Office of Health Facility Complaints

2018
EVALUATION REPORT

Program Evaluation Division

OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

Program Evaluation Division

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OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA • James Nobles, Legislative Auditor

March 2018

Members of the Legislative Audit Commission:

The Office of Health Facility Complaints (OHFC) within the Minnesota Department of Health is responsible for investigating allegations of maltreatment by certain licensed providers, such as nursing homes and home care providers.

We found that OHFC has not met its responsibilities to protect vulnerable adults in Minnesota. The reasons for this failure are two-fold: poor internal operations at OHFC and Minnesota's complex regulatory structure.

We recommend a number of actions needed to improve OHFC's internal operations. We also present several legislative recommendations, including a recommendation that the Legislature establish a workgroup to examine the state's oversight of senior care providers and housing facilities.

Our evaluation was conducted by Judy Randall (project manager), Laura Schwartz, and Katherine Theisen. The Minnesota Department of Health cooperated fully with our evaluation, and we thank the department for its assistance.

Sincerely,

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THE GREAT SEAL OF THE STATE OF MINNESOTA
L'ETOILE DU NORD
1858

Summary

Key Facts and Findings:

- The Office of Health Facility Complaints (OHFC) within the Minnesota Department of Health (MDH) investigates allegations of maltreatment by MDH-licensed providers, such as nursing homes and home care providers. (pp. 3-4)
- Between fiscal years 2012 and 2017, the number of allegation reports OHFC received increased by more than 50 percent, reaching 24,100 in Fiscal Year 2017. OHFC triaged for onsite investigation only 5 percent of the reports it received that year. (p. 7)
- OHFC does not have an effective case management system, which has contributed to lost files and poor decisions regarding resource allocation. (pp. 10-12)
- The majority of OHFC staff do not have confidence in OHFC leadership's ability to lead the office. (pp. 19-20)
- OHFC has frequently failed to meet required triage and investigation deadlines. (pp. 57-63)
- OHFC's intake, triage, and investigation processes lack sufficient quality control measures. (pp. 32-33, 37-41)
- OHFC does not inform vulnerable adults or their family members whether providers have reported suspected maltreatment. (pp. 64-65)
- OHFC posts investigation reports on its website, but the website is incomplete and difficult to navigate. (pp. 71-72)
- OHFC does a poor job managing its data, and MDH does not use available allegation and investigation data to identify trends and inform prevention efforts. (pp. 75-78)
- "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 or other licensed service providers. (pp. 83-88)

Key Recommendations:

- OHFC should implement an electronic case management system. (p. 12)
- The MDH Commissioner's Office should play a stronger role overseeing OHFC. (p. 21)
- OHFC should incorporate quality control measures into its triage and investigation processes. (pp. 33, 41)
- The Legislature should require OHFC to regularly report on its progress in meeting state and federal requirements. (p. 62)
- The Legislature should amend state law to allow OHFC to inform a vulnerable adult and his or her legal representative when a provider has filed a report that involves the vulnerable adult. (p. 65)
- The Legislature should require OHFC to post all investigation reports on its website, and OHFC should improve its website. (p. 72)
- OHFC should better manage its data, and MDH should analyze the data to identify trends and share its findings with providers and other stakeholders. (pp. 76-77)
- The Legislature should establish a work group to examine the state's oversight of senior care providers and housing facilities. (p. 88)

OHFC has not met its responsibilities to protect vulnerable adults in Minnesota.

OHFC has been poorly managed.

Report Summary

The Office of Health Facility Complaints (OHFC) in the Minnesota Department of Health (MDH) receives and responds to allegations that MDH-licensed providers—such as nursing homes and home care providers—violated the state's Vulnerable Adults Act.[1] OHFC also responds to allegations about licensing violations.

When OHFC receives an allegation report, staff review it to determine whether OHFC should conduct an onsite investigation. If OHFC staff determine that an investigation is needed, an investigator conducts an investigation and makes a determination about whether maltreatment or licensing violations occurred.

In Fiscal Year 2017, OHFC received about 24,100 reports of alleged maltreatment or licensing violations, an increase of more than 50 percent from Fiscal Year 2012. The number of reports OHFC investigated during this time period also increased by more than 50 percent, reaching about 1,300 in Fiscal Year 2017.

OHFC's case management system has numerous deficiencies.

OHFC does not have an office-wide system in which its supervisors can monitor the progress of cases or the workload of staff. Office leadership told us that they do not know the current size of investigators' caseloads, and they do not assign cases with respect to investigators' current workload.

Furthermore, although OHFC receives most allegation reports electronically, it prints those reports and conducts its work using paper case files. OHFC's paper-based system has contributed to files being lost or misplaced.

We recommend that OHFC implement an electronic case management system.

High staff turnover, few written policies, and a lack of confidence in senior leadership reflect a dysfunctional office culture.

In fiscal years 2015 and 2017, OHFC's staff turnover exceeded 25 percent. In 2015, for example, 8 of the 32 staff people in OHFC resigned, retired, or transferred to another position within state government. Almost half of OHFC's current staff have been working at the office for less than two years.

Many of OHFC's internal policies are unwritten. For example, OHFC has few written policies to standardize routine investigation tasks, such as who to interview during investigations. Similarly, OHFC does not provide guidelines for investigators about how to investigate common types of incidents, such as when a vulnerable adult with dementia leaves a locked facility unsupervised, or when a vulnerable adult experiences an unexplained injury.

As part of our evaluation, we conducted a survey of all OHFC staff. Staff reported that they are proud of the work they do at OHFC. However, almost 60 percent of survey respondents indicated that they do not have confidence in OHFC senior leadership, and more than 60 percent indicated that OHFC senior leadership does not do a good job of communicating the goals and strategy of the office. Respondents also

[1] The 1980 Minnesota Legislature created the Vulnerable Adults Act; *Laws of Minnesota* 1980, Chapter 542, codified as *Minnesota Statutes* 2017, 626.557. The act establishes protections for "vulnerable adults," who are individuals age 18 or over and residents of a facility, such as a nursing home; receive certain state-licensed services; or have an infirmity that impairs their ability to protect themselves from maltreatment. The act defines "maltreatment" as abuse, neglect, and financial exploitation.

commented about "disorganization" and "mistrust" in the office.

We recommend that the MDH Commissioner's Office play a stronger role in overseeing OHFC and its work.

Inadequate quality controls have resulted in triage and investigation practices that do not always meet standards.

Neither OHFC leadership nor supervisors regularly audit case files to ensure that triage decisions and investigations meet expectations. Audits conducted by the federal Centers for Medicare and Medicaid Services (CMS) concluded that OHFC did not meet triage standards for the past two years.[2]

As part of our evaluation, we reviewed files of 53 cases that OHFC investigated. We found that OHFC investigators sometimes failed to interview key individuals—including the vulnerable adult. Many of the case files we reviewed did not contain documentation to support information in OHFC's investigation reports.

We recommend that OHFC incorporate quality control measures and that supervisors regularly review triage decisions and investigation practices.

OHFC did not meet triage and investigation deadlines for a large share of its cases.

Both state law and federal regulations prescribe how quickly OHFC must triage allegation reports. For example, federal regulations require OHFC to triage certain allegation reports within two business days from the date that OHFC received the allegation report. In Fiscal Year 2017, OHFC met this two-day deadline for only 56 percent of investigated reports.

There are also multiple deadlines for conducting and completing investigations. For example, state law requires OHFC to conclude an investigation within 60 days of receiving an allegation report. OHFC concluded investigations within this 60-day timeline for only 12 percent of the cases it investigated in Fiscal Year 2017.

We recommend that the Legislature require OHFC to regularly report on its progress toward meeting these deadlines.

OHFC does not inform vulnerable adults or their legal representatives whether providers have reported suspected maltreatment.

State law protects the identity of those who report allegations. The law states: "The identity of any reporter may not be disclosed."[3] OHFC leadership told us that they consider the name of a healthcare provider to be protected under this law. As a result, if a vulnerable adult or family member asks OHFC whether a provider reported an incident, OHFC will not provide this information.

We heard two key concerns about this issue. First, if a provider informs a vulnerable adult that it has reported suspected maltreatment to OHFC, the vulnerable adult has no way to verify if the provider is telling the truth. Second, even if the provider did report the allegation, the vulnerable adult has no way to verify whether the description of the incident the provider reported matches the vulnerable adult's understanding of the incident.

OHFC has not met required deadlines for triaging or investigating allegations.

[2] CMS regularly audits OHFC's triage decisions. CMS's standard is that OHFC followed federal triage guidelines for at least 90 percent of the cases reviewed. In 2016, 85 percent of the cases reviewed met this standard; in 2015, only 38 percent met this standard.

[3] *Minnesota Statutes* 2017, 626.557, subd. 5(d).

Minnesota has less oversight of housing with services establishments—which include assisted living facilities—than nursing homes and other licensed providers.

We recommend that the Legislature revise the law to allow OHFC to inform a vulnerable adult and his or her legal representative when a provider has filed a report that involves the vulnerable adult.

OHFC's website is incomplete and difficult to navigate.

OHFC does not post to its website all of its investigation reports. We estimate that the website may be missing up to 19 percent of reports that, according to OHFC leadership, should be posted. Missing investigation reports limit consumers' ability to learn about the quality of different providers.

OHFC's website is also difficult to navigate. Consumers must sometimes search for a provider using the name and address of a parent company, rather than the name and street address of the actual facility they are researching.

We recommend that the Legislature require OHFC to post all recent investigation reports on its website. We also recommend that OHFC improve its website.

OHFC does not manage its allegation or investigation data well, and MDH does not use available data to inform prevention efforts.

OHFC does not have documented guidance for how data fields in its database should be used, or even descriptions of the codes used within each field. As a result, staff record information inconsistently in the database. Additionally, OHFC does not collect data necessary to inform and focus prevention activities. For example, to determine whether certain vulnerable adults have a higher risk of experiencing maltreatment, OHFC should collect data about the vulnerable adults involved in alleged maltreatment incidents, such as their diagnoses or disabilities.

Other than presenting high-level trend data in statutorily mandated reports, MDH does not analyze the data that OHFC does collect. Neither MDH nor OHFC shares trend data with providers regarding the allegation reports OHFC receives or the investigations it conducts.

We recommend that OHFC better manage its existing data and collect more complete data. Additionally, we recommend that MDH analyze and share trend data regarding maltreatment allegations and investigations. These data could help providers identify patterns and protect against future incidents.

Minnesota's regulatory structure provides less oversight of "housing with services" establishments, which include assisted living facilities.

Even if OHFC makes needed changes, some vulnerable adults will receive less protection than others due to Minnesota's regulatory structure. Many vulnerable adults in Minnesota live in housing with services establishments, but these facilities are subject to limited state regulatory oversight because they are registered (not licensed) by MDH. Through its investigations and periodic inspections, MDH verifies that *licensed* providers meet certain standards. However, MDH does not have the same oversight of providers or facilities that are merely *registered* with the department, such as assisted living facilities.

We recommend the Legislature establish a work group to examine the state's oversight of senior care providers and housing facilities. The Legislature should holistically examine the state's oversight of these providers and facilities to ensure the state's regulatory approach supports state policy priorities.

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Introduction

In April 2017, the Legislative Audit Commission directed the Office of the Legislative Auditor to evaluate the Office of Health Facility Complaints (OHFC), an office within the Minnesota Department of Health (MDH). OHFC is responsible for investigating allegations of maltreatment by nursing homes, home care providers, hospitals, and other licensed health care providers. At the time, legislators were concerned about the rise in the number of maltreatment allegations the office had received. Legislators were also concerned about what they heard regarding OHFC's performance and its workload.

While we were conducting our evaluation, media reports heightened concerns about maltreatment allegations and OHFC's ability to investigate them. In addition, Governor Dayton appointed a working group to address maltreatment issues, and the Commissioner of Health resigned.

In light of this increased level of concern, we are hopeful that our evaluation will help legislators, state officials, and the public more fully understand the seriousness and complexity of the current situation. In our evaluation, we addressed the following questions:

- **To what extent does OHFC effectively process and investigate allegations?**
- **How often does OHFC impose sanctions or require providers to develop corrective action plans, and what types of sanctions are imposed?**
- **Does OHFC maintain appropriate levels of communication with complainants and other stakeholders? To what extent are OHFC's processes, reports, and website transparent and accessible?**

We interviewed OHFC leadership and staff to understand the office's policies and practices for receiving, triaging, and investigating allegations. We also reviewed relevant state and federal laws. To examine OHFC's caseload and identify general trends regarding the nature of allegation reports submitted to the office, we assessed the integrity of OHFC's primary database and analyzed the data it contained.

To gain a deeper understanding of the allegation reports OHFC receives and the investigations it conducts, we reviewed 103 case files of allegation reports that OHFC received and closed in fiscal years 2016 and 2017.[1] Of these 103 files, 53 were cases OHFC investigated, and 50 were cases that OHFC did not investigate. We also shadowed OHFC investigators on ten investigations to obtain a more in-depth understanding of their work. These ten investigations involved nursing homes, assisted living facilities, and home care providers in the Twin Cities metropolitan area. We observed investigations into allegations of abuse, neglect, and financial exploitation.

We met with numerous stakeholders regarding their concerns about OHFC. We spoke with concerned family members and their lawyers. We met with representatives from a number of organizations, including AARP, the Alzheimer's Association, Care Providers of Minnesota, LeadingAge, and the Minnesota Directors of Nursing Administration. They

[1] We randomly selected 100 of these 103 case files; we intentionally selected the remaining 3 cases.

shared with us their perspectives on what was working well at OHFC and where there were opportunities for improvement. We spoke with the Ombudsman for Long-Term Care and the Ombudsman for Mental Health and Developmental Disabilities. We met with representatives from the Department of Human Services (DHS) Office of Inspector General, which performs a function similar to OHFC. We also met with DHS staff responsible for Minnesota's centralized call center for reporting maltreatment allegations (the Minnesota Adult Abuse Reporting Center, commonly referred to as "MAARC").

Finally, we spoke with many individual OHFC staff—both current and former—about their experiences working at OHFC, and we conducted a survey of all current OHFC staff. Through this survey, we learned about staff training, internal policies, and office culture. We received responses from 49 of the 50 staff actively employed when we conducted our survey, reflecting a 98 percent response rate.

This report is organized into five chapters. Chapter 1 provides an overview of OHFC. In Chapter 2, we examine OHFC's internal operations, and in Chapter 3, we review OHFC's investigation process. In Chapter 4, we analyze more closely the extent to which OHFC has met legally required deadlines, and how OHFC communicates its triage and investigation determinations. In Chapter 5, we discuss MDH's efforts to prevent maltreatment, as well as broader concerns regarding Minnesota's oversight and regulation of senior care and housing facilities.

At the end of this report, we provide a glossary of key terms. There are also two appendices with more detailed information regarding health care providers licensed and registered by MDH (Appendix A) and OHFC's jurisdiction to investigate maltreatment allegations (Appendix B).

Chapter 1: Background

Throughout 2017, state and local media reported stories of individuals who were maltreated (abused, neglected, or financially exploited) in Minnesota nursing homes and other health care facilities. The reports provided disturbing accounts of residents who suffered serious consequences, including death, from the maltreatment. Among other things, these reports raised questions about the Minnesota Department of Health (MDH)—the state agency responsible for investigating allegations of maltreatment in nursing homes and other health care facilities—and the extent to which it was fulfilling its responsibilities.

Within MDH, the Office of Health Facility Complaints (OHFC) is responsible for investigating maltreatment allegations; the office also investigates allegations of licensing violations. In this chapter, we provide background information about OHFC and the investigations it conducts. We also highlight some key trends related to OHFC's work, including the number of allegation reports OHFC receives, the number of investigations it conducts, and how funding and staffing for the office have changed in recent years.

Key Findings in This Chapter:

- OHFC receives and investigates two broad types of allegations: (1) those involving suspected maltreatment and (2) those involving suspected licensing violations.
- OHFC's workload has increased in recent years.
- The 2017 Legislature appropriated new funding to protect vulnerable adults in health care settings.

OHFC Overview

OHFC is an office within MDH's Health Regulation Division.[1] The Health Regulation Division licenses health care providers, including nursing homes, home care providers, and hospitals.[2] Other offices within the Health Regulation Division regularly inspect these licensed providers to determine whether they are complying with federal and state laws.[3] In contrast, OHFC conducts investigations of MDH-licensed providers in response to specific allegations.

[1] OHFC was established in 1976. *Laws of Minnesota*, 1976, chapter 325, sec. 2, codified as *Minnesota Statutes* 2017, 144A.52.

[2] In Appendix A, we provide additional information on the types of providers MDH licenses.

[3] Some providers are certified by the federal government. "Federally certified" providers are eligible to receive Medicare or Medicaid payments.

OHFC receives and investigates two broad types of allegations: (1) those involving suspected maltreatment and (2) those involving suspected licensing violations.

Maltreatment allegations involve allegations of neglect, abuse, or financial exploitation of a specific individual.[4] Allegations of licensing violations involve a provider's alleged failure to comply with state licensing or federal certification requirements. For example, a maltreatment allegation might allege that a nursing home neglected a *specific resident* when it failed to provide that person with his or her medication. On the other hand, an allegation of a licensing violation might allege that a nursing home failed to have proper protocols in place to ensure that *all of its residents* correctly received their medications. Whenever OHFC investigates an allegation of maltreatment, it also investigates whether the provider named in the allegation violated any licensing requirements.

When someone submits a verbal or written statement containing an allegation, we refer to that statement as an "allegation report." Some allegation reports that OHFC receives contain multiple allegations; some contain only one. For example, OHFC may receive an allegation report that alleges a provider abused a nursing home resident when the provider slapped the resident on the wrist. OHFC may receive another allegation report that alleges abuse because a provider slapped the resident on the wrist, and also alleges neglect because the provider failed to administer the correct dosage of medication.

OHFC's investigation process begins when the office receives an allegation report involving an MDH-licensed provider. OHFC triage staff review the allegation report and determine whether OHFC staff should conduct an investigation. If OHFC triage staff determine that an investigation is needed, the allegation report is assigned to an investigator who visits the location of the alleged incident and conducts an investigation. Once the investigator completes the investigation, he or she makes a determination about whether maltreatment or licensing violations occurred and writes a final investigation report.

It is important to note that OHFC's role is regulatory; it is not an emergency-response office. Other agencies—such as county adult protection service agencies or law enforcement—may provide an emergency response to maltreatment allegations. For example, county adult protection staff may respond immediately to a report of an individual living in a home with no heat, and law enforcement may respond immediately to a report of an individual in immediate physical danger.

A complex array of federal and state laws govern OHFC's work. Guidance issued by the federal Centers for Medicare and Medicaid Services (CMS) establishes some requirements for OHFC's investigations, and Minnesota statutes establish additional requirements.[5] We review some of these legal requirements in more depth below and in subsequent chapters.

[4] *Minnesota Statutes* 2017, 626.5572, subds. 2, 9, 15, and 17. We define these and other terms in the Glossary, which can be found at the end of this report.

[5] Guidance to federal regulations are detailed in Centers for Medicare and Medicaid Services, *State Operations Manual, Chapter 5* (Baltimore, 2016). State laws governing OHFC investigations include *Minnesota Statutes* 2017, 144.651, 144A.44, 144A.52-144A.54, 626.557, and 626.5572. OHFC's investigations are also governed by statutes specific to licensing requirements for each provider type. See, for example, *Minnesota Statutes* 2017, 144.50-144.586, 144A.01-144A.1888, and 144A.43-144A.482.

Minnesota's Vulnerable Adults Act

In 1980, the Minnesota Legislature established the Vulnerable Adults Act, the Minnesota law on which OHFC bases most of its maltreatment investigations.[6] The purpose of the act is to:

> …protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment; to assist in providing safe environments for vulnerable adults; and to provide safe institutional or residential services, community-based services, or living environments for vulnerable adults who have been maltreated.[7]

Minnesota's Vulnerable Adults Act establishes three important aspects related to OHFC's work: (1) the definition of a "vulnerable adult," (2) what constitutes "maltreatment," and (3) which state or local entity has jurisdiction for investigating maltreatment allegations involving vulnerable adults.

First, the act defines "vulnerable adults" as persons 18 years of age or older who meet any of the following conditions:

- Is a resident or inpatient of a facility, such as a hospital or nursing home.
- Receives certain services licensed by the state, including those offered by home care providers licensed by MDH and providers licensed by DHS.
- Has a physical or mental infirmity or dysfunction that impairs the individual's ability to protect one's self from maltreatment.[8]

For example, as defined under the Vulnerable Adults Act, residents of nursing homes are considered vulnerable adults. In contrast, an older person living at home who does not receive any licensed services, and who is able to protect him or herself from maltreatment, is not considered a vulnerable adult.

Second, the Vulnerable Adults Act defines three types of maltreatment: abuse, neglect, and financial exploitation.[9] Allegations of **abuse** typically involve alleged actions by a provider that are likely to harm a vulnerable adult. For example, an allegation that a provider sexually assaulted a vulnerable adult is an allegation of abuse. An allegation that a provider spoke to a vulnerable adult in a threatening manner is also an allegation of abuse.

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[6] *Laws of Minnesota* 1980, Chapter 542, codified as *Minnesota Statutes* 2017, 626.557. MDH also enforces the Maltreatment of Minors Act (*Minnesota Statutes* 2017, 626.556). From Fiscal Year 2012 through Fiscal Year 2017, OHFC received a total of 238 reports of maltreatment of minors and conducted 41 investigations related to minors (less than 1 percent of all OHFC investigations). As a result, our evaluation focused only on OHFC's responsibilities related to allegations of maltreatment involving vulnerable adults.

[7] *Minnesota Statutes* 2017, 626.557, subd. 1.

[8] *Minnesota Statutes* 2017, 626.5572, subds. 6 and 21.

[9] *Minnesota Statutes* 2017, 626.5572, subds. 2, 9, 15, and 17.

Examples of maltreatment allegations:

Abuse:
- Physical or sexual assault
- Biting, kicking, pinching, or slapping
- Verbal intimidation

Neglect:
- Failure to provide adequate supervision, resulting in harm to the vulnerable adult
- Misuse of equipment, such as a mechanical lift

Financial Exploitation:
- Theft of medication or valuables from a vulnerable adult
- Withholding funds or property of a vulnerable adult

Allegations of **neglect** typically involve an alleged failure to provide care that is "reasonable and necessary to obtain or maintain…physical or mental health or safety."[10] For example, an allegation that a provider administered the wrong dosage of medication, resulting in the resident's death, is an allegation of neglect. An allegation that a nursing home failed to supervise a resident with dementia who wandered out of a care facility is also an allegation of neglect.

Allegations of **financial exploitation** typically involve theft from a vulnerable adult or the misuse of a vulnerable adult's funds. For example, an allegation that a provider stole a vulnerable adult's medication is an allegation of financial exploitation. Similarly, an allegation that a provider stole a vulnerable adult's credit card and made personal purchases with it is also an allegation of financial exploitation.

Finally, Minnesota's Vulnerable Adults Act identifies which state or local agency has jurisdiction to investigate allegations of maltreatment. In general, the most important factors in determining jurisdiction are (1) whether the vulnerable adult involved in the allegation received some type of licensed services; (2) whether the person accused of committing the maltreatment (the "alleged perpetrator") is licensed by, or is employed by a provider that is licensed by, a state agency; and (3) which state agency licenses the provider.[11]

The act gives MDH jurisdiction to investigate allegation reports involving providers licensed by the department.[12] Similarly, the Department of Human Services (DHS) has jurisdiction to investigate allegation reports involving providers it licenses. County social services agencies investigate maltreatment allegation reports that involve family members or other providers not licensed by either MDH or DHS.

Recent Trends

Below, we present summary information about how OHFC's workload has changed over the past six fiscal years. We also discuss recent changes in funding for OHFC.

Workload

A number of factors affect OHFC's workload. The number of allegation reports OHFC receives determines the number of reports it must review and triage. Similarly, the number of investigators OHFC has on staff affects the number of investigations OHFC can conduct.

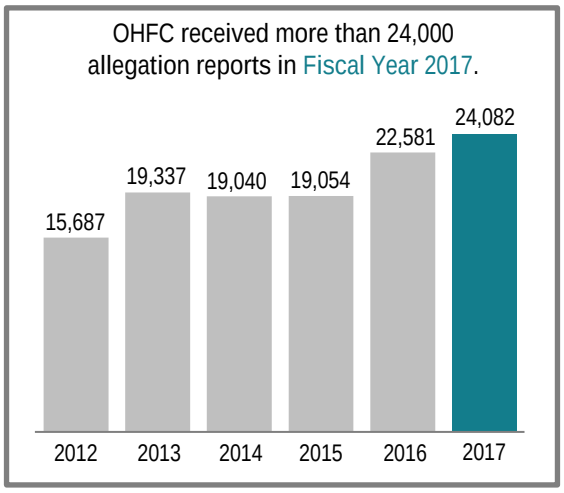
[10] *Minnesota Statutes* 2017, 626.5572, subd. 17(a)(1).

[11] See Appendix B at the end of this report for more information about which agency has jurisdiction to investigate each type of provider.

[12] *Minnesota Statutes* 2017, 626.5572, subd. 13(a).

OHFC's workload has increased in recent years.

All three key components of OHFC's workload—allegation reports, investigations, and staff—increased by more than 50 percent between fiscal years 2012 and 2017. Allegation reports can come from a variety of sources, including providers, family members, ombudspersons, and others.[13] In Fiscal Year 2017, OHFC received about 24,100 reports of alleged maltreatment or licensing violations. This was an increase of nearly 54 percent from Fiscal Year 2012, when OHFC received fewer than 15,700 such reports.



OHFC had a similar increase (58 percent) in the number of allegation reports it triaged for investigation during this time period. It triaged almost 800 of the allegation reports it received in Fiscal Year 2012 for investigation, and about 1,300 of the allegation reports it received in Fiscal Year 2017. OHFC investigated only between 3 and 5 percent of the allegation reports it received each year from Fiscal Year 2012 to Fiscal Year 2017. We discuss OHFC's investigations in more detail in Chapter 3.

While OHFC's workload has increased in recent years, its staffing complement has increased at roughly the same rate. Based on our review of state human resources data, OHFC had 27 people on staff at the end of Fiscal Year 2012. The number of OHFC staff increased to 42 at the end of Fiscal Year 2017, an increase of nearly 56 percent.

Revenues and Expenditures

OHFC's funding comes from federal funds, state licensing fees, and state General Fund appropriations. The federal government pays for some of OHFC's expenses associated with investigating allegations of maltreatment involving nursing homes that accept Medicare or Medicaid payments. All of the providers that MDH licenses—including nursing homes, hospitals, and home care providers—are required to pay an annual state licensing fee, the amount of which is established in law.[14] Finally, the Minnesota Legislature appropriates General Fund money to OHFC as part of the "base funding" it provides MDH.

Prior to Fiscal Year 2017, federal funds composed the majority of OHFC's revenues, as shown in Exhibit 1.1. However, between fiscal years 2015 and 2017, the state's General Fund appropriations for OHFC increased significantly, from less than $200,000 to nearly $2 million.

[13] In Minnesota, two offices of ombudspersons may submit allegation reports to OHFC: the Office of Ombudsman for Long-Term Care (OOLTC), and the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD). The OOLTC is part of the Minnesota Board on Aging and advocates for adults needing or receiving long-term care. The OMHDD is an independent state agency that advocates for persons receiving services for mental health, developmental disabilities, chemical dependency, or emotional disturbance.

[14] *Minnesota Statutes* 2017, 144.122; 144A.472, subd. 7; and 144A.753.

Exhibit 1.1: OHFC revenues are increasing significantly.

In thousands

Revenue Source	Fiscal Year 2015	2016	2017	2018	2019	2020	2021
General Fund	$ 161	$ 218	$1,879	$3,041	$3,909	$4,280	$ 5,284
Federal Funds	1,433	2,084	2,535	2,585	2,637	2,690	2,744
Licensing Fees	1,134	1,762	964	964	1,652	1,652	1,996
Total	$2,728	$4,064	$5,378	$6,591	$8,199	$8,622	$10,024

NOTES: Revenue amounts for Fiscal Year 2018 and later are estimates. The General Fund appropriations include OHFC's "base" appropriations and the Legislature's new appropriations targeted to protecting vulnerable adults in health care settings. Numbers may not sum to the totals due to rounding.

SOURCE: Minnesota Department of Health.

The 2017 Legislature appropriated new funding to protect vulnerable adults in health care settings.

During the 2017 session, the Legislature appropriated targeted funding to MDH specifically for protecting vulnerable adults in health care settings. This appropriation was *in addition* to the base funding OHFC already received from the General Fund as part of MDH's existing budget.[15] The 2017 Legislature designated an increasing amount of funding for this targeted purpose over a four-year period, starting with $1.2 million in Fiscal Year 2018 and culminating in $3.4 million in Fiscal Year 2021.[16] The combination of this targeted funding and OHFC's existing base funding is projected to significantly increase OHFC's General Fund appropriations in Fiscal Year 2018 and beyond. OHFC's Fiscal Year 2021 budget includes total General Fund appropriations of more than $5 million, as shown in Exhibit 1.1.

Targeted state funding specifically for protecting vulnerable adults:

FY 2018: $1.2 million
FY 2019: $2.0 million
FY 2020: $2.4 million
FY 2021: $3.4 million

As part of its effort to increase funding to help protect vulnerable adults, the 2017 Legislature also increased licensing fees for nursing homes and home care providers.[17] These licensing fee increases are authorized to take effect in Fiscal Year 2019. The increases are expected to generate an additional $685,000 of revenue annually in fiscal years 2019 and 2020, and an additional $1 million in Fiscal Year 2021.

OHFC leadership told us they plan to use much of the additional revenue appropriated for Fiscal Year 2018 and beyond to increase the number of staff. As of late 2017, OHFC had 54 staff people, including a director, an assistant director, 6 supervisors, 27 investigators, and 8 intake or triage staff.

OHFC's expenditures have increased in line with its overall increase in revenue. From Fiscal Year 2015 to Fiscal Year 2017, OHFC's expenditures nearly doubled, from about $2.8 million to $5.4 million. In Fiscal Year 2017, almost 72 percent of OHFC's expenditures were for personnel costs, such as salaries.

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[15] *Laws of Minnesota* 2017, First Special Session, chapter 6, art. 18, sec. 3, subd. 3(b).

[16] *Ibid*.

[17] *Laws of Minnesota* 2017, First Special Session, chapter 6, art. 10, secs. 59 and 68.

Chapter 2: OHFC Operations

Staff in the Office of Health Facility Complaints (OHFC) have an important task: they determine whether to substantiate allegations that vulnerable adults have been abused, neglected, or financially exploited. They also determine the validity of allegations that certain health care providers have violated licensing requirements. Reviewing these allegations and conducting investigations require OHFC staff to have a deep understanding of the complex laws that govern their work.

Both the number of allegation reports and the number of OHFC staff increased by more than 50 percent between fiscal years 2012 and 2017. Such significant changes in workload and staffing can make an already difficult task that much more challenging.

Key Findings in This Chapter:

- OHFC does not have an effective case management system, which has contributed to lost files and poor decisions regarding resource allocation.
- OHFC has had high levels of staff turnover.
- Many of OHFC's internal policies are unwritten and change frequently.
- The majority of OHFC staff do not have confidence in OHFC leadership's ability to lead the office.

In this chapter, we examine OHFC's internal operations. In particular, we describe OHFC's case management system and note the office's reliance on an inefficient, paper-based system. We analyze recent staff turnover, and highlight concerns related to staff training and internal policies. Finally, we discuss serious concerns about the culture and leadership within OHFC.

Given its increasing workload and complex duties, we are concerned that OHFC will not be able to fulfill its responsibilities unless it implements the recommendations we make in this chapter. Most importantly, we recommend that: (1) OHFC implement an electronic case management system, (2) OHFC develop clear and specific written policies, and (3) the Minnesota Department of Health (MDH) Commissioner's Office increase its oversight of OHFC.

Investigation Process Overview

OHFC has a complex, multi-step investigation process. The first step in OHFC's process is for the office to receive a report alleging maltreatment or a licensing violation by an MDH-licensed provider. These allegation reports can come from a variety of sources, including providers, family members, ombudspersons, and others.[1]

OHFC intake staff receive the allegation reports, print each report, and route them to triage staff. These staff review each allegation report and determine whether OHFC staff should conduct an investigation.

[1] In Minnesota, two offices of ombudspersons may submit allegation reports to OHFC: the Office of Ombudsman for Long-Term Care (OOLTC), and the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD). The Glossary provides more information about these offices and other terms used throughout this report.

