elder voice
FAMILY ADVOCATES

Date: 1/11/2021

To: Administrative Law Judge Ann C. O'Reilly

From: Elder Voice Family Advocates

Kristine Sundberg, Executive Director

Jean Peters, President, RN

Suzanne Scheller, Legal Advisor

Eilon Caspi, PhD, Gerontology and Dementia Advisor

Regarding: Comments on MN Department of Health Assisted Living Proposed Rules – Rule 4659; Minnesota Revisor ID: R-4605

Elder Voice Family Advocates (Elder Voice) appreciates this opportunity to comment on the assisted living licensure rules related to Minn. Stat. 144G.08-.9999. Our perspective is based on the actual experience of residents and family members, an elder law attorney with extensive experience in elder neglect, abuse and exploitation in long-term care; an internationally known gerontology and dementia PhD; several RN's with forensic and assisted living expertise; and numerous members donating their analytic skills to research and document the investigations of the Office of Health Facilities Complaints and research of professional literature for analysis of elder care issues in long-term care.

Many members have submitted their comments independently, but some members asked that we include their comments with this Elder Voice filing. Also included in this submission is additional information providing context for our comments and concerns. We are also attaching the April 2018 data search of Office of Health Facilities Complaints related to long-term care and the April 2019 '***Review of Substantiated Maltreatment Investigations of Minnesota Assisted Living Facilities***,' which analyzes the causes of the neglect documented in these investigations, highlighting how they relate to general categories in these proposed rules.

Assisted Living Rules of Priority Interest

Our experience and research identifies key areas of care failures that result in injuries, abusive trauma, medical errors, decline in health and death. The areas addressed in these rules include:

- **Staffing** - under staffing, poor staff management, evening and weekend under staffing, weak RN oversight of care, gaps in training for temporary staff, a culture of indifference to the needs of the residents, and much more.
- **Training** - no training, poor training, unlicensed staff performing cares beyond their preparation, etc.
- **Initial assessment and continuing assessments** – some are never done before admittance of the resident nor upon a change of condition. Without this assessment by an RN, there can be no adequate care plan to assure residents get the services required.
- **Lack of a uniform assessment tool** - leads to inconsistency between facilities and failure by many facilities to adopt an effective assessment tool.

Elder Voice Member Experiences

Elder Voice was organized in 2017 because our members had loved ones suffer preventable neglect and abuse that resulted in traumatic injury and even death. Many of our members have had loved ones suffer long, painful deaths or had limbs amputated because of untreated infections, ignored emergency conditions, or the failure to give basic care. Additionally, many are malnourished because they are not being fed enough nutritious food or given the necessary assistance to eat.

Others report sexual assaults by other residents and sometimes even by staff. There are also many instances of broken bones, bruises, festering sores, and abrasions that are the result of physical abuse, mishandling or neglect. In other cases, residents have been left for many hours without being moved, fed, given water or kept clean. Cruel treatment is often reported such as hitting, insulting, belittling, scaring and other humiliations.

Elder Voice Professional Expert Input

Our Legal Advisor, Suzanne Scheller, has given detailed suggestions for language changes that address the many issues reported by the residents and their families. Additionally, Eilon Caspi, PhD and Elder Voice Gerontology and Dementia Advisor, has researched this area extensively. Their insights offer expert input and suggestions that we hope you seriously consider as you review these rules.

RN expertise is provided by Jean Peters, RN/CNP and president of Elder Voice and Nancy Haugen, RN, MS, PHN and MS in Mental Health Nursing. Their professional expertise provides input into appropriate nurse roles and responsibilities and standards of care that provide safe and effective care.

Trends in Assisted Living

Assisted living facilities are the fastest growing residential care option for elders in the U.S. and "dementia care" is the fastest-growing segment of assisted living. A substantial portion (7 out of 10) of the residents living in these facilities have serious cognitive disabilities, which are considered a risk factor for experiencing various forms of maltreatment. [Sources: 1. Zimmerman et al. 2014; 2. Gruber-Baldini et al. 2004]

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

The following is the basic profile of residents in assisted living facilities in Minnesota, based

on a survey conducted between August 2016 and February 2017:

Assisted Living Resident Characteristic %

72% -- Female 72.4%

51% -- Age 85 and over

20.4% -- Medicaid (some or all services paid by Medicaid in last 30 days):

15.1 % -- Diagnosed with Diabetes

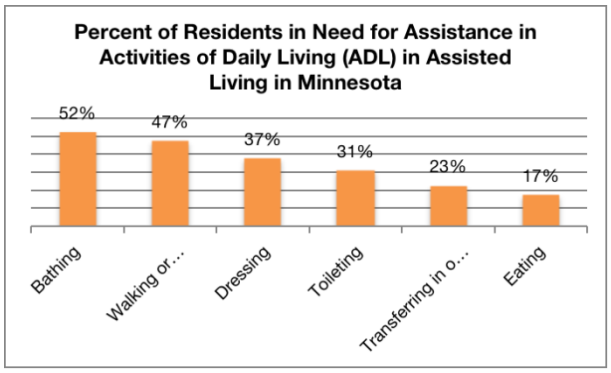
33.2% -- Diagnosed with Dementia

25% -- Diagnosed with Depression

24.2% -- Diagnosed with Heart Disease

9.7% -- E.R. Visit in the last 90 days

It is also important to be aware that many residents of assisted living need assistance for daily living activities as the following chart demonstrates.



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

2018 Elder Voice Long-term Care Research

Elder Voice has completed two research projects analyzing the Office of Health Facilities Complaints (OHFC) investigations. The 2018 data research reviews the period of November 2014 – April 2018 and includes all long-term care facilities. This public data is posted to the MDH website and represents the resolved complaints of the facilities that had an onsite investigation (only approximately five percent of all reported incidents reported to OHFC are given an onsite investigation). It should be noted that per the 2018 Office of the Legislative Auditor (OLA) OHFC report, that MDH may be missing up to 19 percent of the reports that should be posted.

https://www.auditor.leg.state.mn.us/ped/2018/ohfcsum.htm

https://www.auditor.leg.state.mn.us/ped/updates/2019/ohfc.pdf

A total of 1733 reports were sifted through with the intent of determining the number of OHFC investigated incident reports that could be positively affected through assisted living licensure and proposed rules.

Proposed rule category that was an area of concern in the 2014-2018 OHFC Investigations:

1.Staffing 4659.0180	85% (1508)
2.Training Requirements 4659.0190	70% (1251)
3.Initial Assessment & Continuing Assessments 4659.0140	23% (422)

4.Uniform Assessment Tool 4659.0150 23% (412)

This clearly demonstrates that areas of serious concern are staffing and training. Of significant concern are the failures regarding assessment of condition of the resident nor a uniform assessment tool, both of which would significantly improve safety and care.

2019 Elder Voice Assisted Living Research

We have attached an Elder Voice research report from April 2019 which was conducted by Dr. Caspi titled, ***Review of Substantiated Maltreatment Investigations in Minnesota Assisted Living Facilities,*** April 22, 2019. Please refer to it for the detailed discussion of the research.

This research of substantiated neglect investigations found the main factors that impacted poor care include, in part:

- Dangerously low staffing levels.
- Lack of basic nursing assessment or recognition of warning signs and timely intervention.
- Lack of or inadequate individualized care plans / service plans.
- Lack of adequate supervision of residents, especially those with dementia.
- "Secured" Memory Care Unit not being secured.
- Inadequate or lack of supervision of direct care staff.
- Communication breakdowns within care teams.
- Operating beyond scope of practice and staff skills/training.
- Preventable health decline followed by a move of resident to a higher level of care (skilled nursing home or hospice).
- Thirty-seven of the 128 substantiated neglect cases (29%) contributed to or directly caused the death of a resident.

Investigation Case Examples of Neglect of Care

The following are a few cases from Dr. Caspi's research that highlight what happens when there is under staffing, poor training, inadequate assessments, and no uniform assessment tool.

1. Wellness Checks required in Service Plan > Not provided > Several residents found injured and `dead many hours / two or more days later

2. Resident with dementia > Falls at night > Used pendant at 1:55am to call for help get off floor > Left unanswered for six hours > Found on floor by day staff at 8am - Arm fracture
3. Lack of or inadequate fall-risk assessment / prevention > Injurious falls (e.g. hip fracture) with no post-fall assessment
4. Unsafe manual & mechanical lift transfers & use of BRODA chair against Service Plan > Several injurious falls & deaths
5. Resident with TBI & stroke > Re-positioning not provided > 10 cm x 10am pressure sore > No intervention > 25cm x 25cm pressure sore > Septic shock > Died
6. Resident in "memory care" Setting > Catheter not draining > E. Coli/Septic shock > Hospitalized > Nursing home > Died
7. Residents with diabetes > High blood sugar levels (540 & 765 mg/dL) > Deaths
8. Resident with large bulge on stomach moaning in pain > Delays in recognition > Strangulated hernia > Death of small intestine > Died
9. Resident cognitively impaired > In pain > Metal object found in heel > Infection > Foot amputated > Died
10. Medication errors (fentanyl patches; blood thinner; antibiotics; antipsychotic meds) > Several deaths
11. Three residents with dementia > Cleaning detergent/supply left unattended/unlocked > Ingested > Severe burns > Died
12. Resident requiring monitoring for suicide attempts > No staff supervision at night > Broke into locked medication cabinet > Ingested 85 dosages in an attempted suicide
13. Resident with Alzheimer's "up most nights" > Walks at night in common area > Staff asleep on sofa (caught on camera) > Fell > Femur fracture > Died
14. Resident with dementia and heart failure > Failed to plug heart pump to outlet at bedtime > Batteries depleted > Died

In summary, the licensure of assisted living will help prevent many of these instances of maltreatment and death. Elder Voice requests your consideration of our language suggestions in these proposed rules and the reasons for their need. Please feel free to contact for further information either Suzanne Scheller or Kristine Sundberg.

