

**SENATE**  
**STATE OF MINNESOTA**  
**NINETY-SECOND SESSION**

**S.F. No. 935**

(SENATE AUTHORS: DIBBLE)

DATE  
02/11/2021

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Introduction and first reading  
 Referred to Aging and Long-Term Care Policy

OFFICIAL STATUS

1.1 A bill for an act

1.2 relating to health; modifying electronic monitoring requirements; modifying Board

1.3 of Executives for Long-Term Service and Supports fees; establishing private

1.4 enforcement of certain rights; establishing a private cause of action for retaliation

1.5 in certain long-term care settings; modifying infection control requirements in

1.6 certain long-term care settings; modifying hospice and assisted living bills of

1.7 rights; establishing consumer protections for clients receiving assisted living

1.8 services; prohibiting termination of assisted living services during a peacetime

1.9 emergency; establishing procedures for transfer of clients receiving certain

1.10 long-term care services during a peacetime emergency; requiring the commissioner

1.11 of health to establish a state plan to control SARS-CoV-2 infections in certain

1.12 long-term care settings; establishing the Long-Term Care COVID-19 Task Force;

1.13 changing provisions for nursing homes, home care, and assisted living; requiring

1.14 a report; appropriating money; amending Minnesota Statutes 2020, sections 144.56,

1.15 by adding subdivisions; 144.6502, subdivision 3, by adding a subdivision; 144.6512,

1.16 by adding a subdivision; 144.652, by adding a subdivision; 144A.04, by adding

1.17 subdivisions; 144A.291, subdivision 2; 144A.4798, subdivision 3, by adding

1.18 subdivisions; 144A.751, subdivision 1; 144G.03, by adding subdivisions; 144G.07,

1.19 by adding a subdivision; 144G.09, subdivision 3; 144G.10, by adding a subdivision;

1.20 144G.42, by adding subdivisions; 144G.91, by adding a subdivision; 144G.92, by

1.21 adding a subdivision; Laws 2019, chapter 60, article 1, section 46; article 5, section

1.22 2; proposing coding for new law in Minnesota Statutes, chapters 144A; 144G.

1.23 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

1.24 Section 1. Minnesota Statutes 2020, section 144.56, is amended by adding a subdivision

1.25 to read:

1.26 Subd. 2d. Severe acute respiratory syndrome-related coronavirus infection

1.27 control. (a) A boarding care home must establish and maintain a comprehensive severe

1.28 acute respiratory syndrome-related coronavirus infection control program that complies

1.29 with accepted health care, medical, and nursing standards for infection control according

1.30 to the most current SARS-CoV-2 infection control guidelines or their successor versions

2.1 issued by the United States Centers for Disease Control and Prevention, Centers for Medicare  
2.2 and Medicaid Services, and the commissioner. This program must include a severe acute  
2.3 respiratory syndrome-related coronavirus infection control plan that covers all paid and  
2.4 unpaid employees, contractors, students, volunteers, residents, and visitors. The commissioner  
2.5 shall provide technical assistance regarding implementation of the guidelines.

2.6 (b) The boarding care home must maintain written evidence of compliance with this  
2.7 subdivision.

2.8 **EFFECTIVE DATE.** This section is effective the day following final enactment.

2.9 Sec. 2. Minnesota Statutes 2020, section 144.56, is amended by adding a subdivision to  
2.10 read:

2.11 Subd. 2e. **Severe acute respiratory syndrome-related coronavirus response plan.** (a)  
2.12 A boarding care home must establish, implement, and maintain a severe acute respiratory  
2.13 syndrome-related coronavirus response plan. The severe acute respiratory syndrome-related  
2.14 coronavirus response plan must be consistent with the requirements of subdivision 2d and  
2.15 at a minimum must address the following:

2.16 (1) baseline and serial severe acute respiratory syndrome-related coronavirus testing of  
2.17 all paid and unpaid employees, contractors, students, volunteers, residents, and visitors;

2.18 (2) use of personal protective equipment by all paid and unpaid employees, contractors,  
2.19 students, volunteers, residents, and visitors;

2.20 (3) separation or isolation of residents infected with SARS-CoV-2 or a similar severe  
2.21 acute respiratory syndrome-related coronavirus from residents who are not;

2.22 (4) balancing the rights of residents with controlling the spread of SARS-CoV-2 or  
2.23 similar severe acute respiratory syndrome-related coronavirus infections;

2.24 (5) resident relocations, including steps to be taken to mitigate trauma for relocated  
2.25 residents receiving memory care;

2.26 (6) clearly informing residents of the boarding care home's policies regarding the effect  
2.27 of hospice orders, provider orders for life-sustaining treatment, do not resuscitate orders,  
2.28 and do not intubate orders on any treatment of COVID-19 disease or similar severe acute  
2.29 respiratory syndromes;

2.30 (7) mitigating the effects of separation or isolation of residents, including virtual visitation,  
2.31 outdoor visitation, and for residents who cannot go outdoors, indoor visitation;

2.32 (8) compassionate care visitation;

3.1 (9) consideration of any campus model, multiple buildings on the same property, or any  
 3.2 mix of independent senior living units in the same building as assisted living units;

3.3 (10) steps to be taken when a resident is suspected of having a SARS-CoV-2 or similar  
 3.4 severe acute respiratory syndrome-related coronavirus infection;

3.5 (11) steps to be taken when a resident tests positive for a SARS-CoV-2 or similar severe  
 3.6 acute respiratory syndrome-related coronavirus infection;

3.7 (12) protocols for emergency medical responses involving residents with SARS-CoV-2  
 3.8 or similar severe acute respiratory syndrome-related coronavirus infections, including  
 3.9 infection control procedures following the departure of ambulance service personnel or  
 3.10 other first responders;

3.11 (13) notifying the commissioner when staffing levels are critically low; and

3.12 (14) taking into account dementia-related concerns.

3.13 (b) A boarding care home must provide the commissioner with a copy of a severe acute  
 3.14 respiratory syndrome-related coronavirus response plan meeting the requirements of this  
 3.15 subdivision.

3.16 (c) A boarding care home must make its severe acute respiratory syndrome-related  
 3.17 coronavirus response plan available to staff, residents, and families of residents.

3.18 **EFFECTIVE DATE.** This section is effective the day following final enactment.

3.19 Sec. 3. Minnesota Statutes 2020, section 144.6502, subdivision 3, is amended to read:

3.20 Subd. 3. **Consent to electronic monitoring.** (a) Except as otherwise provided in this  
 3.21 subdivision, a resident must consent to electronic monitoring in the resident's room or private  
 3.22 living unit in writing on a notification and consent form. If the resident has not affirmatively  
 3.23 objected to electronic monitoring and the resident representative attests that the resident's  
 3.24 medical professional ~~determines~~ determined that the resident currently lacks the ability to  
 3.25 understand and appreciate the nature and consequences of electronic monitoring, the resident  
 3.26 representative may consent on behalf of the resident. For purposes of this subdivision, a  
 3.27 resident affirmatively objects when the resident orally, visually, or through the use of  
 3.28 auxiliary aids or services declines electronic monitoring. The resident's response must be  
 3.29 documented on the notification and consent form.

3.30 (b) Prior to a resident representative consenting on behalf of a resident, the resident must  
 3.31 be asked if the resident wants electronic monitoring to be conducted. The resident  
 3.32 representative must explain to the resident:

4.1 (1) the type of electronic monitoring device to be used;

4.2 (2) the standard conditions that may be placed on the electronic monitoring device's use,  
4.3 including those listed in subdivision 6;

4.4 (3) with whom the recording may be shared under subdivision 10 or 11; and

4.5 (4) the resident's ability to decline all recording.

4.6 (c) A resident, or resident representative when consenting on behalf of the resident, may  
4.7 consent to electronic monitoring with any conditions of the resident's or resident  
4.8 representative's choosing, including the list of standard conditions provided in subdivision  
4.9 6. A resident, or resident representative when consenting on behalf of the resident, may  
4.10 request that the electronic monitoring device be turned off or the visual or audio recording  
4.11 component of the electronic monitoring device be blocked at any time.

4.12 (d) Prior to implementing electronic monitoring, a resident, or resident representative  
4.13 when acting on behalf of the resident, must obtain the written consent on the notification  
4.14 and consent form of any other resident residing in the shared room or shared private living  
4.15 unit. A roommate's or roommate's resident representative's written consent must comply  
4.16 with the requirements of paragraphs (a) to (c). Consent by a roommate or a roommate's  
4.17 resident representative under this paragraph authorizes the resident's use of any recording  
4.18 obtained under this section, as provided under subdivision 10 or 11.

4.19 (e) Any resident conducting electronic monitoring must immediately remove or disable  
4.20 an electronic monitoring device prior to a new roommate moving into a shared room or  
4.21 shared private living unit, unless the resident obtains the roommate's or roommate's resident  
4.22 representative's written consent as provided under paragraph (d) prior to the roommate  
4.23 moving into the shared room or shared private living unit. Upon obtaining the new  
4.24 roommate's signed notification and consent form and submitting the form to the facility as  
4.25 required under subdivision 5, the resident may resume electronic monitoring.

4.26 (f) The resident or roommate, or the resident representative or roommate's resident  
4.27 representative if the representative is consenting on behalf of the resident or roommate, may  
4.28 withdraw consent at any time and the withdrawal of consent must be documented on the  
4.29 original consent form as provided under subdivision 5, paragraph (d).

4.30 **EFFECTIVE DATE.** This section is effective the day following final enactment.

5.1 Sec. 4. Minnesota Statutes 2020, section 144.6502, is amended by adding a subdivision  
5.2 to read:

5.3 Subd. 7a. **Installation during isolation.** (a) Anytime visitation is restricted or a resident  
5.4 is isolated for any reason, including during a public health emergency, and the resident or  
5.5 resident representative chooses to conduct electronic monitoring, a facility must place and  
5.6 set up any device, provided the resident or resident representative delivers the approved  
5.7 device to the facility with clear instructions for setting up the device and the resident or  
5.8 resident representative assumes all risk in the event the device malfunctions.

5.9 (b) If a facility places an electronic monitoring device under this subdivision, the  
5.10 requirements of this chapter, including requirements of subdivision 7, continue to apply.

5.11 **EFFECTIVE DATE.** This section is effective the day following final enactment.

5.12 Sec. 5. Minnesota Statutes 2020, section 144.6512, is amended by adding a subdivision  
5.13 to read:

5.14 Subd. 6. **Other laws.** Nothing in this section affects the rights and remedies available  
5.15 under section 626.557, subdivisions 10, 17, and 20.

5.16 **EFFECTIVE DATE.** This section is effective the day following final enactment.

5.17 Sec. 6. Minnesota Statutes 2020, section 144.652, is amended by adding a subdivision to  
5.18 read:

5.19 Subd. 3. **Enforcement of the health care bill of rights by nursing home residents.** In  
5.20 addition to the remedies otherwise provided by or available under law, a resident of a nursing  
5.21 home or a legal representative on behalf of a resident, in addition to seeking any remedy  
5.22 otherwise available under law, may bring a civil action against a nursing home and recover  
5.23 actual damages or \$3,000, whichever is greater, plus costs, including costs of investigation,  
5.24 and reasonable attorney fees, and receive other equitable relief as determined by the court  
5.25 for violation of section 144.651, subdivision 14, 20, 22, 26, or 30.

5.26 **EFFECTIVE DATE.** This section is effective the day following final enactment.

5.27 Sec. 7. Minnesota Statutes 2020, section 144A.04, is amended by adding a subdivision to  
5.28 read:

5.29 Subd. 3c. **Severe acute respiratory syndrome-related coronavirus infection**  
5.30 **control.** (a) A nursing home provider must establish and maintain a comprehensive severe  
5.31 acute respiratory syndrome-related coronavirus infection control program that complies

6.1 with accepted health care, medical, and nursing standards for infection control according  
6.2 to the most current SARS-CoV-2 infection control guidelines or their successor versions  
6.3 issued by the United States Centers for Disease Control and Prevention, Centers for Medicare  
6.4 and Medicaid Services, and the commissioner. This program must include a severe acute  
6.5 respiratory syndrome-related coronavirus infection control plan that covers all paid and  
6.6 unpaid employees, contractors, students, volunteers, residents, and visitors. The commissioner  
6.7 shall provide technical assistance regarding implementation of the guidelines.

6.8 (b) The nursing home provider must maintain written evidence of compliance with this  
6.9 subdivision.

6.10 **EFFECTIVE DATE.** This section is effective the day following final enactment.

6.11 Sec. 8. Minnesota Statutes 2020, section 144A.04, is amended by adding a subdivision to  
6.12 read:

6.13 Subd. 3d. **Severe acute respiratory syndrome-related coronavirus response plan.** (a)  
6.14 A nursing home provider must establish, implement, and maintain a severe acute respiratory  
6.15 syndrome-related coronavirus response plan. The severe acute respiratory syndrome-related  
6.16 coronavirus response plan must be consistent with the requirements of subdivision 3c and  
6.17 at a minimum must address the following:

6.18 (1) baseline and serial severe acute respiratory syndrome-related coronavirus testing of  
6.19 all paid and unpaid employees, contractors, students, volunteers, residents, and visitors;

6.20 (2) use of personal protective equipment by all paid and unpaid employees, contractors,  
6.21 students, volunteers, residents, and visitors;

6.22 (3) separation or isolation of residents infected with SARS-CoV-2 or a similar severe  
6.23 acute respiratory syndrome-related coronavirus from residents who are not;

6.24 (4) balancing the rights of residents with controlling the spread of SARS-CoV-2 or  
6.25 similar severe acute respiratory syndrome-related coronavirus infections;

6.26 (5) resident relocations, including steps to be taken to mitigate trauma for relocated  
6.27 residents receiving memory care;

6.28 (6) clearly informing residents of the nursing home provider's policies regarding the  
6.29 effect of hospice orders, provider orders for life-sustaining treatment, do not resuscitate  
6.30 orders, and do not intubate orders on any treatment of COVID-19 disease or similar severe  
6.31 acute respiratory syndromes;

7.1 (7) mitigating the effects of separation or isolation of residents, including virtual visitation,  
 7.2 outdoor visitation, and for residents who cannot go outdoors, indoor visitation;

7.3 (8) compassionate care visitation;

7.4 (9) consideration of any campus model, multiple buildings on the same property, or any  
 7.5 mix of independent senior living units in the same building as assisted living units;

7.6 (10) steps to be taken when a resident is suspected of having a SARS-CoV-2 or similar  
 7.7 severe acute respiratory syndrome-related coronavirus infection;

7.8 (11) steps to be taken when a resident tests positive for a SARS-CoV-2 or similar severe  
 7.9 acute respiratory syndrome-related coronavirus infection;

7.10 (12) protocols for emergency medical responses involving residents with SARS-CoV-2  
 7.11 or similar severe acute respiratory syndrome-related coronavirus infections, including  
 7.12 infection control procedures following the departure of ambulance service personnel or  
 7.13 other first responders;

7.14 (13) notifying the commissioner when staffing levels are critically low; and

7.15 (14) taking into account dementia-related concerns.