If an allegation report is triaged for an investigation, the report is routed to a supervisor who assigns it to an OHFC investigator. The investigator conducts an investigation to determine whether maltreatment occurred and to identify any licensing violations. Investigations often involve observing the provision of care; reviewing medical records and provider policies; and interviewing numerous people, such as the vulnerable adult, family members, provider staff, medical professionals, other residents at the facility, and others, as needed. We discuss OHFC's triage and investigation process in more depth in Chapter 3.

Once the investigator has completed an investigation, he or she makes a determination about whether maltreatment or licensing violations occurred and writes the investigation report for internal review. When the report is finalized, OHFC sends notification letters to the relevant parties (such as the vulnerable adult and provider) and posts the investigation report on its website. The vulnerable adult and provider have an opportunity to appeal the final determination and request an additional review.

Case Management

An office like OHFC must have systems in place to effectively manage its workflow and allocate its resources. Because OHFC has experienced such a large increase in allegation reports in recent years, having an effective case management system in place is even more important. The office needs to be able to: assess the caseloads of its intake and triage staff and investigators, assign new cases to those staff, schedule investigations, monitor the progress of each case, and ensure that the office is meeting required deadlines.

OHFC does not have an effective case management system, which has contributed to lost files and poor decisions regarding resource allocation.

As part of our evaluation, we reviewed OHFC's systems and found numerous deficiencies. First, OHFC's electronic database is flawed, and staff do not have easy access to the data within it. Second, OHFC does not have an office-wide system in which its supervisors can monitor the progress of cases or the workload of staff. Third, although OHFC receives most allegation reports electronically, it prints those reports and conducts its investigations using paper case files, which causes a number of problems. We describe the effects of these issues below.

Although OHFC has an electronic database that tracks certain case management information—such as the status of a case, the investigator assigned to the case, and the time investigators spend on each case—it is not an effective case management tool. The quality of the data in the database is poor, in part because OHFC leadership has not provided sufficient guidance to staff about how the fields in the database should be used. (We discuss this more in Chapter 5.) In addition, OHFC leadership told us they have to either (1) ask supervisors to count by hand the number of cases assigned to each investigator, or (2) make special requests to IT staff to extract case management information from the database, because they cannot access these data on their own.

Because of the lack of an effective case management system, OHFC leadership and supervisors often have a poor understanding of staff caseloads. According to OHFC leadership, supervisors assign cases to investigators based largely on which investigator is physically available to visit a provider location on a given day, and not based on a real-time

understanding of an investigator's caseload. As a result, some investigators could have a large number of open cases while others have far fewer.

OHFC leadership told us that the office's goal for each investigator's caseload is a maximum of 15 cases at any one time (including cases at any stage of the investigation process). When we asked whether OHFC was meeting this goal, office leadership told us that they did not know the current size of investigators' caseloads. As part of our evaluation, we conducted a survey of all current OHFC staff.[2] In our survey, we asked OHFC investigators to estimate their current caseloads.[3] For the 26 investigators who replied to our survey, the average caseload was 21.4 open cases. One investigator reported a caseload of 46 open cases.

OHFC staff told us about other effects from the office's lack of an effective case management system. For example, we learned about a case where an OHFC triage staff person called a provider to get more information about an allegation report (as part of the triage process) at the exact same time an investigator was at that provider's location actively investigating that same allegation. In other words, the triage staff person did not know the case had already been triaged and assigned to an investigator, let alone that the investigator was already conducting the investigation. Similarly, we learned about a case where two different OHFC investigators visited the same provider a week apart from each other to investigate the same allegation report, only to each (separately) learn that OHFC did not have jurisdiction to conduct the investigation.[4]

Finally, OHFC's paper-based case file system has contributed to files being lost or misplaced. In response to our survey, some respondents reported files being lost. For example, one person commented: "The staff in the office need to be held accountable for missing case files, missing recordings, etc." Another respondent said:

> Some of the processes here in OHFC are too cumbersome and too many things go through too many people. The reports are one example. Another would be the handling of investigator files. No one is accountable for these files and they can be found just about anywhere.

As part of our evaluation, we also reviewed a sample of 103 case files (53 files of cases that OHFC staff investigated, and 50 files of cases that OHFC staff did not investigate). One of the cases included in our file review appeared to have been lost for a significant period of time. It was triaged the day before our file review—more than two years (742 days) after OHFC received the allegation report.

The e-mail quoted below, sent to intake staff on May 2, 2017, from the OHFC Assistant Director, demonstrates the scale of the problem of lost files in OHFC.

> We are wrapping up an audit in [OHFC's primary database]. During the course of this audit it has been identified that some of the files we have

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[2] On November 6, 2017, we sent a questionnaire to all current OHFC employees. We received responses from 49 of the 50 employees actively employed at that time (a 98 percent response rate).

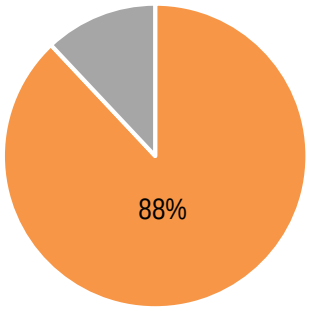
[3] OHFC staff responded to the survey between November 6, 2017, and November 23, 2017.

[4] As we discuss more in Chapter 3, OHFC has jurisdiction to conduct investigations of only providers who are licensed by the Minnesota Department of Health (MDH). The Department of Human Services (DHS) investigates allegations involving providers licensed by DHS, and county social services agencies investigate allegations involving providers who are licensed by neither MDH nor DHS.

> assumed have just vanished may be in your cubes. Any [allegation] reports from March 2017 or earlier need to be accounted for right away. Can you please check your cubes to make sure that all of the [allegation] reports are from April…. If not, they need to get to [staff person] right away. [She or he] has already printed over 100 [allegation] reports that were not accounted for and assumed lost…. Again, any [allegation] reports older than April not triaged need to be pulled out of your cubes immediately….

All of the issues discussed above affect OHFC's ability to address allegation reports in a timely manner. For example, high caseloads result in investigators not having enough time to complete investigations within required deadlines. Similarly, a paper-based case management system results in lost allegation reports or delayed review of completed investigation reports. As we discuss in more detail in Chapter 4, OHFC staff did not meet required deadlines for completing investigations for nearly 90 percent of the allegation reports it received and triaged for investigation in Fiscal Year 2017. On average, OHFC took nearly 140 days to complete investigations in Fiscal Year 2017—more than double the 60 days allowed by state law.[5]

OHFC did not conclude investigations within 60 days for 88 percent of the allegation reports it received and triaged for investigation in Fiscal Year 2017.



RECOMMENDATION

OHFC should implement an electronic case management system.

Similar to OHFC, the Department of Human Services' (DHS) Office of Inspector General (OIG) investigates maltreatment allegations related to vulnerable adults receiving services from providers licensed by DHS. While the DHS investigations are narrower in scope than those conducted by OHFC, both offices conduct investigations under the state's Vulnerable Adults Act.

According to DHS-OIG staff, DHS previously had a paper-based case management system for the maltreatment investigations it conducted. It also experienced problems similar to OHFC. Staff told us that it took the DHS-OIG office anywhere from six months to two years to complete investigations. Staff also told us that some case files were temporarily "lost" because people would not know which files were sitting on their desks.

DHS-OIG staff told us that the office underwent a "continuous improvement process" in 2014 that resulted in an overhaul to the office's processes. The office also implemented a paperless case management system. DHS-OIG staff report that the office now completes about 90 percent of its investigations within the 60-day deadline required by the Vulnerable

[5] If OHFC is unable to complete its investigation within the 60 calendar days required by law, it must notify the vulnerable adult and provider of the delay. We discuss this notification requirement in more detail in Chapter 4. *Minnesota Statutes* 2017, 626.557, subd. 9c(e).

Adults Act.[6] With the improved work process, DHS-OIG also reduced the number of investigators it needed to fulfill its responsibilities.

In mid-December 2017, MDH leadership told us they were partnering with DHS-OIG and the DHS Continuous Improvement team to initiate a large-scale continuous improvement process in OHFC. Later that month, MDH and DHS signed an interagency agreement that, among other things, obligated DHS to provide a "technology solution" for OHFC by April 2018. We encourage MDH and OHFC to make these process and technology improvements a top priority.

Staff and Office Management

Having an inefficient case management system puts additional pressure on OHFC leadership and staff. In this section, we discuss several management issues, including staff turnover, training for new staff, office policies, and general concerns regarding office leadership.

Staffing Trends

Staff turnover creates complications for any office; it requires managers to spend time reviewing applications, interviewing candidates, and hiring and training new staff.

OHFC has had high levels of staff turnover.

In fiscal years 2015 and 2017, OHFC's staff turnover exceeded 25 percent. In 2015, for example, 8 of the 32 staff people in OHFC resigned, retired, or transferred to another position within state government. Between fiscal years 2014 and 2017, OHFC had a higher staff turnover rate than the rest of the Health Regulation Division.[7]

Almost

50%

of staff have been working at OHFC for less than two years.

In fiscal years 2015 and 2016, OHFC hired nine and ten new staff, respectively; in Fiscal Year 2017, the office hired 18 new staff. Based on responses to our survey, almost half of the staff who responded (24 of 49) have been working at OHFC for less than two years; 15 of these staff have been at OHFC less than one year. As we discussed in Chapter 1, the 2017 Legislature increased appropriations to OHFC. MDH and OHFC leadership plan to use the majority of these increased funds to hire additional staff.

Having additional staff could help OHFC better manage the large number of allegation reports it receives, but these new staff will need significant training to learn the nuances of OHFC's work. Providing training takes time on the part of existing staff. It also takes time for new staff to learn the responsibilities of the new position. Given the complex nature of the work, OHFC leadership and staff told us that it takes at least one year—if not more—for new investigators to be fully trained to conduct OHFC investigations.

[6] According to DHS-OIG staff, the 10 percent of reports that are not completed within 60 days are typically delayed because investigators are waiting for additional documents, such as bank or medical records.

[7] As we discussed in Chapter 1, OHFC is housed within MDH's Health Regulation Division. The Health Regulation Division licenses health care providers, including nursing homes, home care providers, and hospitals.

Training

Most of OHFC's staff come to the office with experience in health care, having previously worked as a nurse or an administrator in a health care facility. More than three-fourths of OHFC investigators have experience working as a registered nurse in a hospital. A few investigators have law enforcement or investigation experience. Although new staff typically have expertise in health care or law enforcement, many do not have expertise in the complex regulatory framework within which OHFC operates. As a result, they must undergo a significant amount of training to learn state and federal regulations and OHFC's standards and policies.

OHFC's training involves several components. New investigators attend MDH-administered training and may attend training administered by the federal government. Staff also spend time reading federal and state laws and regulations, and reviewing other written materials. Finally, before investigators are permitted to lead onsite investigations, they "shadow" experienced investigators to observe investigations in practice.

Many OHFC staff do not find the training provided by OHFC to be effective.

In our survey of OHFC staff, we asked several questions about the training staff received to prepare them for their work at OHFC. We asked staff the extent to which they agreed with the following statement: "I received training sufficient to conduct my job well." Almost half of respondents (49 percent) said they disagreed or strongly disagreed with this statement.[8] In their survey responses, more than two-thirds of the respondents indicated that they would recommend changes to the training they received.

Several staff responded that OHFC's training did not have stated goals, so it was hard to determine whether they had learned the important material. For example, one respondent who has been with OHFC for less than two years wrote:

> There are no specific task objectives or step-by-step instructions to guide the investigator. Resources are scattered in different programs or software. The videos and manuals are voluminous, boring, and never-ending. This type of presentation does not appeal to most learning styles. There is no opportunity to apply learning immediately or shortly after learning to enhance understanding or make corrections in a safe, learning environment. Shadowing appears to work better than other training options but no consistency of trainers, systems, or standards. There is no opportunity to see a case from beginning to end within a manageable timeframe to be helpful. There are no opportunities to gauge your own competency.

Several respondents commented more generally on the inadequacy of the training OHFC provides new staff. For example, one respondent who has been with OHFC for more than two years wrote:

[8] Among the remaining responses, 4 percent responded "Strongly agree," 37 percent responded "Agree," and 10 percent responded "Don't know."

> The training being provided now is not adequate. Staff do not have enough time to be trained before they are sent out to complete investigations independently.

Another respondent who has also been with OHFC for more than two years made a similar comment:

> There are new employees training in newer employees who were never trained in themselves. I hear questions from new employees every day [and] I can't believe this information was not shared with them.

A third respondent who has been with OHFC for less than two years summed up the impact of being insufficiently trained:

> I feel like I was set up to fail, and I can never catch up.

A key part of training new investigators is to have them "shadow" a more experienced investigator. OHFC leadership told us that ideally, a new investigator would shadow an experienced investigator several times for each of the three types of maltreatment allegations (abuse, neglect, and financial exploitation). They told us that a new investigator would first "observe" the more experienced investigator conducting an investigation. Next, the new investigator would "participate" in the investigation, helping the more experienced investigator conduct the work. Finally, when the new investigator felt prepared, he or she would "lead" the investigation, and the experienced investigator would observe and provide assistance as needed.

However, more experienced investigators do not always have time to train new investigators. As one survey respondent who has been with OHFC for more than two years lamented:

> We need mentors for new employees who can take time to complete the…cases with them or have the new employees follow them specifically for a period of 3 to 6 months to see the role…. The caseload is so high we are not able to take the time to train any new employee[s].

OHFC investigators told us that shadowing experienced investigators is a good way to learn how to conduct investigations, but the current process is ineffective because new staff do not shadow an investigator throughout the entire lifecycle of an investigation. Instead, newer staff typically accompany an experienced investigator during the onsite investigation but do not participate in any follow-up interviews, record reviews, or report writing. For example, one survey respondent who has been with OHFC for less than two years wrote:

> I went out with three different investigators on six investigations, but never worked with any of them on what happens after the onsite portion of the investigation. The majority of my time was spent in my cubicle looking at online education, reading manuals, and peeking at reports…. I was really given no training specific to OHFC.

Finally, one respondent who has been with OHFC for less than two years summed up the problems associated with OHFC's current training approach:

> There is a high level of training required just to be adequate at this job. Most employees that come to this job are already highly skilled and

> accomplished in at least one area of expertise. Yet, under the current model, there is too much confusion, disorganization, and mismanagement for those employees to be successful. Even after the "training period," there is a high level of dysfunction, which directly impacts retention.

Given OHFC's training needs, the office established a full-time trainer position in 2016. This person is responsible for helping to orient new staff and initiate the training process; the trainer is not responsible for providing job-specific training. In their survey responses, several staff made positive remarks about having a full-time trainer. For example, one respondent who has been with OHFC for less than two years wrote:

> Training is now greatly improved since the department hired a fulltime trainer. However, there is need for updating and standardizing [the] training and investigation process.

We agree that having a full-time trainer is a good first step, but it is not enough.

RECOMMENDATION

OHFC should revise its training program to better prepare staff to perform their duties.

According to OHFC leadership, new investigators are assigned "mentors" to help them develop. But the new investigators do not shadow these more experienced investigators on all aspects of their work, and mentors are not given reduced caseloads to give them time to focus on training. This is a change from how training used to be done when, according to OHFC leadership, new investigators and mentors were "tied at the hip" for six months, and mentors had time to develop the new investigator.

OHFC should develop a more robust mentor-based training program that allows new investigators to observe experienced investigators conducting all aspects of an investigation, from beginning to end. Given the volume of allegation reports, OHFC leadership told us they sometimes rush through the training process and assign new investigators to cases as soon as possible. However, putting investigators out in the field before they are fully prepared is not a successful, long-term strategy for retaining staff and producing quality work.

Policies

Having standardized policies helps to ensure that staff understand what is expected and helps to ensure a consistent approach to the work. We reviewed OHFC's written policies and practices for different aspects of its work, but focused especially on policies related to conducting investigations.

Many of OHFC's internal policies are unwritten and change frequently.

OHFC has few written policies to standardize routine investigation tasks. For example, the office does not have a clear, written policy outlining expectations for who investigators should interview during investigations. Similarly, OHFC does not provide guidelines for investigators about how to investigate common types of incidents, such as when a

vulnerable adult with dementia leaves a facility unsupervised, or when a vulnerable adult experiences an unexplained injury or falls from a mechanical lift. This guidance would be particularly helpful for new investigators or those that are investigating a certain type of allegation for the first time. As one investigator who responded to our survey wrote:

> There is not a specific manual for investigations and the Assistant Director does not want the process written down in any way. I understand that the job and the investigations are different in every situation, but a guide for a new investigator to follow is always helpful when on your own. At one point, this summer, the Assistant Director asked that any and all of the "cheat sheets" or investigative prep sheets be turned into her so there aren't "any of these floating around."

Several staff told us about the lack of OHFC policies. For example, one person said that it was ironic for OHFC to cite providers for failing to develop policies when the office did not have its own policies. Another survey respondent wrote about how he or she has dealt with the lack of written policies:

> I quickly learned that there were numerous unwritten expectations of how OHFC does things, which no one told me until the issue came up, or later, and which could never be guessed simply by looking at the law. Those expectations need to be written down so that [staff] can reference them. I learned numerous things by talking to [other] staff. Many other tasks, I learned by trial and error—I did something, handed it in, and if no one further down the process questioned my decision, I simply assumed it was acceptable.

The written policies OHFC does have are unclear and not consistently followed. As an example, one OHFC policy about recording interviews states: "The Office of Health Facility Complaints will record interviews related to the investigation of complaints." However, the policy does not clearly explain *which* interviews should be considered "related" to the investigation of a given complaint. A second policy about a different topic "reminds" staff that: "All individuals interviewed to evaluate your allegation need to be…recorded. Exceptions are the vulnerable adult and family—they can opt out of being recorded." However, the requirements described in this second policy are not actually included in OHFC's interview-recording policy.

When we asked OHFC leadership about the policy to record interviews, they added another exception that is not written in policy. They said "informal" interviews with providers' staff do not have to be recorded. We saw differences in staff practices during our observations of investigators; some investigators recorded all staff interviews, others did not.[9]

In addition to being unclear, OHFC policies change frequently, and at times without formal explanation. For example, OHFC leadership told us that over the past two years, the office has made a gradual transition to investigating only those allegation reports that allege serious harm. We asked how leadership communicated this change to staff. OHFC

[9] As part of our evaluation, we shadowed a total of ten investigations in the Twin Cities metropolitan area. The investigations involved allegations of abuse, neglect, and financial exploitation and involved nursing homes, assisted living facilities, and home care providers.

leadership told us that this was not a formal policy change that they communicated across the office; instead, they communicated the changes in person to triage staff only.

One survey respondent commented on the frequency with which OHFC policies and expectations change, and how these changes are not well communicated:

> …we need consistent practices that address the needs in OHFC. The way cases are being triaged changes over time, the way we write reports changes frequently, even the way neglect is defined seems to change on a whim.

Another respondent commented:

> Things change rapidly and unless you are on the front of the conversation or happen to be in the room when the decision is made, you are the last to know. Sweeping decisions are made without much conversation. Some [decisions are] necessary, some not.

Finally, yet another respondent wrote:

> There has never been a specific process or policy written for several of our tasks to complete in investigation, and they often change quickly, without notice and without discussion.

RECOMMENDATION

OHFC should develop written policies regarding the work staff conduct and communicate them in a consistent manner.

The lack of written policies and the informal way in which OHFC leadership communicates policy changes contribute to an environment of uncertainty and confusion.

Federal law requires states to have "written procedures for the timely review and investigation of allegations of resident abuse and neglect, and misappropriation of resident property."[10] Minnesota law outlines some investigation requirements, but OHFC does not have comprehensive policies for conducting investigations.[11] As a result, we are not confident that Minnesota fully meets this federal requirement.

As OHFC leadership works to improve the office's processes, they should establish clear internal policies for how staff are expected to meet their responsibilities. These policies should be available in a centralized place so staff can easily consult the policies and have a clear understanding of office expectations. When OHFC needs to make changes to the policies in the future—such as when state or federal laws change—the changes should be conducted in a thoughtful manner and result in revised official, documented policies.

[10] 42 *CFR*, sec. 488.335(a)(3) (accessed electronically May 9, 2017).

[11] *Minnesota Statutes* 2017, 144A.53 and 626.557.

Leadership

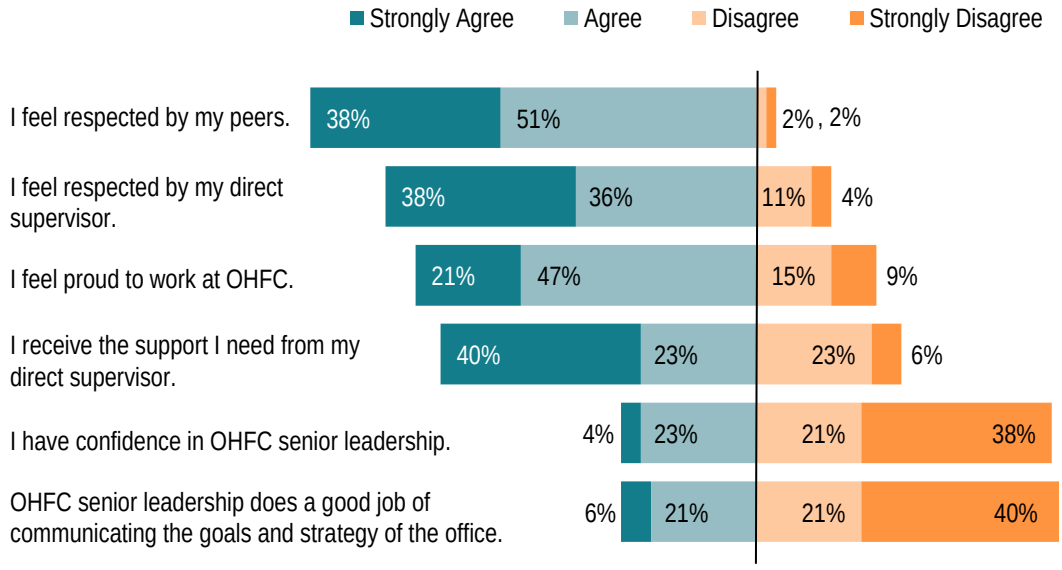
In an office such as OHFC, where the work is extremely complex and difficult, strong leadership is especially important. We heard many concerns about office culture from current and former staff, including allegations of bullying and intimidation by OHFC leadership. Given the concerns we heard, our survey of OHFC staff included questions about office leadership and culture.

The majority of OHFC staff do not have confidence in OHFC leadership's ability to lead the office.

As Exhibit 2.1 shows, OHFC staff are proud of the work they do at OHFC and feel respected by their peers and direct supervisors. However, almost 60 percent of survey respondents indicated that they do not have confidence in OHFC senior leadership, and more than 60 percent indicated that OHFC senior leadership does not do a good job of communicating the goals and strategy of the office.

Exhibit 2.1: Staff are proud to work at OHFC but do not have confidence in senior leadership.

Survey respondents were asked to indicate the extent to which they agreed or disagreed with the following statements:



NOTES: "OHFC" is the Office of Health Facility Complaints within the Minnesota Department of Health. On November 6, 2017, we sent a questionnaire to all current OHFC employees. We received responses from 49 of the 50 employees actively employed at that time (a 98 percent response rate). In the above exhibit, we excluded responses from the OHFC Director and Assistant Director. The exhibit does not include the following responses: "Don't know," "Not applicable," and no response. As a result, the responses do not sum to 100 percent.

SOURCE: Office of the Legislative Auditor, OHFC Staff Survey, November 6, 2017.

Staff provided a significant amount of feedback in response to our questions about OHFC's culture. Below is a sampling of what we learned.

> The culture here is like nothing I have ever experienced. It's disorganized chaos, with band aid after band aid being applied to broken processes and never a permanent fix to the problem.
>
> ***
>
> OHFC is a disaster. I have never seen such a disorganized unit and with poor management from the top on down. There is no communication…. There are too many internal inconsistencies within OHFC. If there is a strategic plan on improving this unit, I have no idea what it is because it was not communicated…. OHFC is running on chaos day in and day out.
>
> ***
>
> The environment is not conducive to collaboration or teamwork. The direction from leadership is often ineffective, contradictory and condescending.
>
> ***
>
> I think we need changes top down. Our leadership is not strong and it is causing a mistrust and lack of direction that is felt throughout…. It's hard to stay on track with no direction.
>
> ***
>
> It often feels like no one is driving the ship.

One survey respondent linked problems with management directly to the high staff turnover, especially among newer staff:

> …I like the job, I like the work we do, but the management of the department has failed many during their orientation and [staff] often leave the position before fulfilling six months of a probationary period.

Another respondent linked problems with management to inadequate policies and training and summed up many of the problems we observed:

> Written procedures need to be developed for all aspects of the investigative and enforcement process. Leadership needs to be willing to listen to alternative points of view…. Continued learning needs to be encouraged. [Staff] have described the current environment at OHFC as a "culture of blame." There is almost no tolerance for trying new approaches. Instead, any deviation from the usual is met with scorn…. Explanations for practices are often "historically in OHFC we have…," rather than looking at the statutes or the current reality. There is currently no culture of learning or growth. Other than the recent [federal] required training, staff development is always sacrificed in favor of initiating more cases, no matter how short-sighted that approach will be.

Commissioner's Office Oversight

OHFC conducts extremely important work on behalf of Minnesota; it helps to protect vulnerable adults from maltreatment. However, the problems we outlined in this chapter raise concerns that OHFC, as it is currently operating, may not be able to meet its responsibilities.

In their survey responses, several OHFC staff talked about the importance of the office's work and the struggle to protect vulnerable adults in an office that is not functioning well. For example, one survey respondent wrote:

> I really think the work we do here is so valuable, but it's hard to be proud and want to stay at a job with a broken process…. I feel like I can't do a thorough job on my cases, because the work just keeps piling up. It's not fair to the vulnerable adult.

Another survey respondent wrote:

> I have worked in OHFC for [X] years. I have been proud of the work done by myself and the office.… I sacrifice my family for my work and the vulnerable adults in Minnesota and I know I am not the only employee who gives of themselves and their free time to do more, when we know more is not enough…. Unless you have done the work, I don't think anyone will understand the selflessness of the employees, the compassion, and the conviction we have to the health and safety of the Vulnerable in Minnesota. If it was up to us, we would have sufficient resources, both people and technology to investigate every allegation, to respond to every family member timely, and hold the facilities responsible for the lack of care or poor care the staff they hire provide…. The vulnerable in Minnesota deserve better than what we have been able to give and in some cases what care they are receiving…. The gravity of it all is tremendous.

As we have discussed throughout this chapter, OHFC has a number of problems. These problems did not appear overnight; they have been developing over the past several years. However, the breadth and depth of the problems have now reached the point where MDH senior leadership needs to be more significantly involved.

RECOMMENDATION

The Minnesota Department of Health Commissioner's Office should play a stronger role overseeing OHFC.

In late 2017, the Commissioner of Health resigned amid questions regarding the department's handling of maltreatment investigations. Following the commissioner's resignation, MDH and DHS signed an interagency agreement that acknowledged problems within OHFC and granted DHS authority to make improvements.

Among other things, the agreement states:

> …ultimately DHS shall have full authority to implement any of the recommendations, including the ability to direct MDH and MNIT@MDH staff, make personnel decisions, and commit MDH resources, including space and operational resources, as needed….

MDH leadership told us that as part of this interagency agreement, DHS is also helping OHFC develop internal policies and staff training. We think the interagency agreement between MDH and DHS is a good first step.

In addition to entering into this agreement with DHS, members of the Commissioner's Office—namely the Deputy Commissioner and the Assistant Commissioner of the Health Systems Bureau—have become more heavily involved in OHFC's operations in recent months. We think this level of involvement is appropriate and should continue until OHFC is fully meeting its responsibilities. More specifically, we think it is imperative for the MDH Commissioner's Office to ensure that OHFC (1) improves its work processes, (2) improves staff training, (3) clarifies and documents policies and procedures, and (4) improves the office's culture. All of these pieces are necessary for OHFC to retain staff and fulfill its responsibilities.

Chapter 3: Investigation Process

A core function of the Office of Health Facility Complaints (OHFC) is to investigate allegations of maltreatment.[1] In this chapter, we examine how well OHFC performs this function and describe serious problems that we uncovered related to oversight and quality control of OHFC's investigation process.

Key Findings in This Chapter:

- OHFC's intake, triage, and investigation processes lack sufficient quality control measures and oversight.
- OHFC has had difficulty determining whether it has jurisdiction to investigate certain allegations.
- OHFC investigators did not always interview key individuals, including the vulnerable adult involved in the alleged incident.

We begin this chapter by reviewing the types of providers that OHFC has authority to investigate, the types of allegations that OHFC receives, and the parties who submit allegations.[2] We then review how OHFC processes allegations and determines whether to investigate them. Next, we examine OHFC's investigation procedures, the outcomes of those investigations, and the steps OHFC takes to ensure that providers correct any issues identified during the investigations. We finish by reviewing how parties can appeal OHFC's investigation outcomes.

Mary's Story: Introduction

To illustrate OHFC's investigation process, we present a fictional case about a vulnerable adult named Mary. We present Mary's case in episodes throughout this chapter and the next. Although Mary is fictional, her case highlights examples of problems experienced by real vulnerable adults that we encountered during our evaluation.

To follow Mary's case, look for the gray boxes titled "Mary's Story." Some episodes of Mary's story appear out of chronological order. In this chapter, we explain the processes that OHFC used to investigate Mary's case. In the next chapter, we explain how quickly OHFC handled Mary's case, and how well the office communicated with Mary and her family over the course of its investigation.

Providers Under OHFC's Jurisdiction

State law authorizes OHFC to investigate providers licensed by the Minnesota Department of Health (MDH).[3] Being licensed by MDH means that a provider has met certain criteria established in law, such as having proper procedures for administering medication or controlling the spread of infections.

In addition, the federal government authorizes OHFC to investigate MDH-licensed providers that are federally certified to receive federal Medicare or Medicaid payments.

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[1] *Minnesota Statutes* 2017, 144A.53, subd. 1.

[2] See the Glossary at the end of this report for a definition of "allegation" and definitions of other terms used throughout this report.

[3] *Minnesota Statutes* 2017, 626.557, subd. 9c; 626.5572, subd. 13; and 144A.53, subd. 1. Appendix A at the end of this report provides more information about the types of providers that OHFC has authority to investigate.

These providers must meet specific federal requirements, in addition to state licensing requirements.

Most of the investigations that OHFC conducts involve nursing homes or home care providers.

In Fiscal Year 2017, OHFC chose to investigate about 1,300 of the allegation reports that it received. The majority of these allegation reports involved either nursing homes (43 percent) or home care providers (43 percent); the remaining 14 percent involved other types of providers, such as hospitals.

Because OHFC investigators spend most of their time investigating nursing homes and home care providers, it is important to understand the services these two provider types offer. Nursing homes provide nursing care to individuals on an inpatient basis. Most nursing homes in Minnesota are federally certified; thus, they are subject to both state and federal requirements. Home care providers, on the other hand, deliver services such as nursing and personal care in a person's home. Most home care providers in Minnesota are not federally certified; thus, most are subject only to state licensing requirements.[4]

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 age 55 or older.[5] Assisted living facilities are one type of housing with services establishment.[6]

State law does not require housing with services establishments to be licensed by MDH; rather, it only requires them to *register* with the state.[7] Because housing with services establishments are not licensed, OHFC does not have authority to investigate them. (We discuss the state's oversight of housing with services establishments in more depth in Chapter 5.) OHFC can, however, investigate a licensed home care provider that is operating within a housing with services establishment.

Reporting Allegations

In this section, we describe the types of allegations reported to OHFC and the sources of those allegations. Then, we review the volume of allegations that OHFC has received, and discuss possible reasons why the volume has increased over the past several years.

[4] Federally certified home care providers are called "home health agencies."

[5] *Minnesota Statutes* 2017, 144D.01, subd. 4.

[6] *Minnesota Statutes* 2017, 144D.015, and Chapter 144G.

[7] *Minnesota Statutes* 2017, 144D.02.

