



**OFFICE OF
OMBUDSMAN FOR
LONG-TERM CARE**

Annual Report

2016



Dear Citizens of Minnesota:

I am honored to present the 2016 Annual Report of the Minnesota Long-Term Care Ombudsman Program. This report highlights; program success, problems experienced by consumers of long-term care, and defines systemic issues and recommendations for improving quality of life for those we serve.

The Minnesota Board on Aging (MBA) is the designated State Unit on Aging for purposes of administering the Older Americans Act. The Long-Term Care Ombudsman Program is a program of the Minnesota Board on Aging. As Ombudsmen we provide; a regular presence in residential settings to work with consumers and staff to prevent problems, a means to help consumers resolve disputes informally with providers, provide education to enable consumers and caregivers to become self-advocates, and advocate for change at a policy level to address systemic problems.

We serve consumers who receive long-term care services in nursing facilities, home and community-based settings such as housing with services (assisted living), and their own private homes. During the reporting period the Office of Ombudsman for Long-Term Care resolved 2,473 complaint investigations from consumers about long-term care services, provided over 5000 sessions of consultation and information, and worked with at least 274 resident councils in nursing homes.

In February of 2015, the Administration for Community Living/Administration on Aging (ACL/AoA) published the Long-Term Care Ombudsman Programs Final Rule. Over the last year the MN Ombudsman program reviewed and revised program policies and procedures to meet compliance with provisions of the Older American's Act. The Final Rule guides implementation of portions of the Older Americans Act that govern Federal grants to states for the operation of Long – Term Care Ombudsman Programs. The MN Ombudsman Program did achieve compliance with Federal Regulation.

It is often said the only thing constant in life is change; the MN Ombudsman program is ever-changing to continuously provide quality person-centered consumer advocacy. What consumers say about the work of the Office of Ombudsman for Long-Term Care: *"Thank you so much for your help, my stress level dropped 100%", "Our quality of life has changed 100% with your help."*

The work of the Ombudsman is not accomplished in isolation. With gratitude and appreciation I express my thanks to; Ombudsman staff, the Executive Director of the MBA, members of the MBA, collaboration with stakeholders, community members, and consumers who join me in the effort to improve quality of life and quality of care for consumers of long-term care.

Yours Sincerely,

Cheryl Hennen

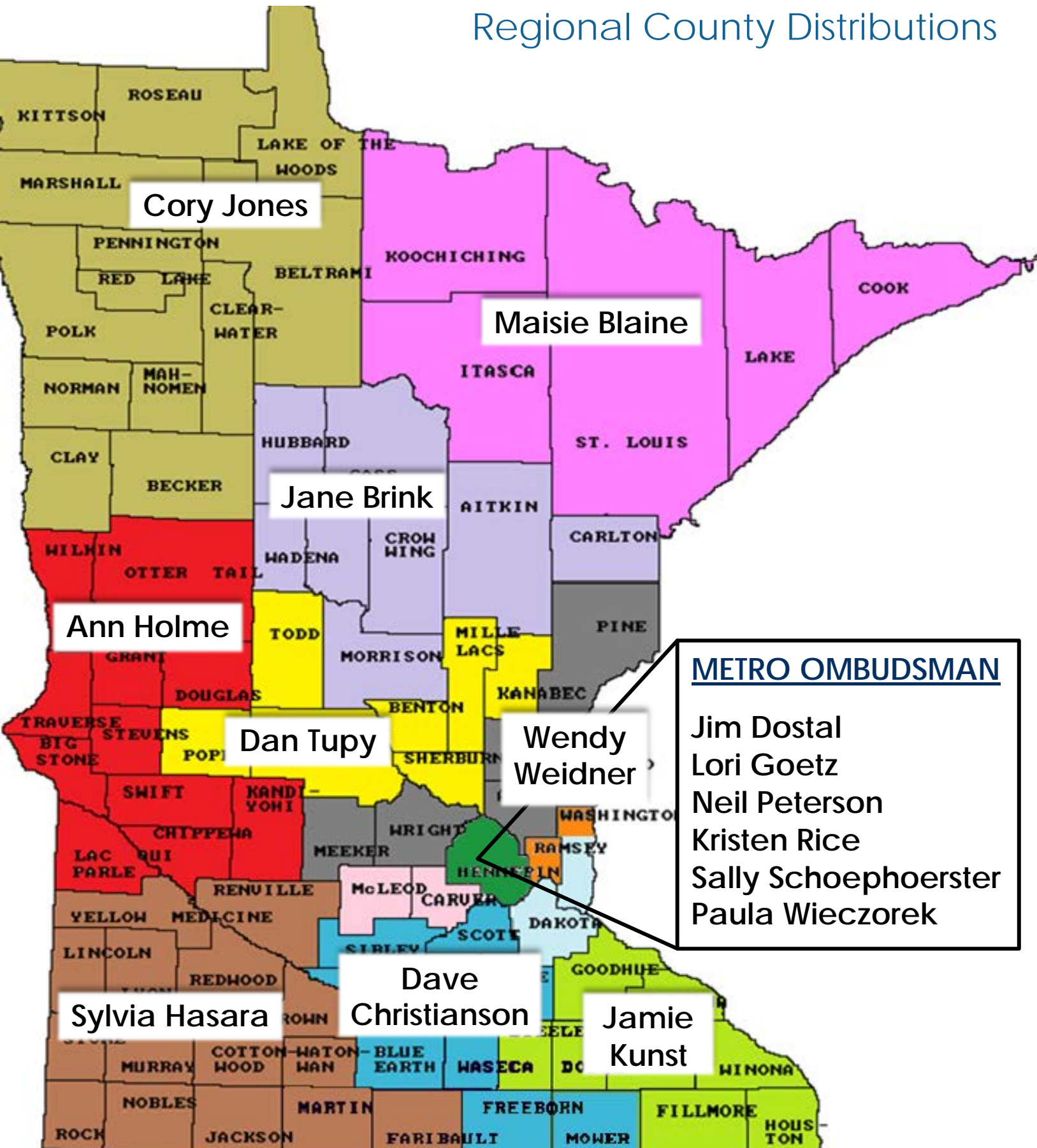
State Long-Term Care Ombudsman

Table of Contents

Regional County Distributions	4
Central Office Staff	5
Metro Minnesota Staff	5
Greater Minnesota Staff	6
What Is An Ombudsman?	7
Who Do We Serve?	7
How Can We Help?	7
Authority	8
Governance	8
 Mandates:	 8
Funding Sources	9
Mission	10
 Advocacy: Individual Complaint Handling	 10
Types of Long-Term Care Residential Settings in Minnesota	10
The chart below shows examples of ombudsman advocacy in these complaints categories:	12
Education: Ombudsman Activities	13
Systemic Advocacy and Education	14
Systemic Issues in Long-Term Care in Minnesota: Summary and Recommendations	14
 Issue: Consumers not allowed to return to their long-term care facility home following hospitalization	 16
Recommendations	18
1. Increase Provider Training and Capacity	18
2. Adapt existing resources to develop person-centered behavioral support services for long-term care providers and consumers	19
3. Build on Existing Stakeholder Work Groups	19

Issue: Lack of Consumer Protections and Lack of Transparency in paying fees or rates in Assisted Living settings.....	21
Bernie’s Story	21
Irene’s Story	24
Recommendations.....	25
 Issue: Minnesota’s Workforce shortage is diminishing quality of care across long-term care settings	26
Recommendation	27
 Issue: Lack of Consumer Protections in Assisted Living Memory Care Units.....	28
Irene L.’s Story	28
Recommendations.....	29
 Issue: Minnesotans’ Rights are Restricted by Unnecessary Guardianships	32
Recommendations.....	33
 Resident and Family Advisory Council Education (R-FACE)	35
Regional Ombudsman working with R-FACE	37
Resident and Family Advisory Council Education and Certified Ombudsman Volunteers	38
 The Volunteer Program	40
Innovative Projects in the Volunteer Program.....	43
COVs in Action: Yolanda	44
Certified Ombudsman Volunteers	45
 Long-Term Care Issues to Watch.....	46
 Conclusion.....	50

Regional County Distributions



Central Office Staff

Staff	Title	Region
Cheryl Hennen	State Long-Term Care Ombudsman	Central Office
Natasha Merz	Deputy State Long-Term Care Ombudsman	Central Office
Sarah Grebenc	Ombudsman Specialist	Central Office
Neil Peterson	Program Coordinator	Minneapolis
Josh Witte	Data Control Specialist	Central Office
Rhonda DeBough	Volunteer Coordinator	Central Office
Amy Nop	Office Administrator	Central Office

Metro Minnesota Staff

Staff	Region	County/City
Jim Dostal	West Metro	Carver & McLeod County; cities: Deephaven, Eden Prairie, Excelsior, Golden Valley, Hopkins, Long Lake, Loretto, Maple Plain, Minnetonka, Minnetrista, Mound, Plymouth, Shorewood, Spring Park & Wayzata
Lori Goetz	Southeast Metro	Dakota and Southern Washington County; & the cities of Bloomington, Edina & Richfield
Neil Peterson	Minneapolis	Minneapolis
Kristen Rice	Metro – Minneapolis	Minneapolis & St. Louis Park
Sally Schoephoerster	Metro – Northwest	Arden Hills, Brooklyn Center, Brooklyn Park, Crystal, Falcon Heights, Maple Grove, Moundsview, New Brighton, New Hope, Osseo, Robbinsdale, Roseville & St. Anthony Village
Paula Wieczorek	Metro – Northeast	Ramsey County & Northern Washington County

Greater Minnesota Staff

Staff	Region	County/City
Maisie Blaine	Northeastern MN	Cook, Itasca, Koochiching, Lake & St. Louis
Jane Brink	North Central MN	Aitkin, Carlton, Cass, Crow Wing, Hubbard, Morrison & Wadena
Sylvia Hasara	Southwestern MN	Brown, Cottonwood, Faribault, Jackson, Lincoln, Lyon, Martin, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Watonwan & Yellow Medicine
Ann Holme	West Central MN	Big Stone, Chippewa, Douglas, Grant, Kandiyohi, Lac qui Parle, Otter Tail, Stevens, Swift, Traverse & Wilkin
Cory Jones	Northwestern MN	Becker, Beltrami, Clay, Clearwater, Kittson, Lake of the Woods, Mahnommen, Marshall, Norman, Pennington, Polk, Red Lake & Roseau
Dave Christianson	South Central MN	Blue Earth, Le Sueur, Nicollet, Rice, Scott, Sibley & Waseca
Jamie Kunst	Southeastern MN	Dodge, Goodhue, Fillmore, Freeborn, Houston, Mower, Olmsted, Steele, Wabasha & Winona
Dan Tupy	Mid-Central MN	Benton, Kanabec, Mille Lacs, Pope, Sherburne, Stearns & Todd
Wendy Weidner	East Central MN	Anoka, Chisago, Isanti, Meeker, Pine, Wright & the cities of Rogers, Champlin, Dayton & Elk River

What Is An Ombudsman?

