SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 1918

(SENATE AUTHORS: DIBBLE)

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02/27/2025	559	Introduction and first reading Referred to Health and Human Services

A bill for an act

relating to health; modifying consent to electronic monitoring requirements; modifying provisions related to retaliation in nursing homes and assisted living facilities; expanding membership and duties of the home care and assisted living program advisory council; modifying the hospice bill of rights; prohibiting required binding arbitration agreements in assisted living contracts; modifying medication management requirements; modifying authority of health care agents to restrict visitation and communication; amending Minnesota Statutes 2024, sections 144.6502, subdivision 3; 144.6512, subdivision 3, by adding a subdivision; 144A.04, by adding a subdivision; 144A.474, subdivision 11; 144A.4799, subdivisions 1, 3; 144A.751, subdivision 1; 144G.08, by adding a subdivision; 144G.31, subdivision 8; 144G.51; 144G.71, subdivisions 3, 5; 144G.92, by adding a subdivision; 145C.07, by adding a subdivision; 145C.10.

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

Section 1. Minnesota Statutes 2024, section 144.6502, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

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

Sec. 2. Minnesota Statutes 2024, section 144.6512, subdivision 3, is amended to read:

Subd. 3. **Retaliation against a resident.** A resident has the right to be free from retaliation. For purposes of this section, to retaliate against a resident includes but is not limited to any of the following actions taken or threatened by a nursing home or an agent of the nursing home against a resident, or any person with a familial, personal, legal, or professional relationship with the resident:

(1) a discharge or transfer;

(2) any form of discrimination;

(3) restriction or prohibition of access:

(i) of the resident to the nursing home or visitors; or

(ii) of a family member or a person with a personal, legal, or professional relationship with the resident, to the resident, unless the restriction is the result of a court order;

(4) the imposition of involuntary seclusion or the withholding of food, care, or services;

(5) restriction of any of the rights granted to residents under state or federal law;

(6) restriction or reduction of access to or use of amenities, care, services, privileges, or living arrangements; or

(7) unauthorized removal, tampering with, or deprivation of technology, communication, or electronic monitoring devices.

Sec. 3. Minnesota Statutes 2024, section 144.6512, is amended by adding a subdivision to read:

Subd. 5a. **Other remedies.** In addition to the remedies otherwise provided by or available under the law, a resident or a resident's legal representative may bring an action against a nursing home for retaliation as defined in this chapter.

Sec. 4. Minnesota Statutes 2024, section 144A.04, is amended by adding a subdivision to read:

Subd. 13. **Retaliation prevention training required.** All employees of a nursing home, including managerial officials and licensed administrators, must participate in annual training on the requirements of section 144.6512 and preventing retaliation against nursing home residents.

Sec. 5. Minnesota Statutes 2024, section 144A.474, subdivision 11, is amended to read:

Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be assessed based on the level and scope of the violations described in paragraph (b) and imposed immediately with no opportunity to correct the violation first as follows:

(1) Level 1, no fines or enforcement;

(2) Level 2, a fine of $500 per violation, in addition to any of the enforcement mechanisms authorized in section 144A.475 for widespread violations;

(3) Level 3, a fine of $3,000 per incident, in addition to any of the enforcement mechanisms authorized in section 144A.475;

(4) Level 4, a fine of $5,000 per incident, in addition to any of the enforcement mechanisms authorized in section 144A.475;

(5) for maltreatment violations for which the licensee was determined to be responsible for the maltreatment under section 626.557, subdivision 9c, paragraph (c), a fine of $1,000. A fine of $5,000 may be imposed if the commissioner determines the licensee is responsible for maltreatment consisting of sexual assault, death, or abuse resulting in serious injury; and

(6) the fines in clauses (1) to (4) are increased and immediate fine imposition is authorized for both surveys and investigations conducted.

