

Written Testimony in Support of SF 2972

94th Legislature (2025–2026)

Monday March 2, 2026

Chair and Members of the Committee:

My name is Deborah Fideldy, and I serve as Power of Attorney for my mother, who resides in an assisted living facility in Minnesota. I am writing in support of SF 2972 and its provisions establishing minimum staffing standards, onsite registered nurse requirements, competency standards, and guardrails related to ownership practices.

Although this bill addresses nonprofit ownership transfers, the structural safeguards it proposes are urgently needed across the long-term care system — particularly in facilities that transition to for-profit ownership groups.

My mother's assisted living facility was acquired on December 2, 2024, by a for-profit ownership group. The facility advertises 24-hour RN availability; however, that means an RN is on call. Two RNs primarily serve administrative roles during the day. One LPN works mostly afternoons and some weekends. Direct care staff provide most hands-on assistance. There is not an onsite registered nurse 24 hours per day.

Over the past several months, my mother has experienced repeated instances of preventable harm, systemic breakdowns in care delivery, and poor communication and response from management.

In August, staff pulled on her catheter during routine care, causing bleeding and requiring replacement. I requested a review and never received follow-up. I was told they would conduct an internal review.

In October, the facility initiated eviction proceedings, stating they could not manage her catheter care needs. Those needs consisted of two flushes per week, with home health handling additional days. During a court proceeding, when asked how they had been providing care up to that point, the facility acknowledged it had been managing it. The eviction effort proceeded despite this.

During the holiday period, coordination failures resulted in missed catheter flushes and administration of medication. Within days, my mother developed a 102-degree fever and was hospitalized with a bladder infection and sepsis. Following hospitalization, the facility attempted to refuse readmission, asserting her needs were too great — despite medical providers indicating her care requirements had actually decreased. Legal intervention was required to ensure she could return.

On February 16 and again on February 24, her catheter was pulled during clothing removal. The first incident resulted in blood and clotting. The second required emergency room transfer due to heavy leakage. These events occurred during routine assistance — not medical procedures — and reflect improper technique and lack of supervision. Again, I requested a review and follow-up and was told they would conduct an internal review. I never received a summary of this review nor what measures would be taken to prevent this again in the future.

In addition, there have been delays in medication administration and repeated attempts to obtain my mother's medical records without proper authorization. A MAARC report was filed against me after I exercised our right to limit unnecessary record access. Another report was filed against the hospital for discharging her. Her care plan was revised and shared externally without our involvement in the rewrite and there were obvious disparaging statements in it against myself, but also false statements against my mother.

Individually, these events may appear administrative. Collectively, they reveal vulnerability families face when oversight, staffing standards, and accountability mechanisms are weak.

SF 2972 addresses structural protections that families like mine depend on:

- A requirement for an onsite registered nurse 24 hours per day
- Enforceable minimum staffing ratios tied to resident acuity
- Competency standards aligned with resident care plans
- Civil fines for noncompliance
- Transparency in ownership transfers
- Prohibitions on practices that undermine quality of care
- A requirement that at least 75 percent of public funds be spent on direct resident care

When facilities transition to for-profit ownership groups, financial pressures can influence operational decisions. Without clear guardrails, staffing levels, care coordination, and discharge practices may be shaped by factors other than resident well-being.

Residents in assisted living are medically fragile. Proper staffing and supervision are not optional — they are foundational to safety. Families should not need attorneys to secure readmission after hospitalization. They should not need to monitor bedside technique to prevent injury.

Minimum staffing standards establish a floor below which care cannot fall. Ownership guardrails ensure public dollars support resident care, not structural arrangements that diminish it.

SF 2972 is about preventing harm before it happens and ensuring that accountability mechanisms protect residents and their families.

I respectfully urge you to support SF 2972 and maintain strong, enforceable staffing standards and ownership safeguards.

Thank you for your consideration and your commitment to protecting Minnesota's seniors. Respectfully,

Deborah Fideldy

Deborah Fideldy

Grand Rapids, Minnesota

Power of Attorney for Carol Fideldy

HOUSE BILL 2771

My name is Brad Broberg. I'm 63. My mother is in memory care in a Minneapolis facility and has been since April 2025. My mom's husband (second marriage lasting 28 years) also had dementia and died at the same memory care facility in October last year.

My mother-in-law had Alzheimer's for 15 years and died December 15, 2024 after a fall in the facility she was at for the last 2 years.

Any buyer of a memory care facility, whether converting from nonprofit or not, knows that moving a resident to a new facility dramatically increases the resident's anxiety about the unfamiliar and can, I've read and been told, increase mortality. Voting with your feet in these facilities is fraught with so many challenges and often life-or-death risk. That makes the initial promises freely offered by these facilities when a resident moves in so much more important. Changes that negatively and materially impact care, facility offerings, facility quality, and price for our most vulnerable elderly and their stressed-out and guilt-ridden caregiving family members should absolutely be avoided.



Legal Services Advocacy Project

February 27, 2026

The Honorable Robert Bierman
Co-Chair, Health Finance and Policy Committee
Minnesota House of Representatives
5th Floor Centennial Office Building
St. Paul, MN 55155

The Honorable Jeff Backer
Co-Chair, Health Finance and Policy Committee
Minnesota House of Representatives
2nd Floor Centennial Office Building
St. Paul, MN 55155

Dear Co-Chair Bierman, Co-Chair Backer, and Members of the Health Finance and Policy Committee:

The Legal Services Advocacy Project (LSAP) writes in strong support of HF 2779 and HF 2771, two bills that attempt to rein in the harms that have been wrought by private equity entities acquiring health care facilities, including specifically, nursing homes and assisted living facilities. LSAP provides policy, legislative, and administrative advocacy on behalf of Legal Aid's low-income, disabled, and elder clients statewide.

There is ever-increasing and dramatically disturbing evidence of adverse outcomes for patients and residents after the acquisition of health care facilities by private equity and corporations. Take for example this deeply troubling finding in the Journal of the American Medical Association: "Private equity acquisition was associated with increased hospital-acquired adverse events, including falls and central line-associated bloodstream infections."¹

Further, an article in the Stanford Law Journal identifies the significant risks posed by these private equity and corporate takeovers:

PE investment poses three main risks to patients, medical professionals, and the health care market overall. First, PE investment spurs health care consolidation, which increases prices and potentially reduces quality and access. Second, the pressure from PE investors to increase revenue can lead to exploitation of billing loopholes, overutilization, upcoding, aggressive risk-coding, harming patients through unnecessary care, excessive bills, and increasing overall health spending. Third, physicians acquired by PE companies may be subject to onerous employment terms and lose autonomy over clinical decisions.²

Finally, the byzantine ownership structures of these private equity and corporate entities make it extremely difficult for regulators to identify the licensee's responsible persons and to hold these entities accountable when violations and harms occur. LSAP urges the committee's support for HF 2779 and HF 2771, which together would take a major step to addressing the harms evidenced by private equity and corporate takeover of health care facilities.

Sincerely

Supervising Attorney

¹ Kannan S, Bruch JD, Song Z. *Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition*. *JAMA*. 2023;330(24):2365–2375. doi:10.1001/jama.2023.23147

² Erin C. Fuse Brown, Mark A. Hall, *Private Equity and the Corporatization of Health Care*, 76 *STAN. L. REV.* 527, 543 (2024).



