SENATE
STATE OF MINNESOTA
NINETY-THIRD SESSION

S.F. No. 3265

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DATE	D-PG	OFFICIAL STATUS
04/14/2023	5050	Introduction and first reading Referred to Health and Human Services

A bill for an act

relating to health; modifying electronic monitoring requirements; modifying Board of Executives for Long-Term Service and Supports fees; establishing private enforcement of certain rights; establishing a private cause of action for retaliation in certain long-term care settings; modifying infection control requirements in certain long-term care settings; modifying hospice and assisted living bills of rights; establishing consumer protections for clients receiving assisted living services; requiring the commissioner of health to establish a state plan to control SARS-CoV-2 infections in certain long-term care settings; establishing the Long-Term Care COVID-19 Task Force; changing provisions for nursing homes, home care, and assisted living; requiring a report; appropriating money; amending Minnesota Statutes 2022, sections 144.56, by adding subdivisions; 144.6502, subdivision 3, by adding a subdivision; 144.6512, by adding a subdivision; 144.652, by adding a subdivision; 144A.04, by adding subdivisions; 144A.291, subdivision 2; 144A.4798, subdivision 3, by adding subdivisions; 144A.751, subdivision 1; 144G.09, subdivision 3; 144G.10, by adding a subdivision; 144G.42, by adding subdivisions; 144G.91, by adding a subdivision; 144G.92, by adding a subdivision; Laws 2019, chapter 60, article 1, section 46; article 5, section 2; proposing coding for new law in Minnesota Statutes, chapters 144A; 144G.

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

Section 1. Minnesota Statutes 2022, section 144.56, is amended by adding a subdivision to read:

Subd. 2d. **Severe acute respiratory syndrome-related coronavirus infection control.** (a) A boarding care home must establish and maintain a comprehensive severe acute respiratory syndrome-related coronavirus infection control program that complies with accepted health care, medical, and nursing standards for infection control according to the most current SARS-CoV-2 infection control guidelines or their successor versions issued by the United States Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services, and the commissioner. This program must include a severe acute

respiratory syndrome-related coronavirus infection control plan that covers all paid and unpaid employees, contractors, students, volunteers, residents, and visitors. The commissioner shall provide technical assistance regarding implementation of the guidelines.

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

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

Sec. 2. Minnesota Statutes 2022, section 144.56, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

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

(8) compassionate care visitation;

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

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

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

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

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

(14) taking into account dementia-related concerns.

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

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

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

Sec. 3. Minnesota Statutes 2022, 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).

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

Sec. 4. Minnesota Statutes 2022, section 144.6502, is amended by adding a subdivision to read:

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

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

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

Sec. 5. Minnesota Statutes 2022, section 144.6512, is amended by adding a subdivision to read:

Subd. 7. **Other laws.** Nothing in this section affects the rights and remedies available under section 626.557, subdivisions 10, 17, and 20.

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

Sec. 6. Minnesota Statutes 2022, section 144.652, is amended by adding a subdivision to read:

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

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

Sec. 7. Minnesota Statutes 2022, section 144A.04, is amended by adding a subdivision to read:

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

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

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

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

Sec. 8. Minnesota Statutes 2022, section 144A.04, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

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

(8) compassionate care visitation;

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

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

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

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

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

(14) taking into account dementia-related concerns.

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

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

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

Sec. 9. Minnesota Statutes 2022, section 144A.291, subdivision 2, is amended to read:

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

(1) application for licensure, $200;

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

(3) state examination, $125;

(4) initial license, $250 if issued between July 1 and December 31, $100 if issued between January 1 and June 30;

(5) acting permit, $400;

(6) renewal license, $250;

(7) duplicate license, $50;

(8) reinstatement fee, $250;

~~(9) health services executive initial license, $250;~~

~~(10) health services executive renewal license, $250;~~

~~(11)~~ (9) reciprocity verification fee, $50;

~~(12)~~ (10) second shared assignment, $250;

~~(13)~~ (11) continuing education fees:

(i) greater than six hours, $50; and

(ii) seven hours or more, $75;

~~(14)~~ (12) education review, $100;

~~(15)~~ (13) fee to a sponsor for review of individual continuing education seminars, institutes, workshops, or home study courses:

(i) for less than seven clock hours, $30; and

(ii) for seven or more clock hours, $50;

~~(16)~~ (14) fee to a licensee for review of continuing education seminars, institutes, workshops, or home study courses not previously approved for a sponsor and submitted with an application for license renewal:

(i) for less than seven clock hours total, $30; and

(ii) for seven or more clock hours total, $50;

~~(17)~~ (15) late renewal fee, $75;

~~(18)~~ (16) fee to a licensee for verification of licensure status and examination scores, $30;

~~(19)~~ (17) registration as a registered continuing education sponsor, $1,000;

~~(20)~~ (18) mail labels, $75; and

~~(21)~~ (19) annual assisted living program education provider fee, $2,500.