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ELDER VOICE FAMILY ADVOCATES COMMENTS ON PROPOSED RULE 4659 – ASSISTED LIVING LICENSURE

1. **4659.0010 APPLICABILITY AND PURPOSE.**
   This chapter establishes the criteria and procedures for regulating assisted living facilities and assisted living facilities with dementia care and must be read in conjunction with Minnesota Statutes, chapter 144G. The licensee is legally responsible for ensuring compliance by the licensee's facility, and any individual or entity acting on its behalf, with this chapter and Minnesota Statutes, chapter 144G.

   COMMENT: The wording on the last sentence seems unclear. Would a temporary worker be considered acting on the assisted living facilities' behalf? We presume yes and support that they act on the facilities' behalf. Suggested wording for clarity is "The licensee is legally responsible for ensuring that the assisted living facility and individuals and entities acting on its behalf operate in compliance with this Rule and Minnesota Statutes, chapter 144G."

2. **4659.0020 DEFINITIONS.**

   A. Subp. 3. **Assisted living facility or facility.** "Assisted living facility" or "facility" has the meaning given in Minnesota Statutes, section 1440.08, subdivision 7.

   COMMENT: When looking for the definition of "facility" in these rules it initially appears as if it is undefined because it appears here at the end of the combination with the definition of "assisted living facility." Separate out the definition of "facility" or use only one term throughout the rules.

   B. Subp. 4. **Assisted living facility with dementia care or facility with dementia care.** "Assisted living facility with dementia care" or "facility with dementia care" has the meaning given in Minnesota Statutes, section 1440.08, subdivision 8.

   COMMENT: When looking for the definition of "facility with dementia care" in these rules it initially appears as if it is undefined because it appears here at the end of the combination with the definition of "assisted living facility with dementia care." Separate out the definition of "facility with dementia care" or use only one term throughout the rules.

   C. Subp. 8. **Clinical nurse supervisor.** "Clinical nurse supervisor" means a facility's registered nurse required under Minnesota Statutes, section 144G.41, subdivision 4.

   COMMENT: Clinical Nurse Supervisor is defined as a registered nurse under 144G.41, subd. 4 and in this subpart. However, for clarity the CNS should be referenced as an RN throughout to highlight this important licensure and to avoid the facility attempting to place an LPN or other person in this role, such as through a variance.

D. Subp. 11. **Competent.** "Competent" means appropriately trained and able to perform an assisted living service, supportive service, or delegated health care task or duty under this chapter and Minnesota Statutes, chapter 144G.

COMMENT – Competency should include the concept of comprehensive training by licensed professionals, successful evaluation of skills, and ability to proficiently perform services. See also comment under Variances Rule 4659.0040.

E. Subp. 14. **Elopement.** "Elopement" means a resident leaves the premises or a safe area without authorization or necessary supervision to do so.

COMMENT: For clarity, please remove the words "to do so." Elopement means leaving without authorization or necessary supervision. The word "necessary" already signifies that the person has been assessed as one needing supervision.

F. Subp. 19. **Ombudsman.** "Ombudsman" means the Office of Ombudsman for Long-Term Care.

COMMENT – Should this also include the Ombudsman for Mental Health and Developmental Disabilities? Both offices need to be referenced within the context of the rules. See also Comments under 4659.0040, Subparts 4 and 5.

G. Subp. 21. **Prospective resident.** "Prospective resident" means a non-resident individual who is seeking to become a resident of an assisted living facility.

COMMENT: Should this also say, "become a resident and is seeking services of an assisted living facility"? What about the spouse of a resident who may not receive services? This language would depend on how the word is used throughout the rule.

H. Subp. 31. **Wandering.** "Wandering" means random or repetitive locomotion by a resident. This movement may be goal-directed such as the resident appears to be searching for something such as an exit, or may be non-goal-directed or aimless.

COMMENT: This should specify that the behavior is within the facility as opposed to elopement which is leaving the facility.

3. **4659.0040 LICENSING IN GENERAL.**

A. Subp. 1. **License required.**

COMMENT: Subpart 1 contradicts Subpart 2 regarding when a facility can advertise that it provides dementia related services. Subpart 1 states that the facility cannot advertise the provision of dementia services unless licensed. Subpart 2 states that the facility can advertise the provision of dementia services upon application. More clarity is needed, particularly in light of the MDH technical bill

enacted under Law 2020, 7th Special Session, Chapter 1, Article 6, Sec. 10, related to Minnesota Statutes 2020, section 144G.10, subdivision 1.

COMMENT: Throughout there seems to be a need for additional clarity related to when a license is required for dementia care. Paragraph (B) seems to emphasize a concept similar to the current assisted living title protection. Because of the history of title protection, additional clarity is needed for the assisted living license with dementia care. Wouldn't (B) be more than just not being able to advertise dementia care without a license but rather not being able to provide such dementia-related services without an assisted living with dementia care license? In addition, (B) could be interpreted as two separate concepts, that as (1) not being able to market as an assisted living (regardless of whether services are to a resident with dementia) without a license; and (2) not marketing specialized care for those with dementia.

B. Subp. 2. **Issuance of assisted living facility license.**

B(3). Before any building to be included on a campus advertises, markets, or promotes itself as providing specialized care for individuals with Alzheimer's disease or other dementias or a secured dementia care unit, the individual, organization, or government entity must apply for and receive an assisted living facility with dementia care license for the campus, or apply for and receive a separate assisted living facility with dementia care license for the building. These services may not be provided at the building until the license is issued by the commissioner.

COMMENT: Is Paragraph B(3) stating that a person cannot advertise they provide dementia services until they apply for one, or that they cannot advertise they provide dementia care services until they receive a dementia care license? In general, more clarity is needed to confirm this is only referring to advertising and that prior to services commencing, a license must be issued.

COMMENT: Is this saying that in a campus model, a dementia care license could be issued for the whole campus under the single license, regardless of whether only one building on the campus provides such services? A concern is that the public may believe that all buildings on the campus provide dementia care when only one building does. How will the public know which of the buildings offers dementia care and/or be able to investigate maltreatment investigations or surveys at the memory care building alone. Similarly, if the dementia care license is issued to just one building on the campus while all buildings operate under one assisted living license, how will disclosure to the public be made as to which building is offering such services.

C. Subp. 3. **License to be posted.**

COMMENT: Please add language in a new paragraph c that requires posting of

an assisted living license with dementia care license at the entrance of the building actually operating as such (not just a building that has a dementia care license because they are one building on a campus and the whole campus has the license, but rather the specific building that is operating under the dementia care license). Proposed language for a new paragraph (c) is below.

(c). For a license issued under subpart 3, item B (3), any assisted living facility with dementia care license must be posted at the main public entrance of any and all buildings that are actually operating as an assisted living facility with dementia care under such license.

D. **Subp. 4. Required submissions to Ombudsman.**

COMMENT: While the definitions section in these rules does define "Ombudsman" as the "Ombudsman for Long-Term Care," it would seem that certain provisions related to the Ombudsman in the Rules should also apply to the Ombudsman for Mental Health and Developmental Disabilities. In this subpart 4, it would seem also helpful for the Ombudsman for Mental Health and Developmental Disabilities to also get notice of licensure. Many group homes or facilities serving those with mental health diagnoses and/or developmental disabilities may elect to receive the assisted living license and the rules needs to accommodate for this possible outcome. Please clarify that these requirements relate to both the "Ombudsman for Long-Term Care" and the "Ombudsman for Mental Health and Disabilities."

E. **Subp. 5. Location for submissions to ombudsman.**

COMMENT: Similar to Subpart 4 above, include both the Ombudsman for Long-Term Care and the Ombudsman for Mental Health and Developmental Disabilities in the notice requirements.

COMMENT: What is the "manner required by the ombudsman"? How will that be communicated to providers?

4. **4659.0060 ASSISTED LIVING LICENSURE; CONVERSION OF EXISTING ASSISTED LIVING PROVIDERS.**

A. Subpart 1. **License application required.**
A. Effective August 1, 2021, a housing with services establishment registered under Minnesota Statutes, chapter 144D, that is providing assisted living services to residents at the time of license application, as allowed under Minnesota Statutes, sections 144G.01 to 144G.07, through an arranged home care provider licensed under Minnesota Statutes, chapter 144A, must convert to an assisted living facility license [and/]or an assisted living facility with dementia care license in order to continue to provide assisted living services in Minnesota.

COMMENT: Under 144G.08, subd. 8 in the definition section, it could be interpreted that an assisted living facility with dementia care must be a licensed assisted living facility first. It may seem as if the dementia care license is an add-on to the assisted living facility license, rather than an either/or as suggested here. This issue is flagged to ensure clarity throughout.