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March 2, 2026

Co-Chair Robert Bierman
Co-Chair Jeff Backer
House Health Finance & Policy Committee
2nd Floor Centennial Office Building
658 Cedar St.
St. Paul, MN 55155

Dear Co-Chairs Bierman and Backer and committee members:

On behalf of Minnesota Farmers Union (MFU), I am writing to share our support for Representative Reyer's HF2771 which will create important guardrails around the acquisition of nursing homes and assisted living facilities by private equity and other corporate investors. This bill responds to the alarming increase in private equity investment in our healthcare system that spurs greater consolidation and reduces healthcare access.

MFU is a grassroots organization that has represented Minnesota's family farmers, ranchers and rural communities since 1918. In recent years MFU has helped lead efforts to address the extreme consolidation in our healthcare system that is driving up costs, reducing access and limiting opportunities for independent healthcare providers. This includes working with legislators in 2023 to pass new tools for cracking down on large health system mergers. HF2771 builds off that work by addressing the role private equity is playing in monopolizing Minnesota's healthcare system to the detriment of patients and taxpayers.

Nursing home access in rural Minnesota is rapidly declining right as the population is aging. More than half of the nursing home closures in Minnesota between 2013 and 2023 were in rural counties according to the MDH.ⁱ Analysis by the Center for Rural Policy and Development estimated that peak demand for nursing home beds in entirely rural counties will occur between 2035 and 2040 and yet the number of beds in those communities has declined by 41% since 2005.ⁱⁱ For the nursing homes that remain, they have become an attractive target for private equity.

A study in 2022 by the Gerontological Society of America found that large out-of-state chains, including those backed by private equity, have been rapidly acquiring Minnesota nursing homes and that a significant portion of those transactions involve selling nursing home property to real estate investment trusts.ⁱⁱⁱ The study found that the nursing homes that were acquired performed worse on Minnesota Department of Health inspection scores and spent significantly more on management fees while cutting employee health insurance coverage and laying off workers. Private equity firms that purchase nursing homes are also notorious for shifting their pharmacy business from a community pharmacy to an out-of-state mail order pharmacy, further exacerbating the rapid decline of community pharmacies in Minnesota.

Minnesotans are also confronting high costs and a high level of private equity ownership among assisted living facility operators. Between 2023 and 2024 Minnesota experienced some of the largest long-term care price increases in the country.^{iv} Four of the five largest assisted living

operators in the country are owned by private equity and two of those four have operations in Minnesota.^v

While private equity control of long-term care in Minnesota has already exploded, HF2771 would put strong checks on further acquisitions of nursing homes and assisted living facilities. The legislation would require robust reporting of proposed acquisitions and transfer of ownership to the Attorney General's Office, Department of Health and Department of Human Services. The Attorney General would be newly empowered to approve or deny private equity acquisitions of nursing homes and assisted living facilities after considering a set of factors such as the potential for higher prices or reductions in staffing.

We urge the committee to support HF2771 and thank Rep. Reyer for her leadership in authoring this bill. MFU looks forward to working with members to protect rural healthcare access and drive down costs. If you have any questions, please contact our Antimonopoly Director, Justin Stofferahn, at justin@mfu.org or (612) 594-1252 (C). Thank you for considering the needs and perspectives of Minnesota's farm families.

Sincerely,

A handwritten signature in black ink that reads "Gary Wertish". The signature is written in a cursive style with a large, looped initial "G".

Gary Wertish
President, Minnesota Farmers Union

ⁱ <https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/rhcmn.pdf>

ⁱⁱ <https://www.ruralmn.org/wp-content/uploads/2024/11/Final-nursing-homes-one-page-summary.pdf>

ⁱⁱⁱ <https://pmc.ncbi.nlm.nih.gov/articles/PMC9196681/pdf/igac022.pdf>

^{iv} <https://investor.genworth.com/news-events/press-releases/detail/994/long-term-care-costs-increase-in-minnesota-exceeding>

^v <https://pestakeholder.org/news/private-equity-behind-top-senior-housing-operators/>



The answer to one simple question exposes a harsh reality in long-term care: which carries a higher penalty—elder abuse or animal abuse?

If you answered elder abuse, you would be dead wrong.

State of Minnesota Long-Term Care in 2025

In Minnesota, if an elderly person dies as a result of neglect or abuse in a long-term care facility, the maximum fine is just \$5,000. Meanwhile, animal cruelty can result in up to two years in prison, a \$5,000–\$10,000 fine, and restitution for the cost of care.

This indifference to the suffering—and needless deaths—of older adults is commonplace in far too many long-term care facilities, as this research demonstrates.

Elder Voice Advocates (EVA) and others successfully worked to pass legislation to license assisted living facilities, believing it would finally lead to improved care. That law took effect on August 1, 2021—and yet, the trajectory has not improved and seems to be moving in the opposite direction.

Transparency drives accountability and reform. EVA prioritizes transparency because we have learned that secrecy protects poor performers, not residents. When the public can see the true scope and patterns of abuse, neglect, and exploitation, providers face greater pressure to improve care, policymakers are more likely to act, and families can make informed decisions. Visibility drives accountability, and accountability drives change.

EVA will continue its mission to use research and insights to make transparent the actual state of elder care in Minnesota.

EVA Uncovers Alarming Patterns of Substandard Care by For-Profit Providers



EVA has identified troubling patterns of poor care by for-profit long-term care providers throughout Minnesota. These profit-driven operators dominate the assisted living landscape and are linked to needless suffering and death.

The 2025 Minnesota Department of Health (MDH) substantiated investigations of abuse, neglect and exploitation were reviewed with a focus on underlying causes, history of maltreatment and staff issues.

EVA's research is distinct in scope and methodology. While maltreatment has been studied through isolated incident reports, surveys, or administrative datasets, this research has systematically integrated regulatory findings, investigative records, and historical patterns of maltreatment to reveal the full scope of harm across care settings.

Key Findings from MDH Substantiated Investigations of Abuse, Neglect and Exploitation:

- 79% occurred in for-profit assisted living, assisted living/memory care, nursing homes, home care, boarding care and hospice (for-profit ownership is dominant).
- 72% occurred in assisted living and assisted living with memory care.
- 23 deaths in 2025 are directly attributed to neglect and/or abuse:
 - 21 deaths were by for-profit providers – 91%
 - No recorded fines were issued for any of these deaths
 - 19 providers had a history of prior substantiated investigations

Drivers of Substandard Care

- **For-profit failures.**

The growing influx of for-profit operators has significantly degraded the quality of care. These providers operate on a business model, not a quality-of-care model. Their cost-cutting leads to substandard care, while owners maintain generous profits. ***Revenue transparency is lacking, and revenues are clearly not being reinvested into improving care.***
- **Severe lack of accountability.**

A \$5,000 fine is merely a cost of doing business, not a meaningful deterrent. The most egregious facilities are investigated but remain open, even when some have long histories of dozens of substantiated investigations and failed surveys.
- **Underfunded oversight and enforcement.**

With its current funding, the Minnesota Department of Health is able to investigate only approximately 15% of the complaints it receives. These findings, therefore, represent the tip of the iceberg and reflect systemic state public policy indifference toward the elder rights to quality care. ***Laws are only as effective as their enforcement.***

Improve Transparency to Drive Reform of Elder Care

Minnesota's older adults and people with disabilities have a fundamental human right to safe, quality care. Yet repeated findings of systemic breakdowns in oversight and enforcement show that the current public policy framework is not strong enough to protect them. Residents' needs must come before provider profitability. To change outcomes, Minnesota must adopt stronger public policy protections, meaningful transparency, and real accountability. Without them, the promise of quality care remains out of reach.