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

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

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

For a violation of section 144A.44, subdivision 1, paragraph (a), clause (2), (14), (19), or (22), or 144A.4791, subdivision 11, paragraph (d), a resident or resident's designated representative may bring a civil action against an assisted living establishment and recover actual damages or $3,000, whichever is greater, plus costs, including costs of investigation, and reasonable attorney fees, and receive other equitable relief as determined by the court in addition to seeking any other remedy otherwise available under law.

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

Sec. 11. Minnesota Statutes 2022, section 144A.4798, subdivision 3, is amended to read:

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

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

Sec. 12. Minnesota Statutes 2022, section 144A.4798, is amended by adding a subdivision to read:

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

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

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

Sec. 13. Minnesota Statutes 2022, section 144A.4798, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

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

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

(9) taking into account dementia-related concerns.

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

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

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

Sec. 14. Minnesota Statutes 2022, section 144A.4798, is amended by adding a subdivision to read:

Subd. 6. **Disease prevention and infection control in congregate settings.** (a) A home care provider providing services to a client who resides in an assisted living facility licensed under chapter 144G must coordinate and cooperate with the assisted living director of the assisted living facility in which a client of the unaffiliated home care provider resides to ensure that the home care provider meets all the requirements of this section while providing services in these congregate settings.

(b) In addition to meeting the requirements of subdivision 5, a home care provider providing services to a client who resides in an assisted living facility licensed under section 144G.10 must also address in the provider's severe acute respiratory syndrome-related coronavirus response plan the following:

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

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

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

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

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

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

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

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

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

(c) A home care provider providing services to a client who resides in an assisted living facility licensed under chapter 144G must make the home care provider's severe acute respiratory syndrome-related coronavirus response plan available to the assisted living director of the assisted living facility in which a client of the unaffiliated home care provider resides.

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

Sec. 15. Minnesota Statutes 2022, 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~~.~~;

(23) revoke hospice election at any time; and

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

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

Sec. 16. Minnesota Statutes 2022, section 144G.09, subdivision 3, is amended to read:

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

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

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

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

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

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

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

(5) emergency disaster and preparedness plans;

(6) uniform checklist disclosure of services;

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

(8) conditions and fine amounts for planned closures;

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

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

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

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

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

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

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

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

Sec. 17. Minnesota Statutes 2022, section 144G.10, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective August 1, 2023.

Sec. 18. **[144G.21] CAUSE OF ACTION.**

A cause of action for violations of this chapter may be brought and nothing in this chapter precludes a person from pursuing such an action. Any determination of retaliation by the commissioner may be used as evidence of retaliation in any cause of action under this chapter.

EFFECTIVE DATE. This section is effective August 1, 2023.

Sec. 19. Minnesota Statutes 2022, section 144G.42, is amended by adding a subdivision to read:

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

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

EFFECTIVE DATE. This section is effective August 1, 2023.

Sec. 20. Minnesota Statutes 2022, section 144G.42, is amended by adding a subdivision to read:

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

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

EFFECTIVE DATE. This section is effective August 1, 2023.

Sec. 21. Minnesota Statutes 2022, section 144G.42, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

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

(8) compassionate care visitation;

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

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

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

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

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

(14) taking into account dementia-related concerns.

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

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

EFFECTIVE DATE. This section is effective August 1, 2023.

Sec. 22. **[144G.46] INFECTION CONTROL; COMMUNICABLE DISEASES.**

Subdivision 1. **Disease prevention and infection control.** A person or entity receiving assisted living title protection under this chapter and the person primarily responsible for oversight and management of a facility must coordinate and cooperate with a home care provider providing services to a client who resides in the establishment, regardless of the home care provider's status, to ensure that the home care provider meets all the requirements of section 144A.4798.

Subd. 2. **Tuberculosis (TB) infection control.** (a) A person or entity receiving assisted living title protection under this chapter must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.

(b) A person or entity receiving assisted living title protection under this chapter may comply with the requirements of this subdivision by participating in a comprehensive tuberculosis infection control program of a facility.

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

Subd. 3. **Communicable diseases.** A person or entity receiving assisted living title protection under this chapter must follow current state requirements for prevention, control, and reporting of communicable diseases in Minnesota Rules, parts 4605.7040, 4605.7044, 4605.7050, 4605.7075, 4605.7080, and 4605.7090.

