Inhumane and Deadly Neglect Revealed in State Assisted Living Facilities

Driven by Insufficient Funding for Regulatory Standards of Care and Oversight

April 22, 2019

Funded by Stevens Square Foundation.

In Honor of the Thousands of Who Have Suffered and Prematurely Died at Assisted Living Facilities Throughout Minnesota.

Overview - Legislative Reform of Assisted Living and Protections Must Pass in the 2019 Legislative Session

"Assisted living is a ticking time bomb."
– Professor Catherine Hawes during an interview for PBS Frontline investigation: https://tinyurl.com/y5q48bsv
Note: Professor Hawes conducted the first national study in the late 90's on Assisted Living Residences in the U.S.

Elder Voice Family Advocates' (Elder Voice) review of substantiated investigations reveals shocking deaths and suffering that need urgent solutions that only the Minnesota Legislature can remedy. We undertook this review of publicly available investigations data from the Minnesota Department of Health's (MDH) Office of Health Facilities Complaints (OHFC) to get a clearer picture of what is happening in assisted living facilities throughout Minnesota and why is it happening.

Elder Voice reviewed OHFC Investigative Reports of maltreatment in Assisted Living Facilities and identified many systemic problems.

Key Findings – Limited Regulatory Oversight Driving Dramatic Increase in Neglect in Minnesota Assisted Living Facilities

The horrific cases of neglect revealed in substantiated investigations point to several key failings in the assisted living industry. These failings result in serious harm and contribute to many premature, painful deaths. The key reasons for all this suffering and death include, in part, the following:

- Assisted living is accepting a wide range of care needs without credible authority and responsibility:
  - No clear, consistent standards of care to guide the industry, residents or families.
  - No nurse assessment of care needs prior to moving in to the facility.
  - Poor communications among staff, management and other providers.
- Severe staffing issues include under-staffing, poor hiring practices, and training insufficiencies that result in:
  - Medication errors and theft.
  - Ignored or untreated emergencies or changes of condition.
  - Inadequate or lack of staff supervision.
  - Falls as a result of staff not trained in the use of equipment to perform safe transfers.
  - Neglect of care sometimes leaving residents for many hours without food, water, toileting care, etc. or poor care of wounds that lead to severe and sometimes fatal infections.
  - Sexual predators taking advantage of elders and vulnerable residents.
- Inferior memory care standards result in:
  - Unsafe facility practices and environments that allow dangerous wandering outside the facility and the person's residence.
  - Lack of adequate dementia care training leads to poor handling of common dementia related behaviors.
  - Lack of meaningful engagement to calm residents living with dementia.

Significant Under Reporting. It is critically important to understand that we reviewed only a portion of substantiated maltreatment in Minnesota's assisted living facilities - the tip of the iceberg. It is estimated that only 1 in every 14 to 24 cases of abuse ever get reported. Additionally, relatively few are investigated due to minimal resources and funding for the OHFC.

Minnesota Legislators – Please hear the voices of our elders and vulnerable adults coming through these reports, pleading to be helped and to end their suffering and premature deaths. Our loved ones deserve much better.

Minnesota House and Governor Target $33 million for elder care – Thank You!

Minnesota Senate Target $5 million for elder care – Shockingly Insufficient!

Stop the Delays – Stop the Suffering

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"*The investigations OHFC conduct and the enforcement actions it imposes take place only after maltreatment occurs. Taking action to prevent maltreatment may be a more effective way to protect vulnerable adults from experiencing maltreatment in the first place.*" – Office of The Legislative Auditor, 2018.

Thank you to Eilon Caspi, PhD who led the study and the significant contributions of Elder Voice members Anne Sterner, Debbie Singer, Kay Bromelkamp, Jean Peters, Barb Luck, Jane Overby, Anna Ostroushko and Kristine Sundberg.

Current Conditions in Assisted Living

Case Summaries Illustrate Seriousness of the Neglect, Abuse and Exploitation – Assisted Living Failures

Elder Voice reviewed 200 OHFC Investigative Reports of substantiated maltreatment in assisted living facilities. Only substantiated investigations were reviewed, although the unsubstantiated and inconclusive categories are important and deserve future examination.

Patterns emerged from this analysis showing the vast majority of these cases are preventable. For example, with proper nutrition and hydration, residents wouldn't be malnourished and dehydrated. Additionally, attention to pressure sores would prevent the major infections have resulted in amputations in extreme cases.

Failure to follow care plan

- Wellness checks as prescribed were not completed and several residents were found dead.
- Diabetics went untreated and a resident died of renal failure, while another had feet amputated and later died.
- Batteries on a heart pump were depleted when the unit was not plugged into a power outlet and a resident died.

Failure to assess a change in condition and get care quickly enough

- A nurse refused to send a resident to the hospital after a significant change in the resident's condition; the resident later died of a heart attack.
- One person crying out, "help me, help me," was left untreated for hours resulting in an excruciatingly painful death from an untreated hernia.
- Staff reported that management forbade them from obtaining care for a man who was beaten by several staff members. This resident died of a brain-bleed.

Poor staff training

- Staff didn't clean a urinary catheter, which led to the resident's death.
- Staff failed to contain a septic C. difficile outbreak that led to death.
- Numerous incidents of death due to falls were a direct result of poorly trained staff.
- Medications were not given or were given incorrectly, with some resulting in serious harm and death.

Failure to provide a safe facility environment

- Two residents died from drinking cleaning detergent containing corrosive chemicals while unsupervised. The toxic cleaning agents were unsecured and left within reach of the resident.

Poor supervision and care

- Due to an improper transfer a resident fell to the floor. Staff left the resident on the floor and ignored the person for nearly 4 hours while he/she watched TV, read magazines and left the room. The resident was found crawling on the floor, covered in feces. Staff lied about it, but video evidence verified the incident occurred.
- A resident attempted suicide when no staff were present in the building. Residents were unsupervised from 11 p.m. to 8 a.m.

- Two cases of resident-to-resident altercations involving improper assessment and not following the care plan or not providing adequate intervention.

Lack of memory care standards results in deaths and serious harm

Currently, Minnesota law does not require a locked memory care unit to have a staff member present at all times. Many dementia residents, however, need specialized care and close supervision. Many are wanderers who don't understand the risks of their actions or are unable to communicate their needs. Disappearances due to improper maintenance of the facility or failure to implement care plan that lead to the following incidents:

- Two memory care residents died of hypothermia after being able to freely walk out of the facility.
  - One was outside when the temperature was at 5°F and -18 °F wind chill.
  - Another was found outside in a snowbank by the family after the nurse was not allowed to get emergency help.
- One facility had a problem with doors that unlocked, but they did not regularly check them to make sure doors were safely locked.
- A care plan prescribed wellness checks every 2 hours but no checks were done for at least 4 hours. The resident wandered outside and was found drowned in a pond.

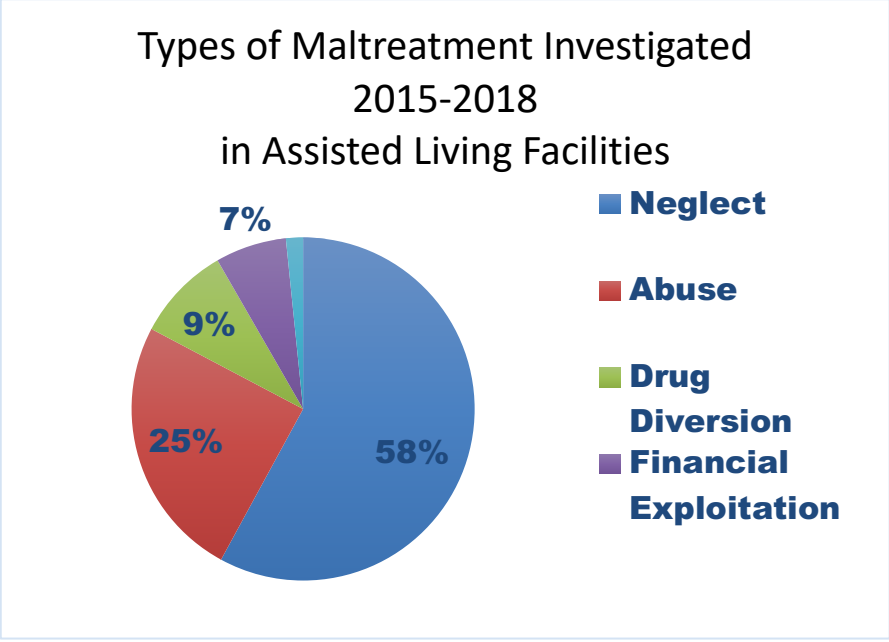
Financial exploitation:

- Total Amount of $116,917 was stolen from 103 residents, averaging $1,135 per resident.
- A staff member stole gold jewelry valued at more than $1,850 from one resident.

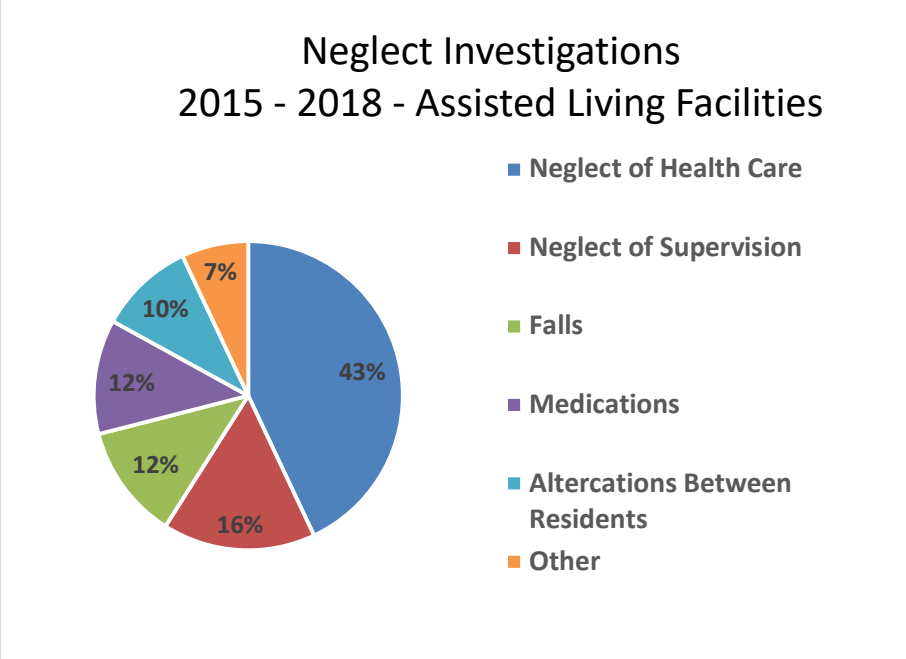
Statewide Trends

Neglect Dominates the Investigations

The allegations of neglect investigated increased over 300% between 2015 and 2018. Neglect dominates the other maltreatment categories for assisted living.

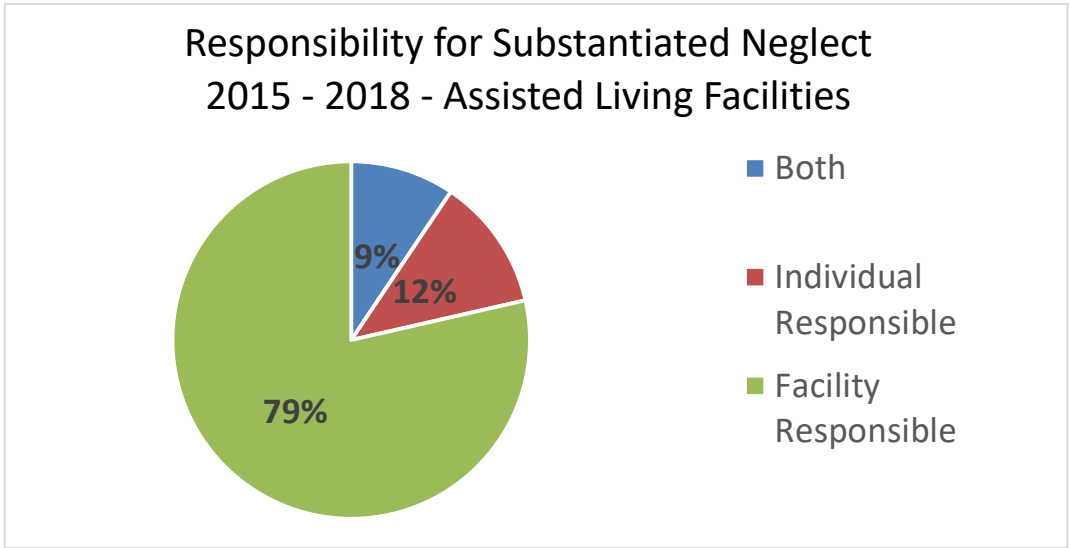


Within the 14 types of neglect tracked by OHFC, most of the neglect allegations investigated were classified as Neglect of Healthcare or Neglect of Supervision. These two types accounted for 59% of the investigations, therefore we focused our review on these two categories.



Provider Responsible for Majority of Neglect

Our analysis of the neglect allegations substantiated in assisted living facilities from 2015 to 2018 showed that the majority (79%) of the reports found the licensed home care provider responsible for the neglect. OHFC determined that only 12% were the responsibility of individual(s) for the neglect and 9% were the responsibility of both the provider and individual(s).



Profile of Assisted Living

Growth of Assisted Living

Assisted living facilities are the fastest growing residential care option for elders in the U.S. and "dementia care" is the fastest-growing segment of assisted living. A substantial portion of the residents living in these facilities have serious cognitive disabilities, which are considered a risk factor for experiencing various forms of maltreatment.

7 out of 10 residents in Assisted Living Facilities nationally have **some level of cognitive impairment** (1)**:**

Mild cognitive impairment: **29%**
Moderate cognitive impairment: **23%**
Severe cognitive impairment: **19%**

Nearly 50% of residents in assisted living facilities nationally have a diagnosis of **dementia**

Sources: 1. Zimmerman et al. 2014; 2. Gruber-Baldini et al. 2004

"Residents with dementia are at higher risk of abuse compared with those who do not have dementia."

Professor Brian Kaskie

Source: Kaskie et al. (2015). Policies to protect persons with dementia in assisted living: Déjà vu all over again?

In addition, several U.S. Government Accountability Office reports and research studies have shown that abuse and neglect of residents in assisted living facilities across the country are a prevalent and concerning phenomenon causing far reaching negative consequences to residents' well-being, health, and safety. Maltreatment of vulnerable and frail elders in assisted living facilities is a violation of their human and legal rights.

The New York Times recently published an article titled; *Dementia Patients Fuel Assisted Living Growth. Safety May be Lagging* (2018). It describes frequent and disturbing violations of state rules pertaining to care and safety related to people with dementia in assisted living facilities in several states. Areas of care found to be deficient include but are not limited to staffing levels, adequate staff training, individualized care planning, ability to provide medical care and meet residents scheduled and unscheduled needs and gaps in ability to ensure residents' safety. This includes preventing residents in advanced stages of dementia from leaving the assisted living facility unattended and experiencing serious harm and death.

"Housing with Services establishments, which include Assisted Living Facilities, are not licensed by the state and do not have the same level of oversight as nursing homes…"

– Office of The Legislative Auditor of Minnesota (2018)

Basic Profile of Residents in Assisted Living Facilities in Minnesota

In Minnesota, a substantial portion of residents in assisted living facilities have dementia and require extensive assistance in activities of daily living. In addition, one-third of assisted living facilities in the state were reported to serve only residents with dementia or have a "dementia care unit."

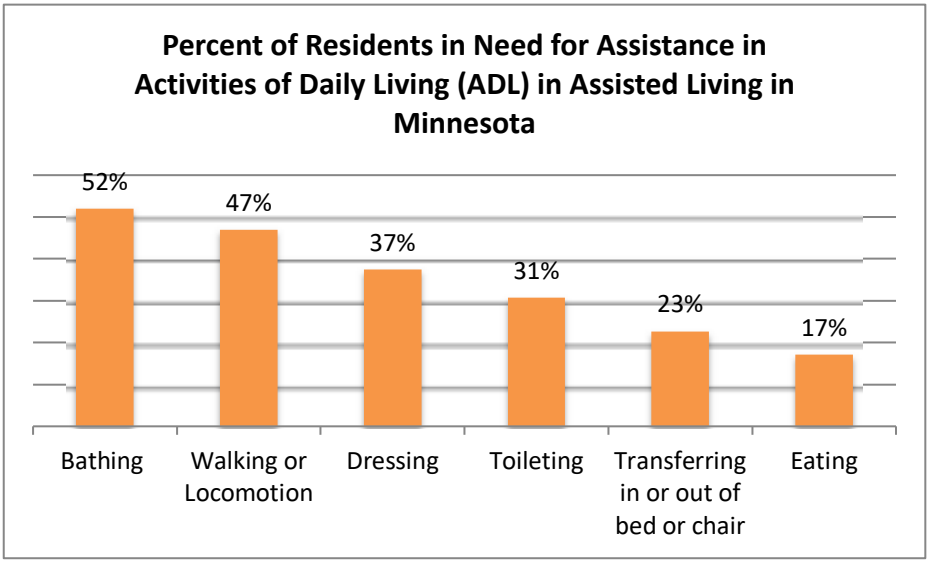
The following is the latest available basic profile of residents in assisted living facilities in Minnesota, based on a survey conducted between August 2016 and February 2017:

Resident Characteristic	%
Female	72.4%
Age 85 and over	51%
Medicaid (some or all services paid by Medicaid in last 30 days):	20.4%
Diagnosed with Diabetes	15.1%
Diagnosed with Dementia	33.2%
Diagnosed with Depression	25%
Diagnosed with Heart Disease	24.2%
E.R. Visit in the last 90 days	9.7%

It is important to recognize that nationally "only about half of those with Alzheimer's dementia have been diagnosed" (Healthy People, 2020). It is likely that a higher number of residents in assisted living facilities in Minnesota have an undiagnosed cognitive impairment and dementia.