We must:

- Strengthen and fund effective and transparent regulatory oversight of all providers
- Increase and enforce meaningful fines for harmful care
- Pass laws that raise standards of care
- Allow consumers legal recourse when providers commit wrongdoing
- Require for-profit operators to report detailed financial and operational data

True reform requires a coordinated approach: stronger oversight, meaningful transparency, and penalties significant enough to change behavior. Together, these tools create the accountability necessary to protect people receiving care and motivates providers to improve care.

Kristine Sundberg,
Executive Director
Elder Voice Advocates – Elder Care IQ

State of Minnesota Long-Term Care in 2025

*A Comprehensive Review of Abuse, Neglect, and Exploitation
in Long-Term Care Facilities*

Findings from the Minnesota Department of Health
Resolved Complaint Investigation Reports

Prepared by: Elder Voice Advocates
Publication Date: February 2026

Executive Summary

In 2025, the Minnesota Department of Health (MDH) reported substantiated investigations of abuse, neglect, and exploitation in long-term care facilities.

Elder Voice Advocates is a 501(c)(3) nonprofit organization is dedicated to protecting the rights, safety, and dignity of older adults. EVA advances elder justice reforms, promotes transparency and accountability in long-term care, and equips the public with research and easy to use tools, such as Elder Care IQ, to increase transparency and help reduce the risk of abuse, neglect, and exploitation in long-term care.

Using publicly available MDH “Resolved Complaint” reports, EVA reviewed 200 substantiated investigations to better understand:

- Where poor care occurs
- The types of maltreatment involved
- How often poor care results in death
- Systemic drivers that allow harm to continue

The findings reveal a clear and urgent pattern: for-profit providers—and especially assisted living and assisted living/memory care—account for the vast majority of substantiated maltreatment. Staffing issues are central to most problems, and weak accountability allows harm to persist.

This research summary is based on reported information from the weekly reported MDH resolved complaint investigation records from 2025. The information presented is for informational and educational purposes and may not include every complaint, allegation, investigation detail, corrective action, or enforcement outcome associated with a provider. Resolved complaint findings reflect what MDH determined based on available evidence at the time of investigation.

The MDH reports provided the specific incident findings, and EVA used our Elder Care IQ screening tool to easily access the entire record of investigations, surveys, fines, and staffing data for the provider. Elder Care IQ is a free online screening tool, developed by EVA, that helps families and advocates find and compare long-term care providers by showing government investigation reports and quality indicators related to abuse, neglect, and exploitation. This gives a deeper understanding of what drives poor care.

Purpose of this Research

This report is not a critique of all providers—many deliver excellent, compassionate care, and we are grateful to them. Rather, it documents areas of systemic failures and provides evidence to inform accountability, transparency, and policy solutions. Understanding the data is essential to ensuring older Minnesotans receive safe, dignified care, and that repeat harm is prevented.

We go beyond the data by adding our insights into what drives poor care. Only by understanding what is happening—and why—can we propose solutions to address these systemic failures.

Methodology

We conducted a systematic review of publicly available regulatory surveys and investigative records, examining all licensed long-term care providers with substantiated findings of abuse, neglect, or exploitation in 2025. Only MDH-substantiated findings were included.

Data Availability

The underlying dataset was developed through proprietary, original research and analysis. Aggregate findings and methodology are provided in this report.

Overall Findings

Key patterns identified include:

- **For-Profit providers are associated with the poorest quality of care**
- **Assisted Living, whether for-profit or nonprofit, perform at lower standards of care**
- **Assisted Living with Memory Care residents are at the highest risk of maltreatment**
- **Metro providers have proportionately higher rates of abuse, neglect, and exploitation**
- **Financial exploitation occurs disproportionately more in memory care or home care**

We included only substantiated investigations to ensure this research relies only on findings that have met the state's evidentiary standard, even though many inconclusive or unsubstantiated cases present serious and credible concerns about harm.

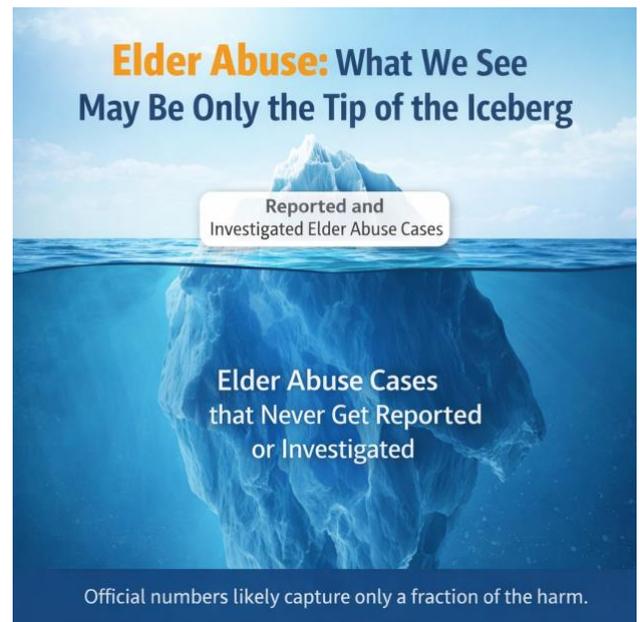
We also used Elder Care IQ to document each provider's full record, including previous investigations, safety violations, fines, and unlicensed staff levels reported in the 'Uniform Disclosure of Unlawful Sexual Abuse, Maltreatment, or Serious Injury/Death' (UDULSA). However, the UDULSA relies on self-reported, unverified data, which may affect the accuracy and reliability of its findings.

Minuscule Number of Elder Abuse Cases Get Reported and Investigated

1) Less than 15% of all complaints are investigated and even fewer are reported. MDH prioritizes investigations based on severity, urgency, and jurisdiction. Some reports are referred to other authorities or resolved through alternative processes. Limited evidence or regulatory thresholds can also prevent substantiation.

2) Only 1 in 24 elder abuse cases are reported to authorities according to the World Health Organization, National Council on Aging and others. Applying this commonly cited estimate, 200 substantiated cases could suggest the true number of people harmed is far higher—potentially well over 4,500.

When you compound how few cases of elder abuse complaints ever get reported with only 15% of these complaints being investigated, ***we can clearly see that the findings of this research are only the tip of the iceberg.***



Key Issue Areas

1) For-Profit Providers Account for 79% of Substantiated Maltreatment Findings

Substantiated maltreatment findings were four times more likely in for-profit, long-term care settings than in nonprofit settings.



Unfortunately, this is not surprising, given how the long-term care system is structured—especially in assisted living. The numbers are predictable: for-profit facilities are built on a profit model—not a care model. Labor is the highest cost, so cuts usually happen there, leading to issues such as:

- Chronic understaffing
- Lower wages → higher turnover
- Fewer licensed nurses providing clinical oversight
- Reliance on minimally trained aides

This is why assisted living is dominated by for-profit providers. Nursing homes are under more national regulatory oversight than assisted living.

When residents' needs increase—as they inevitably do with age—care intensity doesn't rise to match it. National research consistently reinforces this pattern, showing that for-profit ownership correlates with lower staffing, weaker oversight, and poorer outcomes:

- 1. National Evidence: For-Profit Chains Have Lower Staffing + More Deficiencies** — Harrington et al. (2011), *Health Services Research*
 - Largest for-profit nursing home chains had lower RN and total nurse staffing and received more regulatory deficiencies, including serious deficiencies, compared to government facilities.
- 2. COVID Era Research Reinforced Ownership Risk** — Stall et al. (2020), *CMAJ Open*
 - Observational studies show that for-profit long-term care homes delivered inferior care across many measures, including staffing, complaints, hospital admissions, and mortality; U.S. evidence also links for-profit homes to more infection-control deficiencies.
- 3. National Literature Review: For-Profit Nursing Homes Linked to Higher COVID Cases/Deaths** — Kaiser Family Foundation (2021)
 - Studies consistently showed for-profit nursing homes were associated with higher COVID-19 cases and/or deaths.
- 4. Private Equity (Subset of For-Profit) Shows Worse Quality Signals** — Braun et al. (2021), *JAMA Health Forum*
 - Private-equity owned nursing homes provided somewhat lower-quality care than other for-profit homes based on multiple quality measures.
- 5. Systematic Review + Meta-Analysis** — Commodore et al. (2009), *CMAJ*
 - Not-for-profit nursing homes deliver higher-quality care than for-profit nursing homes on average, based on the body of published studies.