An ombudsman is an independent consumer advocate. Ombudsmen investigate complaints concerning the health, safety, welfare and rights of long-term care consumers, work to resolve concerns to the satisfaction of the consumers of long-term care services.

Ombudsmen also offer information and consultation about nursing home, boarding care home, housing with services, assisted living, customized living, home care and hospital services, rights and regulations. Additionally, ombudsmen work with providers of long-term care services to promote a culture of person-centered living.

Who Do We Serve?

- Residents of nursing homes and boarding care homes
- Residents of other adult and residential care homes
- Persons receiving home care services, including waived services and recipients of hospice services
- Medicare beneficiaries with hospital access or discharge concerns
- Anyone seeking consultation about long-term care services

How Can We Help?

Ombudsmen provide information and consultation about consumer rights and the regulations that apply to long-term care facilities, home and community-based settings, and home care services. Ombudsmen help to resolve disputes between consumers and providers of long-term care services, regardless of where those services are provided.



Ombudsmen handle complaints and problems relating to:

- Quality Care/Services
- Quality of Life
- Rights Violations
- Access to Services
- Service Termination
- Discharge or Eviction
- Public Benefit Programs

Authority

The Minnesota Long-Term Care Ombudsman Program is authorized by the federal Older Americans Act (OAA) of 1975; 42 U.S. Code, Section 3058g and MN Statute 256.9742.

Governance

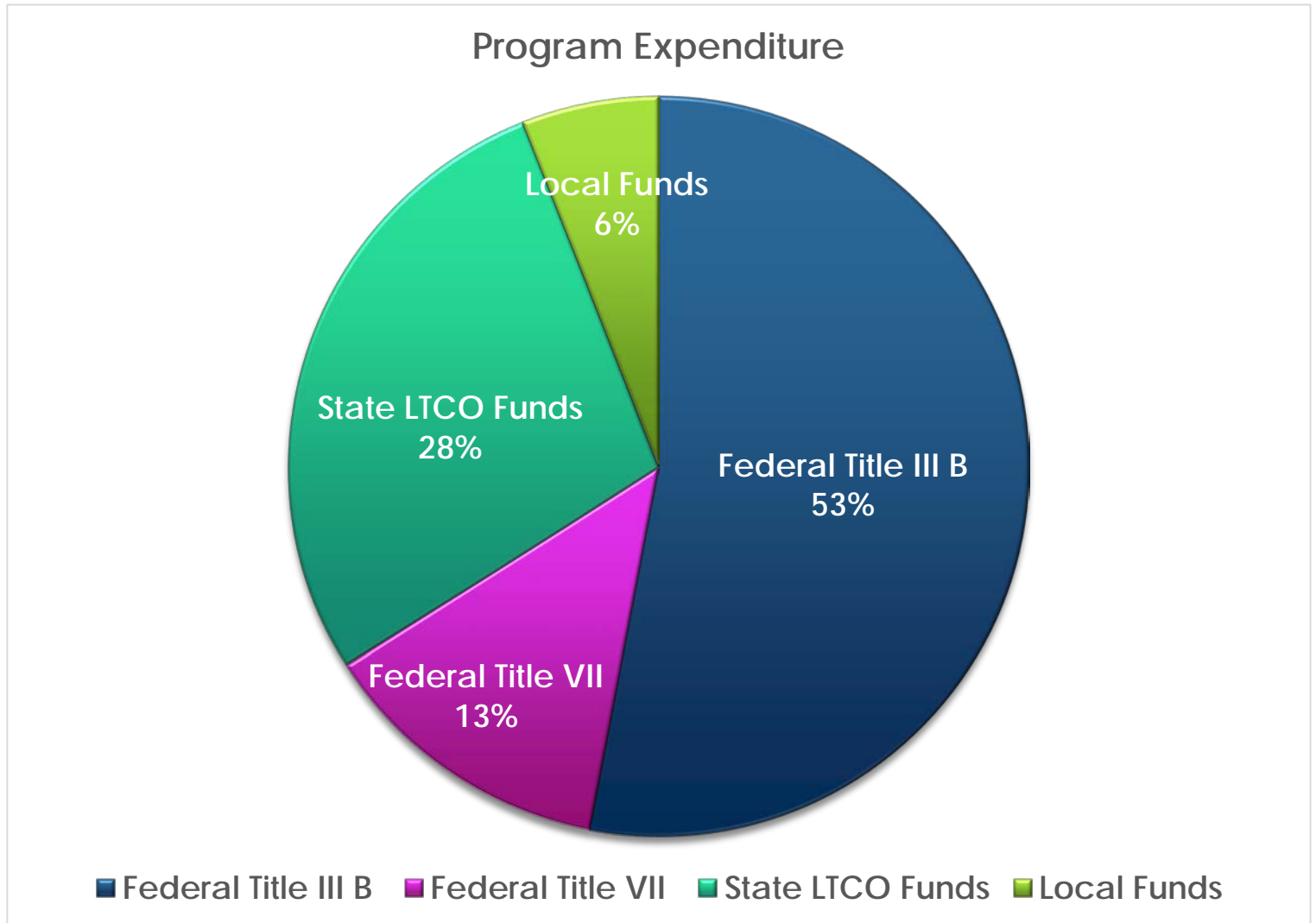
The OAA requires an Ombudsman Program in each state. Each state must identify the State Unit on Aging. The Minnesota Board on Aging; a 25 member board appointed by the governor, is the MN State Unit on Aging. The MBA is responsible to ensure the Minnesota Long-Term Care Ombudsman Program meets federal compliance on an annual basis.

Mandates:

1. The Ombudsman provides individual consumer advocacy: The consumer is the client. The Ombudsman provides problem-solving through mediation, education or referral to another agencies.
2. The Ombudsman conducts systemic advocacy: evaluates any act, practice, procedure or administrative action of a long-term care facility, acute care facility, home care service provider or government agency that may adversely affect the health, safety, welfare or rights of consumers.
3. The Ombudsman monitors the development and implementation of governmental regulations affecting consumers' rights and benefits.
4. The Ombudsman is responsible to comment on and make recommendations to public and private agencies regarding laws, rules regulations and policies affecting the rights and benefits of consumers.
5. The Ombudsman informs public agencies about the problems of clients.
6. The Ombudsman provides public education about the health, safety, welfare and rights of consumers.
7. The Ombudsman provides opportunities for volunteer and citizen participation in advocacy efforts.

8. The Ombudsman promotes and supports the development of citizen participation in the work of the office through resident and family councils.

Funding Sources



Mission

The Office of Ombudsman for Long-Term Care’s (OOLTC) mission is to promote quality of life and care for long-term care consumers in Minnesota through advocacy, education, and empowerment. OOLTC provides services to long-term care consumers throughout Minnesota.

Advocacy: Individual Complaint Handling

Regional Ombudsmen across Minnesota help long-term care consumers with complaints about violations of their rights or quality of care. Ombudsmen work directly with the person receiving long-term care services (“client or consumer”) to resolve concerns about their care, rights, or quality of life.

Ombudsmen advocate for people receiving services in their own home as well as people that live and receive services in long-term care residential settings throughout Minnesota.

Types of Long-Term Care Residential Settings in Minnesota

Table 1 - This chart shows the breakdown in types of long-term care residential settings in Minnesota

Type	Number of Homes	Number of Beds
Housing with Services	763	34,270
Nursing Homes ¹	396	31,950
Other long-term care settings ²	4,585	19,951
TOTAL	5,744	86,621

The goal of the ombudsman’s work is to resolve the concern to the satisfaction of the consumer. Ombudsmen protect confidentiality of the consumer’s information and do not take action on

¹ Includes Medicaid certified boarding care homes (NF: 28,962, B and C 1494)
² Includes 245D-licensed community residential settings, board and lodge with special services, and adult foster care bed

behalf of the consumer without permission from the consumer. Ombudsmen investigate concerns to fully identify the problem and develop potential solutions.

