

Maltreatment of Vulnerable Adults Update

STATISTICAL MALTREATMENT REPORT SUMMARIZING ALLEGATIONS
AND INVESTIGATIONS OF MALTREATMENT FOR STATE FISCAL YEAR
2014

Maltreatment of Vulnerable Adults Update

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As requested by Minnesota Statute 3.197: This report cost approximately \$3,525 to prepare, including staff time, printing and mailing expenses.

Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording. Printed on recycled paper.

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Executive Summary

The Minnesota Department of Health (MDH) Health Regulation Division (HRD) licenses over 2,600 health care entities including: nursing homes, hospitals, boarding care homes, supervised living facilities, assisted living providers, home care providers, hospice providers, and free standing outpatient surgical centers. These entities account for over 54,000 licensed beds and provide services for over 36,000 vulnerable adults statewide each year.

Created in 1976 by the Minnesota Legislature, the Office of Health Facility Complaints (OHFC) is a section within the HRD of MDH designated to investigate allegations of non-compliance with both federal certification requirements and state licensing regulations. With the enactment of the Vulnerable Adults Act (VAA) in 1981, the responsibilities of OHFC were expanded to include investigations into claims of abuse and neglect of residents in licensed health care facilities, and to receive and evaluate incidents reported from facilities that may constitute violations of the VAA.

Minnesota Statutes, section 626.557, requires the Minnesota Department of Health and the Department of Human Services (DHS) to annually report to the Legislature and the Governor information about alleged maltreatment in licensed health care entities. The Minnesota Department of Health – through the Office of Health Facility Complaints – and the Department of Human Services – through the Licensing Division – are both designated as “lead investigative agencies” for cases of adult maltreatment under the Vulnerable Adults Act (Minn. Stat. sec. 626.557). Historically, the VAA required both lead investigative agencies to separately submit annual reports to the legislature about alleged maltreatment of vulnerable adults in facilities and programs licensed by the two agencies.

However, the maltreatment reporting law changed in the 2014 Minnesota Legislative Session to allow the Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS) to combine the two agencies’ data and information about vulnerable adults’ maltreatment investigations and outcomes into one comprehensive biennial report. During non-report years, both agencies are required to publish statistical information about their maltreatment investigations and outcomes on their websites:

“(e) The commissioners of health and human services shall annually publish on their Web sites the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigation under this section, and the resolution of those investigations.”

Refer to [Minnesota Statutes, section 626.557, subdivision 12b, paragraph \(e\)](#) for the full reporting requirements. Also, please refer to the [State Fiscal Year 2013 Maltreatment Report: Vulnerable Adults in Minnesota Health Care Facilities](#) for additional information such as background information on the Vulnerable Adults Act and OHFC’s Intake/Triage Process.

The following satisfies the requirement for statistical information about maltreatment investigations and outcomes. This web report was prepared by staff of the Health Regulation Division. This report is based on OHFC program data during State Fiscal Year 2014 (SFY14), which occurred from July 1, 2013 through June 30, 2014

Maltreatment Data Requirements

There are more than 2,700 health care entities licensed by the Minnesota Department of Health (MDH) involving over 54,000 licensed beds. Licensed health care entities include nursing homes, hospitals, boarding care homes, supervised living facilities, home care providers, assisted living providers, hospice programs, hospice residences, and free standing outpatient surgical facilities. The licensure laws contained in Minnesota Statutes Chapters 144 and 144A detail the department's authority and responsibilities in this area. Many of these licensed health care entities are also federally certified for purposes of participation in the Medicare and/or Medicaid programs.

While the Office of Health Facility Complaints (OHFC) investigates other complaints, the data in this report is specific to complaints and facility-reported incidents of alleged maltreatment occurring in facilities that are licensed by MDH.

The number and type of reports of alleged maltreatment

State and federal laws authorize anyone to file a complaint about licensed health care facilities, including complaints of alleged maltreatment. State law also mandates that licensed health care entities report all incidents of potential maltreatment (allegations) against a vulnerable adult or a minor. Maltreatment allegations are received from two types of sources:

- *Complaints:* When a client or interested party makes a complaint about abuse, neglect, financial exploitation, or an unexplained injury to OHFC. **1,817 complaint allegations of maltreatment were received in SFY14.**
- *Provider Self-reports:* When providers have an incident of possible abuse, neglect, financial exploitation, or an unexplained injury and report that incident to OHFC. **18,233 provider self-reported allegations of maltreatment were received in SFY14.**

Types of Maltreatment – Addition of Drug Diversion

Under the Vulnerable Adults Act (VAA), maltreatment is defined as abuse, neglect or financial exploitation. Historically, MDH has reported on two subsets of neglect: unexplained injury and accident. The categories of types of maltreatment in this report have changed this year compared to previous years.