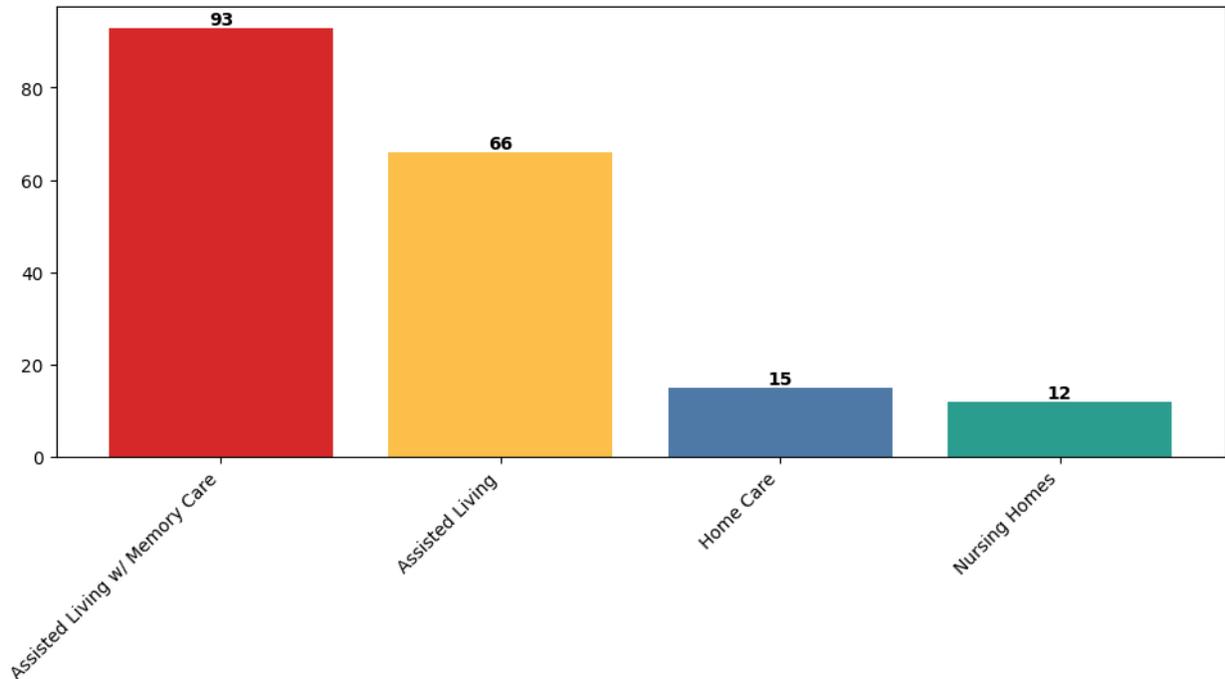
Taken together, these studies show that the profit-driven model—especially in large chains and private-equity ownership—tends to compromise staffing, oversight, and overall quality of care.

2) Assisted Living Dominates Substantiated Maltreatment Findings

Assisted living facilities—including memory care—accounted for the highest volume of substantiated maltreatment findings:

- 159 cases in assisted living memory care and assisted living
- 41 cases across all other long-term care settings combined

Nearly 80% of Maltreatment Investigations in Assisted Living



Assisted living and assisted living/memory care represent nearly 80% of substantiated maltreatment investigations, but that statistic reflects more than one simple cause. These settings serve far more residents across many locations than nursing homes, so a higher volume of investigations is expected.

At the same time, assisted living is generally less regulated and less medically supervised than nursing homes, even as residents' needs have become increasingly complex—especially for people living with dementia.

Assisted living has become high-acuity care without high-acuity safeguards.

Most residents now:

- Are in their late 80s or 90s years of age
- Have multiple chronic conditions
- Need help with activities of daily living
- Require medication management, mobility assistance, and monitoring

Yet assisted living:

- Is not regulated like nursing homes
- Often has no onsite nurse 24/7

- Lacks enforceable staffing ratios
- Operates under vague “hospitality-style” regulations

When residents’ health declines, the system simply absorbs it, often without additional safeguards. Many residents who *once* would’ve been transferred to skilled nursing or hospitals remain in assisted living because:

- Transfers are expensive
- More filled beds mean more revenue/profit
- Families are reassured, “this is normal aging”
- Facilities delay calling for higher-level care
- Oversight agencies rarely intervene early

So, needless deaths occur when the setting is not staffed to provide complex medical care.

Dangerously Low Staffing Documented

Our review identified providers staffing at extremely low levels, including:

- 1 staff to 70 residents at one facility
- 1 staff to 50 residents at another
- Other examples: 1 to 30, 1 to 37, 1 to 42

Understaffing is very common:

- A national survey by the American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) found 63% of assisted living providers experienced staffing shortages, and about 1 in 4 rated them at a high level.
- Another AHCA/NCAL survey reported 96% of assisted living communities faced a staffing shortages.

Key Staffing Issues in Assisted Living

Even conservative estimates show that over half of assisted living providers report staffing shortages—other surveys suggest it’s nearly universal at times. Understaffing is common because several forces stack on top of each other:

- **Low wages and demanding work:** Care staff are often paid near entry-level wages for physically and emotionally demanding work, making it difficult for facilities to recruit and retain staff.
- **High turnover and burnout:** The job includes heavy workloads, injuries, stress and constant pressure, so people leave quickly, and the remaining staff get overloaded.
- **“Acuity creep” (residents require more care than staffing can accommodate):** Assisted living residents often age into more complex needs (dementia, mobility issues, medication management), but staffing levels often aren’t adjusted to keep pace.
- **No strong minimum staffing standards:** Unlike nursing homes, assisted living often doesn’t have clear staffing ratios tied to resident needs, so staffing can be driven by budgets instead of safety.
- **Profit and cost-cutting pressure:** Staffing is the biggest expense, and some operators keep staffing lean to protect margins—especially in large corporate chains.
- **Competition for workers:** Assisted living competes with hospitals, home care, retail, and fast food—many of which now offer similar pay with less stress.

3) Assisted Living and Assisted Living with Memory/Dementia Care Are the Highest Risk Settings

Residents living with dementia and cognitive impairment face a significantly elevated risk. Substantiated maltreatment findings by the primary facility types included:

<u>Facility Type</u>	<u>Substantiated Findings</u>
Assisted Living with Memory/Dementia Care	93
Assisted Living	66
Home Care	15
Nursing Homes	12
Hospice	3
Hospital	1
State Facility	1

Memory care multiplies the risk

Memory care units concentrate on residents who:

- Can't communicate pain or distress clearly
- Are at higher risk of falls, dehydration, malnutrition, and infections
- Depend entirely on staff for safety

Combine this with:

- Locked units
- Undertrained staff
- High turnover
- Inadequate supervision

...and the risk of missed medical emergencies, neglect, and preventable death increases.