Types of Allegations Reported

In Chapter 1, we explained that OHFC receives two broad types of allegations: (1) those involving suspected maltreatment and (2) those involving suspected licensing violations. A single allegation report may contain more than one type of allegation. In Fiscal Year 2017, OHFC received about 24,100 allegation reports. Approximately 87 percent of the allegation reports (about 21,000) contained allegations of maltreatment *and* licensing violations; 11 percent (about 2,600) contained *only* allegations of licensing violations.[8]

Of the reports that contained allegations of maltreatment, most involved neglect. Sixty percent of the allegation reports contained at least one allegation of neglect, 14 percent contained at least one allegation of abuse, and 11 percent contained at least one allegation of financial exploitation. Another 13 percent of these reports described unexplained injuries, and 4 percent described other types of incidents.[9]

Sources of Reports

OHFC receives allegation reports from two groups: (1) individuals and (2) providers. More than three quarters (76 percent) of the 24,100 allegation reports that OHFC received in Fiscal Year 2017 came from providers; the rest came from individuals (24 percent). In this section, we describe the types of individuals and providers that submit allegation reports to OHFC and the methods they use to do so.

OHFC receives allegations from individuals, such as vulnerable adults and their families and friends, as well as advocates, members of the public, and employees of providers.

State law allows any individual to report suspected maltreatment.[10] It also *requires* certain people, including physicians, nursing assistants, and other employees of health care providers, to report suspected maltreatment.[11] Although state law protects the identity of any individual that reports an allegation to the state, some people still submit allegation reports anonymously.[12] The state's Office of Ombudsman for Long-Term Care and Office

[8] The remaining 2 percent of allegation reports were either missing information in OHFC's database or involved children. Each year, OHFC receives and investigates a small number of allegation reports about children in accordance with Minnesota's Maltreatment of Minors Act, *Minnesota Statutes* 2017, 626.556. We did not evaluate OHFC's investigations of child maltreatment and do not include any data about reports involving children in the remainder of this chapter.

[9] These percentages sum to greater than 100 because a single allegation report may contain more than one allegation. For example, a report could contain one allegation of neglect and one allegation of abuse, both involving the same vulnerable adult. Another report could contain two allegations of abuse involving two different vulnerable adults.

[10] *Minnesota Statutes* 2017, 626.557, subds. 1 and 3(b).

[11] Individuals required to report suspected maltreatment are called "mandated reporters." Mandated reporters may report their allegations directly to the state; alternatively, they may report internally to the provider involved in the allegation. If they report an allegation to the provider, it is the provider's responsibility to report the allegation to the state. *Minnesota Statutes* 2017, 626.557, subds. 3, 4, and 4a; and 626.5572, subd. 16.

[12] *Minnesota Statutes* 2017, 626.557, subds. 5(d), and 12b(b) and (c).

of Ombudsman for Developmental Disabilities, both of which advocate for the rights of vulnerable adults, also report allegations.[13]

Most individuals report allegations by calling the Minnesota Adult Abuse Reporting Center (MAARC). Minnesota established MAARC in 2015 to receive allegation reports from across the state.[14] The MAARC call center receives allegation reports 24 hours per day, seven days per week. The allegations that MAARC receives involve a wide variety of provider types. MDH has jurisdiction to investigate allegations involving MDH-licensed providers, while DHS has jurisdiction to investigate allegations involving DHS-licensed providers. Counties typically have jurisdiction to investigate allegations involving unlicensed providers. MAARC forwards the allegation reports that it receives to the agency with jurisdiction.[15] OHFC also receives a small number of allegation reports directly via phone, e-mail, and other methods.

In Fiscal Year 2017, individuals submitted about 5,700 of the about 24,100 allegation reports OHFC received that year. Nearly half (46 percent) of the allegation reports from individuals involved home care providers; another 35 percent involved nursing homes, 12 percent involved hospitals, and 7 percent involved other types of providers.

Most of the allegation reports that OHFC receives come from providers, who are required by state and federal law to report suspected maltreatment.

State law requires providers licensed by MDH to establish and enforce a written procedure to ensure that its employees report all suspected cases of maltreatment.[16] Federal regulations also require federally certified nursing homes to report suspected maltreatment.[17] In addition to maltreatment, both state law and federal regulations require providers to report injuries caused by an unknown source.[18]

State law and federal regulations also specify *how quickly* providers must report suspected maltreatment. State law requires providers to report incidents within 24 hours.[19] Federal regulations also require federally certified nursing homes to report within 24 hours, unless

[13] Although OHFC tracks the types of individuals that report allegations in an electronic database, its records are incomplete. As a result, we were not able to provide reliable data about the types of individuals who submit allegation reports. See *Minnesota Statutes* 2017, 256.974-256.9744 and 245.91-245.97, for information about the state's ombudspersons.

[14] *Minnesota Statutes* 2017, 626.557, subd. 9, requires the Department of Human Services (DHS) to establish a "common entry point" to receive reports of suspected maltreatment as defined in the Vulnerable Adults Act. MAARC is the state's common entry point. DHS oversees MAARC, which is operated by a contracted company. Individuals can report maltreatment through MAARC's toll-free number: **(**844) 880-1574.

[15] *Minnesota Statutes* 2017, 626.557, subd. 9a. MAARC also forwards reports with criminal allegations to law enforcement.

[16] *Minnesota Statutes* 2017, 626.557, subd. 4a.

[17] 42 *CFR*, sec. 483.12(c)(1) (accessed electronically May 9, 2017).

[18] State law requires providers to report when a vulnerable adult sustains an injury that cannot be reasonably explained; see *Minnesota Statutes* 2017, 626.557, subd. 3(a). Federal regulations require nursing homes to report injuries from an unknown source; see 42 *CFR*, sec. 483.12(c)(1) (accessed electronically May 9, 2017).

[19] *Minnesota Statutes* 2017, 626.557, subd. 3(a); and 626.5572, subd. 10.

the incident involves serious bodily harm or abuse, in which case they must report within 2 hours.[20]

Many providers report suspected maltreatment through MAARC. Federally certified nursing homes, however, submit reports through an application on OHFC's website, called the Nursing Home Incident Reporting System.[21] Federal regulations require federally certified nursing homes to report allegations directly to the state agency that licenses them, which is MDH. Because DHS, not MDH, administers MAARC, federally certified nursing homes cannot report allegations using MAARC.[22] Like reports from individuals, OHFC receives a handful of reports from providers through other methods.

Mary's Story: Reporting

Mary is an 82-year-old woman living in a nursing home in St. Cloud while she recovers from a fall. She is a retired teacher with a daughter named Jane. Mary relies on the nursing home's staff to provide her with daily medication and other support.

One day, Mary's daughter, Jane, visits Mary and finds her unresponsive. She immediately alerts nursing home staff. The nursing home sends Mary to the hospital.

Later, the nursing home discovers that staff had incorrectly given Mary ten times the intended dosage of medication. Jane reports the error to the Minnesota Adult Abuse Reporting Center (MAARC). The nursing home did not report the error to OHFC, although legally required to do so.

In Fiscal Year 2017, 55 percent of all allegation reports that OHFC received (from both providers and individuals) came through its nursing home web portal; 40 percent came through MAARC; and 5 percent came through other methods, such as phone calls or e-mails to OHFC.

In Fiscal Year 2017, providers submitted about 18,400 of the about 24,100 allegation reports OHFC received that year. Of those 18,400 allegation reports, the majority (75 percent) came from nursing homes; home care providers submitted another 19 percent; and other types of providers submitted the remaining 6 percent.

Volume of Reports

As part of our evaluation, we analyzed the number of allegation reports that OHFC has received in recent years. Exhibit 3.1 illustrates the number of reports OHFC received from individuals and providers.

From fiscal years 2012 to 2017, the total number of allegation reports that OHFC received increased by more than 50 percent.

Reports from both providers and individuals increased during this period. In Fiscal Year 2017, OHFC received about 18,400 reports from providers—35 percent more than it received five years earlier, in Fiscal Year 2012. Even more dramatic was the rise in reports

[20] 42 *CFR*, sec. 483.12(c)(1) (accessed electronically May 9, 2017).

[21] *Ibid*.

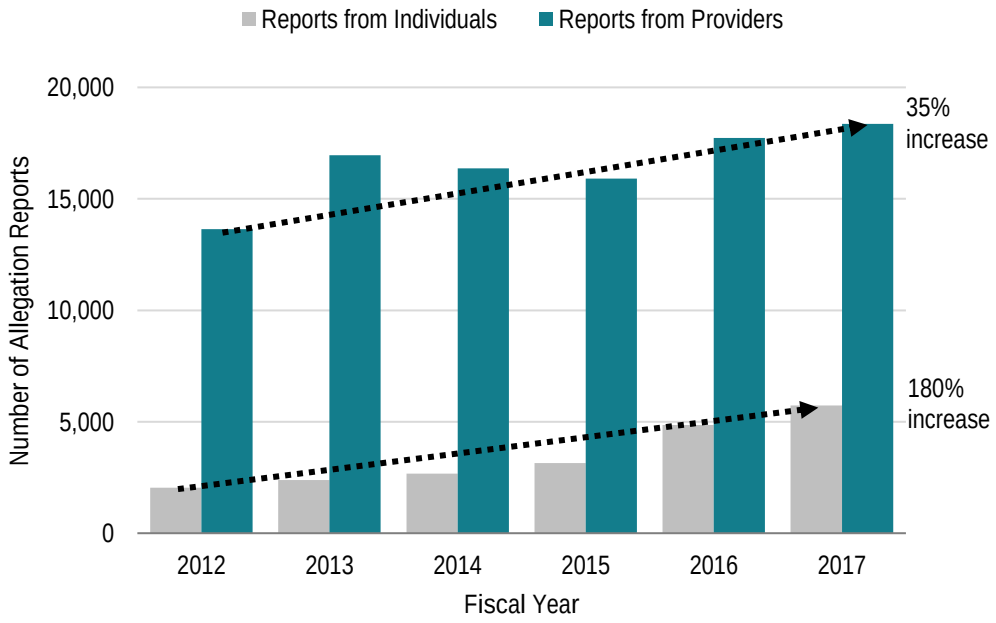
[22] In January 2018, MDH received permission from CMS to allow federally certified nursing homes to report suspected maltreatment through MAARC, pending implementation of specific protocols.

from individuals. In Fiscal Year 2017, OHFC received about 5,700 reports from individuals—180 percent more than it received in Fiscal Year 2012.

It is not entirely clear how we should interpret these increases in allegation reports. On the one hand, they could reflect an increase in the occurrence of maltreatment. On the other hand, they could reflect an increase in individuals' and providers' efforts to report suspected maltreatment. Or, they could reflect unknown factors. We do know, however, that the increases have added to OHFC's workload and compounded the management problems that we described in Chapter 2.

We identified several factors that *may* have contributed to the increase in reports over the last several years, including: (1) the launch of MAARC, (2) targeted efforts by federal regulators to encourage providers to report, and (3) a failure by OHFC to provide sufficient reporting guidance to providers.

Exhibit 3.1: OHFC experienced a large increase in allegation reports from both individuals and providers from fiscal years 2012 through 2017.



NOTES: "OHFC" is the Office of Health Facility Complaints within the Minnesota Department of Health. An "allegation report" is a verbal or written statement alleging maltreatment or a licensing violation that is submitted by an individual or a provider. A single allegation report may contain multiple allegations. For example, an allegation report could contain an allegation of neglect and an allegation of abuse about the same vulnerable adult. Alternatively, an allegation report could contain multiple allegations of neglect related to multiple vulnerable adults.

SOURCE: Office of the Legislative Auditor, analysis of OHFC data.

First, the launch of MAARC in 2015 may have contributed to an increase in reports because it simplified the reporting process.[23] Prior to MAARC, individuals had to figure out whether they should report an allegation to MDH, DHS, or one of the many county social services agencies. Once MAARC was implemented, individuals could submit all allegations to a single entity. Additionally, during MAARC's launch, the state implemented a public information campaign to increase public awareness about reporting suspected maltreatment.

Second, OHFC staff told us that, in 2011, the federal government encouraged MDH to focus on nursing homes' maltreatment reporting efforts during its annual inspections. (If a nursing home or other provider fails to report an incident, inspectors can issue a citation.) OHFC staff told us they believe nursing homes increased their reporting efforts as a result of this inspection effort in 2011.

Third, lack of guidance from OHFC may have contributed to the increase in allegation reports from providers. Under federal regulations, OHFC is responsible for explaining federal requirements to providers—such as when providers should report an incident.[24] State law and federal regulations outline certain types of incidents that providers must report.[25] State law also specifies some incidents that providers do *not* have to report, such as certain accidents, errors, and self-abuse.[26] Still, determining whether a given incident should be reported can be challenging for providers and their employees (and even for OHFC).

OHFC does not provide sufficient guidance to providers about the types of incidents they should report.

OHFC currently does not offer written guidance to providers about the types of incidents they should report. OHFC leadership told us that the office once provided a reporting "decision tree" to providers, but stopped doing so after federal regulations changed. Organizations representing providers told us that MDH staff—including OHFC staff—have issued insufficient and, at times, conflicting guidance about the kinds of incidents providers should report. Even OHFC leadership told us that providers "constantly" complain to the department that they receive conflicting guidance.

Organizations representing providers told us that they have asked OHFC for a decision-making tool that would help providers determine what to report and what not to report. This lack of guidance may have contributed to the rise in reports from providers. In the absence of such a tool, organizations representing providers told us that providers report "everything," even those incidents they know likely do not need to be reported. Although

[23] Although MAARC simplified the reporting process, MDH leadership told us MAARC has created other problems for OHFC. For example, they told us that the state designed MAARC without sufficient consultation with MDH and launched it without providing funding for the agency to integrate MAARC into OHFC's operations. They also told us that MAARC does not collect all of the data that OHFC needs to effectively conduct its work. During our evaluation, we did not evaluate the performance of MAARC or the full effect it has had on OHFC.

[24] CMS publishes extensive regulatory requirements that MDH must follow in a document called the *State Operations Manual*. Centers for Medicare and Medicaid Services, *State Operations Manual, Chapter 1* (Baltimore, 2016), sec. 1010.

[25] *Minnesota Statutes* 2017, 626.557, subd. 3; and 42 *CFR*, sec. 483.12(c)(1) (accessed electronically May 9, 2017).

[26] *Minnesota Statutes* 2017, 626.557, subd. 3a.

we see a potential for over-reporting, we did not analyze whether providers have in fact reported incidents that should not be reported.

RECOMMENDATION

OHFC should provide a decision-making tool for providers to help them make appropriate reporting decisions.

While state law requires providers to report suspected maltreatment, significant over-reporting of immaterial incidents could hamper OHFC's ability to identify those that truly warrant an investigation. Given the large and increasing volume of allegation reports that OHFC is facing, we think the office should ensure that its limited resources are being used to address allegations that truly warrant its attention. Therefore, we encourage OHFC to make a decision-making tool available for providers on OHFC's website. In late 2017 and early 2018, MDH leadership told us they were in the process of developing a new decision-making tool.

Intake and Triage

After OHFC receives allegation reports, its intake and triage staff determine whether OHFC should investigate them. These staff perform an important function—directing OHFC's limited resources toward the highest priority allegations. In this section, we describe the processes that staff use to carry out this function and some problems we found.

Process Overview

OHFC's intake and triage staff perform a number of steps when processing allegation reports. The steps vary somewhat according to the allegation type. Generally, staff (1) compile a file for each allegation report, (2) verify and gather additional information, (3) verify that OHFC has jurisdiction over the case, (4) determine whether OHFC will investigate the case, and (5) assign a priority level to cases triaged for investigation. We describe these steps below.

1. Intake. OHFC receives most allegation reports electronically from MAARC or the Nursing Home Incident Reporting System (an application on OHFC's website). Staff print these allegation reports and start a paper-based case file for each one.

2. Verify and gather information. Staff may verify information in the allegation report and, depending on the allegation, collect additional information. For example, they may verify the name of the provider identified in the allegation report. If the allegation report comes from a nursing home, staff may collect a copy of the nursing home's internal investigation report. (Federal regulations require federally certified nursing homes to conduct internal investigations of alleged incidents and report their results to OHFC within five days.)[27] Staff also may gather other information about the case, such as ambulance or emergency room records.

3. Verify jurisdiction. Staff may also try to verify that OHFC has jurisdiction over the allegation. As we discussed earlier, OHFC has the authority to investigate allegations

[27] 42 *CFR*, sec. 483.12(c)(4) (accessed electronically May 9, 2017).

involving only MDH-licensed providers. DHS and county social services agencies have authority to investigate other types of providers. Sometimes, OHFC receives an allegation report that falls outside of its jurisdiction.[28]

4. Decide whether to investigate. Staff review the information compiled in each case file and determine whether the allegation warrants an investigation. OHFC's written triage policies instruct staff to select for investigation reports that allege violations of state licensing or federal certification requirements. The policies require staff to collect enough information to make this determination.

When triaging an allegation report about a federally certified nursing home, triage staff may review the nursing home's internal investigation report. However, if an allegation report contains a serious allegation, OHFC staff may not wait to receive the facility's internal investigation report before going onsite to investigate. If an allegation is less serious, and if OHFC staff think that a nursing home's internal investigation was sufficiently thorough and that the facility corrected any relevant problems, they may decide that OHFC does not need to investigate further.

Not all of the allegation reports OHFC receives warrant an investigation. As part of our evaluation, we reviewed a sample of 103 case files; 50 of those files involved allegation reports that OHFC decided not to investigate.[29] One report that OHFC did not investigate, for example, alleged that a facility was repeatedly mixing up residents' meal trays, giving the wrong food to residents with dietary restrictions. Another report alleged that a staff member ran over a resident's toe when pushing another resident in a wheelchair. Another alleged that a resident's hearing aid was missing.

5. Assign a priority status. If staff decide that OHFC should investigate an allegation report, then they must assign a priority status to the case. The priority status determines how quickly an investigator must go onsite—typically within 2 business days of receiving the most serious allegations or within 10 business days or 45 calendar days of triaging less serious allegations. OHFC's policies, which are based on federal guidance, instruct staff to consider the following factors (and others) when assigning a priority status: the severity of the allegation (such as whether harm or death occurred), the frequency or duration of the alleged behaviors, whether a threat is still present, and the number of reports submitted about a single alleged incident.

Mary's Story: Intake and Triage

OHFC receives the allegation report regarding Mary's medication error. OHFC intake staff print the report and start a file for Mary's case.

Staff classify the allegation in the report as neglect, because it alleges that the nursing home failed to provide adequate care. Because the error was serious, OHFC staff triage the case for an investigation and assign an investigator to be onsite within 10 days.

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[28] See Appendix B at the end of this report for more information about the types of providers that fall under the jurisdiction of MDH, DHS, and county social services agencies.

[29] In our file review, we reviewed 103 case files of allegation reports that OHFC received and closed in fiscal years 2016 and 2017. We randomly selected 100 of these 103 case files; we intentionally selected the remaining 3 cases. Because of the small sample size, the results from our case file review should not be extrapolated to all of OHFC's work. We did not evaluate whether OHFC made the right decision not to investigate these cases or OHFC's rationale for making its decisions.

Allegations Selected for Investigation

Each year, OHFC triage staff identify for investigation only a small share of the allegation reports that OHFC receives. For example, OHFC decided to investigate only 5 percent (about 1,300) of the 24,100 reports it received in Fiscal Year 2017.[30]

When OHFC receives multiple allegation reports about the same incident, its staff sometimes investigate those allegation reports at the same time, under a single investigation. In its database, OHFC does not systematically track how frequently staff investigate multiple allegation reports together. Based on our review of OHFC's database, we estimate that about 18 percent of the 1,300 allegation reports that OHFC received in Fiscal Year 2017 and triaged for investigation were investigated alongside other allegation reports.

Over the past six fiscal years, OHFC has investigated a larger share of the allegation reports that it received from individuals than those that it received from providers. For example, OHFC chose to investigate less than 3 percent of the 18,400 reports it received from providers in Fiscal Year 2017; but it chose to investigate 13 percent of the 5,700 allegation reports it received from individuals that year.

Quality Control Issues

In our review of OHFC's intake and triage processes, we did not assess the accuracy of OHFC's triage decisions—that is, we did not assess whether the office was right to investigate or not investigate any given case. CMS, however, regularly audits OHFC's triage decisions (for allegation reports involving federally certified providers).

In its two most recent audits, CMS found that OHFC fell below CMS standards.[31] In its federal fiscal year 2015 audit, CMS found that OHFC correctly triaged only 15 of the 40 allegation reports that auditors reviewed (38 percent). In its 2016 audit, OHFC performed better, but still below standards. CMS found that OHFC correctly triaged 34 of the 40 allegation reports that auditors reviewed (85 percent).

OHFC's intake and triage processes lack sufficient quality control measures.

OHFC's failure to meet federal triage standards may be due, in part, to a lack of quality control measures within OHFC's intake and triage processes. We found several quality control issues during the course of our evaluation. First, OHFC leadership told us that OHFC supervisors review only some of the triage decisions that staff make. They said that supervisors review the triage decisions of all of the allegation reports that staff decide

[30] A small share of the reports that OHFC received and chose not to investigate in Fiscal Year 2017 were outside of OHFC's jurisdiction. OHFC referred those allegation reports to DHS, county social services agencies, law enforcement, and other state agencies. Due to limitations with OHFC's data, we were not able to identify the exact number of allegation reports that OHFC referred; we estimate that OHFC referred less than 1 percent of the 24,100 reports it received in Fiscal Year 2017.

[31] CMS's standard is that OHFC followed federal triage guidelines for 90 percent of the cases CMS reviewed during the audit. Centers for Medicare and Medicaid Services, *State Performance Measures Review: Review of Minnesota, Fiscal Year 2015* (Chicago, 2016); and Centers for Medicare and Medicaid Services, *State Performance Measures Review: Review of Minnesota, Fiscal Year 2016* (Chicago, 2017).

should be investigated, but not all of those that staff decide not to investigate. As a result, a lone OHFC employee could decide the fate of a given allegation report.

Second, OHFC does not audit a random, representative sample of both investigated and non-investigated case files to determine whether staff collected and reviewed sufficient information to make appropriate triage decisions. Although CMS conducts regular triage audits, CMS auditors review only a small number of cases, and only those involving federally certified providers. In Fiscal Year 2017, about one-quarter of the reports OHFC received involved non-federally certified providers.

Third, although OHFC's triage policies require staff to collect enough information to make a triage decision, staff have significant discretion over how much information, and the types of information, that they review. The policies do not require staff, for example, to look up trend data relating to the case, such as whether a provider or staff member has a history of alleged maltreatment.

RECOMMENDATION

OHFC should incorporate quality control measures into its intake and triage processes.

OHFC's intake and triage unit serves a critical function—it controls which allegations get investigated and which do not. OHFC leadership should implement measures to ensure that OHFC triage staff are making sound and consistent decisions. First, OHFC supervisors should review the triage decisions of a random, representative sample of all allegation reports. Second, OHFC supervisors should regularly audit a random sample of case files to ensure that staff are collecting and reviewing the right information before making triage decisions, and to make sure that staff properly maintain this information in the case files. Third, OHFC leadership should review the office's triage policies. In Chapter 2, we explained that we found numerous problems with OHFC's policies. We think OHFC should provide clearer and more prescriptive guidance in its triage policies about the kinds of information that staff should review when making triage decisions.

Jurisdiction Issues

Determining which agency (MDH, DHS, or one of Minnesota's county social services agencies) has jurisdiction over a given allegation is not always easy. This is due in part to Minnesota's complex long-term care industry and regulatory environment. Consider the following hypothetical example.

Company A operates an assisted living facility, which is registered with MDH. The company also holds an MDH license to provide home care services and a DHS license to provide other services. The company provides MDH-licensed services to some of the residents in the facility and DHS-licensed services to others. Some residents living in the facility hire another MDH-licensed home care provider, *Company B*, to deliver services to them. Other residents hire *Company C*, an unlicensed provider, to deliver unlicensed services to them. Imagine that a bystander witnesses a staff member abusing a resident, and reports the alleged abuse to MAARC.

In this example, to determine whether MDH, DHS, or a county social services agency has jurisdiction over the case, MAARC staff would have to figure out (1) which company was

involved in the allegation and (2) whether the service involved in the allegation was licensed by MDH or DHS, or not licensed at all. Some allegation reports that MAARC receives contain enough information for MAARC staff to determine jurisdiction definitively; others do not. As a result, some of the allegation reports that OHFC receives from MAARC are not actually within OHFC's jurisdiction. OHFC, therefore, must verify that it has jurisdiction over the allegation reports that it receives.

OHFC staff use a variety of methods to confirm jurisdiction. They may look up MDH-licensed providers and their licenses in an MDH database. Alternatively, they may look on a provider's website to see what types of services the provider advertises. They may also call the person who reported the allegation or call the provider directly. However, they must be careful if they call the provider. Federal regulations and OHFC policy prohibit staff from notifying a provider of an investigation before an investigator arrives onsite.[32]

OHFC has had difficulty determining jurisdiction for some allegation reports.

Throughout our evaluation, we found that OHFC struggled to confirm jurisdiction before sending an investigator onsite.[33] As part of our evaluation, we shadowed investigators when they went onsite to investigate ten different cases. On two of the ten investigations that we shadowed, the investigators discovered that OHFC did not have jurisdiction over the case only after spending several hours onsite investigating.

On a third investigation that we shadowed, the investigator struggled over the course of the two days he or she spent onsite to establish the name of the provider involved in the allegation and the licenses that it held. In this case, numerous providers were operating in an assisted living facility under at least five different names, and the owner of the facility was associated with all of them.

We also surveyed OHFC's investigators as part of our evaluation.[34] In our survey, we asked investigators whether they had any jurisdiction questions arise while they were onsite during the month of October 2017. One-quarter of the investigators who responded (7 out of 26) indicated that they had jurisdiction questions arise during that month.

RECOMMENDATION

OHFC should improve its processes for verifying jurisdiction.

Jurisdictional errors affect OHFC's efficiency. It wastes the state's resources when investigators go onsite to conduct an investigation over which they do not have jurisdiction. It may also waste the providers' time, cause undue stress on their employees, and take time

[32] Federal guidelines prohibit OHFC from notifying federally certified providers before OHFC investigators arrive onsite to investigate an allegation. Such investigations are referred to as "unannounced visits." Centers for Medicare and Medicaid Services, *State Operations Manual, Chapter 5* (Baltimore, 2016), sec. 5000.2.

[33] OHFC does not systematically track in its database how frequently it incorrectly sends investigators onsite to investigate cases for which it does not have jurisdiction. As a result, we were unable to identify the full extent of the problem OHFC has with determining jurisdiction.

[34] On November 6, 2017, we sent a questionnaire to all current OHFC employees. We received responses from 49 of the 50 employees actively employed at that time (a 98 percent response rate). Of those 49 responses, 26 came from investigators.

away from the vulnerable adults that they should be serving. OHFC could employ a number of strategies to reduce jurisdictional errors, such as improving its databases of service providers under OHFC jurisdiction, providing additional training to staff, or hiring more staff to determine jurisdiction.[35]

Investigations

After triage staff determine that a report should be investigated, an OHFC investigator conducts an investigation. In Fiscal Year 2017, OHFC triaged approximately 1,300 allegation reports for investigation.

OHFC conducts investigations to determine (1) whether maltreatment occurred and (2) whether the provider violated any federal or state licensing requirements.

To determine whether maltreatment occurred or whether the provider violated any licensing requirements, OHFC investigators gather and review evidence. In this section, we describe the types of evidence that investigators collect and the steps they take over the course of an investigation. We then describe the possible outcomes of investigations.

Process Overview

Although the specific steps investigators take during an investigation depend on the allegation, the steps outlined below describe a typical OHFC investigation.

1. Prepare for the investigation. Investigators may conduct various activities to prepare for an onsite investigation. For example, investigators may read the allegation report or other materials OHFC obtained during its intake and triage process, review applicable licensing requirements, or plan what information to obtain during the onsite investigation. If the allegation report was submitted to OHFC by an individual (not a provider), investigators may call the individual to explain OHFC's investigation process.

2. Conduct the onsite investigation. After preparing for an investigation, OHFC investigators visit the location of the alleged incident. Investigators may visit a facility—such as a nursing home or hospital—or a vulnerable adult's home. According to OHFC leadership, all onsite investigations are "unannounced." In other words, OHFC does not notify a provider that it will conduct an investigation before investigators arrive the day of the onsite investigation.

While the tasks investigators conduct while onsite vary based on the allegations reported, investigators typically observe staff providing care to vulnerable adults, collect medical and personnel records, and interview staff and residents. For example, if OHFC was investigating an allegation that a vulnerable adult was neglected when he or she fell while being transferred from a wheelchair to a bed, the investigator would observe staff performing the same type of transfer. Additionally, the investigator would review information from the file that the facility keeps on the vulnerable adult, such as the vulnerable adult's care plan and progress notes. The investigator would also interview staff

[35] In February 2018, MDH leadership told us they were working on solutions to improve the accuracy of OHFC's jurisdiction determinations.

or other witnesses to learn more about the alleged incident. In addition, the investigator may ask the vulnerable adult and other residents questions about the care they have received.

3. Collect additional evidence. Investigators usually do not finish all of their evidence collection during a single day. They often must interview witnesses, family members, primary care providers, or others in person or by telephone at a later date to gather more information about the alleged incident. Additionally, investigators commonly review information collected from a provider after the onsite visit is complete.

4. Determine the result of the investigation. Once an investigator has gathered all the information he or she can, the investigator evaluates each piece of evidence. The investigator then determines the result of the investigation based on the evidence. OHFC's investigations have two parts: a maltreatment component and a compliance component. For the maltreatment component, OHFC determines whether the maltreatment allegation is substantiated, inconclusive, or not substantiated.[36] For the compliance component, the investigator determines whether the provider is in compliance with federal or state licensing requirements.

5. Write the investigation report. After determining the result of the investigation, the investigator writes an investigation report that OHFC sends to the individuals and entities involved in the investigation. OHFC also posts its investigation reports on its website.

The investigation report has several components, including the name of the provider, the date of the onsite investigation, and the date the investigator completed the investigation. It also contains information about the steps the investigator took during the investigation and a description of the investigator's findings.

6. Impose enforcement actions (when applicable). If OHFC finds that a provider violated a licensing requirement, the investigator can cite the provider for a licensing violation. In most cases, providers are allowed some time to fix the licensing violation OHFC identified before receiving a fine or other enforcement action. After the provider addresses the licensing violation, OHFC returns to the provider to determine whether it corrected its noncompliant practice.

[36] See the Glossary for definitions of "substantiated," "inconclusive," and "not substantiated."

Mary's Story: Investigation

OHFC assigns an investigator to Mary's case. Before going onsite, the investigator reviews the allegation report and calls Jane, Mary's daughter, to learn more about the incident. Jane tells the investigator that she has witnessed staff giving other residents the wrong dosage of medication on other occasions.

The investigator then travels to the nursing home. He introduces himself to the nursing home administrator and explains that he is there to investigate an allegation of neglect. He does not divulge other details of the case at that time.

The investigator begins by touring the facility and interviewing a handful of residents about their care. Then, he requests records from the nursing home administrator, including the nursing home's medication administration policy, staff training records, and records about medication errors. The investigator then spends time reviewing the records.

Next, because Mary's case involves a medication error, the investigator observes the nursing home's medication protocols. He observes staff as they receive new medication orders from doctors over the phone, enter those orders into the nursing home's records, and distribute medication to residents.

Finally, the investigator interviews staff. He questions staff about the nursing home's training, medication protocols, and supervision, as well as the specific circumstances surrounding Mary's case. After eight hours at the nursing home, the investigator leaves.

The following week, back at OHFC's office, the investigator collects additional evidence about Mary's case. He requests records from the hospital that treated Mary. He also tries to call the emergency room doctor who treated Mary, but cannot reach her. To determine whether Mary sustained any "lasting harm" from the incident, the investigator calls Mary's primary care doctor. Even though required by law, the investigator does not try to interview Mary, who had moved to a different nursing home before the investigator went onsite.

Finally, the investigator calls some nursing home staff involved in Mary's case who were not working the day the investigator was onsite. He calls the staff person who incorrectly transcribed the medication order from Mary's doctor and the staff person who administered the incorrect dosage.

Investigation Oversight

In Chapter 2, we discussed serious concerns with OHFC's internal operations. Among other things, we noted that OHFC has struggled with managing its workflow, staff turnover, and staff training. We also noted that many of OHFC's policies are unwritten and change frequently. While these concerns affect all of OHFC's operations, they were most evident in OHFC's management of investigations.

OHFC has not provided sufficient oversight of its investigations.

As part of our evaluation, we reviewed 53 of OHFC's investigation case files to examine how OHFC investigates the allegation reports it receives. While reviewing case files, we observed substantial variation in how investigators conducted certain routine investigation practices—some of which were contrary to state law.