5. **4659.0080 VARIANCE**

GENERAL COMMENTS: A major concern related to the definition of CNS in 144G.61, subd. 4 is in this larger section on variances. See comment in definition of "clinical nurse supervisor." It seems that a variance may be sought if a provider cannot get an RN for the CNS position. The provider may request that an LPN be a CNS with an RN occasional consult. This is the place where a facility could raise the case that they cannot find/hire/keep RNs and would ask for a variance to allow an LPN in that role of CNS with limited 'supervision' by a consulting RN. They might even propose a variance for RN assessments and supervision of unlicensed caregivers.

Also, make sure that the resident, resident's representative, and Ombudsman are notified of any variance granted to ensure transparency.

6. **4659.0090 UNIFORM CHECKLIST DISCLOSURE OF SERVICES**

GENERAL COMMENTS: This rule should apply to both "assisted living facility" and an "assisted living facility with dementia care." Both licensees should have requirements as to the Uniform Checklist. Please add language to accommodate both throughout this rule.

Also, the checklist becomes less relevant if the facility can remove a service at any time and simply update the checklist within 30 days. Residents rely on the services provided when making admissions decisions. Perhaps the rule could at minimum state that the facility needs to inform the residents of changes in service offerings 30 days prior to the change of a service.

A. Subpart 1. **Definition.** The term used in this part has the meaning given in this subpart.

"Uniform Checklist Disclosure of Services" or "checklist" means the checklist developed and posted by the commissioner under subpart 2 and Minnesota Statutes, section 144G.40, subdivision 2 that an assisted living facility is required to provide to prospective residents before a contract is executed to enhance understanding of policies and services that are provided and [that] are not provided by the [assisted living] facility.

COMMENT – The word "facility" is not in the definition section and perhaps should be, or else use "assisted living facility" throughout. See comment in the "assisted living facility" or "facility" definition section of these rules. Also please consider proposed wording in the [..] in this paragraph.

B. Subp. 4. **Use of uniform checklist disclosure of services.** A facility shall:
A. provide an up-to-date checklist to each prospective resident and each prospective resident's representative who requests information about the facility;
B. provide the checklist separately from all other documents and forms;
C. not use another form to substitute for the checklist;
[D. provide an explanation of the checklist; and]
[E. identify the licensee name and license number on the checklist.]

COMMENT. Please consider including the new suggested language in [ ] to add requirements for the facility when supplying the uniform checklist.

7. **4659.0100 EMERGENCY DISASTER AND PREPAREDNESS PLAN; INCORPORATION BY REFERENCE.**

GENERAL COMMENT – Emergency preparedness language was previously much more detailed than this in a 12/12/2019 MDH working draft. However, 42 CFR 483.73 contains significant detail that provides key components for assisted living facilities. The concept of self-preservation is also included in the federal regulation, which is important. The facility needs to take into account the ability of each resident to remove themselves from harm.

8. **4659.0110 MISSING RESIDENT PLAN.**

A. Subpart 1. **Applicability.**

COMMENT: Ensure that the assessment defines and accounts for this risk of wandering or elopement. Paragraph A(2) relies on identification of those at risk for wandering or elopement. Therefore, the assessment in 4659.0140 and 4659.0150 should specifically assess this risk.

COMMENT: Both parts A and B are dependent on an assessment by a registered nurse with input from resident, family and PCP prior to contracting with the AL provider AND depends on the every 90-day reassessment and documentation update by the RN. Ensure language that highlights such dependency.

B. Subp. 2. **Missing resident policies and procedures.**

COMMENT: Paragraphs A(1), (2), and (3) wrongly assume that there is more than one person on site 24 hours a day (paragraph A(2) has staff reporting to the person in paragraph A(1))) AND that person is awake and able to report missing resident. Please address staffing level in order to satisfy the protocol such that there are at least two staff on site to carry out the missing resident plan.

COMMENT: Paragraph A(4) wrongly assumes that there is enough staff on site capable of searching, in a timely manner the entire building and the neighborhood

without leaving the other residents in danger. Please address the staffing level necessary to complete this step of the policy – searching for a missing resident.

COMMENT: For Paragraph A(5) and A(6), please define "immediately," such as within thirty minutes or one hour.

C. Subp. 3. **Additional notification required.**
After the missing resident is located, a staff member must immediately notify local law enforcement, the resident's representatives, and the resident's case manager, if any.

COMMENT: In addition, document in the medical record the incident of a missing person. This should be considered a "change of condition" and a nursing assessment must be initiated.

D. Subp. 4. **Review missing resident plan.**
The assisted living director and clinical nurse supervisor must review the missing resident plan at least quarterly and document any changes to the plan.

COMMENT: Add language that requires the assisted living director and clinical nurse supervisor to inform staff to changes in the plan.

9. **4659.0120 PROCEDURES FOR RESIDENT TERMINATION AND DISCHARGE PLANNING.**

A. Subpart 1. **Pretermination meeting notice.**

COMMENT: Add in Paragraph A that the facility must document the date and time that notification of termination was given and by what method. Also, document in the resident's record that the resident and the resident's representative acknowledge receipt of the letter notifying of termination. There is a concern that lack of transparency may result the parties are stuck in a situation where they must rely on oral communication. Particularly as to the resident, the reliance on oral communication is troublesome given the facility is the one discharging the resident.

COMMENT: Also, we support scheduling the pretermination meeting at least seven days before issuing a notice of termination.

COMMENT: This notice of a right to appeal in Paragraph D(8) is good. Also, it is good to include language about reasonable accommodations in Paragraph D(7).

B. Subp. 2. **Emergency relocation notice.**
A. If there is an emergency relocation under Minnesota Statutes, section 144G.52, subdivision 9, and the licensee intends to issue a notice of termination following the relocation, and an in-person pretermination meeting is impractical or impossible, the facility must use telephonic, video, or other electronic format for the meeting under

Minnesota Statutes, section 144G.52, subdivision 2.

COMMENT: As to 144G.52, subd. 9, there are no criteria listed, such as what are "urgent medical needs" or what actions pose "an imminent risk" to the health or safety of others. These should be defined in rule.

C. Subp. 4. **Summarizing pretermination meeting outcomes.**
Within 24 hours after the pretermination meeting, the facility must provide the resident with a written summary of the meeting, including any agreements reached about any accommodation, modification, intervention, or alternative that will be used to avoid terminating the resident's assisted living contract.

COMMENT: We support that the written summary be produced within 24 hours after the meeting.

D. Subp. 6. **Resident-relocation evaluation.**

COMMENT: There is no indication of who should be included in this evaluation. An RN should conduct or at least be included because health conditions can significantly affect a person's actions, such as in the case of UTI's, adverse medication effects, negligence in administering medication, or theft of medication by staff (diversion). Also, isolation affects a person's actions as does abuse. All of those areas should be addressed in a relocation evaluation.

E. **Subp. 7. Resident Relocation Plan.**

COMMENT: We support the inclusion of "or the resident plans to move out of the facility because the facility has initiated the pretermination or termination process." Oftentimes the resident must look elsewhere for necessary services when being told the facility can no longer meet their needs, but that should not be considered to be engaging in a "voluntary discharge" without resident relocation obligations by the facility.

F. Subp. 11. **Expedited termination.**

COMMENT: What is the difference between an emergency relocation versus an expedited termination? This may need more clarity in rule.

10. **4659.0130 CONDITIONS FOR PLANNED CLOSURES.**

A. Subp. 6. **Resident relocation plan.**
D. The facility must implement the resident relocation plan, must comply with the coordinated move requirements under Minnesota Statutes, section 144G.55, and must provide a copy of the resident relocation plan to the resident, and with the resident's consent, the resident's representative and case manager, if applicable, [and the facility to where the resident is being transferred].

COMMENT: Please consider adding the language in the [ ] for the accepting facility as well since the relocation plan will likely include personal health information of the resident and such transmission must be consented to by the resident prior to release. The concern is that care plans contain medical information that is private. Client and families must be informed and agree in writing to medical information being transferred. Also, the facility should keep a record and make available all documents of the discharge summary during resident relocation. The concern is that chaos can ensue during discharge and transfer, written instructions should be able to be reproduced.

11. **4659.0140 INITIAL ASSESSMENTS AND CONTINUING ASSESSMENTS.**

GENERAL COMMENTS ON THE ASSESSMENT RULE: There is nothing in the Rule draft regarding RN development of a suitable and up-to-date Care Plan. Is there a presumption that a previous statute or rule applies and if so which one(s)? That needs to be clearly stated in this rule. It also needs to include "developed in collaboration with any personal representative/family member decision maker." Without that collaboration the care plan is inadequate because it may not respect the resident's preferences for their care that the facility may not have incorporated.

There is nothing in the Rule Draft that specifically references Restraint - Is there a presumption that a previous statute or rule applies and if so which one(s)? Again, this needs to be clearly stated in this Rule. This should address not locking persons in rooms to prevent freedom of movement (wandering) as a response to inadequate staff levels, locking wheelchairs to prevent freedom of movement, and any other restraint.

Please reference the Nurse Practice Act under Minn. Stat. 148 to ensure that nurses are operating under those obligations, including with delegation to unlicensed personnel and an RN performing assessments.

A. Subpart 1. **Admissions.**
A. The assisted living director, in cooperation with the clinical nurse supervisor, is responsible for admitting residents to the facility according to the facility's admission policies. [Admissions includes initial and return admissions, such as from the hospital, rehabilitation center, or other provider back to the facility].