Why Assisted Living and Memory Care Are Higher Risk Providers

- **Assisted living is generally less regulated than nursing homes**, results in fewer required safeguards, weaker enforcement mechanisms, and greater variability in care standards.
- **Residents often have higher needs than the public realizes**, mobility assistance, toileting, medication management, and supervision—but the staffing models don't always match those needs.
- **Memory care residents' vulnerability** increases risks for neglect, poor supervision, medication errors, falls, wandering/elopement, dehydration, malnutrition, and preventable injury.
- **Staffing in assisted living is often lower and less trained** than in nursing homes, with fewer licensed nurses onsite and less consistent medical oversight.
- **Oversight often depends heavily on the provider's internal policies**, creating gaps in reporting, documentation, emergency response, and follow-through on serious incidents.
- **Residents may receive fewer routine clinical assessments**, so health decline, infections, weight loss, untreated pain, and worsening conditions can go unnoticed longer.

- **For-profit business pressure can be more pronounced**, where cost-cutting can show up in understaffing, high turnover, rushed care, and limited training—conditions closely linked to neglect and abuse risk.
- **Assisted living often emphasizes “independence” and “housing” over clinical care**, which can blur responsibility when residents become too impaired to safely live in that level of care.
- **Families may assume memory care equals intensive care**, but many units operate with limited staffing and uneven dementia training—making serious harm more likely without timely intervention.

4) Direct Care Failures Dominate Findings

The most prevalent issues identified include neglect/untreated wounds, physical abuse, medication errors, financial exploitation, and staffing deficiencies. Deaths resulting from medication errors and neglect often involve multiple system failures.

While this report concentrates on the most common issues, it acknowledges that all categories are significant and warrant attention.

A single complaint often spans multiple categories. For example, an RN failing to properly assess a resident or develop a care plan, may result in:

- Neglect because needed care wasn’t delivered
- Medication errors
- Staffing or training deficiencies



79	Neglect/Untreated Wounds
41	Physical Abuse
38	Medication Errors
29	Financial Exploitation
25	Staffing Issues
14	Mental Abuse
13	Medication Theft
8	Sexual Assaults

The majority of substantiated complaints were tied to breakdowns in basic care, resident safety, and clinical oversight.

5) Medication Errors

Again, medication errors are greater in Assisted Living with Memory Care (22) and Assisted Living (11), while all other settings account for the remaining 5 cases.

Staffing issues are at the core of most medication errors with understaffing or staffing shortages. These are followed by communications breakdowns, transition of care and training and delegation failures.

6) Financial Exploitation

Financial exploitation is a significant harm in long-term care, often affecting residents most vulnerable.

<u>Facility Type</u>	<u>Cases</u>
Assisted Living	8
Home Care	7
Assisted Living/Memory/Dementia Care	7
Nursing Homes	4
Hospice	1

Common exploitations include:

- Staff stealing cash, cards, or jewelry
- Coercing residents to give gifts
- Misuse of resident funds/accounts
- Manipulating cognitively impaired residents

6) Failures in Reporting: Noncompliance Raises Additional Concern

EVA found that several providers were out of compliance with Minnesota assisted living disclosure requirements. Minnesota requires assisted living providers to file a UDULSA report (Uniform Disclosure of Unlawful Sexual Abuse, Maltreatment, or Serious Injury/Death) containing critical safety and staffing information. Failure to file required disclosures may signal deeper operational issues and weak accountability.

Maltreatment-Related Deaths: Preventable Harm with Fatal Consequences

It is important to research deaths in long-term care because they are often the clearest warning sign that a system meant to protect people is failing. Long-term care settings have residents who are frequently medically fragile, dependent on others for basic needs, and unable to easily report harm or advocate for themselves, which creates a heightened risk of abuse, neglect, exploitation, and preventable tragedies. Every death deserves accountability, transparency, and a serious examination of whether it could have been avoided.

23 Deaths Due to Maltreatment

Elder Voice Advocates identified 23 deaths in Minnesota long-term care facilities in 2025 that were reported to be directly connected to substantiated abuse, neglect, or untreated wounds.

Because MDH does not maintain a public statewide tally of long-term care deaths specifically tied to substantiated maltreatment, Elder Voice Advocates conducted this review using MDH resolved complaint investigation reports. Our key findings follow.

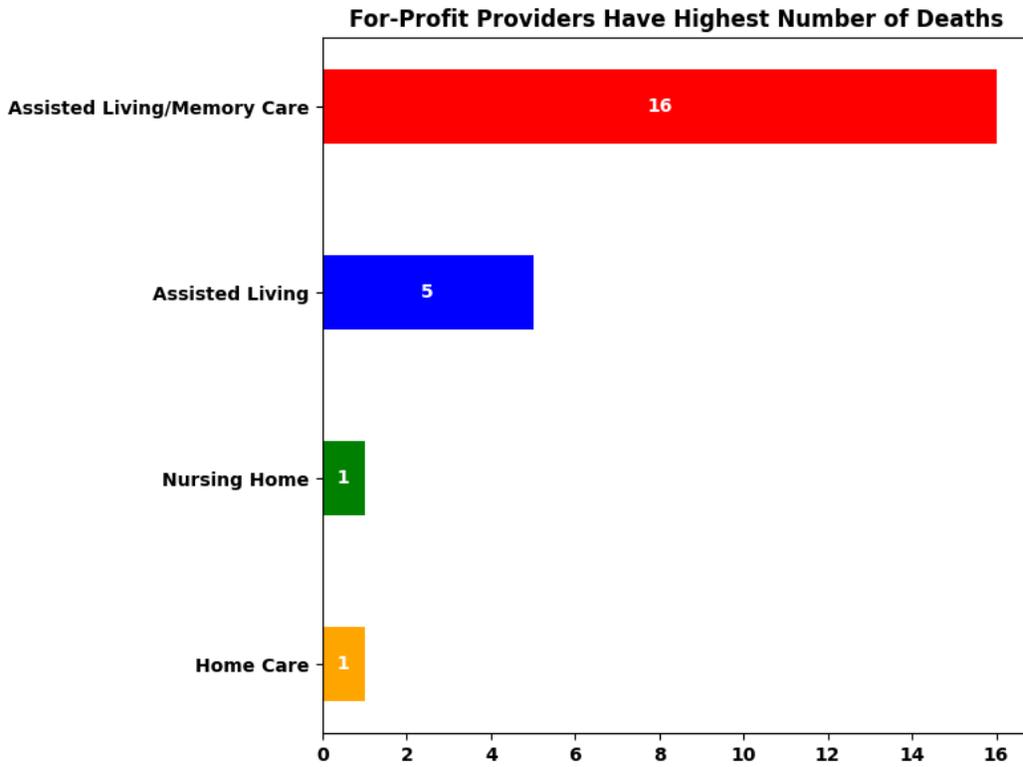
Over 87% of Deaths Occurred in Assisted Living and Assisted Living with Memory Care

Assisted living and assisted living with memory care account for a striking share—over 87%—of substantiated deaths, but that statistic reflects more than one simple cause. These settings constitute a much larger share of the long-term care landscape than nursing homes, serving far more residents across far more locations; therefore, a higher volume of investigations is expected. The points below highlight several key factors that help explain why assisted living and memory care settings are so heavily represented in substantiated findings of abuse, neglect, and exploitation.