Extensive Need for Assistance in Personal Care Tasks

The chart below displays the extent to which residents need help with personal care tasks assessed as necessary to maintain their functional independence (known as Activities of Daily Living, ADL).



Source: 2016 National Study of Long-Term Care Providers (3rd wave). State Estimates on Residential Care Community Residents. The survey was conducted between August 2016 and February 2017.

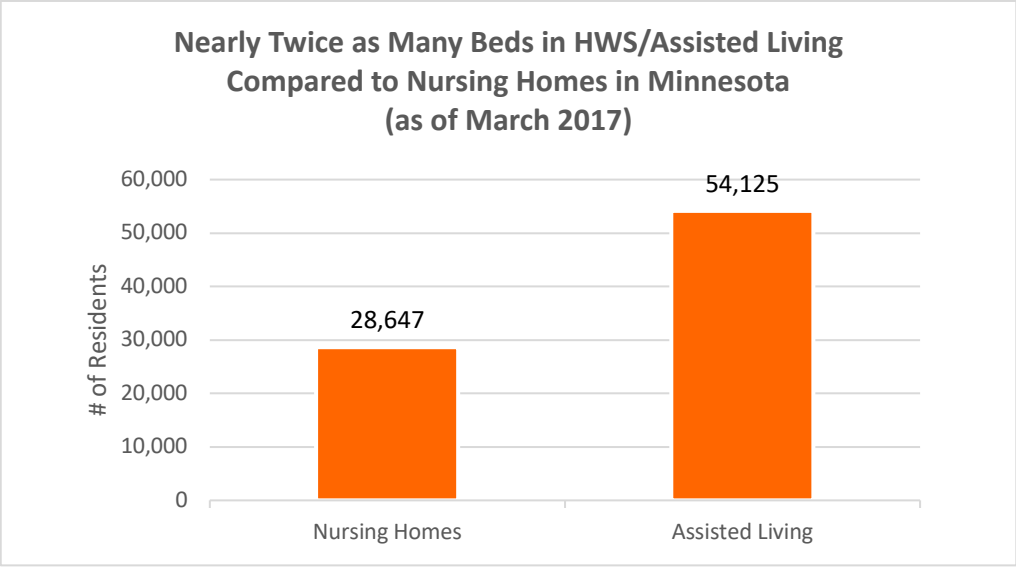
"When elders reside in an institutional setting, **the risk of abuse increases simply as a function of their dependence on staff for safety, protection, and care**." – Dr. Anne W. Burgess, RN, DNSc, a leading national authority on abuse of elders in long-term care homes

The need to examine and improve understanding of maltreatment in assisted living facilities in Minnesota is clear and urgent. Together, these resident characteristics, medical diagnoses, high rates of cognitive impairment and dementia and extensive need for daily scheduled and unscheduled assistance in various personal care tasks make it clear that a large portion of individuals living in assisted living facilities across our state are highly vulnerable and frail.

The resident characteristics and extensive personal care needs of residents in assisted living facilities also suggest that many of these individuals are at risk of abuse, neglect, financial exploitation, among other sources of harm.

Assisted Living Facilities Nearly Double the Number of Nursing Homes

The sheer volume of residents receiving care in assisted living facilities demands careful attention to the quality and safety of their care and environment. The bar chart below, based on a recent estimate, shows that the assisted living industry in Minnesota is nearly double in size compared to nursing homes:



Source: Office of the Legislative Auditor of MN, 2018

On March 15, 2019, MDH reported the following rough estimates about HWS/ALR in Minnesota:

2018 Estimates – HWS/Assisted Living in MN

Total number of HWS/Assisted Living: 1,345

Total Capacity Assisted Living: 55,582

Total Number of Assisted Living Residents: 41,219

Total HWS with Dementia Units/Programs: 633

Source: The data were extracted in November 2018 by the Health Regulation Division, MDH

Undetected and Underreported Maltreatment

Elder abuse, neglect, and financial exploitation are underreported in residential care facilities nationally[i]. According to professors Linda Phillips and Guifang Guo (2011): "There are considerable problems with underreporting of mistreatment in residential settings because of resident and family fear of retaliation by staff/management, lack of housing alternatives, lack of knowledge among residents/families about where to/how to report, staff reluctance to report out of fear of recrimination, difficulty in substantiating mistreatment, and failing memories of victims/other residents that hinder substantiation and prosecution."

Research studies have found that only 1 out of 14 to 24 cases of elder abuse are known to authorities

Note: Estimates of underreporting of elder abuse vary due to various factors (such as definitions used, types of maltreatment examined, settings studied, research methods used, etc.) and thus caution is recommended in interpreting the above findings.
Source: Bonnie, R.J. & Wallace, R.B. (2003). Elder Mistreatment: Abuse, Neglect, and Exploitation in Aging America. National Academies Press: Washington DC.
Lifespan Greater Rochester, Inc., Weill Cornell Medical Center of Cornell University, and NY City Department for the Aging (2011). Under the Radar: New York State Elder Abuse Prevalence Study.

Key Factors Leading to Underreporting of Abuse, Neglect, Maltreatment

Following are the key factors that contribute to major breakdowns in underreporting:

Poor Regulatory Framework or Oversight for assisted living facilities limits MDH's ability to investigate violations properly. Abuse, neglect and financial exploitation are undetected and underreported nationally due to strong disincentives for operators to report incidents, which may lead to liability and adverse publicity. Selected reasons include:

- The Office of Ombudsman for Long-Term Care in Minnesota was ranked lowest in staffing levels by the National Ombudsman Reporting System.

- Separate authority for "Housing" and "Services," and who is responsible for each type of care.
- Lack of requirements for Plans of Correction; it is uncertain whether violations are tracked over time and investigated systematically without standards of care and regulatory oversight.
- Grossly insufficient number of surveys of assisted living facilities – only one survey every three years in Minnesota (we know that even this minimal requirement is not met in many cases). In comparison, the state of Arizona surveys its similar-sized facilities annually (with a higher-level substantiation rate).
- Standard inspections have been shown to underestimate the actual level of maltreatment. A study conducted by the U.S. Government Accountability Office (2008) found that 15% of state surveys miss actual harm and immediate jeopardy of a nursing home resident.

Resident / Family Concerns That Discourage Reporting

- Lack of awareness by residents and their families about how and where to report complaints.
- Fear that a complaint will result in retaliation.
- Many residents in mid-to-late stages of dementia are unable, frightened or embarrassed to report neglect and abuse.
- A substantial number of residents in general and those with dementia do not have a family advocate.

OHFC Specific Issues That Impact Investigations

- OHFC investigated on-site only 5% of more than 24,000 complaints in 2016.
- Long delays in operators' internal and external reporting and by OHFC in investigating complaints in a timely manner compromise the collection of critical evidence of maltreatment.
- Due to internal improvements in OHFC during 2018, 30% of cases substantiated reflects a significant increase from the Office of the Legislative Auditor (OLA) reported findings of 16 -19% substantiated cases from 2012-2016.

Industry Practices That Impede Investigations

- Many direct care staff are afraid to report abuse for fear of disciplinary action or losing their job.
- There is often a lack of scope and quality in residents' individual care planning and inadequate reporting and documentation of significant changes in medical conditions, that contribute to limited ability to effectively investigate complaints.
- There are insufficient thorough and immediate internal investigations of residents' and families' concerns and complaints by assisted living facilities, making it difficult to gather critical evidence.
- There are communications breakdowns in assisted living facilities, relating to serious care concerns that are often insufficiently documented.
- A 2015 change in statute allows home care providers with multiple facilities to avoid a survey for each facility for a substantial number of years.

Other Oversight Issues:

- Lack of sufficient and skilled involvement of the police.
- Insufficient reports involving the medical examiner in unusual, premature, sudden, suspicious and unnatural deaths of vulnerable and frail residents.

Legislative Recommendations

Elder Voice Family Advocates, AARP Minnesota and Mid-Minnesota Legal Aid are pursuing comprehensive reform in the 2019 legislative session. We have been meeting with staff from the Department of Health and the Department of Human Services as well as assisted living industry representatives to better understand the concerns of all and try to reach common ground of agreement. The following are the key provisions of the protection legislation that we are pursuing and advocating with these stakeholders.

Establish Licensing for Assisted Living Establishments

Licensing Structure

Single contract required for housing and services and adds new contract protections and creates three tiers of licensees:

Level 1: Provides housing and basic home care services
Level 2: Provides housing and comprehensive home care services
Level 3: Provides either basic or comprehensive home care services plus dementia care

Maintains a Housing with Services registration for establishments providing only a limited set of supportive services

- Assistance with laundry, shopping, household chores;
- housekeeping services;
- provision or assistance with meals or food preparation;
- help with arranging for or arranging transportation to medical, social, recreational, personal, or social service appointments; or
- provision of social or recreational services.

Require assisted living administrators to be licensed.

Require affiliated home care providers to be licensed.

MDH Regulatory Powers / Authority

- Vests MDH with authority to issue, deny, suspend, revoke, and refuse to renew licenses.
- Vests MDH with power to inspect licensees and issue correction orders and fines for violations.

Resident Assessments

- Requires pre-admission and ongoing nurse assessments of physical, cognitive, emotional/psychological, behavioral, social and service needs.
- Requires development of service plan and modifications if ongoing assessment necessitates changes.
- Provides that resident, family and others of resident's choosing may participate in planning.

Minimum Standards

Requires MDH to issue rules regarding:

- Health, sanitation, safety, and comfort standards.
- Physical plant, equipment, maintenance and operational standards.
- Educational, professional, experiential and training requirements for administrators and staff responsible for medication administration, management and storage.

- Dementia care, which is specialized care requiring separate standards.

Establish Clear Resident Protections

Home Care Bill of Rights expanded and strengthened

Electronic monitoring authorized

- Clarify resident's right to place a camera or other monitoring device in their residence.
- Create procedures and safeguards for residents and roommates.
- Notification to facility required except where resident fears retaliation, facility has not acted timely on a complaint or a maltreatment report has been filed.

Prohibit retaliation against residents and employees who

- File a maltreatment report or a complaint with the operator or the state.
- Advocate for improved care, service, or enforcement of rights.
- File a civil action.
- Participate in an administrative or judicial proceeding.

Prohibit Deceptive Marketing

- Bans untruthful and misleading promises to residents and families regarding provision of services and care. In addition, prohibit untruthful and misleading promises beyond the assisted living facility's ability and/or Scope of Practice.
- Strong enforcement to minimize the serious harm to residents when the assisted living facility accepts a resident that they are not capable of giving adequate and promised care.

Private Enforcement of Key Rights

- Give residents and designated representatives the right to enforce a limited set of rights in court, such as violations of prohibition on retaliation or denial of visitors or access to legal or advocacy assistance.

Protections Against Arbitrary Discharge/Service Terminations

- Pre-discharge/termination conference to attempt to avoid inappropriate or wrongful discharge/termination required.
- Reasons for discharge or termination limited (provides exceptions for emergencies).
- Right to appeal provided in general and in a timely manner.
- If discharge/termination is necessary, the assisted living facilities have duty to actively participate with resident/families to ensure orderly relocation to a safe and appropriate care setting.

Increase Funding for State Regulatory Oversight

There are a number of areas that need a substantial increase in funding to better enable MDH to regulate and enforce the laws. MDH has been deluged with complaints in the past few years but hasn't received budget increases sufficient to handle the work load and better curtail the neglect and abuse. We support increasing the funding for the following program improvements:

- Assisted living licensure will require significant increase in staffing to properly regulate this industry. Without this very important work we will be leaving our frail and vulnerable adults at risk for continued neglect, abuse, and exploitation.

- Modernize MDH case management system to an electronic system.

- Coordinate civil and criminal investigations with improvement to the Minnesota Adult Abuse Reporting Center and improve the data management abuse reporting system so consumers can see performance of operators.
- Establish an assisted living report card.
- Conduct more on-site investigations of assisted living facilities.
- Increase on-site reviews from the current once every 4.8 years to every 3 years. While still inadequate, this is an improvement.
- Increase the staffing levels at the Office of Ombudsman for Long-Term Care of MN to improve the ability to detect, investigate, and resolve resident and family member concerns regarding quality of care, safety and allegations of maltreatment.

The Office of Ombudsman for Long-Term Care of Minnesota is ranked the lowest in the nation (52 out of 52 states) in staffing levels, with an approximate 1:9,000 ratio of Ombudsman staff per LTC home beds.
Source: Cheryl Hennen, director, Office of Ombudsman for Long-Term Care of Minnesota, during her testimony at the MN House of Representatives Long-Term Care Division, March 4, 2019

It is important to emphasize, however, that even if the legislation for the 31 additional Ombudsman staff is passed, the ratio with these new positions is estimated to be approximately 1 FTE Ombudsman staff per 3,300 long-term care facility beds. This is significantly lower than the 1:2,000 ratio recommended by the Institute of Medicine. The new ranking for Minnesota is estimated to be 38th ranking among the 52 states.

"Because state law provides few requirements for HWS / ALR, the state has few requirements on which it could base enforcement actions for substantiated maltreatment allegations. This is true even for instances when a vulnerable adult who lived in HWS / ALR experiences maltreatment that results in serious injury or death."

Source: Office of The Legislative Auditor of MN (2018)

Additional Recommendations for Future Legislative Remedy

There is an urgent Need for a Standard Survey of Assisted Living Facilities (at the specific care home floor level) once a year. Minnesota law authorizes MDH to inspect assisted living facilities at least once every three years to ensure services are being provided in accordance with home care laws (Office of the Legislative Auditor of MN, 2018).

However, the current requirement by which MDH inspects operators at least once every three years is completely inadequate to protect the rights, health and safety of assisted living residents. The three-year inspection cycle not only prevents the public from obtaining timely performance information about assisted living residences, but care standards and residents' rights become virtually meaningless when inspections are so infrequent. Issuing a license under these conditions deceives consumers who assume that the state is conducting regular inspections and offering oversight and protection to residents.

Need Plans of Corrections in Assisted Living Facilities

We recommend that Minnesota law be aligned with federal licensing requirements on plans of corrections. According to the Office of Legislative Audit of MN (2018), "Within 10 calendar days of receiving OHFC's notification of licensing violations, providers (operators) that violated a *federal* licensing requirement must submit to OHFC a written plan detailing how they will correct certain noncompliant practices. Once OHFC receives the plan, it determines whether the plan is acceptable and notifies the operator of its determination. According to federal guidance, an acceptable plan must address how they will correct each licensing violation, how it will prevent the noncompliant practice from occurring again, how it intends to monitor its performance, and when its corrective actions will be completed."

By contrast, Minnesota law indicates, "For violations of state licensing requirements, providers (operators) are not required to submit a plan to OHFC detailing how they will correct noncompliant practices. Instead, Minnesota's law requires only certain operators, home care providers, to "document in [their] records any action taken to comply with the [citation]." "It also authorizes OHFC to request from these operators copies of the documentation at any time.

Plan of Corrections is a core mechanism for ongoing oversight, enforcement and accountability. The gross lack of strong requirements for Plans of Correction in assisted living facilities limits MDH's ability to fulfill its mission to protect vulnerable and frail elders in this fast growing but minimally regulated long-term care setting.

Conclusion

Without legislative *reform* consisting of a comprehensive set of basic safeguards to protect residents in this rapidly growing assisted living setting, vulnerable and frail residents will continue to be at high risk for neglect, abuse, avoidable accidents, financial exploitation, drug diversion and other forms of harm.

The sorely needed and long-overdue meaningful licensure of assisted living facilities in Minnesota combined with assisted living industry commitment to implementation of evidence-based best care policies, procedures, and practices will ultimately increase the likelihood that vulnerable residents will remain safe and free from physical and psychological harm.

It will also fulfill the important promise of assisted living facilities as a safe care environment; one that is fully committed in action to ensuring that vulnerable and frail residents will experience the "highest practical medical, psychological, and social well-being."

It is their human right.