Following an investigation, the ombudsman seeks to resolve the complaints or concerns. The ombudsman works collaboratively with consumer and providers to reach a productive resolution for all parties. To resolve a complaint, an ombudsman may:

- Attend care conferences with the consumer
- Seek changes to the plan of care
- Develop an action plan to resolve the situation
- Follow up to ensure that the complaint is resolved

In the 2015-16 federal fiscal year³, OOLTC resolved 1130 cases, which included 2,473 complaints about long-term care services. Compared to last federal fiscal year, complaints rose roughly 4%. The most common types of complaints for this fiscal year fall into 3 main categories, or types of complaints:

- Involuntary/discharge/eviction
- Autonomy/choice/privacy
- Family conflict/ financial exploitation by a family member, substitute decision-making issues (guardianship/powers of attorney, health care directives)⁴

These three types of complaints comprise 45% of all ombudsman complaint work for this fiscal year.

³ 10/1/15 - 9/30/16

⁴ In the Ombudsman reporting system, these complaints are categorized as “systems/others” major complaint code P.

The chart below shows examples of ombudsman advocacy in these complaints categories:

Involuntary Discharge and Eviction

- Prevented unlawful discharge to a hospital by educating the nursing home administrator of the resident's right to receive written notice; assisted in care planning upon the resident's return
- Prevented loss of housing and services through negotiating changes to service plan
- Enabled resident at the hospital to return to their housing with services/assisted living (HWS/AL) after they were told they couldn't come back and no legal appropriate notice of service termination was given

Autonomy/Choice/Privacy

- Ensured that resident with dementia was able to see her children despite the health care agent's restriction of visitation
- Assisted 123 residents and families during a major nursing facility closure by promoting resident involvement in the planning process and honoring resident preferences about the move
- Assisted a resident discharging from a nursing home back to her home in the community, despite being told she had no choice
- Empowered resident to understand her medication regime by ensuring that staff provided a list with pictures of the pills

Family Conflict, Exploitation, and Legal Issues

- Assisted resident to get a Hardship Waiver to allow for Medical Assistance coverage for a resident whose daughter financially exploited him and stole assets needed to pay for Long Term Care
- Helped a resident access the court system to be restored to capacity
- Assisted Veteran in obtaining legal representation to help replace a professional guardian (with Veteran input/selection) and move to more desirable community setting
- Advocated for a victim of sexual assault to receive specialized counseling

Education: Ombudsman Activities

Ombudsman and Certified Ombudsman Volunteers⁵ (COVs) work in many different ways to improve the quality of the long-term care system; including consultations, training, and participating in the inspection and survey processes with the Minnesota Department of Health.

Other Ombudsman Program Activities for FY 2016	Number of Sessions ⁶	Most Common Topic	2 nd Most Common Topic
Training for facility staff	90	discharge/eviction	abuse/neglect
Consultation to facility/providers	1349	discharge/eviction	care issues
Information and consultation to individuals	4,470	care issues	discharge/eviction
Participation in facility surveys (inspections)	197	n/a	n/a
Work with resident council	274	autonomy and choice	rights
Work with family council	86	autonomy and choice	council development

⁵ For more information about the Ombudsman Volunteer Program, see page 41

⁶ Figures include Ombudsman Volunteer Program data

Systemic Advocacy and Education

In addition to individual complaint handling, OOLTC is also charged with advocating for systemic change to improve the quality of the long-term care system in Minnesota.

OOLTC uses the information and experiences of clients to identify the major issues affecting consumers and other long-term care stakeholders. OOLTC works with legislators, policy makers, providers, and other stakeholders to continuously improve the quality of long-term care in Minnesota.

Systemic Issues in Long-Term Care in Minnesota: Summary and Recommendations

ISSUE	RECOMMENDATIONS
Consumers are prevented from returning to their long-term care facility home following hospitalization	<ul style="list-style-type: none">• Increase provider capacity to serve people with behavior health needs• Adapt existing training and resources• Build on existing stakeholder work to develop new solutions For more information, see Jay's story on page 16 of this report.
Lack of transparency and consumer protections in assisted living fees and rates	<ul style="list-style-type: none">• Create enforcement mechanisms for provider disclosures of the costs of services and fees• Give consumers better tools for comparing quality and customer satisfaction across different providers For more information, see Bernie's story on page 21.
Workforce shortage is diminishing quality of long-term care services	<ul style="list-style-type: none">• Build on existing policy efforts to address workforce shortage by adding stakeholders• Increase scholarship funding for direct care workers to further education• Ensure that rate increases are directly increasing wages for staff directly interacting with resident

ISSUE	RECOMMENDATIONS
<p>Lack of adequate consumer protections in assisted living memory care units</p>	<ul style="list-style-type: none"> • Create appeal rights for provider-initiated service termination • Require posting of staffing levels • Enhance effectiveness of Disclosure of Special Care Status statute • For more information on a family's experience in a memory care unit, see Irene L.'s story on page 24 of this report
<p>Consumer rights restricted by unnecessary guardianships</p>	<ul style="list-style-type: none"> • Educate families, providers, and human services staff about alternatives to guardianship • Support developing Center of Excellence for Supportive Decision-making • Facilitate communication to the court for people under guardianship • For more information, see page 35 of this report

Issue: Consumers not allowed to return to their long-term care facility home following hospitalization



“Jay” is an 80 year-old man living at a metro area nursing home. He was admitted due to increased needs for support and supervision – his dementia was progressing to the point where he was no longer safe at home due to wandering, agitation, and an attempt to hit his wife while she was providing personal cares for Jay.

Jay’s wife signed an admission agreement for the nursing home’s memory care unit, as well as reviewed a plan of care for staff to help him with bathing, grooming, and meals as well as providing supervision to keep him safe.

The transition to a new home was difficult for Jay. He was anxious in the new setting and wondered the hallways most of the day. One day as he was wondering, Jay walked into another resident, causing both to fall down. Jay was sent to the hospital for evaluation. The social worker from the nursing home called Jay’s wife and informed her that they could not meet his needs and he was not allowed to return. Jay remained in the hospital for 2 extra weeks and was ultimately moved to the only available nursing home bed, which was 1 hour away from his wife and family.

This is not an unusual situation. Complaints about involuntary discharge and eviction is a common complaint category received by the Office of Ombudsman for Long-Term Care. Of

“The nursing home backed off about pushing my friend out of the nursing home. [The Regional Ombudsman] was excellent. Very knowledgeable and I learned a lot from her.”

Consumer Comment

the complaints that involve admission/transfer/discharge 67% percent involve the provider refusing to readmit the resident following hospitalization or otherwise violating resident rights by refusing to provide notice and due process for the discharge or eviction.

Residents of nursing homes and people living in assisted living settings cannot be discharged, or evicted, without notice and applicable due process rights, but some providers ignore or do not understand these rights, resulting in refusal to allow people to return to their homes.

Jay, for example, had the right to receive written notice of the facility's attempt to involuntary discharge him. He had the right, through his legal representative, to challenge his involuntary discharge in a legal hearing. Failure to abide by these rights and protections endangers the consumer's health by suddenly disrupting the coordination of care across settings. This practice also creates chaos and stress for loved ones and advocates for the consumer. Jay's wife was scared and worried about what to do when she learned the provided would not let him return. She knew that she could no longer care for him safely at home and had relied on the facility's promise that it specialized in providing care for people with memory loss and associated behaviors. Finally, this practice forces hospitals to keep consumers in already scarce hospital beds because the consumer suddenly lost his or her home and ability to access services.



While it is important that a provider be able and willing to meet a person's needs, involuntary discharge should be the last resort for providers who care for vulnerable adults. When such steps are necessary, providers should follow applicable laws and regulation and respect clients' due process rights.

This problem is not exclusive to Minnesota. Recent national media⁷ report that this issue is a symptom of a larger and more complex problem: lack of staff, training, and capacity to care for people with complex behavior or mental health needs. The Centers for Medicare and Medicaid Services (CMS) also recognize this growing problem in nursing homes. Recent enforcement

⁷ ["Dumped: When Nursing Homes Abandon Poor Patients"](#)

memos require that all citations for improper discharges be forwarded to the regional CMS office for penalties and enforcement.

Recommendations

To address this problem fully, Minnesota should increase provider training and capacity related to behavioral and mental health needs, adapt existing resources to be more responsive to the needs people living in long-term care settings, and build on existing stakeholder work to develop innovative strategies to address this problem across the long-term care spectrum.

1. Increase Provider Training and Capacity



The Ombudsman “was the BEST help I could have received! He was on our side and gave me the reassurance and confidence and assistance that I needed for my husband’s care.”

Consumer Comment

To begin to address this situation, OOLTC has developed in-depth training for hospital discharge planners on resident rights related to admission/transfer/discharge in nursing homes. This project, titled “Let Me Return Home,” provides a detailed curriculum that Regional Ombudsman present at hospitals and facilities across the state.

This practice also occurs in housing with services/assisted living providers in Minnesota. OOLTC has adapted this curriculum for housing with services/assisted living establishments in Minnesota. Working with hospital systems and provider organizations across the state, OOLTC works to educate discharge planning professionals and facility staff on how to manage these situations and advocate for the client’s rights.

2. Adapt existing resources to develop person-centered behavioral support services for long-term care providers and consumers

Education and enforcement, while critical, will not solve this problem. Discharges and evictions like these are due to many complex factors, but the root cause to these improper discharge most often relate to the provider being unable or unwilling to meet the mental or behavioral health needs of the resident. These needs may be related to psychological symptoms associated with dementias or to mental/behavior health needs.

When OOLTC investigates these complaints, providers most often inform the ombudsman that the resident posed a danger to the safety of other individuals in the setting, or the resident requires 1-to-1 care that cannot be provided in nursing homes or assisted living settings.