COMMENT: Please consider adding the language in [..] to ensure that admissions assessment is conducted not just upon initial admission, but also upon return from another provider or facility.

B. Unless otherwise provided by law, an assisted living facility must not admit or retain a resident unless it can provide sufficient care and supervision to meet the resident's needs [as identified through assessment and monitoring], based on the resident's known physical, mental, or behavioral condition.

[If a prospective resident is not admitted or a resident is not retained based on this subpart, such a person must be informed of the reasons for the admission's denial or discharge and must be informed of his or her right to bring in additional services to meet his or her needs.]

COMMENT: The words "physical, emotional, mental health conditions and behavioral expressions" is more complete and respectful wording in the last sentence. Behavior is not a condition in and of itself but an expression of a condition, such as behavioral expressions with Autism Spectrum Disorder, Bipolar Disorder, Dementia/Alzheimer's related.

COMMENT: Please consider adding the language in the middle of Paragraph B in [..] to clarify that the facility must be able to meet all needs and not just ones identified within the contract.

COMMENT: If the prospective resident is denied admissions based on an assessment, the person should be informed of the reasons for the denial. It should also be noted in this section that a prospective resident or resident preserves the right to bring in additional caregivers to meet needs and thus perhaps eliminate the reasons for admission's denial or discharge. Please consider adding language in [..].

B. Subp. 2. **Nursing Assessment.**

A. A nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted by a registered nurse on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, paragraphs 6 – 12.

COMMENT: Please clarify that 144G.70, subd. 3 does not allow admission of a resident without a nursing assessment. The temporary service plan in subd. 3 was not to be a means to allow admission without an assessment. In addition, the "nursing assessment" in 144G.70, subd. 2 indicates "using telecommunication methods based on practice standards." What are these practice standards for using telecommunication methods? Where can they be found? Also, in 144G.70, subd. 2, "resident reassessment and monitoring" is referenced. What are the practice standards for "monitoring"?

B. The nursing assessment or reassessment under item A must:

1) address items A-N of part 4659.0105, subpart 2;

2) be conducted in person unless an exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b) applies;

3) be conducted using a uniform assessment tool that complies with Minnesota Rule part 4659.0105;

4) be in writing, dated, and signed by the registered nurse who conducted the Assessment;

[5) be conducted prior to the creation of a temporary service plan;]

[6) include information from the resident's family and/or representative; and]
[7) as to reassessments, must be conducted at least every 90 days or upon a resident's change in needs as specified in Minn. Stat. 144G.70, subd. 2, paragraph (c).]

COMMENT: "Registered Nurse" is not mentioned until the last lines of the section where it states that the RN must sign and date the assessment. It should be stated at the beginning of the section that the "Assessment or reassessment must be conducted by a Registered Nurse."

In addition, please add language such as in 5), 6), and 7) in [..]. The assessment section is missing any reference to the importance of including family/personal representatives in the assessment process. Add a statement like "Information from family/personal representatives must be included in initial and reassessments." This is especially critical for AL's providing Dementia Care Services (but also for other persons in AL who are beginning to display signs of cognitive decline). Without this information from the family members who often know the person's needs with a deeper understanding, the assessment may be incomplete.

Also, more language is needed to emphasize the frequency and requirements for reassessment. A reassessment is at least every 90 days but also more frequent in response to a significant change in needs. This must be clarified so that there is no way to ignore changing needs, especially when the AL may be attempting to discharge a resident.

C. Subp. 3. **Individualized Review.**

COMMENT: Assessment/Review? What is the difference? Statutory references are given but it would be clearer for specifics as to the difference and who can conduct the review versus the assessment, as included in the rule.

D. Subp. 4. **Assessor; Qualifications.**

A. A registered nurse shall complete nursing assessments and reassessments.
B. A staff member who meets the qualifications set forth in Minnesota Statutes, section 144G.60, subdivision 2, shall conduct the individualized initial review and subsequent reviews.

COMMENT: "A staff member who meets the qualifications" is unclear? Only an RN can conduct assessments. 144G.60 does not address the qualifications of a person who conducts the individualized reviews. RN is listed for assessments, there should be equivalent specificity for those who can conduct reviews, not merely a statutory reference.

E. Subp. 5. **Temporary Service Plan Admission.**
[An assessment as described in Minn. Stat. 144G.70, subd. 2 is standard practice and must be followed unless exceptional circumstances warrant.] If [under exceptional

circumstances] a facility admits an individual according to a temporary service plan under Minnesota Statutes, section 144G.70, subdivision 3, the ~~nurse~~ assessment [by a registered nurse] must be conducted within 72 hours of initiating services.

COMMENT: Thank you for adding this language since 144G.70, subd. 3 lacks clarity and seems to not completely reflect HF90 discussions. This may need to be clarified more related to highlighting that the standard practice is 144G.70, subd. 2 in terms of requiring an assessment prior to admission. The use of subd. 3 is considered an exception for when a person could be admitted without the assessment. Please add the language in [ ].

F. Subp. 6. **Consumer Protections under Temporary Service Plan.**
An individual who is admitted to an assisted living facility under a temporary service plan under Minnesota Statutes, section 144G.70, subdivision 3 [not the proposed service plan under 144G.70, subd.2], and has not executed an assisted living contract shall receive the same consumer protections and rights under Chapter 144G provided to a resident who has executed an assisted living contract[, including but not limited to under the 144G.50-.57 and 144G.91,

COMMENT: Thank you for this addition. It is necessary to ensure other responsibilities under the law if a temporary service plan is utilized. Another note that the words "proposed temporary service plan" are used under 144G.70, subd. 2 for the plan created after assessment. Additional language may be considered to clarify that such "proposed temporary service plan" does not equate to the temporary service plan under 144G.70, subd. 3. Please consider adding the language in [ ].

COMMENT: Please also consider adding the language of retention of rights and protections even if an AL contract has not been executed, which includes under the AL Bill of Rights and the discharge and appeal rights.

G. Subp. 7. **Weekend [and Holiday] Assessments.**
An assisted living facility must be able to conduct an ~~nurse~~ assessment [by a registered nurse] during the weekend for a resident who is ready to be discharged from the hospital and return to the facility.

COMMENT: Thank you for this addition. Residents admitted on the weekend or holidays often lack a thorough admission process and care sometimes falls through the cracks. Consider including "weekend and holidays." Please consider adding the language in [ ].

12. **4659.0150 UNIFORM ASSESSMENT TOOL**

A. Subpart 1. **Definition. The term used in part has meaning given in this subpart**
"Uniform Assessment Tool" means an assessment tool that meets the requirements of this rule and is used by a licensee to comprehensively evaluate a resident's or

prospective resident's physical and cognitive needs [, including under Minn. Stat. 144G.70, subd. 2(b)&(c)].

COMMENT: More specificity may be needed to clarify that the pre-admission assessment in 144G.70, subd. 2(b) & (c) also requires the use of the Uniform Assessment Tool. Please add suggested language in [..].

B. Subp. 2. **Assessment Tool Elements.**
Each facility must develop a uniform assessment tool. The facility may use any acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart A uniform assessment tool must address the following:

COMMENT: It appears that MDH decided against creating a Uniform Assessment Tool itself and rather set parameters for providers to ensure inclusion. It is recommended that a consistent form be used to ensure greater understanding of the resident's condition upon transfer, for the licensee's personnel to best understand the resident's condition, and for MDH to best complete surveys, investigations, and analysis related to the resident's needs. A person should receive an assessment prior to going into a higher (or lower) level of care, such as assisted living to dementia care.

A. the resident's personal lifestyle preferences, including:
1) [sleep patterns, daily routine, food preferences, social participation, leisure activity preferences], and any other customary routine that is important to the resident's quality of life;

COMMENT: Please add the language in [..] to better reflect personal preferences.

2) spiritual and cultural preferences; and
3) [advance healthcare directives and/or end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order from a physician or a "physician/provider orders for life sustaining treatment" order (POLST), and the resident's designated representative];

COMMENT: Health Care Directives are good to include in the person's preferences. Also include the resident's designated representative. Include the POLST abbreviation since it is common language. Please consider rephrasing this paragraph with the alternate language in [..].

B. activities of daily living, including:
1) toileting pattern, bowel, and bladder control;
2) dressing, grooming, bathing, and personal hygiene;
3) mobility, including ambulation, transfers, and assistive devices; and
4) eating, [drinking], dental status, oral care, and assistive devices and

dentures, if applicable;

COMMENT: A clarification regarding the resident's ability to eat and drink would prevent many occurrences of dehydration and malnutrition. Please consider adding the language in [..].

C. independent activities of daily living, including:
1) ability to self-manage medications;
2) housework and laundry;
3) transportation; [and
4) mobility.]

COMMENT: mobility is a critical determinant of ability to safely move around the facility. Please consider adding the language in [..].

D. physical health status, including
1) a review of relevant health history and current health conditions including medical and nursing diagnoses;
2) allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening;
3) infectious conditions;
4) a review of medications according to Minnesota Statutes, section144G.71, subdivision 2, including prescriptions, over-the-counter medications, and, supplements, and for each:
a. the reason taken;
b. any side effects, contraindications, allergic or adverse reactions, and actions to address these issues;
c. dosage;
d. frequency of use;
e. route administered or taken;
f. any difficulties the resident faces in taking the medication;
g. whether the resident self-administers the medication;
h. the resident's preferences in how to take medication;
i. interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and
j. provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications.

