services. No relocation services were required to offer help with those transitions as people move. There were inadequate physical plant specifications, limited dietary protections, and very little definition of what it means to provide dementia care.

In the 2018 legislative session there was some progress made towards creating a new Assisted Living License for the roughly 2000 assisted living facilities around the state. Those efforts were included in a larger omnibus bill that was vetoed by the Governor in late spring 2018. It was clear that more discussion needed to occur. The Minnesota Department of Health created six workgroups to examine the idea of an Assisted Living License.

The SLTCO was the leader of the Consumer Workgroup which met regularly from September to December 2018. The stakeholders in the Consumer Workgroup included industry leaders, assisted living operators, and client advocates.

The workgroup proposed strengthening anti-retaliation language, restricting the reasons for lease or service terminations, and promoted the formation of resident councils in assisted living facilities among other topics. The workgroup also unani-

mously supported more funding to the OOLTC with an understanding that education to empower residents will help with preventing elder abuse. OOLTC staff participated in other workgroups as well including the Electronic Monitoring and Dementia Care Standards workgroups. Ultimately a group of consensus items was put forward for consideration during the winter/spring 2019 legislative session.

Stakeholders met throughout the 2019 legislative session which ran January 2019 to May 2019. Hundreds of hours were spent in small and large groups led by the Minnesota Department of Health. The OOLTC was at every discussion table lifting up the voice of assisted living residents. Luckily, the major shift between the 2018 and 2019 legislative sessions was a general agreement among all stakeholders that there was a need for an Assisted Living License. The discussion shifted from a disagreement over whether to license at all but instead how to design this new license. The new license will move from a separate lease and service contract to one contract where the resident would have one agreement for both housing and services from their assisted living provider. This was a monumental amount of work with the SLTCO and OOLTC staff being integral to the design of the new law and the wordsmithing of the law itself. The Elder Care and Vulnerable Adult Protection Act of 2019 was a bipartisan bill passed by the legislature and signed into law in May 2019 with a number of elements championed by the OOLTC and other consumer advocates. Here are some of the highlights of the 2019 legislative session:

Assisted Living Licensure:

The OOLTC used actual case examples from our complaint work to show why the previous model of assisted living did not provide enough protections for residents. OOLTC staff made it clear that there is a need for an Assisted Living License. Here are some of the key elements from the new Assisted Living License that will be fully effective July 2021.

1. Two levels of licensure were created. There will be an Assisted Living License and an Assisted Living with Dementia Care License. Residents with dementia preserve the right to choose where they wish to live and will not be required to reside in a dementia care facility. Consumers and their families will have a better understanding of what services are provided in an assisted living setting.
2. Minimum standards are set for assisted living facilities. That includes a way to request assistance around the clock, an alignment with home and community based standards for medical assistance waivered rules, and a clinical nurse supervisor who oversees cares and is a licensed RN.
3. Minimum service offerings are set such as three nutritious meals per day, culturally sensitive programs, available housekeeping and laundry, and daily programs of activities.
4. Necessary policies/procedures were created in areas such as infection control, supervision, and complaints.
5. Resident and family council standards were set such as the facility being obligated to provide space for meetings.
6. Standardized disclosures at admission were created.
7. Termination, emergency relocation, and room transfer protections were created.
8. Staffing standards such as training, staffing plans, and awake staff requirements were created.
9. Assessment standards such as initial assessments, 14-day assessments, and 90-day assessments were put in place to assure a high and tailored standard of care.
10. Retaliation protections were added.

11. Quality of care standards were set including medication and therapy management requirements.
12. Notices will be provided to residents about the OOLTC and the OOLTC will receive many documents from providers.
13. Additional standards for Assisted Living with Dementia Care including training standards, location considerations for new licensees, necessary policies and minimum requirements.

These items comprise a much stronger framework for care and services for the nearly 80,000 residents in Minnesota residing in assisted living facilities. They also address a number of the systemic issues that the OOLTC has raised as major issues in past NORS reports. Specifically, last year the NORS report included the systemic issue that residents are evicted from their homes by provider-initiated discharges and evictions. However, when the new law is fully in place, residents will not be able to be evicted unless certain circumstances are met. Also, there will be a new appeal right so that if an assisted living provider wants to terminate a care service, there will be a way for the recipient to ask an administrative law judge to have that service continue provided payment is made and other conditions are met. The new law is a monumental step forward. OOLTC is working to identify any needed technical or other changes to the law and is monitoring how the law can be strengthened to protect residents.