For-Profit Providers Have the Highest Number of Deaths

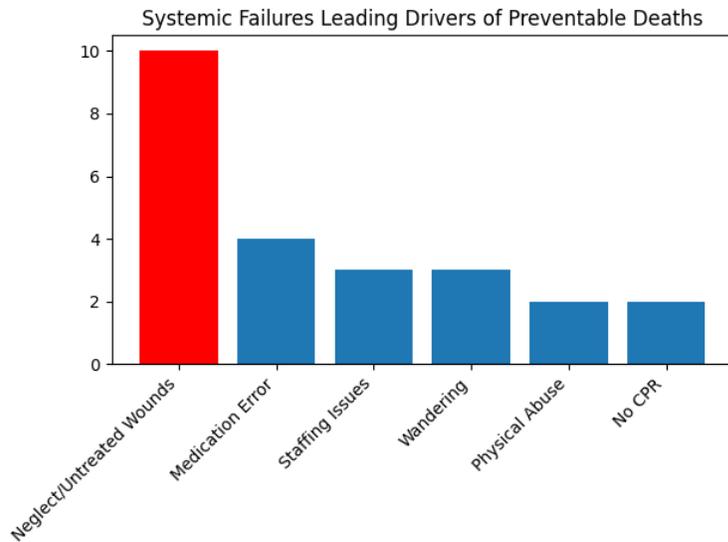
It is not surprising that over 91 % of for-profit providers are most likely to be associated with wrongful death, because when profits or revenue targets are prioritized, then staffing, training, supervision, and quality of care can become “cost centers” to minimize, placing vulnerable residents at significantly greater risk of harm.

These are not simply deaths tied to aging alone. These are deaths linked to confirmed failures in care that meet Minnesota’s legal definitions of maltreatment. Often, these are agonizing deaths causing needless suffering and death.



Causes of Death in Maltreatment Findings

Untreated wounds and neglect are more than double medication errors, staffing issues, wandering/elopement, physical abuse, no CPR given.



Minimal staffing is common in for-profits where deaths occurred

The number of unlicensed assisted living staff must be reported to MDH. Daytime, nighttime, and overnight staffing numbers are required. We used the daytime staff number, which is typically where the highest number of staff are present. Therefore, it is important to keep in mind that this reports best case scenarios.

The unlicensed staff have no professional care training, and is self-reported by the providers, therefore not verifiable.

For-Profit Unlicensed Staffing

- 4 providers with 1 staff for 6 – 10 residents
- 8 providers with 1 staff for 15 – 25 residents
- 1 provider with 1 staff for 30 residents
- 3 did not provide the required report

Nonprofit Unlicensed Staffing

- 2 providers with 1 staff for 4 residents
- 1 provider with 1 staff for 16.75 residents
- 1 provider with 1 staff for 31.6 residents
- 2 did not provide the required report

Reporting on RN, LPN, or APN staffing is required, **but they do not need to provide the number of nursing staff on duty**. All reported having an RN on staff, except for the 2 who didn't report. The absence of information on the number of nursing staff assigned to the day, evening, and night shifts is a significant flaw, as larger facilities require more nursing staff and this information is critically important when assessing adequacy of care.

Public accountability is weakest where deaths are highest

19 facilities where death occurred had prior substantiated investigations for abuse, neglect, and exploitation. There are alarming records of a prior history of maltreatment. Examples include:

- **25 substantiated investigations and 84 unsubstantiated investigations:** For-profit Duluth nursing home
- **14 substantiated, 17 unsubstantiated, 52 safety violations, and a \$6,000 fine in 2022:** For-profit assisted living with memory care
- **11 substantiated and 28 unsubstantiated investigations:** A nonprofit MN Veterans Home
- **It appears that no fines were assessed for the death of the residents in 2025.**

For-profit assisted living sits in a regulatory blind spot:

- Fewer inspections
- Limited public reporting of financial and operational records
- Weak enforcement even after serious incidents
- Complaints are often dismissed unless death or extreme harm occurs
- That lack of transparency allows systemic problems to persist until tragedy makes them visible.

The bottom line—when you combine:

- Profit-driven decision-making
- Moderate regulatory oversight
- Increasingly frail residents
- Memory care concentration

...it becomes entirely predictable that many wrongful deaths will occur in for-profit assisted living and memory care settings.

Why This Matters

Maltreatment-related deaths are preventable. Investigation reports include cases involving:

- Untreated wounds that progressed into infection and death
- Neglected injury care
- Failures to monitor residents at high risk
- Failures to provide timely medical follow-up

Even a few dozen deaths tied to substantiated maltreatment in one year represents a serious warning sign of systemic breakdown and preventable suffering.

What Is Driving Poor Care?

In Minnesota, long-term care (nursing homes, assisted living/home care settings), neglect, abuse, and exploitation most often stem from a handful of recurring system failures—with understaffing at the center of most.

Based on our observational review of these resolved complaint investigations and our years of advocacy work, Elder Voice Advocates identified consistent drivers of poor care.

1) Understaffing and high workload are the #1 drivers of neglect

When there aren't enough direct-care staff (CNAs, aides, nursing staff), residents' basic needs get delayed or skipped:

- Missed toileting/brief changes → skin breakdown, infections
- Not enough help with eating/drinking → malnutrition, dehydration
- Delayed call-light response → falls, injuries
- Residents left in bed too long → pressure ulcers, decline
- Reduced supervision → wandering/elopement risks (esp. dementia care)

2) Staff burnout, stress, and compassion fatigue

Understaffing leads to exhaustion and frustration, which increases risk for:

- Rough handling
- Verbal degradation/intimidation
- Shortcuts that become neglect
- Resentment-based retaliatory behavior (especially toward residents with dementia-related behaviors)

Even when staff don't intend harm, burnout can create an environment where harm becomes predictable.

3) Inadequate training (especially dementia care + behavior support)

A common pathway into both neglect *and* abuse is staff being unprepared for:

- Dementia behaviors (agitation, wandering, "resistance to care")
- Safe transfers and mobility support
- De-escalation and trauma-informed care
- Recognizing/reporting maltreatment

4) High turnover + unstable staffing model

Frequent staff departures cause:

- Inconsistent care plans
- Missed care tasks during shift transitions
- Residents not known well enough to spot that something is out of character
- Heavier reliance on temporary staff who don't know residents' needs/routines

This is closely tied to wages, workload, weak support, and working conditions.

5) Weak provider culture + retaliation or fear of reporting

Based on our work, we have gained insight into how retaliation is a common method of control that affects the quality of care. In many facilities, neglect/abuse persists not just because it happens, but because staff and families fear consequences if they speak up:

- Residents fear retaliation
- Staff fear discipline or job loss
- Coworkers protect each other (“closed culture”)
- Leadership discourages “making trouble”

6) Poor oversight, delayed investigations, and low accountability

When enforcement is inconsistent, facilities learn they can operate below standard without meaningful consequences. Minnesota's Office of Health Facility Complaints (within MDH) is responsible for investigating complaints and violations.

As currently resourced, the agency investigates only 15% of complaints, and only 5% receive an onsite investigation.

7) Medication management failures

Medication-related harm is a very common form of neglect and sometimes abuse, including:

- Missed medications
- Incorrect doses
- Lack of monitoring (sedation, falls, adverse reactions)
- Inappropriate antipsychotic use in dementia care

Elder Voice's analysis has identified staffing and medication issues as central patterns in abuse/neglect investigations. Medication errors occur in long-term care due to a mix of *system issues* and *human factors*—and many conditions make errors more likely than in other settings.

Here are the most common reasons for staffing and medication issues:

1. Staffing shortages + turnover: Too few trained staff, rushed med passes, and constant new hires = higher risk of mistakes.
2. Residents have complex medication regimens: Many residents are on a variety of medications, with frequent changes and high risk for interactions.
3. Communication breakdowns: Orders get missed or misunderstood during transitions like:
 - hospital → nursing home
 - provider → nurse
 - pharmacy → facility staff
4. High-interruption environment: Med passes are constantly interrupted (call lights, alarms, emergencies), increasing wrong time/wrong dose errors.

