

2002

Great Expectations—Flawed Implementation: the Dilemma Surrounding Vulnerable Adult Protection

Mike Hatch

Follow this and additional works at: <http://open.mitchellhamline.edu/wmlr>

Recommended Citation

Hatch, Mike (2002) "Great Expectations—Flawed Implementation: the Dilemma Surrounding Vulnerable Adult Protection," *William Mitchell Law Review*: Vol. 29: Iss. 1, Article 3.

Available at: <http://open.mitchellhamline.edu/wmlr/vol29/iss1/3>

This Article is brought to you for free and open access by the Law Reviews and Journals at Mitchell Hamline Open Access. It has been accepted for inclusion in William Mitchell Law Review by an authorized administrator of Mitchell Hamline Open Access. For more information, please contact sean.felhofer@mitchellhamline.edu.

© Mitchell Hamline School of Law

**GREAT EXPECTATIONS—FLAWED IMPLEMENTATION:
THE DILEMMA SURROUNDING VULNERABLE ADULT
PROTECTION**

Mike Hatch[†]

I.	INTRODUCTION	10
	A. <i>Statistics and Problems</i>	10
II.	VICTOR’S HYPOTHETICAL	12
III.	CRIMINAL LAWS AIMED AT PROTECTING VULNERABLE ADULTS	13
	A. <i>General</i>	13
	B. <i>Criminal Abuse Statute, Minn. Stat. § 609.2325</i>	14
	C. <i>Criminal Neglect Statute, Minn. Stat. § 609.233</i>	15
	D. <i>Criminal Financial Exploitation Statute, Minn. Stat. § 609.2335</i>	16
	E. <i>Penalties</i>	16
	F. <i>Prosecutorial Jurisdiction</i>	17
	G. <i>Prosecutorial Problems with Vulnerable Adult Crimes</i>	17
	H. <i>Victor’s Case</i>	21
IV.	STATE REGULATORY SYSTEM	22
	A. <i>The Vulnerable Adults Act</i>	22
	B. <i>Minnesota Department of Human Services</i>	26
	C. <i>Minnesota Department of Health</i>	27
	D. <i>The Health Professional Licensing Boards</i>	29
	E. <i>The Ombudsmen’s Offices</i>	30
	F. <i>Problems Under the Regulatory Scheme</i>	31
V.	CIVIL REMEDIES.....	34
	A. <i>State Common Law Remedies</i>	34
	B. <i>California Elder and Dependent Adult Civil Protection Act</i> ..	35
	C. <i>The Vulnerable Adults Act</i>	35
	D. <i>Wrongful Death Statute</i>	36
	E. <i>The Consumer Protection Laws</i>	36

[†] Minnesota Attorney General. Specials thanks to the staff of the Minnesota Attorney General's Office for their assistance on this article: Assistant Attorneys General Michael Burns, Margaret Chutich, Sara DeSanto, Theresa Gray, Kerri Hermann, Cyndi Jahnke, and Frank Ling.

10	WILLIAM MITCHELL LAW REVIEW	[Vol. 29:1
	<i>F. Limitations of Civil Litigation</i>	38
	<i>G. How did the Civil Remedies Perform in Victor's Case?</i>	39
VI.	RECOMMENDATIONS.....	39
	<i>A. Recommendations for Criminal Laws</i>	40
	<i>B. Recommendations in the Regulatory Arena</i>	42
	<i>C. Increasing Effectiveness of Civil Litigation</i>	45
VII.	CONCLUSION.....	45

I. INTRODUCTION

A. Statistics and Problems

Minnesota's vulnerable adults¹ are a significant and diverse part of the state's profile. Tens of thousands² of Minnesota vulnerable adults receive treatment in a myriad of state licensed facilities, including 140 hospitals, 417 nursing homes, 312 assisted living home care facilities, 57 boarding care homes, 741 housing with service facilities ("board & lodge"), 3,678 adult foster care homes, 112 residential chemical dependency treatment programs, 261 intermediate care facilities for persons with mental retardation ("ICF/MRs"), 76 "Rule 36" facilities (residential facilities for adults with mental illness), and four "Rule 80" facilities (serving the physically handicapped).³ These individuals receive treatment from thousands of physicians, physician assistants, nurses, nursing assistants, social workers, family therapists, nutritionists, psychologists, and unlicensed health care workers.

Minnesota's vulnerable adult population is also growing at a

1. The term "vulnerable adults" in this article is defined in MINN. STAT. § 626.5572 (2001). Vulnerable adults include the elderly, physically and mentally disabled adults, and chemically dependent adults who reside in and receive care in licensed facilities. MINN. STAT. § 626.5572, subd. 21 (2001). It also includes those who do not reside in or receive care from facilities, but who are impaired in their ability to adequately care for themselves due to physical or mental infirmity, or due to physical, mental or emotional dysfunction. *Id.*

2. An estimated 37,000 people live in nursing homes alone, based on nursing home beds available in 2001 and an occupancy rate of approximately ninety percent. *See* MINNESOTA DEPARTMENT OF HUMAN SERVICES, RIGHTSIZING THE NURSING HOME INDUSTRY 2001, A REPORT TO THE MINNESOTA LEGISLATURE, March 1, 2002.

3. Telephone interview with Michael Tripple, Assistant Director for Policy, Minnesota Department of Health, Facility and Provider Compliance Division (June 14, 2002); telephone interview with Jim Schmidt, Management Analyst, Minnesota Department of Human Services, Licensing Division (June 12, 2002).

rate much faster than the state's general population.⁴ Looking at the elderly alone, Minnesota had a population of 4.9 million in 2000, of which about 594,000, or approximately twelve percent, were 65 years of age or older.⁵ It is estimated that by the year 2025, the number of Minnesotans aged 65 or older will almost double to over one million.⁶ During this same time period, the overall population in the state is projected to increase by less than ten percent.⁷ Clearly, the number of elderly Minnesotans with long term care needs will greatly increase in the future.⁸ The manner in which this population is protected from maltreatment will become even more important in the years ahead.

John F. Kennedy once remarked that a society's quality and durability can best be measured by the respect and care given its elder citizens.⁹ Minnesota has established a complex regulatory system designed to protect adults who cannot fend for themselves.¹⁰ It has also enacted criminal and civil laws designed to deter maltreatment.¹¹ The aim of these regulatory and statutory efforts--to protect our most fragile citizens--is laudable. The application of this unwieldy web of laws, however, all too often fails to achieve these goals.

For instance, at a state regional treatment center, employees cancelled a 911 telephone call by a pregnant patient who was being treated for chemical dependency, and claimed to be in labor while going through treatment.¹² As a result, the patient gave birth in a non-assisted delivery.¹³ Even though the employees disregarded her claims of labor pains and failed to adequately assess her condition, the employees and administrator of the hospital were

4. See UNITED STATES CENSUS BUREAU, Census 2000, *available at* <http://www.census.gov/prod/2001pubs/czkbr01-10.pdf>.

5. *Id.*

6. See MINNESOTA PLANNING, STATE DEMOGRAPHICS CENTER, ESTIMATES AND PROJECTIONS, *available at* <http://www.mnplan.state.mn.us/cgi-bin/datanetweb/prj?year=25&sex=TOT&age=all&>.

7. *Id.*

8. Long-Term Care Task Force, Final Report (January 2001).

9. John F. Kennedy, Special Message to Congress (1963), *quoting* Arnold Toynbee.

10. See MINN. STAT. §§ 626.557, 626.5572 (2001).

11. See, e.g., MINN. STAT. §§ 609.2325, 609.233, 609.2335 (2001).

12. Investigation Memorandum from the Minnesota Department of Human Services, Division of Licensing, Report No. 980082 (May 29, 1998) (on file with the William Mitchell Law Review).

13. *Id.*

allowed to continue working in the facility.¹⁴

In another case, an elderly woman refused to take a shower in an Eden Prairie Assisted Living Center.¹⁵ Frustrated, a nursing aide stripped the woman in a common hallway and forced her to take a sponge bath in front of the other residents.¹⁶ The judge dismissed the charge of assault, finding that the state did not prove that the nursing aide had the requisite criminal intent to sustain a conviction.¹⁷

This article looks at Minnesota's criminal, regulatory, and civil laws that have been designed to protect vulnerable adults, and identifies where those laws could be strengthened and improved. It also examines specific recommendations that lawmakers may wish to consider in improving our laws to better protect the elderly and vulnerable.

The following hypothetical, which presents a set of facts that could occur at any facility, highlights some of the flaws in the design of our present system to protect vulnerable adults.

II. VICTOR'S HYPOTHETICAL

Victor suffers from dementia and lives at the Superior Assisted Living Facility ("Superior") in Duluth. He is seventy-five years old and weighs 250 pounds. For several years, Superior has had problems finding help and operates many shifts short-staffed. One evening, Axel, a nursing assistant at Superior, fails to use two people to transfer Victor from his wheelchair to his bed, as required under his care plan. Instead, Axel tells Victor to help himself as Axel shifts Victor on the bed. Perched halfway on the bed, Victor crashes to the ground when Axel lifts Victor's legs to swing them onto the bed. Alice and Betty, two residents at Superior, overhear the commotion when Victor crashed to the ground. They also heard Axel tell Victor, just before the crash, that he was a fat pig who should learn to help himself into bed.

Victor suffers bruising on his body and a gash to his right eye. After much tugging and pulling, Axel is able to get

14. *Id.*

15. State v. Ahern, File No. 00093511 (Minn. Dist. Ct., Hennepin County, Dec. 5, 2000) (order dismissing case for lack of probable cause). See *infra* section III.G. for a more complete discussion of this case.

16. *Id.*

17. *Id.*

Victor back into the bed. Later in the shift, Axel makes passing mention to Nancy, the nurse in charge, that Victor had a fall. Nancy is busy attending to another resident, and neither Nancy nor Axel check back in on Victor or make a report of the incident.

Two days later, Victor receives a visit from his daughter, Millie, who discovers the gash, and notices considerable swelling on Victor's head. She also notices that he is partially paralyzed. Betty sees Millie and tells her what she and Alice heard the night of the fall. Millie files a complaint with Superior and with St. Louis County Social Services. Victor's condition deteriorates, and doctors later determine that Victor suffered a brain injury leaving him partially paralyzed and unable to speak.