When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

(b) Correction orders for violations are categorized by both level and scope and fines shall be assessed as follows:

(1) level of violation:

(i) Level 1 is a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety;

(ii) Level 2 is a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death;

(iii) Level 3 is a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death; and

(iv) Level 4 is a violation that results in serious injury, impairment, or death;

(2) scope of violation:

(i) isolated, when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally;

(ii) pattern, when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive; and

(iii) widespread, when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients.

(c) If the commissioner finds that the applicant or a home care provider has not corrected violations by the date specified in the correction order or conditional license resulting from a survey or complaint investigation, the commissioner shall provide a notice of noncompliance with a correction order by email to the applicant's or provider's last known email address. The noncompliance notice must list the violations not corrected.

(d) For every violation identified by the commissioner, the commissioner shall issue an immediate fine pursuant to paragraph (a), clause (6). The license holder must still correct the violation in the time specified. The issuance of an immediate fine can occur in addition to any enforcement mechanism authorized under section 144A.475. The immediate fine may be appealed as allowed under this subdivision.

(e) The license holder must pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies by paying the fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(f) A license holder shall promptly notify the commissioner in writing when a violation specified in the order is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order, the commissioner may issue a second fine. The commissioner shall notify the license holder by mail to the last known address in the licensing record that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(g) A home care provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14.

(h) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder shall be liable for payment of the fine.

(i) In addition to any fine imposed under this section, the commissioner may assess a penalty amount based on costs related to an investigation that results in a final order assessing a fine or other enforcement action authorized by this chapter.

(j) Fines collected under paragraph (a), clauses (1) to (4), shall be deposited in a dedicated special revenue account. On an annual basis, the balance in the special revenue account shall be appropriated to the commissioner to implement the recommendations of the advisory council established in section 144A.4799. The commissioner must publish on the department's website a report on the fines collected and how the appropriated money was allocated.

~~(k) Fines collected under paragraph (a), clause (5), shall be deposited in a dedicated special revenue account and appropriated to the commissioner to provide compensation according to subdivision 14 to clients subject to maltreatment. A client may choose to receive compensation from this fund, not to exceed $5,000 for each substantiated finding of maltreatment, or take civil action. This paragraph expires July 31, 2021.~~

Sec. 6. Minnesota Statutes 2024, section 144A.4799, subdivision 1, is amended to read:

Subdivision 1. **Membership.** The commissioner of health shall appoint ~~13~~ 15 persons to a home care and assisted living program advisory council consisting of the following:

(1) ~~two~~ four public members as defined in section 214.02 ~~who shall be persons who are currently receiving home care services, persons who have received home care services within five years of the application date, persons who have family members receiving home care services, or persons who have family members who have received home care services within five years of the application date~~ one of whom must be a person who either is or has received home care services, one of whom must be a person who has or had a family member receiving home care services, one of whom must be a person who either is or has been a resident in an assisted living facility, and one of whom must be a person who has or had a family member residing in an assisted living facility;

(2) two Minnesota home care licensees representing basic and comprehensive levels of licensure who may be a managerial official, an administrator, a supervising registered nurse, or an unlicensed personnel performing home care tasks;

(3) one member representing the Minnesota Board of Nursing;

(4) one member representing the Office of Ombudsman for Long-Term Care;

(5) one member representing the Office of Ombudsman for Mental Health and Developmental Disabilities;

(6) beginning July 1, 2021, one member of a county health and human services or county adult protection office;

(7) two Minnesota assisted living facility licensees representing assisted living facilities and assisted living facilities with dementia care levels of licensure who may be the facility's assisted living director, managerial official, or clinical nurse supervisor;

(8) one organization representing long-term care providers, home care providers, and assisted living providers in Minnesota; and

(9) two ~~public members as defined in section 214.02. One public member shall be a person who either is or has been a resident in an assisted living facility and one public member shall be a person who has or had a family member living in an assisted living facility setting~~ representatives of consumer advocacy organizations, one of which must represent older adults who are receiving long-term care from a licensed home care or assisted living provider and one of which must represent adults living with disabilities who are receiving long-term care from a licensed home care or assisted living provider.