The two most serious issues we found involved the interviews OHFC has conducted during its investigations and the extent to which OHFC has documented its investigations. As we discuss below, OHFC sometimes failed to interview key individuals in the case files we reviewed. And many of the case files we reviewed did not contain documentation to support information in OHFC's investigation reports.

According to OHFC leadership, supervisors are responsible for ensuring staff conduct consistent and thorough investigations. However, supervisors have had little time to accompany investigators onsite to assess their performance and provide suggestions for improvement. And neither OHFC leadership nor supervisors regularly audit case files to ensure that the information in the files are complete. Rather, supervisors are responsible for reviewing the content of investigation reports after the investigator finishes writing the report. If supervisors have questions about a completed case, only then do they review the documentation the investigator retained in the case file.

Interviews

OHFC investigators conduct interviews to gather information about alleged incidents. For example, during an interview, investigators may ask questions to understand who was affected by the alleged incident, who or what was responsible for the alleged incident, and whether any witnesses observed the alleged incident.

An **"alleged perpetrator"** is an individual employee of a provider who is alleged (suspected) to be responsible for the abuse, neglect, or financial exploitation of a vulnerable adult.

As part of a maltreatment investigation, Minnesota law requires OHFC to interview, when appropriate: (1) the vulnerable adult involved in the alleged incident, (2) at least one member of the vulnerable adult's family, (3) the person who submitted the allegation report, (4) the alleged perpetrator named in the allegation report, and (5) others who may have relevant information.[37] The investigation reports that OHFC investigators write at the conclusion of their investigations indicate who they interviewed during the course of their investigations.

In the case files we reviewed, OHFC investigators did not always interview key individuals, including the vulnerable adult involved in the alleged incident.

Interviewing the vulnerable adult involved in the alleged incident could provide important details to OHFC's investigations. Vulnerable adults may also be eager to share their side of the story. As we stated above, Minnesota law states that OHFC must interview the vulnerable adult when "appropriate."[38] The law does not define the conditions under which such an interview would be "appropriate," and OHFC does not have a written policy specifying when investigators should or should not interview a vulnerable adult.

OHFC leadership told us that they expect investigators to interview the vulnerable adult "at all times," even if the vulnerable adult is no longer at the facility or receiving services from the provider being investigated.[39] However, in the case files we reviewed, OHFC's investigation reports indicated that investigators did not always interview the vulnerable

[37] *Minnesota Statutes* 2017, 144A.53, subd. 2(a); and 626.557, subd. 10b.

[38] *Minnesota Statutes* 2017, 626.557, subd. 10b(1).

[39] The one exception, according to OHFC leadership, is if the vulnerable adult is in an intensive care unit.

adults involved in the alleged incidents. Investigators reportedly did not interview the vulnerable adults involved in the alleged incidents in 11 of the 37 investigated cases we reviewed in which the vulnerable adults were alive and able to be interviewed.[40] For 7 of these 11 cases, the reason why the vulnerable adult was not interviewed—as explained in OHFC's investigation reports—was that they were located in different facilities than those named in the allegation reports. The investigation reports did not offer an explanation for the other 4 cases (of 11).

Interviews with primary care providers (such as a physician or nurse practitioner) can provide important information about the vulnerable adult's medical condition before and after an alleged incident, especially in cases involving an allegation of neglect. However, based on our case file review, OHFC investigators sometimes failed to interview a primary care provider. Minnesota law does not specifically require OHFC to interview the vulnerable adult's primary care provider, although it does require OHFC to consult with professionals, as appropriate.[41] Furthermore, OHFC does not have a clear written policy specifying when investigators should interview a primary care provider. OHFC did not interview a primary care provider in 22 of the 35 cases we reviewed with a neglect allegation.

OHFC generally did better at interviewing at least one member of the vulnerable adult's family, the person who filed the allegation report, and the alleged perpetrator, as required by Minnesota law.[42] For 44 of the 53 investigated cases we reviewed, OHFC reportedly interviewed at least one family member during the course of the investigation. In eight of the nine other cases, OHFC provided in the investigation report a legitimate reason why the interview did not occur.[43]

Similarly, OHFC reportedly interviewed the person who filed the allegation report in 30 of the 34 cases we reviewed in which an individual (not a provider) filed the allegation report. OHFC provided a legitimate reason in the investigation report why the interview did not occur in three of the four remaining cases.[44]

Of the 20 cases we reviewed that named an alleged perpetrator, OHFC reportedly interviewed the alleged perpetrator in 17 cases. In the remaining three cases, OHFC's investigation report indicated that the alleged perpetrator either declined to be interviewed or did not respond to OHFC's subpoena.

Documentation

Interviews, record reviews, and observations are essential fact-finding tools investigators can use to determine what happened related to an allegation. Throughout the investigation, investigators take notes about their interviews and observations. They also collect various

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[40] We reviewed 53 files of cases that OHFC investigated in fiscal years 2016 and 2017. For this particular analysis, we excluded cases where OHFC indicated in its investigation report that the vulnerable adults involved in the alleged incident were deceased or not cognitively intact.

[41] *Minnesota Statutes* 2017, 626.557, subd. 10b(6).

[42] *Minnesota Statutes* 2017, 144A.53, subd. 2(a); and 626.557, subd. 10b.

[43] For example, the investigation reports indicated that interviews did not occur because the vulnerable adult requested that a family member not be interviewed, or the investigators' attempts to contact a family member were unsuccessful.

[44] Two investigation reports indicated that the investigator was unable to contact the individual, and one investigation report indicated that the allegation report was filed anonymously.

records, such as medical or personnel records. At the completion of an investigation, investigators produce a report that is based on the information obtained during the investigation.

During our case file review, we examined the extent to which OHFC investigators documented their investigations. Specifically, we compared the numbers and types of interviews conducted, observations conducted, and records reviewed—as reported in OHFC's investigation reports—to the information contained in each case file. We did so because complete investigation files allow OHFC leadership, or an outside entity, to verify the thoroughness and accuracy of the investigations. Additionally, if OHFC does not retain evidence of *all* the interviews and observations it conducts, as well as *all* of the records it reviews, parties involved in an appeal cannot confirm whether the case file contains an accurate representation of the evidence collected during the investigation.

OHFC has few written policies regarding *how* investigators should document key investigation tasks, including interviews, observations, and record reviews. It also does not have written policies specifying *what* evidence should be retained in the case file. According to OHFC leadership, OHFC's policy—although unwritten—is to retain all evidence that, at a minimum, could identify noncompliance with federal and/or state law.[45]

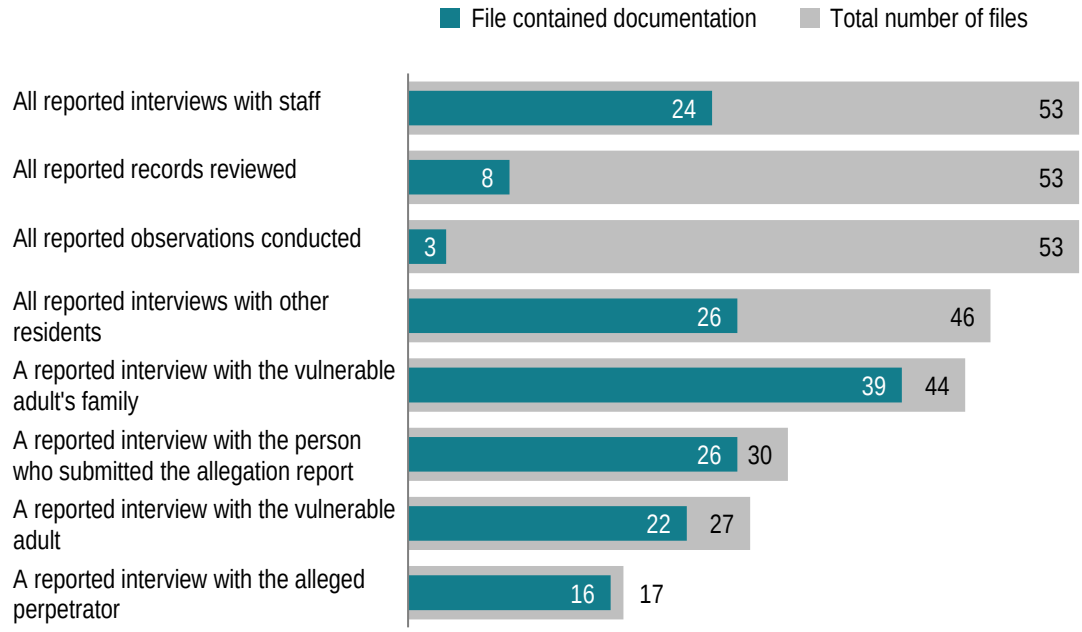
In the case files we reviewed, OHFC investigators inconsistently documented interviews, observations, and record reviews.

We compared the interview notes contained in the case files with the interviews identified as "conducted" in OHFC's investigation reports. The number of staff interviews documented in the case files matched the number of staff interviews listed in the investigation report for only 24 of the 53 case files we reviewed, as Exhibit 3.2 shows. Among the 46 case files we reviewed that had at least one interview with other residents, only 26 had the same number of resident interviews documented in the file as recorded in the investigation report. Some case files did not contain documentation of interviews reportedly conducted with the person who filed the investigation report (4 of 30 case files), the vulnerable adult's family (5 of 44 case files), or the vulnerable adult (5 of 27 case files).

We also compared the types of observations documented in the case files to the types of observations identified as "conducted" in OHFC's investigation reports. OHFC leadership told us that investigators should take notes about all of the observations they conduct, even if the observations revealed no problems with the provider. However, only 3 of the 53 case files we reviewed had sufficient documentation to support that the investigator conducted all of the observations reported in the investigation report.

[45] CMS annually audits OHFC's investigations involving federally certified providers. One of the practices it audits is whether OHFC's case files contain documentation of sufficient interviews, observations, and record reviews to determine compliance or noncompliance with federal licensing requirements. OHFC has met CMS's requirements for this criterion for all five of the past five audits. CMS does not check, however, whether the information OHFC retains in its case files is sufficient to support its investigations of providers that are licensed only by the state.

Exhibit 3.2: Many case files we reviewed did not contain documentation to support information in OHFC's investigation reports.



NOTE: "OHFC" is the Office of Health Facility Complaints within the Minnesota Department of Health.

SOURCE: Office of the Legislative Auditor, analysis of OHFC case files.

Additionally, we compared the types of records—such as medical records, care plans, and staff timesheets—retained in the case files with the types of records identified as "reviewed" in OHFC's investigation reports. Only 8 of the 53 case files we reviewed contained all of the records in the file that were reportedly reviewed during the investigation.

RECOMMENDATION

OHFC should regularly perform audits to ensure that investigators conduct and document investigations in a consistent and thorough manner.

In this section, we raised concerns about the consistency of OHFC's investigations and the office's general lack of oversight of investigations. Based on our case file review, OHFC investigators have not consistently interviewed key individuals involved in the allegations they have investigated. OHFC investigators also have not consistently documented their investigations. We believe these issues are the result of OHFC's lack of internal policies and lack of quality controls.

In Chapter 2, we recommended that OHFC develop written policies regarding the work staff conduct and communicate them to staff in a consistent manner. However, developing policies is not enough. OHFC supervisors and leadership need to ensure that investigators and other staff follow the policies and meet office expectations.

After it develops policies, OHFC supervisors and leadership should regularly audit investigations. Supervisors should periodically accompany investigators on investigations to evaluate their performance. Additionally, OHFC leadership should occasionally audit a random sample of case files to ensure investigators document their investigations according to office policy. OHFC should also build into its investigation process a requirement that supervisors review investigators' case files for completeness before approving the investigation determination.

Investigation Determinations

After an investigator conducts an onsite investigation and finishes any necessary follow-up work, the investigator determines whether the maltreatment allegation is substantiated. The investigator also determines whether the provider violated any state or federal licensing requirements.

Maltreatment Determinations

Minnesota law defines the possible determinations for a maltreatment investigation: substantiated, inconclusive, and not substantiated.[46] A "substantiated" determination means that, based on a preponderance of evidence, maltreatment occurred. An "inconclusive" determination means that there was less than a preponderance of evidence to show whether maltreatment occurred. A determination of "not substantiated" means that, based on a preponderance of evidence, maltreatment did not occur.

A **"preponderance of evidence"** means that the evidence collected during an investigation shows that it is more probable that the maltreatment occurred than did not occur.

According to Minnesota law, if OHFC substantiates a maltreatment allegation, it must determine whether an individual employee, the provider, or both were responsible.[47] If OHFC finds the individual employee or provider responsible, OHFC issues to the provider a licensing violation related to the substantiated maltreatment allegation.[48]

If OHFC finds that an individual was responsible for the substantiated maltreatment allegation, and the maltreatment was "serious" or "reoccurring," OHFC can recommend that the individual be disqualified from providing direct-care services to vulnerable adults for seven years.[49] Minnesota law defines serious maltreatment as sexual abuse, maltreatment that results in death, or abuse or neglect that results in serious injury.[50] Reoccurring

[46] *Minnesota Statutes* 2017, 626.5572, subds. 7, 11, and 19. In this report, we use the phrase "not substantiated" instead of "false." State law allows for a fourth determination—that no determination will be made (see *Minnesota Statutes* 2017, 626.5572, subd. 8). In this report, we focus only on maltreatment investigation determinations of substantiated, inconclusive, and not substantiated.

[47] *Minnesota Statutes* 2017, 626.5572, subd. 8.

[48] If OHFC substantiates a maltreatment allegation, it cites providers for a violation of Minnesota's "Bill of Rights" laws. These laws outline rights individuals have while living in nursing homes and other long-term care facilities, or while receiving services at home; one of these rights is the right to be free from maltreatment. See *Minnesota Statutes* 2017, 144.651 and 144A.44.

[49] *Minnesota Statutes* 2017, 245C.15, subd. 4(b)(2).

[50] *Minnesota Statutes* 2017, 245C.02, subd. 18.

maltreatment is defined as more than one incident of substantiated maltreatment for which the subject was responsible.[51]

OHFC substantiated the maltreatment allegation in less than one-fifth of the investigations it conducted in fiscal years 2012 to 2016.

The portion of OHFC's maltreatment investigations that resulted in a substantiated determination has been relatively stable over time.[52] Of the allegation reports OHFC received in fiscal years 2012 to 2016, OHFC substantiated maltreatment allegations in 16 to 19 percent of the cases it investigated each year, as Exhibit 3.3 shows.[53] During the same time period, OHFC determined that the majority of the maltreatment allegations it investigated were not substantiated (ranging from 48 percent in Fiscal Year 2012 to 66 percent in Fiscal Year 2016). OHFC found the remaining portion of maltreatment allegations from fiscal years 2012 to 2016 to be inconclusive.

In Fiscal Year 2016, of the three types of maltreatment defined in Minnesota law (abuse, neglect, and financial exploitation), OHFC most frequently substantiated financial exploitation allegations.[54] OHFC substantiated 76 percent of financial exploitation allegations it investigated that year. In contrast, OHFC substantiated maltreatment in only 11 percent of investigations with a neglect allegation, and 8 percent of investigations with an abuse allegation in Fiscal Year 2016.

Mary's Story: Determination

After collecting and reviewing the evidence, the investigator has to decide whether to (1) substantiate the allegation of neglect and (2) issue any licensing violations.

Although Mary had to be hospitalized because of the medication error, she did not experience any "lasting harm" from it. As a result, the investigator does not substantiate the allegation of neglect.

The investigator does, however, cite the nursing home for licensing violations. He issues one citation for failing to provide adequate medication administration training to staff and another for failing to report Mary's incident to OHFC.

Compliance Determinations

In addition to determining whether maltreatment occurred, investigators also determine whether the provider violated any federal or state licensing requirements.[55] If an OHFC investigator finds that a provider did not comply with federal or state licensing requirements, the investigator can issue citations ordering the provider to correct the licensing violations. Providers must correct their violations to avoid receiving fines or other penalties from the federal and/or state government.

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[51] *Minnesota Statutes* 2017, 245C.02, subd. 16.

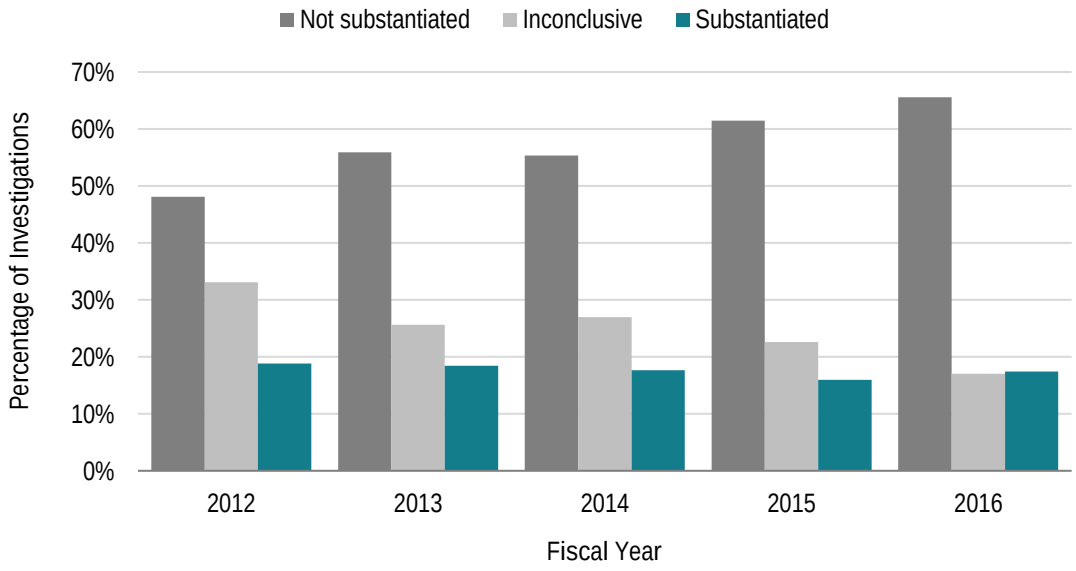
[52] We did not evaluate whether OHFC's maltreatment determinations were correct.

[53] In this section, we do not report data for Fiscal Year 2017 because the data were incomplete at the time of our analysis. As of August 10, 2017, OHFC had completed 48 percent of its investigations involving allegation reports it received in Fiscal Year 2017. (Fiscal Year 2017 began on July 1, 2016, and ended on June 30, 2017.)

[54] This category also includes allegations of drug diversion.

[55] As we stated earlier in this chapter, nursing homes and other providers that wish to accept Medicare or Medicaid payments must comply with federal licensing requirements. Federally certified nursing homes and home health agencies must also be licensed by MDH and comply with state licensing requirements. Other providers—such as some state-licensed home care providers—do not accept Medicare or Medicaid payments and do not have to comply with federal licensing requirements.

Exhibit 3.3: Since Fiscal Year 2012, OHFC has substantiated the maltreatment allegation in 19 percent or fewer of its investigations.



NOTES: "OHFC" is the Office of Health Facility Complaints within the Minnesota Department of Health. A "substantiated" determination means that, based on a preponderance of evidence, maltreatment occurred. An "inconclusive" determination means that there was less than a preponderance of evidence to show whether maltreatment occurred. A determination of "not substantiated" means that, based on a preponderance of evidence, maltreatment did not occur.

Data in this exhibit are displayed by the fiscal year in which OHFC received the allegation reports. In this exhibit, we do not report data for Fiscal Year 2017 because these data were incomplete at the time of our analysis. Additionally, open investigations from earlier years are excluded from this exhibit.

SOURCE: Office of the Legislative Auditor, analysis of OHFC data.

OHFC can cite a provider for licensing violations regardless of the outcome of a maltreatment investigation. For example, OHFC investigated two allegation reports involving two different nursing homes in late 2016. Each report involved an allegation of neglect when two different vulnerable adults fell and sustained injuries to their heads. OHFC substantiated the maltreatment allegation in only one of the investigations; however, in both investigations, OHFC cited the provider for licensing violations.[56]

OHFC cited providers for licensing violations in about one-quarter of the investigations it conducted in fiscal years 2012 to 2016.

The portion of OHFC's investigations that identified at least one licensing violation has been relatively stable over time.[57] From fiscal years 2012 to 2016, OHFC cited providers

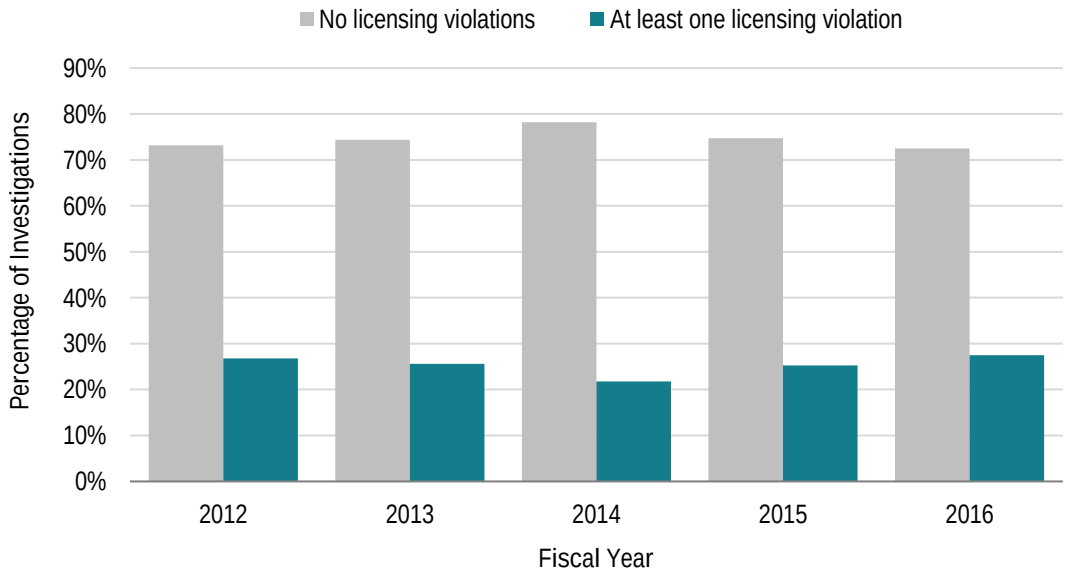
[56] See Minnesota Department of Health, *Office of Health Facility Complaints Investigative Report, Numbers H5445011 & H5445012* (St. Paul, 2017); and Minnesota Department of Health, *Office of Health Facility Complaints Investigative Report, Number H5105134* (St. Paul, 2016).

[57] We did not evaluate whether OHFC cited the correct licensing violations.

for at least one licensing violation in 27 percent or fewer of its investigations each year, as Exhibit 3.4 shows.

A single investigation can identify multiple citations for licensing violations. For most of the investigations OHFC conducted in Fiscal Year 2016 that identified at least one licensing violation, OHFC issued three or fewer citations. In one investigation in Fiscal Year 2016, OHFC cited a provider for 35 violations, the most cited from a single investigation that year.

Exhibit 3.4: Since Fiscal Year 2012, OHFC has cited providers for licensing violations in 27 percent or fewer of its investigations.



NOTES: "OHFC" is the Office of Health Facility Complaints within the Minnesota Department of Health. This exhibit shows the portion of OHFC investigations that resulted in a citation for at least one state or federal licensing violation. Data in this exhibit are displayed by the fiscal year in which OHFC received the allegation reports. In this exhibit, we do not report data for Fiscal Year 2017 because the data were incomplete at the time of our analysis.

SOURCE: Office of the Legislative Auditor, analysis of OHFC data.

Enforcement Actions

After OHFC cites a provider for licensing violations, it takes steps to assess whether the provider has corrected its noncompliant practices. Some of the steps differ depending on whether the provider violated federal or state licensing requirements, as we describe next.

Enforcement Process

Within ten calendar days of receiving OHFC's notification of licensing violations, providers that violated a *federal* licensing requirement must submit to OHFC a written plan detailing how they will correct certain noncompliant practices.[58] Once OHFC receives the plan, it determines whether the plan is acceptable and notifies the provider of its determination. According to federal guidance, an acceptable plan must address how the provider 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.[59]

For violations of *state* licensing requirements, providers are not required to submit a plan to OHFC detailing how they will correct noncompliant practices. Instead, Minnesota law requires certain providers to "document in [their] records any action taken to comply with the [citation]."[60] It also authorizes OHFC to request from these providers copies of the documentation at any time.[61]

Federal enforcement actions include:

- Correction plan developed by the state.
- State monitoring.
- Required in-service training for provider's staff.
- Fines, ranging from $50 to $10,000 per day, or up to $10,000 per violation.
- Denial of Medicare or Medicaid payments.
- Temporary management.
- License revocation.

State enforcement actions include:

- Fines ranging from $50 to $500 per day, or up to $5,000 per violation.
- License suspension or revocation.

Regardless of the type of licensing violation, OHFC conducts "revisits" to assess whether providers have corrected their noncompliant practices.[62] According to OHFC leadership, revisits are conducted in a manner similar to onsite investigations. For example, during a revisit, the investigator visits the provider and interviews its staff to see whether they understand any policies the provider changed to correct its noncompliant practices. When applicable, investigators also speak with residents to evaluate whether the provider has implemented changes and conduct observations to examine how care is being delivered.

In contrast with violations of federal law, providers have an opportunity to correct even the most serious violations of state law before being penalized.

For federally certified nursing homes, CMS and OHFC can immediately impose enforcement actions if OHFC discovers a serious violation of federal licensing

[58] 42 *CFR*, sec. 488.402 (accessed electronically May 9, 2017); and Centers for Medicare and Medicaid Services, *State Operations Manual, Chapter 7* (Baltimore, 2016), sec. 7304.4. Providers are not required to submit a correction plan if the noncompliant practice was isolated, had little potential to cause harm, and no actual harm occurred.

[59] Centers for Medicare and Medicaid Services, *State Operations Manual, Chapter 7* (Baltimore, 2016), sec. 7304.4.

[60] *Minnesota Statutes* 2017, 144A.474, subd. 8(c). This requirement applies only to home care providers.

[61] *Ibid.*

[62] Federal and state law do not require OHFC to conduct revisits for all licensing violations, such as those that are limited in scope or had little potential to cause harm. However, OHFC leadership told us that OHFC always conducts revisits, regardless of the severity of the licensing violation.

requirements.[63] (A serious licensing violation constitutes an immediate threat to resident health or safety, or a pattern of or potential for harm.) For example, CMS and OHFC may immediately impose enforcement actions for an incident where the vulnerable adult suffered a serious head trauma or a sexual assault.

However, if the *federal* licensing violation is less serious, the provider has some time to make a correction. If OHFC conducts a revisit and finds that the provider did not correct its noncompliant practices by the date specified in its correction plan, OHFC recommends to CMS that it impose an enforcement action. On the other hand, if OHFC finds that the provider resolved the concern, it does not recommend that CMS take enforcement action.

Mary's Story: Enforcement

After issuing licensing violations against Mary's nursing home, OHFC monitors the nursing home to make sure it corrects its noncompliant practices.

Because the nursing home is federally certified, it must submit a plan of correction to OHFC within ten days of receiving notice of the licensing violations. OHFC receives and accepts the nursing home's plan within this deadline.

About a month later, the investigator goes back to the nursing home to see if the nursing home has implemented the corrections outlined in its plan. Because the facility has implemented the corrections, OHFC does not recommend that CMS issue any fines to the nursing home.

In contrast, providers that violate a *state* licensing requirement always have a chance to correct noncompliant practices before receiving a state enforcement action, even in cases where the vulnerable adult died as a result of the noncompliant practice. Regardless of the scope and severity of state licensing violations, OHFC imposes state enforcement actions only if it finds that the provider has not corrected its noncompliant practice by a date specified by OHFC. (Minnesota law does not specify how much time providers have to correct state licensing violations.)

Fines

One type of federal and state enforcement action is monetary fines. When we asked MDH for data regarding the fines providers pay as a result of OHFC's investigations, the department could not provide it. MDH could not separately report the fines issued by OHFC from those issued by other offices within MDH's Health Regulation Division.[64] In addition, MDH could not report which individual OHFC investigations resulted in fines. As a result, our analysis of the fines issued as a result of OHFC investigations is limited.

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[63] In this case, MDH is authorized by CMS to impose one or more of the following enforcement actions: a state-developed plan of correction, state monitoring, or required in-service training for the provider's staff. CMS may impose additional enforcement actions, such as fines or temporary management.

[64] As we stated in Chapter 1, the Health Regulation Division within MDH is responsible for monitoring health care providers' compliance with federal and state laws. While OHFC is responsible for responding to specific allegations of maltreatment or licensing violations by MDH-licensed providers, other offices within the Health Regulation Division regularly inspect licensed facilities and providers. Similar to OHFC, these other offices can cite providers for violations of federal or state licensing requirements.

From fiscal years 2013 to 2017, federal fine amounts issued to MDH-licensed providers were substantially larger than state fine amounts.

From fiscal years 2013 to 2017, CMS imposed on Minnesota providers a total of $1.4 million in federal fines resulting from inspections and investigations conducted by all of the offices within MDH's Health Regulation Division. CMS imposed 113 fines on 59 federally certified providers during that time period. The maximum fine CMS levied against one provider was $134,000 and the minimum was $650; the average fine amount was nearly $12,700.

$1.4 million
Total amount of federal fines issued from fiscal years 2013 to 2017.

$518,000
Total amount of state fines issued from fiscal years 2013 to 2017.

Although a larger number of providers received state fines, the total amount of fines issued by MDH in fiscal years 2013 to 2017 was less than half the amount of the federal fines issued during the same time period. MDH's Health Regulation Division issued a total of nearly $518,000 in state fines in fiscal years 2013 through 2017. Similar to federal fines, many providers received multiple fines; the department issued 1,622 fines to 363 providers during that time period. From fiscal years 2013 to 2017, the maximum state fine amount MDH levied against one provider was $4,000 for a single fine; the average fine amount was less than $350.

The difference in the total amount of fines issued by CMS and MDH over the past five fiscal years is likely due in part to differences in the range of fine amounts each entity can issue. Possible *federal* fine amounts range from $50 to $10,000 per day, or up to $10,000 per violation. In contrast, possible *state* fine amounts range from $50 to $500 per day, or up to $5,000 per violation. The difference is particularly notable when comparing the range of federal and state fines for serious violations of federal and state law. As an example, federal law permits CMS to impose fines in the range of $3,050 to $10,000 per day if a federally certified nursing home is found to be responsible for an incident that results in serious injury or death.[65] In contrast, Minnesota law authorizes MDH to impose fines ranging from $1,000 to $5,000 per violation for similarly serious incidents involving state licensed home care providers.[66]

For both federal and state fines, CMS and MDH may use discretion when imposing specific fine amounts. For example, federal law requires CMS to consider the provider's history of noncompliance, the provider's financial condition, the seriousness of the licensing violation, and the provider's degree of culpability.[67] Similarly, Minnesota law requires MDH to consider the scope and severity of the state licensing violation before imposing a fine on a home care provider.[68]

[65] 42 *CFR*, sec. 488.438(a)(1)(i) (accessed electronically May 9, 2017).

[66] *Minnesota Statutes* 2017, 144A.474, subds. 11(a)(4) and 11(b)(1)(iv).

[67] 42 *CFR*, sec. 488.438(b) and (f) (accessed electronically May 9, 2017).

[68] *Minnesota Statutes* 2017, 144A.474, subd. 11.

RECOMMENDATION

The Legislature should review the state's options for enforcement actions for nursing homes, home care providers, and other long-term care providers.

As we stated above, regardless of the severity of state licensing violations, providers are always given a chance to correct noncompliant practices before receiving a state fine or other enforcement action. And, compared to federal fines, state fines are much less severe.

The Legislature should review the enforcement actions available to MDH. Among other things, the Legislature should consider whether it is appropriate that providers who violate state licensing requirements do not have to submit to MDH a correction plan. It should also consider whether allowing providers an opportunity to correct even the most serious licensing violations aligns with state policy priorities. Additionally, the Legislature should evaluate the fines and other enforcement actions the state can take to penalize providers for perpetrating maltreatment.

Appeals

The right to appeal OHFC's determinations is an important part of the investigation process. While both individuals and providers may appeal OHFC's investigation determinations, their appeal rights differ. We provide an outline of the different appeals options in Exhibit 3.5.