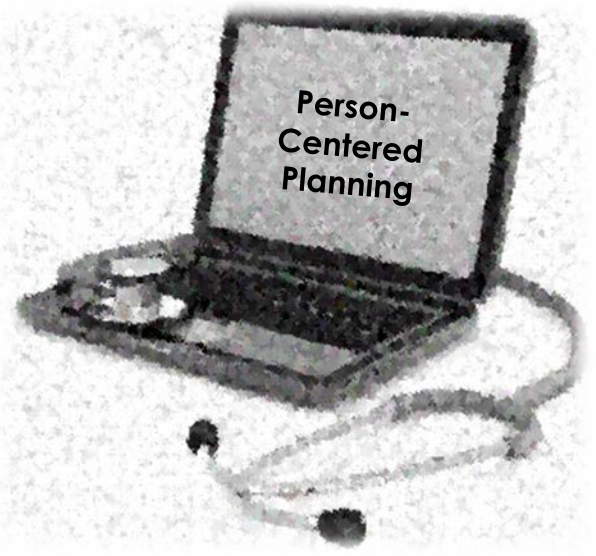
Providers, especially direct care staff, need more support, training and resources to manage these difficult, and sometimes dangerous, behaviors safely and in a way that supports the consumer's rights and dignity. This is a very difficult balance to strike. Substantive training in person-centered thinking and planning should be fully incorporated into nursing home and assisted living staff training procedures and a standard part of care planning.

Existing and publically-available resources and training should be adapted and refreshed to focus on managing complex behaviors in a residential setting. CMS and Minnesota's Department of Health have published and disseminated multiple trainings that could serve as a foundation for this work: [Partnership to Improve Dementia Care](#), [Quality of Life Initiative: interdisciplinary approach to activities](#), and [Root Cause Analysis](#). For a comprehensive list of these resources, please also visit the [Department of Health's Clinical Web Window](#).

3. Build on Existing Stakeholder Work Groups

Minnesota should address this issue collaboratively by building on existing collaborative workgroups with long-term care providers, hospitals, consumers, and regulators. The Office of Ombudsman for Long-term care participates in a chartered workgroup with providers to address swing

bed utilization and discharge planning from hospital to long-term care settings. These groups have already identified key stakeholders and have begun work defining systemic problems. This work should continue and include special attention to this serious problem in Minnesota.



During the 2016 Legislative session, some hospitals identified concerns with inability to discharge patients in need of post-acute care due to lack of available discharge sites. Legislation was introduced to amend Minnesota Law to allow for greater use of swing beds by critical access hospitals.

This raised a number of associated questions related to discharge practices, the characteristics of those patients difficult to place, the readiness of post-acute providers, the capacity of post-acute settings to adequately meet individual needs, and finally compliance with regulations governing discharge and residents choice.

The objectives of the work group include:

The overall purpose of this workgroup is to advance safe and successful transitions of care for consumers through efforts of the collective and individual roles of each group member. Group members include: State Long Term Care Ombudsman, Provider Organizations, MN Hospital Association, Minnesota Department of Health, Minnesota Home Care Association, Mayo Health Systems, Minnesota Council of Health Plans, and Minnesota Medical Directors Association.

Consumers of long-term care services have federal and state rights related to person-directed discharge planning, the right to be properly informed of all choices, and the right to live in the least restrictive environment.

- Discuss information available to consumers discharging and how information is communicated to consumers in order to make an informed choice
- Discuss solutions for special needs of the people difficult to place
- Determine the level of hospital compliance with the 2015 law requiring that post-acute discharge options be documented, including providing the patient with a list of post-acute discharge options in the patients preferred geographic area
- Identify solutions to the issues described above - Solutions may be in the form of proposed legislation/regulatory changes and/or non-policy solutions

Groups like these have built a stakeholder network that allow for an interdisciplinary and multi-faceted review of reasonable policy options to address this critical issue.

Issue: Lack of Consumer Protections and Lack of Transparency in paying fees or rates in Assisted Living settings

Compared to nursing homes, housing with services establishments that offer assisted living services (“assisted livings”) have few regulations to protect consumers. OOLTC complaint work demonstrates a need for increased disclosure and transparency from providers about their rate structures, extra fees, and the actual cost of the services being provided. Bernie’s story illustrates the need for systemic reform to ensure that consumers understand what they are purchasing when they move into assisted living.

Bernie’s Story

Bernie, pictured at the right, signed an agreement to pay an assisted living in Minnesota a set amount per month.

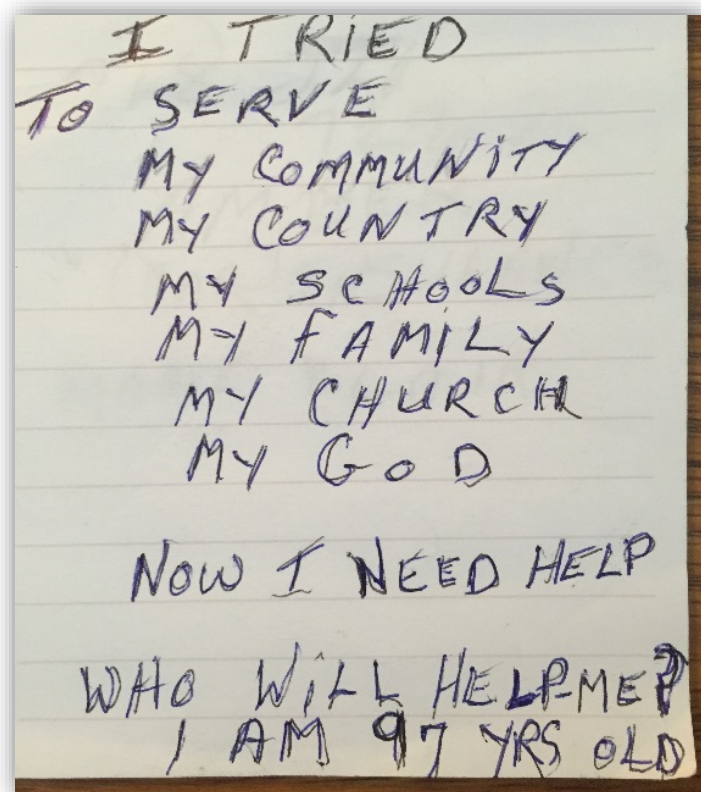
The first bill Bernie received from the provider caused Bernie alarm and anger. The revised amount being charged was nearly double the stated amount. Bernie contacted OOLTC and was visited by the Regional Ombudsman for that area. Bernie told her that he was deeply concerned about being charged fees and costs that were not disclosed when he agreed to move in and receive services.

After reviewing his contracts, the Ombudsman confirmed that these fees and charges were not disclosed before he signed the contract. The Ombudsman helped Bernie discover that the additional fees and charges were: security deposit (buried within the contract and not appropriately disclosed), a “community fee” (not disclosed at all) and a fee for in-home care services each month.



While landlords are allowed to charge security deposits, this information and the amount of the deposit should be clearly disclosed in the lease agreement. Even after the Ombudsman investigated, the purpose of the community fee remains unclear.

The contract did specify that a fee would be charged for services, but the service prices were not listed in the service contract, but rather on a separate piece of paper outlining the cost of their packaged services.



Bernie and the Ombudsman were able to convince the provider to refund about half the disputed amount, but they refused to refund some additional charges. As a result of this advocacy, the provider also agreed to

change all of their contracts to fully disclose the service fees in one prominent location on the contract. The provider contacted Bernie's children, without his permission, and got them to agree to pay the additional service fees without disclosing this to Bernie.

This note, pictured to the left, written from Bernie to the Ombudsman, explains Bernie's sense of frustration and vulnerability. He feels that the staff were disrespectful to him, deceitful, and did not honor his right to make his own decisions about his life and his money.

Bernie's story highlights the need for additional regulation or reform for fees and rates in assisted livings. This lack of consumer protection results in a power imbalance between the consumer and the provider. The consumer, due to the need for the 24-hour care provided in an assisted living, is dependent on that provider for care and not empowered to challenge fees without fear of loss of their services and their homes. There are no appeal rights if an assisted living home care provider decides to terminate services and the provider is free to terminate at any time by providing a notice in writing.

Assisted living consumers have the right to bring in alternative home care agencies when they are dissatisfied with the service provided on-site in the assisted living. However this solution is rarely utilized for most assisted living consumers.

Consumers chose assisted livings because of the presence of the home care agency “on site” in the building and that agency’s ability to provide care, such assistance to the bathroom, at unscheduled times during the day. Despite having the right to arrange for outside home care services, it is very difficult to fulfil the intermittent and un-schedulable care services with an outside home care agency. For more information on this issue, please see Irene L.’s story on page 24.

Housing with Services Assisted Living providers are required to disclose their fees, fee structures, and other costs in a [Uniform Consumer Information Guide](#)⁸. In Bernie’s case, the provider’s Uniform Consumer

information Guide also did not list the price of services, just the rental fees and that there are “services available at an additional cost”.

This issue is especially problematic for those that use public benefits – such as [Elderly Waiver](#) or [Community Access for Disability Inclusion \(CADI\) Waiver](#), to pay for services. Some assisted living providers do not accept waivers as a payment source, or accept only a small number of consumers with those payment sources. If the provider does not accept public benefits, the consumer will be forced to move and find a new provider. Irene’s story illustrates the consumer’s experience with this issue.



⁸ [Minn. Stat. 144D.08](#)

Irene's Story



Irene S. moved into a housing with services establishment that provides assisted living services in 2013. The establishment is owned and operated by a national provider. Irene and her family were assured by the administrator of the organization that Irene would be allowed to stay in her apartment after she was eligible for Medical Assistance so long as she paid privately for 2 years. Irene paid home care and service fees out of her own private pay resources until 2015, when she became eligible for Medical Assistance/Elderly Waiver program to pay for her services.