Axel is "let go" by Superior, but soon thereafter finds a job transporting vulnerable adults, a business activity that is not licensed by the state. Axel finds the job particularly difficult when he later drops Zelda, a 200 pound patient, from the back of the van.

Sections III.H., IV.F., and V.F. below discuss how Minnesota's criminal, regulatory, and civil systems and laws would provide inconsistent remedies for our hypothetical victim. Axel's new employer is unable to discover the incident because the maltreatment finding is "private data;" Nancy receives virtually no consequences for her conduct; Superior receives no fines, sanctions, or penalties; various state agencies render conflicting determinations regarding the same set of facts; the prosecutor declines to pursue this case; and responsible actors are not held accountable under the civil laws. Ultimately, the current system did nothing to change the poor quality of care that Victor received and continues to receive, and that Axel provided at Superior and continues to provide to patients in his new employment.

III. CRIMINAL LAWS AIMED AT PROTECTING VULNERABLE ADULTS

A. *General*

Historically, prosecutors in Minnesota had to rely on statutes enacted to protect the general populace. In 1995, however, the Minnesota Legislature enacted several criminal laws to specifically

address the maltreatment of vulnerable adults.¹⁸ These laws relate to criminal abuse, criminal neglect, and financial exploitation of a vulnerable adult.¹⁹ The Legislature also made it a crime for a mandated reporter to intentionally fail to report suspected maltreatment of a vulnerable adult or fail to provide material information for a report.²⁰

Prosecutions under these laws from 1999 to 2001 were as follows:²¹

	1999	2000	2001
Criminal Neglect (§ 609.233)	2	9	10
Criminal Abuse (§ 609.2325)	8	9	14
Financial Exploitation (§ 609.2335)	20	30	30
Total	30	48	54

While these statistics show that the use of these laws has increased, it remains to be seen whether the 1995 legislative initiative will have any major effect on the prevention, detection, or punishment of vulnerable adult maltreatment.

B. Criminal Abuse Statute, Minn. Stat. § 609.2325

The scope of the criminal abuse statute is narrow. One provision applies to a caregiver who subjects a vulnerable adult to “any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion,” intended “to produce physical or mental pain or injury.”²² If this conduct causes the death of a vulnerable adult, the penalty provided for by the statute is the same as that for

18. See 1995 Minn. Sess. Law Serv., ch. 229, art. 2, §§ 2-5 (West).

19. MINN. STAT. §§ 609.2325, 609.233, 609.2335 (2001).

20. See 1995 Minn. Sess. Law Serv., ch. 229, art. 2, § 6 (West). Failure to report is generally a misdemeanor offense, but may rise to the level of a gross misdemeanor offense under certain circumstances, including where the failure to report causes or contributes to the death of the vulnerable adult. See MINN. STAT. § 609.234 (2001).

21. Data compiled by Craig Hagensick, Research Analyst, State Court Administrator’s Office, based on electronic records in the Minnesota Courts Criminal Data Mart (May 13, 2002).

22. MINN. STAT. § 609.2325, subd. 1(a) (2001). For purposes of the vulnerable adult crimes, the definitions of “caregiver” and “vulnerable adult” are the same as the definitions in the civil, regulatory scheme. See MINN. STAT. §§ 609.232, subds. 2, 11; 626.5572, subds. 4, 21 (2001).

first degree manslaughter.²³ A second provision applies to “sexual contact or penetration” by a “caregiver, facility staff person, or person providing services in a facility,” but only if the conduct does not otherwise meet the definition of criminal sexual conduct in the first through fourth degrees.²⁴ The penalty for a violation of this provision is only a gross misdemeanor, imposing not more than one year of imprisonment, or a fine of not more than \$3,000, or both.²⁵

C. Criminal Neglect Statute, Minn. Stat. § 609.233

The scope of the criminal neglect statute is substantially broader and covers both abuse and neglect.²⁶ This statute makes it a crime for a caregiver or operator of a licensed facility to either (1) intentionally neglect a vulnerable adult or (2) knowingly permit “conditions to exist that result in the abuse or neglect of a vulnerable adult.”²⁷ The explicit inclusion of “operators” as possible perpetrators and the second clause for “knowing” conduct show that the statute was meant to target facility administrators and supervisors who may not provide direct care to patients or residents, but have oversight responsibilities.²⁸ Although the statute addresses conduct that could result in death or great harm to the victim, the crime is classified only as a gross misdemeanor.²⁹ The maximum punishment for criminal neglect is one year of imprisonment and/or a \$3,000 fine.³⁰

23. MINN. STAT. § 609.2325, subd. 3(a)(1) (2001). First-degree manslaughter carries a maximum penalty of fifteen years and/or a \$30,000 fine. MINN. STAT. § 609.20 (2001).

24. MINN. STAT. § 609.2325, subd. 1(b) (2001).

25. MINN. STAT. § 609.2325, subd. 3(b) (2000). Unlike the criminal sexual conduct offenses, this crime does not carry the requirement that the perpetrator register as a sexual offender. See MINN. STAT. § 243.166 (2001) (requiring the registration of so-called “predatory offenders”).

26. MINN. STAT. § 609.233 (2001). The statute imports the definition of “abuse” from the civil, regulatory statute and defines neglect as “a failure to provide a vulnerable adult with necessary food, clothing, shelter, health care, or supervision.” MINN. STAT. § 609.233, subd. 1 (2001).

27. MINN. STAT. § 609.233 (2001).

28. MINN. STAT. § 609.232, subd. 7 (2001) (defining “operator” as “any person whose duties and responsibilities evidence actual control of administrative activities or authority for the decision making of or by a facility”).

29. MINN. STAT. § 609.233, subd. 1 (2001).

30. MINN. STAT. §§ 609.233, subd. 1; 609.02, subd. 4 (2001).

D. Criminal Financial Exploitation Statute, Minn. Stat. § 609.2335

The criminal financial exploitation statute addresses three general categories of conduct.³¹ First, it covers the failure of a “fiduciary” agent to use a vulnerable adult’s financial resources for “food, clothing, shelter, health care, therapeutic conduct, or supervision for the vulnerable adult.”³² Second, it covers the “use of undue influence, harassment, or duress” to obtain a vulnerable adult’s money or property.³³ Third, it covers conduct by which a person “forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult’s will to perform services for the profit or advantage of another.”³⁴ The penalties for the first two categories of conduct are based on the penalties for theft, which can range from a misdemeanor-level penalty to a felony-level penalty, depending on the dollar value of the wrongfully used or obtained assets.³⁵ A gross misdemeanor penalty attaches to the third category of conduct.³⁶

E. Penalties

In addition to incarceration and fines, a perpetrator convicted of a vulnerable adult crime is prohibited from working in direct contact with persons receiving services from licensed facilities and programs.³⁷ In addition, the perpetrator is prohibited from participating in Medicare or state health care programs, such as Medicaid, for a minimum of five years.³⁸

Federal regulations also require prosecutors to report criminal convictions for crimes “related to the delivery of a health care item or service” to a national registry, which is designed to identify

31. *See generally* MINN. STAT. § 609.2335 (2001).

32. MINN. STAT. § 609.2335, subd. 1(1) (2001).

33. MINN. STAT. § 609.2335, subd. 1(2)(i) (2001).

34. MINN. STAT. § 609.2335, subd. 1(2)(ii) (2001).

35. *See* MINN. STAT. §§ 609.2335, subd. 3; 609.52, subd. 3 (2001).

36. *See* MINN. STAT. §§ 609.2335, subd. 3; 609.02 (2001).

37. *See* MINN. STAT. § 245A.04, subd. 3d (2001).

38. *See* Medicare & Medicaid Patient & Program Protection Act of 1987, Pub. L. No. 100-93, 101 Stat. 680 (codified as amended at 42 U.S.C. § 1320a-7 (1991)). The period of exclusion may be extended for more than five years if any of the four following factors exist: (1) the acts resulting in the conviction, or similar acts, were committed over a period of at least one year; (2) the acts resulting in conviction had a significant adverse physical or mental impact on the patient; (3) the sentence imposed by the court included imprisonment; or (4) the convicted abuser has a prior criminal, civil, or administrative sanction record. 42 C.F.R. § 1001.102(b)(5) (2001).

perpetrators seeking participation or employment in health care settings.³⁹ While state disqualifications help to protect other vulnerable adults in the state, the federal regulations provide some assurance that perpetrators will not be able to prey upon vulnerable adults in other states as well.⁴⁰

F. Prosecutorial Jurisdiction

There is no single, statewide authority responsible for prosecuting crimes against vulnerable adults. Rather, the prosecuting authority for vulnerable adult crimes is the same as for general crimes against persons. For instance, county attorneys are typically responsible for prosecuting felony-level and some gross misdemeanor-level offenses committed within their jurisdictions, while city attorneys are generally responsible for prosecuting misdemeanor and certain gross misdemeanor-level offenses.⁴¹ The Office of the Attorney General has recently become more actively involved in prosecuting crimes against vulnerable adults on a referral basis from city and county attorneys, but it does not have original or concurrent jurisdiction under which it can independently prosecute such cases.

G. Prosecutorial Problems with Vulnerable Adult Crimes

The prosecution of a vulnerable adult crime presents many special challenges. These challenges begin at the investigative stage. Unlike “street crimes” or crimes of violence that occur in homes, reports of vulnerable adult maltreatment in nursing homes or other care facilities may not be reported through 911 calls or reports directly to local law enforcement. More often than not, a vulnerable adult report is called in to a “common entry point,” which then processes the complaint before reporting it to the “lead agency.”⁴² The lead agency will then receive the report, process it once again, conduct its own investigation, and, if appropriate, refer the matter to a law enforcement agency.⁴³ As a result, many of these reports are not quickly relayed to law enforcement, which

39. 45 C.F.R. § 61.8 (2001). This registry is known as the Healthcare Integrity and Protection Data Bank. 45 C.F.R. § 61.1 (2001).

40. *See infra* section 4.1.D (explaining state disqualifications).