COMMENT: Add confirmation of PRN medications and the criteria for administration, as well as any standing orders. Also include list of physician orders for treatment, such as administration of wound care, nutritional supplements, or other orders. Also noting any psychotropic medications. Also

include orders for specialized diets. Finally, indicate the mode of medication administration, such as crushed medications.

5) a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility;
6) a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months;
7) weight; and
8) initial vital signs if indicated by health conditions or medications;

COMMENT: Also include any swallowing difficulties and any specialized diets, including honey-thickened liquids to this list.

E. emotional and mental-health conditions, including:
1) review of history of and any diagnoses of mood disorders including depression, anxiety, bipolar disorder, and thought or behavioral disorders;
2) current symptoms of mental health conditions and behavioral expressions of concerns; and
3) effective medication treatment and non-medication interventions;

COMMENT: Consider adding an elopement risk as well as any civil commitment or orders for medications through a Jarvis Order or similar court order.

F. cognition, including:
1) review of any neurocognitive evaluations and diagnoses; and
2) current memory, orientation, confusion, and decision-making status and ability;

COMMENT: Add the ability to self-preserve somewhere, whether based on physical or cognitive diagnoses. Also consider adding an elopement and wandering risk somewhere in this list.

G. communication and sensory capabilities, including:
1) hearing;
2) vision;
3) speech;
4) assistive communication and sensory devices including hearing aids and [eyeglasses]; and

COMMENT: Please add the language in [..] (eyeglasses).

5) the ability to understand and be understood;

H. pain, including:
1) location, frequency, intensity, and duration; and
2) effectiveness of medication and non-medication alternatives;
I. skin conditions[, including wound staging and characteristics];

COMMENT: Please add language in [..].

J. nutritional and hydration status and preferences;
K. list of treatments, including type, frequency, and level of assistance needed;

COMMENT: This comment is made above as well. Include physician orders for treatment, such as wound care.

L. nursing needs, including potential to receive nursing-delegated services;
M. risk indicators, including:
1) risk for falls including history of falls;
2) emergency-evacuation ability[, such as self-preservation related to both physical and cognitive ability];

COMMENT: Please add language in [..] to ensure that self-preservation risk indicators are included.

3) complex medication regimen;
4) risk for dehydration including history of urinary tract infections and current fluid intake pattern;
5) risk for emotional or psychological distress due to personal losses;
6) [prior living situations and reasons for change];

COMMENT: Is there another way to say, "unsuccessful placements"? It really is institutional language and objectifies the person as something to be acted upon. Would " prior living situations and reasons for change" work? That way it does not blame the person and opens the discussion to decline in care or changes in the person's needs or family or financial considerations. Please consider using the alternate language in [..].

7) elopement [and wandering risk] including history or previous elopements;

COMMENT: Please add the language in [..] since they are separately defined.

8) smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and
9) alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; and

N. who has decision-making authority for the resident, including:

1) the presence of any advance healthcare directive or other legal document that establishes a substitute decision-maker; and

2) the scope of decision-making authority of a substitute decision maker under subitem (1); [and the resident's designated representative].

COMMENT: Please add the language in [..] to clarify that the designated representative be named in the assessment tool as well.

O. the need for follow-up referrals for additional medical or cognitive care by health professionals.

C. Subp. 3. **Recordkeeping**. Assessment tool results, including those from an assessment supplement, must be maintained in the resident's record as required under Minnesota Statutes, section 144G.43 [and available to the resident under the Minnesota Health Care Records Act].

COMMENT: Please include the language in [..] to confirm that the assessment is available to the resident (and the resident's representative) as a medical record. Often this information is difficult for the resident to obtain.

D. Subp. 4. **Licensee Attestation.**
An applicant for an assisted living facility license or a licensee renewing an assisted living facility license must attest to the commissioner in a manner determined by the commissioner that the uniform assessment tool used by the applicant or licensee complies with this rule part.

COMMENT: Can the uniform assessment tool be attached to the license application rather than simply attesting to compliance? Please consider this suggestion.

E. Subp. 5**. Department access to the Uniform Assessment Tool.**
At the time of a survey, investigation, or other licensing activity the licensee must provide the department access to or copy of the uniform assessment tool as required under Minnesota Statutes, section 144G.30, subdivision 4, to verify the compliance with this rule.

COMMENT: In the December 2019 working draft, MDH listed several subparts related to reassessment and review (Subparts 6-10). Several portions seem to be necessary to include, such as concepts of documenting changes upon reassessment and make the records available to staff; keeping the last 2 years of assessments in an accessible, onsite location; focusing reassessments on identified problems; involving the resident and their representative; and monitoring changes of condition. Please consider re-adding this language.

13. **4659.0160 RELINQUISHING AN ASSISTED LIVING FACILITY WITH DEMENTIA CARE LICENSE.**

A. Subp. 3. **Notice to residents.**

COMMENT: Add to document the date and time that notification of license relinquishment was given and by what method. Also, document in the resident's record that the resident and the resident's representative acknowledged the letter notifying of relinquishment of licensure. There is a concern of lack of transparency may result in the parties being stuck in a situation where they must rely on oral communications, which is particularly troublesome for the resident since the facility is trying to discharge them.

14. **4659.0170 DISEASE PREVENTION AND INFECTION CONTROL.**

GENERAL COMMENTS: Stronger infection control language is needed, in general, particularly considering SARS-COV2 and related viruses. Please consider including the language in [..]. Below are additional suggested insertions for the licensee to perform. Please also consult SF60/HF99 from the 2020 session.

- ***Maintain a comprehensive SARSr-COV infection control program that covers employees, contractors, visitors, and residents.***
- ***Create a written response plan to SARSr-COV, which addresses at least in part staffing, PPE, testing, isolation concerns, ascertaining end of life wishes, and transfers/discharges under temporary infection control measures.***
- ***Adhere to visitation guidance from CMS and MDH.***

A. Subp. 2. **Infection control program**. The facility's infection control program required under Minnesota Statutes, section 144G.41, must be consistent with current guidelines for infection prevention and control for long term care facilities[, including during a disease pandemic,] from the national Center for Disease Control and Prevention (CDC) and comply with accepted health care, medical, and nursing standards for infection control.

COMMENT: What are the "accepted health care, medical, and nursing standards for infection control"? Perhaps cite those references to a statute or rule. Also, does the Minnesota Nurse Practice Act or Board of Nursing have a nursing standard for infection control? Please reference such a standard. If there is not one for nurses, then greater detail would seem to be warranted here.

15. **4659.0180 STAFFING.**

GENERAL COMMENTS ON STAFFING RULE: This is significantly different than the previous draft on 3/27/2020 from MDH. There are several parts that are important to meeting the needs of residents and are noted where possible. In general, utilize the 3/27/2020 working draft of this rule to provide sufficient detail for staffing requirements.

There seems to be no clear reference to or identification of the RN role in determining the competency of LPNs or direct care staff for any nursing delegated functions including medication administration and activities of daily living care. There was no reference to delegation as an RN or a specific task to a specific individual by the supervising RN. Records of delegation must be completed, dated, and signed by the delegating RN and kept by the facility.

Also, there needs to be mention of the role of the LPN and that LPNs do not practice independently but under the supervision of the RN. They may reference to the Nurse Practice Act, but it needs to be mentioned separately and additionally as well. The RN delegates specific tasks to competent individuals and the LPN may assign individual direct caregivers to perform those tasks that have been delegated to those specific direct caregivers.

A. Subpart 1**. Definition.** For the purposes of this part "direct-care staff" means staff who provide services for residents that include assistance with activities of daily living, medication administration, resident-focused activities, supervision, and support.

COMMENT: Why is this rule related to staffing limited to direct care staff only and not also support staff? It should include both. Also, specifically clarify that direct care staff includes unlicensed personnel and temporary personnel.

B. Subp. 2. **Clinical nurse supervisor.**
The facility's clinical nurse supervisor[, who is a registered nurse,] may also fulfill any of the responsibilities that a registered nurse is required to perform at the facility under Minnesota Statute, chapter 144G.

COMMENT: See comments under Definitions Section as to CNS. If not clarified it could leave open the possibility that an interim CNS or LPN CNS by variance may fulfill any of the responsibilities that a registered nurse is required to perform, such as assessments/care planning and delegation. This potentially leaves a wide hole that may skew the intent of the statute and rule. Please consider adding the language in [..].

C. Subp. 3. Direct-care staffing; plan required.

GENERAL COMMENT: Add a factor in this subpart of a management evaluation under Minn. Stat. 144G.42, subd. 2. Also, it is suggested that for the assisted living (not a dementia care unit), there be at minimum one direct care staff for every 12 residents from 7 am – 7 pm and one direct care staff for every 18 residents from 7 pm – 7 am. It is suggested that there be at minimum one direct care staff for every ten residents from 7 am – 7 pm and one direct care staff for every five residents from 7 pm – 7 am. In addition, a factor of resident census changes should also be included when setting staffing.

A clinical nurse supervisor must develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. When developing a direct-care staffing plan, the clinical nurse supervisor[, who is a registered nurse,] must ensure that staffing levels are adequate to address the following:

COMMENT: Please consider adding the language in [..] to clarify that the clinical nurse supervisor is an RN.