7.16 (b) A nursing home provider must provide the commissioner with a copy of a severe  
 7.17 acute respiratory syndrome-related coronavirus response plan meeting the requirements of  
 7.18 this subdivision.

7.19 (c) A nursing home provider must make its severe acute respiratory syndrome-related  
 7.20 coronavirus response plan available to staff, residents, and families of residents.

7.21 **EFFECTIVE DATE.** This section is effective the day following final enactment.

7.22 Sec. 9. Minnesota Statutes 2020, section 144A.291, subdivision 2, is amended to read:

7.23 Subd. 2. **Amounts.** (a) Fees may not exceed the following amounts but may be adjusted  
 7.24 lower by board direction and are for the exclusive use of the board as required to sustain  
 7.25 board operations. The maximum amounts of fees are:

7.26 (1) application for licensure, \$200;

7.27 (2) for a prospective applicant for a review of education and experience advisory to the  
 7.28 license application, \$100, to be applied to the fee for application for licensure if the latter  
 7.29 is submitted within one year of the request for review of education and experience;

7.30 (3) state examination, \$125;

- 8.1 (4) initial license, \$250 if issued between July 1 and December 31, \$100 if issued between  
8.2 January 1 and June 30;
- 8.3 (5) acting ~~administrator~~ permit, \$400;
- 8.4 (6) renewal license, \$250;
- 8.5 (7) duplicate license, \$50;
- 8.6 (8) reinstatement fee, \$250;
- 8.7 ~~(9) health services executive initial license, \$200;~~
- 8.8 ~~(10) health services executive renewal license, \$200;~~
- 8.9 ~~(11)~~ (9) reciprocity verification fee, \$50;
- 8.10 ~~(12)~~ (10) second shared ~~administrator~~ assignment, \$250;
- 8.11 ~~(13)~~ (11) continuing education fees:
- 8.12 (i) greater than six hours, \$50; and
- 8.13 (ii) seven hours or more, \$75;
- 8.14 ~~(14)~~ (12) education review, \$100;
- 8.15 ~~(15)~~ (13) fee to a sponsor for review of individual continuing education seminars,  
8.16 institutes, workshops, or home study courses:
- 8.17 (i) for less than seven clock hours, \$30; and
- 8.18 (ii) for seven or more clock hours, \$50;
- 8.19 ~~(16)~~ (14) fee to a licensee for review of continuing education seminars, institutes,  
8.20 workshops, or home study courses not previously approved for a sponsor and submitted  
8.21 with an application for license renewal:
- 8.22 (i) for less than seven clock hours total, \$30; and
- 8.23 (ii) for seven or more clock hours total, \$50;
- 8.24 ~~(17)~~ (15) late renewal fee, \$75;
- 8.25 ~~(18)~~ (16) fee to a licensee for verification of licensure status and examination scores,  
8.26 \$30;
- 8.27 ~~(19)~~ (17) registration as a registered continuing education sponsor, \$1,000; and
- 8.28 ~~(20)~~ (18) mail labels, \$75.



9.1 (b) The revenue generated from the fees must be deposited in an account in the state  
9.2 government special revenue fund.

9.3 **EFFECTIVE DATE.** This section is effective the day following final enactment.

9.4 Sec. 10. **[144A.4415] PRIVATE ENFORCEMENT OF RIGHTS.**

9.5 For a violation of section 144A.44, paragraph (a), clause (2), (14), (19), or (22), or section  
9.6 144A.4791, subdivision 11, paragraph (d), a resident or resident's designated representative  
9.7 may bring a civil action against an assisted living establishment and recover actual damages  
9.8 or \$3,000, whichever is greater, plus costs, including costs of investigation, and reasonable  
9.9 attorney fees, and receive other equitable relief as determined by the court in addition to  
9.10 seeking any other remedy otherwise available under law.

9.11 **EFFECTIVE DATE.** This section is effective the day following final enactment.

9.12 Sec. 11. Minnesota Statutes 2020, section 144A.4798, subdivision 3, is amended to read:

9.13 Subd. 3. **Infection control program.** A home care provider must establish and maintain  
9.14 an effective infection control program that complies with accepted health care, medical,  
9.15 and nursing standards for infection control, including during a disease pandemic.

9.16 **EFFECTIVE DATE.** This section is effective the day following final enactment.

9.17 Sec. 12. Minnesota Statutes 2020, section 144A.4798, is amended by adding a subdivision  
9.18 to read:

9.19 Subd. 4. **Severe acute respiratory syndrome-related coronavirus infection control.** (a)  
9.20 A home care provider must establish and maintain a comprehensive severe acute respiratory  
9.21 syndrome-related coronavirus infection control program that complies with accepted health  
9.22 care, medical, and nursing standards for infection control according to the most current  
9.23 SARS-CoV-2 infection control guidelines or the successor version issued by the United  
9.24 States Centers for Disease Control and Prevention, Centers for Medicare and Medicaid  
9.25 Services, and the commissioner. This program must include a severe acute respiratory  
9.26 syndrome-related coronavirus infection control plan that covers all paid and unpaid  
9.27 employees, contractors, students, volunteers, clients, and visitors. The commissioner shall  
9.28 provide technical assistance regarding implementation of the guidelines.

9.29 (b) A home care provider must maintain written evidence of compliance with this  
9.30 subdivision.

9.31 **EFFECTIVE DATE.** This section is effective the day following final enactment.

10.1 Sec. 13. Minnesota Statutes 2020, section 144A.4798, is amended by adding a subdivision  
10.2 to read:

10.3 Subd. 5. Severe acute respiratory syndrome-related coronavirus response plan. (a)  
10.4 A home care provider must establish, implement, and maintain a severe acute respiratory  
10.5 syndrome-related coronavirus response plan. The severe acute respiratory syndrome-related  
10.6 coronavirus response plan must be consistent with the requirements of subdivision 4 and  
10.7 at a minimum must address the following:

10.8 (1) baseline and serial severe acute respiratory syndrome-related coronavirus testing of  
10.9 all paid and unpaid employees, contractors, students, volunteers, clients, and visitors;

10.10 (2) use of personal protective equipment by all paid and unpaid employees, contractors,  
10.11 students, volunteers, clients, and visitors;

10.12 (3) balancing the rights of clients with controlling the spread of SARS-CoV-2 or similar  
10.13 severe acute respiratory syndrome-related coronavirus infections;

10.14 (4) clearly informing clients of the home care provider's policies regarding the effect of  
10.15 hospice orders, provider orders for life-sustaining treatment, do-not resuscitate orders, and  
10.16 do-not intubate orders on any treatment of COVID-19 disease or similar severe acute  
10.17 respiratory syndromes;

10.18 (5) steps to be taken when a client is suspected of having a SARS-CoV-2 or similar  
10.19 severe acute respiratory syndrome-related coronavirus infection;

10.20 (6) steps to be taken when a client tests positive for SARS-CoV-2 or a similar severe  
10.21 acute respiratory syndrome-related coronavirus infection;

10.22 (7) protocols for emergency medical responses involving clients with SARS-CoV-2 or  
10.23 similar severe acute respiratory syndrome-related coronavirus infections, including infection  
10.24 control procedures following the departure of ambulance service personnel or other first  
10.25 responders;

10.26 (8) notifying the commissioner when staffing levels are critically low; and

10.27 (9) taking into account dementia-related concerns.

10.28 (b) A home care provider must provide the commissioner with a copy of a severe acute  
10.29 respiratory syndrome-related coronavirus response plan meeting the requirements of this  
10.30 subdivision and subdivision 6.

10.31 (c) A home care provider must make its severe acute respiratory syndrome-related  
10.32 coronavirus response plan available to staff, clients, and families of clients.

11.1 **EFFECTIVE DATE.** This section is effective the day following final enactment.

11.2 Sec. 14. Minnesota Statutes 2020, section 144A.4798, is amended by adding a subdivision  
11.3 to read:

11.4 **Subd. 6. Disease prevention and infection control in congregate settings.** (a) A home  
11.5 care provider providing services to a client who resides either in an assisted living facility  
11.6 licensed under section 144G.10 or in a housing with services establishment registered under  
11.7 chapter 144D, regardless of the provider's status as an arranged home care provider as  
11.8 defined in section 144D.01, subdivision 2a, must coordinate and cooperate with the assisted  
11.9 living director of the assisted living facility in which a client of the unaffiliated home care  
11.10 provider resides or with the person primarily responsible for oversight and management of  
11.11 a housing with services establishment, as designated by the owner of the housing with  
11.12 services establishment, in which a client of the home care provider resides, to ensure that  
11.13 the home care provider meets all the requirements of this section while providing services  
11.14 in these congregate settings.

11.15 (b) In addition to meeting the requirements of subdivision 5, a home care provider  
11.16 providing services to a client who resides in either an assisted living facility licensed under  
11.17 section 144G.10 or a housing with services establishment registered under chapter 144D,  
11.18 regardless of the provider's status as an arranged home care provider as defined in section  
11.19 144D.01, subdivision 2a, must also address in the provider's severe acute respiratory  
11.20 syndrome-related coronavirus response plan the following:

11.21 (1) baseline and serial severe acute respiratory syndrome-related coronavirus testing of  
11.22 all paid and unpaid employees, contractors, students, volunteers, clients, and visitors of a  
11.23 congregate setting in which the home care provider provides services;

11.24 (2) use of personal protective equipment by all paid and unpaid employees, contractors,  
11.25 students, volunteers, clients, and visitors of a congregate setting in which the home care  
11.26 provider provides services;

11.27 (3) separation or isolation of clients infected with SARS-CoV-2 or a similar severe acute  
11.28 respiratory syndrome-related coronavirus from clients who are not infected in a congregate  
11.29 setting in which the home care provider serves clients;

11.30 (4) client relocations, including steps to be taken to mitigate trauma for relocated clients  
11.31 receiving memory care;

12.1 (5) mitigating the effects of separation or isolation of clients, including virtual visitation,  
 12.2 outdoor visitation, and for clients who cannot go outdoors, indoor visitation in a congregate  
 12.3 setting in which the home care provider serves clients;

12.4 (6) compassionate care visitation in a congregate setting in which the home care provider  
 12.5 serves clients;

12.6 (7) consideration of any campus model, multiple buildings on the same property, or any  
 12.7 mix of independent senior living units in the same building as units in which home care  
 12.8 services are provided;

12.9 (8) steps to be taken when a client in a congregate setting in which the home care provider  
 12.10 serves clients is suspected of having a SARS-CoV-2 or similar severe acute respiratory  
 12.11 syndrome-related coronavirus infection; and

12.12 (9) steps to be taken when a client in a congregate setting in which the home care provider  
 12.13 serves clients tests positive for SARS-CoV-2 or a similar severe acute respiratory  
 12.14 syndrome-related coronavirus infection.

12.15 (c) A home care provider providing services to a client who resides in either an assisted  
 12.16 living facility licensed under section 144A.10 or a housing with services establishment  
 12.17 registered under chapter 144D, regardless of the provider's status as an arranged home care  
 12.18 provider as defined in section 144D.01, subdivision 2a, must make the home care provider's  
 12.19 severe acute respiratory syndrome-related coronavirus response plan available to the assisted  
 12.20 living director of the assisted living facility in which a client of the unaffiliated home care  
 12.21 provider resides or to the person primarily responsible for oversight and management of a  
 12.22 housing with services establishment, as designated by the owner of the housing with services  
 12.23 establishment, in which a client of the home care provider resides.

12.24 **EFFECTIVE DATE.** This section is effective the day following final enactment.

12.25 Sec. 15. Minnesota Statutes 2020, section 144A.751, subdivision 1, is amended to read:

12.26 Subdivision 1. **Statement of rights.** An individual who receives hospice care has the  
 12.27 right to:

12.28 (1) receive written information about rights in advance of receiving hospice care or  
 12.29 during the initial evaluation visit before the initiation of hospice care, including what to do  
 12.30 if rights are violated;

13.1 (2) receive care and services according to a suitable hospice plan of care and subject to  
13.2 accepted hospice care standards and to take an active part in creating and changing the plan  
13.3 and evaluating care and services;

13.4 (3) be told in advance of receiving care about the services that will be provided, the  
13.5 disciplines that will furnish care, the frequency of visits proposed to be furnished, other  
13.6 choices that are available, and the consequence of these choices, including the consequences  
13.7 of refusing these services;

13.8 (4) be told in advance, whenever possible, of any change in the hospice plan of care and  
13.9 to take an active part in any change;

13.10 (5) refuse services or treatment;

13.11 (6) know, in advance, any limits to the services available from a provider, and the  
13.12 provider's grounds for a termination of services;

13.13 (7) know in advance of receiving care whether the hospice services may be covered by  
13.14 health insurance, medical assistance, Medicare, or other health programs in which the  
13.15 individual is enrolled;

13.16 (8) receive, upon request, a good faith estimate of the reimbursement the provider expects  
13.17 to receive from the health plan company in which the individual is enrolled. A good faith  
13.18 estimate must also be made available at the request of an individual who is not enrolled in  
13.19 a health plan company. This payment information does not constitute a legally binding  
13.20 estimate of the cost of services;

13.21 (9) know that there may be other services available in the community, including other  
13.22 end of life services and other hospice providers, and know where to go for information  
13.23 about these services;

13.24 (10) choose freely among available providers and change providers after services have  
13.25 begun, within the limits of health insurance, medical assistance, Medicare, or other health  
13.26 programs;

13.27 (11) have personal, financial, and medical information kept private and be advised of  
13.28 the provider's policies and procedures regarding disclosure of such information;

13.29 (12) be allowed access to records and written information from records according to  
13.30 sections 144.291 to 144.298;

13.31 (13) be served by people who are properly trained and competent to perform their duties;

14.1 (14) be treated with courtesy and respect and to have the patient's property treated with  
14.2 respect;

14.3 (15) voice grievances regarding treatment or care that is, or fails to be, furnished or  
14.4 regarding the lack of courtesy or respect to the patient or the patient's property;

14.5 (16) be free from physical and verbal abuse;

14.6 (17) reasonable, advance notice of changes in services or charges, including at least ten  
14.7 days' advance notice of the termination of a service by a provider, except in cases where:

14.8 (i) the recipient of services engages in conduct that alters the conditions of employment  
14.9 between the hospice provider and the individual providing hospice services, or creates an  
14.10 abusive or unsafe work environment for the individual providing hospice services;

14.11 (ii) an emergency for the informal caregiver or a significant change in the recipient's  
14.12 condition has resulted in service needs that exceed the current service provider agreement  
14.13 and that cannot be safely met by the hospice provider; or

14.14 (iii) the recipient is no longer certified as terminally ill;

14.15 (18) a coordinated transfer when there will be a change in the provider of services;

14.16 (19) know how to contact an individual associated with the provider who is responsible  
14.17 for handling problems and to have the provider investigate and attempt to resolve the  
14.18 grievance or complaint;

14.19 (20) know the name and address of the state or county agency to contact for additional  
14.20 information or assistance;

14.21 (21) assert these rights personally, or have them asserted by the hospice patient's family  
14.22 when the patient has been judged incompetent, without retaliation; ~~and~~

14.23 (22) have pain and symptoms managed to the patient's desired level of comfort;

14.24 (23) revoke hospice election at any time; and

14.25 (24) receive curative treatment for any condition unrelated to the condition that prompted  
14.26 hospice election.