41. *See* MINN. STAT. §§ 388.051; 487.25, subd. 10 (2001).

42. *See infra* Part IV.A.2. for a full discussion of the reporting process.

43. *Id.*

may result in important evidence being lost or forgotten before a criminal investigation begins. For example, injuries (such as bruising, bumps, swelling, or lacerations) often fade before police can take any photographs, or a photo line-up of possible assailants may not occur while the attack is still fresh in the mind of an aging victim or witness.

In addition, law enforcement officers may lack adequate training and experience in conducting investigations involving elderly or disabled victims with physical and cognitive impairments. As with child abuse victims, special interviewing techniques are necessary to elicit critical information from victims who have difficulties communicating, or who are fearful or reluctant to accuse the caregivers upon whom they are dependent. Moreover, properly assessing allegations of abuse or neglect of such victims may require medical expertise to distinguish age or disability-related symptoms from intentional physical abuse or neglect. For example, elderly patients can be susceptible to bruising or bone fractures unrelated to blunt trauma or physical force. Further, cases of financial exploitation may require special expertise in accounting and may consume more resources than are available to engage in the time-intensive task of tracking and analyzing financial transactions.

Even if a case is promptly and thoroughly investigated, further challenges arise at trial. The physical abuse of a vulnerable adult is unlikely to occur in the presence of witnesses. The victim may be non-communicative or suffer from dementia or other cognitive impairments that diminish the victim's ability to convey information or to remember details about the abuse. Without clear testimony from the victim, it may be difficult or impossible to prove beyond a reasonable doubt that the abuse occurred. Even if the victim is able to provide a statement after the incident, by the time of trial, the victim may no longer be able to testify because of deteriorating physical or mental condition, or even death.

A case of criminal neglect can be particularly difficult to prosecute if a victim is in a facility and receiving care from many people with various levels of responsibility. In such cases, there may be no single person to hold responsible for the neglect. The neglect may also be attributable to corporate policies or management decisions, such as supply and staffing cuts. This presents another set of evidentiary problems, including those relating to proof of specific intent or knowledge on the part of

corporate officers or other management-level employees who are removed from the direct care setting.

Finally, challenges also exist when judges are unfamiliar or uncomfortable with the prosecution of caregivers working in institutional health care settings. This phenomenon may have played a role in two abuse cases recently brought by the Attorney General's Office.

The first case involved an elderly nursing home resident who suffered from dementia.⁴⁴ He was found with a bloody, bruised eye that was swollen shut and required eight stitches.⁴⁵ The defendant, a nursing home employee, claimed that she accidentally scratched the resident with her fingernails as she pulled away from being touched on the breast by the resident while she washed his face.⁴⁶ The defendant waived a jury trial and the case was tried to a judge.⁴⁷ The judge found the defendant not guilty, despite the uncontroverted medical testimony of the treating physician that the injuries were not consistent with the defendant's explanation, and could only have occurred as a result of a forceful, blunt trauma.⁴⁸

The second case involved a complaint alleging that a caregiver at an assisted living facility used brute force to bathe a resident.⁴⁹ The resident suffered from dementia, but was communicative and could bathe and groom herself with minimal assistance.⁵⁰ According to other facility staff, when the resident refused to take a shower, the defendant grabbed the resident by the hands and wrists and pushed her onto her bed.⁵¹ The resident began screaming and resisting.⁵²

The complaint further alleged that the defendant then restrained the resident in a wheelchair and took her down the hall to the shower room.⁵³ Before reaching the shower room, the

44. State v. Jamison, File No. K8-00-77 (Minn. Dist. Ct., Olmsted County, Jan. 5 2000).

45. *Id.*

46. *Id.*

47. *Id.*

48. *Id.* The victim in this case did not testify because he was non-communicative. *Id.* The defendant also did not testify. *Id.*

49. State v. Ahern, File No. 00093511 (Minn. Dist. Ct., Hennepin County, Dec. 5, 2000).

50. *Id.*

51. *Id.*

52. *Id.*

53. *Id.*

resident slid from the wheelchair to the floor.⁵⁴ The defendant then stripped the resident on the hallway floor, with two other residents watching, and proceeded to forcibly bathe the resident with wet towels as the resident screamed and struggled.⁵⁵ The resident suffered bruising on her shoulders, hands, wrists, and arms.⁵⁶ More importantly, the resident was devastated due to the humiliation of being stripped naked in front of other residents.⁵⁷ The defendant admitted her actions, but denied any wrongdoing.⁵⁸

The defendant was charged with fifth degree assault, criminal abuse, and disorderly conduct.⁵⁹ The case, however, was never brought before a jury because at the pretrial stage, the judge dismissed all three charges for lack of probable cause.⁶⁰ Finding that the defendant acted with the intent to fulfill her job duties, and not with the intent to harm the victim, the judge concluded that, while the defendant's conduct was inappropriate, it did "not amount to criminal conduct."⁶¹

Despite the difficulties in prosecuting crimes against vulnerable adults, it is possible to successfully convict perpetrators. In a recent prosecution by the Attorney General's Office, a jury convicted a nursing assistant of criminal sexual conduct against a nursing home resident who suffered from both physical and mental disabilities.⁶² The perpetrator shaved the pubic area of the patient and proceeded to have sexual contact with the victim under the guise of providing necessary care.⁶³ There were no other witnesses to the illegal touching, and the conduct became known only when the victim, who suffered from schizophrenia, asked another nursing assistant whether that assistant was going to engage in similar conduct.⁶⁴ The victim's question precipitated an internal

54. *Id.*

55. State v. Ahern, File No. 00093511 (Minn. Dist. Ct., Hennepin County, Dec. 5, 2000).

56. *Id.*

57. *Id.*

58. *Id.*

59. *Id.*

60. State v. Ahern, File No. 00093511 (Minn. Dist. Ct., Hennepin County, Dec. 5, 2000).

61. *Id.*

62. See State v. Sawyer, File No. K6-01-692 (Minn. Dist. Ct., Ramsey County, July 17, 2002).

63. *Id.*

64. *Id.*

inquiry and, ultimately, an investigation by local law enforcement.⁶⁵

Even without third party eyewitnesses, the prosecution in this case was able to present a compelling case. The court found the victim competent to testify, and she was able to tell the jury about the sexual assault in her own words.⁶⁶ To help the jury assess the victim's testimony, a psychologist testified about the nature of the victim's mental disability.⁶⁷ To the jury's credit, the victim's testimony clearly was given great weight and was not discounted based simply on her disability.

H. Victor's Case

How do the criminal laws fare in Victor's case? The most likely charge in this case would be criminal neglect, which is a gross misdemeanor. The prosecution's case is hampered by a number of factors, including delays in receiving adequate investigation reports to facilitate charging Axel. Moreover, even if prosecutors did receive the information soon enough to charge, other factors would make this case difficult to prosecute. These factors include the lack of physical evidence such as photos showing Victor's injuries after the fall, the healing of the unphotographed bruises, Betty and Alice's poor recollection or memory lapses, the lack of supporting testimony from Nancy, and Victor's inability to testify. The prosecutor would also likely have to depend upon expert testimony concerning the cause of the injuries. Furthermore, aggressive defense counsel could build considerable doubt as to the source of Victor's injuries. After all, Victor is senile, and has probably fallen down on other occasions. Assuming that the prosecutor in Victor's case has a typical caseload, which may include two pending murder cases, a rape charge, five aggravated assaults and over twenty pending drug cases, he or she may well decide that there is not enough time to adequately prepare for a criminal case that requires an expert witness, and for which the defendant may only receive probation.

65. *Id.*

66. *Id.*

67. *Id.*

IV. STATE REGULATORY SYSTEM

A. *The Vulnerable Adults Act*

The Vulnerable Adults Act (hereinafter “the Act”) is the general source of jurisdiction for Minnesota state agencies to investigate care provided to vulnerable adults.⁶⁸

1. *Mandated Reports*

The Vulnerable Adults Act requires certain professionals, designated “mandated reporters,”⁶⁹ to immediately report to a “common entry point”⁷⁰ any incident where the professional has reason to believe that a vulnerable adult is being or has been maltreated. The Act also requires reporting where the reporter has knowledge that a vulnerable adult has sustained a physical injury that is not reasonably explained.⁷¹ The Act defines maltreatment of a vulnerable adult to include abuse,⁷² financial exploitation, and neglect.⁷³

2. *Common Entry Point*

Under the Act, the “common entry point” is to receive, screen, and refer a report of alleged maltreatment to one or more of several different agencies.⁷⁴ For instance, if there is reason to believe that a crime has been committed, the report should be

68. See MINN. STAT. §§ 626.557, 626.5572 (2001).

69. “Mandated reporters” are defined as:

a professional or professional’s delegate while engaged in: (1) social services; (2) law enforcement; (3) education; (4) the care of vulnerable adults; (5) any of the occupations referred to in section 214.01, subdivision 2; (6) an employee of a rehabilitation facility certified by the commissioner of jobs and training for vocational rehabilitation; (7) an employee or person providing services in a facility as defined in subdivision 6; or (8) a person that performs the duties of the medical examiner or coroner.

MINN. STAT. § 626.5572, subd. 16 (2001).

70. The “common entry point” is the entity responsible for receiving reports of suspected maltreatment under the Vulnerable Adults Act. MINN. STAT. § 626.5572, subd. 5 (2001). Each of the 87 counties in Minnesota has a designated common entry point. See MINN. STAT. § 626.557, subd. 9 (2001).

71. See MINN. STAT. § 626.557, subd. 3 (2001).

72. “Abuse” includes physical, verbal, emotional, and sexual abuse. MINN. STAT. § 626.5572, subd. 2 (2001).