Sec. 7. Minnesota Statutes 2024, section 144A.4799, subdivision 3, is amended to read:

Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide advice regarding regulations of Department of Health licensed assisted living and home care providers in this chapter, including advice on the following:

(1) community standards for home care practices;

(2) enforcement of licensing standards and whether certain disciplinary actions are appropriate;

(3) ways of distributing information to licensees and consumers of home care and assisted living services defined under chapter 144G;

(4) training standards;

(5) identifying emerging issues and opportunities in home care and assisted living services defined under chapter 144G;

(6) identifying the use of technology in home and telehealth capabilities;

(7) allowable home care licensing modifications and exemptions, including a method for an integrated license with an existing license for rural licensed nursing homes to provide

limited home care services in an adjacent independent living apartment building owned by the licensed nursing home; and

(8) recommendations for studies using the data in section 62U.04, subdivision 4, including but not limited to studies concerning costs related to dementia and chronic disease among an elderly population over 60 and additional long-term care costs, as described in section 62U.10, subdivision 6.

(b) The advisory council shall perform other duties as directed by the commissioner.

(c) The advisory council shall annually make recommendations to the commissioner for the purposes of allocating the appropriation in ~~section~~ sections 144A.474, subdivision 11, paragraph ~~(i)~~ (j), and 144G.31, subdivision 8. The recommendations shall address ways the commissioner may improve protection of the public under existing statutes and laws and improve quality of care. The council's recommendations may include but are not limited to special projects or initiatives that:

(1) create and administer training of licensees and ongoing training for their employees to improve residents' lives, supporting ways that licensees can improve and enhance quality care and ways to provide technical assistance to licensees to improve compliance;

(2) information technology and data projects that analyze and communicate information about trends of violations or lead to ways of improving client care;

(3) communications strategies to licensees and the public;

(4) provide equitable wages for staff providing direct care;

(5) ensuring sufficient education related to the care of vulnerable adults in professional nursing programs, nurse aide programs, and home health aide programs; and

(6) other projects or pilots that benefit clients, families, and the public.

Sec. 8. Minnesota Statutes 2024, section 144A.751, subdivision 1, is amended to read:

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

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

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

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

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

(5) refuse services or treatment;

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

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

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

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

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

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

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

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

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

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

(16) be free from physical and verbal abuse;

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

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

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

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

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

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

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

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

(22) have pain and symptoms managed to the patient's desired level of comfort, including ensuring appropriate pain medications are immediately available to the patient;

(23) revoke hospice election at any time; and

(24) receive curative treatment for any condition unrelated to the condition that qualified the individual for hospice, while remaining on hospice election.

Sec. 9. Minnesota Statutes 2024, section 144G.08, is amended by adding a subdivision to read:

Subd. 55a. **Registered nurse.** "Registered nurse" has the meaning given in section 148.171, subdivision 20.

Sec. 10. Minnesota Statutes 2024, section 144G.31, subdivision 8, is amended to read:

Subd. 8. **Deposit of fines.** Fines collected under this section shall be deposited in a dedicated special revenue account. On an annual basis, the balance in the special revenue account shall be appropriated to the commissioner for special projects to improve resident quality of care and outcomes in assisted living facilities licensed under this chapter in Minnesota as recommended by the advisory council established in section 144A.4799. The commissioner must publish on the department's website a report on the fines collected and how the appropriated money was allocated.

Sec. 11. Minnesota Statutes 2024, section 144G.51, is amended to read:

144G.51 ARBITRATION.