Vulnerable adults (or their representative) can appeal any type of maltreatment investigation determination (substantiated, not substantiated, or inconclusive). The first step they can take is filing a "Request for Reconsideration" within 15 days of receiving notice of OHFC's investigation determination.[69] Each lead investigative agency is responsible for conducting these "reconsiderations." In MDH, OHFC's director conducts OHFC's Requests for Reconsideration.[70] According to OHFC leadership, the OHFC director reviews the entire investigation file, speaks with the investigator who conducted the investigation, and determines whether to reverse or uphold the investigator's original determination.[71]

Mary's Story: Appeal

Mary's daughter, Jane, decides to appeal OHFC's decision not to substantiate the neglect allegation.

Jane first submits a "Request for Reconsideration" to OHFC on behalf of her mother, Mary. OHFC's director reviews Mary's case, but upholds the OHFC investigator's decision not to substantiate the allegation.

Next, Jane asks the Maltreatment Review Panel to review the case. The panel reviews the case and disagrees with OHFC's decision. The panel, however, does not have the power to overturn OHFC's decision. It can only require that OHFC review the case again.

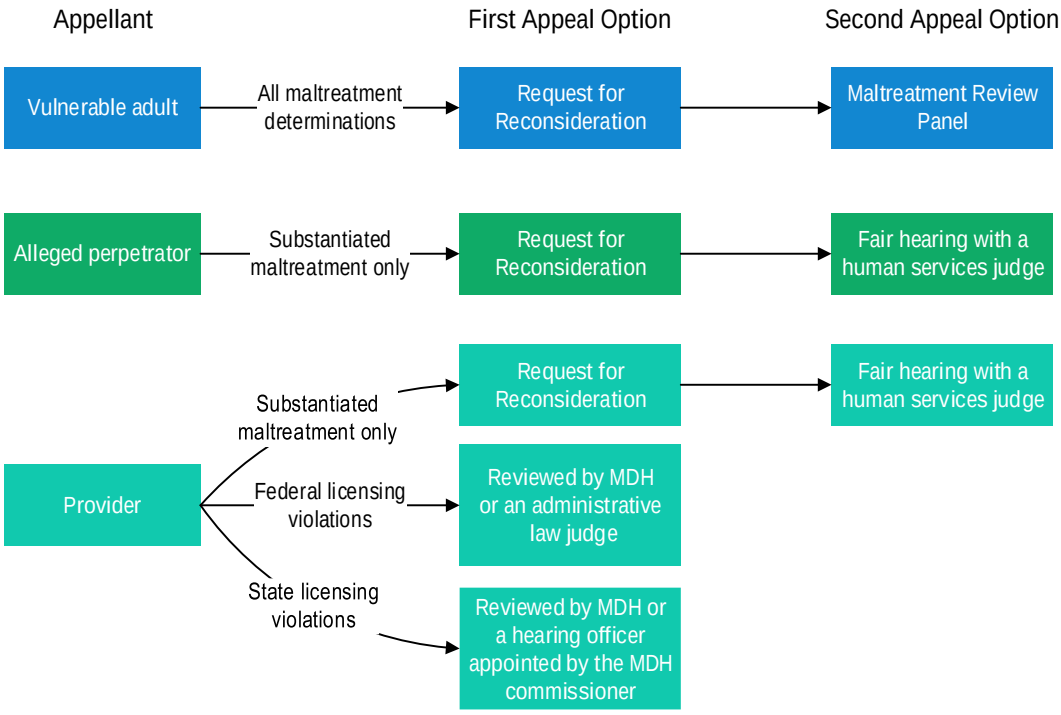
Finally, given the Maltreatment Review Panel's decision, MDH's commissioner reviews the case. Ultimately, the commissioner upholds OHFC's initial investigation determination.

[69] *Minnesota Statutes* 2017, 626.557, subd. 9d(a).

[70] *Ibid*. The lead investigative agencies are MDH, DHS, and county social services agencies. See *Minnesota Statutes* 2017, 626.5572, subd. 13.

[71] Until late 2017, OHFC's director conducted "Requests for Reconsideration" of OHFC's maltreatment determinations; in early 2018, MDH leadership told us that an MDH attorney now conducts these reviews.

Exhibit 3.5: Vulnerable adults, alleged perpetrators, and providers have different appeal rights.



NOTES: "OHFC" is the Office of Health Facility Complaints. "MDH" is the Minnesota Department of Health. Until late 2017, OHFC's director conducted "Requests for Reconsideration" of OHFC's maltreatment determinations; in early 2018, MDH leadership told us that an MDH attorney now conducts these reviews. The Maltreatment Review Panel is a panel consisting of representatives from several state and local agencies.

SOURCE: Office of the Legislative Auditor, analysis of *Minnesota Statutes* 2017, 144.653, subd. 8; 144A.10, subds. 15 and 16; 144A.474, subd. 12; 256.021; 256.045; and 626.557, subd. 9d.

If the vulnerable adult disagrees with the result of the Request for Reconsideration, or if OHFC denies or fails to act on the request, the vulnerable adult (or their representative) can request a review from the Maltreatment Review Panel.[72] The Maltreatment Review Panel meets quarterly and consists of six representatives, one from each of the following: MDH, DHS, the Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, the Minnesota Board on Aging, and county human services administrators. The panel reviews OHFC's case file before affirming OHFC's original determination or requiring that OHFC reconsider its original determination.

[72] *Minnesota Statutes* 2017, 626.557, subd. 9d(b). *Minnesota Statutes* 2017, 256.021, establishes the Maltreatment Review Panel.

Alleged perpetrators, on the other hand, can appeal only substantiated maltreatment determinations for which OHFC determined the alleged perpetrator responsible.[73] Similar to a vulnerable adult, an alleged perpetrator's first appeal option is OHFC's Request for Reconsideration. Then, if the alleged perpetrator disagrees with the result, or OHFC denies or fails to act on the request, the alleged perpetrator can request a "fair hearing" with a human services judge.[74] Human services judges review OHFC's case file and hold a hearing in which OHFC and the appellant participate. After the hearing, the human services judge determines whether a preponderance of evidence supports OHFC's maltreatment determination. If it does, the human services judge affirms OHFC's original determination; if not, the human services judge recommends that OHFC reconsider its original determination.

Providers may appeal substantiated maltreatment determinations and citations for licensing violations. For appeals of substantiated maltreatment determinations, providers can first file a Request for Reconsideration with OHFC.[75] If the provider disagrees with the result, or OHFC denies or fails to act on the request, the provider can request a fair hearing with a human services judge.

Two appeal options are available for appeals of federal licensing violations issued by OHFC: a review conducted by supervisors in another section in MDH's Health Regulation Division, or a review by an administrative law judge in DHS's Office of Administrative Hearings.[76] Providers may also appeal state licensing violations; the MDH commissioner or a hearing officer appointed by the MDH commissioner conduct these reviews.[77]

As we explained above, even if the Maltreatment Review Panel, a human services judge, or an administrative law judge disagrees with OHFC's original determination, they do not have the authority to overturn OHFC's decision.[78] The panel and judges can only make a recommendation to OHFC to change its determination. In all three cases, the MDH commissioner ultimately determines whether to reverse or uphold OHFC's original determination.

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[73] *Minnesota Statutes* 2017, 626.557, subd. 9d(a).

[74] *Minnesota Statutes* 2017, 626.557, subd. 9d(b). *Minnesota Statutes* 2017, 256.045, describes the fair hearing process.

[75] *Minnesota Statutes* 2017, 626.557, subd. 9d(a).

[76] *Minnesota Statutes* 2017, 144A.10, subds. 15 and 16. These appeal options are called "informal dispute resolutions" and "independent informal dispute resolutions." Minnesota law charges the MDH commissioner with conducting informal dispute resolutions, but OHFC leadership told us that supervisors in another section in MDH's Health Regulation Division fulfill these responsibilities. DHS's Office of Administrative Hearings is authorized by state law to conduct independent informal dispute resolutions. The informal dispute resolution process is available only to federally certified *nursing homes*. The independent informal dispute resolution process is available to *any* federally certified provider.

[77] Home care providers may appeal state licensing violations to the MDH commissioner (see *Minnesota Statutes* 2017, 144A.474, subd. 12). Other state licensed providers, including hospitals and boarding care homes, may also appeal state licensing violations to the MDH commissioner. Minnesota law directs the MDH commissioner to appoint a hearing officer to review these appeals (see *Minnesota Statutes* 2017, 144.653, subd. 8).

[78] *Minnesota Statutes* 2017, 144A.10, subd. 16(d)(6); 256.021, subd. 2(b); and 256.045, subd. 3b(d).

Vulnerable adults, alleged perpetrators, and providers rarely appeal OHFC's maltreatment determinations.

From 2014 to 2016, OHFC received a total of 92 Requests for Reconsideration from a total of approximately 2,700 maltreatment allegations it triaged for investigation in those years (about 3 percent).[79] OHFC reversed only a small portion of the appealed determinations. The OHFC director reversed the original maltreatment investigation determination for 3 of the 40 requests (8 percent) OHFC received in 2014, 1 of 21 requests (5 percent) received in 2015, and 1 of 31 requests (3 percent) received in 2016.

An even smaller number of OHFC's maltreatment determinations are appealed to the Maltreatment Review Panel or human services judges. In calendar year 2016, the Maltreatment Review Panel received only one appeal regarding an OHFC investigation determination. Alleged perpetrators or providers appealed seven of OHFC's maltreatment determinations to human services judges in that same year.

OHFC does not cite providers for licensing violations uncovered through the appeal process.

If OHFC finds through the appeals process that a substantiated maltreatment determination should not have been substantiated, OHFC rescinds the licensing violation associated with the substantiated maltreatment determination. However, if OHFC finds that a maltreatment allegation that was not substantiated should have been substantiated, it does not cite the provider for any associated licensing violation. It also does not cite the provider for other licensing violations, even if it uncovers evidence during the appeal process that indicates the provider did not comply with federal or state licensing requirements.[80]

A recent Request for Reconsideration appeal illustrates this issue. OHFC received a report in late 2016 alleging that a vulnerable adult was neglected by a provider after he or she became trapped between his or her bed and a transfer device. The provider found the vulnerable adult deceased and trapped in this position. OHFC investigated the alleged incident and determined that the maltreatment allegation was not substantiated because, according to OHFC leadership, the investigator was unable to locate key information regarding the proper use of the transfer device.

As part of a Request for Reconsideration, the appellant gave OHFC information that demonstrated that the provider "failed to ensure that staff followed the manufacturer's instructions for the installation of the transfer [device] and did not have adequate policy or procedure in place to ensure safe placement of the [device]."[81] In October 2017, the OHFC director reversed the investigator's initial maltreatment determination by substantiating the maltreatment allegation and finding the provider responsible for neglect. However, OHFC

[79] Due to limitations with OHFC's data, we were not able to present the numbers of Requests for Reconsiderations OHFC received earlier than 2014; 2016 was the last year for which we had complete data.

[80] In this case, however, OHFC would revise its investigation report to reflect the new maltreatment determination and any new information uncovered during the Request for Reconsideration process. OHFC would then post the revised investigation report to its website. Additionally, *Minnesota Statutes* 2017, 626.557, subd. 9d(c), requires OHFC to notify certain individuals and entities of its changed determination.

[81] Minnesota Department of Health, *Office of Health Facility Complaints Investigative Report, Number HL22361005* (St. Paul, 2017).

did not cite the provider for licensing violations related to the now substantiated neglect allegation.

According to OHFC leadership, it has never been OHFC's practice to issue violations based on Requests for Reconsideration. While it is uncommon for OHFC to reverse its original investigation determination after a Request for Reconsideration, Minnesota law directs MDH to cite providers for licensing violations.[82]

RECOMMENDATION

OHFC should cite providers for licensing violations uncovered through the appeal process.

One of OHFC's key responsibilities is to hold MDH-licensed providers and their employees accountable for maltreatment. Because OHFC does not cite providers for substantiated maltreatment identified as a result of appeal processes, the office is not fulfilling this responsibility.

If OHFC finds through an appeal that an inconclusive or not substantiated maltreatment allegation should have been substantiated, it should—at a minimum—cite the provider for violating Minnesota's Vulnerable Adults Act. In addition, OHFC should consider citing providers for other licensing violations it uncovers during the appeal process.

[82] *Minnesota Statutes* 2017, 144.653, subd. 5; 144A.10, subd. 4; and 144A.474, subd. 8.


THE GREAT SEAL OF THE STATE OF MINNESOTA
L'ETOILE DU NORD
1858

Chapter 4: Timeliness and Communication

In Chapter 3, we described how the Office of Health Facility Complaints (OHFC) receives, triages, and investigates allegation reports. In addition to federal and state process requirements that dictate how OHFC conducts it work, federal and state laws require OHFC to triage and investigate allegation reports within prescribed deadlines. State law also requires OHFC to notify vulnerable adults, family members, providers, and others about triage and investigation determinations, investigation delays, and appeals rights.

In this chapter, we assess the extent to which OHFC has met key triage and investigation deadlines. We also examine OHFC's communication with its stakeholders. In short, we found significant investigations delays. We also found OHFC's communications to be unclear and inconsistent.

Key Findings in This Chapter:

- OHFC has frequently failed to meet state and federal triage and investigation deadlines.
- OHFC does not effectively communicate its triage and investigation decisions.
- In the case files we reviewed, OHFC did not consistently notify the vulnerable adult or provider of investigation delays, in violation of Minnesota law.
- OHFC posts its investigation reports on its website, but the website is incomplete and difficult to navigate.

Timeliness

OHFC's timely response to allegations of maltreatment and licensing violations is important for protecting the health and safety of vulnerable adults receiving services from MDH-licensed providers.[1] To ensure that OHFC conducts its work in a timely manner, federal and state laws require OHFC to complete certain tasks within prescribed deadlines. Exhibit 4.1 summarizes the most important triage and investigation deadlines.

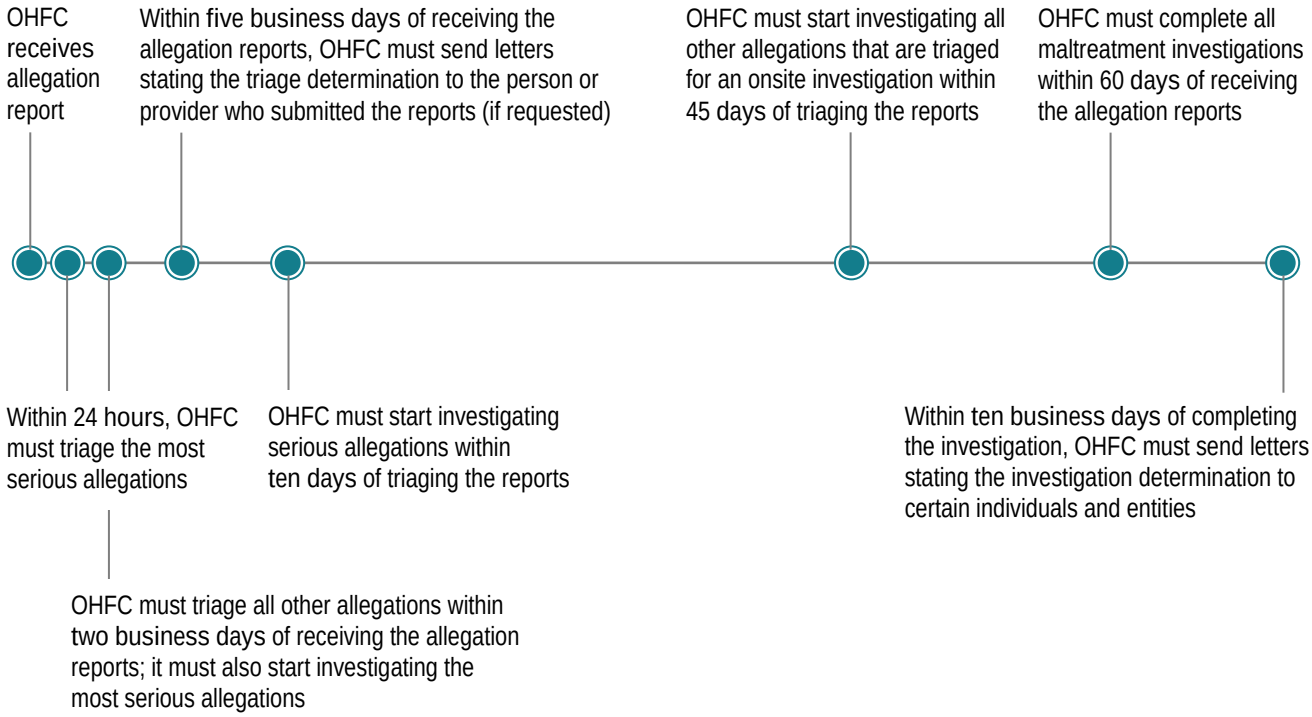
In this section, we describe in more detail the time frames in which OHFC must triage and investigate allegation reports. We found that OHFC has not consistently met required deadlines, which may have negative effects on vulnerable adults, their families, providers, and the integrity of OHFC's investigations.

Triage

Both state law and federal guidelines prescribe how quickly OHFC must triage allegation reports, but they set forth different deadlines. State law requires that, within **five business days** of receiving an allegation report, OHFC must notify the individual who submitted the report of (1) its receipt of the allegation report, and (2) its decision whether to investigate it,

[1] We define "allegation," "maltreatment," "licensing violation," "vulnerable adults," "MDH-licensed providers," and other terms in the Glossary at the end of this report.

Exhibit 4.1: Federal and state law require OHFC to triage and investigate allegation reports within prescribed deadlines.



NOTE: "OHFC" is the Office of Health Facility Complaints within the Minnesota Department of Health.

SOURCE: Office of the Legislative Auditor, analysis of *Minnesota Statutes* 2017, 626.557; Centers for Medicare and Medicaid Services, *State Operations Manual, Chapter 5* (Baltimore, 2016); "Triaging Non-Long Term Care Complaints and Provider Self-Reports" (policy, Minnesota Department of Health, Office of Health Facility Complaints, May 12, 2016); and "Triaging Long Term Care Complaints and Facility Self-Reports" (policy, Minnesota Department of Health, Office of Health Facility Complaints, June 1, 2016).

if the individual requests such notification.[2] Federal guidelines, on the other hand, require OHFC to triage allegation reports within **two business days** from the date that OHFC received the allegation report.[3]

OHFC leadership told us that—given these two sets of deadlines—the office adopted the two-day federal triage deadline for all of its allegation reports, even those involving providers that are not federally certified.[4] In addition, the office adopted a stricter policy for triaging the most serious, highest-priority allegation reports (those that allege serious injury or harm).[5] The policy requires staff to triage these allegation reports within **24 hours**.

[2] *Minnesota Statutes* 2017, 626.557, subd. 9c(a).

[3] Centers for Medicare and Medicaid Services, *State Operations Manual, Chapter 5* (Baltimore, 2016), sec. 5070.

[4] Being federally certified means that a provider meets specific federal requirements. Federal certification allows a provider to receive Medicare or Medicaid payments.

[5] To reduce the complexity of this discussion, we use the phrase "most serious" to refer to "immediate jeopardy" allegation reports. "Immediate jeopardy" allegations are those that claim that a provider's alleged noncompliance with one or more federal requirements "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident…" (42 *CFR*, sec. 488.1 (accessed electronically May 9, 2017)).

OHFC frequently failed to meet state and federal triage deadlines.

We reviewed OHFC's database to determine the extent to which the office met triage deadlines between fiscal years 2012 and 2017. Even though OHFC has chosen to follow the more stringent two-day federal deadline for triaging all of its allegation reports, we measured OHFC's triage performance against both deadlines—the two-day deadline and the more lenient, five-day deadline. We also measured the extent to which OHFC has met the 24-hour deadline for triaging the highest priority cases.

Unfortunately, our analysis was limited because of missing data in OHFC's database. Until late 2016, OHFC did not track the date it triaged reports that it decided not to investigate.[6] As a result, we were only able to analyze the extent to which OHFC met its triage deadlines for *investigated* reports. The triage date was also missing in OHFC's database for about one-third of the allegation reports that OHFC chose to investigate. Therefore, we were only able to determine how quickly OHFC triaged about two-thirds of its investigated reports.

We found that, from fiscal years 2012 through 2017, OHFC failed to consistently meet the five-day, two-day, and 24-hour triage deadlines outlined above, as Exhibit 4.2 shows. For example, in Fiscal Year 2017, OHFC met the five-day triage deadline for 72 percent of the reports that it investigated, and it met the two-day deadline for only 56 percent of the reports that it investigated. That year, OHFC also triaged only 45 percent of the highest-priority cases that it investigated within the 24-hour requirement. In some cases, OHFC far exceeded its triage deadlines. For example, in Fiscal Year 2017, OHFC took 99 business days to triage one allegation report that the office eventually went on to investigate.

As we stated above, within five business days of receiving an allegation report, OHFC must notify the individual who submitted the report of (1) OHFC's receipt of the allegation report, and (2) its decision whether to investigate the report.[7] When OHFC receives an allegation report from an individual, OHFC notifies the individual of its triage decision via letters sent through the mail. State law allows OHFC not to provide this notice, if doing so would "endanger the vulnerable adult or hamper the investigation."[8]

We were not able to measure comprehensively whether OHFC has sent these letters within the five-day deadline because OHFC does not maintain reliable electronic data about this correspondence. However, we were able to examine this issue in our case file review.[9] Thirty-eight of the 103 cases we reviewed involved allegation reports submitted by individuals who requested notification of OHFC's triage decision.[10] Of those 38 cases, 34 case files contained evidence that OHFC sent a letter to the person who reported the allegation. OHFC met the five-day notification deadline for only 11 of the 34 cases.

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[6] OHFC tracked the triage date in each of its paper case files, but not in its electronic database.

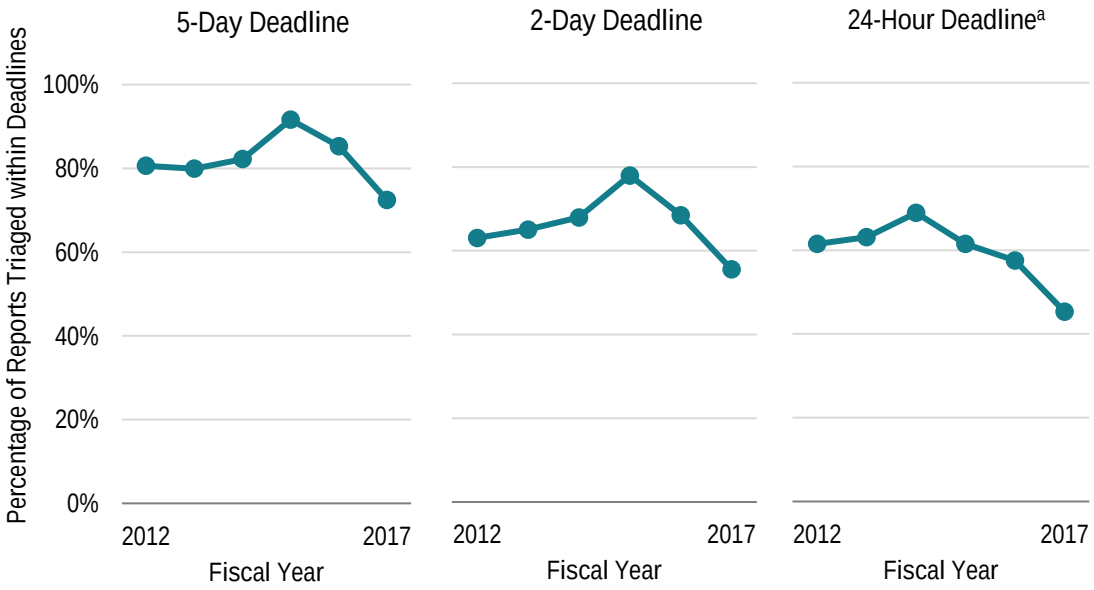
[7] OHFC must provide this notification if the person who submitted the allegation report requests it. *Minnesota Statutes* 2017, 626.557, subd. 9c(a).

[8] *Ibid.*

[9] As part of our evaluation, we reviewed 103 case files of allegation reports that OHFC received and closed in fiscal years 2016 and 2017. Of these 103 files, 53 were cases OHFC had investigated, and 50 were cases that OHFC did not investigate. We randomly selected 100 of these 103 case files; we intentionally selected the remaining 3 cases. Because of the small sample size, the results from our case file review should not be extrapolated to all of OHFC's work.

[10] Individuals submitted the allegation report for 42 of the 103 case files we reviewed. We excluded from this analysis the cases in which the allegation reports were filed anonymously; in these cases, OHFC would not have been able to send such a letter to the person who filed the complaint.

Exhibit 4.2: OHFC failed to meet its 5-day, 2-day, and 24-hour triage deadlines for many cases in Fiscal Years 2012 to 2017.



NOTES: "OHFC" is the Office of Health Facility Complaints within the Minnesota Department of Health. State law requires OHFC to triage all allegation reports within five days (see *Minnesota Statutes* 2017, 626.557, subd. 9c(a)). Federal guidance requires OHFC to triage allegation reports involving federally certified providers within two business days, but OHFC applies this standard to allegation reports involving all types of providers. In addition, OHFC policy requires the office to triage the most serious cases within 24 hours.

This exhibit shows only the percentage of *investigated* cases that were triaged within required deadlines. It does not show the percentage of non-investigated cases that were triaged within required deadlines because, until late 2016, OHFC did not maintain those data in its database. In addition, this exhibit reflects only about two-thirds of the cases that OHFC investigated because OHFC did not maintain data about how quickly the remaining cases were triaged.

[a] This measure includes only those cases that OHFC flagged as the most serious, highest-priority cases.

SOURCE: Office of the Legislative Auditor, analysis of OHFC data.

Investigations

Federal guidelines and OHFC policy dictate the number of days within which OHFC must conduct onsite investigations. Depending on the type of provider involved in the allegation and the severity of the alleged incident, OHFC must conduct an onsite investigation within **2 business days** of receiving an allegation report, or within **10 business days** or **45 calendar days** of triaging an allegation report.

Mary's Story: Investigation Delays

Because of a backlog of cases, it takes 15 days to triage Mary's case, rather than the 5 days required by law. Due to the severity of Mary's case, the investigator has to visit the nursing home (the site of the alleged incident) within 10 days of the triage decision. However, because of the backlog, the investigator does not visit the nursing home for 30 days after the triage decision.

As Mary and her daughter, Jane, wait for OHFC to triage and investigate her allegation, they have to decide whether Mary should go back to the nursing home after she recovers, or whether she should move to another facility.

In addition, as time passes between the alleged incident and the onsite investigation, the memories of the people involved in the alleged incident, including Mary, Jane, the nursing home staff, and the doctors who treated Mary, begin to fade.

Minnesota law specifies other time frames in which OHFC must complete certain tasks. It requires that OHFC complete its maltreatment investigations within **60 calendar days** of receiving the allegation report.[11] And, within **ten calendar days** of completing its investigation, state law requires that OHFC report its findings to the vulnerable adult, person who submitted the allegation report, alleged perpetrator (when relevant), provider, and ombudsperson(s).[12]

Due to limitations with OHFC's data, we were unable to measure OHFC's timeliness in meeting some deadlines specified in federal guidelines and state law for all of its cases. Instead, we used a subset of cases and our case file review to evaluate OHFC's performance.[13]

From fiscal years 2012 to 2017, OHFC did not meet required deadlines for a large and increasing portion of its investigations.

For federally certified nursing homes, federal guidelines require that OHFC investigators conduct an onsite investigation within two business days of receiving a report involving the most serious allegations. OHFC failed to meet this two-day investigation deadline in roughly 62 percent of these cases from fiscal years 2012 to 2017. Federal guidelines also require that OHFC investigators conduct an onsite investigation within ten business days of triaging a report involving a moderately serious allegation.[14] OHFC failed to meet this ten-day requirement for 17 percent of these cases from fiscal years 2012 to 2017.

Mary's Story: Report Delays

After the investigator returns from the nursing home where he investigated Mary's case, he spends time collecting additional evidence and writing the investigation report. OHFC leadership also spend time reviewing the report draft. Because of a backlog in cases, staff take a long time to complete Mary's case.

OHFC finally releases its investigation report about Mary's case 4.5 months after first receiving the allegation report from Mary's daughter, Jane. This is in contrast to state law, which requires OHFC to complete investigation reports within 60 days.

[11] *Minnesota Statutes* 2017, 626.557, subd. 9c(e), states: "The lead investigative agency [OHFC] shall complete its final disposition within 60 calendar days. If the lead investigative agency is unable to complete its final disposition within 60 calendar days, the lead investigative agency shall notify" the vulnerable adult and the provider.

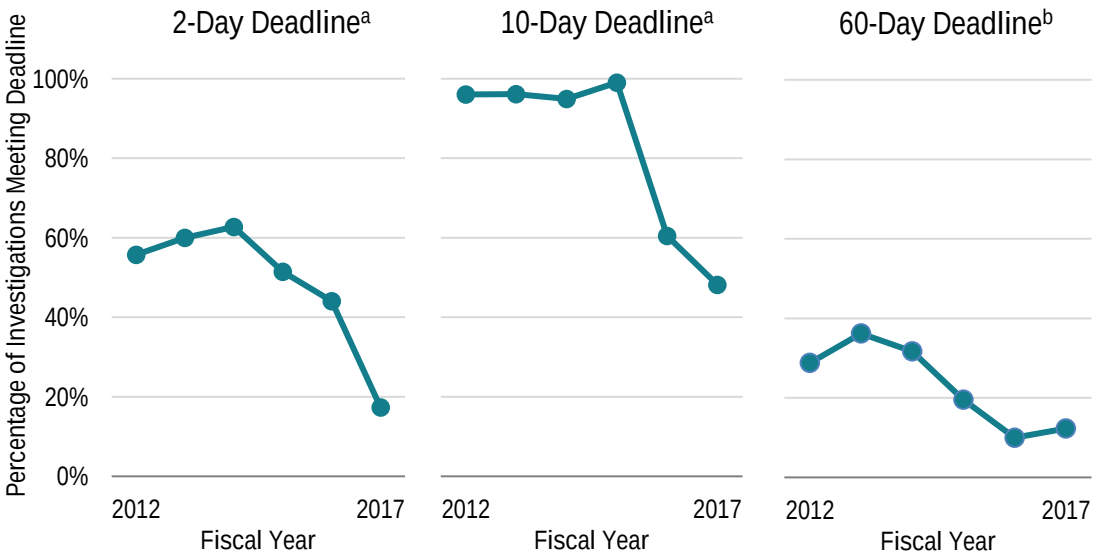
[12] *Minnesota Statutes* 2017, 626.557, subd. 9c(f).

[13] We were able to measure the extent to which OHFC met required deadlines for starting investigations only for investigations involving federally certified nursing homes. From fiscal years 2012 to 2017, 48 percent of OHFC's investigations involved federally certified nursing homes.

[14] To reduce the complexity of this discussion, we use the phrase "moderately serious" to refer to "non-immediate jeopardy high" allegation reports. "Non-immediate jeopardy high" means that a provider's alleged noncompliance with one or more federal requirements may have negatively impacted the resident's mental, physical, and/or psychosocial status (Centers for Medicare and Medicaid Services, *State Operations Manual*, *Chapter 5* (Baltimore, 2016), sec. 5075.2).

Over the past six fiscal years, OHFC has failed to meet both the two- and ten-day investigation deadlines for an increasing portion of its cases involving federally certified nursing homes. As Exhibit 4.3 shows, OHFC failed to meet the two-day deadline for 44 percent of its most serious cases in Fiscal Year 2012 and 83 percent in Fiscal Year 2017. Similarly, OHFC failed to meet the ten-day deadline for 4 percent of its moderately serious cases in Fiscal Year 2012 and 52 percent in Fiscal Year 2017.

Exhibit 4.3: Over the past six fiscal years, OHFC has increasingly missed deadlines to begin and conclude its investigations.



NOTES: "OHFC" is the Office of Health Facility Complaints within the Minnesota Department of Health. For federally certified nursing homes, federal guidelines require that OHFC investigators conduct onsite investigations within two business days of receiving reports involving the most serious allegations. Federal guidelines also require that OHFC investigators conduct onsite investigations of federally certified nursing homes within ten business days of triaging reports involving moderately serious allegations. Minnesota law requires that OHFC complete its maltreatment investigations within 60 calendar days of receiving allegation reports. Data in this exhibit are displayed by the fiscal years in which OHFC received the allegation reports.

[a] This measure includes only investigations involving federally certified nursing homes. Due to limitations with OHFC's data, we were unable to calculate the portion of *all* of OHFC's investigations that met these requirements for initiating onsite investigations. From fiscal years 2012 to 2017, 48 percent of OHFC's investigations involved federally certified nursing homes.