73. See MINN. STAT. § 626.5572, subd. 15 (2001).

74. See MINN. STAT. § 626.557, subd. 9a (2001).

referred to a law enforcement agency.⁷⁵ If the common entry point determines that there is an immediate need for adult protective services, it should also refer the report to the appropriate county adult protective services unit.⁷⁶

The common entry point may also refer the report to an administrative agency, which is designated as the “lead agency” for investigation.⁷⁷ The Minnesota Department of Health (“MDH”) is the lead agency if the report alleges that the maltreatment occurred in a hospital, nursing home, residential home, boarding care home, or by a home care provider.⁷⁸ The Minnesota Department of Human Services (“DHS”) is the lead agency if the alleged maltreatment occurred in a program licensed as an adult daycare center, an adult foster care center, a program for people with developmental disabilities, a mental health program, a chemical health program, or a personal care provider organization.⁷⁹ Finally, the county social service agencies or their designees are the lead agencies for all other reports, including reports of alleged familial maltreatment in the vulnerable adult’s own home.⁸⁰

3. *Substantiating Maltreatment and Determining Culpability*

Upon the conclusion of its investigation, a lead agency is required to determine whether the report of maltreatment is “substantiated,”⁸¹ “inconclusive,”⁸² or “false.”⁸³

If the lead agency determines that the report is substantiated, it must then decide whether the facility or an individual caregiver

75. See MINN. STAT. § 626.557, subd. 9a(2) (2001). When a law enforcement agency concludes an investigation of alleged maltreatment of a vulnerable adult, it decides whether to forward its determination to a city or county attorney for criminal charges. See *id.*

76. See MINN. STAT. § 626.557, subd. 9a(1) (2001).

77. See MINN. STAT. § 626.557, subd. 9a(3) (2001).

78. See MINN. STAT. § 626.5572, subd. 13(a) (2001).

79. See MINN. STAT. § 626.5572, subd. 13(b) (2001).

80. See MINN. STAT. § 626.5572, subd. 13(c) (2001).

81. “Substantiated” means that “a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.” MINN. STAT. § 626.5572, subd. 19 (2001).

82. “Inconclusive” means that “there is less than a preponderance of evidence to show that maltreatment did or did not occur.” MINN. STAT. § 626.5572, subd. 11 (2001).

83. See MINN. STAT. §§ 626.557, subd. 9c(b) (2001). “False” means that “a preponderance of evidence shows that an act that meets the definition of maltreatment did not occur.” MINN. STAT. § 626.5572, subd. 7 (2001).

was responsible for the maltreatment.⁸⁴ In so doing, the lead agency must consider, among other things, the comparative responsibility between the facility and other caregivers, and the requirements placed upon the employee.⁸⁵ For example, the lead agency must evaluate the adequacy of the facility's policies and procedures, training program, caregiver supervision, staffing levels, and the individual caregiver's participation in the training.⁸⁶

4. *Disqualification*

If maltreatment is substantiated, the agency must then determine whether the maltreatment is "serious" or "recurring" so as to require disqualification of the individual health care provider. Disqualification prevents an individual from working in any position allowing direct contact with vulnerable adults in DHS or MDH licensed programs, unlicensed personal care provider organizations, supplemental nursing services, and some Department of Corrections programs.⁸⁷

5. *Duration of Disqualification and Set Aside*

A disqualification for serious or recurring maltreatment lasts seven years.⁸⁸ The disqualified person may request that the lead agency "set aside" a disqualification to allow the individual to work in a specific program.⁸⁹ To obtain a set aside, the person must show that he or she does not pose a "risk of harm" to the people receiving services from that program.⁹⁰

6. *Impact on Regulated Health Facilities*

If the facility is found culpable for maltreatment, the maltreatment finding alone has no impact on the facility. The licensing agency may or may not sanction the facility based on the maltreatment finding.⁹¹

84. See MINN. STAT. § 626.557, subd. 9c(c) (2001).

85. MINN. STAT. § 626.557, subd. 9c(c) (2) (2001).

86. *Id.*

87. See MINN. STAT. § 245A.04, subd. 3d(a) (2001).

88. See MINN. STAT. § 245A.04, subd. 3d(a) (4) (2001).

89. MINN. STAT. § 245A.04, subd. 3b(a) (2001).

90. MINN. STAT. § 245A.04, subd. 3b(a) (2) (2001).

91. If the lead agency determines that it is appropriate to sanction the facility, it might take a licensing action against the facility. See MINN. STAT. § 245A.07 (2001).

7. *Impact on Unlicensed Health Workers*

The workers most affected by the determination of maltreatment are unlicensed caregivers, such as nursing assistants and orderlies. Having no funds to pay for an attorney and little ability to defend themselves, these people become the easy scapegoats of licensed facilities and licensed professionals.

If the maltreatment is serious or recurring, the person will be disqualified. If the maltreatment is not considered serious or recurring, and the individual is not a nursing assistant,⁹² the only consequence of the lead agency's maltreatment determination is that the name of the substantiated perpetrator is placed on a database maintained by the Commissioner of Human Services.⁹³

The DHS database is used to conduct background studies on people working in the settings where background studies are required by Minnesota statute.⁹⁴ If the individual maltreats a vulnerable adult again, the two instances of maltreatment may constitute recurring maltreatment and result in disqualification of the individual.⁹⁵ DHS is the only agency that has access to the database. The identity of the persons substantiated as perpetrators is private data and cannot be disclosed to the public without a court order.⁹⁶ Because the consequences of a violation are not public, there is no deterrent effect in the process.

8. *Impact on Licensed Health Professionals*

A licensed health professional, such as a nurse, social worker, psychologist, family therapist, family physician, or physician's assistant, may not be disciplined by a lead agency for maltreatment of a vulnerable adult, unless it relates to work in a foster care or family child care setting.⁹⁷ Instead, the lead agency can only refer its maltreatment finding to the appropriate health-related licensing board for consideration of possible disciplinary action.⁹⁸ Indeed, the lead agency cannot generally disqualify a licensed health professional except as it relates to work in family child care or

92. Nursing assistants have additional consequences stemming from a maltreatment determination. *See infra* Section IV.C.

93. *See* MINN. STAT. § 626.557, subd. 9c(i) (2001).

94. *See* MINN. STAT. § 245A.04, subd. 3 (2001).

95. *See* MINN. STAT. § 245A.04, subd. 3d (2001).

96. MINN. STAT. § 626.557, subd. 12b(b)(2)(iii) (2001).

97. *See* MINN. STAT. § 245A.04, subd. 3d(b) (2001).

98. *See* MINN. STAT. § 245A.04, subd. 3d(b)(1) (2001).

foster care.

B. Minnesota Department of Human Services

DHS licenses and regulates adult foster care programs, day training and habilitation services, intermediate care facilities for adults with mental retardation or related conditions, residential-based habilitation programs, semi-independent living services providers, and chemical dependency programs.⁹⁹ As the regulator, DHS inspects these programs every two years and, if it finds a deficiency during an inspection, may issue a corrective order, place a license on conditional status, temporarily or permanently suspend a license, revoke a license, and impose a fine of up to \$1,000 per violation.¹⁰⁰

DHS is also a “lead agency” under the Vulnerable Adults Act that investigates reports of maltreatment in the above programs. DHS currently has twenty employees assigned to investigate vulnerable adult complaints and ten employees assigned to inspect its vulnerable adult programs.¹⁰¹ In 1999 and 2000, DHS substantiated 153 and 157 reports of maltreatment respectively.¹⁰² DHS disqualified sixty-six people in 1999 and fifty-one people in 2000 for serious or recurring maltreatment.¹⁰³ The agency also took four licensing actions in 1999 based on four reports, and eleven licensing actions in 2000 based on sixteen reports.¹⁰⁴

DHS also conducts “background studies” on persons working in agency-licensed programs and certain other specified programs.¹⁰⁵ The purpose of the background study is to screen for individuals who have been convicted of certain crimes, who have committed serious or recurring maltreatment, or who have failed to report serious or recurring maltreatment. Such individuals are

99. See MINN. STAT. § 245A.03, subd. 1 (2001); see also MINN. STAT. ch. 245B (2001) (day training and habilitation services, intermediate care facilities for adults with mental retardation or related conditions, residential-based habilitation programs, and semi-independent living services); MINN. R. 9530.4100-.4450 (2001) (chemical dependency); MINN. R. 9543 (2001) (adult foster care).

100. See MINN. STAT. §§ 245A.06-.07 (2001).

101. Interview with Jim Schmidt, Management Analyst, Minnesota Department of Human Services, Licensing Division, in St. Paul, Minn. (June 12, 2002).

102. *Id.*

103. *Id.*

104. *Id.*

105. See MINN. STAT. § 144.057, subd. 1 (West Supp. 2002); MINN. STAT. § 245A.04, subd. 3(b)(1) (West Supp. 2002); MINN. STAT. § 245A.04, subd. 3(e) (2001).

disqualified from having direct contact with vulnerable adults.¹⁰⁶

In addition to regulating these programs, DHS must negotiate with and provide funding to such programs on behalf of the state and federal government. As a result, DHS is sometimes caught in the financial stress of a government agency that needs to contain welfare and Medicaid costs, while it regulates providers that need money to provide adequate service to a growing population of vulnerable adults. This dual role creates a dilemma for DHS. As the government contractor, it must negotiate tight service contracts with nursing homes and other providers. As the provider's regulator, it must tell these providers that they do not have sufficient training or sufficient staff. Faced with this inherent conflict of interest, it is sometimes difficult for the agency to reprimand, much less threaten to close, a facility that has insufficient staff.

C. Minnesota Department of Health

The Minnesota Department of Health ("MDH") regulates care provided to vulnerable adults in facilities such as hospitals, nursing and boarding care homes, supervised living facilities, home health care organizations, and assisted living facilities.¹⁰⁷ MDH's authority to sanction a program varies depending upon the type of program.¹⁰⁸ MDH contracts with DHS for DHS to conduct background studies for employees who have direct contact with

106. See MINN. STAT. § 245A.04, subd. 3d(a) (West Supp. 2002).

107. See MINN. STAT. §§ 144.50-.581 (West Supp. 2002) (hospitals); MINN. STAT. §§ 144A.01-.18 (West Supp. 2002) (nursing homes); MINN. STAT. §§ 144A.43-.48 (West Supp. 2002) (home care providers and assisted living care providers); MINN. STAT. §§ 144A.70-.74 (West Supp. 2002) (supplemental nursing services agencies); MINN. STAT. ch. 144D (West Supp. 2002) (housing with services establishments); MINN. STAT. § 157.17 (2001) (board and lodging establishments with special services).