14.27 **EFFECTIVE DATE.** This section is effective the day following final enactment.

15.1 Sec. 16. Minnesota Statutes 2020, section 144G.03, is amended by adding a subdivision  
15.2 to read:

15.3 Subd. 7. **Disease prevention and infection control.** A person or entity receiving assisted  
15.4 living title protection under this chapter and the person primarily responsible for oversight  
15.5 and management of a housing with services establishment, as designated by the owner of  
15.6 the housing with services establishment, must coordinate and cooperate with a home care  
15.7 provider providing services to a client who resides in the establishment, regardless of the  
15.8 home care provider's status as an arranged home care provider as defined in section 144D.01,  
15.9 subdivision 2a, to ensure that the home care provider meets all the requirements of section  
15.10 144A.4798.

15.11 **EFFECTIVE DATE.** This section is effective the day following final enactment.

15.12 Sec. 17. Minnesota Statutes 2020, section 144G.03, is amended by adding a subdivision  
15.13 to read:

15.14 Subd. 8. **Tuberculosis (TB) infection control.** (a) A person or entity receiving assisted  
15.15 living title protection under this chapter must establish and maintain a comprehensive  
15.16 tuberculosis infection control program according to the most current tuberculosis infection  
15.17 control guidelines issued by the United States Centers for Disease Control and Prevention  
15.18 (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and  
15.19 Mortality Weekly Report. This program must include a tuberculosis infection control plan  
15.20 that covers all paid and unpaid employees, contractors, students, and volunteers. The  
15.21 commissioner shall provide technical assistance regarding implementation of the guidelines.

15.22 (b) A person or entity receiving assisted living title protection under this chapter may  
15.23 comply with the requirements of this subdivision by participating in a comprehensive  
15.24 tuberculosis infection control program of an arranged home care provider.

15.25 (c) A person or entity receiving assisted living title protection under this chapter must  
15.26 maintain written evidence of compliance with this subdivision.

15.27 **EFFECTIVE DATE.** This section is effective the day following final enactment.

15.28 Sec. 18. Minnesota Statutes 2020, section 144G.03, is amended by adding a subdivision  
15.29 to read:

15.30 Subd. 9. **Communicable diseases.** A person or entity receiving assisted living title  
15.31 protection under this chapter must follow current state requirements for prevention, control,

16.1 and reporting of communicable diseases in Minnesota Rules, parts 4605.7040, 4605.7044,  
16.2 4605.7050, 4605.7075, 4605.7080, and 4605.7090.

16.3 **EFFECTIVE DATE.** This section is effective the day following final enactment.

16.4 Sec. 19. Minnesota Statutes 2020, section 144G.03, is amended by adding a subdivision  
16.5 to read:

16.6 Subd. 10. **Infection control program.** (a) A person or entity receiving assisted living  
16.7 title protection under this chapter must establish and maintain an effective infection control  
16.8 program that complies with accepted health care, medical, and nursing standards for infection  
16.9 control.

16.10 (b) A person or entity receiving assisted living title protection under this chapter may  
16.11 comply with the requirements of this subdivision by participating in an effective infection  
16.12 control program of an arranged home care provider.

16.13 **EFFECTIVE DATE.** This section is effective the day following final enactment.

16.14 Sec. 20. Minnesota Statutes 2020, section 144G.03, is amended by adding a subdivision  
16.15 to read:

16.16 Subd. 11. **Severe acute respiratory syndrome-related coronavirus infection**  
16.17 **control.** (a) A person or entity receiving assisted living title protection under this chapter  
16.18 must establish and maintain a comprehensive severe acute respiratory syndrome-related  
16.19 coronavirus infection control program that complies with accepted health care, medical,  
16.20 and nursing standards for infection control according to the most current SARS-CoV-2  
16.21 infection control guidelines or their successor versions issued by the United States Centers  
16.22 for Disease Control and Prevention, Centers for Medicare and Medicaid Services, and the  
16.23 commissioner. This program must include a severe acute respiratory syndrome-related  
16.24 coronavirus infection control plan that covers all paid and unpaid employees, contractors,  
16.25 students, volunteers, clients, and visitors. The commissioner shall provide technical assistance  
16.26 regarding implementation of the guidelines.

16.27 (b) A person or entity receiving assisted living title protection under this chapter may  
16.28 comply with the requirements of this subdivision by participating in a comprehensive severe  
16.29 acute respiratory syndrome-related coronavirus infection control program of an arranged  
16.30 home care provider.

16.31 (c) A person or entity receiving assisted living title protection under this chapter must  
16.32 maintain written evidence of compliance with this subdivision.



17.1 **EFFECTIVE DATE.** This section is effective the day following final enactment.

17.2 Sec. 21. Minnesota Statutes 2020, section 144G.03, is amended by adding a subdivision  
17.3 to read:

17.4 Subd. 12. **Severe acute respiratory syndrome-related coronavirus response plan.** (a)  
17.5 A person or entity receiving assisted living title protection under this chapter must establish,  
17.6 implement, and maintain a severe acute respiratory syndrome-related coronavirus response  
17.7 plan. The severe acute respiratory syndrome-related coronavirus response plan must be  
17.8 consistent with the requirements of subdivision 11 and at a minimum must address the  
17.9 following:

17.10 (1) baseline and serial severe acute respiratory syndrome-related coronavirus testing of  
17.11 all paid and unpaid employees, contractors, students, volunteers, clients, and visitors;

17.12 (2) use of personal protective equipment by all paid and unpaid employees, contractors,  
17.13 students, volunteers, clients, and visitors;

17.14 (3) separation or isolation of clients infected with SARS-CoV-2 or a similar severe acute  
17.15 respiratory syndrome-related coronavirus from clients who are not;

17.16 (4) balancing the rights of residents with controlling the spread of SARS-CoV-2 or  
17.17 similar severe acute respiratory syndrome-related coronavirus infections;

17.18 (5) client relocations, including steps to be taken to mitigate trauma for relocated clients  
17.19 receiving memory care;

17.20 (6) clearly informing clients of the home care provider's policies regarding the effect of  
17.21 hospice orders, provider orders for life-sustaining treatment, do not resuscitate orders, and  
17.22 do not intubate orders on any treatment of COVID-19 disease or similar severe acute  
17.23 respiratory syndromes;

17.24 (7) mitigating the effects of separation or isolation of clients, including virtual visitation,  
17.25 outdoor visitation, and for clients who cannot go outdoors, indoor visitation;

17.26 (8) compassionate care visitation;

17.27 (9) consideration of any campus model, multiple buildings on the same property, or any  
17.28 mix of independent senior living units in the same building as assisted living units;

17.29 (10) steps to be taken when a client is suspected of having a SARS-CoV-2 or similar  
17.30 severe acute respiratory syndrome-related coronavirus infection;

18.1 (11) steps to be taken when a client tests positive for a SARS-CoV-2 or similar severe  
18.2 acute respiratory syndrome-related coronavirus infection;

18.3 (12) protocols for emergency medical responses involving clients with SARS-CoV-2  
18.4 or similar severe acute respiratory syndrome-related coronavirus infections, including  
18.5 infection control procedures following the departure of ambulance service personnel or  
18.6 other first responders;

18.7 (13) notifying the commissioner when staffing levels are critically low; and

18.8 (14) taking into account dementia-related concerns.

18.9 (b) A person or entity receiving assisted living title protection under this chapter must  
18.10 provide the commissioner with a copy of a severe acute respiratory syndrome-related  
18.11 coronavirus response plan meeting the requirements of this subdivision.

18.12 (c) A person or entity receiving assisted living title protection under this chapter must  
18.13 make its severe acute respiratory syndrome-related coronavirus response plan available to  
18.14 staff, clients, and families of clients.

18.15 (d) A person or entity receiving assisted living title protection under this chapter may  
18.16 comply with the requirements of this subdivision by participating in a comprehensive severe  
18.17 acute respiratory syndrome-related coronavirus infection control program of an arranged  
18.18 home care provider.

18.19 (e) The commissioner may impose a fine not to exceed \$1,000 on the housing with  
18.20 services registrant for a violation of this subdivision. A registrant may appeal an imposed  
18.21 fine under the contested case procedure in section 144A.475, subdivisions 3a, 4, and 7.  
18.22 Fines collected under this section shall be deposited in the state treasury and credited to the  
18.23 state government special revenue fund. Continued noncompliance with the requirements  
18.24 of this subdivision may result in revocation or nonrenewal of the housing with services  
18.25 registration. The commissioner shall make public the list of all housing with services  
18.26 establishments that have complied with paragraph (b).

18.27 **EFFECTIVE DATE.** This section is effective the day following final enactment.

18.28 Sec. 22. Minnesota Statutes 2020, section 144G.07, is amended by adding a subdivision  
18.29 to read:

18.30 Subd. 7. **Cause of action.** A cause of action for violations of this section may be brought  
18.31 and nothing in this section precludes a person from pursuing such an action. Any

19.1 determination of retaliation by the commissioner under subdivision 5 may be used as evidence  
 19.2 of retaliation in any cause of action under this subdivision.

19.3 **EFFECTIVE DATE.** This section is effective August 1, 2021.

19.4 Sec. 23. Minnesota Statutes 2020, section 144G.09, subdivision 3, is amended to read:

19.5 Subd. 3. **Rulemaking authorized.** (a) The commissioner shall adopt rules for all assisted  
 19.6 living facilities that promote person-centered planning and service delivery and optimal  
 19.7 quality of life, and that ensure resident rights are protected, resident choice is allowed, and  
 19.8 public health and safety is ensured.

19.9 (b) On July 1, 2019, the commissioner shall begin rulemaking.

19.10 (c) The commissioner shall adopt rules that include but are not limited to the following:

19.11 (1) staffing appropriate for each licensure category to best protect the health and safety  
 19.12 of residents no matter their vulnerability, including staffing ratios;

19.13 (2) training prerequisites and ongoing training, including dementia care training and  
 19.14 standards for demonstrating competency;

19.15 (3) procedures for discharge planning and ensuring resident appeal rights;

19.16 (4) initial assessments, continuing assessments, and a uniform assessment tool;

19.17 (5) emergency disaster and preparedness plans;

19.18 (6) uniform checklist disclosure of services;

19.19 (7) a definition of serious injury that results from maltreatment;

19.20 (8) conditions and fine amounts for planned closures;

19.21 (9) procedures and timelines for the commissioner regarding termination appeals between  
 19.22 facilities and the Office of Administrative Hearings;

19.23 (10) establishing base fees and per-resident fees for each category of licensure;

19.24 (11) considering the establishment of a maximum amount for any one fee;

19.25 (12) procedures for relinquishing an assisted living facility with dementia care license  
 19.26 and fine amounts for noncompliance; and

19.27 (13) procedures to efficiently transfer existing housing with services registrants and  
 19.28 home care licensees to the new assisted living facility licensure structure.

20.1 (d) The commissioner shall publish the proposed rules by December 31, 2019, and shall  
20.2 publish final rules by December 31, 2020.

20.3 (e) Notwithstanding section 14.125, the commissioner's authority to adopt rules authorized  
20.4 in this subdivision does not expire at the end of the 18-month time limit that began on July  
20.5 1, 2019.

20.6 **EFFECTIVE DATE.** This section is effective the day following final enactment.

20.7 Sec. 24. Minnesota Statutes 2020, section 144G.10, is amended by adding a subdivision  
20.8 to read:

20.9 Subd. 1b. **Definitions.** (a) For the purposes of this section, the terms defined in this  
20.10 subdivision have the meanings given them.

20.11 (b) "Adjacent" means sharing a portion of a legal boundary.

20.12 (c) "Campus" means an assisted living facility that provides sleeping accommodations  
20.13 and assisted living services operated by the same licensee in:

20.14 (1) two or more buildings, each with a separate address, located on the same property  
20.15 identified by a single property identification number;

20.16 (2) a single building having two or more addresses, located on the same property,  
20.17 identified by a single property identification number; or

20.18 (3) two or more buildings at different addresses, identified by different property  
20.19 identification numbers, when the buildings are located on adjacent properties.

20.20 (d) "Campus' main building" means a building designated by the commissioner as the  
20.21 main building of a campus and to which the commissioner may issue an assisted living  
20.22 facility license for a campus.

20.23 **EFFECTIVE DATE.** This section is effective August 1, 2021.