Appendix

A. Investigation Case Study Summaries

Our case studies reflect only a small fraction of the spectrum and scope of maltreatment of vulnerable adults in assisted living residences across Minnesota.

This section contains summaries of a subset of the 200 substantiated cases of maltreatment examined for this report. We regret that the limited time and resources did not allow us to summarize all the cases where lives were tremendously or tragically impacted from maltreatment incidents. The maltreatment cases summarized here from Office of Health Facility Complaints Investigative Public Reports include substantiated:

- Neglect (including 25 Neglect of Healthcare, 8 Neglect of Supervision and 2 Neglect of Supervision: Resident-to-Resident Altercation).
- Sexual Abuse (including 2 Rape by Staff and 2 Touching/Fondling by Staff).
- Physical Abuse (1 case study).

Note: ***This report is based on the publicly available investigative reports of the Minnesota Department of Health's Office of Health Facilities Complaints (OHFC). Elder Voice Family Advocates does not vouch for the accuracy of the OHFC Investigative Reports. To the best of our knowledge these case study summaries are accurate interpretations of the data provided. See the Data Sources and Data Examination Approach discussion on page 74 of this report for more information.***

Neglect Case Study Summaries

Our review revealed a shocking indifference to the fate of grossly neglected vulnerable and frail elders.

Much of the human suffering, emotional and physical traumas experienced by vulnerable adult residents in assisted living facilities across Minnesota were clearly preventable.

DEFINITION OF NEGLECT IN MINNESOTA

Minnesota Statutes, section 626.5572, subdivision 17 "**Neglect" means:**

(a) The **failure or omission** by a caregiver **to supply** a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, **health care**, or **supervision** which is:

(1) Reasonable and **necessary to obtain or maintain** the vulnerable adult's physical or mental **health or safety**, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) Which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of **absence of** care or services, including but not limited to, food, clothing, shelter, **health care, or supervision** necessary to maintain the physical and mental health of the vulnerable adult **which a reasonable person would deem** essential to obtain or maintain the vulnerable adult's **health, safety, or comfort** considering the physical or mental capacity or dysfunction of the vulnerable adult.

Definition of Elder Neglect:

"Failure by a caregiver or other responsible person to protect an elder from harm, or the failure to meet needs for essential medical care, nutrition, hydration, hygiene, clothing, basic activities of daily living or shelter, which results in a serious risk of compromised health and safety."

– The Centers for Disease Control and Prevention

Our review of 135 OHFC Investigative Reports substantiated as neglect in assisted living facilities identified an overarching theme and several systemic patterns.

Overarching Theme

Numerous neglect incidents where the emotional/psychological and physical harm experienced by the vulnerable resident could have been prevented had there been early assessment, documentation, monitoring, intervention, treatment, communication and/or notification.

Main Patterns Identified

- Lack of basic nursing assessment or recognition of warning signs and timely intervention.
- Lack of basic care assistance.
- Lack of or inadequate individualized care plans / service plans.
- Lack of adequate supervision of residents, especially those with dementia.
- "Secured" Memory Care Unit not secure.
- Inadequate or lack of supervision of direct care staff.
- Communication breakdowns within care teams.
- Operating beyond scope of practice and staff skills/training.
- Lack of or failure to follow internal policies and procedures.
- Dangerously low staffing levels.
- Avoidable hospitalizations – At least 55% of the 128 substantiated neglect cases reviewed resulted in an E.R. visit or hospitalization.
- Preventable health decline followed by a move of resident to a higher level of care (skilled nursing home or hospice).
- Thirty-seven of the 128 substantiated neglect cases (29%) contributed to or directly caused the death of a resident.

NEGLECT OF HEALTHCARE

1. NEGLECT OF HEALTHCARE

Death due to Cardiorespiratory (heart & lung) Complications of Decreased Motility related to Fractures as a Consequence of Fall.

Client with Dementia on Memory Care Unit ➔Repeated falls (4 in one month) ➔No assessment, no interventions ➔Failed to develop care plan to reduce risk of falls ➔Multiple fractures of pelvis, back & ribs ➔Moaning in pain ➔Hospital ➔Died.

Summary of Conclusion

A frail client with dementia and osteoporosis residing in a memory care unit required assistance with reorientation, dressing/grooming, showers and reminders to use the walker. The client had four falls in four weeks, the first two within 24 hours while the client was alone. After the first fall, the client was found with dried blood and pain in the tailbone and after the second fall, the client was found on the floor and complained of lower back pain. A physician was notified, and a CT indicated the client had an acute L5 compression fracture. Although a nurse had initiated an assessment after the second fall, he/she did not evaluate any change in the client's needs.

The third fall was sustained when the client attempted to transfer independently to the bathroom and was found on the floor with a rug burn and pain in both legs. The physician was notified and suggested a hospice consult due to the client's dementia, malnutrition and poorly controlled pain due to the back fracture and other musculoskeletal pain. A fourth fall occurred when staff left the client unattended in the bathroom. The client had pain in the right shoulder and back. The following day the client was grabbing at his/her leg and moaning in pain and was sent to the hospital where the client was transferred to the trauma center hospital. Hospital records indicated the client had multiple fractures of the pelvis, back, and ribs.

Additional Notes: The licensee failed to identify and consider contributing factors to the incident and failed to develop a care plan to reduce the risk of falls and injuries from falls.
The client was unable to be interviewed at the time of the investigative visit because the client had died.

Report #	HL23848005
Date of Visit	April 16, 2013
Date Concluded	June 20, 2013
Facility Name	**Lighthouse At Waconia *Also known as New Perspectives**
City	**Waconia**
Zip Code	55387
Type of Facility	Home Care Provider/Assisted Living
Source of Report	Complaint
Determination	Substantiated
Responsibility Determination	Facility

2. NEGLECT OF HEALTHCARE

Death Due to failure to Assess and Treat Diarrhea, Vomiting, and Severe Dehydration.

Client with Neurocognitive Disorder on Memory Care Unit → Weight loss, nausea, vomiting, loose stool, & severe dehydration → Not assessed → Hospital ICU → Died 2 days later.

Summary of Conclusion

A frail client with a neurocognitive disorder residing in a memory care unit for three months required total assistance with toileting and assistance with bathing and used a walker for mobility. The client lost at least 25 pounds over the course of the first two months. Documentation indicated the client "did not eat meals served nineteen times" for the two months prior to discharge and during the month prior to discharge, the client did not receive his/her medications as they were given in her food and the client wasn't eating.

The client had periodic episodes of loose stools, vomited and /or felt nauseous and was unable to eat. Staff failed to assess or report to the nurse and/or the physician the change in condition including weight loss, lacking eating, not getting all of the medication, loose stools/diarrhea, nausea, episodes of vomiting or complaints of not feeling well. In addition, there was no evidence of the client receiving intervention for the vomiting, loose stools or nausea. The day before the client was transferred to a second facility, the client did not receive any of his/her medications nor had eaten anything.

Upon admission to the second facility, the client was found to be pale, very shaky, had cool and clammy skin, and low blood pressure and body temperature. By 2 pm, the client was transferred by ambulance with abdominal pain, low blood pressure and body temperature to the emergency room and was found to be severely dehydrated. The client was transferred to an intensive care unit where two days later, he/she became unresponsive and died.

Additional Notes: The attending physician had stated it was very unlikely that the client's condition on arrival at the emergency room and the client's level of dehydration occur in a few hours.

The client's physician stated had the home care provider called and notified him/her of the client's change in condition, he/she would have assisted the home care provider to assess the client and recommended treatment pertinent to that assessment.

Report #	HL2580002
Date of Visit	February 1, 2016
Date Concluded	April 4, 2016
Facility Name	**Milestone Senior Living**
City	**Faribault**
Zip Code	55021
Type of Facility	Home Care Provider/Assisted Living
Source of Report	Complaint
Determination	Substantiated
Responsibility Determination	Facility

3. NEGLECT OF HEALTHCARE

Neglect Due to failure to provide daily checks according to service plan. Client died and was discovered by family two days later.

Client had a history of falls and diagnosis of seizures ➔ Daily "I'm o.k." checks not conducted for at least two days ➔ Client discovered dead with bruising in recliner by family member two days later ➔Facility falsified records ➔Phone records provided proof of lack of daily checks.

Summary of Conclusion

A client with a documented vulnerability and history of falls (five within five months from May to October 2017) and a past diagnosis of seizures lived in an independent/assisted living unit and used a walker for mobility. The client received services for care with a feeding tube as required, nursing assessments and vital signs. As part of the facility's residency agreement, the facility had a daily "I'm o.k." program to ensure safety of clients that was not performed for at least two days in October 2017. The daily "I'm o.k." was as follows: "There is a check-in button located on the wall in your bedroom. When you wake up in the morning, we ask that you push the check mark button to notify the front desk. If you have not pushed the button by 10 am, the front desk will call you to make sure that everything is all right." No other safety prevention measures were instituted to protect the client. The client's individual abuse prevention plan had been reviewed three times between April and October 2017. A RN indicated no changes to be made to the prevention plan. Only two assessments had been completed since the first fall in May 2017. Neither of the assessments mentioned any of the fall events or history of falls.

<u>The family meeting October 24</u>:
A family meeting took place with the client, Hospice nurse and Home Care representative. The client was alert, participated in the meeting, ambulatory and oriented. The client performed many of his/her daily tasks and activities of daily living independently. The meeting concluded mid-afternoon when a facility housekeeper arrived after being asked to come back at this time to clean the apartment. The family member left telling the client they would be back in a couple of days. According to the housekeeper, the client intended to go to the Halloween party that evening and meet the housekeeper's children. The housekeeper left the apartment with the client standing in the kitchen at 3:40 and the party went from 5:30 to 7pm of which the client was not seen.

<u>Client found two days later October 26</u>:
A family member arrived in the evening to find several boxes outside the apartment door and two newspapers dated October 25th and 26th. Upon entering the room, the client was found in his/her recliner deceased. The footrest on the recliner was extended, the client was leaning in a horizontal position eyes partially open, with bruising around the jawbone, cheek and both sides of the lower neck area. Client was wearing the same clothing that was worn at a meeting on October 24. The window blinds were up, and the October 24th newspaper was folded next to the client in the recliner. The bed and bathroom did not appear to have been used since housekeeping had been there on October 24. Medications had not been taken for October 25th and 26th. The client did not attend the Halloween party as she had planned.

<u>Receptionist interview/falsified records</u>:
The receptionist stated the daily "I'm ok" check program did not consist of a written policy or procedure. At times not all the clients had been checked because of other responsibilities being performed. He/she

indicated it was the responsibility of the daytime receptionist and that if all the clients did not get checked on after a phone call, it usually did not get done. Phone messages were not left with "I'm ok" calls as clients don't listen to phone messages. The receptionist stated the client had called the front desk on October 26th inquiring if a package had been delivered. There was no memory of having to call the client to do an "I'm ok" check. The most common way to confirm if the client was ok was through aides or the client's family member. The receptionist stated there was a camera in the lobby but it either didn't work or was not wired.

The facility did not have documentation the daily "I'm ok" checks were performed for the client on October 24th or October 25th. There was a check mark on the form indicating the client was ok for October 26th.

Phone records:
No calls were made to or from the client's land-line to the facility's front desk between October 23rd and October 26th. Records showed the client did not answer several calls received from other family members.

Senior leadership:
The October 24th page was missing from the daily "I'm ok" checks. No system was in place to track packages from the front desk to the client's rooms. Senior leadership did attend the Halloween gathering and did not see the client.

Additional Notes: There is evidence the client had died or was incapacitated for unknown reasons where she/he could not get out of the chair on the evening of October 24th through the time of discovery on October 26th. From the summary of deficiencies: At the time of the incident, the licensee did not have a policy on the daily "I'm ok" check program.

Report #	HL20662013
Date of Visit	November 21, 2017
Date Concluded	January 29, 2018
Facility Name	**The Commons On Marice**
City	**Eagan**
Zip Code	55121
Type of Facility	Home Care Provider/Assisted Living
Source of Report	Complaint
Determination	Substantiated
Responsibility Determination	Facility

4. NEGLECT OF HEALTHCARE

Death secondary to hip fracture sustained by failure to use mechanical lift for transfer.

Client required mechanical lift for all transfers ➔Manually transferred client from wheelchair ➔Fractured hip ➔Hospital Physician – contributing factor to end of life.

Summary of Conclusion

A client received assistance with medication administration, transferring, bathing, eating and repositioning according to the service plan. The client required a mechanical lift with an assist of two for all transfers.

A hip fracture was sustained after two staff members manually transferred the client from a wheelchair to his/her bed. The nursing staff was notified of a deformity in the leg and the client was sent to the hospital where non-surgical intervention was decided by the family.

Observations and interviews: Multiple staff were unable to properly identify the different lifts used in the facility, to find different sized slings and policies. Inconsistent lift training between staff and no documented training was in the file for the two staff involved in the transfers. The two involved received training after the incident and said it was beneficial and they learned things they never knew before. Both staff made the facility aware of their uncomfortableness using the lift with the client.

Additional Notes: The medical doctor stated the hip fracture was a contributing component to the client's end of life.

Report #	HL20532013
Date of Visit	August 15, 2017
Date Concluded	November 17, 2017
Facility Name	**The Homestead of Coon Rapids**
City	**Coon Rapids**
Zip Code	55433
Type of Facility	Home Care Provider/Assisted Living
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

5. NEGLECT OF HEALTHCARE

Death due to complicated urinary tract infection with failure to provide necessary cares for urinary catheter.

Client with Alzheimer's disease & urinary catheter ➔Malpractice/Negligence of flushing, changing, monitoring urinary catheter ➔Severe urinary tract infection (UTI) ➔Died.

Summary of Conclusion

A client with Alzheimer's disease and a neurogenic bladder (bladder dysfunction) with a suprapubic catheter (catheter empties the bladder through an incision in the belly) required assistance with medication, treatment administration, and all activities of daily living (ADL). The client had a history of on-going issues with the catheter becoming blocked.

During the four months prior to the client's death, catheter flushes were not performed as ordered by a licensed nurse practitioner (LPN) nor were urinary catheter changes performed as directed by a urologist. The urologist changed the catheter and the home care provider lacked any records indicating any further catheter changes. Several episodes of catheter blockage occurred with difficulty draining. Two weeks prior to death, the client became lethargic, had a low-grade fever, had no drainage from the urinary catheter, and was diagnosed at the ER with a urinary tract infection.

Two days after the emergency visit, an on-site investigation found the client sleepy, unable to communicate verbally or answer questions, the lips were dry, and a white substance was on the teeth and gums. A small amount of dark amber colored urine was in the catheter bag on the floor. A RN stated the previous director of nursing had left suddenly and it was confusing for the remaining two RNs to figure out when things were done. The family had expressed concerns the client was not doing well, looked emaciated and needed the urinary catheter flushed. After the on-site investigation, the client's family provided information that the client had died.

Additional Notes: The cause of death was a complicated urinary tract infection involving a suprapubic catheter. The home care provider was not following their transcription orders and failed to ensure that ordered and necessary cares were provided.

Report #	HL21049031
Date of Visit	February 6, 7, 2017
Date Concluded	August 3, 2017
Home Care Provider	**Minnesota Heritage House**
Facility Name	**Shiloh Assisted Living**
City	**Little Falls/Pequot Lakes**
Zip Code	56345
Type of Facility	Home Care Provider/Assisted Living
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

6. NEGLECT OF HEALTHCARE

Death due to complications of cerebellar (brain) hemorrhage following 2 ER visits after client fell on the floor & left for 4 hours, died 21 days later on hospice in the hospital.

Client with high risk of falls ➔fell on floor ➔ left for 4 hours ➔staff did not contact nurse or emergency services ➔2 days later hospitalized, diagnosed with brain hemorrhage ➔ sent to ER two more times, diagnosed with encephalopathy (brain disease that alters brain function)➔ placed on hospice and died 21 days later due to complications of cerebellar hemorrhage.

Summary of Conclusion

A client with a high risk for falls resided at a comprehensive home care facility receiving services for activities of daily living (ADLs), transfers and required safety checks every hour during the night. A staff member found the client on the floor at night and unable to move or transfer the client, left the client on the floor with a pillow and blanket. The morning staff transferred the client back into bed 4 hours later. Two days later, the client complained of headache and neck pain, was sent to the ER, diagnosed with a brain hemorrhage and sent back to the facility the following day. The client returned to the ER two more times within 10 days, was diagnosed with encephalopathy and hyponatremia (low sodium), developed a fever, was placed on hospice and died 20 days later.

The facility nurse was unaware of the client's fall from bed until the client complained of pain. The staff member did not contact the nurse as she/he did not think the incident was serious. The morning staff did not recall assisting the client off the floor.

Additional Notes: The cause of death was complications due to cerebellar (brain) hemorrhage. The client's family was unable to be contacted. The facility had no system to ensure falls, incidents or changes in condition were immediately reported to the nurse. The staff was unaware of facility policy or procedure to contact a nurse or emergency medical services following a client fall or change in condition.