108. See, e.g., MINN. R. ch. 4640 (2001) (hospital licensing rules do not provide for monetary penalties or licensing sanctions); MINN. R. ch. 4655 (2001) (boarding care home rules allow monetary penalties for license violations); MINN. R. ch. 4658 (2001) (nursing home rules allow monetary penalties and licensing sanctions including conditional licenses, limited licenses, license suspensions, license revocations, and denied license renewals for license violations); MINN. R. ch. 4665 (2001) (supervised living facility rules do not provide for monetary penalties or licensing sanctions); MINN. R. 4668.0002-.0240 (2001) (home health care facility rules allow monetary penalties and licensing sanctions for license violations); MINN. R. 4668.0800-.0870 (2001) (assisted living facility rules do not provide for monetary penalties or licensing sanctions).

patients in MDH-regulated facilities.¹⁰⁹

MDH is the designated “lead agency” under the Vulnerable Adults Act to investigate allegations of maltreatment of vulnerable adults in the above facilities.¹¹⁰ If it finds a person culpable of maltreatment, MDH makes a recommendation to DHS about whether the maltreatment was “serious” or “recurring.”¹¹¹ DHS then assesses the report and recommendations, and determines whether the person should be disqualified.¹¹²

MDH also maintains a nursing assistant registry, required by federal law¹¹³ to track reports of substantiated maltreatment against nursing assistants.¹¹⁴ Any reports of substantiated maltreatment become a permanent part of a nursing assistant’s registry entry.¹¹⁵ Under federal and state law, nursing facilities are prohibited from employing nursing assistants who have a finding of maltreatment in the registry.¹¹⁶

In 1999, MDH investigated 446 allegations of maltreatment.¹¹⁷ Of those, it substantiated 110 determinations of maltreatment against individuals, and sixty-one against facilities.¹¹⁸ In 2000, the agency investigated 587 allegations of maltreatment.¹¹⁹ It substantiated ninety-four maltreatment determinations against individuals and eighty-nine against facilities.¹²⁰

109. See MINN. STAT. § 144.057, subd. 1 (West Supp. 2002).

110. MINN. STAT. § 626.5572, subd. 13(a) (2001).

111. See MINN. STAT. § 144A.53, subd. 3 (2001). After determining that a complaint is valid, MDH may also recommend that an administrative agency, health care provider, home care provider, residential care home, or a health facility should (1) modify or cancel actions giving rise to a complaint; (2) alter the practice, rule or decision giving rise to the complaint; (3) provide more information about the action under investigation; or (4) take any other step considered appropriate by the Office of Health Facility Complaints. *Id.*

112. See MINN. STAT. § 245A.04, subd. 3d(a) (4) (2001).

113. See 42 C.F.R. § 483.156 (2001) (requiring states to establish and maintain a nursing assistant registry in compliance with federal regulations regarding purpose, operation, content, and information disclosure).

114. See MINN. STAT. § 144A.61 (2001) (requiring the Minnesota Department of Health to implement a nursing assistant registry as mandated by federal law).

115. See 42 C.F.R. § 483.156(c) (1) (iv) (D) (2001).

116. See 42 C.F.R. § 483.13(c) (ii) (2001).

117. Interview with Arnie Rosenthal, Director, Office of Health Facility Complaints, Minnesota Department of Health, in St. Paul, Minn. (June 13, 2002).

118. *Id.*

119. *Id.*

120. *Id.*

D. The Health Professional Licensing Boards

Separate from the two agencies described above are the health-related state licensing boards (“boards”) that regulate professionals working in health-related occupations.¹²¹ Composed primarily of members of the regulated occupation,¹²² the mission of each board is to protect the citizens of Minnesota from incompetent or unethical health professionals.¹²³

Each board is governed by a statute that addresses the grounds for discipline and the type of disciplinary action that a board can impose against a licensed health professional.¹²⁴ A lead agency such as DHS or MDH cannot disqualify a licensed health professional even if it substantiates a report of “serious” or “recurring” maltreatment by the licensee.¹²⁵ Rather, it may only forward its investigative memorandum to the appropriate board.¹²⁶ The appropriate board is then supposed to consider these findings, but can also consider other information in determining whether disciplinary action is appropriate.¹²⁷ During a one year period

121. See MINN. STAT. § 144A.19 (2001) (board of examiners of nursing home administrators); MINN. STAT. § 146A.02 (2001) (office of unlicensed complementary and alternative health care practice); MINN. STAT. § 147.01 (2001) (board of medical practice); MINN. STAT. § 148.02 (2001) (board of chiropractic examiners); MINN. STAT. § 148.181 (2001) (board of nursing); MINN. STAT. § 148.52 (2001) (board of optometry); MINN. STAT. § 148.622 (2001) (board of dietetics and nutrition practice); MINN. STAT. § 148.67 (2001) (board of physical therapy); MINN. STAT. § 148.90 (2001) (board of psychology); MINN. STAT. § 148B.19 (2001) (board of social work); MINN. STAT. § 148B.30 (2001) (board of marriage and family therapy); MINN. STAT. § 148B.61 (2001) (office of mental health practice); MINN. STAT. § 148C.02 (2001) (alcohol and drug counselors licensing advisory council); MINN. STAT. § 150A.02 (2001) (board of dentistry); MINN. STAT. § 151.02 (2001) (board of pharmacy); MINN. STAT. § 153.02 (2001) (board of podiatric medicine); and MINN. STAT. § 156.01 (2001) (board of veterinary medicine).

122. See *id.* For example, the Board of Nursing consists of sixteen members, of whom eight must be registered nurses, four must be licensed practical nurses, and four must be members of the public. MINN. STAT. § 148.181, subd. 1 (2001).

123. See MINN. STAT. § 214.001, subd. 1 (2001).

124. See *supra* note 121 for a list of each board and its statutory authority. For example, the Board of Nursing has authority to deny a license, registration or registration renewal; revoke or suspend the license; impose limitations on the nurse’s practice or conditions on the retention of the license; impose a civil penalty not to exceed \$10,000, order the nurse to provide unremunerated service, censure or reprimand the nurse, or take any other action justified by the facts in the case. MINN. STAT. § 148.261, subd. 1 (2001).

125. MINN. STAT. § 626.557, subd. 9(c)(g) (2001).

126. See MINN. STAT. § 245A.04, subd. 3d(b) (2001).

127. See MINN. STAT. § 626.557, subd. 9c(h) (2001); see also MINN. STAT.

between 2000 and 2001, DHS and MDH referred 130 maltreatment referrals and other matters regarding vulnerable adults to the Board of Nursing. Of those, only fourteen resulted in any disciplinary action, and six in agreements for non-disciplinary corrective action.¹²⁸

E. The Ombudsmen's Offices

Minnesota has two ombudsmen,¹²⁹ whose clientele largely consists of vulnerable adults: the Ombudsman for Mental Health and Mental Retardation,¹³⁰ and the Ombudsman for Older Minnesotans.¹³¹ The ombudsmen are primarily responsible for advocating on behalf of their clients to ensure that their clients receive adequate care.¹³² The Ombudsman for Mental Health and Mental Retardation has an annual budget of 1.4 million dollars and a statewide staff of only seventeen full-time positions, of which at most twelve or thirteen function in a client contact capacity.¹³³ The Ombudsman for Older Minnesotans has an annual budget of only

§ 214.104(a) (2001).

128. Telephone interview with Rene Cronquist, Board of Nursing (June 17, 2002).

129. BLACK'S LAW DICTIONARY 1115 (7th ed. 1999) (defining *ombudsman* as "an official appointed to receive, investigate, and report on private citizens' complaints about the government . . . who serves as an alternative to the adversary system for resolving disputes, especially between citizens and government agencies").

130. See MINN. STAT. §§ 245.91-.97 (2001) (establishing the Office of the Ombudsman for Mental Health and Mental Retardation). The mission of the Ombudsman for Mental Health and Mental Retardation is to "promote the highest attainable standards of treatment, competence, efficiency and justice for persons receiving care and treatment for mental development, chemical and emotional disabilities." *Vision, Mission and Values Statements*, Office of the Ombudsman for Mental Health & Mental Retardation *available at* <http://www.ombudmhm.state.mn.us/about/vision.htm>.

131. See MINN. STAT. §§ 256.974-.9742 (2001) (establishing the Office of the Ombudsman for Older Minnesotans). The Office of the Ombudsman for Older Minnesotans is charged with working with consumers, citizens, providers, and social service agencies to "enhance the quality of care and services of individuals receiving health care and supportive services at home, in the hospital, nursing home or other community setting." Aging Initiative: Office of the Ombudsman for Older Minnesotans, *available at* <http://www.dhs.state.mn.us/agingint/services/ombuds.htm>.

132. To ensure their independence, the Ombudsmen are not tied to any agency that they might investigate, and are appointed by the governor without regard to political affiliation. They can only be removed for cause. See MINN. STAT. § 245.92 (2001).

133. Interview with Roberta Opheim, Minnesota Ombudsman for Mental Health & Mental Retardation, in St. Paul, Minn. (June 13, 2002).

1.3 million dollars and a staff of only seventeen people, most of whom provide advocacy services.¹³⁴

While the two ombudsmen have authority to investigate complaints against facilities, they have no enforcement authority.¹³⁵ An Ombudsman may only issue recommendations to a facility; it does not have the power to require that the facility comply with its recommendations.¹³⁶ In 2000, the limited resources of the two ombudsmen resulted in very few formal reports being issued.¹³⁷

F. Problems Under the Regulatory Scheme

The laws in the regulatory arena were enacted to protect vulnerable adults from maltreatment, but the regulatory system has become so complex and unwieldy that the laws are not as effective as they could be.