At that point, the provider issued a notice to evict Irene and terminate her home care services. Irene's dementia had progressed and she was no longer able to manage her affairs. Her son and attorney-in-fact contacted the Ombudsman, retained counsel, and

also made a complaint to the Office of Attorney General in Minnesota. The Office of Attorney General responded promptly to this complaint by corresponding with the provider's parent company and requested the following clarifications to the provider's policies:

- 1. Whether the provider was evicting Ms. S. due to her receipt of public benefits**
- 2. If so, how this complies with Minnesota law that prohibits discrimination in terms and conditions of housing due to receipt of public benefits**
- 3. Whether it is the provider's policy to not admit residents unless they have at least two years of personal funds to pay the services at the time they are admitted**

Following receipt of this letter and due to the ombudsman's and legal aid's advocacy efforts, the provider quickly rescinded the eviction notice and allowed Irene to stay in the same apartment.

Recommendations

Experiences like Bernie's and Irene's demonstrate the need for reform. To address fees and billing practices in assisted living settings, OOLTC Recommends increased enforcement for the disclosure of fees and rates and increased consumer access to pricing and quality information.

1. Increase enforcement of required disclosures for fees and rates

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](#).⁹ 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.

2. Increase consumer access to pricing and quality information

Currently, there is no comprehensive mechanism for a potential consumer of assisted living services to easily compare price and quality across different assisted living service providers. Minnesota has made significant strides in increasing consumer access to information about services¹⁰, but gaps remain related to quality measures and price in assisted living settings. Consumers of long-term care and their loved ones would benefit greatly from an online resource outlining the cost of services, updated/current pricing and quality information, including consumer reviews. Such a resource would support the consumer's right to make fully-informed choice about providers and settings.

⁹ See also: [Uniform Consumer Information Guide](#)

¹⁰ See the [Senior Linkage Line](#), [Disability Linkage Line](#), and [Minnesotahelp.info](#)

Issue: Minnesota's Workforce shortage is diminishing quality of care across long-term care settings

Minnesotans in need of long-term care services, as well as agency providers, cannot find or retain the staff they need to provide quality care. Long-term care direct care staff and leadership staff turnover rates are staggeringly high.

Provider organizations, as represented by the Long-Term Care Imperative, surveyed their members and identified open positions in nursing homes grew from an average of one per facility to 2.5 between 2013 and 2014.¹¹ The nursing home vacancies are the highest in the metro area – 13.8% compared to a statewide average of 12%. The turnover rate for registered nurses increased almost 10% from 2013 to 2014, with the turnover rate identified as 47.1%. The direct care staff turnover rate was nearly 51% in 2014. 45% of nursing homes denied admissions in 2014 due to insufficient staffing. These trends are similar in senior housing settings.

When there are insufficient staff numbers, or staff that do not know the people they serve due to turnover, quality of care and quality of life suffer for the long-term care consumer.

.

31,950
Represents the number
of skilled nursing
facility beds in MN

From 2014 to 2015, complaints about staffing shortages increased 19%. Between 2015 and 2016, complaints increased by an additional 33 percent.

Federal enforcement data show that 43% of all nursing homes surveyed in 2015 were cited for failing to provide services according to the individualized plan of care for the resident. 31.3% of all surveys cited for not providing the necessary care to reach the highest level of well-being for the resident.¹² While other factors may influence the frequency of citations in a particular regulatory area, the connection between inadequate staffing levels and decreased quality of care for Minnesotans is significant and increasing

¹¹ Long Term Care Imperative 2015 Legislative Report

¹² CMS regional survey data (Ktag and Ftag) FY2015, PDQ "Average Number of Deficiencies Report" November 17, 2015.

Recommendation

Minnesota has already taken steps to address the long-term care staffing crisis. OOLTC recommends that policy makers, providers, and advocates continue and further develop efforts to address workforce shortage. In July 2015, DHS hosted a long-term care workforce summit and follow up meeting in September 2016. This work led to 4 main strategies to improve Minnesota's workforce:

- Increase workers' wages and or benefits
- Expand the worker pool
- Provide additional direct care support worker training
- Execute a public awareness campaign to elevate the profession

DHS cannot effectively pursue these 4 strategies alone. This issue spans across industries and affects all Minnesotans who do, or will someday, need long-term care services. Policy-makers, providers, consumers, and workers should fully engage across public and private sectors to identify and implement creative and innovative solutions.

Increased funding for wages is part, but not all, of the solution. Given the recent changes to nursing home reimbursement rates¹³, further study is needed to learn if increasing reimbursement to nursing homes is correlated with fewer denials of admission

due to lack of staffing and correlated with increased retention.

Current employee scholarships programs should be expanded and incorporated into the public awareness campaign. Training in person-centered care and practices for direct care workers will support the skills needed by direct care workers to be successful and fulfilled by long-term care services. Long-term care management should change practice to involve direct care workers in service and care planning with the consumer to better coordinate care as well as to demonstrate the true value of direct care work and the dramatic affect it has on quality of life for long-term care consumers.

¹³ [DHS Nursing Home Rates and Policy Division](#)

Issue: Lack of Consumer Protections in Assisted Living Memory Care Units

Eric's Continued Efforts

Eric Linn continues to advocate for changes memory care units through meeting with the ombudsman, his legislators, and telling his mother's story. For more information on the Linn family and their support of their mother, please see also Kare 11: [Land of 10,000 stories - Alzheimer's Truck](#).

Irene L.'s Story

Irene L. is the mother of 5 sons. She was admitted to a central Minnesota assisted living memory care unit one year ago after her dementia progressed beyond what her family could handle at home. Within a few days of admission, Irene found a way to leave the building unaccompanied. The provider, despite advertising as providing memory care, did not have a secured unit. To manage Irene's exit seeking, the provider called the police

when Irene eloped, and eventually said that they could not meet Irene's needs and sent her to the hospital (see also systemic Issue number 1). They refused to let her come back despite the presence of a contractually-binding lease and service agreement.

She was admitted to a different memory care unit in a nearby community, where problems continued related to medication administration. Staff were not watching Irene actually ingest the medication, but were marking that it had been administered. As Irene's dementia-related behavior and agitation increased, her medication was also increased, including the addition of psychotropic medication (including Haldol). Because staff were not assuring that she actually took her medication, dosages kept increasing along with dementia-related behaviors, to the point that the provider said she would need in-patient psychiatric care. Her son and the ombudsmen pointed out that pills she spit out were found all over her apartment.

Irene's son, Eric, grew increasingly concerned about other aspects of her care in the 2nd memory care unit. Eric visited his mother and often sought the assistance of the regional ombudsman for the following concerns:

- Irene seated in the dining room, with food in front of her, but with no assistance in eating, which was required due to the progression of her dementia.
- The provider failed to arrange for podiatry care despite offering this specific service.

- Showers were traumatic for Irene; she appeared frightened and agitated during and after showers (fear and agitation during showers are common for people with dementia). The provider did not have an available bathtub to provide less-traumatic bathing options.
- Feces often found smeared around the toilet and no consistent housekeeping to clean the bathroom.

Eric was so concerned, that he installed a live-stream camera in his mother's room so that he could monitor her care (see also “Long-Term Care issues to Watch” section on electronic monitoring of page 47). Irene moved to yet a third long-term care facility, where care has generally been better.

Recommendations

The Linn family's experience illustrates the significant gaps in essential consumer protections in memory care units. The following recommendations, if adopted, would be effective in filling some of these gaps: appeal rights for provider-initiated service termination, require posting of staffing levels, and enforce the disclosure of special care status and require those disclosures in marketing materials

1. Appeal Rights for Provider Initiated Service Termination

Unlike other states, assisted living (including memory care) in Minnesota is considered a package of home care services and is regulated under a [Comprehensive Home Care License](#). The housing component of assisted living settings is regulated only by landlord tenant law, so there is no requirement that assisted living providers have bathtubs or other bathing options more suitable for people with dementias and related conditions. Similarly, there is no requirement that the assisted living memory

care provider actually have a secured unit to safely care for people exhibiting wandering or exit-seeking behavior.

If a provider terminates housing and services, the consumer's only recourse is fighting the termination through the eviction process in housing court. For assisted living service terminations, there are no appeal rights or legal mechanism to ensure the consumer of these services is being treated fairly.

34,270
housing with
services beds
throughout
Minnesota

While consumers have the right to bring in alternative home care if services are terminated, this right is not sufficient to protect consumers with advancing dementias and related conditions. In these situations, terminating services constructively terminates the tenancy as well. People suffering from a dementia that has progressed to the point of needing professional care need intermittent, but ongoing, cues, supervision, assistance and redirection to be safe.

When the assisted living provider opts to terminate services, it is often logistically or financially impossible to bring an alternative home care agency into that setting. Home care agencies often have minimum standards of time required for in-home care, for example 2 hours or 4 hours, making it impossible to set a package of services for intermittent care by an outside provider.

Irene L., was evicted from the first memory care unit due to wandering and exit-seeking behavior. For a consumer like Irene L., bringing in an alternative agency was not a legitimate option. Exit-seeking/wandering behavior requires that the caregiver be able to redirect the person to a different activity or area when they are trying to leave the building. This redirection may only take a moment or it might take several minutes, depending on the needs of the consumer. This support may be needed multiple times a day and at unpredictable times.

If Irene L. remained in the first setting with no services from the on-site provider, it would have been impossible for Irene or her family members to find a home care agency that would agree to come into the building to re-direct her at unscheduled and unpredictable times. Given the current workforce shortage in long-term care, agencies prioritize serving clients whose needs conform to their business model of providing a variety of services during a scheduled timeframe (e.g. 2 hours, 4 hours, 8 hours). Current home care providers are simply not equipped to provide “on-call” support for short periods of time. Even if such home care agency existed, people that require a memory care unit likely lack the cognitive ability to call an outside agency and articulate their care needs.