Report #	HL23665003
Date of Visit	September 18, 2017
Date Concluded	January 17, 2018
Facility Name	**Golden Nest LLC**
City	**Minneapolis**
Zip Code	55418
Type of Facility	Home Care Provider/Assisted Living
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

7. NEGLECT OF HEALTHCARE

Death due to sepsis (total body infection) after client sustained permanent paralysis in arm secondary to staff placing tourniquet on client's arm against hospital nurse's directions and not contacting facility on-call nurse.

Client with lung cancer fell, fracturing arm ➔staff placed tourniquet against hospital nurse directions ➔permanent paralysis of arm ➔5 days later, hospitalized ➔long term care facility ➔died 19 days after tourniquet placed due to sepsis.

Summary of Conclusion

A client with terminal lung cancer remained independent of activities of daily living (ADLs) but needed assistance with bathing, wellness checks and monitoring of the humidifier of the oxygen concentrator. The client had occasional bouts of confusion due to the illness. The client fell sustaining an arm fracture, was treated at the emergency department and returned to the home care provider the same day needing assistance with one-person transfers and personal cares. The client received a skin tear later that night and requested a tourniquet be placed on her arm. A call to the hospital nurse advised against this but the staff applied a tourniquet using an apron tie. The client's arm turned color and had no mobility once the tourniquet was removed around 2 am. The management staff stated there was a delay in determining what happened due to conflicting statements from the two staff members involved.

Five days later, the client was sent to the hospital, was diagnosed with permanent paralysis of the forearm due to ischemic neuropathy (cutting off blood supply and nerve connections) and also with a pulmonary embolism (blood clot in lung) that was resolved. The client was sent to a long-term care facility and died nineteen days after the tourniquet was placed due to sepsis.

Additional Notes: The death record indicated the cause of death was sepsis. The two staff members were terminated.

Report #	HL24552001, HL24552002
Date of Visit	March 28, 29, 2017
Date Concluded	December 22, 2017
Facility Name	**Lake Song Assisted Living**
City	**Onamia**
Zip Code	56359
Type of Facility	Home Care Provider/Assisted Living
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

8. NEGLECT OF HEALTHCARE

Death due to depleted batteries on heart pump device when device was not plugged into external power source according to daily procedure.

Client with heart failure with a LVAD (left ventricle assist device, heart pump) & dementia ➔Staff failed to plug in "heart pump" device to external power source ➔batteries depleted ➔Died.

Summary of Conclusion

A client with heart failure with a heart pump device and dementia required assistance with daily living activities, meals and heart pump management. The client had 10% heart function and the heart pump was required to increase blood flow to the rest of the body to increase the client's quality of life and survival while in end stage heart failure.

The heart pump ran off batteries during the day and sleep procedures requirements were to change from battery to wall/outlet power. The heart pump unit had low battery system alarms that sounded with a loud, intermittent tone followed by a loud continuous tone which according to the owner, sounded like a smoke detector. The staff member was distracted by another client and forgot to change the device from battery power to wall/outlet power. Two other staff members did not check the device and the client was found deceased at 5 am. Both batteries were depleted. No treatment plan was implemented for evening staff to sign after managing the heart pump or any monitoring of the heart pump overnight.

Additional Notes: The medical examiner's report stated the device did sound a low battery alarm at 1:30 am. The death record indicated the client died by accident when the heart pump batteries depleted when it was not connected to another external power supply. A family member explained the client was dependent on staff to manage the device.

Report #	HL24640003
Date of Visit	July 15, 18, 19, 2016
Date Concluded	January 4, 2017
Facility Name	**Aging Joyfully**
City	**Eden Prairie**
Zip Code	55347
Type of Facility	Home Care Provider/Assisted Living
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

9. NEGLECT OF HEALTHCARE

Death due to failure to provide timely medical response of vomiting, diarrhea, abdominal pain & distention (enlarged) of known history of hernia.

Client with Dementia & history of hernia ➔Complains stomach hurts, screamed "help me, help me" ➔Abdomen like pregnant woman with twins ➔Family calls "911" ➔ Hospital, "shock" & "strangulated hernia" ➔Respiratory failure, bowel infarction (death of small bowel) ➔Died.

Summary of Conclusion

A client with dementia and history of a twice treated hernia diagnosed nine months prior to the client's death was able to communicate his/her needs independently and required assistance with daily living activities. The physician instructed staff in the facility's electronic record to check for tenderness/pain when changing his/her incontinence pad. The staff indicated they were not aware of this intervention.

One evening the client complained of his/her stomach hurting and had vomited. These symptoms were not reported to a nurse. The facility policy indicated staff were to report changes in a client's condition immediately to a licensed nurse. The following morning staff observed: client's stomach hurting, screaming "help me, help me", pointed to his/her stomach, vomited, and had explosive bowel movements. The abdomen was "tight, distended" and/or "bloated". Further symptoms developed: abdomen was "hard" and appeared to look like a pregnant woman with twins with an extremity poking out. The client repeatedly cried "ow, ow". The RN and LPN failed to evaluate and/or denied the client's symptoms.

A family member noted the client was in so much pain, he/she could not talk and called "911". The client was in shock and respiratory failure and placed on a ventilator. A large strangulated hernia with obstruction and necrosis (death of tissue) of the entire small bowel too extensive for surgery was found. Comfort care was provided, the client was removed from the ventilator and died that evening.

Additional Notes: The cumulative effect of lack of reporting and knowledge to report represented a system failure on the facility's part. The physician stated: There is six hours once the herniated area is bulging before you have a risk of death of the bowel. This is an emergency and if not treated can be fatal. Had the client gone to the hospital sooner the client would have had a better outcome.

Report #	HL26853008
Date of Visit	October 20, 2014
Date Concluded	December 8, 2014
Facility Name	**Lighthouse of Columbia Heights Also known as New Perspectives of Columbia Heights**
City	**Columbia Heights**
Zip Code	55421
Type of Facility	Comprehensive Home Care Provider
Source of Report	Complaint
Determination	Substantiated
Responsibility Determination	Facility

10. NEGLECT OF HEALTHCARE

Death due to bronchopneumonia (lung infection) 26 days after client fell on floor, unnoticed overnight for 10 hours despite alarms & required checks per service plan, becoming non-ambulatory, and hospitalized.

Client with Alzheimer's disease, coronary heart disease (CAD), Raynaud's disease (blood vessel disorder) ➔ fell on floor, not discovered for 10 hours overnight despite alarms sounding & required checks per service plan ➔ non-ambulatory➔ 10 days after fall hospitalized for 5 days ➔hospice ➔dies of bronchopneumonia 10 days later.

Summary of Conclusion

A client with Alzheimer's disease, CAD and Raynaud's disease resided in a home care facility and ambulated with a walker and required assistance with all activities of daily living (ADLs). The service plan indicated assistance with continence care when the bed alarm activated and overnight at midnight and 7am to assist, if the client was awake, with getting to the bathroom. A safety check at 3 am for all residents was to be performed.

The client fell around 11 pm and despite an alarm which alerted staff on their cell phones, rolling from one phone to another, no one responded to the alarm. The scheduled overnight required checks were not performed nor the required safety check at 3 am and the client was not found for 10 hours. The client was found at 8:45 am incontinent of urine, confused and in pain. The client could no longer ambulate, requiring a wheelchair and mechanical lift for transfers and expressed pain upon moving. X-rays taken were negative for fractures, but the client was hospitalized on the tenth day, diagnosed with a urinary tract infection, aspirated, and was transferred to hospice and died of bronchopneumonia 10 days later.

Additional Notes: There were four different occasions that a staff member should have entered the client's room and did not: Alarm going off, midnight check, 3 am check and 7 am check. Staff did not enter the client's room at any time during the overnight shift.

Report #	HL27108013
Date of Visit	September 26, 27, 2017
Date Concluded	December 13, 2017
Home Care Provider	**Ebenezer Home Care**
Facility Name	**Trails of Orono**
City	**Minneapolis / Orono**
Zip Code	55407
Type of Facility	Home Care Provider / Assisted Living
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

11. NEGLECT OF HEALTHCARE

Untimely Death due to Not Receiving Chemotherapy Medication as Prescribed.

Client with multiple myeloma (blood cancer) ➔26 of 42 doses of chemotherapy meds not given over 12 weeks ➔ sub-therapeutic levels of chemotherapy in blood ➔died sooner than expected.

Summary of Conclusion

A client with multiple myeloma (blood cancer) received services including medication management of a chemotherapy drug with a strict administration schedule. The client did not receive 26 of 42 doses of oral chemotherapy medication over a 12-week period. A second form of chemotherapy was given at the cancer center to work concurrently with the oral form, but lab work performed indicated sub-therapeutic values due to the missed doses.

Several medication errors occurred resulting in the missed doses of medication and the family was notified only once when one week of medication was missed.

Additional Notes: A cancer center nurse said the chemotherapy regime never had a chance to work and the client passed away sooner than expected since he/she did not receive the chemotherapy medication as prescribed.

Report #	HL27112004
Date of Visit	July 6, 2017
Date Concluded	September 15, 2017
Facility Name	**The Legacy of St. Michael**
City	**St. Michael**
Zip Code	55376
Type of Facility	Home Care Provider/Assisted Living
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

12. NEGLECT OF HEALTHCARE

Death due to Complications of a Femur Fracture resulting from a Fall as a Consequence of Failure to Develop a Safety Plan on the use of a BRODA (high backed wheelchair) chair.

Client in memory care unit dependent on all ADLs (activities of daily living) ➔fell from BRODA chair ➔femur fracture ➔Hospital ➔Died at facility the next day.

Summary of Conclusion

A client with an advanced disease limiting his/her cognition and physical abilities resided in a memory care unit and was totally dependent for all ADLs. Initially on hospice, the facility used a BRODA chair without establishing a plan of care for the client's use of the chair. The client graduated from hospice and the client's family purchased a BRODA chair for the client's use for safety positioning.

Several staff indicated the facility did not provide instructions on how to use the BRODA chair, how to maintain the client's safety when in use nor how to position the client in the chair. The client was not assessed on the individual's needs when using the BRODA chair.

On the day of the incident, the client had an unwitnessed fall sustaining an abrasion on the forehead, a 0.5 cm laceration on the corner of an eye and the client complained of knee pain.
Later that night, with increased pain, a contacted physician ordered an x-ray revealing a fracture of the femur. The client was sent to the hospital and discharged back to the facility on hospice since the client was not a candidate for surgical repair of the fracture. The client died at the facility.

Additional Notes: The manufacturer of the BRODA chair indicated the facility is responsible to ensure staff follows the safety and operating instructions and arranges an in-service on the operations and safety requirements in the manual. Staff were not trained, and the facility did not follow its policy and procedure to develop a safety plan for the client.

Report #	HL27306007
Date of Visit	April 6,7, 2015
Date Concluded	August 6, 2015
Home Care Provider	**Cherrywood Advanced Living**
Facility Name	**Cherrywood Advanced Living of Big Lake 177**
City	**Sauk Rapids / Big Lake**
Zip Code	56379
Type of Facility	Home Care Provider/Assisted Living
Source of Report	Complaint
Determination	Substantiated
Responsibility Determination	Facility

13. NEGLECT OF HEALTHCARE

Death due to embolic vascular event (blood clot occluding a blood vessel, stroke) due to failure to administer anticoagulant (blood thinner) medication for 14 days per physician orders & client suffered a stroke leading to death.

Client Did Not Receive Anticoagulant Medication For 14 days ➔ Stroke ➔Hospitalization ➔ Died (physician Stated Missed Medication Direct Cause of Death).

Summary of Conclusion

A client with a history of stroke received services including medication management for long term oral anticoagulant therapy due to a higher risk of stroke. Ten days prior to death, a blood test to determine clotting rate was done and the alleged perpetrator (AP) noted it was abnormally low. The client had not received any anticoagulation medication for the previous 14 days as the AP had not ordered the medications. The client's physician was notified and ordered the medication to be started again. Four days later, the client had symptoms of a stroke, emergency services were called, and the client was hospitalized with a diagnosis of a stroke. The client subsequently died despite receiving IV (in the vein) blood thinners.

Several staff members had assisted the client with medications, but none had reported the medication was unavailable. The AP stated the nurse who usually reordered medications was off duty for an extended period of time and the AP missed reordering the medication.

Additional Notes: The primary care physician stated in his/her medical opinion, the client missing 14 days oral anticoagulant therapy was a direct cause of the client's death. The family stated they had not been informed of the missed doses of medication until the hospital staff notified them. The facility failed to ensure multiple personnel followed the policy and procedures for medication administration. The AP knew the policy and procedures and had written warnings for medication concerns in 2009, 2010 and in 2016 for missed anticoagulation doses.

Report #	HL28288004, HL28288005
Date of Visit	April 4, 2016
Date Concluded	December 29, 2016
Home Care Provider	**Vision Quest Property Management**
Facility Name	**Osseo Gardens Assisted Living**
City	**White Bear Lake/Osseo**
Zip Code	55110
Type of Facility	Home Care Provider/ Assisted Living
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

14. NEGLECT OF HEALTHCARE

Death due to Atherosclerotic Cardiovascular Disease (arteries become narrowed and hardened due to a buildup of plaque around the artery wall) following staff unaware of client's move to memory care unit, not provided fluids, food or monitoring for more than 24 hours & found wedged between toilet & wall after 18.5 hours with abrasions on forehead, thighs, forehead, & died the following day in the hospital.

Client With Dementia ➔Moved From Assisted Living To Memory Care Unit Of Same Facility ➔Move Not Documented & Memory Care Staff Unaware ➔Staff Failed To Provide Food, Fluids, Medication, Personal Cares Or Supervision For Over 24 hours ➔Found On Toilet With Head Wedged Between Toilet & Wall After 18 Hours, 38 Minutes ➔Abrasion On Forehead, Large Red Areas Under Ribs To Hip & Thigh Areas ➔Died Following Morning.

Summary of Conclusion

A client with a diagnosis of dementia received hospice care and was moved from the assisted living portion of the facility to the memory care unit requiring a wheelchair, services of medication administration, personal cares including dining, Safety Checks and visual checks every hour. On the overnight shift there was to be a Safety Check at 1:30 am and hourly visual checks thereafter. During the day shift the client was to receive personal cares including taken to the dining room and medication administration as well as Safety Checks. Staff found the client the next day at 2:15 pm on the toilet with her/his head wedged between the toilet and the wall with abrasions on the forehead and large red areas between the bottom rib and hip and on both thighs. The client did not receive services for 18 hours and 38 minutes. The client died the following morning. Staff on the overnight and day shift stated they were not aware the client was on the memory care unit and stated no documentation was in the communication book regarding the move.

Additional Notes: The death certificate stated cause of death as Atherosclerotic Cardiovascular Disease and the medical examiner's Final Anatomic Diagnosis also included rib fractures and contusions (bruising) of the body. The facility's surveillance camera footage revealed after 7:45pm no staff person entered the client's room until 2:23 pm the following day. No "walking rounds" occurred at shift change and the client was not checked on every hour as required by the a staff person who knew the client was there during shift from 7:45pm until 10 pm. Multiple breakdowns in policies/procedures occurred and staff did not document the client had moved from the assisted living to the memory care unit.

Report #	HL28604002
Date of Visit	June 17, 2014
Date Concluded	July 10, 2014
Facility Name	**Summit Hill Senior Living**
City	**St. Paul**
Zip Code	55119
Type of Facility	Home Care Provider/Assisted Living
Source of Report	Facility Self Report
Determination	Substantiated
Responsibility Determination	Facility

15. NEGLECT OF HEALTHCARE

Death following 6 days of hospitalization and transfer to comprehensive care provider where client died after absence of wound care on buttocks by home care provider.

Client with cognitive impairment ➔develops open bleeding wound on buttocks ➔no assessment, documentation, & staff failed to follow physician's orders regarding wound care ➔hospitalization 6 days ➔transferred to a long-term care facility ➔wound did not heal ➔ client died.

Summary of Conclusion

A client with cognitive impairment, stress incontinence, hearing loss and osteoarthritis received services for toileting assistance every two hours as needed and required use of incontinence products. On initial exam by a nurse practitioner (NP) the client had no skin lesions or rashes. Over the course of several weeks, the client developed a rash, then an open bleeding wound as seen by a NP despite previous orders for turning and repositioning. A request for a wound consultation was made but no wound care services were initiated by the home care provider over the course of 7 days. The home health agency assessed the wound two days after receiving the request for consult, found the wound had dark/dead tissue and the physician ordered the client sent to the hospital. The nurse noted the client was wearing a double padded incontinence brief soiled with stool and urine. There was no communication between the home care provider staff or the home care provider and the physician.

The client was hospitalized for 6 days, and then transferred to a long-term care facility. The wound did not heal, and the client subsequently died.