1. Victor's Scenario

To demonstrate some of the problems in the regulatory arena, let us consider the outcome that would likely occur in Victor's case:

134. Interview with Mary Jean Mulherin, Office and Administrative Specialist, in St. Paul, Minn. (June 18, 2002).

135. See MINN. STAT. §§ 245.91-.97; 256.974-.9742 (2001). The relevant statute specifies that the Ombudsman for Mental Health and Mental Retardation "shall give particular attention to unusual deaths or injuries" and establishes a medical review subcommittee that assists agencies in investigations of suspicious deaths. MINN. STAT. § 256.9742, subd. 1 (2001). The Ombudsman for Older Minnesotans shall investigate "any act, practice, policy, procedure or administrative action of a long term care facility, acute care facility, home care service provider, or government agency that may adversely affect the health, safety, welfare, or rights of any client." *Id.*

136. See MINN. STAT. § 245.94, subd. 4 (2001). Specifically, the ombudsman may recommend that the facility consider the matter further; modify or cancel its actions; alter a rule or policy; explain the action more fully; or take other action. MINN. STAT. § 245.94, subd. 4(a) (2001). The facility must then inform the ombudsman about the action taken or the reasons for not complying with it. MINN. STAT. § 245A.94, subd. 4(b) (2001). The ombudsman can also send a report to the governor's office with whatever conclusions or suggestions it may have concerning an investigation or review. MINN. STAT. § 245.95, subd. 1 (2001). If the report is adverse to a program, agency or facility, however, the ombudsman must consult with the governor and the program, agency or facility and allow them an opportunity to include a statement in defense or mitigation of the report's conclusions or recommendations. *Id.*

137. Interview with Mary Joan Mulherin, Office and Administrative Specialist, in St. Paul, Minn. (June 18, 2002); interview with Roberta Opheim, Minnesota Ombudsman for Mental Health & Mental Retardation, in St. Paul, Minn. (June 13, 2002).

Axel would likely be found culpable for maltreatment by MDH, which licenses Superior. Because his maltreatment was "serious," Axel could subsequently be disqualified from working in a position that allowed direct contact with patients at licensed facilities, or access to persons in nursing homes and boarding care homes. Axel's new employer, however, would never learn of Axel's role in Victor's fall because the maltreatment determination and disqualification are private data under Minnesota statutes.

Nancy would similarly be found culpable for maltreatment based on her failure to assess Victor's injuries. Unlike Axel, however, Nancy is not disqualified because neither MDH nor DHS have authority to disqualify licensed health professionals. Instead, the Board of Nursing, upon reviewing the matter, might determine that a failure to report charge is too onerous for Nancy. It may accordingly enter into a non-disciplinary Agreement for Corrective Action with her, which is dismissed upon her completing an essay on proper transfers and reporting duties.

Superior would be assessed no fines because assisted living home care providers are not required by law to maintain particular staffing levels. The Ombudsman for Older Minnesotans may be unable to assign an investigator in a timely manner, and as a result conclude that the cause of Victor's fall is "undetermined."

Victor would continue to receive his primary care at Superior under conditions similar to those before his injury.

2. Regulatory Report Card

As Victor's scenario illustrates, Minnesota's unwieldy regulatory system often wastes too many resources, produces incongruous decisions between state agencies, and is a burdensome and confusing system for all parties to navigate. It is not uncommon to have several different administrative agencies (not including law enforcement agencies) conducting independent investigations of the same incident. In addition, one agency may review maltreatment findings made by another agency for the sole purpose of deciding consequences based on the finding. The duplication of efforts by these agencies is both unnecessary and costly.

Minnesota's cumbersome regulatory system may also result in incongruous decisions between state agencies. Because agencies operate under different statutory schemes, they have different authority regarding actions that they can or must take. Moreover,

the agencies may view the conduct at issue differently. In Victor's hypothetical situation, MDH concludes that Nancy maltreated Victor, but has no authority to impose any consequence upon her. The Board of Nursing, on the other hand, reviewed Nancy's conduct and did not find it egregious enough to warrant discipline. MDH found that Axel's actions constitute maltreatment, and DHS further found that the maltreatment was serious, resulting in Axel's disqualification. In the meantime, the Ombudsman for Older Minnesotans, limited by meager resources, concluded that the cause of the incident was "undetermined." As a result of inconsistent agency decisions, similarly-situated people end up being treated differently. Understandably, participants lose trust in the system after seeing these consequences.

This unwieldy system also has a negative effect on the care of vulnerable adults. Good caregivers who may have been wrongly accused of misconduct may not challenge a maltreatment finding made against them because they do not understand the effect of an agency's decision. Furthermore, they might not be able to afford an attorney to assist them in negotiating the process. As a result, facilities that serve vulnerable adults may lose good caregivers in an industry that is in desperate need of conscientious employees.

Despite all of the efforts to regulate and provide oversight in this area, the current system is simply not as effective as it could be because of loopholes in enforcement efforts. For example, there are virtually no consequences to a person, other than a nursing assistant, who is found culpable of maltreating a vulnerable adult unless the maltreatment is considered serious or recurring.¹³⁸ Under the relevant law, if a caregiver steals \$5,000 from a vulnerable adult under her care, it is not considered "serious" under the statute and the caregiver would be free to continue working with vulnerable adults.¹³⁹ Similarly, if a caregiver commits verbal or emotional abuse it is not considered "serious" under the law unless it results in serious injury.¹⁴⁰ Moreover, no one other than DHS has access to DHS's database of maltreatment determinations. Furthermore, as Axel's situation illustrates, even if an employee is disqualified for serious or recurring maltreatment of a vulnerable adult, the person may continue to work with vulnerable adults by obtaining a job with a non-licensed company.

138. See MINN. STAT. § 245A.04, subd. 3d(4) (2001).

139. See *id.*

140. See *id.*

Because the maltreatment information is not available to the public, the new employer has no way of knowing of past events.

Finally, the sanctions against facilities for maltreatment are weak. For example, DHS has authority to fine a program only \$1,000 for each occurrence of maltreatment in its facility even if it results in death. Such a nominal fine amounts to nothing more than the “cost of doing business” such as paying a \$5.00 late fee at the library. Such small fines provide no incentive for programs to improve the quality of care they are providing to vulnerable adults. As a result, programs may continue to staff their facilities inadequately and to train their employees inadequately. In Victor’s case, the facility’s chronic understaffing problems are not specifically addressed by any state statutes or regulations. Both before and after Victor’s improper transfer and fall, the facility offered the same insufficient levels of staffing and care to Victor and residents like him. The facility, which did not properly train employees or hire enough staff, was not held accountable for the conditions that helped to create Victor’s tragedy.

V. CIVIL REMEDIES

A. *State Common Law Remedies*

A person who is abused, neglected, or financially exploited by a caregiver may be able to pursue a common law cause of action based on the maltreatment. Some of the relevant common law causes of action available in Minnesota include professional malpractice, breach of contract, personal injury caused by sexual abuse, assault, battery, false imprisonment, intentional and negligent infliction of emotional distress, negligence, and breach of fiduciary duty.¹⁴¹

141. See, e.g., *K.A.C. v. Benson*, 527 N.W.2d 553 (Minn. 1995) (involving claim against physician for negligent infliction of emotional distress); *Brett v. Watts*, 601 N.W.2d 199 (Minn. Ct. App. 1999) (involving claim against physician for personal injury caused by sexual abuse); *D.A.B. v. Brown*, 570 N.W.2d 168 (Minn. Ct. App. 1997) (involving claim against physician for breach of fiduciary duty); *Hempel v. Fairview Hosps.*, 504 N.W.2d 487 (Minn. Ct. App. 1993) (involving claim against hospital for medical malpractice, assault, battery, false imprisonment, and intentional and negligent infliction of emotional distress); *Roettger v. United Hosps. of St. Paul, Inc.*, 380 N.W.2d 856 (Minn. Ct. App. 1986) (involving claim against hospital for negligence).

B. California Elder and Dependent Adult Civil Protection Act

State statutes may also give rise to causes of action for abuse or neglect of a vulnerable adult. Several states have enacted laws that create a specific civil cause of action for victims of elder abuse. California, for example, has enacted the Elder and Dependent Adult Civil Protection Act, which creates criminal and civil remedies for the abuse of an elder or dependent adult.¹⁴² Under this law, if the elements are proven, the plaintiff is entitled to enhanced remedies, including attorney's fees and costs, and noneconomic losses for a decedent.¹⁴³ Other states have created a private cause of action for nursing home residents based on infringement of residents' rights or benefits.¹⁴⁴

Minnesota, however, has not enacted a law to provide a private cause of action specifically for vulnerable adults for damages caused by a caregiver's abuse or neglect. Although Minnesota has a Patient's Bill of Rights that prohibits maltreatment, it is uncertain whether a private cause of action may be brought under the statute.¹⁴⁵ Nevertheless, there are some statutory remedies available to vulnerable adults that will be discussed below.

C. The Vulnerable Adults Act

The Vulnerable Adults Act creates a civil cause of action for negligent or intentional failure to report maltreatment of a vulnerable adult.¹⁴⁶ While the Act provides that a mandated

142. CAL. WELF. & INST. CODE § 15600 (West 2000).

143. *Id.*

144. *See, e.g.*, N.Y. PUB. HEALTH LAW § 2801-d(1)-(10) (McKinney 2002); 210 ILL. COMP. STAT. ANN. 45/3-602 (West 2002); MO. REV. STAT. § 198.093 (2002); LA. REV. STAT. ANN. § 40:2010.9 (West 2001); MASS. GEN. LAWS, ch. 111 § 70E (2002).

145. *See* MINN. STAT. § 144.651 (2001) (patients' bill of rights); *Stubbs v. North Mem'l Med. Ctr.*, 448 N.W.2d 78, 83 (Minn. Ct. App. 1989) (noting, without deciding, that the Patients Bill of Rights may not provide a private cause of action), *rev. denied* (Minn. Jan. 12, 1990). Nevertheless, the Vulnerable Adults Act, Patient's Bill of Rights, and licensing regulations for licensed providers, can provide strong evidence for the standard of care in a negligence or malpractice cause of action.