A. each resident's needs, as identified in the resident's service plan and assisted living contract;
B. each resident's acuity level, as determined by the most recent assessment or individualized review;
C. the ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises;
D. whether the facility has a secured dementia care unit; and

COMMENT: The staffing level for a dementia care unit should have additional factors and requirements.

E. staff experience, training and competency.

D. Subp. 4. **Daily Staffing Schedule.**

GENERAL COMMENT: Please include the concept that staff that are in training do not count in the staff scheduled at any given time. In the alternative, the daily staff schedule should show those staff that are still in training. The staff schedule should be retained for seven years. Also, the staffing plan must be evaluated for efficacy and the evaluation available upon request. The commissioner should also be authorized to receive and review the staffing plan.

In addition, the person that supervises the staffing is often not in contact with the RN who develops the staffing schedule. Problems arise when the resident/client needs change, there is a new MD order, and that information may not be reflected, both in an overall staffing plan as well as an individual's care plan.

A. The clinical nurse supervisor[, who is a registered nurse,] must develop a 24-hour daily staffing schedule. The schedule must:

COMMENT: Please consider adding the language in [..] to clarify that the CNS must be a registered nurse.

1) include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; and
2) identify the direct-care staff member's resident assignments or work

location.

B. The daily work schedule in Item A must be posted at the beginning of each work shift in a central location on each floor of the facility, accessible to staff, residents, volunteers and the public[, while maintaining the privacy of any protected health information of the resident].

COMMENT: The schedule should ensure that any protected health information is not disclosed without the consent of the resident. Please consider adding the language in [..].

E. Subp. 5. **Direct-care staff availability.**
A minimum of two direct-care staff must be scheduled and available at all times whenever a resident requires the assistance of two direct-care staff for scheduled and unscheduled needs.

COMMENT: This is a helpful provision to ensure staff are available.

F. Subp. 6. **Direct-care staff availability: night supervision.**
During the hours of 10:00 p.m. to 6:00 a.m., direct-care staff shall respond to a resident's request for assistance with health or safety needs as soon as possible, but no later than 10 minutes after the request is made.

COMMENT: This is a helpful provision. Please add the 10-minute requirement for the day shifts as well (6 am – 10 pm). Also make the request response times available upon request.

16. **4659.0190 TRAINING REQUIREMENTS.**

GENERAL COMMENTS ON TRAINING RULE: In general, the MDH working draft dated 3/25/2020 should be utilized given greater detail for multiple training provisions in that draft.

Add the "Temporary personnel must receive orientation on facility-specific policies and the service plan of each resident." In addition, include orientation on the facility's preparedness plan and orientation on basic communication skills, both verbal and nonverbal communication. Also, additional orientation should be completed for all "additional areas of training" as referenced in the missing section below on "Additional Training."

Add "Additional Training" Section. A section should be added here addressing specific types of training to ensure quality care. Additional training should include for infection control (this requirement is seen as critical), mental health, grievance procedures, transportation and transfers, food handling, diabetes, wound monitoring, pain assessment, fall prevention, physical restraints, and developmental disabilities.

As to infection control, specifically include infection-control training, which would include a properly trained instructor who trains staff on general infection control techniques such as handwashing, use of PPE, and protection from exposure to blood or bodily fluids, as well as specific infection control, including during a disease pandemic, such as quarantine and isolation as needs arise.

In addition, under Minn. Stat. 144G.61, subd. 2(10) "modified diets as ordered by a licensed health professional" is referenced. Preparation" can mean plating food or heating up packaged foods. Staff should also be trained in the components of specific modified diets, benefits and risks.

A. Subp. 1. **Training policy**. A facility must establish, implement, and keep current policies and procedures for staff orientation, training, and competency evaluation, and a process for [continuously] evaluating staff performance as required under Minnesota Statutes, section 144G.41, subdivision 2, that meets:

(1) the orientation, training, and competency requirements under this rule part and Minnesota Statutes, section 144G.42, and sections 144G.60 through 144G.64; and
(2) for a facility with an assisted living facility with dementia care license, the additional staff training requirements under Minnesota Statutes, sections 144G.80, 144G.82, and 144G.83.

COMMENT: Include that such orientation and training be person-centered. In addition, even though Minn. Stat. 144G.60, subd. 5 references that temporary staff must meet all the same requirements, the concern is that many temporary workers, per contract, are to come to the facility with general training. However, the facility has the obligation to orient the temporary worker to the facility-specific policies and to the service plan of the resident. See below for a suggested insertion related to temporary workers. Also, define "staff" as all unlicensed personnel, temporary personnel, and licensed personnel. Please consider adding the language in [..] to highlight the need for ongoing evaluation, not just one time.

a. Subp. 2. **Additional orientation**. In addition to the staff orientation requirements identified in subpart 1, the facility's training policy must include orientation training on:

(1) the staff person's job description upon hire and whenever there is a change to the job description that changes the nature of the job or how the job is to be performed;
(2) the facility's organization chart and the roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist disclosure of services; and
(3) the identification of incidents of maltreatment as defined under Minnesota Statutes, section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited.

b. Subp. 3. **Additional training requirements for assisted living facilities with dementia care licenses.**

A. In addition to the other training requirements identified in subpart 1, direct care dementia-trained staff under Minnesota Statute, section 144G.83, subdivision 1 and other staff having direct contact with residents of a facility that has an assisted living facility with dementia care license must receive training on the following topics:

(1) understanding cognitive impairment, and behavioral and psychological symptoms of dementia; and

(2) standards of dementia care, including non-pharmacological dementia care practices that are person-centered and evidence-informed.

COMMENT: Add additional training on pain assessment, elopement and wandering and behaviors accompanying a dementia diagnosis. Also, with reference to 144G.83, subd. 1(d), there should be a restriction on how long "emergencies" last. "Emergencies" should not be allowed to be sequential or cumulative, such as having an "emergency" on the evening shift for a month straight. Residents and their representatives who have contracts and are paying for trained care givers must be notified of the "emergency."

B. A facility with an assisted living facility with dementia care license is responsible for ensuring and maintaining documentation that individuals providing or overseeing staff training relating to dementia and dementia care have the work experience and training required under Minnesota Statutes, section 144G.83, subdivision 3, and have successfully passed a skills competency or knowledge test required by the commissioner before the individual provides or oversees staff training. The commissioner must publish and update as needed a list of acceptable skills competency or knowledge tests on the department's website that are based on current best practice standards in the field of dementia care and meet requirements of Minnesota Statutes, section 144G.83, subdivision 3, clause (3).

e. Subp. 4. **Staff competency; retraining.** The facility's training policy must identify the requirements for retraining staff when the facility determines that a staff person is not demonstrating competency when performing assigned tasks. If retraining does not result in competency, the facility must identify the additional steps it will follow to ensure the staff person achieves competency, the time frame for completing the additional steps, and the actions the facility will take to protect resident rights until competency is achieved.

COMMENT: The competency evaluation needs to be better defined, such as completion of competency evaluations for those providing assisted living services must occur prior to providing assisted living services. Also, that the competency evaluations must be completed by all personnel providing assisted living services, including unlicensed and temporary personnel. In addition, the evaluation content must include CPR and first aid, including the Heimlich maneuver as well as all topics under 144G.61. As to CPR, residents should be told whether a staff member has this basic training. In addition, the evaluator must be appropriately trained

and credentialed. The evaluation must include a skills test to determine if the services provided are performed according to the training and with competency as well as a setting forth what constitutes passing on a skills test.

f. Subp. 5. **Portability of staff training.**
A. Unlicensed personnel providing assisted living services who transfer from one licensed assisted living facility to another or who are newly hired by a licensed assisted living facility may satisfy the training requirements under Minnesota Statutes, section 144G.61, subdivision 2 by providing written proof of previously completed training within the past 18 months.

COMMENT: In addition to written proof of completed training, training in Minnesota must have occurred and verification by RN should occur. A concern is that written proof is not enough, particularly since there is no state agency to verify ULP matters. Verification by an RN is necessary as the ULP will be providing care under the supervision of that RN license. ULP with previous training documents must be able to demonstrate the skills to the RN supervisor upon hire.

B. The facility must complete an evaluation of the competency of the unlicensed personnel in the areas where the previously completed training is being accepted by the facility before the staff person may provide assisted living services to residents. Competency evaluations must be conducted by a competency evaluator under Minnesota Statute, section 144G.61, subdivision 1 and maintained under Minnesota Statute, section 144G.42, subdivision 8 and subpart 6 of this rule part.

g. Subp. 6. **Training records and certificate**.
A. The facility must maintain a record of staff training and competency required under this rule and Minnesota Statutes, chapter 144G that documents the following information for each competency evaluation, training, retraining, and orientation topic:
(1) Facility name, location, and license number;
(2) Name of the training topic or training program, and the training methodology (such as classroom style, web-based training, video, or one-to one training);
(3) Date of the training and the competency evaluation, and the total amount of time of the training and competency evaluation;
(4) Name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and
(5) Name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described on the certificate.

B. A copy of the certificate of completed competency evaluation, training, retraining, or orientation must be provided to the employee at the time the evaluation or training is completed.

COMMENT: Add new sections that the director must ensure that training manuals and policies and procedures are available and accessible in the facility. Also add the qualifications of the instructor as well as that the training programs must be available and accessible to the commissioner for review and approval.