20.24 Sec. 25. Minnesota Statutes 2020, section 144G.42, is amended by adding a subdivision  
20.25 to read:

20.26 Subd. 9b. **Infection control program.** (a) The facility must establish and maintain an  
20.27 effective infection control program that complies with accepted health care, medical, and  
20.28 nursing standards for infection control, including during a disease pandemic.

20.29 (b) The facility must maintain written evidence of compliance with this subdivision.

20.30 **EFFECTIVE DATE.** This section is effective August 1, 2021.

21.1 Sec. 26. Minnesota Statutes 2020, section 144G.42, is amended by adding a subdivision  
21.2 to read:

21.3 Subd. 9c. **Severe acute respiratory syndrome-related coronavirus infection**  
21.4 **control.** (a) A facility must establish and maintain a comprehensive severe acute respiratory  
21.5 syndrome-related coronavirus infection control program that complies with accepted health  
21.6 care, medical, and nursing standards for infection control according to the most current  
21.7 SARS-CoV-2 infection control guidelines or their successor versions issued by the United  
21.8 States Centers for Disease Control and Prevention, Centers for Medicare and Medicaid  
21.9 Services, and the commissioner. This program must include a severe acute respiratory  
21.10 syndrome-related coronavirus infection control plan that covers all paid and unpaid  
21.11 employees, contractors, students, volunteers, residents, and visitors. The commissioner shall  
21.12 provide technical assistance regarding implementation of the guidelines.

21.13 (b) The facility must maintain written evidence of compliance with this subdivision.

21.14 **EFFECTIVE DATE.** This section is effective August 1, 2021.

21.15 Sec. 27. Minnesota Statutes 2020, section 144G.42, is amended by adding a subdivision  
21.16 to read:

21.17 Subd. 9d. **Severe acute respiratory syndrome-related coronavirus response plan.** (a)  
21.18 A facility must establish, implement, and maintain a severe acute respiratory  
21.19 syndrome-related coronavirus response plan. The severe acute respiratory syndrome-related  
21.20 coronavirus response plan must be consistent with the requirements of subdivision 9c and  
21.21 at a minimum must address the following:

21.22 (1) baseline and serial severe acute respiratory syndrome-related coronavirus testing of  
21.23 all paid and unpaid employees, contractors, students, volunteers, clients and visitors;

21.24 (2) use of personal protective equipment by all paid and unpaid employees, contractors,  
21.25 students, volunteers, clients, and visitors;

21.26 (3) separation or isolation of clients infected with SARS-CoV-2 or a similar severe acute  
21.27 respiratory syndrome-related coronavirus from clients who are not;

21.28 (4) balancing the rights of residents with controlling the spread of SARS-CoV-2 or  
21.29 similar severe acute respiratory syndrome-related coronavirus infections;

21.30 (5) client relocations, including steps to be taken to mitigate trauma for relocated clients  
21.31 receiving memory care;

22.1 (6) clearly informing clients of the facility's policies regarding the effect of hospice  
 22.2 orders, provider orders for life-sustaining treatment, do not resuscitate orders, and do not  
 22.3 intubate orders on any treatment of COVID-19 disease or similar severe acute respiratory  
 22.4 syndromes;

22.5 (7) mitigating the effects of separation or isolation of residents, including virtual visitation,  
 22.6 outdoor visitation, and for residents who cannot go outdoors, indoor visitation;

22.7 (8) compassionate care visitation;

22.8 (9) consideration of any campus model, multiple buildings on the same property, or any  
 22.9 mix of independent senior living units in the same building as assisted living units;

22.10 (10) steps to be taken when a client is suspected of having a SARS-CoV-2 or similar  
 22.11 severe acute respiratory syndrome-related coronavirus infection;

22.12 (11) steps to be taken when a client tests positive for a SARS-CoV-2 or similar severe  
 22.13 acute respiratory syndrome-related coronavirus infection;

22.14 (12) protocols for emergency medical responses involving clients with SARS-CoV-2  
 22.15 or similar severe acute respiratory syndrome-related coronavirus infections, including  
 22.16 infection control procedures following the departure of ambulance service personnel or  
 22.17 other first responders;

22.18 (13) notifying the commissioner when staffing levels are critically low; and

22.19 (14) taking into account dementia-related concerns.

22.20 (b) A facility must provide the commissioner with a copy of a severe acute respiratory  
 22.21 syndrome-related coronavirus response plan meeting the requirements of this subdivision.

22.22 (c) A facility must make its severe acute respiratory syndrome-related coronavirus  
 22.23 response plan available to staff, clients, and families of clients.

22.24 **EFFECTIVE DATE.** This section is effective August 1, 2021.

22.25 Sec. 28. Minnesota Statutes 2020, section 144G.91, is amended by adding a subdivision  
 22.26 to read:

22.27 Subd. 5a. **Choice of provider.** Residents have the right to choose freely among available  
 22.28 providers and to change providers after services have begun, within the limits of health  
 22.29 insurance, long-term care insurance, medical assistance, other health programs, or public  
 22.30 programs.

22.31 **EFFECTIVE DATE.** This section is effective August 1, 2021.

23.1 Sec. 29. Minnesota Statutes 2020, section 144G.92, is amended by adding a subdivision  
23.2 to read:

23.3 Subd. 6. Cause of action. A cause of action for violations of this section may be brought  
23.4 and nothing in this section precludes a person from pursuing such an action. Any  
23.5 determination of retaliation by the commissioner under subdivision 4 may be used as evidence  
23.6 of retaliation in any cause of action under this subdivision.

23.7 EFFECTIVE DATE. This section is effective August 1, 2021.

23.8 Sec. 30. [144G.925] PRIVATE ENFORCEMENT OF RIGHTS.

23.9 (a) For a violation of section 144G.91, subdivision 6, 8, 12, or 21, a resident or resident's  
23.10 designated representative may bring a civil action against an assisted living establishment  
23.11 and recover actual damages or \$3,000, whichever is greater, plus costs, including costs of  
23.12 investigation, and reasonable attorney fees, and receive other equitable relief as determined  
23.13 by the court in addition to seeking any other remedy otherwise available under law.

23.14 (b) For a violation of section 144G.51, a resident is entitled to a permanent injunction,  
23.15 and any other legal or equitable relief as determined by the court, including but not limited  
23.16 to reformation of the contract and restitution for harm suffered, plus reasonable attorney  
23.17 fees and costs.

23.18 EFFECTIVE DATE. This section is effective August 1, 2021.

23.19 Sec. 31. Laws 2019, chapter 60, article 1, section 46, is amended to read:

23.20 Sec. 46. **PRIORITIZATION OF ENFORCEMENT ACTIVITIES.**

23.21 Within available appropriations to the commissioner of health for enforcement activities  
23.22 for fiscal years 2020 ~~and~~, 2021, and 2022, the commissioner of health shall prioritize  
23.23 enforcement activities taken under Minnesota Statutes, section 144A.442.

23.24 EFFECTIVE DATE. This section is effective the day following final enactment.

23.25 Sec. 32. Laws 2019, chapter 60, article 5, section 2, is amended to read:

23.26 Sec. 2. **COMMISSIONER OF HEALTH.**

23.27 Subdivision 1. **General fund appropriation.** (a) \$9,656,000 in fiscal year 2020 and  
23.28 \$9,416,000 in fiscal year 2021 are appropriated from the general fund to the commissioner

24.1 of health to implement regulatory activities relating to vulnerable adults and assisted living  
24.2 licensure.

24.3 (b) Of the amount in paragraph (a), \$7,438,000 in fiscal year 2020 and \$4,302,000 in  
24.4 fiscal year 2021 are for improvements to the current regulatory activities, systems, analysis,  
24.5 reporting, and communications relating to regulation of vulnerable adults. The base for this  
24.6 appropriation is \$5,800,000 in fiscal year 2022 and \$5,369,000 in fiscal year 2023.

24.7 (c) Of the amount in paragraph (a), \$2,218,000 in fiscal year 2020 and \$5,114,000 in  
24.8 fiscal year 2021 are to establish assisted living licensure under Minnesota Statutes, ~~section~~  
24.9 ~~144L.01~~ sections 144G.08 to 144G.9999. The fiscal year 2021 appropriation is available  
24.10 until June 30, 2023. This is a onetime appropriation.

24.11 Subd. 2. **State government special revenue fund appropriation.** \$1,103,000 in fiscal  
24.12 year 2020 and \$1,103,000 in fiscal year 2021 are appropriated from the state government  
24.13 special revenue fund to improve the frequency of home care provider inspections and to  
24.14 implement assisted living licensure activities under Minnesota Statutes, ~~section 144L.01~~  
24.15 sections 144G.08 to 144G.9999. The base for this appropriation is \$8,131,000 in fiscal year  
24.16 2022 and \$8,339,000 in fiscal year 2023.

24.17 Subd. 3. **Transfer.** The commissioner shall transfer fine revenue previously deposited  
24.18 to the state government special revenue fund under Minnesota Statutes, section 144A.474,  
24.19 subdivision 11, estimated to be \$632,000 to a dedicated special revenue account in the state  
24.20 treasury established for the purposes of implementing the recommendations of the Home  
24.21 Care Advisory Council under Minnesota Statutes, section 144A.4799.

24.22 **EFFECTIVE DATE.** This section is effective the day following final enactment.

24.23 Sec. 33. **SUSPENDING SERVICE TERMINATIONS, TRANSFERS, AND**  
24.24 **DISCHARGES DURING THE COVID-19 PEACETIME EMERGENCY.**

24.25 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

24.26 (b) "Arranged home care provider" has the meaning given in Minnesota Statutes, section  
24.27 144D.01, subdivision 2a.

24.28 (c) "Client" has the meaning given in Minnesota Statutes, section 144G.01, subdivision  
24.29 3.

24.30 (d) "Facility" means:



25.1 (1) a housing with services establishment registered under Minnesota Statutes, section  
25.2 144D.02, and operating under title protection under Minnesota Statutes, sections 144G.01  
25.3 to 144G.07; or

25.4 (2) a housing with services establishment registered under Minnesota Statutes, section  
25.5 144D.02, and required to disclose special care status under Minnesota Statutes, section  
25.6 325F.72.

25.7 (e) "Home care provider" has the meaning given in Minnesota Statutes, section 144A.43,  
25.8 subdivision 4.

25.9 (f) "Service plan" has the meaning given in Minnesota Statutes, section 144A.43,  
25.10 subdivision 27.

25.11 (g) "Services" means services provided to a client by a home care provider according  
25.12 to a service plan.

25.13 Subd. 2. **Suspension of home care service terminations.** For the duration of the  
25.14 peacetime emergency declared in Executive Order 20-01 or until Executive Order 20-01 is  
25.15 rescinded, an arranged home care provider providing home care services to a client residing  
25.16 in a facility must not terminate its client's services or service plan, unless one of the conditions  
25.17 specified in Minnesota Statutes, section 144G.52, subdivision 5, paragraph (b), clauses (1)  
25.18 to (3), are met. Nothing in this subdivision prohibits the transfer of a client under section  
25.19 47.

25.20 Subd. 3. **Suspension of discharges and transfers.** For the duration of the peacetime  
25.21 emergency declared in Executive Order 20-01 or until Executive Order 20-01 is rescinded,  
25.22 nursing homes, boarding care homes, and long-term acute care hospitals must not discharge  
25.23 or transfer residents except for transfers in accordance with guidance issued by the Centers  
25.24 for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, and  
25.25 the Minnesota Department of Health for the purposes of controlling SARS-CoV-2 infections,  
25.26 or unless the failure to discharge or transfer the resident would endanger the health or safety  
25.27 of the resident or other individuals in the facility.

25.28 Subd. 4. **Pending discharge and transfer appeals.** For the duration of the peacetime  
25.29 emergency declared in Executive Order 20-01 or until Executive Order 20-01 is rescinded,  
25.30 final decisions on appeals of transfers and appeals under section 52, subdivisions 5 to 11,  
25.31 and Minnesota Statutes, section 144A.135, are stayed.

26.1 Subd. 5. Penalties. A person who willfully violates subdivisions 2 and 3 of this section  
26.2 is guilty of a misdemeanor and upon conviction must be punished by a fine not to exceed  
26.3 \$1,000, or by imprisonment for not more than 90 days.

26.4 EFFECTIVE DATE. This section is effective the day following final enactment.

26.5 Sec. 34. TRANSFERS FOR COHORTING PURPOSES DURING THE COVID-19  
26.6 PEACETIME EMERGENCY.

26.7 Subdivision 1. Definitions. (a) The definitions in this subdivision apply to this section.

26.8 (b) "Dedicated COVID-19 care site" means:

26.9 (1) a dedicated facility for the care of individuals who have SARS-CoV-2 or similar  
26.10 infections; and

26.11 (2) dedicated locations in a facility for the care of individuals who have SARS-CoV-2  
26.12 or similar infections.

26.13 (c) "Facility" means:

26.14 (1) a housing with services establishment registered under Minnesota Statutes, section  
26.15 144D.02, and operating under title protection under Minnesota Statutes, sections 144G.01  
26.16 to 144G.07;

26.17 (2) a housing with services establishment registered under Minnesota Statutes, section  
26.18 144D.02, and required to disclose special care status under Minnesota Statutes, section  
26.19 325F.72;

26.20 (3) a nursing home licensed under Minnesota Statutes, chapter 144A; or

26.21 (4) a boarding care home licensed under Minnesota Statutes, sections 144.50 to 144.58.

26.22 Facility does not mean a hospital.

26.23 (d) "Resident" means:

26.24 (1) a person residing in a nursing home;

26.25 (2) a person residing in a boarding care home;

26.26 (3) a housing with services resident who receives assisted living that is subject to the  
26.27 requirements of Minnesota Statutes, sections 144G.01 to 144G.07; or

26.28 (4) a resident of a housing with services establishment required to disclose special care  
26.29 status under Minnesota Statutes, section 325F.72.

27.1 Subd. 2. Prohibited transfers and discharges. A hospital may not discharge or transfer  
27.2 any patient who previously tested positive for SARS-CoV-2, regardless of the patient's  
27.3 symptoms, to a facility other than a dedicated COVID-19 care site, unless the hospital  
27.4 documents a test confirming the patient does not have a SARS-CoV-2 infection.