Further, the vast majority of lease agreements in assisted living memory care units are month-to-month. The assisted living provider can opt not to renew the lease without reason or justification after giving appropriate written notice - usually 30 days, but sometimes as short as 10 days¹⁴.

¹⁴ [Minn. Stat. 144A.441](#)

Minnesota should amend current statute to provide for due process and appeal rights for consumers of assisted living memory care services.

2. Require Posting of Staffing Levels

Unlike nursing homes, there is no requirement that an assisted living post its staffing levels. Many providers utilize on-call nursing services on evening and weekends, and may not have a full-time nurse on staff during regular business hours. When ombudsmen talk to consumers with complaints or concerns about these units, consumers and their representatives are very surprised to learn that there are no staffing requirements or even the requirement to disclose how many staff are working on any given day.

Requiring the posting of daily staffing levels is an important step towards ensuring loved ones of people with dementia have sufficient information to make informed choices about the appropriate setting for their loved ones.

3. Enhance Effectiveness of Disclosure of Special Care Status Statute

Currently, providers of memory care services must disclose the following prior to executing a housing and service agreement:

- 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

This disclosure is called a [Disclosure of Special Care Status](#). OOLTC recommends amending 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).

Currently, only the Minnesota Office of Attorney General¹⁵ has authority to enforce the current statute. OOLTC recommends that the Department of Health be provided the statutory authority to assess the provider's fealty to the promises made in the disclosure. The Department of Health inspects/surveys comprehensive home care licensees at least every 3 years, so including the disclosure of special care status in its survey protocol would ensure that providers are held accountable for providing the services they state they provide in the disclosure and marketing materials.

Issue: Minnesotans' Rights are Restricted by Unnecessary Guardianships

Legal guardianship is one of the most intrusive acts a court may impose upon a person. Plenary guardianships remove the person's ability to decide where they live, how their needs are met, and generally what type of life they lead. Guardianship puts another person, sometimes a stranger, in charge of these fundamental choices, effectively stripping them of many rights.

Current statute requires that court-imposed substitute decision-making be limited to the least restrictive method necessary to protect the vulnerable adult. However, the vast majority of guardianships in Minnesota give the maximum amount of powers authorized by the statute to guardians, i.e. plenary powers. As Minnesota pursues its Olmstead/integration goals, current guardianship practices conflicts with Olmstead's mandate to ensure that people live with the maximum amount of freedom and independence possible, while still acknowledging that some vulnerable adults needs support and assistance making decisions.

Complaints related to guardianship and other substitute decision-making instruments fall into the 3rd most common complaint category in Ombudsman data¹⁶. Common complaints from people under guardianship include:

- The desire to live in their community of choice, rather than where the guardian has placed them
- Restriction of visitors and friends by the guardian
- Restriction on the ability go places they want to go (guardian restricts ability to leave the premises
- The guardian does not know the person, never visits, and makes choices without including the person in the process

¹⁵ See Minn.Stat.325F.72(subd.4)

¹⁶ Guardianship/Conservatorship/Powers of attorney and Wills are coded in the "systems/others" NORS complaint category.

- Continued reports of waiver services or placement admissions requiring guardianship

Guardianship should be the last resort to protect someone's health and safety. People denied the ability to control their lives experience significant harms. Research suggests that those denied self-determination experience low self-esteem, passivity, and feelings of inadequacy. Persons under guardianship are at increased risk for institutionalization and mortality.

Nationally and in Minnesota, the frequency of guardianships and the outcomes associated with guardianship are not fully known or consistently studied. While guardianship is sometimes necessary to protect a vulnerable adult, alternatives to guardianship should be explored and eliminated as viable options before the court grants a guardianship to allow for the maximum of amount of self-determination possible.



Recommendations

To address the prevalence of unnecessary guardianships, OOLTC recommends continuing support for current policy work in this area (WINGS-MN), education and outreach on alternatives to guardianship targeted respectively to family guardians, professional guardians, and the judiciary, as well as providing more avenues for people under guardianship to communicate their experiences and outcomes to the court.

1. Support WINGS-MN and the developing Center for Excellence in Supportive Decision making

Minnesota has already begun work on guardianship reform. Stakeholders from across the state and across disciplines have joined together to form Minnesota's Working Interdisciplinary Network of Guardianship

Stakeholders (WINGS-MN). The Office of Ombudsman for Long-Term Care is a member of the WINGS-MN steering committee.

WINGS is a national model developed by the American Bar Association and the National Guardianship Network. The goal of this model is continuous improvement in guardianship practices and consensus-based reform. These broad-based, collaborative working groups can drive changes that will affect the ways courts and guardians practice, and improve the lives of people who have or may need guardians. For more information see: [American Bar Assn: WINGS state replication guide](#).

Minnesota WINGS has held several important educational sessions on supportive decision-making and alternatives to guardianship. The resources and collaboration of court administration has been invaluable in increasing education. Current efforts include changes to court forms to require more disclosure attempts at using alternatives before guardianship.

The WINGS steering committee received a grant September 2016 from the Administration on Community Living, Elder Justice & Adult Protective Services Elder Justice Innovation Grants to develop Minnesota's Center for Excellence in Supported Decision Making. This grant provides funding to build upon the foundation WINGS-MN built and to further WINGS-MN work and promote supported decision-making, standards for guardians, protection from abuse/fraud, and reduce the number of unnecessary guardianships in MN. A primary goal of the Center is to provide education and outreach on alternatives to guardianship to families, service providers, and professional guardianships. While details are still being discussed and worked, the Center will be hosted by and through Volunteers of America in collaboration with Lutheran Social Services with advisory support from current WINGS-MN steering committee.

2. Facilitate Communication to the Court for People under Guardianship

Under current Minnesota law, people under guardianship (“wards”) do not have a standard way to inform the court of their experiences with their guardian. Wards are served every year with a notice of their right to petition to be restored to capacity (to get rid of the guardian) and the guardian submits an annual “wellbeing” report to the court. Minnesota should amend its annual wellbeing report process to allow wards a consistent pathway to communicate with the

court about the conduct of their guardian, any rights restrictions that are in place, and any other pertinent information that the ward wants to provide. In addition to giving the ward a more powerful voice in the process, these reports would provide some baseline data for the court to begin tracking outcomes of guardianships and learn how these legal decisions affect the lives of wards.

“The Ombudsman explained resident rights... which ultimately gave the client the ability to say to family what he wanted.”

Consumer Comment

Resident and Family Advisory Council Education (R-FACE)

What are Resident and Family Advisory Councils?

The Councils are operated by and for the residents or the families of people who live in nursing homes and boarding care homes. Councils are an independent group of individuals who advocate for the wellbeing of all residents and promoting and enhancing quality of life. A council offers a forum for residents or their family members to be part of decision-making within their own home or the home of their loved one.

The Office of Ombudsman for Long Term Care provides educational resources and support to consumers who live in nursing homes and boarding care homes and their families about:

1. Self-advocacy in relation to quality of care and life;
2. Rights and responsibilities;
3. Care and services;
4. Regulations that apply to homes and residents; and

5. Resident and Family Council organization and maintenance.

What is the purpose of Family Council?

- Respect and promote resident directed living and quality of resident life
- Advocate for resident rights and quality care and services
- Suggest improvements in services, practices and policy
- Received important information about the home's operations
- Receive education about rights and regulations
- Partner with residents and Resident Council on joint events
- Share experiences and seek support among family members

Regional Ombudsman working with R-FACE

FAMILY COUNCILS :

Are a source of empowerment for families within a facility. They can provide resources and education from the community, they bridge communication between families and administration, and they can provide needed support for family members.

invited him/her to the next family council meeting. The RO also encouraged families to submit questions ahead of time to the administrator. The night of the council meeting, there were over 25 family members present, along with the RO, the administrator and director of nursing. The administrator presented information about the facility and staffing. Questions that were submitted by the families were addressed in the presentation. The families that were present were appreciative of the RO and her work with the family council.

In the last year the RO has spent over 11 hours working with the families and the family council at that nursing home. Today there is still ongoing communication with the provider and the families about staffing. With the support of the RO, the families continue to meet with facility staff to present issues and possible suggestions and solutions.

In a metro nursing home, families were frustrated with the high staff turnover and felt that they weren't getting straight answers from the provider. They reached out to the Regional Ombudsman (RO) for support.

The RO encouraged the families to contact other family members to see if they shared the same concerns, encouraged the families to talk to the administrator and

Our ROs attended **27** family councils last year with **317** families in attendance.

Our Certified Ombudsman Volunteers (COV) attended **39** family councils with **292** families in attendance.

The Regional Ombudsman can provide support, education and direction to family councils.

Resident and Family Advisory Council Education and Certified Ombudsman Volunteers


What is the purpose of resident council?

- Empower residents to improve their quality of life and exercise their rights
- Promote friendships and understanding among residents, families and friends
- Suggest improvements in services, practices and policy to the home's staff and administration
- Provide important information that affects all residents
- Exchange (non-confidential) news about residents, staff and new projects
- Enable connections to the community through sponsored events
- Raise funds for council projects or activities

A Certified Ombudsman Volunteer (COV) can have an important role within a resident council. The COV can guide the resident council's members to grow, learn, support and work together to solve problems and offer solutions. Resident councils can significantly influence resident self-advocacy, self-empowerment and resident directed decision making and living.

How do COVs make a difference for Resident Councils?

There are many examples that our COVs have made a difference with resident councils. One COV found that staff were running a council meeting and not the residents. When the staff were too busy, there was no council meeting. The COV educated the staff and empowered the residents that meetings could be held without the staff being there. Now the residents meet on a regular basis.