At the start of state fiscal year 2014, OHFC made a change to internal maltreatment coding to allow the tracking of allegations of maltreatment that specifically relate to drug diversions. This distinction provides data that enables OHFC to track allegations and trends of diversion of

pharmaceutical drugs by health care professionals. Prior to SFY14, all allegations relating to drug diversion were coded as financial exploitation. Therefore, just as unexplained injury and accident have been pulled out as subsets of neglect, the category of drug diversion is now being reported as a subcategory of financial exploitation.

Like the subcategories of neglect, the drug diversion number is being reported as its own total, and therefore should be considered *in addition to* the financial exploitation count to arrive at the true total count of financial exploitation allegations.

Table 1 and Figure 1 reflect the number and type of allegations of maltreatment received from State Fiscal Year 2010 (SFY 10) through State Fiscal Year 2014 (SFY 14). The numbers include the total of both complaints and facility-reported incidents of alleged maltreatment.

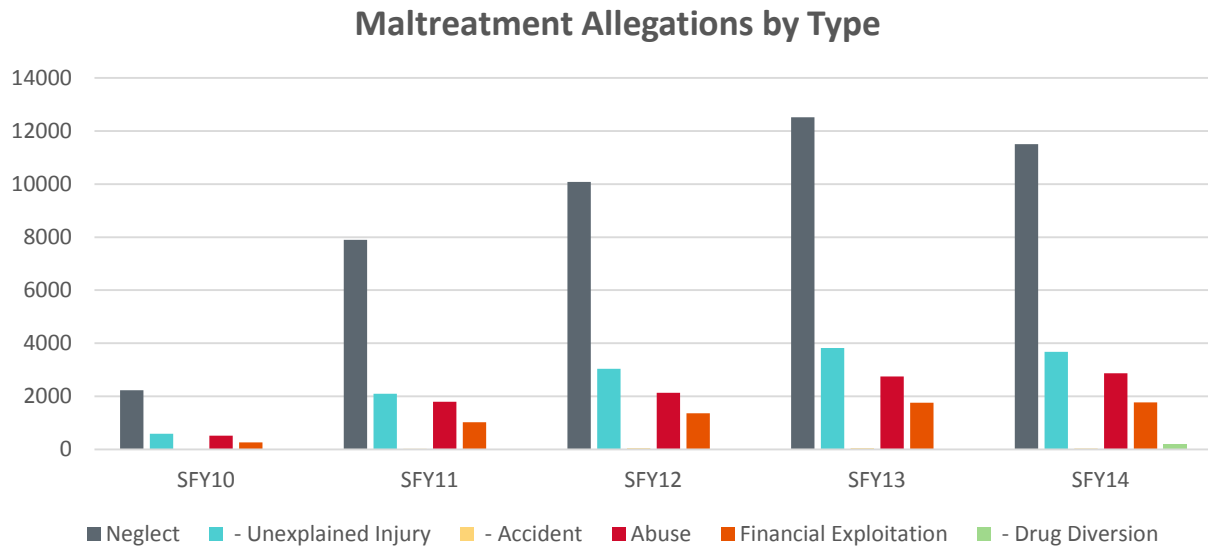
Table 1: Total Maltreatment Allegations Received, by Type

Type of Allegation	SFY10	SFY11	SFY12	SFY13	SFY14
Neglect	2,228	7,895	10,082	12,513	11,507
- Unexplained Injury	591	2,092	3,044	3,819	3,675
- Accident	3	24	48	42	35
Abuse	518	1,792	2,132	2,751	2,867
Financial Exploitation	268	1,020	1,361	1,757	1,773
- Drug Diversion	N/A	N/A	N/A	N/A	192
Total	3,608	12,823	16,667	20,882	20,049
Percent change from the previous year	--	255%	30%	25%	-4%

In a five year trend (SFY10-14), SFY14 is the first year where there was not an increase in the number of maltreatment allegations received. In fact, OHFC received almost the same number of maltreatment allegations in fiscal years 13 and 14, with 4% fewer maltreatment allegations received 2014 compared to the previous year.

Figure 1 illustrates the number of maltreatment allegations received by OHFC over a five year period, by type of allegation.

Figure 1: Maltreatment Allegations Received, by Type



Neglect continues to be the largest source of allegations, with OHFC receiving 1,247 complaint allegations of neglect and 10,260 allegations of neglect from provider-reported incidents in SFY14. These 11,507 total allegations of neglect constitute 57% of all allegations received, which is similar to the 60% received in the previous year.