Additional Notes: The home care provider terminated 6 care staff in relation to double padding of incontinence products. Multiple staff were aware of the wound and failed to document an assessment of the skin "breakdown" and failed to ensure the physician's orders for wound care were implemented within 24 hours per policy.

Report #	HL29078012, HL29078013
Date of Visit	December 8, 9, 2016
Date Concluded	December 22, 2017
Facility Name	**Waterford Manor**
City	**Brooklyn Park**
Zip Code	55428
Type of Facility	Home Care Provider/Assisted Living
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

16. NEGLECT OF HEALTHCARE

Death due to complications of aspiration pneumonia & metabolic encephalopathy (altered brain dysfunction) secondary to receiving the wrong medication.

Client receives wrong medication ➔Unresponsive ➔ER Hospital ➔ICU - fever & aspiration pneumonia, metabolic encephalopathy ➔Died nine days later at another facility.

Summary of Conclusion

A client had a service plan agreement to administer medications three times a day. A staff member administered morning medications to the client and by noon the client was unresponsive and sent to the hospital emergency room. A medication cup was found in the client's pocket labeled for another client. The medication for the other client was an anti-psychotic medication, clozapine, found in the affected client's blood.

The client was transferred to the intensive care unit (ICU) and deteriorated with onset of fever and presumed aspiration. The client was discharged to another facility and died nine days later.

The staff member denied administering the wrong medication. Staff indicated no medication cups had client room numbers. During the on-site visit, medication cups labeled with room numbers were in the medication cart.

Additional Notes: Death due to complications of aspiration pneumonia and metabolic encephalopathy. The manner of death included inadvertent use of a non-prescribed clozapine cannot be excluded as a contributing cause of death. The facility failed to monitor to ensure the medication administration procedures were implemented by staff.

Report #	HL 29078014
Date of Visit	January 27, 2017
Date Concluded	May 1, 2017
Facility Name	**The Waterford Manor**
City	**Brooklyn Park**
Zip Code	55428
Type of Facility	Home Care Provider/Assisted Living
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

17. NEGLECT OF HEALTHCARE

Death from a pulmonary embolism (one or more arteries in the lungs are blocked) after staff failed to respond to client's change in condition of labored breathing over the course of more than 15 hours.

Client With Dementia ➔Pale & Labored Breathing ➔ Respiratory Distress ➔RN Assigned Not Aware Of Change In Condition ➔Physician Not Notified ➔Arrives At Hospital Unresponsive ➔Died Within An Hour Of Arrival At Hospital.

Summary of Conclusion

A client with a diagnosis of dementia, deep vein thrombosis (formation of a blood clot in a vein) had confusion and difficulty communicating his/her needs and required assistance with activities of daily living (ADLs), transferring needs and medication management. An unlicensed staff member noticed the client looked pale, was unable to contact the client's assigned RN and notified a different RN. The client was not assessed, and the day staff did not notify the evening staff of any change in condition. A family member reported labored breathing to the evening staff who informed a RN. Over the next several hours the client was assessed multiple times, found sweating, warm to the touch with increased blood pressure and labored breathing. The client's physician was not notified of the client's labored breathing and respiratory distress. Emergency medical services (EMS) were not contacted. Later in the night a second RN stated that s/he did not know what to do and another RN instructed her/him to call EMS. Prior to calling 911, the client's physician again was not notified. Approximately 15 hours after staff first noticed a change with the client, (EMS) transferred the client to a hospital. The client arrived at the hospital unresponsive and despite resuscitation efforts, the client died within an hour after arriving at the hospital.

Additional Notes: The death certificate indicated death from a pulmonary embolism (one or more arteries in the lungs are blocked by a blood clot). The physician expected to be informed of the changes in the client's condition and the findings indicated the client was in respiratory distress and needed aggressive treatment the facility was not able to provide. The physician stated the delay in treatment may have had a negative effect on the client's health. There was no evidence the first RN received training on the facility's notification of client change of condition policy and procedures.

Report #	HL29646001
Date of Visit	July 16, 2015
Date Concluded	December 3, 2015
Home Care Provider	**The Waters Senior Living Mgmt. LLC**
Facility Name	**The Waters of Edina**
City	**Edina**
Zip Code	55436
Type of Facility	Comprehensive Home Care Provider
Source of Report	Facility Self Report
Determination	Substantiated
Responsibility Determination	Facility

18. NEGLECT OF HEALTHCARE

Death due to consequences of blunt force injuries from a fall down stairwell by failure to provide a secured door.

Client with dementia, cerebral vascular disease (CVD), psychosis, found at bottom of stairwell (the door to be secured) next to dining room ➔bleeding from nose & mouth ➔door didn't lock correctly despite ALL employed people knowing for a year ➔Died five days after fall due to blunt force injuries from fall.

Summary of Conclusion

A client with dementia, CVD and psychosis required total assistance with all activities of daily living (ADLs) except eating and used a wheelchair. The service plan and assessment indicated a risk for falls, elopement (leaving building unattended) and required a secured memory care unit.

The client was unable to be located in the dining room and was found lying on the floor at the bottom of a stairwell bleeding from his/her mouth and nose. The client died five days later due to the blunt force injuries from the fall. Incident report, internal investigation, police report: the door was designed to be a coded lock system. The door had not been locked and could be opened by pushing on it. The client was known to have made previous attempts to open the door. Employees knew the door was not working properly.

Maintenance records indicated written requests were made by staff for over a year and staff verbally made requests to fix the problem. Incidents had occurred without injury to other clients over the past 3 years and as recent as 3-6 months prior to this one. The executive director, maintenance director, director of nursing, maintenance staff had been made aware of the problem for over a year.

Additional Notes: The autopsy report indicated cause of death was pneumonia, due to or as a consequence of immobilization due to OR as a consequence of blunt force injuries from the fall.

Report #	HL21386004, HL21386005
Date of Visit	May 4, 2017
Date Concluded	July 7, 2017
Home Care Provider	**CSL Rose Arbor LLC**
Facility Name	**Wildflower Lodge**
City	**Maple Grove**
Zip Code	55311
Type of Facility	Home Care Provider/Assisted Living
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

19. NEGLECT OF HEALTHCARE

Improper Transfer Leads to Fall and Client Left on the Floor for Over 4 Hours with Personal Cares Neglected.

Client with Severe Cognitive Impairment → Staff Improper Transfer leads to Fall → Client Crawling on Floor Dirty with BM → Client is ignored and Did Not receive Assistance or Care for Nearly 4 Hours.

Summary of Conclusion

Client with severe cognitive impairment required complete assistance of one to two staff for personal cares and activities of daily living. Care plan included assistance to the bathroom every two hours while awake and assist with transfer and ambulation with the use of a gait belt and a walker. A wheelchair was used as needed.

Video evidence shows that staff did not use standard practice for a transfer (lock wheelchair brakes, use a gait belt, stand in front of client to transfer), but stood behind the wheelchair and leaned over wheelchair to reach client when transferring from couch to a wheelchair and the client fell. Staff made no attempt to assist client off the floor and did not assist client to the bathroom every two hours as the care plan indicated. Staff stood over client with hands on hips and shook his/her head. Client crawled around the living space on hands and knees. In 3 hours, 16 minutes, there were fifteen incidents when the AP failed to assist the off the floor or address the client's needs. The staff member walked past client without acknowledgement; watched TV, read a magazine and left the area several times. Client made several attempts to pull self-up on various pieces of furniture and the hand rail. Another employee assisted client off the floor after 3 hours 49 minutes and reported that client was dirty with BM and crawling on the living room floor with no underwear and required a shower at the start of his/her shift.

Additional Notes: Time stamped video recording provided evidence that the alleged perpetrator falsely documented the incident and the care provided to the vulnerable adult.

Perpetrator had been educated by the facility regarding client's care plan, vulnerable adult laws, was counseled regarding neglectful care and false documentation prior to the incident.

Report #	HL20403003
Date of Visit	May 8, 2013
Date Concluded	December 3, 2013
Home Care Provider	**Greenview North**
Facility Name	**Greenview South**
City	**Hibbing,** MN 55746
Type of Facility	Home Care Provider
Source of Report	Facility Self Report
Determination	Substantiated
Responsibility Determination	Individual

20. NEGLECT OF HEALTHCARE

Gross failure to monitor and treat diabetes leads to death from renal failure and diabetes.

Client with Diabetes and Dementia → Hospitalized for Diabetic Coma → Revised orders not implemented → Client falls & fractures clavicle → Orders not implemented → ER for elevated blood sugar → Orders not implemented → Hospitalized for Kidney Injury → Hospitalized for Renal Failure → Death .

Summary of Conclusion

A client with diabetes and dementia had an original service plan that included diabetic medication and insulin per a sliding scale based on blood sugar monitoring once per day and preparing a modified diet. Hospitalization for a diabetic coma (blood sugars 331→353→540) led to orders to monitor blood sugar four times per day and required a carbohydrate-controlled diet. The home care provider failed to implement the blood sugar monitoring four times a day and continued checking the client's blood sugar once a day. Dietary changes and carbohydrate counting were also not implemented. The increased monitoring of blood sugar and treatment was not properly implemented for eleven days, even after renewed orders from the client's physician after eight days. When finally implemented, elevated blood sugars were noted (blood sugar above 325 and >400 at least daily). Within 22 days, the client required three hospitalizations and two ER visits; including a fall that resulted in a right clavicle fracture (broken collarbone), then kidney injury, and finally renal failure. The client died of renal failure and diabetes 33 days after the first hospitalization, and 77 days after arriving at the Assisted Living and Specialty Care facility. The determination of maltreatment was substantiated for neglect of healthcare and medication errors due to nursing staff failing to implement correct hospital orders and acknowledge new orders.

Additional Notes: At the time of the client's admission, there were many transitions in nursing staff and the primary nurse leaving. Nurses were going between two of the home care provider locations. It is unclear which nurse was responsible due to multiple nurses dictating notes on the client's status. The facility electronic management system was not linking blood sugars with the insulin order either by system error or human error, therefore insulin administration was not documented. The client's family were unaware the home care provider failed to implement the orders correctly.

Report #	HL23660009
Date of Visit	March 21, 2018
Date Concluded	May 23, 2018
Facility Name	**Golden Horizons**
City, Zip Code	**Aitkin,** MN 56431
Type of Facility	Home Care Provider
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

21. NEGLECT OF HEALTHCARE

Death Due to Multisystem Organ Failure from Infectious Complications of a foreign metal body in the foot.

A client who is cognitively impaired and diabetic complained of foot pain → Treated for a callous for 7 days & Lab Results not reported → ER → Metal object found in heel → foot amputated → Died 9 days later of multisystem organ failure due to infectious complications of a foreign body in right foot.

Summary of Conclusion

A client who is cognitively impaired client with diabetes and renal failure required stand by assistance with activities of daily living. Client complained of foot pain and saw a medical provider (nurse practitioner) at the facility who described wound as a callous and with no signs of infection. Family described a black area on the heel at the time. Client was assessed by a nurse three times in the following week. Family stated client was in such pain he could hardly walk on the fourth day after assessment. Nursing notes revealed no redness or ulceration and vital signs within normal limits on the sixth day. Seven days after the assessment, client went to ER and was hospitalized due to increased pain, difficulty walking, and the foot red with bleeding.

ER diagnosed pneumonia, diabetic foot ulcer, cellulitis, weakness and a foreign body in the foot (a 2 cm wound). The patient clinically worsened, and the foot was amputated when a severe infection developed, and the client died 9 days later of multisystem organ failure due to infectious complications of a foreign body in the right foot.

After an initial determination of inconclusive, family provided evidence that led to the conclusion of substantiated neglect including that the facility failed to appropriately treat the client's diabetes and failed to follow up on a lab report that indicated a change in client's white blood cell (WBC) count that should have been considered as a possible symptom of infection.

Additional Notes: Written blood sugar readings varied significantly from client's blood sugar monitor and there was no documentation the physician had been notified for blood sugar readings over 300.

Correction orders were issued for failing to establish and implement policies regarding the current available unlicensed personnel and their training and qualifications to perform delegated nursing tasks.

Report #	HL27697001
Date of Visit	December 14, 2012
Date Concluded	April 29, 2013
Facility Name	**St. John Home Care LLC**
City	**Minnetonka,** MN 55305
Type of Facility	Home Care Provider
Source of Report	Complaint
Determination	Substantiated
Responsibility Determination	Facility

22. NEGLECT OF HEALTHCARE

Client's request to go to a doctor was denied and staff failure to contact emergency medical services when vital signs indicated further evaluation and treatment results in death from a heart attack.

Resident with Chronic Obstructive Pulmonary Disease (COPD) experiences significant change in condition from baseline and asks to go to doctor → On call nurse refuses to send to hospital → Symptoms continue through the night → Hospitalized → Heart Attack → Died six days later.

Summary of Conclusion

A client that was independent with transferring and mobility with diagnoses including chronic obstructive pulmonary disease received service from a comprehensive home care provider. Service plan included assistance with bathing, managing incontinent products, and medication administration. The client required supervisory assistance with dressing and grooming. Client resided at facility less than two weeks at the time of the incident.

On-call nurse was responsible for neglect, when s/he failed to properly assess a client's report of a significant change in condition and failed to provide needed care in response to the emergency. The client experienced a significantly elevated blood pressure (200/125), low oxygen saturation (78%), chest pain, coughing, shortness of breath, wheezing in both lungs and was pale and shaky. The client asked to be evaluated at a hospital, but the nurse instructed staff not to send the client to the hospital. The client was brought to the ER the next day, transferred to ICU and died six days later. Cause of death was a cardiac arrest.

The facility is also responsible for the neglect because multiple staff failed to contact emergency medical services when the symptoms, vital signs, and request indicated the client required further evaluation and treatment. Physician stated that if the vitals and symptoms were reported to her, she would have instructed client be sent to the hospital immediately by ambulance. Further stating there are interventions that could have been done if he was in the process of having a heart attack and if he had been sent in sooner it could have made a huge difference in his outcome.

Additional Notes: Physician stated the home care provider had been difficult to work with as they tend to "brush off" issues and concerns that s/he has brought to their attention regarding his/her patients.

The licensee interfered with the investigation by the Department of Health by deleting a component of the client record which was requested by the Department of Health.

Report #	HL32493006 + HL32493007
Date of Visit	January 19, 2018
Date Concluded	March 9, 2018
Home Care Provider	**Serenity Living Solutions of Sebeka**
Facility Name	**Shiloh Assisted Living**
City	**Sebeka,** MN 56477
Type of Facility	Home Care Provider
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Individual & Facility

23. NEGLECT OF HEALTHCARE

Nursing assessment and treatment after incident of fall or injury did not conform to professional standards.

Client in Memory Care Unit → Falls at bedside →Bleeding Head Injury → 12 Hours later cannot bear weight, diarrhea, vomit, staff "lowers" to floor → No Assessment, No Documentation, No Communication or Notification to Physician → Died 11 days after first injurious fall with brain bleed, fractured hip, and fractured arm.

Summary of Conclusion

Client residing in memory care unit (with attached full-service emergency facility) received services for medication management, assistance with verbal reminders for some activities of daily living and some household chores. Client was alert and talkative, independently mobile, ate and performed other physical needs with direction. Client had an advanced directive to have treatment for reversible conditions. Neglect was substantiated when facility's registered nurses failed to provide assessments conforming to professional standards to account for the health and safety of the client after incidents of fall or injury.

A fall triggered a bedside movement alarm and client was later found between a dresser and the bed with a visible head laceration and required three staff to get the client off the floor. Twelve hours later, the client had vomiting and loose stools, couldn't bear weight, and was "lowered" to the floor where client hit his/her head on the floor and injured his/her knee when staff attempted to change bedding. Client was mumbling and striking out at staff that tried to touch him/her, pointing to his/her head as if in pain. Client was unable to take medications and was lethargic. Family members decided against a taking client to the emergency department solely based on the statements from facility professionals and the care plan from the nurses. The family felt misled about the healthcare the facility offered. The incident report for both falls indicated no vital signs were obtained (besides temperature) and neither emergency medical services or physician were called. Shortly after the second fall, a family member was turned away from going into the client's room because of a suspected "flu bug". Over the course of four days, the client's condition noticeably declined, yet there was no documentation indicating observations of changes in condition and no vital signs were documented through the time of the client's death.

After three days, the client's breathing pattern typically observed at end of life was observed and family called. Soon after, the client began having repeated seizures. Facility staff did not notify any physicians, nurse stated it was the family's responsibility. The client died five days after the initial fall with autopsy indicating a subdural and subarachnoid hemorrhage (bleeding in the brain), bruising of the brain, bruising of the knee and foot, a hip fracture, and an upper arm fracture. The medical examiner noted the left leg was short, compared to the right leg and was externally rotated. This is a common, visible sign someone has sustained a hip fracture. The medication administration record did not indicate any pain medication was provided from the time of the first fall through the time of death.