27.5 Subd. 3. Transfers for cohorting purposes. (a) A facility may transfer a resident to  
27.6 another facility or location in a facility for the following cohorting purposes:

27.7 (1) transferring residents with symptoms of a respiratory infection or confirmed diagnosis  
27.8 of COVID-19 to a dedicated COVID-19 care site; or

27.9 (2) transferring residents without symptoms of a respiratory infection or confirmed  
27.10 diagnosis of COVID-19 or related infection to another facility or location in a facility  
27.11 dedicated to caring for such residents and preventing them from acquiring COVID-19 for  
27.12 the purposes of creating a dedicated COVID-19 care site.

27.13 The transferring facility must receive confirmation that the receiving facility agrees to accept  
27.14 the resident to be transferred. Confirmation may be in writing or oral. If verbal, the  
27.15 transferring facility must document who from the receiving facility communicated agreement  
27.16 and the date and time this person communicated agreement.

27.17 (b) A spouse who resides with a transferred resident may elect to accompany the  
27.18 transferred resident to the receiving facility to continue to reside with the resident transferred  
27.19 for cohorting purposes. The transferring facility must disclose to the spouse of the transferred  
27.20 resident the known risks to the spouse of accompanying the resident to the receiving facility.

27.21 Subd. 4. Required cohorting practices. (a) A facility must cohort residents with positive  
27.22 tests for SARS-CoV-2, regardless of symptoms, in a dedicated COVID-19 care site until  
27.23 such time as a resident has a confirmed negative test for SARS-CoV-2. A resident with a  
27.24 confirmed negative test for SARS-CoV-2 may return to the facility or room from which the  
27.25 resident was transferred, provided the facility or room is not a dedicated COVID-19 care  
27.26 site.

27.27 (b) A facility that establishes a dedicated COVID-19 care site must dedicate staff,  
27.28 supplies, and equipment exclusively to either the dedicated COVID-19 care site or to the  
27.29 part of the facility that is not a dedicated COVID-19 care site. A facility must not permit  
27.30 staff, supplies, or equipment to move between a dedicated COVID-19 care site and a building  
27.31 or part of a facility that is not a dedicated COVID-19 care site.

28.1 (c) A facility must not permit a resident with a positive test for SARS-CoV-2 to share  
28.2 a room or living unit with a resident who is not SARS-CoV-2 positive, unless the residents  
28.3 are spouses or otherwise provide informed consent.

28.4 Subd. 5. **Notice required.** A transferring facility shall provide the transferred resident  
28.5 and the legal or designated representatives of the transferred resident, if any, with a written  
28.6 notice of transfer that includes the following information:

28.7 (1) the effective date of transfer;

28.8 (2) the reason permissible under subdivision 3 for the transfer;

28.9 (3) the name and contact information of a representative of the transferring facility with  
28.10 whom the resident may discuss the transfer;

28.11 (4) the name and contact information of a representative of the receiving facility with  
28.12 whom the resident may discuss the transfer;

28.13 (5) a statement that the transferring facility will participate in a coordinated move and  
28.14 transfer of the care of the resident to the receiving facility, as required under section 52,  
28.15 subdivision 16, and under Minnesota Statutes, section 144A.44, subdivision 1, clause (18);

28.16 (6) a statement that a transfer for cohorting purposes does not constitute a termination  
28.17 of a lease, services, or a service plan; and

28.18 (7) a statement that a resident has a right to return to the transferring facility as provided  
28.19 under subdivision 11.

28.20 Subd. 6. **Waived transfer requirements for cohorting purposes.** The following  
28.21 requirements related to rights of residents, as defined in subdivision 1, paragraph (d), clauses  
28.22 (3) and (4), are waived, or modified as indicated, only for purposes related to transfers to  
28.23 another facility under subdivision 3:

28.24 (1) the right to take an active part in developing, modifying, and evaluating the plan and  
28.25 services under Minnesota Statutes, section 144A.44, clause (2);

28.26 (2) rights under Minnesota Statutes, section 144A.44, clause (3);

28.27 (3) rights under Minnesota Statutes, section 144A.44, clause (4);

28.28 (4) rights under Minnesota Statutes, section 144A.44, clause (9);

28.29 (5) rights under Minnesota Statutes, section 144A.44, clause (15);

29.1 (6) timelines for completing assessments under Minnesota Statutes, section 144A.4791,  
29.2 subdivision 8. A receiving facility must complete client assessments following a transfer  
29.3 for cohorting purposes as soon as practicable; and

29.4 (7) timelines for completing service plans under Minnesota Statutes, section 144A.4791,  
29.5 subdivision 9. A receiving facility must complete client service plans following a transfer  
29.6 for cohorting purposes as soon as practicable and must review and use the care plan for a  
29.7 transferred client provided by the transferring facility, adjusting it as necessary to protect  
29.8 the health and safety of the client.

29.9 Subd. 7. **Mandatory transfer of medical assistance clients for cohorting purposes.** (a)  
29.10 The commissioner of health has the authority to transfer medical assistance residents to  
29.11 another facility for the purposes under subdivision 3.

29.12 (b) The commissioner of human services may not deny reimbursement to a facility  
29.13 receiving a resident under this section for a private room or private living unit.

29.14 Subd. 8. **Coordinated transfer required.** Nothing in this section shall be considered  
29.15 inconsistent with a resident's right to a coordinated move and transfer of care as required  
29.16 under section 52, subdivision 16.

29.17 Subd. 9. **Transfers not considered terminations.** Nothing in this section shall be  
29.18 considered inconsistent with a resident's rights under sections 46 and 52. A transfer under  
29.19 this section is not a termination of a lease, services, or a service plan under section 46 or  
29.20 52.

29.21 Subd. 10. **No right of appeal.** A resident may not appeal a transfer under subdivision  
29.22 3.

29.23 Subd. 11. **Right to return.** If a resident is absent from a facility as a result of a transfer  
29.24 under subdivision 3, the facility must allow a resident to return to the transferring facility,  
29.25 provided the resident is determined not to be infectious according to current medical  
29.26 standards.

29.27 Subd. 12. **Appropriate transfers.** The commissioner of health shall monitor all transfers  
29.28 made under this section. The commissioner may audit transfers made under this section for  
29.29 compliance with the requirements of this section and may take enforcement actions for  
29.30 violations, including issuing fines. A violation of this section as applied to a resident is at  
29.31 least a level 2 violation as defined in Minnesota Statutes, section 144A.474.

30.1 Subd. 13. **Expiration.** Subdivisions 1 to 9 expire 60 days after the peacetime emergency  
 30.2 declared by the governor under Minnesota Statutes, section 12.31, subdivision 2, for an  
 30.3 outbreak of COVID-19, is terminated or rescinded by proper authority.

30.4 **EFFECTIVE DATE.** This section is effective the day following final enactment.

30.5 Sec. 35. **LONG-TERM CARE SEVERE ACUTE RESPIRATORY**  
 30.6 **SYNDROME-RELATED CORONAVIRUS TASK FORCE.**

30.7 Subdivision 1. **Membership.** (a) A Long-Term Care Severe Acute Respiratory  
 30.8 Syndrome-Related Coronavirus Task Force consists of the following members:

30.9 (1) two senators, including one senator appointed by the senate majority leader and one  
 30.10 senator appointed by the senate minority leader, who shall each be ex officio nonvoting  
 30.11 members;

30.12 (2) two members of the house of representatives, including one member appointed by  
 30.13 the speaker of the house and one member appointed by the minority leader of the house of  
 30.14 representatives, who shall each be ex officio nonvoting members;

30.15 (3) four family members of an assisted living client or of a nursing home resident,  
 30.16 appointed by the governor;

30.17 (4) four assisted living clients or nursing home residents, appointed by the governor;

30.18 (5) one medical doctor board-certified in infectious disease, appointed by the Minnesota  
 30.19 Medical Association;

30.20 (6) two medical doctors board-certified in geriatric medicine, appointed by the Minnesota  
 30.21 Network of Hospice and Palliative Care;

30.22 (7) one registered nurse or advanced practice registered nurse who provides care in a  
 30.23 nursing home or assisted living services, appointed by the Minnesota Chapter of the American  
 30.24 Assisted Living Nurses Association;

30.25 (8) two licensed practical nurses who provide care in a nursing home or assisted living  
 30.26 services, appointed by the Minnesota Chapter of the American Assisted Living Nurses  
 30.27 Association;

30.28 (9) one certified home health aide providing assisted living services or one certified  
 30.29 nursing assistant providing care in a nursing home, appointed by the Minnesota Home Care  
 30.30 Association;

31.1 (10) one personal care assistant who provides care in a nursing home or a facility in  
31.2 which assisted living services are provided;

31.3 (11) one medical director of a licensed nursing home, appointed by the Minnesota  
31.4 Association of Geriatrics Inspired Clinicians;

31.5 (12) one medical director of a licensed hospice provider, appointed by the Minnesota  
31.6 Association of Geriatrics Inspired Clinicians;

31.7 (13) one licensed nursing home administrator, appointed by the Minnesota Board of  
31.8 Executives for Long Term Services and Supports;

31.9 (14) one licensed assisted living director, appointed by the Minnesota Board of Executives  
31.10 for Long Term Services and Support;

31.11 (15) two representatives of organizations representing long-term care providers, one  
31.12 appointed by LeadingAge Minnesota and one appointed by Care Providers of Minnesota;

31.13 (16) one representative of a corporate owner of a licensed nursing home or of a housing  
31.14 with services establishment operating under Minnesota Statutes, chapter 144G, assisted  
31.15 living title protection, appointed by the Minnesota HomeCare Association;

31.16 (17) two representatives of an organization representing clients or families of clients  
31.17 receiving assisted living services or residents or families of residents of nursing homes, one  
31.18 appointed by Elder Voices Family Advocates and one appointed by AARP Minnesota;

31.19 (18) one representative of an organization representing clients and residents living with  
31.20 dementia, appointed by the Minnesota-North Dakota Chapter of the Alzheimer's Association;

31.21 (19) one representative of an organization representing people experiencing maltreatment,  
31.22 appointed by the Minnesota Elder Justice Center;

31.23 (20) one attorney specializing in housing law, appointed by Mid-Minnesota Legal Aid,  
31.24 Southern Minnesota Regional Legal Services;

31.25 (21) one attorney specializing in elder law or disability benefits law, appointed by the  
31.26 Governing Council of the Elder Law Section of the Minnesota State Bar Association;

31.27 (22) one chaplain in a long-term care setting, appointed by the Association of Professional  
31.28 Chaplains (Minnesota);

31.29 (23) the commissioner of human services or a designee, who shall be an ex officio  
31.30 nonvoting member;

32.1 (24) the commissioner of health or a designee, who shall be an ex officio nonvoting  
32.2 member; and

32.3 (25) the ombudsman for long-term care or designee, who shall be an ex officio nonvoting  
32.4 member.

32.5 (b) Appointing authorities must make initial appointments to the Long-Term Care Severe  
32.6 Acute Respiratory Syndrome-Related Coronavirus Task Force by January 1, 2022.

32.7 Subd. 2. Duties. The Long-Term Care Severe Acute Respiratory Syndrome-Related  
32.8 Coronavirus Task Force is established to study various methods of balancing the rights of  
32.9 assisted living clients and nursing home residents with the risk of outbreaks of SARS-CoV-2  
32.10 or similar severe acute respiratory syndrome-related coronavirus infections and COVID-19  
32.11 disease or similar severe acute respiratory syndromes, and to advise the commissioners of  
32.12 health and human services on the use of their temporary emergency authorities with respect  
32.13 to providing long-term care during a peacetime emergency related to a severe acute  
32.14 respiratory syndrome-related coronavirus or severe acute respiratory syndromes. Goals of  
32.15 the task force are to minimize the number of deaths in long-term care facilities resulting  
32.16 from COVID-19 disease or similar severe acute respiratory syndromes and to alleviate  
32.17 isolation. At a minimum, the task force must study:

32.18 (1) how to minimize isolating assisted living clients and nursing home residents who  
32.19 are neither suspected or confirmed to have active SARS-CoV-2 or similar severe acute  
32.20 respiratory syndrome-related coronavirus infections;

32.21 (2) how to separate assisted living clients and nursing home residents who are suspected  
32.22 or confirmed to have active SARS-CoV-2 or similar severe acute respiratory  
32.23 syndrome-related coronavirus infections from those clients and residents who are neither  
32.24 suspected or confirmed to have active SARS-CoV-2 or similar severe acute respiratory  
32.25 syndrome-related coronavirus infections;

32.26 (3) how to create facilities dedicated to caring for assisted living clients and nursing  
32.27 home residents with symptoms of a respiratory infection or confirmed diagnosis of  
32.28 COVID-19 disease or similar severe acute respiratory syndromes;

32.29 (4) how to create facilities dedicated to caring for assisted living clients and nursing  
32.30 home residents without symptoms of a respiratory infection or confirmed not to have  
32.31 COVID-19 disease or similar severe acute respiratory syndromes to prevent them from  
32.32 acquiring COVID-19 disease or similar severe acute respiratory syndromes;



33.1 (5) how to create facilities dedicated to caring for, isolating, and observing for up to 14  
33.2 days assisted living clients and nursing home residents with known exposure to SARS-CoV-2  
33.3 or a similar severe acute respiratory syndrome-related coronavirus; and

33.4 (6) best practices related to executing hospice orders, provider orders for life-sustaining  
33.5 treatment, do not resuscitate orders, and do not intubate orders when treating an assisted  
33.6 living or nursing home resident for COVID-19 disease or similar severe acute respiratory  
33.7 syndromes.

33.8 Subd. 3. **Advisory opinions.** The task force may issue advisory opinions to the  
33.9 commissioners of health and human services regarding the commissioners' use of temporary  
33.10 emergency authorities granted under emergency executive orders and in law, as well as  
33.11 under any existing nonemergency authorities. The task force shall elect by majority vote  
33.12 an author of each advisory opinion. The task force shall forward any advisory opinions it  
33.13 issues to the chairs and ranking minority members of the legislative committees with  
33.14 jurisdiction over health and human services policy and finance.

33.15 Subd. 4. **Report.** By January 15, 2022, the task force must report to the chairs and  
33.16 ranking minority members of the legislative committees with jurisdiction over health policy  
33.17 and finance. The report must:

33.18 (1) summarize the activities of the task force; and

33.19 (2) make recommendations for legislative action.