17. **4659.0200 Non-Renewal of Housing, Reduction in Services, and Required Notices.**

GENERAL COMMENT: We support the reduction of services concept here and elsewhere in these rules that equates reduction in a resident's services with non-renewal of housing, due to the similar impact on residents of needing to find another place to live and receive necessary services.

18. **4659.0210 TERMINATION APPEALS; PROCEDURES AND TIMELINES FOR APPEALS**

GENERAL COMMENT: We support the insertion of 30 days to appeal in Subpart 1(a)(1) and 15 days below in Subpart 1(A)(2).

Date: 1/11/2021
To: Administrative Law Judge Ann C. O'Reilly
From: Jean Peters
Re: Rules Comments Assisted Living Licensure - 4659

I write this letter of public comment as a daughter who recognized all too late the faults in our system of unlicensed assisted living facilities.
Unfortunately, my comments come from experiencing the abuse and neglect of my mother and the failure of a system that failed to protect her and others.

Attracted to a shiny new assisted living facility my sisters and I were sold (yes sold) a lifestyle by a leasing agent promising companionship, care and comfort to our 83 year-old mother.
Our experience with the assisted living and memory care industry began with moving our mother from Seattle to be near her daughters, moving her again from the first facility because of neglect and medication errors to a newly built facility we thought would be better.
During our mother's stay at the second facility over time she experienced maltreatment, falls, ridicule, neglect, abuse and retaliation.
All along the way her family struggled to understand why this was allowed to happen in a facility that had advertised itself to be the one of the best operators in the state.

Staffing 4659.0180
Currently, the staffing standard in assisted living and memory care under the HWS scheme requires one awake person in the building.
Individuals sign agreements for services without the knowledge that these services they have contracted and are paying for have no guarantee of being fulfilled.
Transparency should be mandatory. Facilities must inform the individual that the "nurses" that are caring for them are most often unlicensed personnel.
When we questioned why we were charged when laundry wasn't done or the "cares" we were paying for were not delivered the answer was "it is what it is" or "your mother didn't want us to do them".
After months of unanswered concerns, our family installed a camera and caught neglect and failure by staff paid to deliver care within the first 12 hours.
Note: I helped 3 other daughters in the same facility install cameras in their mother's rooms within a month of installing ours and all 3 caught abuse, neglect and theft. One of these cases went to the attorney general's office for prosecution and yet the substantiated report was never posted to the OHFC website.
We often found no staff in the memory care unit after 8:30 pm and it was a while before we came to understand that the "clicks" we heard at night on the video was the staff making sure our mother was locked in her room. We understood practice replaced staff. We had to request that staff did not lock my mother in her room at any time.

Training Requirements 4659.0190
It is important that the person providing care to an individual is providing person centered care and is trained on the cares that individual has contracted for.
One only needs to read the resolved complaints to learn attempts at care by untrained staff can lead to injury and death.
At a care conference days before my mother' death I asked the director if staff knew how to operate the bed rails on the hospital bed that had been delivered to my mother's room.
I will never forget the condescending look she gave me as she replied, "of course they do".
Within minutes, my brother came into the conference room asking for help because staff was having my weak, frail 89 -pound mother crawl up and over the foot board because the aide didn't know how to operate the electric bed.

Below is a letter to the facility that addresses both the staffing and training concerns our family expressed:

Nancy and Jon,

I am contacting you regarding a recent incident involving my mom, Jackie Hourigan. Unfortunately, this is at least the 3rd time in the last 2-3 weeks where she has been left unchanged for extended periods of time (and when she was feeling better and interested in eating, unnourished).

On Tuesday evening, December 17th, my sister Jean gave my mother a bath, washed her hair and put on her pajamas and a Depends and tucked her into bed at 6:30 p.m. My mother has not been feeling well and is currently recovering from a urinary tract infection (UTI). I stopped by to visit my mother at 1:30 p.m. on Wednesday, December 18th – 19 hours after my mother was put into bed – and she was still in bed with a wet Depends which was the same pair that was put on her at 6:30 p.m. the night before. I realize there have been days lately, due to her UTI, that she does not want to get up and get dressed.

I questioned Jessica as to whether my Mom had been changed out of her Depends yet today. She informed me that Jackie was refusing getting changed and there were a number of attempts. She said she tried as well. I asked if a nurse would be coming by (our understanding is that in the care plan they will call a nurse if she refuses after so many attempts). Her response was that one was going to be coming around (in the afternoon or something like that). FYI..I left at 3:30 and no nurse stopped in.

I went back to my Mom's room and proceeded to place a towel on her bed, explain to her that I was going to change her Depends, replaced them with a new pair in less than three minutes. I then went back out and asked Jessica if they are allowed to change a resident on their bed, she said yes. I again questioned her about my Mom being left for so long in a wet Depends and that we are trying to have her recover from a UTI. She said she had some concerns that my family may perceive the staff as being too forceful. I said I don't believe it is an issue as long as everyone is kind. I told her I would check with my sister as I believed it would be just fine--which was the case. (My sister also wanted me to remind Jessica that "MY MOM IS IN MEMORY CARE").

In all fairness, Jessica did mention that when she requested to change my Mom's Depends my mom said she was going to kick her. I told Jessica I didn't want the staff to get hurt. She didn't seem to think this was an issue (I would tend to agree, as my Mom's current documented weight is 94 lbs. with a documented recent weight loss of 11 lbs. In her weak state, I doubt she could do much harm.) Her temperament is typically fairly mild, but her energy level has her resisting anything that requires much effort these days.

I understand that you cannot possibly have a protocol for every single possible scenario regarding my mother's situation (and others), however, doesn't it seem neglectful to let an 85 year old dementia patient sit in the same wet depends for 19 hours? Especially a patient who is recovering from an UTI infection which was probably caused by having on a wet Depends for too long to begin with?

Additionally and most concerning is this: when I asked Jessica, the head Memory Care Nurse, at what point would it be too long? She could not give me an answer. I asked her twice. Obviously to her 19 hours was not too long. If your head memory care nurse, who is in charge of a staff of aides doesn't know, it is very unsettling. This means she would not be able to instruct or lead others in when it has been too long. Clearly there

needs to be some someone who needs to take control of this type of situation and change a resident's Depends in the sake of health, humanity and avoid being neglectful. With multiple Ebenezer memory care facilities, I find it hard to believe that your head memory care nurse did not have the knowledge to handle this situation. Are there guidelines around this type of scenario that would prevent this from happening again to any memory care resident? If so, are they trained and communicated staff wide?
I look forward to a timely response on my concerns and questions.
Thank you,
Kay Bromelkamp

Initial Assessment & Continuing Assessments 4659.0140
A meaningful RN assessment is essential and determines not only the care an individual will receive but the number of staff needed to deliver the care that the residents have contracted for.
Our mother was assessed by a newly hired RN and, as a nurse practitioner I was the one who brought the assessment knowledge that our mother's "service" plan was based on. The assessment used was a method used by the facility for determining charges rather than an evaluation of care needs.
Every resident has the right to refuse services under the bill of rights (When we questioned why we were charged when laundry wasn't done or cares we were paying for were not delivered we came to understand that the assessed service plan was actually an income generating scheme.
Thorough initial assessments and assessments after any change in condition are essential.
Additionally, there needs to be protocol for weekend assessments. It is widely understood staff is short on weekends. This makes no sense, as the residents care needs remain the same as M-F so full assessments on weekends must be made available.

Uniform Assessment Tool 4659.0150
We learned that our mother had not had a new nursing assessment when she moved from assisted living to memory care. For over 4 months the facility had charged for care based on an old "care" plan when she resided in the assisted living building. For 4 months we were charged at a higher level of care whose charges were "bundled" preventing accountability for the facility.
It was during this time that our family began to notice neglect and failure to provide cares that we understood were part of the "Memory Care Experience".
The activities aide (the director position went unfilled for 9 months) accused us of not allowing our mother out of her room for activities because the private aides we hired kept her sequestered in her room. Unbeknownst to her, and operating off an old assessment, she had no idea that we had not had private aides since moving our mother to memory care three months earlier.
A meaningful RN assessment is vital to the care an individual will receive and the number of staff needed to deliver the care that the residents have contracted for.
A uniform assessment tool provides every facility RN an opportunity to evaluate a prospective resident's physical, mental and cognitive health based on best practice. A Uniform tool will help inform the individual, their family member as well as the facility on the cares that will be needed upon admission. These completed assessments must be made available to the resident and their family at every reassessment or change in condition.
In addition, I believe that this tool will help improve the quality of care delivered by the unlicensed personnel who are delivering care under the license of the staff RN.

Thank you for the time you have spent learning of our family's concerns.
Sincerely,
Jean Peters

Administrative Law Judge
Rules Comments
Anne Sterner

4659.0140 INITIAL ASSESSMENTS AND CONTINUING ASSESSMENTS
Subpart 1 Admissions
A - "facilities admission policies".

Mom was forced into a dementia care area. This was based on a facility assessment & against assessment of OT testing done independently by the family. There is nothing here to prevent illegal steering or residents into higher cost and unnecessary level of care.

Weekend admissions (not return from hospital?). Will new residents be given a nurse assessment if admitting on the weekend?

Assessment tool - May use any? This doesn't seem appropriate for facilities to use own tool. 4659.0150

(1) Customary routine —
(6) a review of . . . Any reports from. PT, OT . . . IS "REVIEW" SUFFICIENT.