The OOLTC advocated strongly for the Elder Care and Vulnerable Adult Act of 2019 which was a major victory for LTC consumers in MN.

Future Law Changes

Planning Starts Now for 2021

The Elder Care and Vulnerable Adult Protection Act of 2019 includes other components with work through the next program year. They include:

1. Assisted Living Directors will have a new license and standards of education to ensure they can meet the needs of their residents. The SLTCO was actively a part of the stakeholder group which developed that new licensing process. Minnesota was one of only a few states that did not have licensure for assisted living directors. They often manage a team of staff who are responsible for care needs of vulnerable individuals. This is a major responsibility and the people served deserve the highest quality of care provided by people with proper credentials.
2. Electronic Monitoring becomes codified as a right for nursing home and assisted living residents. New requirements for notice of camera placement to facilities became effective January 1, 2020. The OOLTC will receive forms from residents and family who meet certain conditions and do not want to immediately notify the facility of camera placement. Residents will always have a choice to remove a camera if they no longer wish to be recorded.
3. Assisted Living rulemaking process will be followed throughout 2020. The landmark law does not fully go into effect until July 1, 2021. This allows for regulators to fill in the details on some of the procedures. The OOLTC policy staff have a designated seat on an advisory group working with the Minnesota Department of Health to design those rules with meetings in late summer and fall 2020.

LTC Advocacy—Next Steps

The OOLTC Looks Ahead to the Future

As Minnesota's STLCO stated in her opening letter, there was much progress made on improvements for consumers in the long-term care system in Minnesota. This annual report details and celebrates that progress. The OOLTC will continue to advocate alongside residents to improve their quality of care and quality of life. This task has been made more difficult due to the COVID pandemic which may affect LTC consumers for years to come. This 2019 Annual Report will close with a list of some of OOLTC's continuing areas of concern. These concerns are rooted in the Regional Ombudsman's daily work with residents. This list is not exhaustive but it shows some of the areas where consumers of long-term care would welcome improvement.

1) Assisted Living Licensure is a large transition and the OOLTC will continue to participate. Licensure was enacted into law in spring 2019 but there are many steps remaining to complete this process. Assisted living lease and service terminations remain a high concern for the OOLTC so it is critical to ensure that the planned protections are put into place.
2) Residents would benefit from more education about their rights as LTC residents. Residents have many ways to ask for care improvements and to offer their input. However, residents consistently share that they fear retaliation. Retaliation laws have been strengthened but it can be very hard for seniors to speak up and assert their rights when they rely on staff for their daily cares.
3) Access to long-term care is a concern. Many assisted living facilities do not accept Elderly Waiver or restrict its use which leaves lower income Minnesotans with limited housing options. Several rural nursing homes closed this program year which is disruptive to clients and gives them fewer local choices. Additionally, residents with past criminal histories may have a difficult time being admitted to LTC settings.
4) Residents consistently share concerns about quality of care. Care concerns include improper medicine administration, failure to properly treat wounds, short staffing, infection control, and preventable falls. The OOLTC works with residents and facilities to improve individual care and treatment plans.
5) There are not enough legal resources for clients who need legal help in addition to the advocacy services they receive from the OOLTC.
6) The OOLTC is growing to meet the high demand of LTC residents in Minnesota but additional funding is necessary to continue to improve access to service for individuals requesting assistance from the OOLTC.

The future of the OOLTC and LTC in Minnesota is full of good possibilities with the continued efforts of the OOLTC and all of the OOLTC's partners in the LTC community.

Office of Ombudsman for Long-Term Care

A program of the Minnesota Board on Aging

Mailing address: PO Box 64971, St. Paul, MN 55164-0971

Office location: 540 Cedar Street, St. Paul 55101

(651) 431-2555 or Toll-free (800) 657-3591

Fax (651) 431-7452

Intake Line: (651) 431-2555 or Toll-free (800) 657-3591

Email: MBA.OOLTC@state.mn.us

MINNESOTA BOARD ON AGING

Office of Ombudsman for Long-Term Care

Report published on 9/8/20. The report covers the OOLTC prior to the COVID-19 pandemic and OOLTC's efforts during COVID will be profiled in the next annual report. This annual report covers federal program year 2019 which runs October 1, 2018 through September 30, 2019. This document was prepared by Deputy Ombudsman Genevieve Gaboriault with submissions and/or editing help from SLTCO Cheryl Hennen, Deputy Ombudsman Aisha Elmquist, and staff members Jane Brink, Dave Hill, Ann Holme, Dana Manteufel, and Patty Odlaug. Any mistakes or omissions are inadvertent.