~~(a) An assisted living facility must~~ If an assisted living facility includes an arbitration provision in the assisted living contract, the provision and contract must:

(1) clearly and conspicuously disclose, in writing ~~in an assisted living contract~~, any arbitration provision in the contract that precludes~~,~~ or limits~~, or delays~~ the ability of a resident or the resident's agent from taking a civil action~~.~~;

~~(b) An arbitration requirement must not include a choice of law or choice of venue provision. Assisted living contracts must~~ (2) adhere to Minnesota law and any other applicable federal or local law~~.~~;

(3) not require any resident or the resident's representative to sign a contract containing a provision for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility; and

(4) explicitly inform the resident or the resident's representative of the resident's right not to sign a contract containing a provision for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.

Sec. 12. Minnesota Statutes 2024, section 144G.71, subdivision 3, is amended to read:

Subd. 3. **Individualized medication monitoring and reassessment.** ~~The assisted living facility~~ A registered nurse or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually.

Sec. 13. Minnesota Statutes 2024, section 144G.71, subdivision 5, is amended to read:

Subd. 5. **Individualized medication management plan.** (a) For each resident receiving medication management services, ~~the assisted living facility~~ a registered nurse or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:

(1) a statement describing the medication management services that will be provided;

(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;

(3) documentation of specific resident instructions relating to the administration of medications;

(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;

(5) identification of medication management tasks that may be delegated to unlicensed personnel;

(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and

(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.

(b) The medication management record must be current and updated when there are any changes.

(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.

Sec. 14. Minnesota Statutes 2024, section 144G.92, is amended by adding a subdivision to read:

Subd. 4a. **Other remedies.** In addition to the remedies otherwise provided by or available under the law, a resident or a resident's legal representative may bring an action against an assisted living facility for retaliation as defined in this chapter.

Sec. 15. Minnesota Statutes 2024, section 145C.07, is amended by adding a subdivision to read:

Subd. 6. **Visits by others.** A health care agent may not restrict the ability of the principal to communicate, visit, or interact with others, including receiving visitors, making or receiving telephone calls, sending or receiving personal mail, sending or receiving electronic communications including through social media, or participating in social activities, unless the health care agent has good cause to believe a restriction is necessary because interaction with the person poses a risk of significant physical, psychological, or financial harm to the principal, and there is no other means to avoid such significant harm. Notwithstanding section 145C.10, paragraph (c), restrictions made in violation of this subdivision carry no presumption that the health care agent is acting in good faith.

Sec. 16. Minnesota Statutes 2024, section 145C.10, is amended to read:

145C.10 PRESUMPTIONS.

(a) The principal is presumed to have the capacity to execute a health care directive and to revoke a health care directive, absent clear and convincing evidence to the contrary.

(b) A health care provider or health care agent may presume that a health care directive is legally sufficient absent actual knowledge to the contrary. A health care directive is presumed to be properly executed, absent clear and convincing evidence to the contrary.

(c) Except as provided in section 145C.07, subdivision 6, a health care agent, and a health care provider acting pursuant to the direction of a health care agent, are presumed to be acting in good faith, absent clear and convincing evidence to the contrary.

(d) A health care directive is presumed to remain in effect until the principal modifies or revokes it, absent clear and convincing evidence to the contrary.

(e) This chapter does not create a presumption concerning the intention of an individual who has not executed a health care directive and, except as otherwise provided by section 145C.15, does not impair or supersede any right or responsibility of an individual to consent, refuse to consent, or withdraw consent to health care on behalf of another in the absence of a health care directive.

(f) A copy of a health care directive is presumed to be a true and accurate copy of the executed original, absent clear and convincing evidence to the contrary, and must be given the same effect as an original.

(g) When a patient lacks decision-making capacity and is pregnant, and in reasonable medical judgment there is a real possibility that if health care to sustain her life and the life of the fetus is provided the fetus could survive to the point of live birth, the health care provider shall presume that the patient would have wanted such health care to be provided, even if the withholding or withdrawal of such health care would be authorized were she not pregnant. This presumption is negated by health care directive provisions described in section 145C.05, subdivision 2, paragraph (a), clause (10), that are to the contrary, or, in the absence of such provisions, by clear and convincing evidence that the patient's wishes, while competent, were to the contrary.