33.20 Subd. 5. **First meeting; chair.** The commissioner of health or a designee must convene  
33.21 the first meeting of the Long-Term Care Severe Acute Respiratory Syndrome-Related  
33.22 Coronavirus Task Force by August 1, 2021. At the first meeting, the task force shall elect  
33.23 a chair by a majority vote of those members present. The chair has authority to convene  
33.24 additional meetings as needed.

33.25 Subd. 6. **Meetings.** The meetings of the task force are subject to Minnesota Statutes,  
33.26 chapter 13D.

33.27 Subd. 7. **Administration.** The commissioner of health shall provide administrative  
33.28 services for the task force.

33.29 Subd. 8. **Compensation.** Public members are compensated as provided in Minnesota  
33.30 Statutes, section 15.059, subdivision 4.

33.31 Subd. 9. **Expiration.** This section expires one year after the implementation of assisted  
33.32 living licensure under Minnesota Statutes, chapter 144G.

34.1 **EFFECTIVE DATE.** This section is effective the day following final enactment.

34.2 Sec. 36. **DIRECTION TO THE COMMISSIONER OF HEALTH; ELECTRONIC**  
 34.3 **MONITORING CONSENT FORM.**

34.4 The commissioner of health shall modify the Resident Representative Consent Form  
 34.5 and the Roommate Representative Consent Form related to electronic monitoring under  
 34.6 Minnesota Statutes, section 144.6502, by removing the instructions requiring a resident  
 34.7 representative to obtain a written determination by the medical professional of the resident  
 34.8 that the resident currently lacks the ability to understand and appreciate the nature and  
 34.9 consequences of electronic monitoring. The commissioner shall not require a resident  
 34.10 representative to submit a written determination with the consent forms.

34.11 **EFFECTIVE DATE.** This section is effective the day following final enactment.

34.12 Sec. 37. **DIRECTION TO THE COMMISSIONER OF HEALTH; CONTROLLING**  
 34.13 **SEVERE ACUTE RESPIRATORY SYNDROME-RELATED CORONAVIRUS IN**  
 34.14 **LONG-TERM CARE SETTINGS.**

34.15 Subdivision 1. **State plan for combating severe acute respiratory syndrome-related**  
 34.16 **coronavirus.** (a) The commissioner of health shall create a state plan for combating the  
 34.17 spread of SARS-CoV-2 or similar severe acute respiratory syndrome-related coronavirus  
 34.18 infections and COVID-19 disease or similar severe acute respiratory syndromes among  
 34.19 residents of long-term care settings. For the purposes of this section, "long-term care setting"  
 34.20 or "setting" means: (1) a housing with services establishment registered under Minnesota  
 34.21 Statutes, section 144D.02, and operating under title protection under Minnesota Statutes,  
 34.22 sections 144G.01 to 144G.07; (2) a housing with services establishment registered under  
 34.23 Minnesota Statutes, section 144D.02, and required to disclose special care status under  
 34.24 Minnesota Statutes, section 325F.72; (3) a nursing home licensed under Minnesota Statutes,  
 34.25 chapter 144A; (4) a boarding care home licensed under Minnesota Statutes, sections 144.50  
 34.26 to 144.58; or (5) independent senior living. For the purposes of this section, "resident" means  
 34.27 any individual residing in a long-term care setting. The commissioner must consult with  
 34.28 the Long-Term Care Severe Acute Respiratory Syndrome-Related Coronavirus Task Force  
 34.29 regarding the creation of and modifications or amendments to the state plan.

34.30 (b) In the plan, the commissioner of health must provide long-term care settings with  
 34.31 guidance on alleviating isolation of residents who are not suspected or known to have an  
 34.32 active SARS-CoV-2 or similar severe acute respiratory syndrome-related coronavirus  
 34.33 infection or COVID-19 disease or similar severe acute respiratory syndromes, including

35.1 recommendations on how to safely ease restrictions on visitors entering the setting and on  
35.2 free movement of clients and residents within the setting and the community.

35.3 (c) In the state plan, the commissioner must at a minimum address the following:

35.4 (1) baseline and serial severe acute respiratory syndrome-related coronavirus testing of  
35.5 all paid and unpaid employees, contractors, students, volunteers, residents, and visitors;

35.6 (2) use of personal protective equipment by all paid and unpaid employees, contractors,  
35.7 students, volunteers, residents, and visitors;

35.8 (3) separation or isolation of residents infected with SARS-CoV-2 or a similar severe  
35.9 acute respiratory syndrome-related coronavirus from residents who are not;

35.10 (4) balancing the rights of residents with controlling the spread of SARS-CoV-2 or  
35.11 similar severe acute respiratory syndrome-related coronavirus infections;

35.12 (5) resident relocations, including steps to be taken to mitigate trauma for relocated  
35.13 residents receiving memory care;

35.14 (6) clearly informing residents of the setting's policies regarding the effect of hospice  
35.15 orders, provider orders for life-sustaining treatment, do not resuscitate orders, and do not  
35.16 intubate orders on any treatment of COVID-19 disease or similar severe acute respiratory  
35.17 syndromes;

35.18 (7) mitigating the effects of separation or isolation of residents, including virtual visitation,  
35.19 outdoor visitation, and for residents who cannot go outdoors, indoor visitation;

35.20 (8) compassionate care visitation;

35.21 (9) consideration of any campus model, multiple buildings on the same property, or any  
35.22 mix of independent senior living units in the same building as assisted living units;

35.23 (10) steps to be taken when a resident is suspected of having a SARS-CoV-2 or similar  
35.24 severe acute respiratory syndrome-related coronavirus infection;

35.25 (11) steps to be taken when a resident tests positive for a SARS-CoV-2 or similar severe  
35.26 acute respiratory syndrome-related coronavirus infection;

35.27 (12) protocols for emergency medical responses involving residents with SARS-CoV-2  
35.28 or similar severe acute respiratory syndrome-related coronavirus infections, including  
35.29 infection control procedures following the departure of ambulance service personnel or  
35.30 other first responders;

35.31 (13) notifying the commissioner when staffing levels are critically low; and

36.1 (14) taking into account dementia-related concerns.

36.2 Subd. 2. **Enforcement of disease prevention and infection control requirements**  
 36.3 during the pandemic. The commissioner of health shall develop protocols to ensure during  
 36.4 the pandemic safe and timely surveys of licensed providers and facilities providing service  
 36.5 in a long-term care setting for compliance with all applicable disease prevention and infection  
 36.6 control requirements.

36.7 Subd. 3. **Maltreatment investigations during the pandemic.** The commissioner of  
 36.8 health shall develop protocols to ensure during the pandemic that there are safe and timely  
 36.9 investigations of maltreatment complaints involving residents.

36.10 Subd. 4. **Personal protective equipment.** The commissioner shall develop policies and  
 36.11 procedures to ensure that long-term care settings are given priority access to personal  
 36.12 protective equipment similar to the priority granted to hospitals.

36.13 **EFFECTIVE DATE.** This section is effective the day following final enactment.

36.14 Sec. 38. **LONG-TERM CARE COVID-19-RELATED TESTING PROGRAMS.**

36.15 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

36.16 (b) "Allowable costs" means costs associated with COVID-19-related testing services  
 36.17 incurred by a facility while implementing a COVID-19 testing program, provided the testing  
 36.18 products used have received Emergency Use Authorization under section 564 of the federal  
 36.19 Food, Drug, and Cosmetic Act.

36.20 (c) "COVID-19-related testing services" means any diagnostic product available for the  
 36.21 detection of SARS-CoV-2 or the diagnosis of COVID-19; any product available to determine  
 36.22 whether a person has developed a detectable antibody response to SARS-CoV-2 or had  
 36.23 COVID-19 in the past; specimen collection; specimen transportation; specimen testing; and  
 36.24 any associated services from a health care professional, clinic, or laboratory.

36.25 (d) "Facility" means a nursing home licensed under Minnesota Statutes, section 144A.02;  
 36.26 a boarding care home licensed under Minnesota Statutes, sections 144.50 to 144.58; a  
 36.27 housing with services establishment registered under Minnesota Statutes, section 144D.02,  
 36.28 and operating under title protection under Minnesota Statutes, section 144G.02; a housing  
 36.29 with services establishment registered under Minnesota Statutes, section 144D.02, and  
 36.30 required to disclose special care status under Minnesota Statutes, section 325F.72; and  
 36.31 independent senior living settings.

37.1 (e) "Public health care program" means medical assistance under Minnesota Statutes,  
37.2 chapter 256B, and Laws 2020, chapter 74, article 1, section 12; MinnesotaCare; Medicare;  
37.3 and medical assistance for uninsured individuals under Laws 2020, chapter 74, article 1,  
37.4 section 11.

37.5 (f) "Serial COVID-19 testing" means repeat testing for SARS-CoV-2 infections no more  
37.6 than three days after baseline testing and periodically thereafter.

37.7 Subd. 2. **Testing program required.** (a) Each facility shall establish, implement, and  
37.8 maintain a comprehensive COVID-19 infection control program according to the most  
37.9 current SARS-CoV-2 testing guidance for nursing homes released by the United States  
37.10 Centers for Disease Control and Prevention (CDC). A comprehensive COVID-19 infection  
37.11 control program must include a COVID-19 testing program that requires baseline and serial  
37.12 COVID-19 testing of all residents, staff, visitors, and others entering the facility. All staff  
37.13 considered health care workers under the facility's tuberculosis screening program must be  
37.14 included in the facility's COVID-19 testing program. The commissioner of health shall  
37.15 provide technical assistance regarding implementation of the CDC guidance.

37.16 (b) The commissioner may impose a fine not to exceed \$1,000 on a facility that does  
37.17 not implement and maintain a testing program as required under this section. A facility may  
37.18 appeal an imposed fine under the contested case procedure in Minnesota Statutes, section  
37.19 144A.475, subdivisions 3a, 4, and 7. Fines collected under this section shall be deposited  
37.20 in the state treasury and credited to the state government special revenue fund. Continued  
37.21 noncompliance with the requirements of this section may result in revocation or nonrenewal  
37.22 of facilities' license or registration. The commissioner shall make public the list of all  
37.23 facilities that are not in compliance with this section.

37.24 Subd. 3. **Baseline testing grants.** Within the limits of money specifically appropriated  
37.25 to the commissioner of human services under section 53, paragraph (a), the commissioner  
37.26 of human services shall make COVID-19 baseline testing grants to any facility that has not  
37.27 completed COVID-19 baseline testing. The commissioner shall determine the amount of  
37.28 each baseline screening grant, and shall award a grant only if funds are not otherwise  
37.29 available.

37.30 Subd. 4. **Serial screening reimbursement.** (a) Within the limits of money specifically  
37.31 appropriated to the commissioner of human services under section 53, paragraph (b), the  
37.32 commissioner of human services shall reimburse each facility for the allowable costs of  
37.33 eligible COVID-19-related testing services that a facility cannot otherwise afford upon  
37.34 submission by a facility of a COVID-19-related testing services cost report.

38.1 (b) The commissioner of human services shall develop a COVID-19-related testing  
 38.2 services cost report.

38.3 (c) A facility may submit a COVID-19-related testing services cost report once per  
 38.4 month. If the commissioner of human services determines that a facility is in financial crisis,  
 38.5 the facility may submit a cost report once every two weeks.

38.6 **EFFECTIVE DATE.** This section is effective the day following final enactment.

38.7 **Sec. 39. CONSUMER PROTECTIONS FOR ASSISTED LIVING CLIENTS.**

38.8 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

38.9 (b) "Appropriate service provider" means an arranged home care provider that can  
 38.10 adequately provide to a client the services agreed to in the service agreement.

38.11 (c) "Arranged home care provider" has the meaning given in Minnesota Statutes, section  
 38.12 144D.01, subdivision 2a.

38.13 (d) "Client" has the meaning given in Minnesota Statutes, section 144G.01, subdivision  
 38.14 3.

38.15 (e) "Client representative" means one of the following in the order of priority listed, to  
 38.16 the extent the person may reasonably be identified and located:

38.17 (1) a court-appointed guardian acting in accordance with the powers granted to the  
 38.18 guardian under Minnesota Statutes, chapter 524;

38.19 (2) a conservator acting in accordance with the powers granted to the conservator under  
 38.20 Minnesota Statutes, chapter 524;

38.21 (3) a health care agent acting in accordance with the powers granted to the health care  
 38.22 agent under Minnesota Statutes, chapter 145C;

38.23 (4) an attorney-in-fact acting in accordance with the powers granted to the attorney-in-fact  
 38.24 by a written power of attorney under Minnesota Statutes, chapter 523; or

38.25 (5) a person who:

38.26 (i) is not an agent of a facility or an agent of a home care provider; and

38.27 (ii) is designated by the client orally or in writing to act on the client's behalf.

38.28 (f) "Facility" means:

39.1 (1) a housing with services establishment registered under Minnesota Statutes, section  
39.2 144D.02, and operating under title protection under Minnesota Statutes, sections 144G.01  
39.3 to 144G.07; or

39.4 (2) a housing with services establishment registered under Minnesota Statutes, section  
39.5 144D.02, and required to disclose special care status under Minnesota Statutes, section  
39.6 325F.72.

39.7 (g) "Home care provider" has the meaning given in Minnesota Statutes, section 144A.43,  
39.8 subdivision 4.

39.9 (h) "Safe location" means a location that does not place a client's health or safety at risk.  
39.10 A safe location is not a private home where the occupant is unwilling or unable to care for  
39.11 the client, a homeless shelter, a hotel, or a motel.

39.12 (i) "Service plan" has the meaning given in Minnesota Statutes, section 144A.43,  
39.13 subdivision 27.

39.14 (j) "Services" means services provided to a client by a home care provider according to  
39.15 a service plan.

39.16 Subd. 2. Prerequisite to termination; meeting. (a) A facility and the arranged home  
39.17 care provider must schedule and participate in a meeting with the client and the client  
39.18 representative before the arranged home care provider issues a notice of termination of  
39.19 services.

39.20 (b) A facility must schedule and participate in a meeting with the client and client  
39.21 representative before the facility issues a termination of housing.