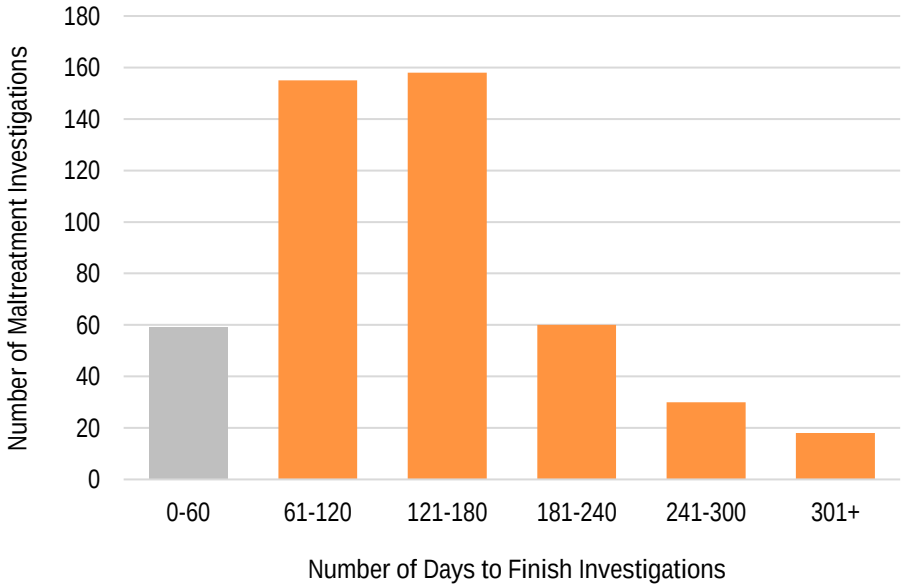
[b] Data in this chart for Fiscal Year 2017 were incomplete at the time of our analysis. As of August 10, 2017, OHFC had completed 48 percent of its investigations involving allegation reports it received and triaged for investigation in Fiscal Year 2017. (Fiscal Year 2017 began on July 1, 2016, and ended on June 30, 2017.) We excluded open investigations from our analysis.

SOURCE: Office of the Legislative Auditor, analysis of OHFC data.

As we stated above, Minnesota law requires that OHFC complete its maltreatment investigations within 60 calendar days of receiving the allegation reports. OHFC has not met this deadline for the majority of its cases since at least Fiscal Year 2012. OHFC met this deadline for only 12 percent of its investigations in Fiscal Year 2017, as Exhibit 4.3 shows.[15]

In Fiscal Year 2017, it typically took OHFC more than double the number of days allowed in Minnesota law to complete its maltreatment investigations, as Exhibit 4.4 shows. On average, it took OHFC nearly 140 calendar days to complete investigations. The number of days OHFC took to complete investigations in Fiscal Year 2017 varied widely, from a minimum of 6 days to a maximum of 378 days.

Exhibit 4.4: OHFC far exceeded the 60-day deadline to finish investigating many of the maltreatment allegation reports it received in Fiscal Year 2017.



NOTES: "OHFC" is the Office of Health Facility Complaints within the Minnesota Department of Health. Minnesota law requires that OHFC complete maltreatment investigations within 60 calendar days of receiving an allegation report. If OHFC is unable to complete its investigation within the 60 calendar days required by law, it must notify the vulnerable adult and provider of the delay (as long as the notification "will not endanger the vulnerable adult or hamper the investigation"). *Minnesota Statutes* 2017, 626.557, subd. 9c(e).

This exhibit shows how long OHFC took to complete investigations of the maltreatment allegations it received during Fiscal Year 2017. However, data for Fiscal Year 2017 were incomplete at the time of our analysis. As of August 10, 2017, OHFC had completed 48 percent of its investigations involving allegation reports it received and triaged for investigation in Fiscal Year 2017. (Fiscal Year 2017 began on July 1, 2016, and ended on June 30, 2017.) We excluded open investigations from our analysis.

SOURCE: Office of the Legislative Auditor, analysis of OHFC data.

[15] The data for Fiscal Year 2017 were incomplete at the time of our analysis. As of August 10, 2017, OHFC had completed 48 percent of its investigations involving allegation reports it received and triaged for investigation in Fiscal Year 2017. (Fiscal Year 2017 began on July 1, 2016, and ended on June 30, 2017.) We excluded open investigations from our analysis.

Minnesota law also requires that OHFC report its findings to certain individuals and entities within ten calendar days of completing its investigations.[16] Based on the letters contained in the case files we reviewed, OHFC sent its investigation reports within 10 days for 41 of the 53 cases we reviewed.

Recommendation

Investigation delays can have serious effects on vulnerable adults and their families. We heard from individuals who filed allegation reports with OHFC and waited months before OHFC began its investigations. For example, one individual told us that it took over three months for OHFC to respond to an allegation report involving his or her family member. In that time, the vulnerable adult—who was receiving services from an MDH-licensed provider—experienced the same incident again numerous times.

Additionally, representatives of provider organizations told us that OHFC's inability to conduct investigations in a timely manner affects providers' operations. For example, one representative told us of a case where the provider reported an allegation to OHFC, suspended a staff person, and then waited several months for OHFC to conduct its investigation. All the while, the provider continued paying the staff person's salary during the suspension. Other provider representatives told us the difficulties providers have with balancing the due-process rights of the suspected employee, employment law, and the care of residents when deciding how to react to allegations before OHFC investigates.

Finally, triage and investigation delays can affect the integrity of OHFC's investigations. It can be difficult for the vulnerable adult, provider's staff, or other witnesses to recall details when investigations are conducted long after an alleged incident occurred. Based on the case files we reviewed, OHFC interviewed the vulnerable adult named in the allegation report an average of 38 days after it received the report; it interviewed alleged perpetrators an average of 75 days after receiving the report.[17] In one case, OHFC interviewed both a family member and the person who filed the allegation report more than one year (454 days) after OHFC received the allegation report. In another case, OHFC conducted three separate interviews with a family member, the person who filed the allegation report, and the alleged perpetrator 337 days after OHFC received the allegation report.

RECOMMENDATIONS

- **OHFC should meet state and federal requirements for triage and investigation deadlines.**
- **The Legislature should require OHFC to regularly report on its progress in meeting state and federal requirements.**

OHFC's timely response to allegation reports is an important component of the state's approach to protecting Minnesota's vulnerable adults. However, OHFC has consistently

[16] *Minnesota Statutes* 2017, 626.557, subd. 9c(f).

[17] We also calculated the span of time between the date OHFC received the allegation report and the date OHFC conducted its first interview with a member of the vulnerable adult's family and the person who filed the allegation report. On average, OHFC conducted these interviews 75 days and 71 days after receiving the allegation report, respectively.

not met deadlines established in state and federal law. We encourage OHFC to develop strategies to meet these deadlines.

In Chapter 2, we described our concerns regarding OHFC's internal operations, including its high level of staff turnover, ineffective staff training, lack of internal policies, toxic culture, and poor leadership. We also raised concerns about OHFC's reliance on an inefficient, paper-based case management system. We offered several recommendations to OHFC to address the concerns we detailed in Chapter 2. We are hopeful that our recommendations—if implemented by OHFC—will help alleviate triage and investigation delays by helping OHFC operate in a more effective and efficient manner.

We also think it is important for the Legislature to hold OHFC accountable to required state and federal deadlines for triaging allegation reports, conducting onsite investigations, and concluding investigations. In particular, the Legislature should require OHFC to report performance metrics that include, but are not limited to:

- Its timeliness in meeting statutorily defined deadlines for triaging allegation reports, conducting onsite investigations, and concluding investigations.

- Its plan to improve performance in areas that are deficient.

Communication

OHFC communicates with a variety of individuals and entities when conducting its work. For example, while triaging allegation reports, OHFC staff may contact providers or the person that filed the allegation report to gather more information. Additionally, OHFC may communicate with vulnerable adults, their families, and providers during the course of its investigations to gather more information or provide updates on the status of the investigations.

In this section, we describe state requirements regarding when OHFC must communicate its triage and investigation determinations and OHFC's performance in meeting these requirements. We also discuss OHFC's practices regarding sharing information with vulnerable adults and their families during the triage and investigation processes. We examine how OHFC communicates individuals' and providers' appeal rights, and conclude this section with a discussion of OHFC's website. In short, OHFC's communications have been unclear and inconsistent.

Triage

As we explained earlier, state law requires OHFC to notify the person who reported an allegation of (1) OHFC's receipt of the allegation report, and (2) OHFC's decision whether to investigate the allegation report.[18] OHFC provides different notifications depending on who submitted the allegation report and the triage decision.

When OHFC receives an allegation report from an *individual*, it sends a letter notifying the individual of its triage decision. Alternatively, when OHFC receives an allegation report from a *provider*—and it decides *not* to investigate—OHFC sends the provider an e-mail

[18] *Minnesota Statutes* 2017, 626.557, subd. 9c(a), requires OHFC to notify the person who reported the allegation only if that person requests such notification.

notification. When OHFC receives an allegation from a provider and decides to investigate, OHFC does not notify the provider in order to protect the integrity of the forthcoming investigation. As we explained earlier, state law allows OHFC not to provide notice of the investigation if doing so would "endanger the vulnerable adult or hamper the investigation."[19]

OHFC does not effectively communicate its triage decisions to individuals.

In our case file review, we found evidence that OHFC may not have always sent letters to individuals notifying them of OHFC's triage decisions. OHFC leadership told us that a copy of every letter that OHFC sends should be kept in the case files. Therefore, we assumed if copies of the letters were not in the files, they were not sent. Four of the 38 case files we reviewed (in which an individual should have received a letter) did not contain a triage notification letter.

We also found the content of the letters to be lacking. Although the letters do notify individuals whether OHFC plans to investigate the allegation, as the law requires, they do not provide other details that would be useful to a stakeholder (such as a family member). For example, the letters do not contain a timeline for when the investigation should be completed, or an explanation of OHFC's investigation process.

OHFC does not inform vulnerable adults or their family members whether providers have reported suspected maltreatment.

State law protects the identity of those who report allegations. The law states: "The identity of any reporter may not be disclosed…."[20] OHFC leadership told us that they consider the name of the provider organization to be protected under this law. As a result, if an interested party, such as a vulnerable adult or family member, asks OHFC whether a provider (or anyone) reported an incident, OHFC will neither confirm nor deny whether anyone has reported the incident.

We heard two types of concerns about this issue. First, if a provider informs a family that it has reported suspected maltreatment to the state, the family has no way to verify if the provider is telling the truth. Consider an example in which an employee of a nursing home abuses a vulnerable adult. The family of the vulnerable adult reports the incident to the nursing home. The nursing home tells the family that it will report the issue to OHFC; later, the family suspects the nursing home did not report the incident. Given OHFC's interpretation of state law, the family has no way to verify whether the nursing home in fact reported the allegation.

Second, even if the nursing home in this example did report the allegation, the family has no way to verify whether the description of the incident that the nursing home reported matches what the family reported to the nursing home. If the facility described the event as relatively minor in its report to the state, then OHFC may decide not to investigate. If OHFC does not investigate, then it may never learn about the family's version of events.

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[19] *Minnesota Statutes* 2017, 626.557, subd. 9c(a).

[20] *Minnesota Statutes* 2017, 626.557, subd. 5(d).

RECOMMENDATION

The Legislature should amend *Minnesota Statutes* 2017, 626.557, subd. 5(d), to allow OHFC to inform a vulnerable adult and his or her legal representative when a provider has filed a report that involves the vulnerable adult.

We think that allowing vulnerable adults and their legal representatives to find out whether providers reported suspected maltreatment would increase transparency and accountability of providers, and provide peace of mind for the public. We also think the Legislature should allow vulnerable adults and their legal representatives to obtain a redacted version of the initial allegation report upon request. Reviewing redacted reports would enable vulnerable adults or their legal representatives to determine whether providers fully or accurately represented the alleged incidents in their allegation reports.

If the Legislature makes these changes to state law, OHFC would have to use some of its resources to carry them out. For example, OHFC staff would have to respond to requests for information from vulnerable adults and their legal representatives. Staff would also have to spend time redacting any not public information from the allegation reports. However, we think this added level of transparency and accountability merits the use of additional state resources.

Investigations

The investigation delays we described earlier in this chapter can result in uncertainty for everyone involved in the investigation. The vulnerable adult may have experienced a serious incident of maltreatment and is depending on OHFC to hold the provider or the alleged perpetrator accountable. Additionally, providers may be waiting on OHFC's investigation determination to make changes to its program or terminate a suspected staff member. For these reasons, it is important that OHFC's communications during and after its investigations are timely and clear.

Communication During an Investigation

Sometimes vulnerable adults' family members or providers contact OHFC to ask about an open investigation. Except for the status of the investigation, OHFC cannot legally share information regarding the investigation before it has made a final investigation determination.[21] For example, investigators may disclose that the investigation is ongoing, but they cannot discuss any details of the case.

Minnesota law requires that OHFC notify the vulnerable adult and the provider if it will not complete its investigation within 60 days of receiving the allegation report.[22] It also requires OHFC to provide subsequent notifications if it is unable to complete the investigation within an additional 60 days.

[21] Minnesota law restricts OHFC's ability to share information with vulnerable adults, providers, or any other individual or entity. The data OHFC collects during an investigation are not accessible to anyone other than OHFC staff, including the subject of the data, because the data collected during an OHFC investigation are classified as "confidential" (regarding data on individuals) or "protected nonpublic" (regarding data not on individuals). *Minnesota Statutes* 2017, 13.02, subds. 3 and 13; and 626.557, subd. 12b(b).

[22] *Minnesota Statutes* 2017, 626.557, subd. 9c(e).

The law allows for two exceptions to these requirements, which we describe below. After applying the exceptions allowed by law to our analysis, we found that OHFC did not always send investigation delay letters as required by law.

In the case files we reviewed, OHFC did not consistently notify the vulnerable adult or provider of investigation delays, in violation of Minnesota law.

OHFC does not collect reliable data in its database regarding whether OHFC investigators sent required letters during their investigations. As a result, we relied on letters retained in the case files we reviewed to assess whether OHFC sent the correct number of investigation delay notification letters to vulnerable adults and providers, as required by law.[23]

As we stated above, Minnesota allows for two exceptions to the requirement that OHFC send investigation delay notification letters. The first exception is that OHFC does not have to send such letters to vulnerable adults or their legal representatives unless it "knows them to be aware of the investigation."[24] To account for this exception in our analysis, we counted cases where the vulnerable adult or a family member either (1) filed the allegation report, or (2) were interviewed during the investigation. (As a result, the vulnerable adult or a family member would have been aware of the investigation.) We found that letters notifying the vulnerable adult or their family of delays were not sent in 29 of the 33 cases in which OHFC should have sent at least one of these letters.

Second, Minnesota law states that OHFC must notify the vulnerable adult and the provider of investigation delays only if the "notification will not endanger the vulnerable adult or hamper the investigation."[25] OHFC leadership told us that OHFC usually does not send investigation delay notification letters to the vulnerable adult because it does not want to draw unnecessary attention to the vulnerable adult, who may be living in the facility under investigation. However, the law does not provide this wide discretion, nor does it preclude OHFC from sending communication to the vulnerable adult in a nondescript envelope.

Additionally, OHFC leadership told us that if 60 days have passed and OHFC has not yet conducted an onsite investigation, it does not send a letter to anyone, not even to the vulnerable adult or the person who submitted the allegation report. Again, the law does not allow for this broad exemption.

We agree with OHFC leadership that sending a letter to the provider *prior* to conducting an onsite investigation could hamper OHFC's investigation. However, based on our file review, OHFC did not consistently send letters to providers notifying them of investigation delays even *after* the onsite investigation had occurred. OHFC investigators did not send letters to providers notifying them of delays in 22 of the 34 cases in which they should have sent at least one of these letters. Of these 22 case files, 18 had *no* letters notifying providers of investigation delays.

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[23] As we stated earlier in this chapter, OHFC leadership told us that copies of all letters sent during investigations were in the case files. Therefore, we assumed if copies of the letters were not in the file, they were not sent.

[24] *Minnesota Statutes* 2017, 626.557, subd. 9c(e). The law states that OHFC must send these letters to the "vulnerable adult or the vulnerable adult's guardian or health care agent." In our case file review, we could not always determine whether the vulnerable adults made their own health care decisions or if they had guardians or health care agents who made decisions for them. As a result, we looked for letters addressed to the vulnerable adult or a member of the vulnerable adult's family.

[25] *Minnesota Statutes* 2017, 626.557, subd. 9c(e).

Our observations may be tied to issues with OHFC's management, such as the office's lack of internal policies. (We discussed concerns with OHFC's management in Chapter 2.) As part of our evaluation, we surveyed OHFC staff.[26] One respondent to our survey told us that he or she did not even know that investigators were supposed to send investigation delay notification letters:

> When I started there was no training. I didn't have any orientation to OHFC as a whole…. Over [number of years] later, something will come up that I didn't know I was supposed to do—as an example, I didn't know I was supposed to send out any 60 day letters.

RECOMMENDATION

OHFC should ensure that investigators send letters notifying vulnerable adults and providers of investigation delays, as required by law.

As we stated above, Minnesota law allows for some discretion when notifying vulnerable adults and providers of investigation delays. Even when accounting for the exceptions in law, however, OHFC did not consistently send these notifications in the case files we reviewed.

OHFC should establish a policy that clearly states when and to whom staff should send letters notifying them of investigation delays. It should also build into its processes a check to ensure that letters are sent as required by law.

Communicating the Investigation Determination

As we explained in Chapter 3, OHFC investigators determine at the conclusion of an investigation whether to substantiate a maltreatment allegation. Investigators also determine whether the provider violated any state or federal licensing requirements. OHFC communicates its findings in different ways to the individuals and entities involved in its investigations.

At the conclusion of an onsite visit, investigators notify providers of their findings regarding the *compliance* portion of their investigations. For example, if an investigator found that a provider violated a licensing requirement regarding infection control procedures, the investigator would inform the provider of his or her observations at the end of the onsite visit. Shortly after, OHFC would send the provider a technical document to formally issue a citation regarding the licensing violation.

Then, investigators complete the *maltreatment* portion of their investigations. As we stated in Chapter 3, investigators often must interview witnesses, family members, primary care providers, or others in person or by telephone after an onsite visit to gather more information about the alleged incident. After an investigator finishes any necessary follow-up work, he or she determines whether the maltreatment allegation is substantiated and writes the investigation report.

Once investigators complete their investigation reports, OHFC supervisors and leadership review the reports and approve them for distribution. OHFC then mails the reports to several individuals and entities, including the vulnerable adult, family members who were interviewed

[26] On November 6, 2017, we sent a questionnaire to all current OHFC employees. We received responses from 49 of the 50 employees actively employed at that time (a 98 percent response rate).

during the investigation, the person who filed the allegation report, the alleged perpetrator (when known), and the provider.[27] OHFC also posts its investigation reports on its website.

OHFC does not notify vulnerable adults, family members, or the people who file allegation reports about its investigation findings at the same time it notifies providers.

Although providers are notified of some of OHFC's findings after OHFC finishes the compliance portion of its investigations, vulnerable adults, family members, and the people who file allegation reports are not notified until both parts of the investigation—the compliance and the maltreatment components—are complete. As a result, vulnerable adults, family members, and the people who file allegation reports may wait much longer to learn any outcomes of the investigation.

In the case files we reviewed, OHFC notified the vulnerable adult, family members, and the person who filed the allegation report about its maltreatment investigation findings more than one month, on average, after it formally notified providers of its compliance determinations. The maximum number of days was 131, or more than 4 months after OHFC notified the provider of its licensing violations.

Mary's Story: Communication

Mary and her daughter, Jane, wait a long time for OHFC to complete its investigation and issue its report. In the meantime, the two women do not receive any communication from OHFC about the status of the investigation.

During that time, Mary and Jane have to decide whether Mary should move to a new facility. Jane wants her mother to have a consistent recovery setting, but is not sure if she can trust the nursing home to correct its medication administration practices. Furthermore, Jane questions whether the nursing home reported the incident to OHFC. (The nursing home administrator told Jane that the facility reported it.) Jane calls OHFC to find out, but OHFC would not confirm or deny whether the nursing home submitted a report.

When OHFC finally releases its investigation report, it sends a copy of the report to Mary and Jane, along with a letter. They find the investigation report difficult to read—it is structured awkwardly and contains technical language. The letter informs them that OHFC did not substantiate her neglect allegation. Because the letter does not explain that OHFC issued licensing violations against the facility, they think the facility faced no consequences for its failures. As a result, Mary and Jane are upset.

OHFC's letters to vulnerable adults, family members, and the people who file allegation reports do not reflect the full extent of OHFC's investigation or its outcome.

The letters OHFC sends at the conclusion of an investigation to vulnerable adults, family members, and the people who file allegation reports address only whether the maltreatment allegation was substantiated. The letters do not specify whether OHFC cited the provider for licensing violations.

For example, if OHFC did not substantiate an allegation of neglect, but cited the provider for a lack of infection control procedures, OHFC's letter would simply state that the maltreatment allegation was not substantiated. The letter would not explain that the provider violated the law or what it is required to do in response to the infection control licensing violation. While the investigation report—which OHFC attaches to the letter—contains information about any licensing violations OHFC cited, the information is technical in nature and is difficult to understand if one is not familiar with the industry.

[27] Minnesota law requires that OHFC provide a copy of the investigation report to the vulnerable adult, the person who filed the allegation report, the alleged perpetrator (when known), the provider, and either the Ombudsman for Long-Term Care or the Ombudsman for Mental Health and Developmental Disabilities. *Minnesota Statutes* 2017, 626.557, subd. 9c(f).

RECOMMENDATION

OHFC should provide complete and timely information about its findings to all parties involved in the investigation.

OHFC should notify vulnerable adults, family members, and the people who file allegation reports of its investigation findings at the same time it notifies providers. Undoubtedly, OHFC must first address its issues with timeliness and its internal operations before it can fully implement this recommendation.

OHFC should also revise the letter it sends to vulnerable adults, family members, and the people who file allegation reports so that the letter clearly describes any licensing violations identified during the investigation. The letter should also state what the provider is required to do to respond to OHFC's citation. At a minimum, the letter should include:

- A plain-language description of the provider's licensing violations.
- How much time the provider has to correct its noncompliant practices.
- The next steps OHFC will take to ensure that the provider corrects its noncompliant practices.

Appeal Rights

Minnesota law requires OHFC to notify the vulnerable adult (or the vulnerable adult's legal representative), alleged perpetrator, and provider of their appeal rights.[28] OHFC provides this notice in the letters it sends at the conclusion of its investigations.

OHFC does not always notify individuals of their appeal rights, as required by law.

In the case files we reviewed, OHFC did not always send letters as required stating OHFC's final investigation determination. As a result, OHFC did not notify some individuals of their appeal rights.[29] For example, our case file review contained eight substantiated cases, four of which placed responsibility for the maltreatment on an individual perpetrator. None of the four case files contained copies of letters addressed to the perpetrators outlining their appeal rights. Additionally, 11 of the 53 files we reviewed (regarding investigated cases) did not contain copies of such a letter addressed to either the vulnerable adult or the vulnerable adult's family.

As we explained in Chapter 3, individuals' and providers' appeal rights differ. However, OHFC does not provide on its website information about how each party could appeal OHFC's investigation determinations. Rather, its website simply states: "If you are not satisfied with the results…you can ask the Office of Health Facility Complaints for

[28] *Minnesota Statutes* 2017, 626.557, subd. 9c(h). We described the different appeal processes in Chapter 3.

[29] As we stated earlier in this chapter, OHFC leadership told us that copies of all letters sent during investigations were in the case files. Therefore, we assumed if copies of the letters were not in the file, they were not sent.

additional review."[30] As a result, it could be difficult for people to find information about their appeal rights, including statutorily required deadlines or documentation required to file an appeal.

RECOMMENDATIONS

- **OHFC should notify the parties required in law of their appeal rights.**
- **OHFC should provide clear information about appeal options on its website.**

The right to appeal OHFC's determinations is an important part of the investigation process, and OHFC should provide information to all applicable individuals and entities about their appeal rights. OHFC should build into its processes a check to ensure that its final letters—which include information about appeals—are sent to the appropriate individuals, as required by law.

Additionally, OHFC should add to its website a plain-language description of the appeals processes for vulnerable adults and their representatives, alleged perpetrators, and providers. For each appeals process, OHFC should explain:

- Required timelines for filing appeals.
- Required documentation to file an appeal.
- The next step an appellant can take if the appeal is dismissed or not acted on, or if the appellant disagrees with the determination.

OHFC's Website

An important way that OHFC communicates with consumers is through its website.[31] On its website, OHFC provides information about what the office can and cannot investigate, as well as an overview of its investigation process. OHFC also posts investigation reports on its website for three years.

A key component of OHFC's website is a "search" function that allows consumers to find investigation reports regarding specific providers. This search function could be especially useful for individuals who are researching possible health care providers or facilities for themselves or a family member. Using the search function, consumers can find recent OHFC investigation reports by provider type, county, city, provider name, or investigation determination (substantiated, unsubstantiated, or inconclusive). The search results display links to the investigation reports that meet the designated criteria.

[30] See Minnesota Department of Health, Office of Health Facility Complaints, *Investigating a Report or a Complaint Filed with the Office of Health Facility Complaints* (St. Paul), http://www.health.state.mn.us/divs/fpc/ohfcinfo/compinvt.htm, accessed February 26, 2018.

[31] OHFC's website can be found at http://www.health.state.mn.us/divs/fpc/ohfcinfo/index.html.

Mary's Story: OHFC's Website

When Mary initially fell and injured herself, Mary's daughter, Jane, quickly had to find a nursing home that would care for Mary while she recovered. Mary lived in St. Cloud. Jane, who worked full time, lived several hours away in northern Minnesota.

When deciding which nursing home to pick, Jane searched OHFC's website. She wanted to know if OHFC had substantiated maltreatment in any of the nursing homes she was considering. Jane found the website difficult to navigate.

Eventually, Jane was deciding between two nursing homes. According to the website, OHFC had recently substantiated one allegation of abuse in the first nursing home, but had not substantiated any maltreatment allegations in the second nursing home. As a result, Jane chose the second nursing home and moved her mother there.

Later, Jane discovered that OHFC had in fact substantiated multiple allegations of neglect in the second nursing home over the last two years. OHFC, however, had failed to post these investigation reports on its website.

OHFC posts its investigation reports on its website, but the website is incomplete and difficult to navigate.

OHFC does not post every investigation report on its website, even though the website suggests that it does. According to OHFC leadership, the office posts only reports concerning *maltreatment* investigations on its website. OHFC does not post to its website investigations that involved only alleged licensing violations. As a result, OHFC posts very few investigations involving hospitals; according to OHFC leadership, hospital investigations typically focus on licensing violations and not maltreatment allegations.

In addition, OHFC does not post to its website all reports regarding its maltreatment investigations. When we checked OHFC's website for completed maltreatment investigation reports, we found that some of these reports were missing. We estimate that the website is missing between 4 and 19 percent of reports that, according to OHFC leadership, should be posted.[32]

Missing investigation reports limit consumers' ability to learn about the quality of care that providers offer. For example, OHFC recently conducted two investigations where the providers were cited for licensing violations regarding serious infection control issues. Because the investigations focused only on licensing violations and not maltreatment allegations, OHFC leadership told us they do not plan to post the investigation reports on its website. As a result, consumers seeking information about these providers on OHFC's website will not learn of these providers' noncompliant practices.

OHFC's website is also difficult to navigate. To see all of OHFC's investigation reports involving a single provider, a consumer would need to conduct three separate searches on the website: one for substantiated allegations, one for unsubstantiated allegations, and one for inconclusive allegations.

Additionally, consumers must sometimes search for a provider using the provider's corporate name and address, rather than the name and street address of the actual nursing home or facility they are researching. OHFC leadership told us that OHFC sometimes posts a report using the name and address of the provider that holds the MDH license, which may be different than the name or address with which consumers are familiar.

When we searched OHFC's website, we had a difficult time finding investigation reports that we knew existed. For example, we searched for an investigation report detailing a substantiated maltreatment determination involving the Heritage House assisted living facility in Pequot Lakes. We thought our first search was sufficiently broad; we searched

[32] We report a range due to the poor quality of OHFC's data. We discuss OHFC's data problems in more detail in Chapter 5.

for all reports issued with a substantiated determination involving any provider type located in Pequot Lakes. This first search returned no matching reports.

Knowing, however, that OHFC had substantiated a maltreatment allegation at this facility, we adjusted our search to include all provider types and all locations with the name "Heritage House." This search returned reports for Heritage House in Milaca and Minnesota Heritage House in Little Falls. In the end, the investigation report we were seeking—for Heritage House in Pequot Lakes—was listed under "Minnesota Heritage House" in Little Falls. If we were a consumer simply trying to research possible options for ourselves or a family member, we might have reasonably concluded that OHFC had not conducted any investigations—let alone substantiated a maltreatment allegation—at Heritage House in Pequot Lakes.

RECOMMENDATIONS

- **The Legislature should require OHFC to post all of its recent investigation reports on its website.**
- **OHFC should improve the search functions for investigation reports on its website.**

Minnesota law does not require OHFC to post its investigation reports to its website.[33] OHFC's internal policy is to post on its website investigation reports involving maltreatment allegations; the office does not post investigation reports regarding only licensing violations. Based on our analysis, OHFC also does not post on its website all of its maltreatment investigation reports.

We think the Legislature should require OHFC to post all of its recent investigation reports on its website, including those involving only licensing violations. This would help consumers get a more complete picture of the providers they may be considering for themselves or family members. OHFC currently posts its investigation reports on its website for three years; however, the Legislature should decide whether this amount of time is appropriate.

Additionally, OHFC should change the search functions on its website so that users can search for investigation reports using the physical location (i.e., the address) of the facility, rather than the corporate office's address. The website should be designed so that when users select a facility, they see *all* completed investigation reports related to the facility, regardless of OHFC's investigation determination. Additionally, we think that OHFC should modify its website so that a search for one provider returns links to reports about the parent corporation's other providers, when relevant.

[33] Minnesota law requires MDH to annually publish on its website "the number and type of reports of alleged maltreatment involving licensed facilities…, the number of those requiring investigation…, and the resolution of those investigations." See *Minnesota Statutes* 2017, 626.557, subd. 12b(e).

Chapter 5: Maltreatment Prevention

If the Office of Health Facility Complaints (OHFC) finds during an investigation that maltreatment occurred, or that the provider violated licensing requirements, OHFC can issue a citation ordering the provider to correct its noncompliant practices. In some circumstances, OHFC can impose on the provider a fine or other enforcement actions, or it can disqualify an individual from providing direct care to vulnerable adults for seven years.

However, the investigations OHFC conducts 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.[1]

Several approaches can help to prevent maltreatment. In this chapter, we focus on two of them: (1) collecting and sharing information with providers, and (2) providing regulatory oversight of care providers and housing facilities that is consistent with their clients' needs. While the Minnesota Department of Health (MDH) and OHFC can take steps to improve how they collect data and share information with MDH-licensed providers, other prevention efforts require action from the Legislature or other state agencies. At the end of this chapter, we recommend that the Legislature study the state's oversight of senior care providers and housing facilities. We also discuss other strategies the state could use to prevent the maltreatment of vulnerable adults.

Key Findings in This Chapter:

- MDH does not use its data related to maltreatment allegations and investigations to identify trends and inform prevention efforts.
- "Housing with services" establishments—which include assisted living facilities—are not licensed by the state and therefore do not have the same level of oversight as nursing facilities or other licensed service providers.
- Minnesota law provides fewer protections for individuals with dementia that live in housing with services establishments than those that live in nursing homes.

The Problem

Leading public health organizations—including the federal Centers for Disease Control and Prevention (CDC) and the World Health Organization—have recognized the maltreatment of older adults as an important public health problem.[2] A recent national estimate indicates

[1] We define "maltreatment," "vulnerable adults," and other terms in the Glossary at the end of this report.