When including the “subsets” of neglect (unexplained injury and accident) OHFC received 1,299 complaint allegations and 13,918 allegations of neglect from provider-reported incidents, for a total of 15,217. With the inclusion of the two subcategories, neglect accounts for 76% of all maltreatment allegations received by OHFC.

Number of allegations requiring investigation and investigation resolutions

If an onsite investigation of alleged maltreatment is conducted, OHFC has three determination options: substantiated, false (OHFC uses the federal terminology of not substantiated), or inconclusive. All substantiated or unsubstantiated determinations must be based on a preponderance of evidence, which is more than 50% of weighted evidence. **This means that although a maltreatment complaint may have merit and the incident may have occurred, there may not be sufficient relevant evidence to support a substantiated finding of non-compliance or “fault.”**

In addition, not all complaints or facility-reported incidents meet the definition of maltreatment under Minnesota Statutes, section 626.5572. Although the evidence may confirm the incidents occurred, it may not constitute a finding of maltreatment under Minnesota Statutes, section 626.5572, subd. 15.

Table 2 represents the number of allegations of maltreatment received, total number of allegations that were assigned for onsite investigation, and the outcome of those onsite investigations. These totals include both complaints and facility-reported incidents of alleged maltreatment.

Table 2: Total Maltreatment Allegations, Total Onsite Investigations & Outcomes

	Total Allegations	Investigated Onsite				% Substantiated
		Total	Substantiated	Not Substantiated	Inconclusive	
SFY10	3,608	591	186	181	224	32%
SFY11	12,823	852	174	438	240	20%
SFY12	16,667	760	139	392	229	18%
SFY13	20,882	581	119	308	154	20%
SFY14	20,049	763	141	438	184	18%

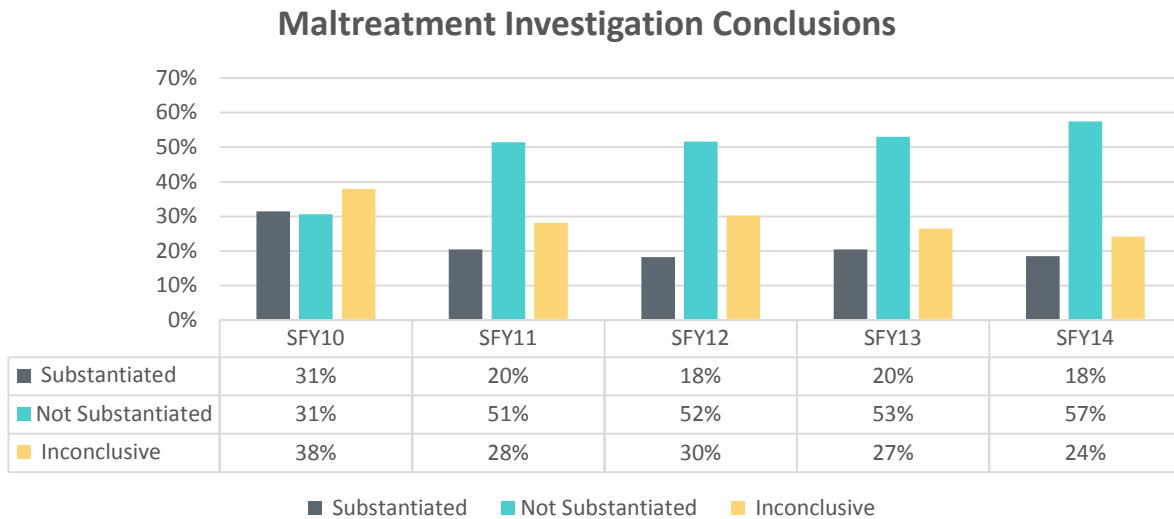
The total number of onsite investigations varies from year to year, but the percentage of onsite investigations resulting in substantiated maltreatment findings remains relatively consistent over time. As reflected in the far right column of Table 2, the percentage of onsite investigations resulting in substantiated findings has varied between 18% - 20% over the past four years.

Additionally, the percentage of investigations resulting in an inconclusive status decreased in SFY14 compared to the prior year. Onsite investigations with an inconclusive determination made up 27% of SFY13 investigation conclusions, compared to the 24% seen in SFY14.

Fewer investigations resulting in an “Inconclusive” status supports an effort by OHFC to consider an investigation to be either substantiated or not substantiated, limiting the use of inconclusive findings to circumstances where parties provide conflicting evidence (he said/she said) to support a finding that the incident did or did not occur.

Figure 2 reflects the percentages of onsite maltreatment investigation determinations of the over a five year period.