39.22 (c) The purposes of the meeting required under paragraph (a) are to:

39.23 (1) explain in detail the reasons for the proposed termination; and

39.24 (2) identify and offer reasonable accommodations or modifications, interventions, or  
39.25 alternatives to avoid the termination including but not limited to securing services from  
39.26 another home care provider of the client's choosing. A facility or arranged home care provider  
39.27 is not required to offer accommodations, modifications, interventions, or alternatives that  
39.28 fundamentally alter the nature of the operation of the facility or arranged home care provider.

39.29 (d) The meeting required under paragraph (a) must be scheduled to take place at least  
39.30 seven days before a notice of termination is issued. The facility or arranged home care  
39.31 provider, as applicable, must make reasonable efforts to ensure that the client and the client  
39.32 representative are able to attend the meeting.

40.1 Subd. 3. Pretermination meeting; notice. (a) The arranged home care provider, the  
40.2 facility, or both, as applicable, must provide written notice of the meeting to the client and  
40.3 the client's representative at least five business days in advance.

40.4 (b) For a client who receives home and community-based waiver services under  
40.5 Minnesota Statutes, section 256B.49, and chapter 256S, the arranged home care provider  
40.6 must provide written notice of the meeting to the client's case manager at least five business  
40.7 days in advance.

40.8 (c) The meeting must be scheduled to take place at least seven calendar days before a  
40.9 notice of termination is issued. The arranged home care provider, in collaboration with the  
40.10 facility, must make reasonable efforts to ensure that the client and the client's representative  
40.11 are able to attend the meeting.

40.12 (d) The written notice under paragraphs (a) and (b) must include:

40.13 (1) the time, date, and location of the meeting;

40.14 (2) a detailed explanation of the reasons for the proposed termination;

40.15 (3) a list of facility and arranged home care provider representatives who will attend the  
40.16 meeting;

40.17 (4) an explanation that the client may invite family members, representatives, health  
40.18 professionals, and other individuals to participate in the meeting;

40.19 (5) contact information for the Office of Ombudsman for Long-Term Care and the Office  
40.20 of Ombudsman for Mental Health and Developmental Disabilities with a statement that the  
40.21 ombudsman offices provide advocacy services to clients;

40.22 (6) the name and contact information of an individual at the facility whom the client  
40.23 may contact about the meeting or to request an accommodation;

40.24 (7) notice that attendees may request reasonable accommodations if the client has a  
40.25 communication disability or speaks a language other than English;

40.26 (8) notice that if the client's housing or services are terminated, the client has the right  
40.27 to appeal under subdivision 10; and

40.28 (9) notice that the client may invite family members, health professionals, a representative  
40.29 of the Office of Ombudsman for Long-Term Care, or other persons of the client's choosing  
40.30 to attend the meeting. For clients who receive home and community-based waiver services  
40.31 under Minnesota Statutes, section 256B.49, and chapter 256S, the facility must notify the  
40.32 client's case manager of the meeting.



41.1 (e) The arranged home care provider and the facility must provide written notice to the  
41.2 client, the client's representative, and the client's case manager of any change to the date,  
41.3 time, or location of the pretermination meeting.

41.4 **Subd. 4. Pretermination meeting requirements; identifying and offering**  
41.5 **accommodations, modifications, and alternatives.** (a) At the meeting described in  
41.6 subdivision 2, the arranged home care provider, the facility, or both, as applicable, must:

41.7 (1) explain in detail the reasons for the proposed termination; and

41.8 (2) collaborate with the client and the client's representative, case manager, and any  
41.9 other individual invited by the client, to identify and offer any potential reasonable  
41.10 accommodations, modifications, interventions, or alternatives that can address the issue  
41.11 identified in clause (1).

41.12 (b) Within 24 hours after the conclusion of the meeting, the arranged home care provider,  
41.13 the facility, or both, as applicable, must provide the client with a written summary of the  
41.14 meeting, including any agreements reached about any accommodation, modification,  
41.15 intervention, or alternative that will be used to avoid termination.

41.16 **Subd. 5. Emergency-relocation notice.** (a) A facility may remove a client from the  
41.17 facility in an emergency if necessary due to a client's urgent medical needs or if the client  
41.18 poses an imminent risk to the health or safety of another client, arranged home care provider  
41.19 staff member, or facility staff member. An emergency relocation is not a termination.

41.20 (b) In the event of an emergency relocation, the facility, in coordination with the arranged  
41.21 home care provider, must provide a written notice that contains, at a minimum:

41.22 (1) the reason for the relocation;

41.23 (2) the name and contact information for the location to which the client has been  
41.24 relocated and any new service provider;

41.25 (3) the contact information for the Office of Ombudsman for Long-Term Care;

41.26 (4) if known and applicable, the approximate date or ranges of dates within which the  
41.27 client is expected to return to the facility, or a statement that a return date is not currently  
41.28 known; and

41.29 (5) a statement that, if the facility or arranged home care provider refuse to provide either  
41.30 housing or services after a relocation, the client has a right to appeal under subdivision 10.  
41.31 The facility, in coordination with the arranged home care provider, must provide contact  
41.32 information for the agency to which the resident may submit an appeal.

- 42.1 (c) The notice required under paragraph (b) must be delivered as soon as practicable to:
- 42.2 (1) the client and the client's representative;
- 42.3 (2) for residents who receive home and community-based waiver services under
- 42.4 Minnesota Statutes, section 256B.49, and chapter 256S, the client's case manager; and
- 42.5 (3) the Office of Ombudsman for Long-Term Care if the client has been relocated and
- 42.6 has not returned to the facility within four days.
- 42.7 (d) Following an emergency relocation, a facility or an arranged home care provider's
- 42.8 refusal to provide housing or services, respectively, constitutes a termination and triggers
- 42.9 the termination process in this section.
- 42.10 (e) When an emergency relocation triggers the termination process and an in-person
- 42.11 meeting as described in subdivision 5 is impractical or impossible, the facility and arranged
- 42.12 home care provider may use telephonic, video, or other electronic format.
- 42.13 (f) If the meeting is held through telephone, video, or other electronic format, the facility
- 42.14 and arranged home care provider must ensure that the client, the client's representative, and
- 42.15 any case manager or representative of an ombudsman's office are able to participate in the
- 42.16 meeting. The facility and arranged home care provider must make reasonable efforts to
- 42.17 ensure that any person the client invites to the meeting is able to participate.
- 42.18 (g) The facility and arranged home care provider must issue the notice in this subdivision
- 42.19 at least 24 hours in advance of the meeting. The notice must include detailed instructions
- 42.20 on how to access the means of communication for the meeting.
- 42.21 (h) If notice to the ombudsman is required under paragraph (c), clause (3), the arranged
- 42.22 home care provider, the facility, or both, as applicable, must provide the notice no later than
- 42.23 24 hours after the notice requirement is triggered.
- 42.24 **Subd. 6. Restrictions on housing terminations.** (a) A facility may not terminate housing
- 42.25 except as provided in this subdivision.
- 42.26 (b) Upon 30 days' prior written notice, a facility may initiate a termination of housing
- 42.27 only for:
- 42.28 (1) nonpayment of rent, provided the facility informs the client that public benefits may
- 42.29 be available and provides contact information for the Senior LinkAge Line under Minnesota
- 42.30 Statutes, section 256.975, subdivision 7. An interruption to a client's public benefits that
- 42.31 lasts for no more than 60 days does not constitute nonpayment; or

43.1 (2) a violation of a lawful provision of housing if the client does not cure the violation  
43.2 within a reasonable amount of time after the facility provides written notice to the client of  
43.3 the ability to cure. Written notice of the ability to cure may be provided in person or by first  
43.4 class mail. A facility is not required to provide a client with written notice of the ability to  
43.5 cure for a violation that threatens the health or safety of the client or another individual in  
43.6 the facility, including the staff of the arranged home care provider, or for a violation that  
43.7 constitutes illegal conduct.

43.8 (c) Upon 15 days' prior written notice, a facility may terminate housing only if the client  
43.9 has:

43.10 (1) engaged in conduct that substantially interferes with the rights, health, or safety of  
43.11 other clients;

43.12 (2) engaged in conduct that substantially and intentionally interferes with the safety or  
43.13 physical health of the staff of the arranged home care provider, the facility, or both, as  
43.14 applicable; or

43.15 (3) committed an act listed in Minnesota Statutes, section 504B.171, that substantially  
43.16 interferes with the rights, health, or safety of other clients.

43.17 (d) Nothing in this subdivision affects the rights and remedies available to facilities and  
43.18 clients under Minnesota Statutes, chapter 504B.

43.19 Subd. 7. **Restrictions on terminations of services.** (a) An arranged home care provider  
43.20 may not terminate services of a client in a facility except as provided in this subdivision.

43.21 (b) Upon 30 days' prior written notice, an arranged home care provider may initiate a  
43.22 termination of services for nonpayment if the client does not cure the violation within a  
43.23 reasonable amount of time after the arranged home care provider provides written notice  
43.24 to the client of the ability to cure. An interruption to a client's public benefits that lasts for  
43.25 no more than 60 days does not constitute nonpayment.

43.26 (c) Upon 15 days' prior written notice, an arranged home care provider may terminate  
43.27 services only if:

43.28 (1) the client has engaged in conduct that substantially interferes with the client's health  
43.29 or safety;

43.30 (2) the client's assessed needs exceed the scope of services agreed upon in the service  
43.31 plan and are not otherwise offered by the arranged home care provider; or

44.1 (3) extraordinary circumstances exist, causing the arranged home care provider to be  
44.2 unable to provide the client with the services agreed to in the service plan that are necessary  
44.3 to meet the client's needs.

44.4 Subd. 8. **Notice of termination required.** (a) An arranged home care provider, a facility,  
44.5 or both, as applicable, must issue a written notice of termination according to this subdivision.  
44.6 The facility and arranged home care provider must send a copy of the termination notice to  
44.7 the Office of Ombudsman for Long-Term Care and, for residents who receive home and  
44.8 community-based services under Minnesota Statutes, section 156B. 49, and chapter 256S,  
44.9 to the client's case manager, as soon as practicable after providing notice to the client. A  
44.10 facility and arranged home care provider may terminate housing, services, or both, only as  
44.11 permitted under subdivisions 8 and 9.

44.12 (b) A facility terminating housing under subdivision 6, paragraph (b), must provide a  
44.13 written termination notice at least 30 days before the effective date of the termination to the  
44.14 client and the client's representative.

44.15 (c) A facility terminating housing under subdivision 6, paragraph (c), must provide a  
44.16 written termination notice at least 15 days before the effective date of the termination to the  
44.17 client and the client's representative.

44.18 (d) An arranged home care provider terminating services under subdivision 7, paragraph  
44.19 (b), must provide a written termination notice at least 30 days before the effective date of  
44.20 the termination to the client and the client's representative.

44.21 (e) An arranged home care provider terminating services under subdivision 7, paragraph  
44.22 (c), must provide a written termination notice at least 15 days before the effective date of  
44.23 the termination to the client and the client's representative.

44.24 (f) If a resident moves out of a facility or cancels services received from the arranged  
44.25 home care provider, nothing in this section prohibits the facility or arranged home care  
44.26 provider from enforcing against the client any notice periods with which the client must  
44.27 comply under the lease or the service agreement.

44.28 Subd. 9. **Contents of notice of termination.** (a) The notice required under subdivision  
44.29 8 must contain, at a minimum:

44.30 (1) the effective date of the termination;

44.31 (2) a detailed explanation of the basis for the termination, including the clinical or other  
44.32 supporting rationale;

45.1 (3) a detailed explanation of the conditions under which a new or amended lease or  
45.2 service agreement may be executed;

45.3 (4) a statement that the resident has the right to appeal the termination by requesting a  
45.4 hearing, and information concerning the time frame within which the request must be  
45.5 submitted and the contact information for the agency to which the request must be submitted;

45.6 (5) a statement that the arranged home care provider, the facility, or both, as applicable,  
45.7 must participate in a coordinated move as described in this section;

45.8 (6) the name and contact information of the person employed by the facility or the  
45.9 arranged home care provider with whom the client may discuss the termination;

45.10 (7) information on how to contact the Office of Ombudsman for Long-Term Care to  
45.11 request an advocate to assist regarding the termination;

45.12 (8) information on how to contact the Senior LinkAge Line under Minnesota Statutes,  
45.13 section 256.975, subdivision 7, and an explanation that the Senior LinkAge Line may provide  
45.14 information about other available housing or service options; and

45.15 (9) if the termination is only for services, a statement that the resident may remain in  
45.16 the facility and may secure any necessary services from another provider of the resident's  
45.17 choosing.

45.18 (b) An arranged home care provider, the facility, or both, as applicable, must provide  
45.19 written notice of the client's termination of housing or services, respectively, in person or  
45.20 by first-class mail. Service of the notice must be proved by affidavit of the person making  
45.21 it.

45.22 (c) If sent by mail, the arranged home care provider, the facility, or both, as applicable,  
45.23 must mail the notice to the client's last known address.

45.24 (d) An arranged home care provider, the facility, or both, as applicable, providing a  
45.25 notice to the ombudsman of a client's termination of housing or services must provide the  
45.26 ombudsman with a copy of the written notice that is provided to the client. The arranged  
45.27 home care provider, the facility, or both, as applicable, must provide notice to the ombudsman  
45.28 as soon as practicable, but in any event no later than two business days after notice is  
45.29 provided to the client. The notice must include a telephone number for the client, or, if the  
45.30 client does not have a telephone number, the telephone number of the client's representative  
45.31 or case manager.

45.32 Subd. 10. **Right to appeal and permissible grounds to appeal termination.** (a) A  
45.33 client has the right to appeal the termination of housing or services termination.

46.1 (b) A client may appeal a termination initiated under subdivisions 6 and 7 on the ground  
46.2 that:

46.3 (1) there is a factual dispute as to whether the arranged home care provider, the facility,  
46.4 or both, as applicable, had a permissible basis to initiate the termination;

46.5 (2) the termination would result in great harm or the potential for great harm to the client  
46.6 as determined by the totality of the circumstances, except in circumstances where there is  
46.7 a greater risk of harm to other clients or staff of the arranged home care provider, the facility,  
46.8 or both, as applicable;

46.9 (3) the client has corrected or demonstrated the ability to correct the reasons for the  
46.10 termination, or has identified a reasonable accommodation or modification, intervention,  
46.11 or alternative to the termination; or

46.12 (4) the arranged home care provider, the facility, or both, as applicable, has terminated  
46.13 housing, services, or both, in violation of state or federal law.