5. Weak systems (training + tech + oversight): Inconsistent training, poor documentation systems, and a lack of regular medication review allow errors to repeat.

8) Resident vulnerability + isolation

Certain resident factors increase risk, especially when paired with poor staffing:

- Dementia/cognitive impairment
- Limited mobility or communication barriers
- Lack of family visitors/advocates
- Language barriers
- Heavy dependence for ADLs (bathing, toileting, eating)

Abuse and neglect thrive where residents cannot report, are not believed, or are alone.

Conclusion

The 2025 MDH resolved complaint investigations reveal a pattern that Minnesotans cannot ignore:

- **For-profit providers and assisted living settings—especially memory care—are where substantiated maltreatment is happening most often.**
- **Neglect, medication breakdowns, and understaffing are not minor issues. These failures cause residents to suffer—and in 23 tragic cases, die. Strikingly, no fines have been recorded in the Resolved Complaint Investigation reports for these deaths.**

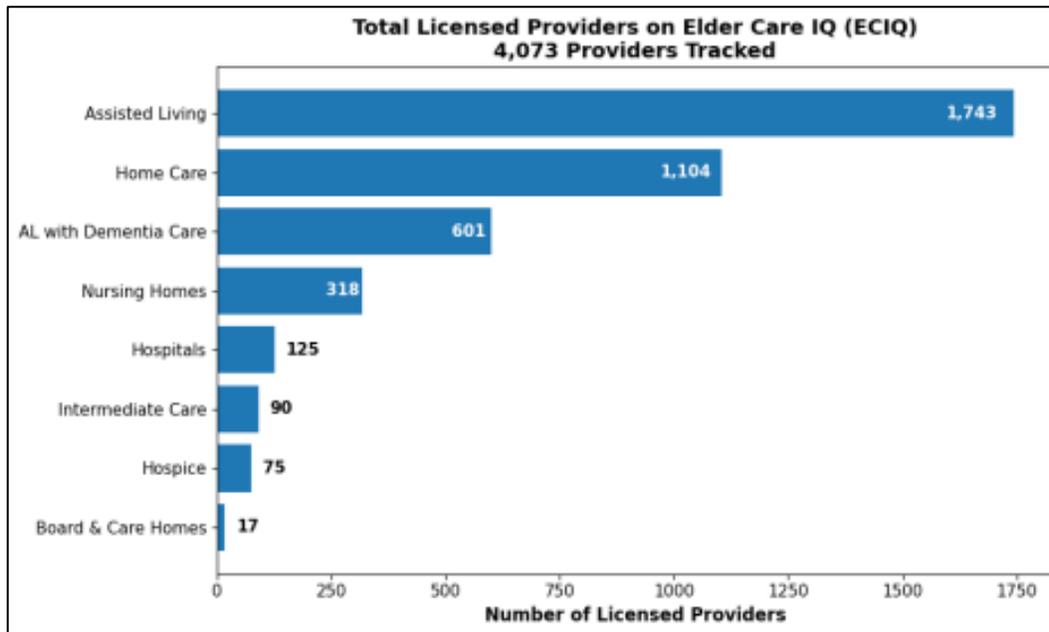
Minnesota families deserve transparency, accountability, and robust safety standards that protect vulnerable adults—not a system that allows dangerous care conditions to persist and recur. How many more lives need to be lost before we demand the systemic overhaul necessary for true accountability and reform? We must act now to prioritize the dignity and safety of our elders over profits.

EVA will continue to shine a light on the realities inside long-term care. We do this because transparency is powerful — when truth is clearly visible, pressure for safer, better care follows. **Transparency is EVA's key strategy for change: when the public can see the real scope of harm in long-term care, legislators, regulators and providers are far more likely to improve the quality and safety of the care delivered.**

Many of these cases involved unimaginable suffering and even death, which could have been avoided with proper staffing and a care-driven model. Review some of these examples in the Addendum which expose the agony many suffered including amputations, deprived of pain medication for many days, festering sores left untreated, slaps and insults, sexual abuse, broken bones, a person left on a bedpan for 11.5 hours and much more.

Addendum

- 1. Market Context: Minnesota Long-Term Care:** Minnesota's long-term care system includes thousands of licensed settings. Elder Care IQ reports the following number of facilities licensed in Minnesota:



- 2. Examples of Investigation Reports Reviewed:** We selected several representative cases from the investigation reports that provide insights into the underlying story of the data.

Medication Errors / Medication Mismanagement

- **Albert Lea – Medication error leads to hospitalization:** A resident with heart failure did not receive an increased dose ordered for fluid retention. Staff continued giving a lower dose for about a week despite the updated prescription, leading to serious symptoms and urgent hospitalization. The resident was later discharged to hospice. **Facility response:** staff re-education, internal investigation, and updated medication storage procedures.
- **Rochester – Hospitalized after receiving 10x medication dose:** A resident with a kidney transplant was given 10 times the prescribed steroid dose on 13 occasions, resulting in dangerously high blood pressure, heart failure, and ICU hospitalization. Multiple nurses failed to verify the dose or alert a physician despite worsening warning signs.
- **Coon Rapids – Individual dies after blood thinner withheld:** A resident with multiple serious medical conditions did not receive a vital blood thinner for three weeks after a nurse incorrectly marked it as discontinued. The resident suffered a stroke, endured seizures, developed severe pneumonia requiring ventilation, and later died.
- **Minneapolis – Medication error causing death:** A nurse miscalculated and gave a resident 20 times the prescribed dose of morphine, failed to follow medication safety protocols, and delayed accurate reporting. The resident died within hours of acute morphine toxicity.



Neglect/Unsafe Care Leading to Serious Injury or Death

- **Roseville – Death from neglect:** A resident with severe cognitive impairment declined over several weeks without adequate assessment or intervention. She became incontinent, fell, lost the ability to walk, and developed multiple pressure wounds, including deep tissue injuries. When hospitalized, she had untreated wounds and signs of infection after lying in soiled bedding. She died 15 days later.
- **Coon Rapids – Neglect during transfer results in fatal injury:** Staff disregarded a resident's care plan and attempted a transfer alone without required assistance or proper equipment. The resident suffered a severe arm fracture and died two days later from complications.
- **Golden Valley – Neglect resulting in death (positional asphyxia):** A resident became trapped between a wall and his electric scooter after falling. Staff reportedly failed to intervene or call 911 in time despite witnessing distress. The resident died from positional asphyxia.
- **Plymouth – Neglect resulting in amputation:** An RN failed to complete a full assessment and did not address visible wounds on a resident's toes. Without timely medical intervention, the wounds progressed to gangrene, resulting in a below-the-knee amputation.
- **Waconia – Left on bedpan for 11.5 hours:** A resident with serious illness and impaired cognition was left on a bedpan for 11.5 hours after a staff member left the building without notifying others. The next shift failed to check on her. The resident developed severe pressure injuries, and staff falsely documented care that had not been provided.
- **Minneapolis – Neglect results in hospitalization and near-death (missed dialysis):** A resident with end-stage renal disease missed 13 dialysis treatments in three months due to failures in transportation coordination, follow-up, and documentation. Staff also did not respond appropriately to dangerously high blood pressure and renal diet needs. The resident suffered a major crisis and required prolonged hospitalization.

Failure to Provide Emergency Care

- **Duluth – Death after CPR was not provided as ordered:** A licensed nurse failed to perform CPR on an unresponsive resident even though medical orders required it. The nurse waited about 40 minutes before notifying leadership. CPR and 911 were initiated too late, and the resident died. The nurse is no longer employed there.