Report #	**HL28279016**
Date of Visit	July 10, 2018
Date Concluded	August 14, 2018
Home Care Provider	**Oxford Property Management LLC**
Facility Name	**The Bluffs of Lake City**
City Zip Code	Rochester, MN 55905/ Lake City, MN 55041
Type of Facility	Home Care Provider/ Assisted Living
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

24. NEGLECT OF HEALTHCARE

Death of client with 24-hour continuous respiratory ventilator dependency due to not following Care Plan and lack of identification and intervention by nurse when ventilator stopped working.

Client requiring 24 respiratory support per physician's orders → Ventilator stopped working overnight without any staff aware it stopped → Overnight monitoring of ventilator and client cares not done → Two low battery alarms not responded to → Client found deceased.

Summary of Conclusion

Client requiring 24-hour nursing care including physician's orders for 24-hour continuous respiratory ventilator. Client could verbally communicate but physically could not move arms/legs. Client required two staff assist for lift transfer. Alleged perpetrator (AP) was a registered nurse that failed to follow the client's Care Plan, failed to assess the client, and failed to provide the client's services essential for her/his health. AP did not complete the ordered cares throughout the night and did not assess the client as recorded on medical charts (AP falsified records). The failures contributed directly to failing to notice that the ventilator was not plugged in when it needed to be and was not operating for most of AP's night shift.

Ventilator set off two low battery alarms (at 12:00am and 12:09am) and a critical low battery alarm at 12:22am as well as a disabled system notification. No client data was logged again until 6:28am; all these potentially life-saving alarms were not responded to by staff. Device log showed low battery alarm did go off several times. Respiratory device was sent to manufacturer for evaluation and internal investigation revealed that two alarms were sounded, and visual alert displays indicating internal alarm low battery detection.

Device was not ventilating between 12:22am and 6:28 am. AP found client unresponsive around 6:00 am, called 911 and initiated CPR. Ambulance staff pronounced client dead after attempted resuscitation. AP told police the last time she/he checked on the client was at 11:00pm. AP falsely documented completing cares which were not performed.

Additional Notes: 1. Client was found deceased in the morning and it is unknown how long the client had been deceased as cares were not completed during the ordered times. 2. Nurse Practitioner stated client could not survive longer than 10 minutes without the ventilator.

Report #	HL27310009
Date of Visit	November 7, 2017
Date Concluded	May 30, 2018
Facility Name	**Plateau Healthcare LLC**
City	**Brooklyn Center**
Zip Code	55429
Type of Facility	Home Care Provider/Assisted Living
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Individual

25. NEGLECT OF HEALTHCARE

Death 8 days after fall due to failure to assess client causes delay in detection of subdural hematoma and rib fractures; contributing factors along with pneumonia in cause of death.

Client with weakness and vision loss → Falls → Not assessed by Nurse as required by Provider Policy→ 2nd fall same day → Assessment → Bump on head → Hospital →Subdural Hematoma & Rib Fractures → Died 8 days later.

Summary of Conclusion

A client with weakness and vision loss requiring a stand by assist in Service Plan. Client was not assessed by a nurse, after a morning fall, as required by provider's policy. Client was found on the floor alone in his/her bedroom by the family during a morning visit.

Second fall same day revealed bump on head by assessing nurse; client did not hit head in 2nd fall. Physical assessment of client was not conducted after the morning fall causing a delay in detection of subdural hematoma and fractured ribs. RN was not aware of first fall until one day after the incident. Client was evaluated at the hospital and remained hospitalized until his/her death 8 days later. Death certificate indicated pneumonia, rib fractures, and a fall from standing height as cause of death.

Additional Notes: Home care provider failed to have an effective communication process to ensure nurse was aware of client's initial fall.

Report #	HL20443004
Date of Visit	November 29,2017
Date Concluded	July 9, 2018
Facility Name	**Walker Methodist Plaza**
City	**Anoka, MN**
Zip Code	55303
Type of facility	Home Care Provider / Assisted Living
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

NEGLECT OF SUPERVISION

26. NEGLECT OF SUPERVISION

Death of Client on a secured memory care unit due to Failure to Assess and Contain Septic C-Diff Outbreak.

Client on secured memory care unit had multiple incidents of diarrhea → Facility staff did not assess or intervene → Loss of appetite, continuous loose stools, expressive aphasia → Client falls in facility and dies that same day.

Summary of Conclusion

Client residing in a secured memory care unit who required assistance with ADLs, medication administration, and bladder/bowel monitoring had ongoing instances of loose stool. Client was prescribed an antibiotic for pneumonia. During the following two weeks, client lost ten pounds. Four weeks after starting the antibiotic, the client experienced diarrhea. Facility nursing staff failed to complete a full assessment or initiate interventions.

Two months later, nursing staff documented the client experienced diarrhea and emesis for two weeks. Again, nursing staff failed to complete a full assessment or initiate interventions. Client had an annual assessment done five days prior to their death. Loose stools were not documented at this assessment. Two days following the annual assessment, client continued to feel unwell, and presented with loss of appetite and ongoing diarrhea.

Client fell from their bed five days after annual assessment and went to the hospital. Client died that same day. Cause of death is listed as septic clostridium difficile (C-diff) diarrhea. Facility had been previously aware of C-Diff outbreak within the client's unit, but failed to contain it, or identify it within the client.

Additional Notes: Physician stated that had the client's condition been identified earlier, the outcome could have been different. Physician stated that C-Diff and antibiotics can predispose people to falls. Client's roommate was diagnosed with C-Diff following the client's death, due to lack of sanitation of client's room. Another resident who wandered into the client's room and laid down in the client's bed also contracted C-Diff following the client's death.

Report #	HL20852032
Date of Visit	April 19 and 20, 2017
Date Concluded	December 29, 2017
Facility Name	**Edgewood Hermantown Senior Living**
City	**Hermantown**
Zip Code	55811
Type of Facility	Home Care Provider
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

27. NEGLECT OF SUPERVISION

Death of Client with Dementia by Drowning after Elopement (left unattended) from Facility.

Client with dementia → Schedule wellness checks not performed → Client elopement from facility → Client found dead in pond three blocks away from facility.

Summary of Conclusion

Client with diagnosis of dementia had service plan which required wellness checks at six set times throughout the day as a safety precaution. Documentation of the client's location and state of consciousness was required from facility staff, as client had history of becoming lost and falling in various locations within the building. Client did not reside in secure memory care unit and had no history of attempted elopement from the building.

At 10:43pm, the client left the building through the door nearest to their room, according to video surveillance footage, which was not actively monitored. Set wellness checks at 9:00pm, 10:30pm, 12:00am and 2:00am were not performed by staff. At 4:00am staff went into the client's room, and discovered the client was missing. Staff searched the building and alerted local law enforcement.

Client was found dead in a pond just three blocks away from the facility. Cause of death is listed as drowning.

Facility staff state that the staff member who was responsible for performing wellness checks was newly hired and was not yet oriented to the client's care plan.

Additional Notes: Facility had offered family opportunity to move into memory care unit, but family refused. Indicates that client's behavior was becoming a safety issue, and facility was aware of this.

Report #	HL23238013
Date of Visit	August 8, 2016
Date Concluded	September 14, 2017
Facility Name	**Augustana Regent of Burnsville**
City	**Burnsville**
Zip Code	55306
Type of Facility	Home Care Provider
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

28. NEGLECT OF SUPERVISION

Death of Client with Dementia due to Hypothermia following Elopement (left unattended) from Facility.

Client with dementia who spoke little English admitted to facility without proper assessment or resources to meet client's needs → Elopement from facility in inclement weather → Delayed identification and notification of client's absence → Death by hypothermia.

Summary of Conclusion

Client with dementia who spoke little English was admitted to facility by family member, without medical records or assessment from facility nursing staff. Family member informed facility that the client did not require any medications and had no medical diagnoses.

During assessment the day after admission, facility nurse identified signs of dementia and initiated a plan to supervise the client 24/7 for safety reasons. Four days following admission, medical records were obtained from the client's clinic, which included a list of medications and a diagnosis of dementia. Six days following admission, a new employee to the facility did not lock the door after entering the house. Just minutes later, another employee is shown on surveillance video failing to secure the door behind them.

The client was able to leave the house through those two unsecured doors, without proper attire on for the weather. Approximately one hour later, facility staff became aware that the client was missing, and began a search of the premises and surrounding neighborhood. One hour later, the facility's executive director alerted the nurse about the missing client. The nurse offered to call emergency services but was told to wait. Another hour later, 911 was called, as well as the client's family members, who joined in the search.

About 8.5 hours after the client eloped from the facility, the client was found by their family outside in a snowbank. The client died that same day from complications related to hypothermia.

Report #	HL23665004 and HL23665005
Date of Visit	March 16, 2018
Date Concluded	June 14, 2018
Facility Name	**Golden Nest**
City	**Minneapolis**
Zip Code	55418
Type of Facility	Home Care Provider
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

29. NEGLECT OF SUPERVISION

Death of Client with Severe Dementia caused by Hypothermia due to Exposure to Cold Weather out of the Facility.

Client with severe dementia in secure memory care unit → Failure to follow care plan to check client every two hours → Client eloped (left unattended) from facility through faulty door → Outside temperature of 5°F with wind chill of -18°F → Found outside and pronounced dead.

Summary of Conclusion

An independently mobile client with severe memory loss residing in a memory care unit had required check-ins on whereabouts and toileting every two hours, due to history of wandering throughout the unit. According to a service invoice, facility was previously aware of an intermittently malfunctioning lock on the unit's secure door that led to the facility's courtyard. Facility failed to ensure this faulty door was properly monitored.

At 9:20pm, facility staff initially noticed the client was missing, however supervisors and law enforcement were not immediately notified, as staff were unaware of proper communication procedures. A search of the property was conducted inside and around the outside perimeter of the facility. Just over one hour later at 10:30pm, the client was found outside on the ground of the courtyard with his/her walker. The outside temperature was reported at 5°F with a wind chill of -18°F.

Shortly after arrival of emergency personnel, the client was pronounced dead. According to the client's death certificate, cause of death was reported to be hypothermia due to exposure to cold weather.

Additional Notes: In addition to the faulty courtyard door, other doors within the memory care unit were noted to unlock without prompting, periodically. This occurred a reported five times within the two months prior to the incident. Repairs were made, but facility did not conduct regular checks to ensure the locks continued to function properly. Multiple staff confirmed the lack of policy or protocol in place to address this issue.

Report #	HL23692001
Date of Visit	January 21, 2014
Date Concluded	January 30, 2014
Facility Name	**Goldfinch Estates**
City	**Fairmont**
Zip Code	56031
Type of Facility	Home Care Provider
Source of Report	Complaint
Determination	Substantiated
Responsibility Determination	Facility

30. NEGLECT OF SUPERVISION

Attempt of Suicide due to Failure to Provide Supervision.

Client with self-injurious behaviors → Facility unable to support management plan → Lack of staffing to provide required cares (no staff in the building) → Unsupervised client attempted suicide by breaking into locked medicine cabinet and ingesting multiple medications (85 dosages).

Summary of Conclusion

Client required supervision due to lengthy history of self-injury and suicide attempts and was placed into facility to receive that care. Facility stated that it could provide 24-hour staffing, seven days a week within its six-year-old Uniformed Consumer Information Guide, to ensure the client's safety. Three months prior to the incident, assessment by a professional nurse determined that the client required one-on-one supervision. This supervision was never implemented.

On the evening of the incident, there were no staff present within the building. Clients remained unsupervised from 11:00pm to 8:00am the following morning. The client broke into a locked medicine cabinet within the facility during the evening and consumed multiple medications, upwards of 85 dosages, belonging to multiple clients. Client presented looking drowsy and disoriented the next morning, and was taken to the emergency room, where they remained hospitalized for several days. Client stated he/she had attempted to commit suicide.

Additional Notes: The facility had a history of being under or un-staffed. Even during the daytime, staff were present only intermittently. Clients were responsible for calling a staff member at home who lived close to the facility if they needed assistance.

Facility staff had also trained an unlicensed maintenance worker who was occasionally present in the building during overnight hours but would frequently be asleep in the garage to be a resident care attendant.

Report #	HL26510004
Date of Visit	February 27, 2017
Date Concluded	April 20, 2017
Facility Name	**Happy Hearts Home Health Agency**
City	**Coon Rapids**
Zip Code	55433
Type of Facility	Home Care Provider
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

31. NEGLECT OF SUPERVISION

Death of Client with Dementia due to Fall Outside of Facility While Unsupervised.

Client with dementia → Eloped (left unattended) from facility unsupervised → Fell and fractured jaw → Hospital for six days → Discharged into hospice care -> Death.

Summary of Conclusion

Client with dementia had history of requesting to go outside of the facility and was required to wear a wander guard device at all times. If client came into close proximity to an open door within the facility, an alarm would sound, which required staff to deactivate using a code.

Alarm sounded when client eloped from facility. While nursing staff were on their way to deactivate the alarm and check on the client's whereabouts, they were alerted by a non-staff visitor that the visitor had deactivated the alarm themselves using the code. Nursing staff assumed the client in question was accounted for and neglected to confirm the whereabouts of the client.

Five to ten minutes after the alarm sounded, a law enforcement officer entered the facility to alert staff that client was found on the ground about one block away from the building. Client suffered lacerations to their chin and lip, as well as a dislocated fracture of the jaw, and was admitted to the hospital by family, where client remained for six days.

Client was subsequently discharged from the hospital into hospice care of family at home and died 14 days later. Primary cause of death is listed as decreased oral intake due to dementia and deconditioning.

Additional Notes: Director of nursing at facility stated the only facility staff should have access to and should perform deactivation of alarms using a code. Staff could not determine how non-staff visitor obtained the code.

Report #	HL28491003
Date of Visit	August 12, 2016
Date Concluded	January 9, 2017
Facility Name	**Hawley Retirement Inc.**
City	**Hawley**
Zip Code	56549
Type of Facility	Home Care
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

32. NEGLECT OF SUPERVISION

Failure to Communicate Changes in Client with Memory Loss's Schedule and Transportation Services. Resulted in Client's Hospitalization After being Left Unattended at Offsite Dialysis Treatment Center.

Client with memory loss and cognitive impairment required dialysis and offsite supervision → Changes in client schedule and transportation services not communicated amongst staff→ Client left unsupervised at location outside of facility → Found Unresponsive → ICU and hospitalization for five days.

Summary of Conclusion

A client with memory loss and cognitive impairment residing within a secure unit required outpatient kidney dialysis offsite three times per week on set days. Client required supervision when outside of the facility for safety reasons. Transportation was set up through Transportation Service A, which required a client's family member to meet the client at the offsite location.

Two weeks into dialysis treatment, client switched transportation services from Transportation Service A to Transportation Service B. Transportation Service B also provided a companion for the client. In addition to the transportation switch, the client's weekend dialysis schedule also changed temporarily for two weeks due to a holiday. While licensed nursing staff was aware of the change, the facility failed to communicate the change to their unlicensed weekend staff.

On a weekend, two weeks after the client switched from Transportation Service A to Transportation Service B, cancelled Transportation Service A arrived at the facility to pick up the client on the incorrect day for off-site treatment. Not having been communicated about either the transportation service or scheduling changes, the weekend staff let the resident go with Transportation Service A.

Upon client's arrival to dialysis treatment location, Transportation Service A left the client. Client was unsupervised outside of the facility, without a family member to meet them. Client was found unresponsive in the treatment location with a low oxygen saturation level and required resuscitation with oxygen and fluids. Client was admitted to the ICU and was kept at the hospital for five days before being discharged back to the facility.

Report #	HL29354007
Date of Visit	February 22, 2016
Date Concluded	March 31, 2016
Facility Name	**Cottagewood Senior Community of Rochester**
City	**Rochester**
Zip Code	55901
Type of Facility	Home Care Provider
Source of Report	Complaint
Determination	Substantiated
Responsibility Determination	Facility

33. NEGLECT OF SUPERVISION: RESIDENT-TO-RESIDENT ALTERCATION

Resident-to-Resident Altercation Resulting in Hip Fracture.

Resident 1 and Resident 2 both with dementia and history of aggression toward one another on secured memory unit → No reassessment and no additional interventions → Resident 2 enters Resident's 1 room → Resident 1 found on floor claiming Resident 2 kicked him/her → Resident 1 is hospitalized with hip fracture.

Summary of Conclusion

Resident 1 and 2 both with diagnoses of dementia resided in a secured memory care unit. Resident 1 had history of wandering around the unit and into other residents' rooms, which required staff to intervene. Resident 1 and Resident 2 had an altercation in which Resident 2 had their arms around Resident 1, then proceeded to punch Resident 1 in the stomach. No re-assessments or additional interventions were documented in either resident's care plan following this incident.

Two weeks following this incident, yelling was heard from Resident 2's room. Resident 1 was found on the ground and presented with leg pain. Resident 1 claimed that Resident 2 had kicked him/her. Staff did not witness the incident, due to shift change and absence of staff in the surrounding area of the unit, and as a result were unable to intervene and prevent the incident from occurring. Resident 1 was hospitalized with a hip fracture.