Our COVs attended **163** resident councils last year with **1,895** residents in attendance.

“Our resident council knows that we can depend on our COV to come to Resident Council meetings and support and provide direction to our council.”

Consumer Comment

Too often resident council meetings are led by facility staff and not the residents. One COV found that this was happening and worked with the residents and staff to advocate for change. Change was implemented and residents are in charge of meetings.

Many COVs have a standing invitation from the residents to attend resident council meetings. COVs provide support and information about resident rights and encourage residents to exercise their rights in their own home.

A new resident council president was elected to a resident council and the resident was feeling anxious about the new role, a COV went to visit with the resident and provided support and self-empowerment.

R-FACE Goals

In the coming year, a survey will be sent to all skilled nursing homes in MN. The purpose of the survey will assist the Office of Ombudsman for Long-Term Care in identifying relevant topics of interest, encouraging resident and family council development and continue advocacy goals.

After resident council meetings, a COV will go over the minutes of the meeting with the president to problem solve any issues.

“...great learning opportunity and experience...”

Consumer Comment

The Volunteer Program

55 Certified Ombudsman Volunteers - COVs Make a Difference

Image of Char

Volunteers for the Office of Ombudsman for Long-Term Care are called Certified Ombudsman Volunteers (COVs).

The volunteers extend the reach of the program by being a regular presence in assigned facilities. COVs build relationships and trust with the consumers. They identify issues and assist with problems. COVs work closely with their Regional Ombudsmen (RO) and report what is happening in facilities on a monthly basis. They enhance the work of the ROs. The work that they do is vital to the program.



**COV: Char H. of
Alexandria**

Examples of how COVs have made a difference:



***Our volunteers
are dedicated.***

***They are
compassionate.***

They are skilled.

- Improved facility's call light response time
- Assisted in getting a tenant council started
- Worked to get a resident her restorative therapy
- Assisted a resident in getting access to her monthly income allowance
- Advocated for getting a sun umbrella for an outdoor patio area for the non-smokers
- Advocated for a client to have a raised toilet seat for more independence and dignity
- Assisted a resident threatened with discharge because of smoking issues
- Worked to get a translator for a non-English speaking resident

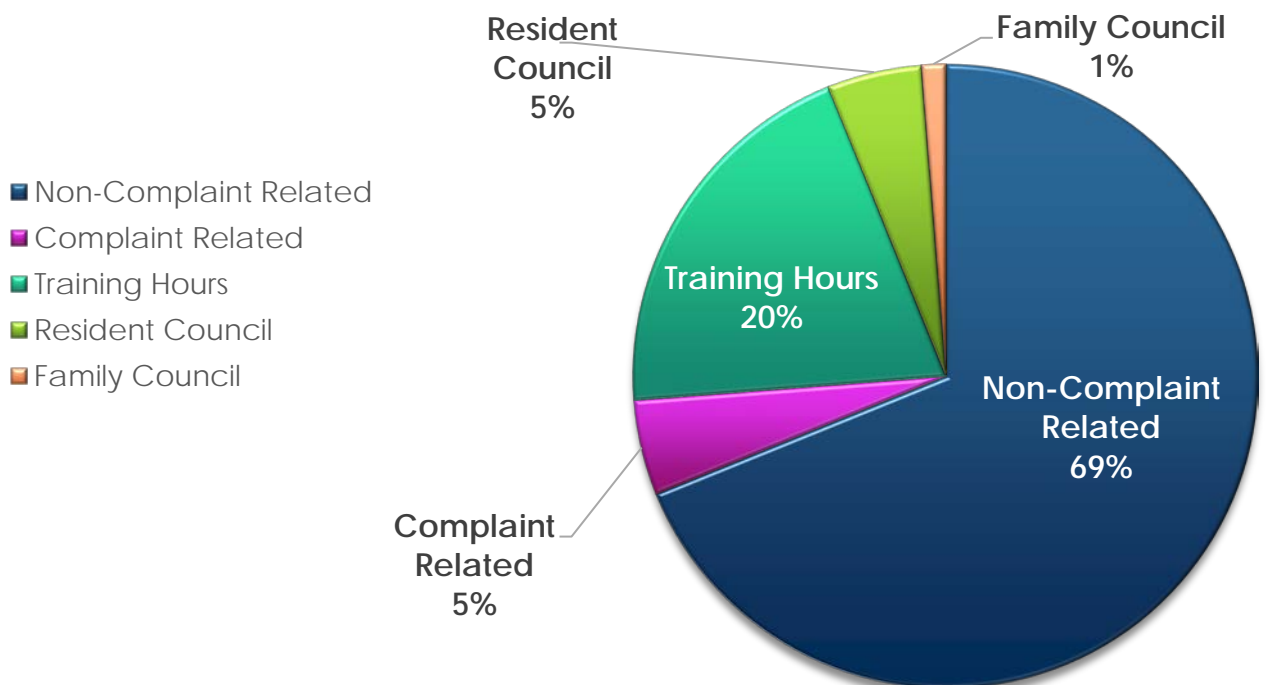
*They are
passionate.*



COV: Barb R. of Minneapolis

- Assisted a resident to make the delivery of her oxygen more manageable
- Worked to get a client's medicine scheduled at more regular times
- Assisted a client with hearing impairment in obtaining a closed captioned TV
- Assisted a spouse to advocate for her husband, who has dementia develop a care plan

2016 COV Hours Based on Activity Type



The COV program strives to have a diverse and inclusive volunteer program that is welcoming and accommodating and that matches the diverse needs of the people we serve.

COVs come with a variety of backgrounds and experiences:

Counseling • Social Services • Regional Ombudsman • Occupational Therapy • Nursing • Finance • Teaching • Student • Business Owner • Professor • Military Service Member • Farming • Public Health • Law Enforcement • Caregiving • Mediation • Community Organizing • Librarian • Corporation President • Public Housing • First Responder • Sales • Medical Technologist • Clinical Psychologist • Forestry Expert • Seamstress • Marketing • Artist

COVs diverse in:

- Race
- Religion
- Sexual Orientation
- Physical Abilities
- Culture
- Education
- Age
- Gender
- Marital Status

Volunteers diverse in housing:

- Single family Homes
- Town Homes
- Mobil Homes
- Apartments
- Farms
- Nursing Home

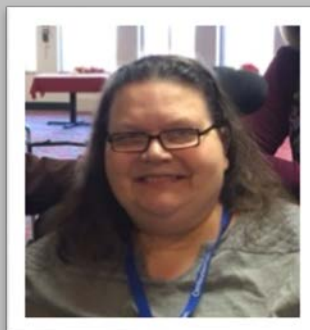
COVs live throughout the state:

- By the Lakes
- By the Woods
- On the Prairie
- On the Iron Range
- In Towns
- In Rural Areas
- In Cities

A FEW OF OUR CERTIFIED OMBUDSMAN VOLUNTEERS:



**Marion J. of
Morris**



**Kate P. of
Cannon Falls**



**Fred S. of
New Prague**



**Resident Janice and COV:
Michele M. of Minneapolis**

Innovative Projects in the Volunteer Program

Our COVs are highly skilled volunteers. We screen, train, and continue to develop their skills as ombudsmen. One way that we have begun to support COVs is through mentoring. Mentors are experienced COVs who receive additional training to offer support to new COVs. They give shadowing experiences, ongoing support and assist new COVs to learn the complex role of being a COV. Successful onboarding of

COVs is important and is an investment of available staff resources. The mentor is able to spend more time to train, and offer support from a COVs perspective.

The mentor works with new COV's initial orientation, but prior to designation. The new COV shadows the mentor in the mentor's assigned facility. The new COVs have an opportunity to go into a facility, talk to a resident, and talk to staff before they are assigned. Mentors offer follow up support by; being available to answer technical questions, offering to accompany the new COV for additional shadowing, if desired.

Benefits for the Mentee include:

- Individuals who are mentored learn their role and responsibilities timely
- Increases the mentee's ability to assist the RO and advocate effectively for consumers.
- Teaches mentees the role of the COV from another COV's perspective

Benefits for the Mentor include:

- Encourages the mentor to share knowledge, and participate in successful onboarding of new COVs
- Provides professional growth opportunities for the experienced COV
- Formally recognizes the experience and value of the mentor

Benefits for the OOLTC include:

- Encourages the mentor to share knowledge, and participate in successful onboarding of new COVs
- Provides professional growth opportunities for the experienced COV
- Formally recognizes the experience and value of the mentor

COVs in Action: Yolanda

Respectful, cheerful, thoughtful and dedicated to the consumers at Golden Living Center, Yolanda Williams has been a COV since 2013. She has exceptional people skills. Yolanda came to the program after spending some time in a transitional care unit. Yolanda visits her assigned facility once a week. She is successful because of her friendly demeanor and outgoing personality.

Yolanda made a difference.

“Sue” is a woman in her 40s who has many health issues and lives in a nursing home that Yolanda contributes her time as a COV. Sue’s spouse began to funnel her monthly income



Yolanda and her significant other Ron as she graduated from program at Vision Loss Resources

4,092 was the
number of hours COVs
donated in the last 12
months – worth
\$103,118*

*from the Independent Sector 2015
estimated value of volunteer time in MN.

allowance into his account, leaving her with no spending money for the month. Sue wasn’t having any success in getting access to that money.

With Sue’s permission, Yolanda worked with Sue and the facility financial staff person. They discovered where the money was being deposited and why it was not in Sue’s account. Yolanda’s work ensures Sue is the only one that has access to her money.

Sue reported that it was horrible not to have any money. She felt like she didn’t have any power. As a result of Yolanda’s work, Sue feels empowered moving forward managing her own money.