Sleeping on Duty/Failure to Respond

- **Savage – Resident falls, calls for help, staff asleep; resident calls 911:** A non-ambulatory resident fell out of bed and repeatedly called for help, but was ignored because the sole overnight staff member was asleep. The resident called 911. The facility also repeatedly failed to staff the required number of overnight caregivers despite residents needing two-person assistance.
- **St. Cloud – Resident calls for help for 45 minutes; staff asleep:** A bedbound resident experiencing severe abdominal pain and low blood sugar called for help for about 45 minutes with no response and eventually dialed 911. EMS could not enter until firefighters broke a window. The resident was found soaked in urine without the call light in reach. The staff member was later terminated.

Abuse/Violence/Harassment by Staff

- **Richfield – Staff knife incident involving dementia resident:** A staff member chased a resident with dementia through the facility while holding a knife. The staff member was arrested.
- **Champlin – Sexual abuse by staff caught on video:** A staff member was recorded groping a woman with dementia in memory care and physically pulling her wheelchair toward him after she tried to move away. Another staff member witnessed the incident.
- **Chisago City – Taunts, threats, and rough handling:** Two staff members taunted and threatened a resident instead of following his care plan for de-escalation. One staff member swore and threatened

jail, while the other threw a blanket over his head and pulled equipment out of his hands. The resident was left crying. Both staff members were removed.

Wandering/Door Alarm Failure

- **Austin – Found outside with neck fracture:** A resident with dementia was left outside for nearly an hour after a caregiver silenced the door alarm without checking on her. She was found in severe pain with a neck fracture requiring treatment. No immediate safety improvement steps were documented.

Theft/Exploitation (Including Medication Theft)

- **St. Louis Park – Hospice nurse stole pain meds from dying resident (For Profit, Hospice):** A hospice nurse stole large quantities of opioid medication from a terminally ill resident's home. The family witnessed the removal of medications under the claim that they would be destroyed, but required documentation, and disposal did not occur. Investigators confirmed major missing quantities. The nurse is no longer employed there.
- **Deer River – Staff stole pain medications from multiple residents (Nonprofit, Nursing Home):** A licensed staff member stole pain medications from residents who depended on them for daily relief. Controlled substances were signed out without documentation of administration. The staff member admitted the theft and is no longer employed there.
- **Bloomington – Staff stole 89 oxycodone tablets from dementia resident:** A staff nurse stole oxycodone and falsely claimed the medication had been destroyed. Required narcotic destruction protocols were not followed. The staff member is no longer employed there.
- **Duluth – Theft of over \$10,000 from blind home care client:** A caregiver stole a blind client's bank card and made over \$10,000 in fraudulent charges for personal expenses. The funds were eventually returned, and the caregiver was terminated.
- **Bloomington – Theft of over \$9,000 from dementia client (home care):** A staff member used a dementia client's credit cards for personal purchases and transfers through payment apps and cryptocurrency accounts. The staff member admitted the exploitation and is no longer employed there, and the agency cooperated with the investigation.
- **Edina – Financial exploitation totaling \$99,000:** A staff member received approximately \$99,000 from a resident over the final 20 months of his life, including large checks during hospice care. The staff member admitted knowing this violated policy but accepted the payments anyway.

3. Testimonials of Poor Care

Family Story: "I want to share a personal experience that has been deeply troubling for my family. I'm doing so anonymously out of fear of retaliation by this facility.

For the past year, my dad, who has dementia, has been receiving inadequate care at a private-pay assisted living memory care facility that charges over \$10,000 a month (not including medications). Despite the high cost, the Resident Assistants (RAs) caring for him lack proper training—putting his life, and the lives of other vulnerable residents, at serious risk.

Here are just a few alarming examples:

- Twice, my dad was served food that can cause a serious reaction—despite doctor's orders. The explanation? 'The service plan and kitchen have these notes, and we'll speak to staff.' After the second incident: 'The RA is new and probably needs more training.'
- Required overnight safety checks are supposed to happen every two hours, but we've reviewed camera footage showing gaps of 4–5 hours with no check-ins.
- Twice, aides left his emergency pendant out of reach after helping him dress.

- One RA admitted he didn't know how to cue or use simple positive prompts to encourage my dad to walk or dress—despite working in a memory care unit.
- Another RA said she couldn't assist him because she didn't know the code to enter his apartment. How would she respond in an emergency?
- We've seen video of him struggling in the bathroom while staff simply walked away.

These aren't isolated incidents. They highlight a broken system that fails to properly train and supervise staff—even as families like mine pay thousands each month for care. There's a dangerous disconnect when people try to excuse serious gaps in competency by saying there aren't enough RAs or that wages are too low. At this facility, the RAs earn \$19 to \$23 an hour.

This is about safety. This is about accountability. This must change.

To our lawmakers: Please do not let profit-driven motives undermine the progress we urgently need. Families like mine are counting on you to require better training and real accountability in assisted living memory care.

Resident Story: “After falling and breaking four ribs, I was discharged from the hospital and sent to a nursing home for physical therapy. What should have been a place of healing became a near-death experience.

Weakened from a recent COVID recovery, I tested positive upon arrival—a lingering false result. That's when everything changed. I was placed in isolation in a hospice room for a week. Aides avoided me because they didn't want to fully gown-up.

- One morning at 5:40 AM, I pressed my call light, needing the bathroom. No one came.
- By 7 AM, a nurse arrived to give me insulin and reminded the aides I needed breakfast now.
- By 9:30 AM, I was still waiting—desperate for food and a bathroom break. My blood sugar was dropping dangerously low.
- If I didn't get food soon, I was going to die.

With no one coming, I gritted my teeth and used my injured side to pull myself up. The pain was so excruciating I screamed, but no one heard. My door was tightly shut. Somehow, I made it to the bathroom and activated the emergency light, praying it would get their attention. Still, no one came. I screamed, “Help me!” but was met with silence.

Finally, an aide appeared—but instead of helping, she yelled, “Your breakfast isn't here yet!” Too weak to stand, I collapsed into a chair. I vaguely remember her pouring orange juice down my throat.

I survived that day, but the memory still haunts me. The neglect and fear replay in my mind. I pray the good Lord takes me before I ever have to endure that again.” ~Beverly

Families Break Silence on Dangerous Conditions at The Homestead at Anoka: Poor infection control at The Homestead at Anoka has led to devastating consequences. In just one month, half of the residents in one section of long-term care died—ten precious lives lost. Families have bravely come forward to share heartbreaking evidence, including photos, videos, and documents, highlighting the shocking conditions their loved ones endured.

Alarming reports reveal that the facility consistently fails to follow basic infection prevention protocols. Staff members often do not wear masks properly, if at all, and used gloves are frequently left lying around. This negligence has contributed to the spread of COVID, influenza, pneumonia, and norovirus. Despite being fined by the Minnesota Department of Health, no changes have been implemented, putting residents at continued risk.

The living conditions further exacerbate the problem. The facility relies on a moldy, deteriorating ice machine as its main water supply. Bathrooms are left filthy, with feces and blood splattered on toilets and walls, which significantly increases infection risks. Aides have neglected to change soiled briefs for over 10 hours—more

than 30 times in a month—resulting in deep, painful wounds and infections. Medications have been carelessly left out in the open. Residents have reported suspected abuse, including bruising and rough handling by staff.

Families who advocate for proper care encounter indifference and retaliation from management. Their concerns are dismissed, and those who speak out face intimidation tactics, such as threats and attempts to silence them. Instead of supporting residents and families, the social worker sides with management, leaving families feeling helpless and afraid.



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