Report #	HL29912006
Date of Visit	December 13, 2017
Date Concluded	May 24, 2018
Home Care Provider	**Welcome Home Health Care- Woodstone**
Facility Name	**Woodstone Senior Living of New Ulm**
City	**New Ulm**
Zip Code	56023
Type of Facility	Home Care Provider
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

34. NEGLECT OF SUPERVISION: RESIDENT-TO-RESIDENT ALTERCATION

Resident-to-Resident Altercation Resulting in Hip Fracture.

Client 1 and Client 2 both with Alzheimer's disease and history of aggression toward one another → Insufficient instruction for intervention and prevention → Client 2 pushes Client 1 to the ground, fracturing Client 1's hip → Client 1 sent to transitional care offsite for several weeks.

Summary of Conclusion

Client 1 and Client 2 both had diagnoses of Alzheimer's disease and required staff assistance for behavior management. Client 1 and Client 2 had history of verbal altercations over several months, including an incident that escalated to be physical in nature. Facility staff were instructed to keep Client 1 and Client 2 away from each other, with no other instructions for intervention or prevention of confrontations.

Client 2 proceeded to push Client 1 to the ground, resulting in a hip fracture for Client 2, requiring Client 2 to reside in transitional care for several weeks offsite.

Report #	HL21673005
Date of Visit	September 13, 2017
Date Concluded	December 29, 2017
Facility Name	**Guardian Angels By The Lake**
City	**Elk River**
Zip Code	55330
Type of Facility	Home Care Provider
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

Promoting a Culture of Learning

"Existing regulatory culture does not promote a learning culture."

– A barrier for quality and safety improvement in LTC homes identified by MDH in the Quality and Safety Work Group led by Marie Dotseth, Assistant Commissioner, Health Systems (January 16, 2019)

This brief segment of the report describes three harmful incidents – one deadly ingestion of a cleaning product as well as injurious and fatal incidents as a result of residents jumping and falling off of a window (a third incident on page 66 describes a resident on a secured memory care unit leaving the building through his/her apartment window).

The learning mechanisms should be required under legislation and funded appropriately to allow for the fullest possible and most effective learning capabilities and prevention.

35. NEGLECT OF SUPERVISION

Death of Client with Dementia due to Ingestion of Cleaning Detergents containing Corrosive Chemicals while Unsupervised.

Client with dementia, cognitive impairment, and poor decision-making → Corrosive chemical detergent left unattended within client's reach ingested → Client presented with sore throat, bloody phlegm, and swollen lip → Hospitalized for 13 days → Death.

Summary of Conclusion

Client had history of dementia, cognitive impairment, poor judgement, and poor decision making. Client also had history of taking food and drinks from facility's kitchen, prompting facility to require locks on cupboards. Facility staff left a container of detergent containing corrosive chemicals unattended within the client's reach (detergent causes respiratory tract irritation and burns to the mouth, throat, and stomach if ingested).

Client poured the detergent into a glass and took a sip of the liquid. While the client was witnessed by another client spitting the detergent out, client did proceed to ingest a quarter cup of coffee afterward. Three hours later, client complained of a sore throat, produced bloody phlegm, and presented with a swollen lip and raspy voice. Facility nursing staff assessed client, and emergency services were contacted.

Client was hospitalized for 13 days. Diagnosis included aspiration pneumonia and severe difficulty swallowing. As a result, client was unable to eat or drink to sustain life and died. Death certificate lists cause of death as complications of sodium hydroxide detergent ingestion.

Additional Notes: Staff were unaware of detergent ingestion until hours after initial ingestion.

Report #	HL29327001 and HL29327003
Date of Visit	March 10, 2016
Date Concluded	January 3, 2017
Facility Name	**Augustana Emerald Crest Shakopee**
City	**Shakopee**
Zip Code	55379
Type of Facility	Home Care
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility

Injurious and Deadly Jump and Fall off a Window
Two Separate MDH Investigations Concluded within one month

We found two MDH investigative reports describing two separate but similar incidents that occurred in an assisted living residence and nursing home in the city of Minneapolis within approximately two months.

1. Ebenezer Care Center (MDH Investigative report #HL5587053 concluded on February 12, 2018)
A nursing home resident with diagnoses of Major Depressive Disorder and Border Personality Disorder "at risk of suicide" who exited the building through a second-floor window, fell to the ground, and fractured her or his femur:
https://www.health.state.mn.us/facilities/regulation/directory/ohfcfindings/h5587053.pdf

MDH concluded that the facility is responsible for the neglect which was substantiated.
A nurse could not find the resident noticed that the window was open at around 6:30am - 6:40am. She looked outside (it was still dark outside) and she saw something white on the ground under the window. The nurse ran outside and found him/her lying on his/her back. The resident told the nurse that her/his leg was hurt and added that s/he jumped out the window because she/he did not want to be at the facility any more.

2. Ebenezer Home Care (MDH Investigative report #HL27773008 concluded on March 13, 2018)
An assisted living resident with diagnoses of Depression and Bipolar disorder who fell from a 5-story window and died:
https://www.health.state.mn.us/facilities/regulation/directory/ohfcfindings/hl27773008.pdf

The death record indicated that the resident immediate cause of death was multiple blunt force injuries and a fall from height. The manner of death was identified as suicide (an autopsy was performed by a medical examiner).MDH concluded the investigation of the alleged neglect as "Not Substantiated."

3. Cedar Crest Estate (Cedar Crest Estate (MDH Investigative Report #HL20040018 concluded on July 18, 2013)
It was determined that Neglect was substantiated when a client on a "Secured Memory Care Unit" left through the window of her/his bedroom. Staff members were not aware that s/he left. Police found client disoriented and exhausted on a hot day 2 miles away from the Assisted Living on her/his hands and knees on a highway shoulder. Police notified the care provider about it. Client was sent to the hospital.

Implication for Learning / Prevention
One would expect lessons to be learned and serious measures to be promptly put in place across all LTC homes in Minnesota promptly after the first incident to prevent injury or death in similar circumstances in other LTC homes, let alone within the same or affiliated home care / LTC provider.
Per the Office of Legislative Auditor of MN in its 2018 MDH OHFC audit report, how can MDH and our LTC industry develop strong mechanisms for timely learning and prevention of injurious and fatal incidents?

"Reliable data are imperative to any public health prevention strategy, including one to prevent the maltreatment of older adults." (Page 74 in OLA 2018 report; under the subheading: Collecting and Sharing Information.

Sexual Abuse Case Study Summaries

Although the reasons for the failure to address the problem of sexual abuse of elders in long-term care homes are not fully understood, two explanations can be posited: the incomprehensibility, and hence rejection of claims of sexual assault of residents and, most importantly, ageism.
– Dr. Anne W. Burgess, RN, DNSc, a leading authority on sexual abuse of elders in long-term care homes

Definition of Sexual Abuse or Abusive Sexual Contact of Elders

"Forced or unwanted sexual interaction (touching and non-touching acts) of any kind with an older adult. This may include forced or unwanted:

- Completed or attempted contact between the penis and the vulva or the penis and the anus involving penetration
- Contact between the mouth and the penis, vulva, or anus
- Penetration of the anal or genital opening of another person by a hand, finger, or other object
- Intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks

These acts also qualify as sexual abuse if they are committed against a person who is not competent to give informed approval."

Source: The Centers for Disease Control and Prevention (2016). Elder Abuse Surveillance: Uniform Definitions and Recommended Core Data Elements (Version 1.0). Compiled by Dr. Jeffrey Hall and colleagues.

36. SEXUAL ABUSE: RAPE BY STAFF

Rape of Client with End Stage Alzheimer's Disease.

Client with end stage Alzheimer's Disease required extensive assistance for all activities of daily living → Staff member found by employee in client's room with his pants and underwear pulled down to his knees → Client found in fetal position in her bed with nightgown pulled up over her waist → Client sent to hospital for sexual assault examination → Examination revealed semen on vaginal and perineal swabs.

Summary of Conclusion

A client with end stage Alzheimer's disease and a history of cerebral vascular accident was dependent on staff for all activities of daily living. It was unknown whether she could understand others.

In the evening hours between 9:00pm and 9:15pm, an employee knocked on the client's door, waited for a few seconds, and entered the room. The employee noticed the client's ceiling light was turned on. As the employee stood in the doorway, he/she saw the Alleged Perpetrator (AP) (another employee), standing about one foot away from the client's bed. According to the witness, the AP had his pants and underwear pulled down to his knees. The client was lying on her bed on her left side in the fetal position wearing a nightgown pulled up above her waist, facing away from the AP. The AP was noted as being sweaty and breathing heavily.

The witness left the client's room and immediately reported the incident to the nurse, who contacted administration. The AP, who later denied the allegations, was sent home for the evening, and placed upon suspension pending further investigation.
The client was sent to the hospital to have a sexual assault examination. The examination revealed that semen was found on the vaginal and perineal swabs. The findings and the case were then forwarded to the county attorney for charges of sexual assault.

Additional Notes: Records indicate that the home care provider had a background study clearance on the AP and at the time of hire, trained the AP on what constitutes abuse, including sexual assault.

Report #	HL21049027, HL21049028, and HL21049029
Date of Visit	May 10 and 11, 2016
Date Concluded	August 8, 2016
Home Care Provider	**Minnesota Heritage House**
Facility Name	**Shiloh Assisted Living**
City	**Pequot Lakes**
Zip Code	56472
Type of Facility	Home Care Provider
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Individual

37. SEXUAL ABUSE: RAPE BY STAFF

Sexual Abuse (Rape) Occurred When the Alleged Perpetrator (AP) Had Sexual Intercourse With A Client Outside Of A Secured Memory Unit & Left Unsupervised By Home Care Provider.

Client With Cognitive Impairment On Secured Memory Unit ➔Required 24 Hour Supervision, Left Unsupervised ➔Client Tells Nurse She Is Concerned She Might Have A Baby, Adding She Had Sexual Intercourse 10 Minutes Earlier ➔ER ➔Sexual Assault Examination ➔Semen Found Matching Perpetrator ➔Perpetrator Criminally Charged With Third Degree Sexual Conduct.

Summary of Conclusion

A client #1 with cognitive impairment had moved to the secured memory unit for the client's safety. The Vulnerability Assessment indicated the client received 24-hour supervision on the memory care unit.

A licensed nurse escorted 3 clients including client #1 to a screened porch in an unsecured area. The receptionist did not recall being informed about the clients, left to do a tour, returning about 45 minutes later finding one of the three clients walking into the front parlor. The memory care staff was contacted and discovered client #1 was not on the memory care unit or the porch. A search was conducted, and the licensed nurse saw client #1 walking down the hallway of the memory care unit. It was undetermined how client #1 arrived there.

The client appeared worried stating she was concerned she might be having a baby as she had had sexual intercourse 10 minutes prior and did not know where she was in her menstrual cycle. Client #1 was unable to identify the person with whom she had sexual intercourse. A sexual exam conducted at the ER and samples taken indicated the presence of semen. DNA testing performed on the sample matched the alleged perpetrator's (AP) DNA. The AP was criminally charged with 3rd degree sexual assault.

Additional Notes: The AP was responsible for the sexual abuse and the facility was responsible for the abuse. The facility failed to follow client #1's plan for supervision to ensure the client's safety and was not in compliance with regulatory standards related to the client's supervision.

Report #	HL23500004
Date of Visit	June 19, 2014
Date Concluded	September 5, 2014
Facility Name	**VOA Home Health at Elder Homestead**
City	**Minnetonka**
Zip Code	55343
Type of Facility	Home Care Provider/Assisted Living
Source of Report	Complaint
Determination	Substantiated
Responsibility Determination	Facility & Individual

38. SEXUAL ABUSE: TOUCHING/FONDLING BY STAFF [SEXUAL INTERCOURSE]

Staff Member Engaged in Sexual Intercourse with Client with Schizoaffective Disorder, Anxiety Disorder, Alcohol Dependence, and Personality Disorder.

Client with schizoaffective disorder, anxiety disorder, alcohol dependence, and personality disorder left the facility on a leave of absence → Staff member engaged in sexual intercourse with the client at the staff member's home → Staff member claims she did not know that the client was a vulnerable adult → Staff member terminated by facility.

Summary of Conclusion

A client with schizoaffective disorder, anxiety disorder, alcohol dependence, and personality disorder had mental health symptoms of paranoia, disorganized thinking, impulsivity, and poor judgment. Client received assistance with medication administration, including antipsychotic medications.

Between the dates of March 20 and 22, 2015, the client left the facility on a leave of absence, stating he would be staying with family. Upon returning to the facility, the client stated that he did not stay with family, but actually stayed with his girlfriend. Several accounts by staff and a police officer stated hearing the alleged perpetrator (AP) telling another staff member that she was in love with client, the client stating he was in love with the AP, and that the two of them engaged in sexual intercourse over the weekend in question.

The AP was suspended from the facility pending investigation. Two days after the suspension, the client said he was going to spend the night at a friend's house who would pick him up from the facility. Shortly after the client left the facility, a staff member observed the client in the AP's personal vehicle, about one block away from the facility. One week later, the client moved out of the facility and into the AP's home. During investigation, the AP admitted to engaging in sexual intercourse with the client at least once while employed at the facility. She also stated that she did not realize the client was a vulnerable adult and did not understand that it was considered sexual abuse to engage in sexual intercourse with a vulnerable adult. The AP was terminated by the facility.

Additional Notes: Records indicate that the AP received multiple training sessions related to the vulnerable.

Report #	HL20533010 and HL20533011
Date of Visit	April 7, 2015
Date Concluded	June 11, 2015
Home Care Provider	**Whispering Pines Assisted Living**
Facility Name	**The Pines**
City	**Anoka**
Zip Code	55303
Type of Facility	Comprehensive Home Care Provider
Source of Report	Self-Report and Complaint
Determination	Substantiated
Responsibility Determination	Individual

39. SEXUAL ABUSE: TOUCHING/FONDLING BY STAFF

Staff Member Sexually Harassed 3 Clients Receiving Services from Comprehensive Home Care Provider.

Client #1 with major depression, anxiety, and personality disorder; Client #2 with schizoaffective disorder; Client #3 → All were made to feel uncomfortable by staff member → Staff member made sexual comments and had sexual contact with clients → Clients felt scared, threatened, and harassed by staff member → Staff member terminated by facility.

Summary of Conclusion

Client #1 with diagnoses of major depression, anxiety and personality disorder had interactions, sexual in nature, with the Alleged Perpetrator (AP) that made client feel scared. The AP expressed sexual attraction to Client #1, who then came up behind the client and kissed him/her on the cheek and neck, then pressed his genitals against the client, asking if he/she could feel it. AP gave Client #1 his name, address, and phone number on a piece of paper. Two or three weeks later, the AP entered Client #1's bedroom and repeated these same actions. Following these two incidents, Client #1 required an increase in medication to help him/her sleep due to increased anxiety. Client #1 got a restraining order against AP after having a panic attack triggered by seeing him on the street.

Client #2 with diagnosis of schizoaffective disorder stated feeling uncomfortable when the AP was watching him/her walk. The AP approached Client #2 and asked for a hug, which he gave, but then proceeded to kiss Client #2 on the cheek. Immediately after kissing Client #2 on the cheek, the AP attempted to kiss the client on his/her mouth. Client #2 pushed the AP away. The AP stated he thought Client #2 wanted the kiss.

Client #3 stated that the AP made him/her feel uncomfortable when he would wink at the client in the dining room. Once, Client #3 was coming out of the shower, and found the AP in his/her apartment. Client yelled for the AP to get out. Client #3 reported other instances where the AP called him/her beautiful, that he would never drop the client, and that he could take care of the client. Client #3 felt scared of the AP and did not want him in his/her room. Eventually, AP was terminated by the facility.

Additional Notes: It is reported that the AP made advances toward other staff members, which made them feel uncomfortable.

Report #	HL28279018
Date of Visit	August 20 and 21, 2018
Date Concluded	August 23, 2018
Home Care Provider	**Oxford Property Management, LLC**
Facility Name	**Prime Time Living**
City	**Rochester**
Zip Code	55904
Type of Facility	Home Care Provider
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Individual

Physical Abuse Case Study Summaries

"Physical abuse may include but is not limited to such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning. In addition, inappropriate use of drugs and physical restraints, force-feeding, and physical punishment of any kind also are examples of physical abuse" – The National Center on Elder Abuse

Due to the time-sensitive nature of this project, it was not possible to examine the disturbing phenomenon of physical abuse of vulnerable and frail residents in HWS / Assisted Living in detail.

An MDH investigation (Lino Lakes Assisted Living, LLC, MDH investigative report HL27529010/1/2, concluded on 8/15/17) determined that "Abuse was substantiated" when two staff members on a Memory Care Unit "used repeated malicious oral and gestural language towards a client, confined the client and humiliated the client.