[2] Centers for Disease Control and Prevention, *Elder Abuse Surveillance: Uniform Definitions and Recommended Core Data Elements* (Atlanta: National Center for Injury Prevention and Control, Division of Violence Prevention, 2016), 15; and World Health Organization, *Elder Abuse Fact Sheet* (Geneva: Media Centre, 2017), http://www.who.int/mediacentre/factsheets/fs357/en/, accessed November 28, 2017. While adults with disabilities can also experience maltreatment, we focus in this chapter on the maltreatment of older adults.

that at least 1 in 13 older adults who live in the community experience maltreatment annually.[3]

According to the CDC, older adults who are abused, neglected, or exploited may experience a variety of physical, psychological, and social consequences.[4] For example, effects could include bruises or other injuries, exacerbation of preexisting health conditions, an increased risk for premature death, distress, depression, anxiety, fear, and social isolation. The CDC reports that nationwide, injuries caused by older adult maltreatment cost more than $5.3 billion annually, and financial exploitation costs older Americans over $2.6 billion annually.[5]

A growing older adult population increases the size of the population potentially at risk for experiencing maltreatment. Between 2010 and 2030, the number of Minnesotans age 65 or older is expected to nearly double, from approximately 690,000 in 2010 (13 percent of the state's population), to more than 1.2 million in 2030 (21 percent of the state's population). As Minnesota's population ages, an increasing number of older adults will need nursing care and help with daily tasks. The federal Department of Health and Human Services estimates that nationally, approximately 70 percent of individuals who reach age 65 will likely need long-term care during their lifetimes.[6]

While researchers do not know the prevalence of maltreatment among older adults living in nursing homes or other long-term care facilities, some suspect that maltreatment is more pervasive in these settings than in the community. As of early 2018, approximately 36,000 Minnesotans were living in 2,600 long-term care facilities, and an additional 90,000 people were receiving home-based care.

Collecting and Sharing Information

Reliable data are imperative to any public health prevention strategy, including one to prevent the maltreatment of older adults. Such data could allow MDH to identify trends of noncompliance or maltreatment across the providers it licenses. Data could also inform policy makers' decisions on how resources should be allocated. Using data in these different ways, however, requires OHFC to first collect consistent and reliable data related to maltreatment allegations and investigations.

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[3] Karl Pillemer, David Burnes, Catherine Riffin, and Mark S. Lachs, "Elder Abuse: Global Situation, Risk Factors, and Prevention Strategies," *The Gerontologist* 56, no. S2 (2016): S197. These estimates include abuse, neglect, and financial exploitation perpetrated by family members or other caregivers. They do not include maltreatment of older adults living in residential or long-term care facilities.

[4] Centers for Disease Control and Prevention, *Elder Abuse: Consequences* (Atlanta: National Center for Injury Prevention and Control, Division of Violence Prevention, 2017), https://www.cdc.gov/violenceprevention /elderabuse/consequences.html, accessed November 27, 2017.

[5] Centers for Disease Control and Prevention, *Elder Abuse Surveillance: Uniform Definitions and Recommended Core Data Elements* (Atlanta: National Center for Injury Prevention and Control, Division of Violence Prevention, 2016), 15.

[6] U.S. Department of Health and Human Services, *Caregiver Resources & Long-Term Care* (Washington, D.C.: Digital Communications Division, 2017), https://www.hhs.gov/aging/long-term-care/index.html, accessed January 18, 2018.

The data OHFC collects are inconsistent and unreliable.

As part of our evaluation, we analyzed the database OHFC uses to maintain data on allegation reports and investigations. We discovered that OHFC did not have documented guidance for how data fields in the database should be used, or even descriptions of the codes used within each field. We had numerous conversations and e-mail exchanges with OHFC and Minnesota IT Services (MNIT) staff to clarify how staff use the data and what each data field means. Over the course of these conversations, it became clear that staff have entered information in the database inconsistently over time.

For example, we found that OHFC's database does not contain the date that triage decisions were made for about one-third of allegation reports OHFC received from fiscal years 2012 to 2017 that it *investigated*. Also, until late 2016, OHFC did not capture in its database the date of the triage decision for all allegation reports that it *did not* investigate. As we discussed in Chapter 4, OHFC is required to triage certain allegation reports within strict federal deadlines. If staff do not consistently record when OHFC made its triage decision, the office cannot measure its performance against this required standard.

As another example, we found that OHFC staff have treated "related" cases differently in the database. (Related cases are those in which OHFC received two or more allegation reports about the same incident.) Sometimes, staff merged the two reports into one investigation record, but other times, staff kept the two reports separate in the database. OHFC staff often used various open text fields within the database—rather than entering a predefined code into a designated field—to indicate whether two allegation reports were related to the same investigation. Additionally, when staff kept the two allegation reports separate in the database, staff did not consistently record information about the allegation reports in OHFC's database. In some cases, staff coded one report as "investigated" and the other report as "not investigated," even though both reports were investigated jointly, as part of the same investigation. In other cases, staff marked both allegation reports as "investigated." As a result, OHFC cannot easily determine how many allegation reports it actually investigated. This makes it difficult for OHFC to accurately measure its performance.

OHFC does not collect some information needed to inform prevention efforts.

In order to help prevent maltreatment from occurring, policy makers, MDH, providers, and other stakeholders need to understand the magnitude and nature of the problem. This requires collecting data that can be analyzed to determine how frequently maltreatment occurs, where it occurs, and whether there are trends associated with the number of provider staff on duty, the time of day, or other factors.

OHFC collects some information that it could use to determine trends of maltreatment involving the providers it licenses. For example, OHFC's database has a field that records the type of alleged maltreatment, such as whether the alleged incident involved physical abuse by another resident, financial exploitation by a staff member, or neglect resulting in a medication error. However, some allegation codes are more detailed than others. OHFC has many detailed categories for neglect, for example, and few for physical abuse. And, as

we stated above, OHFC has not provided guidance to its staff about how these data fields should be used; it has also had problems with staff entering data inconsistently or even at all.

OHFC currently does not collect other information that would be necessary to inform and focus prevention activities. For example, to determine whether certain vulnerable adults have a higher risk of experiencing maltreatment, OHFC would need to collect more data about the vulnerable adults involved in alleged maltreatment incidents, such as demographic characteristics. OHFC's database does not include fields for vulnerable adults' race and ethnicity, gender, diagnosis, or disability.

RECOMMENDATIONS

- **OHFC should develop guidance for its staff that defines the fields in its database, identifies what data staff should enter into its database, and indicates how staff should record information.**

- **OHFC should collect data that will allow for rigorous trend analysis.**

In order for OHFC to have the data it needs to measure its own performance and produce useful information for stakeholders, OHFC needs to improve the quality of the data it collects. This starts with having documented guidance—a "data dictionary"—that defines the different data fields in the database. OHFC should also develop guidance that explains what information staff are required to enter into the database, as well as how to enter the information.

In 2016, the CDC published recommendations for states and other entities to use to structure their data collection programs.[7] Among other things, the CDC provided a list of key data fields needed to establish and evaluate prevention strategies for older adult maltreatment. It also recommended several data fields that states and other entities could use to link records, identify duplicate records, and monitor trends in the data.

OHFC should consider, at a minimum, collecting data consistent with the CDC's recommendations. OHFC should also identify what data are needed to understand the scope of maltreatment involving the providers MDH licenses. It should also identify data that could be useful to inform future prevention efforts.

OHFC has begun taking steps to implement this recommendation. OHFC is currently evaluating and modifying some information it collects to better enable the office to track trends. OHFC has also created a new data management position to improve the consistency of its data, and a data analyst position to identify trends in the data it collects. We encourage OHFC to continue these efforts.

[7] Centers for Disease Control and Prevention, *Elder Abuse Surveillance: Uniform Definitions and Recommended Core Data Elements* (Atlanta: National Center for Injury Prevention and Control, Division of Violence Prevention, 2016).

MDH does not use its data related to maltreatment allegations and investigations to identify trends or inform prevention efforts.

MDH analyzes the data OHFC collects to provide broad, high-level trend data in its statutorily mandated reports.[8] However, the data presented in MDH's mandated reports are not detailed enough to help providers improve the quality of care they deliver to their clients. And, other than its mandated reports, neither MDH nor OHFC shares with providers any trend data regarding the allegation reports OHFC receives or the investigations it conducts.

Other units in MDH share inspection trend data and disease prevention information with providers. For example, the MDH unit that inspects and licenses home care providers posts to its website annual summary-level information regarding common state licensing violations. Additionally, MDH issues "health alert" notifications to health care providers and public health officials to help them respond to disease outbreaks and prevent further illnesses. As an example, MDH distributed information on measles when the state experienced an outbreak in 2017.

RECOMMENDATION

MDH should analyze the data OHFC collects to identify trends and share its findings with providers and other stakeholders.

MDH is in the unique position to influence system-wide practices. After analyzing OHFC's data, MDH could share information with providers about trends it uncovers through OHFC's work.[9] For example, if OHFC receives multiple reports regarding falls from a mechanical lift, the observed trend may indicate deficiencies with the equipment or with staff training. To attempt to prevent additional falls, MDH could notify providers of the observed trend and either provide guidance on how to solve the problem or connect providers to other resources, such as regional or national provider organizations.

According to representatives of provider organizations, knowing trends about reported incidents could help providers identify patterns and protect against future incidents. As an example, one representative said that providers could better prevent narcotic thefts if MDH shared information about the thefts, such as the types of employees implicated and how the narcotics were stored.

MDH could also use the data OHFC collects to inform the design of other maltreatment prevention initiatives. For example, based on observed trends, MDH could develop public awareness campaigns or education programs or resources for direct-care staff. MDH could also post on its website summary information about the types of maltreatment allegations it

[8] As an example, in its most recent report, MDH provided high-level information about the types of providers named in the allegation reports OHFC received in Fiscal Year 2015. See Minnesota Department of Health and Minnesota Department of Human Services, *Maltreatment Report: Vulnerable Adults & Minors Served by Minnesota Licensed Providers* (St. Paul, 2016), 18.

[9] OHFC might not be the appropriate unit in MDH to analyze OHFC's data and share information with providers. Other units in MDH might have more resources than OHFC to dedicate to this work.

receives and the investigations it conducts.[10] This information could be useful for consumers when researching providers or facilities for themselves or family members.

MDH and OHFC leadership told us that they want to provide trend information to providers. MDH leadership also said they would like to send notifications to providers about the trends OHFC observes, as well as messages reminding providers of common types of incidents that occur during certain times of the year. (For example, MDH could send reminders about how to prevent radiator burns during the winter.)

OHFC leadership told us that they would like to post quarterly summary-level data on OHFC's website, such as the number of neglect allegations it received by provider type. We encourage MDH to develop ways in which it can share information with its stakeholders regarding the care of vulnerable adults.

Gaps in Regulatory Oversight

Even if OHFC implements all the recommendations we outlined earlier in this report, OHFC alone will not be able to completely prevent older adult maltreatment in Minnesota. The Legislature, health care providers, state agencies, and other stakeholders will also need to take action to help prevent maltreatment. One of the ways the state can address the maltreatment of older adults living in health care facilities or receiving services from health care providers is by implementing an effective regulatory system.

Federal and state governments regulate health care providers to help protect the health and safety of the public. Regulation offers governments, providers, and the public a set of expectations for the provision of health care services. It also establishes expectations for government oversight, such as the frequency with which government agencies inspect providers and the penalties a provider could receive for not complying with regulatory requirements.

In Minnesota, regulatory protections for vulnerable adults vary based on the type of facility the individual lives in, not on the individual's vulnerability. As a result, some vulnerable individuals live in facilities that operate under limited state oversight. Given the state's array of housing and care options, it can be difficult for consumers to understand the differences in regulatory oversight. When consumers' expectations do not align with actual regulatory requirements, vulnerable individuals may not receive the care they need or expect to receive.

In this section, we give an overview of the types of care providers and housing facilities available to older Minnesotans and note important differences in the amount of state oversight of these different options. We then discuss in detail the state's limited regulatory oversight of one type of housing facility—housing with services establishments. We conclude this section with a recommendation that the Legislature study the regulation of care providers and housing facilities.

[10] Minnesota law requires MDH to annually publish on its website "the number and type of reports of alleged maltreatment involving licensed facilities…, the number of those requiring investigation…, and the resolution of those investigations." See *Minnesota Statutes* 2017, 626.557, subd. 12b(e).

Types of Care Providers and Housing Facilities

Older Minnesotans may live in a variety of settings, ranging from their own homes to nursing homes. In some settings, individuals may receive services from the facility itself, such as meals, cleaning, and medical care. In other settings, individuals may need to contract with outside service providers to receive medical care or other services.

Below we compare housing facilities by the level of care they provide. We describe two broad types of facilities: those that offer nursing care and those that do not. We then discuss some service providers that operate in individuals' homes and in certain housing facilities.

Facilities with Nursing Care

In Minnesota, individuals who require 24-hour nursing care generally have three long-term care options to choose from: nursing homes, boarding care homes, and supervised living facilities. These facilities may offer nursing care and personal care, such as bathing, dressing, and toileting. (Nursing care includes health evaluations, medical treatments, and nursing supervision.) Nursing homes and boarding care homes are licensed by MDH, as Exhibit 5.1 shows. Supervised living facilities are licensed by both MDH and the Department of Human Services (DHS).

Nursing homes, boarding care homes, and supervised living facilities operate under many regulatory requirements. For example, Minnesota laws and rules dictate a range of standards for nursing homes, such as the temperature and humidity of resident-occupied spaces, menu planning, and staffing levels and composition.[11] State law requires that MDH conduct periodic inspections of nursing homes, boarding care homes, and supervised living facilities to verify compliance with state laws and rules.[12]

Facilities that Offer Help with Daily Tasks

Individuals who would like some help with daily tasks, but do not require 24-hour nursing care, may live in facilities that offer help with cooking, cleaning, laundry, bathing, and dressing. These facilities include adult foster care facilities, boarding and lodging facilities, housing with services establishments, and housing with services establishments with assisted living services, as Exhibit 5.1 shows.[13]

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[11] See *Minnesota Statutes* 2017, 144A.01-144A.1888; and *Minnesota Rules*, Chapter 4658.

[12] In addition to being licensed by the state, nursing homes may also be "certified" by the federal government. Federal certification allows a nursing home to receive Medicare or Medicaid payments. As required in 42 *CFR*, sec. 488.308 (accessed electronically May 9, 2017), MDH must conduct a survey of each federally certified nursing home within 15 months of the previous survey. Additionally, the "statewide average interval between standard surveys must be 12 months or less…."

[13] *Minnesota Statutes* 2017, 144G.02, restricts the use of the phrase "assisted living." Facilities that advertise as "assisted living" must be registered with MDH as a housing with services establishment that provides assisted living services. Assisted living services include a package of services detailed in state law, including help with managing medications, access to nursing staff at all times, and a system in which staff check on each resident at least once a day (*Minnesota Statutes* 2017, 144G.03, subd. 2).

Exhibit 5.1: Minnesota's senior care and housing industry is diverse.

Care or Housing Option	Description	State License or Registration
Facilities with Nursing Care[a]		
Nursing Home	Provides comprehensive nursing care and services to five or more persons.	Licensed by MDH
Boarding Care Home	Provides minimal nursing care and services to five or more persons.	Licensed by MDH
Supervised Living Facility	Provides minimal nursing care and services to four or more persons with disabilities.	Licensed by MDH and DHS
Facilities that Offer Help with Daily Tasks[b]		
Adult Foster Care	Provides sleeping accommodations and services for four to five adults.	Licensed by DHS
Boarding and Lodging	Provides sleeping accommodations and meals for five or more adults for a period of one week or more. May provide services depending on the facility.	Licensed and registered by MDH
Housing with Services	Provides sleeping accommodations and services to one or more residents, 80 percent of whom are 55 years of age or older. At a minimum, provides or makes available at least one of the following: • One or more regularly scheduled health-related services, such as nursing services or centralized medication storage. • Two or more regularly scheduled supportive services, such as laundry, handling residents' personal funds, or arranging for medical services.	Registered by MDH
Housing with Services with Assisted Living Services	Provides sleeping accommodations and services to one or more residents, 80 percent of whom are 55 years of age or older. At a minimum, provides or makes available certain services, including: • Assistance with medication administration and management. • Assistance with at least three activities of daily living, including bathing, dressing, grooming, eating, transferring, and toileting. • Physical and cognitive assessments by a registered nurse. • Access to nursing staff at any time. • Daily client checks. • Supportive services, such as meals, housekeeping, and transportation.	Registered by MDH
Service Providers		
Home Care Provider	Offers a variety of services in people's homes or in housing with services establishments, ranging from assistance with daily tasks (such as bathing, dressing, and grooming) to medication management and nursing services.	Licensed by MDH
Home Health Agency	Home care providers that are certified by the federal government to accept Medicare or Medicaid payments.	Licensed by MDH
Home Management	Offers at least two of three types of services (housekeeping, meal preparation, and shopping) to persons who are unable to perform these activities due to illness, disability, or a physical condition.	Registered by MDH

NOTES: "DHS" is the Minnesota Department of Human Services. "MDH" is the Minnesota Department of Health.

[a] Services provided by these facilities may include nursing care; meals; cleaning; laundry; and help with bathing, dressing, and toileting.

[b] Services provided by these facilities may include help with cooking, cleaning, laundry, bathing, and dressing.

SOURCE: Office of the Legislative Auditor, analysis of *Minnesota Statutes* 2017, 144.50-144.586, 144A.01-144A.1888, 144A.43-144A.482, Chapter 144D, Chapter 144G, Chapter 157, and 245A.03.

Minnesota regulates these facility types differently. Adult foster care facilities are licensed by DHS.[14] Minnesota rules authorize county social services agencies to inspect adult foster care facilities once every two years, a responsibility delegated by DHS.[15] In order to provide services, boarding and lodging facilities must be both licensed and registered by MDH; Minnesota law authorizes MDH to inspect boarding and lodging facilities once every one to two years.[16] Housing with services establishments, including those that offer assisted living services, must register with MDH. Housing with services establishments are not subject to regular inspections by MDH.

Service Providers

Individuals living in housing with services establishments or their own homes may contract with different types of service providers to receive care. MDH licenses or registers three types of service providers: home care providers, home health agencies, and home management services.[17]

As Exhibit 5.1 shows, home care providers may offer a variety of services, ranging from assistance with daily tasks (such as bathing, dressing, and grooming) to medication management and nursing services. Minnesota law authorizes MDH to inspect home care providers at least once every three years to ensure that services are being provided in accordance with home care laws.[18]

Certain licensed home care providers may apply to become federally certified home health agencies. Home health agencies provide similar services as home care providers. However, because these providers may receive Medicare and Medicaid payments, they must comply with federal requirements for home health agencies in addition to state requirements for home care providers.

Home management service providers offer at least two of three types of services: housekeeping, meal preparation, and shopping. Minnesota law requires home management service providers to be registered by MDH if they provide at least two of the aforementioned services to a person who is unable to perform these activities due to illness, disability, or physical condition.[19] Home management service providers are not subject to regular inspections by MDH.

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[14] *Minnesota Statutes* 2017, 245A.03.

[15] *Minnesota Rules*, 9543.0030, subp. 1, published electronically December 29, 2005; and 9555.6125, subp. 13, published electronically July 2, 2009.

[16] *Minnesota Statutes* 2017, 157.16; 157.17; and 157.20, subds. 1 and 2.

[17] DHS licenses other types of service providers, including those that offer certain home and community-based services to people with disabilities and those age 65 and older. For more information about some of these service providers, see Office of the Legislative Auditor, Program Evaluation Division, *Home- and Community-Based Services: Financial Oversight* (St. Paul, 2017).

[18] *Minnesota Statutes* 2017, 144A.474, subd. 1.

[19] *Minnesota Statutes* 2017, 144A.482(a).

Limited Oversight of Housing with Services Establishments

Housing with services establishments—including those that offer assisted living services—can provide services through their own home care provider licenses, or they or their residents can contract for services from outside providers. Housing with services establishments can also offer some services without a home care license. For example, housing with services establishments can provide laundry, housekeeping, and meal preparation services to residents who are not receiving such services from a licensed home care provider.[20]

Through maltreatment investigations and periodic inspections, OHFC and other offices in MDH verify that *services* delivered by licensed home care providers that operate in housing with services establishments meet certain care standards. However, MDH does not regulate the housing with services *building*, the *non-licensed services* it provides, or the *people* employed by the housing with services establishment.[21]

Nevertheless, potentially vulnerable individuals may live in housing with services establishments. A recent CDC study provided a profile of individuals who live in assisted living facilities and similar residential care facilities. It estimated that in 2014, 39 percent of Minnesotans living in these types of facilities had a diagnosis of Alzheimer's disease or dementia.[22] Additionally, it estimated that a large portion of Minnesotans living in these facilities needed assistance with daily tasks. For example, the CDC estimated that in 2014, 60 percent of residents needed assistance with bathing, 43 percent with dressing, and 37 percent with toileting.

Fewer Regulations

While vulnerable individuals may live in housing with services establishments, these facilities operate under fewer state regulations than nursing homes or other licensed service providers.

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[20] Residents of housing with services establishments who do not elect to receive home care services are commonly known as "independent living" clients.

[21] Residents of housing with services establishments are effectively tenants renting an apartment from a landlord. Similar to other apartment buildings, housing with services establishments must comply with the federal Fair Housing Act, which prohibits discrimination by landlords on the basis of race, gender, and disability, among other things. Housing with services establishments must also comply with state fire and building codes, boarding and lodging laws, food service laws, and landlord and tenant laws.

[22] Manisha Sengupta, Lauren Harris-Kojetin, and Christine Caffrey, *2014 National Study of Long-Term Care Providers, Web Tables of State Estimates about Residential Care Community Residents* (Hyattsville, MD: Centers for Disease Control and Prevention, National Center for Health Statistics, 2015), https://www.cdc.gov/nchs/data/nsltcp/State_estimates_for_NCHS_Data_Brief_223.pdf, accessed December 8, 2017. Alzheimer's disease is a degenerative brain disorder that causes dementia. Dementia is a term that describes a wide range of symptoms associated with a decline in memory or other cognitive skills.

Housing with services establishments are not licensed by the state and therefore are not subject to the same level of regulation as nursing homes or other licensed service providers.

Being licensed by MDH means a provider has met certain criteria established in law. For example, nursing homes "must meet the minimum health, sanitation, safety and comfort standards prescribed by the rules of the commissioner of health with respect to the construction, equipment, maintenance and operation of a nursing home."[23] Similarly, home care providers must have "documentation of a background study…for any individual seeking employment, paid or volunteer, with the home care provider."[24] As another example, Minnesota law requires nursing homes and home care providers to conduct regular medical assessments of each resident and develop care plans that are based on the assessments.[25]

Being licensed also means that the provider may be subject to regular MDH inspections. MDH is responsible for conducting regular compliance inspections (commonly called "surveys") of licensed providers to ensure that they are complying with applicable licensing requirements.[26] If MDH finds during an inspection that a nursing home or home care provider did not provide the services outlined in a resident's care plan, for example, MDH can cite the provider for this licensing violation.

MDH *registers*—rather than *licenses*—housing with services establishments. To register, housing with services establishments must annually submit to the department a fee and basic information about the facility and its owners, such as names and mailing addresses.[27] It must also verify that it has entered into a housing with services contract with each resident.[28] However, Minnesota law does not authorize MDH or any other state agency to confirm that the information on the registration applications is correct, nor does it authorize MDH or any other state agency to evaluate whether housing with services establishments comply with the few registration requirements specified in state law.[29]

Another difference between housing with services establishments and licensed providers is the level of consumer protections available to residents. Federal and state laws provide protections for nursing home residents against arbitrary evictions. (Nursing homes must provide a notice to the vulnerable adult 30 days before an involuntary discharge or transfer, and the MDH commissioner must establish a hearing process for appeals of involuntary discharges and transfers.)[30]

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[23] *Minnesota Statutes* 2017, 144A.04, subd. 3(a).

[24] *Minnesota Statutes* 2017, 144A.472, subd. 1(7).

[25] *Minnesota Statutes* 2017, 144A.4791, subds. 8 and 9; and *Minnesota Rules*, 4658.0400 and 4658.0405, published electronically October 11, 2007.

[26] See, for example, *Minnesota Statutes* 2017, 144A.10, 144A.101, and 144A.474. MDH also inspects federally certified nursing homes per 42 *CFR*, sec. 488.10 (accessed electronically May 9, 2017).

[27] *Minnesota Statutes* 2017, 144D.03, subds. 1 and 2.

[28] *Minnesota Statutes* 2017, 144D.03, subd. 2.

[29] MDH can sue the housing with services establishment in district court to compel it to meet state or local requirements (*Minnesota Statutes* 2017, 144D.05).

[30] 42 *CFR*, sec. 483.15(c)(4) (accessed electronically May 9, 2017); and *Minnesota Statutes* 2017, 144.651, subd. 29; and 144A.135.

Residents of housing with services establishments do not have the same level of consumer protections as nursing homes. Minnesota law requires that housing with services establishments have contracts with each of its residents.[31] While the contracts must describe the services provided by housing with services establishments and the cost of each service, housing with services establishments are not required by state law to provide the services. Additionally, a housing with services establishment may terminate a contract it has with a resident without providing any notice or reason for the termination.[32]

Limitations on Maltreatment Investigations

Because state law provides few requirements for housing with services establishments, 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 lives in a housing with services establishment experiences maltreatment that results in serious injury or death.

Minnesota's ability to hold housing with services establishments accountable for maltreatment is limited.

Consider an example where an individual with dementia (and who meets the statutory definition of "vulnerable adult") escaped from a secured unit in a housing with services establishment and suffered a serious injury.[33] In this case, the state does not have any regulatory standards on which to evaluate the facility's physical environment to prevent this form of neglect. If this example occurred in a nursing home, however, OHFC could cite a nursing home for violating licensing requirements regarding the facility's physical environment.

Minnesota's current approach to regulating housing with services establishments also causes a jurisdictional "gray area" for the agencies charged with investigating maltreatment allegations. OHFC, DHS, and county social services agencies could all potentially have jurisdiction over maltreatment investigations in housing with services establishments, depending on the allegation, service provider, and the services the resident receives, as Exhibit 5.2 shows.[34]

[31] *Minnesota Statutes* 2017, 144D.04, subd. 1.

[32] A contract with a housing with services establishment is different than a service agreement with a home care provider. If a home care provider terminates its service agreement, the home care provider must provide a notice to the resident.

[33] *Minnesota Statutes* 2017, 626.5572, subd. 21, defines a "vulnerable adult" as a person 18 years of age or older who meets one of the following conditions: (1) is a resident or inpatient of a state-licensed facility, (2) receives services licensed by the state, or (3) has a physical or mental infirmity or dysfunction that impairs the individual's ability to protect one's self from maltreatment.

[34] *Minnesota Statutes* 2017, 626.5572, subd. 13, authorizes MDH and DHS to investigate maltreatment allegations involving the facilities and providers each agency licenses. The law assigns investigative responsibility "for all other reports" to county social services agencies or their designees. As we described in Chapter 3, OHFC has had difficulty determining jurisdiction for some allegations, especially those that involve housing with services establishments.

Exhibit 5.2: The state has limited authority to investigate certain allegations of maltreatment and licensing violations involving housing with services establishments.

Allegation	Nursing Home	Housing with Services Establishment
Scenario 1: A resident complained that there was mold on the ceiling of his room or apartment.	Although this incident does not involve maltreatment, OHFC would have jurisdiction to investigate the alleged licensing violation. OHFC would also have the authority to cite the provider for licensing violations.	Because this incident does not involve maltreatment, neither MDH, DHS, nor county social services agencies would have jurisdiction to investigate this allegation. The resident could, however, report the mold to the building administrator or to the applicable local housing agency.
Scenario 2: A resident fell from a mechanical lift when a nurse aide transferred the resident from her wheelchair to her bed.	OHFC would have jurisdiction to investigate the alleged incident. OHFC would also have the authority to cite the provider for maltreatment and/or licensing violations.	OHFC would only have jurisdiction to investigate the allegation (and take regulatory action, if needed) if the nurse aide was employed by an MDH-licensed provider. Otherwise, DHS or the county social services agency would have jurisdiction to investigate this allegation.
Scenario 3: A resident alleged that a non direct-care employee stole his credit card and proceeded to charge more than $1,000 to the card.	OHFC would have jurisdiction to investigate the alleged incident. OHFC would also have the authority to cite the provider for maltreatment and/or licensing violations.	If the non direct-care staff person was an employee of a state-licensed provider, either MDH or DHS would have jurisdiction to investigate the allegation (and take enforcement action, if needed). If not, county social services agencies would have jurisdiction to investigate this allegation. The resident could also report the incident to law enforcement.
Scenario 4: A resident alleged that the facility discharged her without providing adequate notice.[a]	OHFC would have jurisdiction to investigate the allegation. The resident could also appeal the discharge notice to MDH. OHFC would also have the authority to cite the provider for licensing violations.	Because this incident does not involve maltreatment, neither MDH, DHS, nor county social services agencies would have jurisdiction to investigate this allegation.

NOTES: "DHS" is the Minnesota Department of Human Services. "MDH" is the Minnesota Department of Health. "OHFC" is the Office of Health Facility Complaints.

[a] Federal and state laws require nursing homes to provide notice to the vulnerable adult 30 days before an involuntary discharge or transfer (see 42 *CFR*, sec. 483.15(c)(4) (accessed electronically May 9, 2017); and *Minnesota Statutes* 2017, 144.651, subd. 29). A housing with services establishment, however, may terminate a contract it has with a resident without providing any notice or reason for the termination.

SOURCE: Office of the Legislative Auditor, analysis of *Minnesota Statutes* 2017, 144A.01-144A.1888, Chapter 144D, Chapter 144G, 626.557, and 626.5572.

Because housing with services establishments are not licensed by MDH, OHFC does not have jurisdiction to investigate these facilities or their employees regarding allegations of maltreatment, *unless* the suspected staff person is an employee of an MDH-licensed provider. In other words, OHFC sometimes may not have the authority to investigate maltreatment involving some employees of housing with services establishments. In these cases, county social services agencies would investigate the alleged maltreatment. However, if a report involved alleged maltreatment by a state-licensed service provider in a housing with services establishment, either MDH or DHS would investigate the provider depending on the types of services provided to the resident named in the allegation report.

Dementia Care in Housing with Services Establishments

The gaps in regulatory oversight we described above are even more serious when they involve residents of housing with services establishments who have dementia. In affected individuals, dementia causes difficulties with memory, language, problem solving, and other cognitive skills needed to perform everyday activities. Individuals with dementia may also exhibit wandering and exit-seeking behaviors, as well as physical changes that result in disability. As a result, individuals with dementia may require special care and supervision to maintain their health and safety.

Minnesota law mandates that housing with services establishments that "secure, segregate, or provide a special program or special unit" or that "advertise, market, or otherwise promote the establishment as providing specialized care" for individuals with dementia meet two requirements.[35] First, housing with services establishments with these special units or programs must provide a written disclosure to each person seeking placement within the unit.[36] Second, Minnesota law establishes minimum training requirements for employees of housing with services establishments and those of the facilities' arranged home care providers.[37] In housing with services establishments, direct-care staff and their supervisors are required to complete eight hours of dementia care training at the beginning of their employment.[38] Staff who do not provide direct care, such as maintenance, housekeeping, and food service staff, are required to complete four hours of initial dementia care training.[39]

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[35] *Minnesota Statutes* 2017, 325F.72, subd. 1; and 144D.065.

[36] *Minnesota Statutes* 2017, 325F.72, subd. 1(3). Among other things, the written disclosure must contain explanations of the facility's philosophy, staffing credentials and duties, physical environment and security features, and frequency with which it offers programs and activities. As part of a housing with services establishment's annual registration with MDH, it is required to verify that it has provided the written disclosure to the required individuals. See *Minnesota Statutes* 2017, 325F.72, subd. 2; and 144D.03, subd. 2(5).

[37] According to *Minnesota Statutes* 2017, 144D.065(b), areas of required dementia training include "an explanation of Alzheimer's disease and related disorders; assistance with activities of daily living; problem solving with challenging behaviors; and communication skills."

[38] *Minnesota Statutes* 2017, 144D.065(a)(1)-(2).

[39] *Minnesota Statutes* 2017, 144D.065(a)(3). Minnesota law authorizes MDH to enforce the training requirements through its home care provider inspection process and through the housing with services registration application and renewal process. MDH "may impose a $200 fine for every staff person required to obtain dementia care training who does not have training records to show compliance" (*Minnesota Statutes* 2017, 144D.066, subds. 1 and 2).

Minnesota law provides fewer protections for individuals with dementia that live in housing with services establishments than those that live in nursing homes.