146. *See* MINN. STAT. § 626.557, subd. 7 (2001). This cause of action has been pursued in at least two reported cases in Minnesota. *See Wall v. Fairview Hosp. and Healthcare Servs.*, 584 N.W.2d 395 (Minn. 1998) (involving suit brought by psychiatric patients against nurse for failure to report maltreatment by psychiatrist); *Thelen v. St. Cloud Hosp.*, 379 N.W.2d 189 (Minn. Ct. App. 1985) (involving suit brought by hospital patient against hospital for failure to report sexual abuse by a hospital employee).

reporter who intentionally or negligently fails to report maltreatment is liable for damages caused by the failure, it does not provide a private cause of action for damages caused by the maltreatment itself.¹⁴⁷

D. Wrongful Death Statute

Minnesota also has a wrongful death statute, which allows a spouse of a decedent, or next of kin to a decedent to recover damages caused by a wrongful act or omission.¹⁴⁸ This statute can be used by a deceased vulnerable adult's family member when maltreatment results in the vulnerable adult's death.¹⁴⁹ It may also be used as a basis to continue a tort action initiated by a vulnerable adult before his or her death.¹⁵⁰

E. The Consumer Protection Laws

Finally, Minnesota's consumer protection laws may also provide an avenue of redress for victims who have suffered abuse or neglect because of deceptive practices by a health care provider. Consumer protection laws have been used in several states against nursing homes that have engaged in widespread neglect of their residents or have committed other deceptive practices.¹⁵¹ Minnesota's consumer protection laws can similarly be used to provide relief.¹⁵²

For example, Minnesota's consumer protection laws were used against an assisted-living home care provider that was neglecting its residents. In *State v. Alterra*, the Minnesota Attorney General, on

147. See *Thelen*, 379 N.W.2d at 194 (stating that there is no legislative intent to extend liability beyond damage caused by failure to report). Additionally, the Vulnerable Adults Act does not provide a cause of action against the "lead agencies" required to investigate the allegations of maltreatment for failing to timely investigate or intervene. See *Hoppe v. Kandiyohi County*, 543 N.W.2d 635, 638 (Minn. 1996) (holding that the Act does not impose civil liability for failure to timely investigate or intervene).

148. MINN. STAT. § 573.02 (2001).

149. *Id.*

150. MINN. STAT. § 573.01, subd. 1 (2001).

151. See Diane Horvath & Patricia Nemore, *Nursing Home Abuses as Unfair Trade Practices*, 20 CLEARINGHOUSE REV. 801, 801 (1986).

152. The consumer protection laws most applicable to this setting are the Uniform Deceptive Trade Practices Act (MINN. STAT. §§ 325D.43-49 (2001)), the Prevention of Consumer Fraud Act (MINN. STAT. §§ 325F.68-70 (2001)), and the Deceptive Acts Perpetrated Against Senior Citizens or Handicapped Persons Act (MINN. STAT. § 325F.71 (2001)).

behalf of numerous residents of an Alterra assisted living facility, filed a complaint in district court alleging violations of Minnesota's Uniform Deceptive Trade Practices Act, False Statement in Advertising Act, and Prevention of Consumer Fraud Act.¹⁵³ The complaint alleged that Alterra made false representations to consumers about the quality and quantity of care they would receive and that, as a result, residents were not receiving the proper care and assistance they required.¹⁵⁴ The complaint sought injunctive relief to prevent ongoing violations and to require that the promised care be given.¹⁵⁵ It also sought civil penalties and damages. The case was ultimately settled, and Alterra agreed to discontinue certain deceptive advertising, to comply with representations it had already made to current residents, and to allow an independent professional to monitor Alterra's compliance with the agreement for at least eight months.¹⁵⁶

In another case, *State v. Freeman Health Care Services*, consumer protection laws were used against a temporary personnel agency that provided "nursing assistants" to nursing homes hiring them for temporary assistance.¹⁵⁷ In that case, the complaint alleged that Freeman, a temporary personnel agency, was representing to nursing homes that its employees were qualified nursing assistants with the required background studies. In fact, according to the complaint, background studies had not been completed on many of the employees, and some were not even trained nursing assistants.¹⁵⁸ The court granted the state's request for a temporary restraining order, and the case ultimately settled when the temporary personnel agency owner agreed to be permanently

153. *State v. Alterra Healthcare Corp.*, File No. 19-C1-00-6824, (Minn. Dist. Ct., Dakota County, March 29, 2000) (alleging violations of MINN. STAT. §§ 325D.44, 325F.67, 325F.69).

154. *Id.*

155. *Id.*

156. *See id.*; Stipulation to Entry of Final Order and Order for Final Judgment, filed March 29, 2000. The agreement was subsequently amended to include five additional Alterra locations. *See* Stipulation and Supplemental Order and Amended Judgment, filed November 8, 2000. Since the Alterra case settled, Minnesota has enacted a consumer protection law that specifically targets Housing with Services establishments with special care units, such as Alterra. *See* MINN. STAT. § 325F.72 (2001). The law requires that certain disclosures be made about the services provided by these establishments. *Id.* It specifically provides, however, that no private cause of action may be maintained. *Id.*

157. *State v. Freeman Health Care Servs.*, File No. 99-11-8603, (Minn. Dist. Ct., Hennepin County, 2001).

158. *Id.*

enjoined from engaging in unlawful consumer fraud practices, and from owning or operating a temporary health care agency.¹⁵⁹

These cases demonstrate that consumer protection laws can be effective tools for remedying patterns of neglect by health care providers. The use of these tools will likely become increasingly important as more elderly choose less-regulated assisted living services instead of nursing homes.¹⁶⁰

Although the preceding cases were initiated by the Minnesota Attorney General, some consumer protection laws also provide private causes of action for individual consumers.¹⁶¹ Using these laws, health care consumers can recover restitution, attorneys' fees and costs, and in some cases may obtain injunctive relief. In fact, one consumer protection law specifically targets deceptive acts perpetrated against senior citizens or handicapped persons.¹⁶² That law specifically provides that a senior citizen (defined as someone sixty-two years of age or older) or a handicapped person injured by certain deceptive practices may bring a civil action, and may assert claims for damages, costs, including costs of investigation, attorneys' fees, and other equitable relief.¹⁶³

F. Limitations of Civil Litigation

While tort laws generally provide effective remedies for the victim, many of the same obstacles to recovery for vulnerable adults in criminal cases and regulatory matters are also present in civil litigation. First, many vulnerable adults may be without family members who may bring an action or assist the victim in bringing an action. Second, because many of these victims have cognitive impairments, they may not be mentally aware that they have suffered an injury and therefore will not seek redress. These same

159. *Id.*; Stipulation and Order dated September 27, 1999.

160. See Dorothy Siemon et al., *Consumer Advocacy in Assisted Living*, 30 CLEARINGHOUSE REV. 579 (1996); Dorothy Siemon et al., *Special Care Units for Persons with Alzheimer's Disease: Consumers Beware*, 31 CLEARINGHOUSE REV. 222 (1997).

161. See, e.g., MINN. STAT. §§ 325D.43-48 (2001) (providing private cause of action for injunctive relief); MINN. STAT. § 8.31, subds. 1, 3a (2001) (providing private cause of action for violation of numerous consumer protection laws, including the Prevention of Consumer Fraud Act, MINN. STAT. §§ 325F.68-70); MINN. STAT. § 325F.71 (2001) (providing private cause of action for seniors and handicapped persons injured by deceptive practice).

162. See MINN. STAT. § 325F.71 (2001).

163. MINN. STAT. § 325F.71, subd. 4 (2001).

impairments may also impede their ability to testify if they do bring an action.

Third, victims may have difficulty finding an attorney to represent them. Vulnerable adults often do not have the financial resources to hire an attorney to represent them, and attorneys may be reluctant to take a difficult case on a contingency fee basis if there is not a likelihood of a sizeable recovery.¹⁶⁴ Moreover, many of these cases may be particularly costly to bring because of the need to hire expert witnesses.

Finally, damage recoveries in these cases may be limited because a vulnerable adult typically will not have loss of earning capacity damages and many will not have significant life expectancy damages. The damages are therefore based only on pain and suffering, which may be limited for vulnerable adults who are already debilitated and probably in pain.

G. How did the Civil Remedies Perform in Victor's Case?

Millie will likely not be able to retain a private attorney to take a civil suit, particularly where the likely damage recovery would be minimal for a senile geriatric patient who might die before the trial is scheduled. Even if Millie finds an attorney to take the case, many challenges to proving the case remain. For example, the attorney will need to hire an expert witness to explain causation, as well as an expert on the standard of care. Moreover, since Victor would be unable to testify, someone else will need to testify about his probable pain and suffering. Even if these obstacles are overcome, any eventual monetary recovery may be limited.

VI. RECOMMENDATIONS

As illustrated in Victor's hypothetical and in real cases cited above, there are some real shortcomings in the present laws and systems in place to protect vulnerable adults. How can the state improve on its criminal, regulatory and civil laws to more effectively protect these citizens? While by no means comprehensive, the

164. In fact, Washington State's Abuse of Vulnerable Adults Act specifically recognizes that the elderly are often unable to retain counsel to obtain relief for acts of patient abuse. See WASH. REV. CODE § 74.34.015 (2001) (setting forth legislative finding that a vulnerable adult may not be able to retain legal counsel to obtain protections). Washington's response to this problem was to enact a statute providing a private cause of action against providers who abuse or neglect vulnerable adults. See WASH. REV. CODE § 74.34.200 (2001).

following are several suggestions for making our existing laws and system more streamlined, consistent, and effective.

A. Recommendations for Criminal Laws

1. Enhance Criminal Penalties

As noted above, several of the criminal penalties are too lenient or are not commensurate with the criminal acts at issue. For example, while crimes of financial exploitation can be a felony, sexual criminal abuse and criminal neglect of vulnerable adults are only gross misdemeanors, even if they result in substantial bodily harm to the victim. In a case charged by the Attorney General's Office, a male nursing assistant had sexual intercourse with an 84-year-old nursing home resident, during the time that she was recovering from a hysterectomy.¹⁶⁵ As a result, the woman suffered a hole in her bowel, requiring surgery, and an eighteen-day hospital stay.¹⁶⁶ Because the resident said the intercourse was consensual, the crime could not be charged as a sexual assault. Therefore, despite serious injury to the victim, the perpetrator was charged only with criminal abuse of a vulnerable adult, a gross misdemeanor.¹⁶⁷

This case illustrates the need for graduated penalties for sexual criminal abuse and criminal neglect, with the severity of the penalty based on the egregiousness of the conduct or the severity of the harm to the victim. For example, sexual criminal abuse involving penetration or resulting in substantial bodily harm should be classified as a felony. Similarly, criminal neglect resulting in substantial bodily harm also should be a felony-level offense. This type of graduated penalty scheme already exists for other types of criminal abuse, as well as for the traditional criminal sexual conduct crimes against the general population.¹⁶⁸ It makes sense to apply this type of scheme to all the vulnerable adult crimes.