46.14 (c) Upon receipt of written notice of termination, a client has 30 calendar days to appeal  
46.15 the termination.

46.16 Subd. 11. **Appeal process.** (a) The Office of Administrative Hearings must conduct an  
46.17 expedited hearing no later than practicable under this section, but no later than 14 calendar  
46.18 days after the office receives the request, unless the parties agree otherwise or the chief  
46.19 administrative law judge deems the timing to be unreasonable, given the complexity of the  
46.20 issues presented.

46.21 (b) In a process to be determined by the commissioner, the client shall contact the  
46.22 commissioner to request an appeal of the termination within 30 days of written receipt of  
46.23 the termination notice, which will be timely scheduled with the Office of Administrative  
46.24 Hearings.

46.25 (c) The hearing must be held at the facility where the client lives, unless holding the  
46.26 hearing at that location is impractical, the parties agree to hold the hearing at a different  
46.27 location, or the chief administrative law judge grants a party's request to appear at another  
46.28 location or by remote means.

46.29 (d) The hearing is not a formal contested case proceeding, except when determined  
46.30 necessary by the chief administrative law judge. If the chief administrative law judge  
46.31 determines that the hearing shall proceed as a formal contested case proceeding, the hearing  
46.32 shall be held according to the Minnesota Revenue Recapture Act, Minnesota Rules, parts  
46.33 1400.8505 to 1400.8612.

- 47.1 (e) The administrative law judge shall make a transcript of the hearing.
- 47.2 (f) The informal hearing will allow the client to provide an opportunity to present written  
47.3 or oral objections or defenses to the termination.
- 47.4 (g) If either party is represented by an attorney, the administrative law judge shall  
47.5 emphasize the informality of the hearing.
- 47.6 (h) If the client is unable to represent themselves at the hearing, the resident may present  
47.7 the client's appeal to the administrative law judge on the client's behalf.
- 47.8 (i) Parties may be, but are not required to be, represented by counsel. The appearance  
47.9 of a party without counsel does not constitute the unauthorized practice of law.
- 47.10 (j) The arranged home care provider, the facility, or both, as applicable, bears the burden  
47.11 of proof to establish by a preponderance of the evidence that the termination was permissible  
47.12 if the appeal is brought on the ground listed in subdivision 12, paragraph (a), clause (4).
- 47.13 (k) The client bears the burden of proof to establish by a preponderance of the evidence  
47.14 that the termination was permissible if the appeal is brought on the grounds listed in  
47.15 subdivision 12, paragraph (b), clause (2) or (3).
- 47.16 (l) The hearing shall be limited to the amount of time necessary for the participants to  
47.17 expeditiously present the facts about the proposed termination. The administrative law judge  
47.18 shall issue a final decision as soon as practicable, but no later than ten business days after  
47.19 the hearing.
- 47.20 (m) The administrative law judge's decision may contain any conditions that may be  
47.21 placed on the client's continued residency or receipt of services, including but not limited  
47.22 to changes to the service plan or a required increase in services.
- 47.23 (n) The client's termination must be rescinded if the client prevails in the appeal.
- 47.24 (o) The facility, arranged home care provider, or client may appeal the administrative  
47.25 law judge's decision to the Minnesota Court of Appeals.
- 47.26 Subd. 12. **Service provision while appeal pending.** A termination of housing or services  
47.27 shall not occur while an appeal is pending. If additional services are needed to meet the  
47.28 health or safety needs of the client while an appeal is pending, the client is responsible for  
47.29 contracting for those additional services from the facility or another home care provider  
47.30 licensed under Minnesota Statutes, chapter 144A, and for ensuring the costs for those  
47.31 additional services are covered.

48.1 Subd. 13. **Application of chapter 504B to appeals of terminations.** A client may not  
48.2 bring an action under Minnesota Statutes, chapter 504B, to challenge a termination that has  
48.3 occurred and been upheld under this section.

48.4 Subd. 14. **Restriction on lease nonrenewals.** If a facility decides to not renew a client's  
48.5 lease, the facility must:

48.6 (1) provide the client with 60 calendar days' notice of the nonrenewal;

48.7 (2) ensure a coordinated move as provided under this section;

48.8 (3) consult and cooperate with the client; the client representative; the case manager of  
48.9 a client who receives home and community-based waiver services under Minnesota Statutes,  
48.10 section 256B.49, and chapter 256S; relevant health professionals; and any other person of  
48.11 the client's choosing, to make arrangements to move the client; and

48.12 (4) prepare a written plan to prepare for the move.

48.13 Subd. 15. **Right to return.** If a client is absent from a facility for any reason, the facility  
48.14 shall not refuse to allow a client to return if a lease termination has not been effectuated.

48.15 Subd. 16. **Coordinated moves.** (a) A facility or an arranged home care provider, as  
48.16 applicable, must arrange a coordinated move for a client according to this subdivision if:

48.17 (1) a facility terminates a lease or closes the facility;

48.18 (2) an arranged home care provider terminates services; or

48.19 (3) an arranged home care provider reduces or eliminates services to the extent that the  
48.20 client needs to move.

48.21 (b) If an event listed in paragraph (a) occurs, the arranged home care provider, together  
48.22 with the facility must:

48.23 (1) ensure a coordinated move to a safe location that is appropriate for the client and  
48.24 that is identified by the arranged home care provider;

48.25 (2) ensure a coordinated move to an appropriate service provider identified by the  
48.26 arranged home care provider, provided services are still needed and desired by the client;  
48.27 and

48.28 (3) consult and cooperate with the client; the client's representative; the case manager  
48.29 for a client who receives home and community-based waiver services under Minnesota  
48.30 Statutes, section 256B.49, and chapter 256S; relevant health professionals; and any other  
48.31 person of the client's choosing, to make arrangements to move the client.



49.1 (c) The requirements in paragraph (b), clauses (1) and (2), may be satisfied by moving  
49.2 the client to a different location within the same facility, if appropriate for the client.

49.3 (d) A client may decline to move to the location the facility identifies or to accept services  
49.4 from a service provider the arranged home care provider identifies, and may choose instead  
49.5 to move to a location of the client's choosing or to receive services from a service provider  
49.6 of the client's choosing.

49.7 (e) Sixty days before the arranged home care provider reduces or eliminates one or more  
49.8 services for a particular client, the arranged home care must provide written notice of the  
49.9 reduction or elimination. If the facility, arranged home care provider, client, or client's  
49.10 representative determines that the reduction or elimination of services will force the client  
49.11 to move to a new location, the facility in coordination with the arranged home care provider  
49.12 must ensure a coordinated move in accordance with this subdivision, and must provide  
49.13 notice to the Office of Ombudsman for Long-Term Care.

49.14 (f) The facility or arranged home care provider, as applicable, must prepare a  
49.15 client-relocation evaluation and client-relocation plan as described in this section to prepare  
49.16 for the move to the new location or service provider.

49.17 (g) With the client's knowledge and consent, if the client is relocated to another facility  
49.18 or to a nursing home, or if care is transferred to another service provider, the arranged home  
49.19 care provider, the facility, or both, must timely convey to the new facility, nursing home,  
49.20 or service provider:

49.21 (1) the client's full name, date of birth, and insurance information;

49.22 (2) the name, telephone number, and address of the client's representative, if any;

49.23 (3) the client's current, documented diagnoses that are relevant to the services being  
49.24 provided;

49.25 (4) the client's known allergies that are relevant to the services being provided;

49.26 (5) the name and telephone number of the client's physician, if known, and the current  
49.27 physician orders that are relevant to the services being provided;

49.28 (6) all medication administration records that are relevant to the services being provided;

49.29 (7) the most recent client assessment, if relevant to the services being provided; and

49.30 (8) copies of health care directives, "do not resuscitate" orders, and any guardianship  
49.31 orders or powers of attorney.

50.1 Subd. 17. **Client-relocation evaluation.** If the client plans to move out of the facility  
50.2 due to termination of housing or services, or nonrenewal of housing, the arranged home  
50.3 care provider and the facility must work in coordination to prepare a written client-relocation  
50.4 evaluation. The evaluation must include:

50.5 (a) the client's current service plan;

50.6 (b) a list of safe and appropriate housing and service providers that are in reasonable in  
50.7 close proximity to the facility and are able to accept a new client; and

50.8 (c) the client's needs and choices.

50.9 Subd. 18. **Client-relocation plan.** (a) The arranged home care provider, in coordination  
50.10 with the facility, must hold a planning conference to develop a relocation plan with the  
50.11 client, the client's representative and case manager, if any, and other individuals invited by  
50.12 the client.

50.13 (b) The client-relocation plan must accommodate the client-relocation evaluation  
50.14 developed in subdivision 17.

50.15 (c) The client-relocation plan must include:

50.16 (1) the date and time that the client will move;

50.17 (2) how the client and the client's personal property, including pets, will be transported  
50.18 to the new housing provider;

50.19 (3) how the facility will care for and store the client's belongings;

50.20 (4) recommendations to assist the client to adjust to the new living environment;

50.21 (5) recommendations for addressing the stress that a client with dementia may experience  
50.22 when moving to a new living environment, if applicable;

50.23 (6) recommendations for ensuring the safe and proper transfer of the client's medications  
50.24 and durable medical equipment;

50.25 (7) arrangements that have been made for the client's follow-up care and meals;

50.26 (8) a plan for transferring and reconnecting telephone and Internet services; and

50.27 (9) the party responsible for paying moving expenses and how the expenses will be paid.

50.28 (d) The facility and arranged home care provider must implement the relocation plan  
50.29 and comply with the coordinated move requirements in this section.

51.1 Subd. 19. **Providing client-relocation information to new provider.** With the client's  
51.2 consent, the arranged home care provider and the facility must provide the following  
51.3 information in writing to the client's receiving facility or other service provider:

51.4 (1) the name and address of the facility and arranged home care provider, the dates of  
51.5 the client's admission and discharge, and the name and address of a person at the facility  
51.6 and arranged home care provider to contact for additional information;

51.7 (2) the client's most recent service plan, if the client has received services from the  
51.8 arranged home care provider; and

51.9 (3) the client's currently active "do not resuscitate" order and "physician order for life  
51.10 sustaining treatment," if any.

51.11 Subd. 20. **Client discharge summary.** At the time of discharge, the arranged home care  
51.12 provider in coordination with the facility, must provide the client, and, with the client's  
51.13 consent, the client's representative and case manager, if applicable, with a written discharge  
51.14 summary that includes:

51.15 (1) a summary of the client's stay that includes diagnoses, courses of illnesses, treatments,  
51.16 and therapies, and pertinent lab, radiology, and consultation results;

51.17 (2) a final summary of the client's status from the latest assessment or review under  
51.18 Minnesota Statutes, section 144A.4791, if applicable;

51.19 (3) reconciliation of all predischarge medications with the client's postdischarge  
51.20 prescribed and over-the-counter medications; and

51.21 (4) postdischarge care plan that is developed with the client and, with the client's consent,  
51.22 the client's representative, which will help the client adjust to a new living environment.  
51.23 The postdischarge care plan must indicate where the client plans to reside, any arrangements  
51.24 that have been made for the client's follow-up care, and any post-discharge medical and  
51.25 non-medical services the client will need.

51.26 Subd. 21. **Services pending appeal.** If a client needs additional services during a pending  
51.27 termination appeal, the arranged home care provider must contact and inform the client's  
51.28 case manager, if applicable, of the client's responsibility to contract and ensure payment for  
51.29 those services.

51.30 Subd. 22. **Client assessment.** If an arranged home care provider seeks to terminate a  
51.31 client's services on the basis of subdivision 7, paragraph (c), clause (2), the provider must  
51.32 give the assessment that forms the basis of the termination to the client and include the name  
51.33 and contact information of any medical professionals who performed the assessment.

52.1 Subd. 23. **Appealing on behalf of client.** A client may appeal the termination directly  
 52.2 or through an individual acting on the client's behalf.

52.3 Subd. 24. **No waiver.** No facility or arranged home care provider may request or require  
 52.4 that a client waive the client's rights or requirements under this section at any time or for  
 52.5 any reason, including as a condition of admission to the facility.

52.6 Subd. 25. **Assisted living bill of rights.** (a) Assisted living clients, as defined in  
 52.7 Minnesota Statutes, section 144G.01, subdivision 3, shall be provided with the home care  
 52.8 bill of rights in Minnesota Statutes, section 144A.44, except that for assisted living clients  
 52.9 the provision in Minnesota Statutes, section 144A.44, subdivision 1, paragraph (1), clause  
 52.10 (17) does not apply and instead assisted living clients must be advised they have the right  
 52.11 to reasonable, advance notice of changes in services or charges.

52.12 (b) This subdivision supersedes Minnesota Statutes, sections 144A.441 and 144A.442,  
 52.13 until those sections are repealed.

52.14 **EFFECTIVE DATE.** This section is effective for contracts entered into on or after the  
 52.15 date of enactment for this section and expires July 31, 2022.

52.16 Sec. 40. **APPROPRIATION; COVID-19 SCREENING PROGRAM.**

52.17 (a) \$..... in fiscal year 2022 is appropriated from the coronavirus relief fund to the  
 52.18 commissioner of human services for COVID-19 baseline screening grants under section 1.  
 52.19 This is a onetime appropriation.

52.20 (b) \$..... in fiscal year 2022 is appropriated from the coronavirus relief fund to the  
 52.21 commissioner of human services for cost-based reimbursement for COVID-19 serial  
 52.22 screening under section 1. This is a onetime appropriation.

52.23 **EFFECTIVE DATE.** This section is effective the day following final enactment.

52.24 Sec. 41. **APPROPRIATION; BOARD OF EXECUTIVES FOR LONG TERM**  
 52.25 **SERVICES AND SUPPORTS.**

52.26 \$467,000 in fiscal year 2022 is appropriated from the state government special revenue  
 52.27 fund to the Board of Executives for Long Term Services and Supports for operations and  
 52.28 is effective the day following final enactment. The base for this appropriation is \$722,000  
 52.29 in fiscal year 2023 and \$742,000 in fiscal year 2024.

52.30 **EFFECTIVE DATE.** This section is effective the day following final enactment.