Even with consumer disclosure and training requirements, dementia care units in housing with services establishments are not subject to the same level of regulatory requirements as similar units in nursing homes. For example, Minnesota law provides extensive requirements for the physical structures of nursing homes, including special features designed to restrict residents with dementia from leaving the building unescorted. Secured or locked units in Minnesota nursing homes must be approved by MDH and the state fire marshal prior to beginning operation.[40] Additionally, Minnesota rules specify that a nursing home resident may only be placed in secured units when the resident's assessment indicates "that the resident requires a more secure environment" and the resident's physician provides a written order.[41]

Minnesota law, however, does not provide such protections for residents living in secured dementia care units in housing with services establishments. While these units can have features designed to restrict residents from leaving the building unescorted, the state does not have the authority to approve the secured unit or verify that the residents living in the unit require a secure environment.

Similarly, state and federal law offer different requirements regarding staffing and disclosure of staffing levels for nursing homes and housing with services establishments. Minnesota nursing homes are required to have certain numbers and types of nursing personnel working at all times, regardless of the diagnoses of the residents. In general, nursing homes must have sufficient nursing personnel on duty to provide at least two hours of care per resident per day.[42] Additionally, Minnesota law mandates that nursing homes have a registered nurse on duty eight hours per day, seven days per week, and "on call during all hours when a registered nurse is not on duty."[43] Federal law requires federally certified nursing homes to post their staffing levels.[44]

In contrast, Minnesota law does not specify the number of staff that housing with services establishments—including dementia care units—must have on duty at a given time. Additionally, housing with services establishments are not required to post their staffing levels. According to the state's Office of Ombudsman for Long-Term Care, many providers that deliver care in housing with services establishments "utilize on-call nursing services [in] evenings and [on] weekends," and some "may not have a full-time nurse on staff during regular business hours."[45]

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[40] *Minnesota Rules*, 4658.2000, subps. 4 and 5, published electronically October 11, 2007.

[41] *Minnesota Rules*, 4658.2000, subp. 3, published electronically October 11, 2007.

[42] *Minnesota Statutes* 2017, 144A.04, subd. 7; and *Minnesota Rules*, 4658.0510, subp. 2, published electronically October 11, 2007. State-licensed nursing homes that are not federally certified must provide a minimum of two hours of nursing personnel per resident per day. Federally certified nursing homes must provide the greater of two hours of nursing personnel per resident per day or 0.95 hours per "standardized resident day," a complex calculation defined in *Minnesota Statutes* 2017, 144A.04, subd. 7.

[43] *Minnesota Rules*, 4658.0510, subps. 3 and 4, published electronically October 11, 2007.

[44] 42 *CFR*, sec. 483.35 (accessed electronically May 9, 2017).

[45] Office of Ombudsman for Long-Term Care, *Annual Report 2016* (St. Paul, 2016), 31.

A recent policy study found that states provide varying degrees of oversight of dementia care units in assisted living facilities.[46] Compared to Minnesota, some states provide more regulatory oversight of dementia care units. For example, in 2014, 16 states licensed dementia care units; Minnesota does not license dementia care units or assisted living facilities. In that same year, 14 states required pre-admission screenings to determine whether prospective residents would benefit from dementia care services. Additionally, 29 states required dementia care units in assisted living facilities to have specific building design features, such as delayed locking systems that prevent doors from opening in nonemergency situations. Minnesota does not have comparable requirements. On the other hand, Minnesota and 32 other states required assisted living facilities to disclose their dementia-specific services.

Legislative Work Group

Minnesota's Vulnerable Adults Act declares that "the public policy of this state is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment."[47] However, the state's limited oversight of housing with services establishments may inhibit the state from fully achieving this goal.

RECOMMENDATION

The Legislature should establish a work group to examine the state's oversight of senior care providers and housing facilities.

As we described above, regulatory protections for vulnerable adults vary based on the type of facility the individual lives in, not on the individual's vulnerability. This is due largely to how Minnesota licenses or registers senior care providers and housing facilities. Given Minnesota's current regulatory patchwork, we think the Legislature should holistically examine the state's approach to licensing and registering senior care providers and housing facilities.

We believe the Legislature should establish a work group to review and improve the state's licensing requirements for senior care providers and housing facilities. Among other things, we think the legislative work group should:

- Gather input from the public, providers, ombudspersons, MDH, and other state agencies about the impact of Minnesota's current approach to licensure.
- Evaluate whether the state's licensure framework supports state policy priorities and adequately protects vulnerable adults.
- Decide whether or how Minnesota's licensure laws should be modified to better achieve the state's goals. For example, the Legislature could consider whether to require housing with services establishments to be licensed (rather than registered) by the state. We encourage the Legislature to thoroughly examine the input it

[46] Paula C. Carder, "State Regulatory Approaches for Dementia Care in Residential Care and Assisted Living," *The Gerontologist* 57, no. 4 (2017): 776-786.

[47] *Minnesota Statutes* 2017, 626.557, subd. 1.

receives from the public, providers, ombudspersons, MDH, and state agencies when considering such decisions.[48]

Other Prevention Options

Preventing the maltreatment of vulnerable adults is complex and will likely involve more than improving OHFC's internal operations, sharing trend information with MDH-licensed providers, and evaluating the regulatory protections available for vulnerable adults living in or receiving care from certain facilities or providers.

Because the focus of this evaluation was on the operations of OHFC—not the effectiveness of maltreatment prevention strategies—we cannot offer recommendations regarding what other steps the state should take to address this pressing issue. However, we encourage the Legislature, MDH, and other state agencies to develop a focused effort for preventing the maltreatment of older adults. Among other options, the state could:

- **Address workforce challenges.** In 2016, the Legislative Health Care Workforce Commission identified several workforce challenges facing the state's long-term care industry.[49] We encourage the Legislature to continue to evaluate and address workforce shortage, recruitment, and retention issues.

- **Develop an older adult maltreatment prevention plan.** The Legislature, MDH, or another state agency could develop a maltreatment prevention plan specific to older adults.[50] The plan could include measurable goals, as well as timelines and strategies for meeting the goals. Older adults and members of their families, provider representatives, state agency representatives, the state's ombudspersons, legislators, and others, should be involved in developing a state maltreatment prevention plan for older adults.

- **Evaluate information available to consumers.** The Legislature could evaluate the resources the state provides for those looking for senior care providers and housing facilities, such as information available to consumers through the Board on Aging's website and through the Senior LinkAge Line service.[51] Additionally, the

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[48] A group composed of representatives from five consumer organizations recommended in early 2018 that the Legislature develop a new licensure framework for assisted living and dementia care (see Elder Abuse Consumer Workgroup, *Addressing Elder Abuse in Minnesota Long-Term Care Settings: Public Policy Actions Necessary to Prevent and Deter Abuse* (January 28, 2018), https://18672-presscdn-pagely.netdna-ssl.com/wp-content/uploads/2018/01/Elder-Abuse-Report-Final.pdf, accessed February 16, 2017). We encourage the legislative work group to also seek input from the industry, MDH, and ombudspersons when considering this recommendation and others.

[49] Legislative Health Care Workforce Commission, *Final Report on Strengthening Minnesota's Health Care Workforce* (St. Paul, 2016).

[50] Through its Olmstead Plan, Minnesota has defined maltreatment prevention goals and strategies regarding adults with disabilities (see Olmstead Subcabinet, *Putting the Promise of Olmstead into Practice: Minnesota's Olmstead Plan* (St. Paul, 2017), 95-100). However, we have not seen a similar focus on the prevention of older adult maltreatment.

[51] The Minnesota Board on Aging consists of 25 members who are appointed by the governor. Among other things, the board administers federal funding from the Older Americans Act to fund programs that support older adults. The state's Senior LinkAge Line service provides free phone-based advice to older adults regarding insurance options and housing choices, among other things.

Legislature could consider whether the state should develop an "assisted living report card" similar to the Minnesota's Nursing Home Report Card.[52]

- **Establish advisory groups.** Efforts to investigate, prevent, and treat maltreatment require the knowledge, skill, and collaboration of a variety of professionals, such as health care professionals, social workers, financial experts, psychologists, lawyers, and police. The Legislature, MDH, or another state agency could consider establishing an ongoing advisory group consisting of a range of stakeholders to provide continuing feedback to those working on this issue.

- **Implement prevention initiatives.** According to the CDC, few older adult maltreatment prevention strategies have been rigorously analyzed to determine their effectiveness.[53] However, the federal government and academic researchers are currently funding, implementing, and evaluating several prevention strategies. MDH could monitor these ongoing studies with the goal of implementing prevention initiatives that meet the needs of Minnesota's communities.

[52] The Nursing Home Report Card shows how Minnesota nursing homes scored on eight quality measures, including resident quality of life, state inspection results, and family satisfaction. It can be accessed at: http://nhreportcard.dhs.mn.gov.

[53] Centers for Disease Control and Prevention, *Elder Abuse: Prevention Strategies* (Atlanta: National Center for Injury Prevention and Control, Division of Violence Prevention, 2017), https://www.cdc.gov /violenceprevention/elderabuse/prevention.html, accessed November 27, 2017.

List of Recommendations

- The Office of Health Facility Complaints (OHFC) should implement an electronic case management system. (p. 12)
- OHFC should revise its training program to better prepare staff to perform their duties. (p. 16)
- OHFC should develop written policies regarding the work staff conduct and communicate them in a consistent manner. (p. 18)
- The Minnesota Department of Health Commissioner's Office should play a stronger role overseeing OHFC. (p. 21)
- OHFC should provide a decision-making tool for providers to help them make appropriate reporting decisions. (p. 30)
- OHFC should incorporate quality control measures into its intake and triage processes. (p. 33)
- OHFC should improve its processes for verifying jurisdiction. (p. 34)
- OHFC should regularly perform audits to ensure that investigators conduct and document investigations in a consistent and thorough manner. (p. 41)
- The Legislature should review the state's options for enforcement actions for nursing homes, home care providers, and other long-term care providers. (p. 49)
- OHFC should cite providers for licensing violations uncovered through the appeal process. (p. 53)
- OHFC should meet state and federal requirements for triage and investigation deadlines. (p. 62)
- The Legislature should require OHFC to regularly report on its progress in meeting state and federal requirements. (p. 62)
- The Legislature should amend *Minnesota Statutes* 2017, 626.557, subd. 5(d), to allow OHFC to inform a vulnerable adult and his or her legal representative when a provider has filed a report that involves the vulnerable adult. (p. 65)
- OHFC should ensure that investigators send letters notifying vulnerable adults and providers of investigation delays, as required by law. (p. 67)
- OHFC should provide complete and timely information about its findings to all parties involved in the investigation. (p. 69)
- OHFC should notify the parties required in law of their appeal rights. (p. 70)
- OHFC should provide clear information about appeal options on its website. (p. 70)

- The Legislature should require OHFC to post all of its recent investigation reports on its website. (p. 72)
- OHFC should improve the search functions for investigation reports on its website. (p. 72)
- OHFC should develop guidance for its staff that defines the fields in its database, identifies what data staff should enter into its database, and indicates how staff should record information. (p. 76)
- OHFC should collect data that will allow for rigorous trend analysis. (p. 76)
- MDH should analyze the data OHFC collects to identify trends and share its findings with providers and other stakeholders. (p. 77)
- The Legislature should establish a work group to examine the state's oversight of senior care providers and housing facilities. (p. 88)

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.

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.

Boarding care home: A facility licensed by the Minnesota Department of Health that is similar to a nursing home and that provides personal or custodial care for aged or infirm persons. See *Minnesota Rules*, Chapter 4655.

Centers for Medicare and Medicaid Services (CMS): A federal agency within the U.S. Department of Health and Human Services that administers the federal Medicare and Medicaid programs.

Federally certified provider: A provider certified to participate in the federal Medicare or Medicaid programs. About three-quarters of the allegation reports that the Office of Health Facility Complaints received in Fiscal Year 2017 involved federally certified providers. See *Minnesota Statutes* 2017, 144A.01, subd. 3a.

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.

Health Regulation Division: A division within the Minnesota Department of Health that licenses and enforces regulations for most health care facilities and some health care professions in Minnesota. The Office of Health Facility Complaints is part of the Health Regulation Division.

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.

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.

Investigation 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.

Jurisdiction: The authority of a lead investigative agency to investigate an allegation report.

Lead investigative agency: The agency with jurisdiction to investigate an allegation report submitted under the Vulnerable Adults Act. The Minnesota Department of Health, the Department of Human Services, and county social service agencies are lead investigative agencies under the act. See *Minnesota Statutes* 2017, 626.5572, subd. 13.

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.

Maltreatment Review Panel: A panel established in state law to review appeals of maltreatment investigation determinations made by the Minnesota Department of Health and other lead investigative agencies, at the request of a vulnerable adult or a vulnerable adult's representative. See *Minnesota Statutes* 2017, 256.021.

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.

Nursing Home Incident Reporting System: A portal on the Office of Health Facility Complaints' website through which federally certified nursing homes report suspected maltreatment. Most other types of providers, as well as individuals, report suspected maltreatment through the Minnesota Adult Abuse Reporting Center.

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.

Office of Ombudsman for Mental Health and Developmental Disabilities: A state office that advocates for individuals receiving services or treatment for mental illness, developmental disabilities, chemical dependency, or emotional disturbance. See *Minnesota Statutes* 2017, 245.91-245.97.

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.

Request for Reconsideration: An appeal made by a party (such as a vulnerable adult, a representative of a vulnerable adult, an alleged perpetrator, or a provider) to the Office of Health Facility Complaints (OHFC), requesting that OHFC reconsider its investigation determination. Such a request must be made within 15 days of the investigation determination. See *Minnesota Statutes* 2017, 626.557, subd. 9d.

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.

Supervised living facility: A Minnesota Department of Health-licensed residential facility for four or more individuals with developmental disabilities that offer meals, housekeeping, and health services. See *Minnesota Statutes* 2017, 144.50, subd. 6.

Triage decision: The Office of Health Facility Complaints' decision whether to investigate an allegation report. State law refers to this decision as the "initial disposition." *Minnesota Statutes* 2017, 626.5572, subd. 12.

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.

Appendix A

Health Care Providers Licensed or Registered by the Minnesota Department of Health

Provider Type	Licensed or Registered by State	Federally Certified[a]	Number, as of March 2017	Number of Beds, as of March 2017	Description
Nursing Homes	Licensed	Yes	372	28,647	Facilities that provide nursing care to five or more persons, including those who require nursing supervision on an inpatient basis.
Hospitals[b]	Licensed	Yes	144	16,587	Institutions primarily engaged in providing medical services by or under the supervision of physicians.
Supervised Living Facilities	Licensed	Yes	282	4,801	Facilities that provide a residential, homelike setting for persons who are intellectually disabled, mentally ill, chemically dependent, or physically handicapped. Services include provision of meals, housekeeping services, and health services.
Boarding Care Homes	Licensed	Yes	24	1,494	Facilities that provide personal or custodial care, such as help with bathing or dressing, or supervision of medications that can be safely self-administered.
Housing with Services Establishments	Registered	No	1,559	54,125[c]	Facilities that provide sleeping accommodations to one or more adult residents, at least 80 percent of whom are at least 55 years of age, and offering or providing for a fee certain services. Assisted living facilities are considered housing with services establishments.
Home Care Providers	Licensed	Yes	1,310	N/A	Providers regularly engaged in the delivery of at least one home care service directly in a client's home for a fee. Home health agencies are a type of home care provider.

NOTES: The appendix does not include all providers the Minnesota Department of Health (MDH) licenses; however, the majority of the Office of Health Facilities Complaints' investigations involve the provider types listed above. MDH also licenses board and lodging facilities with special services. Hospice providers are licensed by MDH and may be federally certified. Other federally certified providers include those providing outpatient occupational, physical, or speech therapy; portable x-ray facilities; and comprehensive outpatient rehabilitation facilities, among others.

[a] Provider types with a "Yes" in this column may be federally certified, which qualifies them to receive Medicare or Medicaid funding.

[b] In this appendix, "Hospitals" includes hospitals, psychiatric hospitals, and other specialized hospitals.

[c] This represents the number of beds as of May 2017 in 1,206 assisted living facilities (which are a type of housing with services establishment).

SOURCE: Minnesota Department of Health, 2017 Directory: Licensed, Certified and Registered Health Care Facilities and Services, March 15, 2017.


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Appendix B

Agencies with Jurisdiction to Investigate Maltreatment Allegations

Lead Investigative Agency	Guiding Jurisdiction Principles	Example Providers
Minnesota Department of Health (MDH)	Has jurisdiction for all maltreatment allegations involving: • A vulnerable adult who receives services licensed or required to be licensed by MDH. • An alleged perpetrator who was the service provider, an employee of the service provider, another resident, or another service recipient.	• Boarding care homes • Home care providers • Hospice providers • Hospitals • Nursing homes
Minnesota Department of Human Services (DHS)	Has jurisdiction for all maltreatment allegations involving: • A vulnerable adult who receives services licensed or required to be licensed by DHS. • An alleged perpetrator who was the service provider, an employee of the service provider, another resident, or another service recipient.	• Adult day care • Adult foster care • Home- and community-based services • Mental health programs
County Social Services	Has jurisdiction for all maltreatment allegations involving a vulnerable adult in that agency's county, and the alleged perpetrator was not a provider or employee of a facility or service provider licensed by MDH or DHS.	• Crisis response service • Family caregiver • Halfway house • Homeless shelter • Personal care attendants

SOURCES: *Minnesota Statutes* 2017, 626.5572, subd. 13; "MAARC Procedure Manual" (policy, Minnesota Adult Abuse Reporting Center, Minnesota Department of Human Services, St. Paul, October 25, 2016); and "Vulnerable Adult Lead Investigative Agency Determination Chart" (policy, Minnesota Adult Abuse Reporting Center, Minnesota Department of Human Services, St. Paul, November 21, 2016).


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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

March 1, 2018

James Nobles, Auditor
Minnesota Office of Legislative Auditor
Room 140 Centennial Building
658 Cedar Street
St. Paul, MN 55155-1603

Dear Auditor Nobles:

Thank you for the opportunity to review the Office of Legislative Auditor's evaluation report on the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health. In recent years, OHFC has not met Minnesotans' reasonable expectations for investigating maltreatment complaints in a timely way. Improving the performance of this office is a top priority and we are committed to rebuilding trust with victims, families and the people of Minnesota.

Your evaluation raises a number of serious and important issues, and we are thankful for the diligent work of your team. We understand that due to the evaluation timeline, certain findings and recommendations reflect the state of OHFC operations that existed in early December 2017. We are pleased to report that we have begun to make urgently needed progress on many of the issues raised by the evaluation. We are committed to working aggressively to continue addressing process and system failures through an Interagency Partnership with the Minnesota Department of Human Services (DHS) that began on December 19. Through this partnership, and in collaboration with Governor Dayton, state legislators, care providers and family members, we have started making the changes necessary for OHFC to help prevent vulnerable adult abuse and neglect, respond to abuse complaints in a timely manner, and ultimately, hold accountable those responsible for their failures in care and protection.

As you know, the Interagency Partnership provides a framework for a Core Team of DHS Continuous Improvement and Office of Inspector General staff to work closely with MDH staff on process and system improvement services to help MDH identify and eliminate the backlog of cases at various stages of our vulnerable adult complaint investigations. At the beginning of this work, there were 2,321 complaint reports awaiting triage and 826 open investigations, for a combined total backlog of 3,147 complaints.

As of February 28th, our team had reviewed all 2,321 of the complaints in the triage backlog. Of that total, 2,232 were assessed and closed, 89 were recommended for onsite investigation. The open investigation backlog of 826 cases was from the period of January 1, 2016, through December 31, 2017. As of February 25, 2018, 396 of these investigations were completed and 430 investigations were pending at various stages.

We still have more work to do to complete the remaining cases, further improve our processes, and provide the timely and thorough investigations for all vulnerable adults in Minnesota. We are deeply committed to this work, and we will not rest until every Minnesota family gets the highest level of service and care.

While much progress is being made through the Interagency Partnership with DHS, there are several recommendations in your evaluation that will require more detailed discussions and decisions by the Minnesota Legislature, as they involve steps that will go beyond the current law requirements regarding protections of vulnerable adults.

RESPONSES TO KEY RECOMMENDATIONS BY THE OFFICE OF THE LEGISLATIVE AUDITOR

1. *OHFC should implement an electronic case management system (Chapter 2)*

We agree the OHFC program and affiliated licensing and survey operations at MDH require a new case management system to replace the existing, antiquated PARADISE system that was first developed in the late 1990s. We are in the process of pricing and evaluating options for doing so, including but not limited to, an assessment of the DHS SSIS case management system. We intend to consult extensively with legislative decision-makers to evaluate all options and select a new electronic case management system. The cost and timeline to fully implement such a new system requires careful planning and transparent decision-making, thus we intend to issue a Request for Information (RFI) on a new case management system in early April 2018.

2. *OHFC should revise its training program to better prepare staff to perform their duties (Chapter 2)*

We agree with this recommendation and we are working to improve training processes as part of the Interagency Partnership. Some of the areas that we have addressed and put in place include new decision tools for the Intake and Triage staff. We have developed work aides for the OHFC staff that will help to standardize work. We are doing SharePoint training to assist with new workflow and we are currently developing investigator training to ensure consistent processes are followed.

3. *OHFC should develop written policies regarding the work staff conduct and communicate them in a consistent manner. (Chapter 2)*

The evaluation report states that OHFC did not publish a policies and procedures manuals. This is true. As part of our work through the Interagency Partnership, we are developing employee training and process guidance and work tools that give OHFC employees clear work flow procedures to follow to maximize efficiency.

The evaluation report states "[OHFC] has made a gradual transition to investigating only those allegation reports that allege serious harm." This statement is no longer factual and does not reflect the improved jurisdictional determinations, triage processes, and investigation systems implemented through the Interagency Partnership.

4. <u>The MDH Commissioner's Office should play a stronger role overseeing OHFC (Chapter 2)</u>

We agree with the recommendation for increased involvement by the MDH Commissioner in OHFC. Beginning in December, the MDH Commissioner convened an incident command structure (ICS) on OHFC that is still operational. We have had a committed and sincere effort by the highest levels of DHS leadership on the Interagency Partnership. The MDH Commissioner's executive office staff continue to provide direct leadership to ensure success in the improvement process, better management and a culture of respect in this program. We identified and empowered a talented leader within the OFHC workforce to provide day-to-day leadership.

The OHFC staff hiring plan identified by the OLA is outdated as of January 2018 and does not reflect the identified prioritization of the Interagency Partnership. As our project moved forward, we determined it was more valuable to implement new and improved workflow and processes and an electronic document management system. This is essential to creating a stable work environment that increases our employee retention rate. At a later stage, we will revisit OHFC hiring needs and capacity in the context of new systems.

We believe the high rate of staff turnover identified by the OLA evaluation was reflective of low morale and the challenges new employees were confronted with upon starting work in OHFC. The Interagency Partnership work requires examining every aspect of OHFC's operations and work, down to the physical space and layout of employees' desks, all to maximize efficiency of operations and improve timeliness of triage and investigations. We are working hard to improve morale and all the tools being provided to staff are helping with this goal. It is encouraging to note that on multiple occasions we have heard unsolicited comments from OHFC supervisors and staff about how deeply they care about the work and how committed they are to helping improve the processes. We are confident in the character of those doing this work and optimistic that the changes we have made, and continue to make, will directly address the issues your report raised.

5. *OHFC should provide a decision-making tool for providers to help them make appropriate reporting decisions (Chapter 3)*

We are currently looking at ways to provide additional guidance to providers so that they have resources available to them to efficiently and accurately submit a self-reported complaint.

6. *OHFC should incorporate quality control measures into its intake and triage processes; OHFC should improve its processes for verifying jurisdiction (Chapter 3)*

MDH is now properly assigning priority status with regard to triage (2-day or 10-day) thanks to the process improvements of our Interagency Partnership. The 2 or 10-day standard is a federal triage requirement. The Legislature may want to consider changes to state triage timelines. MDH now uses decision tools to help intake and triage teams better assign cases.

The evaluation report discusses SSIS access as a key component of helping OHFC determine proper jurisdiction of complaints/lead agency status. DHS uses SSIS to help determine jurisdiction, and thanks to the work of our Interagency Partnership, OHFC now has access to this part of SSIS and staff are currently being trained on its use.

7. *OHFC should regularly perform audits to ensure that investigators conduct and document investigations in a consistent and thorough manner (Chapter 3)*

MDH agrees with this recommendation and will incorporate into our systems changes. Audits will be put into place through the work of the Interagency Partnership to ensure investigations are conducted and documented in a consistent manner throughout all investigators and investigation types.

8. *The Legislature should review the state's options for enforcement actions for nursing homes, home care providers, and other long-term care providers (Chapter 3)*

MDH agrees with this recommendation.

9. *OHFC should cite providers for licensing violations uncovered through the appeal process (Chapter 3)*

MDH agrees with this recommendation. The process for this change has already been put into place, and citations will now be issued for violations uncovered through the appeal process.

10. *OHFC should meet state and federal requirements for triage and investigation deadlines. The Legislature should require OHFC to regularly report on its progress in meeting state and federal requirements (Chapter 4)*

Your report found that OHFC frequently failed to meet required triage and investigation deadlines. We agree with this finding, but would seek legislative clarification on certain details of that timeline. For instance, the statute is clear that we need to complete the investigation within 60 days but it also allows OHFC to have another 60 days to complete the investigation as long as the need for an extension is communicated to the complainant. It would be helpful for the Legislature to provide additional clarification on expectations around the 60-day deadline.

11. *The Legislature should amend Minnesota Statutes 626.557, subd. 5(d), to allow OHFC to inform a vulnerable adult and his or her legal representatives when a provider has filed a report that involves the vulnerable adult (Chapter 4)*

MDH agrees with this recommendation.

12. *OHFC should ensure that investigators send letters notifying vulnerable adults and providers of investigation delays, as required by law (Chapter 4)*

MDH agrees with this recommendation and is improving communication to complainants in the process and system improvements underway. OHFC is working towards becoming consistent and timely with sending letters to notify of investigation delays, however the goal is to have investigations completed within the statutory timeline.

13. *OHFC should provide complete and timely information about its findings to all parties involved in the investigation (Chapter 4)*

MDH agrees with this recommendation. As part of the Interagency Partnership work, OHFC is developing a more streamlined investigation process that includes required policies/procedures which will be shared with investigators as part of their training. Investigations will be conducted and completed on time, ensuring that all parties involved are notified in a timely manner.

14. *OHFC should notify the parties required in law of their appeal rights. OHFC should provide clear information about appeal options on its website (Chapter 4)*

MDH agrees with this recommendation. The report calls for process changes to the request for reassessment ("R for R") process. MDH has changed this process to have all such requests go through the MDH Legal Unit to ensure timely review by staff trained in appellate processes.

15. *The Legislature should require OHFC to post all of its recent investigations on its website. OFHC should improve the search functions for investigation reports on its website (Chapter 4)*

While MDH agrees with the evaluation's recommendation that OHFC website improvements are needed, such technology improvements have not been funded by the Legislature and such

changes are not contemplated or funded in the Interagency Partnership. The kind of improvements contemplated for the OHFC website require more extensive fiscal resources and technology staff than currently exist. MDH will work with the Governor's Office and the Legislature on the question of funding for an improved website for this program.

16. *OHFC should develop guidance for its staff that defines the fields in its database, identifies what data staff should enter into its database, and indicates how staff should record information. OHFC should collect data that will allow for rigorous trend analyses. MDH should analyze the data OHFC collects to identify trends and share its findings with providers and other stakeholders (Chapter 5)*

We recognize the value and strongly agree with the evaluation's finding regarding better use of complaint and investigation data for prevention. However, broad changes are neither contemplated nor funded in the Interagency Partnership. MDH has hired a new data analyst and this employee is incorporated into the improvement process, and is working to capture data in a way that providers, advocates and others can use to help develop and implement effective prevention strategies. We will immediately begin to develop a comprehensive prevention plan, in consultation with consumers and providers, using your report's recommendations as a starting point. MDH will work the Governor's Office and the Legislature on the question of funding and statutory authority for increased trends analysis and changes in access to data for prevention.

17. *The Legislature should establish a work group to examine the state's oversight of senior care providers and housing facilities (Chapter 5).*

MDH agrees with this recommendation. The report rightly points out gaps in the regulatory structure for facilities and providers serving elders and vulnerable adults. It is unacceptably difficult for persons served, families, and providers to know what is regulated, under what rules and by which agencies, or whether there are actually no regulations for specific settings or services. The Governor's Consumer Workgroup has made several relevant recommendations that should be considered. A legislative work group could appropriately make further recommendations on this topic. Such a step would require legislative approval and direction. Current laws on vulnerable adults in Minnesota are confusing, complex and frustrating to the public, and a legislative work group may help address needed reforms for these issues.

We are pleased with the early progress of the Interagency Partnership even as we recognize that extensive work remains. Protecting vulnerable adults from abuse and neglect is a goal we can reach if both care providers and government policymakers and regulators take appropriate actions. We are fully committed to continuing this vital work, and we thank you for the thorough evaluation and clear recommendations you provided.

Sincerely,

Jan K. Malcolm
Commissioner


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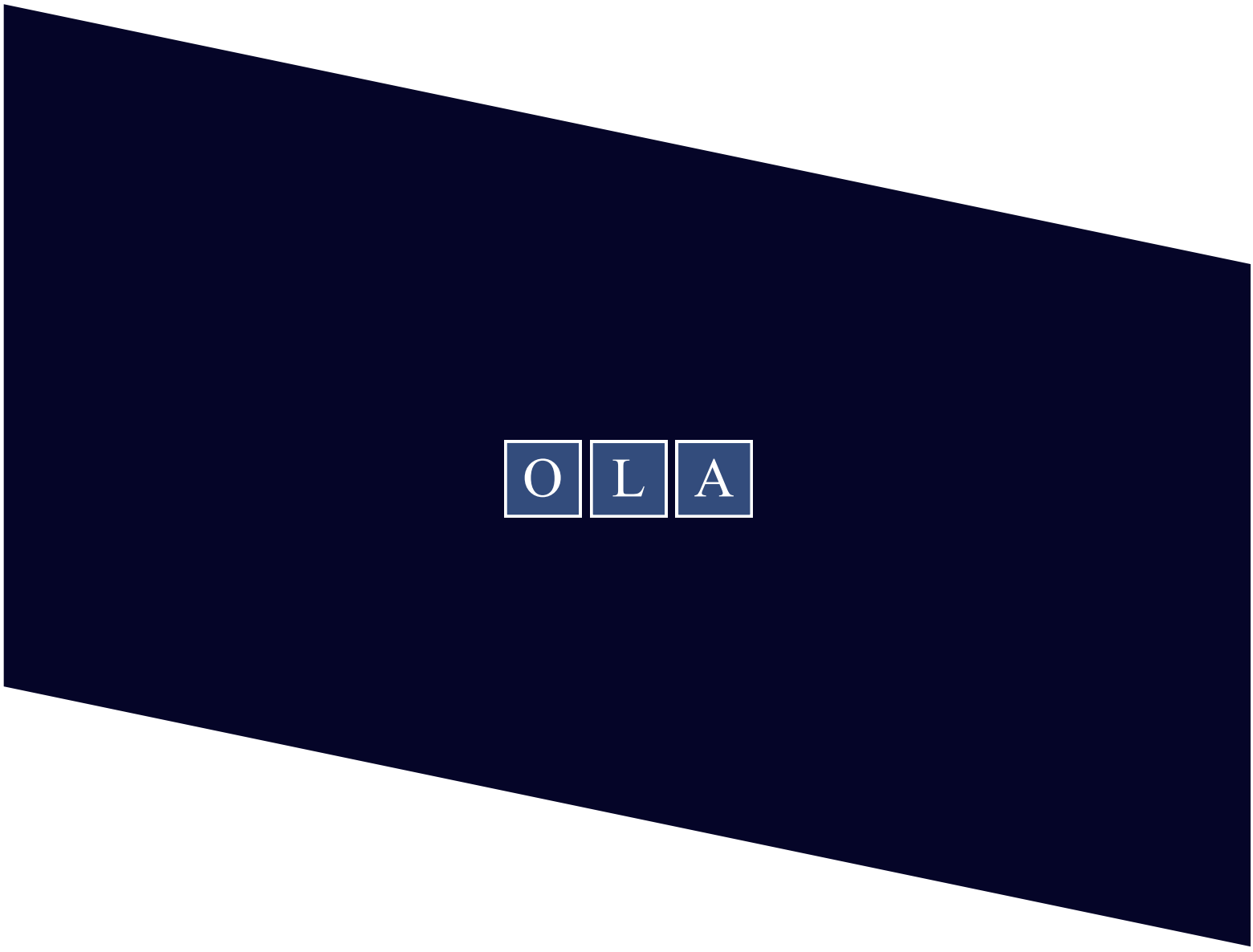

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