165. State v. Obara, File No. K7-02-2328 (Minn. Dist. Ct., Dakota County, 2002).

166. *Id.*

167. *Id.*

168. See MINN. STAT. §§ 609.2325, subd. 3; 609.342, subd. 2; 609.343, subd. 2; 609.344, subd. 2; 609.345, subd. 2; 609.3451, subd. 2 (2001).

2. *Expand Scope of Statutes*

While the criminal abuse and criminal neglect statutes in Minnesota recognize that certain types of vulnerable adult maltreatment should be treated as a crime, they do not extend as far as similar vulnerable adult criminal statutes in other states. For example, Wisconsin's criminal abuse statute extends to abuse that is not only intentional, but also to abuse that is the result of reckless and even negligent conduct.¹⁶⁹ Minnesota's criminal abuse statute is also limited in that it does not clearly cover generally cruel conduct such as repeated verbal or emotional abuse, or other conduct that humiliates, intimidates, or traumatizes these most vulnerable of citizens.¹⁷⁰ Minnesota's criminal statutes should be broadened to include such conduct.

3. *Expedite Referral of Cases to Prosecutors*

As explained above, reports of crimes in care facilities may too often be delayed before they are referred to prosecutors from lead agencies and other parties. The process for reporting possible vulnerable adult crimes to law enforcement and prosecuting authorities should be improved. For example, in those situations in which a report is first referred to a lead agency and the lead agency's investigation indicates a reasonable suspicion that criminal conduct has occurred, the lead agency should be required to immediately contact law enforcement so that time is not lost while the lead agency completes its investigation and report. Lead agencies also could contact the vulnerable adults crime team within the Attorney General's Office, which could facilitate prompt follow-up with local law enforcement and prosecutors.

4. *Reform The Hearsay Exception To Reflect The Complexities Of Vulnerable Adult Litigation.*

It is a travesty of justice when perpetrators of criminal vulnerable adult maltreatment cannot be held accountable for their criminal conduct due to the very vulnerabilities that make their victims the targets of such acts. A case of one such injustice

169. See WIS. STAT. § 940.295, subd. 3 (2001).

170. MINN. STAT. § 609.2325, subd. 1 (2001). The terms "aversive" or "deprivation procedure" are not defined in MINN. STAT. § 609.2325, subd. 1, making it difficult for prosecutors to know how the statute is to be applied.

was recently reported in the *Minneapolis Star Tribune*.¹⁷¹ An elderly woman from northwestern Minnesota was bilked out of \$377,980 of her life savings by an investment con man who used some of the money to buy himself a houseboat, a ski boat, and a motorcycle.¹⁷² Criminal charges were brought, but the woman died before the trial began.¹⁷³ The judge ruled that her grand jury testimony, her diary, and her interview statements were inadmissible hearsay.¹⁷⁴ Without any of this evidence, the prosecution was forced to dismiss the charges, and the perpetrator walked away unpunished.¹⁷⁵

Because the victims of vulnerable adult crimes are often the frail elderly who may not be able to testify at a criminal trial due to illness or death, the evidentiary rules regarding hearsay should be relaxed for prosecution of vulnerable adult crimes. As already exists for child abuse victims, there should be an exception to the hearsay rule that allows the out-of-court statements of vulnerable adult crime victims to be admitted as substantive evidence under certain circumstances, including when the vulnerable adult is unavailable as a witness.¹⁷⁶ Some states have already enacted such a hearsay exception, and Minnesota should follow suit to ensure that perpetrators of vulnerable adult crimes are brought to justice.¹⁷⁷

B. Recommendations in the Regulatory Arena

As illustrated by Victor's hypothetical, the present regulatory scheme is unwieldy and inefficient, with responsibilities for identical or similar tasks often delegated to several different agencies. In too many cases, the end result is duplicative efforts, wasted resources, incongruous results, and confusion.

1. Consolidation

The regulatory system for protecting vulnerable adults may function more effectively and efficiently if one agency is made

171. Robert Franklin, *Man Accused of Bilking Minnesota Woman, but Won't Be Tried*, MINNEAPOLIS STAR TRIB., July 3, 2002, available at <http://www.startribune.com/stories/462/3033766.html>.

172. *Id.*

173. *Id.*

174. *Id.*

175. *Id.*

176. See MINN. STAT. § 595.02, subd. 3 (2001).

177. See, e.g., CAL. EVID. CODE § 1380 (West Supp. 2002); 11 DEL. CODE § 3516 (2001); 725 ILL. COMP. STAT. 5/115-10.3 (2001); OR. REV. STAT. § 40.460 (18a) (2001).

responsible for regulating all of these licensed programs, investigating alleged maltreatment, and making decisions regarding whether an individual should be disqualified. Having one agency responsible for these functions should result in greater efficiency, less confusion, decreased risk of inconsistent or incongruous decisions, and ultimately higher quality investigations and decision-making.

In eliminating duplicative roles, one agency, such as the Minnesota Department of Health, would take responsibility for licensing, investigating alleged maltreatment, conducting background studies, and making disqualification determinations for both licensed professionals and unlicensed workers at any facility, whether or not the facility or alleged perpetrator is regulated by the Department. Thus, workers would not be evaluated by different agencies just because of their professional licensure status, or because they worked in different types of facilities—such as workers in a nursing home compared to workers in a personal care provider organization.¹⁷⁸

Under this proposal, the Ombudsmen's offices could further be relieved of their role in investigating allegations of maltreatment. They could then rely on the investigations of the agency and devote more effort to advocating for their clients. In so doing, they could defer investigation functions to a larger state agency with considerably greater funding, staffing, and resources. This system would not only promote greater consistency and efficiency, but would hopefully also create a tighter "net" to catch matters that might otherwise inadvertently slip between separate agencies performing similar functions.

2. *Data Sharing and Disclosure*

As noted earlier, the classification of maltreatment data as "not public" data poses problems for employers as well as vulnerable adults receiving care. In Victor's case, the lack of access to this data means that, other than nursing assistants, there are no consequences to individuals found culpable of maltreatment if the maltreatment is not serious or recurring. Moreover, even if the perpetrator is disqualified, he may still obtain work with the same vulnerable population with a company not licensed by DHS or MDH, as was the case with Axel.

178. See *supra* sections IV.B. and IV.C.

Maltreatment findings should be made public so that recipients of care, and licensed and unlicensed employers can learn of maltreatment findings against a particular individual. With this information, an employer could decide whether or not to hire a person found culpable for maltreatment, but not disqualified. In addition, the classification of such a finding as public data gives a deterrent effect to the finding--facilities that employ such people will have a major incentive to properly train and supervise such personnel.

Moreover, disqualifications should be given greater "teeth" by: (1) expanding the scope of facilities that are licensed; (2) having unlicensed as well as licensed facilities barred from employing disqualified individuals; (3) expanding the scope of disqualifying actions to include matters such as financial exploitation and emotional abuse; and (4) having disqualification information readily available to prospective employers and patients.

On the agency enforcement side, laws currently allow some exchange of information between government agencies, but should more readily allow sharing of and access to information to protect vulnerable adults. For example, an agency responsible for investigating alleged maltreatments should be authorized to share its entire investigation file and final disposition with the other agencies, such as health licensing boards or ombudsmen's offices. This procedure will enable those agencies to access those investigation files and avoid a duplication of efforts.

3. *Increase Sanctions*

Victor's hypothetical case, and several of the cases previously referred to in this article, illustrate serious problems with the current sanctions as they relate to care provider facilities. In one particular case, a facility was sanctioned just a few thousand dollars based on maltreatment determinations and disqualification decisions following the deaths of two severely disabled individuals.¹⁷⁹ Such inconsequential fines allow facilities to view the penalties as minimal costs of doing business, particularly when much of the investigations are confidential. Sanctions should be significantly increased, and the results of investigations made public where maltreatment is determined to be a contributing

179. *Axis Minnesota, Inc. v. Comm'r of Human Servs.*, 2001 WL 1645712 (Minn. Ct. App. 2001).

factor of serious injuries to a vulnerable adult.

C. Increasing Effectiveness of Civil Litigation

The effectiveness of civil litigation under the present laws is hampered by a number of factors, including the lack of a specific cause of action for vulnerable adult maltreatment, difficulty in retaining attorneys, difficulty with victim testimony, and low monetary recoveries.

To address these problems, legislators should consider expanding the Vulnerable Adults Act or otherwise providing a statutory cause of action for abuse, neglect, and exploitation of a vulnerable adult by a caregiver in a residential facility. Such a law may contain a number of provisions, including: (1) awards for attorneys fees and costs; (2) provisions allowing the action to be brought by the victim, her family, guardian, or other individuals; (3) other relief for the victim in addition to monetary damages, such as injunctive and other equitable relief; (4) vicarious liability for facilities for the torts of caregiver employees; and (5) relaxed evidentiary rules for victim's hearsay statements.

A statutory cause of action that recognizes the difficulty of advocating for a vulnerable adult would hopefully create an additional deterrent to companies that fail to properly train and supervise their personnel.

VII. CONCLUSION.

The Minnesota Vulnerable Adults Act and the Minnesota regulatory system, which were designed to protect vulnerable adults, need to be coordinated in order to be more efficient and to increase the deterrent effect. Statistics demonstrate that an increasing percentage of our population, including our parents and loved ones (and ourselves), will become dependent upon the thousands of licensed and unlicensed care providers and facilities in this state. Vice President Hubert Humphrey echoed President Kennedy's feelings about the importance of this issue by noting that the measurement of society is how it treats those people in the dawn of life, the twilight of life, and the shadows of life. Minnesota's quality of life demands that we be vigilant and vigorous in acting as a steward for our most vulnerable citizens.