The two staff members swore at, yelled at, taunted and mocked the client. Staff member #1 threatened to burn the client with a lit cigarette lighter and asked the client if s/he wanted to fight. The two staff members confined the client to a chair and to the client's room against the client's will. In addition, the two staff members humiliated the client by exposing the client's bare buttocks by lifting the client's garment."

The abuse occurred over 3 to 4 hours. Another staff member who witnessed the abuse recorded it on a cell phone and turned the video over to the facility and the police, along with a written statement documenting the abuse.

This horrific emotional and physical abuse was reported in detail in Part 2 of the Star Tribune *Left to Suffer* Special Report (November 13, 2017):
http://www.startribune.com/secrecy-often-stymies-families-seeking-answers-about-elder-abuse/450625443/

A Summary of Conclusion of a recent physical abuse incident in a home care provider is presented below.

40. PHYSICAL ABUSE BY STAFF

Death of Client with Cerebral Palsy and Cognitive Dysfunction due to Beating by Staff.

Client with Cerebral Palsy and cognitive dysfunction → Two facility staff members hit client repeatedly in his head until bleeding → Client presented several weeks later with high blood pressure and increased weakness → Client transferred to hospital → Client diagnosed with brain bleed → Death of Client 7 weeks following altercation.

Summary of Conclusion

A client diagnosed with Cerebral Palsy and cognitive dysfunction required assistance with all cares and activities of daily living and was dependent on a wheelchair.

According to several accounts of facility staff, family members of the client, and the client's support and care team, one staff member held the client down while the other hit the client in the head until he bled from his head and face. A third staff member stood by during the altercation and did not intervene. The client was unable to defend himself because of his physical limitations.

Several weeks after the altercation, client presented with high blood pressure and increased weakness. When staff called the nurse, staff were told by the nurse to put the client back to bed. Staff took the client to hospital instead using a personal vehicle. Upon arrival to the hospital, the client was diagnosed with a brain bleed, and sent to a critical care hospital via helicopter.

Client died of complications related to the brain bleed seven weeks following the altercation.

Additional Notes: Cause of death was deemed natural due to a non-traumatic brain bleed, by hospital physician. However, had the physician known about the altercation, it would have "definitely affected the finding," and stated that there was potential that the trauma was related to the client's death.

Staff claim that facility management prevent staff members from reporting suspected maltreatment, and were not allowed to accurately document the incident, as part of attempts by the provider to cover up the incident.

Report #	HL21006035
Date of Visit	November 6, 7, 8, 19, 20, and 21, 2018
Date Concluded	January 3, 2019
Facility Name	**Chappy's Golden Shores**
City	**Hill City**
Zip Code	55748
Type of Facility	Home Care Provider
Source of Report	(not public)
Determination	Substantiated
Responsibility Determination	Facility and individual

B. Data Sources and Data Examination Approach

The data used for analysis in this report was obtained from Minnesota Department of Health (MDH) through a Data Practices Request that yielded seven years of maltreatment data for housing with services facilities with an assisted living designation (spanning investigations completed August 31, 2011 through November 13, 2018). To include full years in our analysis, the remainder of the data for investigations completed in 2018 was obtained from an MDH website search of Office of Health Facility Complaints (OHFC) Investigative Reports.

The data was used to identify trends and the individual cases examined in detail to identify patterns. Each OHFC Investigative Report contains a text-based description of the maltreatment allegation(s) and the findings used as the basis for the conclusion of MDH investigator's determination. The OHFC investigative reports were analyzed and summarized for the case studies included in this report.

The qualitative review of OHFC Investigative Reports focused primarily on the neglect category of maltreatment and included only a small number of other concerning and disturbing categories of maltreatment. There was a *very* limited focus on staff emotional, physical, and sexual abuse of residents and financial exploitation and drug diversion categories.

We examined only substantiated allegations for this report. While the allegations of unsubstantiated and inconclusive findings also merit review.

Although a concerted effort was made to represent the investigations accurately, it is possible there are omissions in the case studies, given the complexity, scope and the lack of consistency in the documentation in the OHFC investigative reports. To reference the OHFC Investigative Report sources of these case studies, please see the 'Instructions to Access Minnesota Office of Health Facility Complaints' on page 71.

MDH Maltreatment Dataset

Some characteristics of the MDH maltreatment dataset, particularly the distinction between investigations and allegations must be taken into consideration when interpreting the findings described throughout this report. These include:

1. A single OHFC Investigative Report can contain multiple types of maltreatment allegations (such as neglect of health care and neglect of supervision, or both physical and emotional abuse); involving the same resident. Our statistics are based on investigated maltreatment allegations.

2. A single OHFC Investigative Report can include similar alleged maltreatment acts affecting more than one vulnerable adult, as in many cases of drug diversion where medications are stolen from more than one resident by a single perpetrator. When this is the case, each substantiated act of maltreatment is tracked by MDH as a separate substantiated allegation.

4. A small number of OHFC Investigative Reports are classified and entered under an inaccurate MDH maltreatment code.

5. A small number of OHFC Investigative Reports are classified in the dataset under an inaccurate type of determination (such as "substantiated" when it was "unsubstantiated" or "inconclusive").

6. Investigation completed date was used in our analysis for grouping investigated allegations by year. The date of the incident or the date reported is not publicly available data.

7. The same Housing with Services Provider (Assisted Living Provider) or Home Care Provider in the dataset may appear under multiple names.

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D. Instructions to Access Minnesota Office of Health Facility Resolved Complaints

GENERAL INFORMATION

Regarding the Office of Health Facility Complaints (OFHC), Health Care Provider Resolved Complaints Webpage

The Office of Health Facility Complaints (OFHC) is a division within the MN Department of Health (MDH). The OFHC receives complaints filed by consumers or self-reported by facilities as required by the Vulnerable Adults Act of MN. These complaints are found on the Search for Minnesota Health Care Provider Complaints webpage.

You can see below general guidelines for using the OFHC website for searching for health care providers by name, city or county for resolved complaints that have been investigated and completed. When using this website there are some important points to keep in mind:

- Of the 24,000+ complaints submitted a year, only 10% are investigated and of those investigated, 3-5% of them are investigated on-site, resolved and posted.
- Only the resolved complaints since 2013 are posted. MDH complaints can take several weeks to months to investigate (depending on the case), be resolved and then posted on the webpage.
- Not every facility may be listed by their known name. If you don't find the facility, it doesn't necessarily mean that there is no complaint. At this time, there are facilities that are listed under the corporation/property management company which own several assisted living facilities or by a licensed Home Care Provider that provides the services to the facility. Unless the facility is willing to give you the name of the Home Care Provider, you may not be able to find the investigations for that facility on this website. Please use other resources to continue your search into a facility. The legislation that is being proposed would address these issues.
- MDH is working on their website and currently may not be as easy to navigate and find information.
- This public web page is being provided to be used as one way to find information on facilities. Due diligence on the part of the consumer is encouraged to find further information regarding specific facilities.

Instructions to Access
Minnesota Office of Health Facility Resolved Complaints

A. In your internet search area, type in "**MN MDH**".

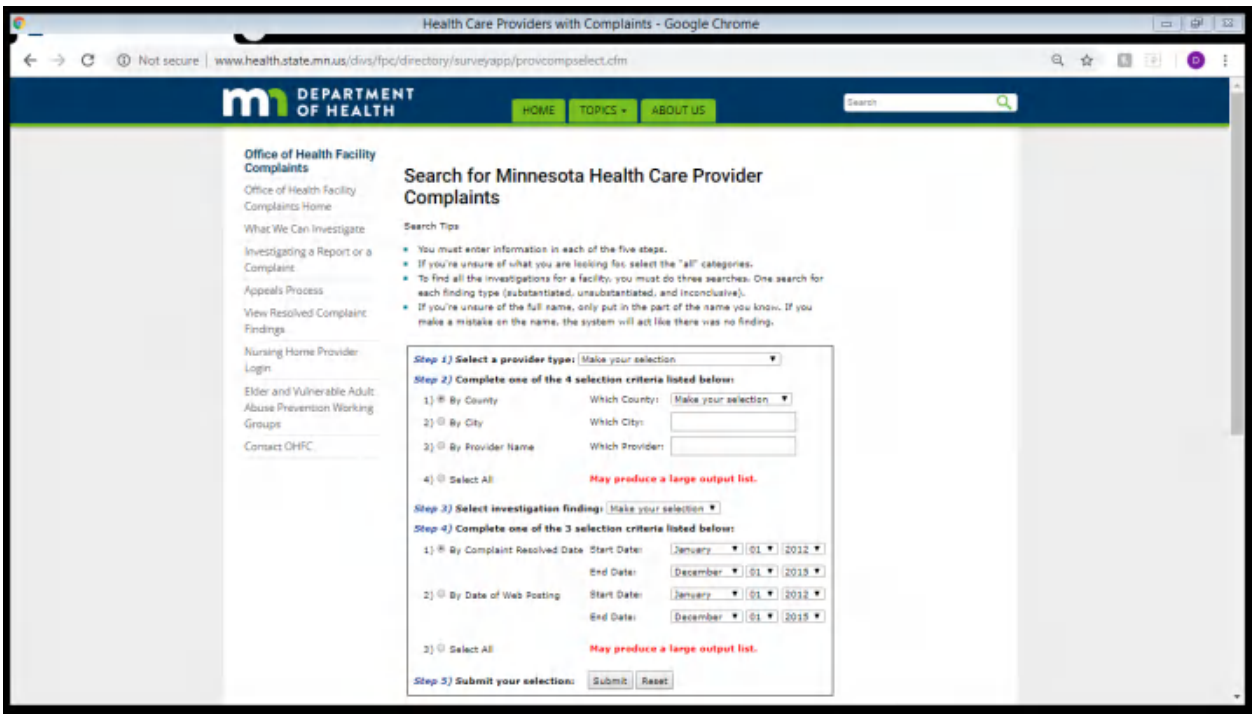
B. Click on the first listed item which should be "**Minnesota Department of Health**".

C. In the upper right corner in the search box type "**OHFC Resolved Complaints".**

D. Click on 2nd listed item "**Investigating a Complaint with the Office of Health Facility Complaints**".

E. Scroll down on the page and click on "**View Resolved Office of Health Facility Complaints"**.

F. Your screen should look like this:



G. Follow the Search Tips listed above the box.

H. Inside the box, for **step 1**, select a provider type: choose "**All**".

I. **Step 2** make your choice of county, city, provider name or all.

J. **Step 3**, you must choose either "substantiated", "unsubstantiated" or "inconclusive".

K. **Step 4**, choose "complaint by resolved date" and change the "**end date**" to "**2019**".

L. **Step 5** – Click on **submit** and follow instructions on that page of listed facilities.

D. Acronyms

HWS – Housing with Services Establishments
ALR – Assisted Living Residences
ADL – Activities of Daily Living
MDH – Minnesota Department of Health
OHFC – Office of Health Facility Complaints
OLA – Office of The Legislative Auditor of Minnesota
CMS – Centers for Medicare and Medicaid Services
SFF – Special Focus Facility

F. Glossary of Terms

Abuse: A type of maltreatment against a vulnerable adult defined in state law, including physical, sexual, verbal, and emotional abuse. See Minnesota Statutes 2017, 626.5572, subd. 2.

Allegation: An assertion that maltreatment of a vulnerable adult occurred or that a provider violated its licensing requirements.

Allegation report: A verbal or written statement alleging maltreatment of a vulnerable adult or a licensing violation. An allegation report may contain multiple allegations. See Minnesota Statutes 2017, 626.5572, subd. 18.

Alleged perpetrator: An individual accused of being responsible for alleged maltreatment of a vulnerable adult. Another definition is "an individual employee of a provider who is alleged (suspected) to be responsible for abuse, neglect, or financial exploitation of a vulnerable adult" (OLA 2018 report).

Assisted living facility: A type of housing with services establishment that provides or makes available health-related services under a Minnesota Department of Health home care license. See Minnesota Statutes 2017, Chapter 144G.

Financial exploitation: A type of maltreatment defined in state law that includes the theft of a vulnerable adult's property, the misuse of a vulnerable adult's funds, or the coercion of a vulnerable adult for the profit of another person. See Minnesota Statutes 2017, 626.5572, subd. 9.

Home care provider: A Minnesota Department of Health-licensed provider that delivers home care services, such as medication administration, to a client for a fee in a client's home or in a facility where a client lives, such as an assisted living facility. See Minnesota Statutes 2017, 144A.43-144A.482.
In addition to operating in people's homes, home care providers operate in facilities called "housing with services establishments." Under Minnesota law, housing with services establishments provide sleeping accommodations and a limited array of services, primarily to persons 55 years and older. Assisted living facilities are one type of housing with services establishments.

Home health agency: A Minnesota Department of Health-licensed home care provider that is federally certified to participate in the federal Medicare or Medicaid programs.

Housing with services establishment: A facility that provides sleeping accommodations to one or more residents (at least 80 percent of whom are at least 55 years of age) and that may offer, for a fee, certain services, some of which may be licensed under a Minnesota Department of Health (MDH) home care license. Assisted living facilities are a type of housing with services establishment. Housing with services establishments are registered, rather than licensed, by MDH. See Minnesota Statutes 2017, Chapter 144D.

Inconclusive: An investigation determination in which there is less than a preponderance of evidence to show that maltreatment did or did not occur. See Minnesota Statutes 2017, 626.5572, subd. 11.

Investigation: A review of evidence by a lead investigative agency to substantiate an allegation of maltreatment under the Vulnerable Adults Act, or to substantiate a licensing violation.

Investigation determination: The outcome of an Office of Health Facility Complaints (OHFC) investigation. State law refers to this determination as the "final disposition." OHFC determines whether the maltreatment allegation is substantiated, inconclusive, not substantiated, or that no determination will be made. It may also find that a provider has violated state or federal licensing requirements. See Minnesota Statutes 2017, 626.557, subd. 9c(b); and 626.5572, subd. 8.

Investigative report: A public report produced by the Office of Health Facility Complaints (OHFC) that summarizes the conclusions of an investigation and the evidence on which OHFC based its conclusions. The report indicates whether OHFC substantiated any allegations of maltreatment or cited the provider for any licensing violations.

Licensing violation: A failure to comply with the conditions of licensure as a health care provider in Minnesota, or a failure by a provider to comply with federal certification requirements for participation in the federal Medicare or Medicaid programs.

Maltreatment: Abuse, neglect, or financial exploitation of a vulnerable adult as defined by the Vulnerable Adults Act. See Minnesota Statutes 2017, 626.5572, subd. 15.

MDH-licensed provider: A health care provider licensed by the Minnesota Department of Health (MDH), such as a nursing home, home care provider, hospital, boarding care home, or hospice provider.

Minnesota Adult Abuse Reporting Center (MAARC): A call center operated by the Minnesota Department of Human Services that opened in 2015 to receive allegation reports from across the state. See Minnesota Statutes 2017, 626.557, subd. 9; and 626.5572, subd. 5.

Minnesota Health Care Bill of Rights: A state law that establishes certain rights for patients and residents of health care facilities, including the right to be free from maltreatment, as defined under the Vulnerable Adults Act. See Minnesota Statutes 2017, 144.651.

Minnesota Home Care Bill of Rights: A state law that establishes certain rights for persons receiving home care services, including the right to be free from maltreatment as defined under the Vulnerable Adults Act. See Minnesota Statutes 2017, 144A.44, subd. 1.

Neglect: A type of maltreatment against a vulnerable adult defined in state law that involves a failure to provide necessary care or services. See Minnesota Statutes 2017, 626.5572, subd. 17.

Not substantiated: An investigation determination in which there is a preponderance of evidence to show that maltreatment did not occur. State law uses the term "false" for this type of determination. See Minnesota Statutes 2017, 626.5572, subd. 7.

Nursing home: A facility that provides nursing care and supervision to five or more persons on an in-patient basis. See Minnesota Statutes 2017, 144A.01-144A.1888.

Office of Ombudsman for Long-Term Care: A state office that advocates for certain individuals, including residents of long-term care facilities, individuals receiving home care services, and individuals receiving Medicare benefits. See Minnesota Statutes 2017, 256.974-256.9744.

Preponderance of evidence: The standard of proof required to substantiate a maltreatment allegation. The standard requires that the evidence shows that it is **more probable** that the **maltreatment occurred than did not** occur. See Minnesota Statutes 2017, 626.5572, subd. 19.

Substantiated: An investigation determination in which there is a preponderance of evidence to show that maltreatment occurred. See Minnesota Statutes 2017, 626.5572, subd. 19.

Vulnerable adult: A person 18 years of age or older who lives in a state-licensed facility, receives services licensed by the state, or has a limited ability to protect one's self from maltreatment. See Minnesota Statutes 2017, 626.5572, subd. 21.

Vulnerable Adults Act: A state law passed in 1980 to protect vulnerable adults. Among other things, the act requires providers and certain individuals to report alleged maltreatment and authorizes the Minnesota Department of Health, the Department of Human Services, and county social services agencies to investigate those allegations. See Minnesota Statutes 2017, 626.557 and 626.5572.