Figure 2: Conclusions of Onsite Maltreatment Investigations

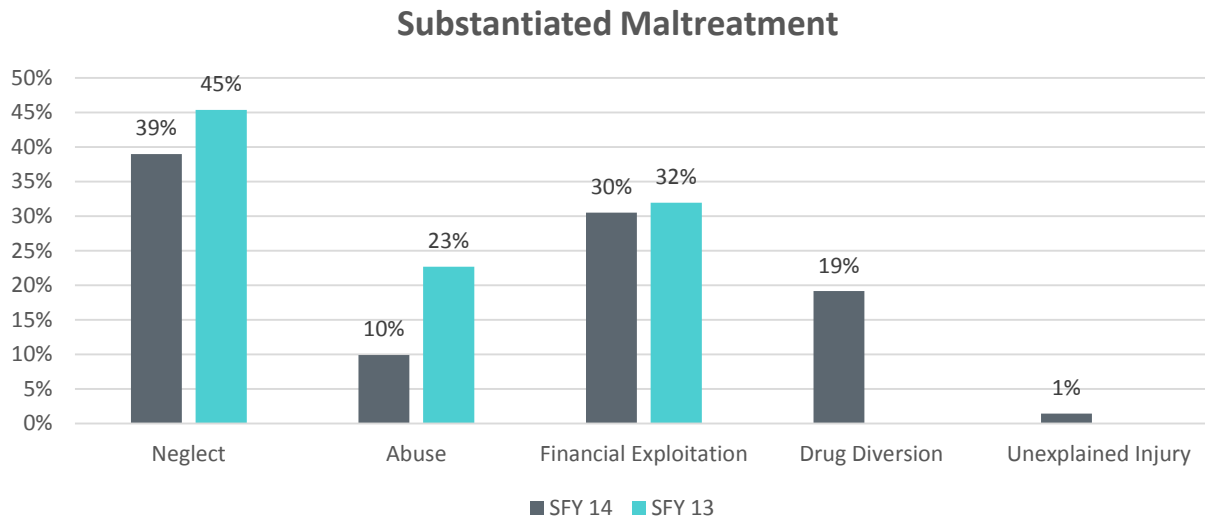


Substantiated Maltreatment by Allegation Type

Figure 3 represents a breakdown of the substantiated onsite maltreatment investigations by type of allegation for state fiscal years 2013 and 2014. Since OHFC began tracking allegations of maltreatment that specifically relate to drug diversions at the start of fiscal year 2014, data does not exist for this subcategory in years prior to SFY14.

Please note that the subcategory of unexplained injury existed in SFY13, but there were no substantiated allegations of unexplained injury during that year.

Figure 3: Substantiated Maltreatment Investigations, by Type



As earlier stated, neglect is the largest source of maltreatment allegations. However, while neglect was also the largest source of substantiated onsite investigations of maltreatment in SFY13, it “took a backseat” to financial exploitation in SFY14. In fiscal year 2014, neglect¹ accounted for 40% of substantiated onsite investigations of maltreatment, whereas financial exploitation² accounted for 50% of substantiated maltreatment investigations. Drug diversion accounted for over half (63%) of those substantiated investigations of financial exploitation.

Maltreatment Data: Statutory Time Frames

It is one of OHFC’s goals to provide timely intervention on high priority complaints to mitigate the possibility of harm to residents (note that harm and/or potential harm is one of the triggers for an onsite investigation). A change to the federal triage protocols in 2011 increased the number of complaints and reports that must be investigated within two days. As a result, OHFC investigators are oftentimes dispatched to different facilities before they have had time to complete previously assigned complaints. This requirement continues to impact investigator’s caseloads and cause delays in meeting the VAA requirement that maltreatment investigations be completed within 60 days.

Although OHFC conducts the initial onsite investigation in a timely manner, the conducting of interviews, requesting additional records, as well as the completion of the required public

¹ “neglect” includes unexplained injury, as this category is a subset of neglect

² “financial exploitation” includes drug diversion, as this category is a subset of financial exploitation

report may fall outside the 60 day timeframe. All parties involved in a maltreatment investigation receive letters at 60 days informing them that the investigation is ongoing.

Table 3: Maltreatment Onsite Investigations: Number & Percent Completed Within 60 Days

	Total Onsite Investigations	Total Onsite Investigations Completed Within 60 Days	Percent Over 60 Days	Percent On Time
SFY 10	591	97	84%	16%
SFY 11	852	152	82%	18%
SFY 12	760	231	70%	30%
SFY 13	581	234	60%	40%
SFY 14	763	239	69%	31%