Certified Ombudsman Volunteers

Including their city of facility placement

Wendy Adams , 2016 Stillwater	Gloria Alexander , 9 years Plymouth	Charlie Anderson , 11 years Montevideo
Jill Ballard , 2016 Cannon Falls	Terry Bird , 1 year Rochester	Linda Carlson , 6 years Warroad
Dorothy Chizek , 16 years Morris	Betty Clark , 1 year Moorhead	Gloria Cory , 11 years Wheaton
Stacy Desai , 5 years St. Louis Park	Marg France , 1 year Duluth	Nancy Galatowitsch , 3 years Pine River
Mary Grunwald , 11 years Onamia	Virida Hall , 2016 Saginaw	Sue Halverson , 2 years St. Paul
Charlotte Hanson , 1 year Alexandria	Natalie Hanson , 1 year Barrett	Gary Hennen , 5 years Cold Spring
Jo Hennen , 2016 Cold Spring	Edith Hoyum , 8 years Blackduck	Sharon Hughes , 3 years Cloquet
Marion Jacobson , 16 years Detroit Lakes	Betty Johnson , 3 years Paynesville	Katherine Konstant , 2016 St. James
Pat Loban , 2016 Pine River	Ronna Locketz , 1 year Crystal	Norma Macdonald , 4 years Bloomington
Christine Marcotte , 4 years Deer River	Donald Matakis , 22 years Sartell	Patricia McCormick , 4 years Crosby
Barbara McGinnis , 18 years Morris	Lois Meiners , 15 years St. Cloud	Joy Mesia , 16 years Eveleth, Proctor & Hibbing
Meredith Morneau , 12 years Grand Rapids	Michele Murphy , 12 years Minneapolis	Cathy Nault , 3 years Pequot Lakes
Halle O'Falvey , 2016 St. Paul	Tom Oven , 3 years St. Cloud	Kathleen Phillippi , 2016 Red Wing
Mel Reinke , 21 years Ortonville	Barb Risken , 12 years St. Louis Park, Minneapolis	Fred Simon , 2016 New Prague
Jim Sowles , 9 years Crosby & Aitkin	Lois Sowles , 15 years Crosby & Aitkin	Susan Spaeth , 19 years Bemidji
Barb Spears , 2016 St. Paul	An Taylor , 2016 Richfield	Joan Thomas , 2 years New Brighton
Kelli Turcotte , 3 years Brainerd	Lois Tyrrel , 10 years Motley	Pat Westman , 10 years Roseau
Jayne Whiteford , 2016 New York Mills	Yolanda Williams , 2 years St. Louis Park	Beverly Winchester , 2016 Rochester
Audrey Wiita , 23 years Eveleth & Hibbing		

Long-Term Care Issues to Watch

Electronic surveillance in long-term care residences

Due to increased media attention and the need for clarification about how electronic surveillance (e.g. hidden cameras in resident rooms, cameras in common areas) is regulated in long-term care residential settings, The Residential Care and Services Electronic Monitoring Workgroup was established by the 2016 legislature.

The goal is to develop recommendations for legislation that addresses the use of electronic monitoring in long-term care settings to protect vulnerable adults and hold accountable perpetrators of abuse.



Typical forms of video surveillance in long-term care facilities include: closed circuit video camera, web camera, or an audio recording device. Family members/loved ones of long-term care consumers report they have resorted to electronic monitoring measures as a “last-ditch” effort because they suspect abuse and feel that concerns brought to the attention of facility administrators are dismissed or not resolved. Consumers may not report abuse/neglect for fear of retaliation or unable to communicate due to mental and physical limitations.

The Residential Care and Services Electronic Monitoring Workgroup must issue a report with recommendations to the legislature by January 15, 2017. This workgroup is a multi-disciplinary group, representatives include; Elder Justice Center, State Long-Term Care Ombudsman, MN Department of Health, Family member consumer representative, Provider organizations, MN State Senator(s), MN State Representative(s), Home Care Association, Department of Human Services, AARP, Alzheimer’s Association, County Attorney, legal experts, and Employee Union Representative.

Consideration of legislation involves a number of provisions that need to be accurately defined such as; informed consent, notification, setting, and recording limitations. For example; Minnesota is a one party consent state so only one person being monitored has to give consent to the monitoring. Consumers who reside in long-term care settings have rights under federal and state law including rights to privacy. Consumers right to privacy during personal cares, visits with others of their choice, and meetings with an advocate are just a few. Some suggest privacy

concerns can be alleviated by focusing camera on only the space of the resident being monitored, although issues of others right to privacy potentially come up for example in the case of roommates or the filming of residents when there is an expectation of privacy.

While it should never be expected to substitute video technology for effective government oversight and enforcement, the use of such technologies should flow from the choice of the consumer or as the consumer would expresses express if able. The use of electronic monitoring must be undertaken in such a way as to avoid compromising the rights and privacy or residents and other residents.

Home and Community-Based Services Final Rule



In 2014, The Centers for Medicare and Medicaid Services (CMS) published extensive regulations that will transform how states and long-term care providers deliver and regulate home and community based services. These regulations, often referred to as the "HCBS Final Rule," applies to publically-funded long-term services and supports. The rule requires that people

receiving these supports receive them in the most integrated setting possible, with full access to the community. The rule also requires that services are assessed and delivered in a person-centered manner.

While Minnesota is a leader in development and delivery of home and community-based services, the HCBS Final Rule will push Minnesota to evolve its system, educate, and train providers on a very rapid timeline. States must be in compliance by 2019. Minnesota submitted an updated transition plan to CMS on December 2, 2016. To date, only one state's transition plan has been accepted by CMS.

OOLTC has participated in the Department of Human Services stakeholder engagement activities related to the HCBS Final Rule, including providing extensive commentary on proposed policies and ensuring that the consumer's experience was reflected in the development of recommendations. OOLTC is monitoring the policy development and future implementation to ensure that they are responsive to consumer needs and experiences.

Nursing Home Regulatory Reform

CMS recently released updated federal nursing home regulations. This is the first comprehensive revision to the regulations since 1991 and there is a strong focus on person-centered care. Highlights to these changes fall into e broad categories: assessments/care planning, grievances, and admission/transfer/discharges.

Assessments and Care Planning



Existing regulation requires that residents have a comprehensive assessment within 14 days of an admission to a nursing home, annually and during a significant change. These comprehensive assessments must now include person-centered planning principles by incorporating the resident's needs, strengths, goals, life history and preferences into the assessment and resulting plan of care. Included in the care plan is a section on discharge plans. The resident must be asked by the facility

their interest in receiving information about moving from the nursing home to the community.

Within 48 hours of admission the facility will now need to complete a baseline care plan for the resident. This will include physician and dietary orders, therapy services as well as social services, and initial goals for the resident. The resident and the resident representative must be given a summary of this plan. To incorporate person centered planning, the facility will develop and implement a care plan with as much input from the resident as possible.

Grievances

The right for a resident to voice a grievance has not changed. However, this fundamental right has been clarified and bolstered by the new regulations. The type of grievances that can be filed have been expanded to include care and treatment, the behavior of staff and of other residents and any other concerns about the residents stay. New regulations now require that the facility must make information about how to file a grievance available to residents. In addition, residents have the right to receive the response to the grievance in writing and the right to know the expected time frame for receiving this response. The facility must establish a grievance official to oversee the grievance process, be able to track grievance, lead any investigations of grievances filed and provide a grievance decision to the resident.

Admission/Transfer/and Discharge Rights

These regulations clarify that facilities cannot waive their liability for loss of resident property in the admission process. During an involuntary discharge, the facility cannot transfer or discharge a resident while a transfer/discharge appeal is pending, unless the health or safety of the resident or other individual in the facility would be endangered. In these situations, the facility has to document the nature of the danger. Additionally, when a facility is going to transfer or discharge a resident, they need to send a written notice to a representative of the Office of Ombudsman for Long Term Care. If a resident who has transferred to the hospital and wants to return to the nursing home and the nursing home determines the resident cannot return, the facility must comply with the discharge requirements.

Person-Centered Thinking and Planning

Person-Centered Thinking and Planning are being increasingly incorporated into federal and state regulation about services and supports across the continuum of long-term care, from services delivered in a person's home to services delivered in institutional settings¹⁷. These new requirements should serve to transform policy and practice for our system. However, past reform efforts have stopped short of promoting true systemic reform and transforming the lives of people receiving services.



OOLTC's vision statement contemplates a time when people that need long-term care services have choices about where to live and where to receive care; flexibility in choosing caregivers; fair service costs to ensure choices; rights, standards, and consumer protections and individualized care and services tailored to meet individual needs, rather than service-provider needs.

OOLTC and consumers should continue to closely monitor how and if the implementation of person-centered requirements in regulation actually translates into a better quality of lives for Minnesotan's that received long-term care services and supports. OOLTC stands ready to promote true person-centered living and ensuring consumers, not their service providers, are directing and determining their own quality of life. At its core, person centered thinking is about helping people receiving services get better lives, not just better paperwork.¹⁸

¹⁷ See HCBS Final Rule, updated federal nursing home regulations, Minn. Stat. 245D, Minnesota's Jensen settlement, for example.

¹⁸ [The Learning Community: Person-Centered Thinking Training, day 1.](#)

Conclusion

As Minnesotans age and boomers retire in record numbers, Minnesota's long-term care system must change and evolve to meet the increasing needs and demands of its citizens. This work belongs equally to people receiving services, advocates, policy-makers, legislators, and providers. Minnesota has a rich history of cooperation across sectors; this work should be continued, amplified, and imbued with people prepared to listen to innovative ideas about payment and quality, as well as support for providers willing to be industry leaders as the standard of care continues to evolve.