Mom was denied the opportunity to do important routines that she was capable of (own laundry) resulting in much stress and reduction of meaningful activities and important routines on a daily basis.

Also see above comment on illegal steering.

. **4659.0150 UNIFORM ASSESSMENT TOOL**

E. emotional and mental-health conditions, including:
1) review of history of and any diagnoses of mood disorders including depression, anxiety, bipolar disorder, and thought or behavioral disorders;

I don't know the technical terms here, but an individual that has a history of sexual advances should have a required plan and appropriate supervision developed to protect other residents. My mother had to endure an advance and fend off a resident that came into her bedroom during the night and made sexual advances. Staff was not aware of the incident even with cameras monitoring the hallways.

4659.0180 STAFFING

Subp 6 Direct care staff availability, night supervision. “Shall respond”.

Seems ambiguous .? Also need to respond in sufficient number if > 1 required. Or what if not requested but a scheduled care? Like scheduled checks or bathroom visits. Are there enough staff to reasonably conduct the check and respond to a normal amount of circumstances found during checks on a nightly basis? How are the needs for appropriate staffing known and monitored?

Video showed consistently that scheduled checks and assisted bathroom visits were not conducted.

My mother suffered multiple UTI due to night incontinence and failure to provide scheduled assistance.

She did not utilize a call pendant, but had a movement alarm that would supposedly notify staff when she crossed the doorway to the bathroom during evening hours. Staff was to respond to check on her when she crossed barrier. This never happened proved by a camera placed by family. Even after complaints of no service and regular testing of the functioning of the alarm that was requested and implemented by the family. No assistance with incontinence briefs due to inaction by staff to respond contributed to suffering multiple UTI.

What about for scheduled cares? Not mentioned here that sufficient staff needed for nights also.

No mention of a substantial change in status and notifying nursing supervisor? Requirement of nurse to address even on weekends or evenings? My mom was admitted on a Friday and ambulatory. Within 2 days (now into weekend), she was. Two person transfer and crying out in pain. There was no nurse assessment, until family visited and noticed stark decline in physical mobility, confusion and extreme pain that nurse came into assess and noted visible symptoms of a broken hip and notified physician. Mom suffered a broken hip and received no medical attention or pain relief for more than two days.

Anne Sterner
Minneapolis, MN

I had been struggling with Country Manor Sartell, MN, an assisted living facility, and their policies for over 4 years now. My mother Lorraine was 88 and has just passed in November 2020 after only 2 months of care due to neglect in Country Manor Rehab on the same campus. Previous to her admittance in the Rehab department she lived independently in the apartments that had a service plan with County Manor. The contract between my mother, Lorraine, and Country Manor stated that aides were to visit Lorraine every two hours, 12 visits per day, to check on her wellbeing and help with toileting, dressing and grooming due to a previous stroke and walking disability. This contract was breached by Country Manor and they were not held liable. Country Manor being extremely short staffed, they did not show up to check on her as scheduled but continued to push a new service plan that is more expensive with more visits when they do not have enough staff to even cover every 2 hours. Country Manor's monthly invoices had arbitrary monetary charges that they would not explain even though I asked numerous times.

In March of 2020 during the heightened anxiety of the COVID lock-down, Country Manor threatened Lorraine that if she would not use some kind of lift and a more expensive plan then they would send her to the nursing home. She would not comply with their request of using the lift so they terminated her service contract after 30 days. They mentally and verbally abused her to the point where she was crying all the time, distraught, distressed and deeply depressed. During that time, she had no one help her at all that day even though they were under contract to help her dress, toilet and groom. One day Country Manor brought her a wrong food tray that she could not eat so she had no food in over 24 hours. When I talked to her by phone that day she was out of breath, slurring her words and told me she did not even have the energy to get up and open her drapes. She is sitting alone in the dark with no nutrition for 24 hours and County Manor did not check on her as their contract stated.

I have voice recordings, emails and a stack of documentation from the past 4 years that shows they are abusive and financially exploiting a vulnerable adult. I am perplexed that many Minnesota Government Departments all say they can help the Elderly yet no one will do anything. I have contacted the MN Adult Abuse Center, Benton County Social Services, the Senior Law Project, Health Department, the Senior Linkage Line and Senator Jim Abeler who is the chair of the Human Services Reform Finance and Policy Committee. I have gotten no action to help and they all just take a report and tell me to contact Ombudsman. I was in contact with Dan Tupy at one point at Ombudsman but he did not even return my calls. He must have talked to Robin Theis at Country Manor because he was copied on the termination notice but did not even contact Lorraine to inquire about her needs or follow up with me. Even our social service departments are negligent. Whenever I would call any of the state departments the retaliation became worse and after a fall Lorraine was admitted into the Rehab department where they killed her in just 2 months due to neglect, lack of sleep, lack of water, mismanagement of medications and my persistent demand that the health department do something.

This abuse is unfair, unwarranted, in violation of the Mn Home Care Bill of Rights and MN statute 144. There is obvious maltreatment under the Vulnerable Adults Act, severe

financial exploitation and violation of human rights. This is all so disappointing and has to stop! Country Manor needs to be held responsible.

I also want to note that there is inadequate wi-fi service available for the assisted living apartment areas on the Country Manor campus so the Nanny Cam law seems pointless. Country Manor is also in violation of the COVID PPE regulations as well as HIPPA violations. I have conclusive evidence and documentation of everything.

Please listen to my cry for help. The mistreatment is inhumane.

Respectfully,

Sandy Klocker
320.267.7313
SandyKlocker@gmail.com

To: Administrative Law Judge Ann C. O'Reilly

From: JacLynn Herron
Author of *Singing Solo: In Search of a Voice for Mom*
jaclynnherron@yahoo.com

Subject: Comments on the Minnesota Department of Health's Published Rulemaking for Assisted Living

Date: January 5, 2021

I am writing to encourage adoption of strong, detailed, and enforceable language within the rules that accompany the 2019 Elder Care and Vulnerable Adult Protection Act. I appreciate the opportunity to comment during the important rule making phase. I do so as a person with eight years of experience as an advocate for a loved one in long term care.

My mother, an otherwise healthy woman, suffered from dementia. As her helplessness increased, so did her vulnerability. For the last four years of her life, she was wheelchair bound, unable to speak, and in need of help with all activities of daily living. During that time the following care-related conditions negatively impacted her quality-of-life in a Minnesota long term care facility:

- inconsistency of care from one shift of caregivers to another
- failure to implement her care plan (when she was not repositioned, fed, or given vital fluids)
- injuries that resulted from her cares
- failures in protocol to take care of her injuries
- concerns regarding her personal safety
- issues involving the security of her belongings

As her advocate, I partnered with her care staff in attempts to improve her condition, but positive changes were always short-lived. The possibility of sustained improvement fell victim, just like my mother (note the examples above), to understaffing and high staff turnover. These realities negatively impacted not only her, but also the overworked staff that were charged with the responsibility of providing the services that my mother's care plan directed and for which she paid dearly.

From this perspective I wish to stress the importance of the following:

4659.0180 Staffing

My mother, like many residents with dementia, was unable to speak which made her unable to ask for assistance. To compound this deficiency she was physically and cognitively incapable of activating the call system.

My mother's experience reinforces the need for:

- **person-centered care** which did not thrive in a facility marred by understaffing and high staff turnover.
- **sufficient staffing 24 hours per day** to not only respond to residents' requests, but also, to initiate around-the-clock health and safety checks, an essential requirement of resident-centered care for people with dementia.
- **sufficient staffing 7 days per week**. Weekends and holidays were times of highest vulnerability due to staff shortages or assignment of untrained staff. Even though my

mother's needs did not change from one day to the next, the care that she received fluctuated wildly.

- **staffing plans that are resident-centered not facility-centered**. For example, as my mother's neediness increased, so did the cost of her care. Yet, the staffing remained the same. The lowliest of the care providers (the certified nursing assistants) absorbed the added assignments. Our family said goodbye to many of them when they resigned to accept less stressful, higher paying jobs.
- **accountability.** Unambiguous, enforcable rules are crucial. How are staffing levels measured? Who is ultimately responsible, and how will facilities be held to account? What is the definition of "available" staff? Are they licensed or unlicensed? Are staff trained in dementia care? How will the public access this information? (Too often in my mother's case accountability was expressed with this statement: "There will be an audit!" Yet, positive changes were rarely apparent and results were never shared.)
- **protection.** People with dementia often cannot report substandard care, neglect, or abuse. Their conditions makes them extremely vulnerable in understaffed facilities.

4659.0190 Training Requirement Subp. 3
Additional training requirements for assisted living facilities with dementia care licenses

- Training is vital. I watched as my mother melted into the care of trained caregivers and became rigid and frightened when approached by untrained staff.
- Dementia is complex. "If you know one person with dementia, you know one person," said a speaker at a dementia conference as he described a condition that uniquely affects each person. Well-trained staff must provide person-centered care.
- Note: I believe that all employees of all facilities should have dementia training, since a level of this condition negatively impacts over 50% of people over 85 years of age. (Is the resident not hungry? Or, is she not eating because she is no longer able to navigate a forkful of food from plate to mouth? My mother would have starved to death if the first assumption had been made.) Dementia creeps in, and well-trained staff can compassionately respond when it presents itself.

Thank you for listening to a piece of our family's elder care story, for considering my comments and concerns, and for your efforts to protect and improve the lives of vulnerable Minnesotans.