Subd. 4. **Infection control program.** (a) A person or entity receiving assisted living title protection under this chapter must establish and maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control.

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

Subd. 5. **Severe acute respiratory syndrome-related coronavirus infection control.** (a) A person or entity receiving assisted living title protection under this chapter must establish and maintain a comprehensive severe acute respiratory syndrome-related coronavirus infection control program that complies with accepted health care, medical, and nursing standards for infection control according to the most current SARS-CoV-2 infection control guidelines or their successor versions issued by the United States Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services, and the commissioner. This program must include a severe acute respiratory syndrome-related coronavirus infection control plan that covers all paid and unpaid employees, contractors, students, volunteers, clients, and visitors. The commissioner shall provide technical assistance regarding implementation of the guidelines.

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

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

Subd. 6. **Severe acute respiratory syndrome-related coronavirus response plan.** (a) A person or entity receiving assisted living title protection under this chapter must establish, implement, and maintain a severe acute respiratory syndrome-related coronavirus response plan. The severe acute respiratory syndrome-related coronavirus response plan must be

consistent with the requirements of section 144A.4798, subdivision 3, and at a minimum must address the following:

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

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

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

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

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

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

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

(8) compassionate care visitation;

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

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

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

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

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

(14) taking into account dementia-related concerns.

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

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

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

Sec. 23. Minnesota Statutes 2022, section 144G.91, is amended by adding a subdivision to read:

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

EFFECTIVE DATE. This section is effective August 1, 2023.

Sec. 24. Minnesota Statutes 2022, section 144G.92, is amended by adding a subdivision to read:

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

EFFECTIVE DATE. This section is effective August 1, 2023.

Sec. 25. **[144G.925] PRIVATE ENFORCEMENT OF RIGHTS.**

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

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

EFFECTIVE DATE. This section is effective August 1, 2023.

Sec. 26. Laws 2019, chapter 60, article 1, section 46, is amended to read:

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

Within available appropriations to the commissioner of health for enforcement activities for fiscal years 2020 ~~and~~, 2021, and 2024, the commissioner of health shall prioritize enforcement activities taken under Minnesota Statutes, section 144A.442.

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

Sec. 27. Laws 2019, chapter 60, article 5, section 2, is amended to read:

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

Subdivision 1. **General fund appropriation.** (a) $9,656,000 in fiscal year 2020 and $9,416,000 in fiscal year 2021 are appropriated from the general fund to the commissioner of health to implement regulatory activities relating to vulnerable adults and assisted living licensure.

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

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

Subd. 2. **State government special revenue fund appropriation.** $1,103,000 in fiscal year 2020 and $1,103,000 in fiscal year 2021 are appropriated from the state government special revenue fund to improve the frequency of home care provider inspections and to implement assisted living licensure activities under Minnesota Statutes, ~~section 144I.01~~

sections 144G.08 to 144G.9999. The base for this appropriation is $8,131,000 in fiscal year 2022 and $8,339,000 in fiscal year 2023.

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

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

Sec. 28. **LONG-TERM CARE SEVERE ACUTE RESPIRATORY SYNDROME-RELATED CORONAVIRUS TASK FORCE.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) how to create facilities dedicated to caring for assisted living clients and nursing home residents without symptoms of a respiratory infection or confirmed not to have

COVID-19 disease or similar severe acute respiratory syndromes to prevent them from acquiring COVID-19 disease or similar severe acute respiratory syndromes;

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

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

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

Subd. 4. **Report.** By January 15, 2024, the task force must report to the chairs and ranking minority members of the legislative committees with jurisdiction over health policy and finance. The report must:

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

(2) make recommendations for legislative action.

Subd. 5. **First meeting; chair.** The commissioner of health or a designee must convene the first meeting of the Long-Term Care Severe Acute Respiratory Syndrome-Related Coronavirus Task Force by August 1, 2023. At the first meeting, the task force shall elect a chair by a majority vote of those members present. The chair has authority to convene additional meetings as needed.

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

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

Subd. 8. **Compensation.** Public members are compensated as provided in Minnesota Statutes, section 15.059, subdivision 3.

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

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

Sec. 29. **DIRECTION TO THE COMMISSIONER OF HEALTH; ELECTRONIC MONITORING CONSENT FORM.**

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

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

Sec. 30. **DIRECTION TO THE COMMISSIONER OF HEALTH; CONTROLLING SEVERE ACUTE RESPIRATORY SYNDROME-RELATED CORONAVIRUS IN LONG-TERM CARE SETTINGS.**

Subdivision 1. **State plan for combating severe acute respiratory syndrome-related coronavirus.** (a) The commissioner of health shall create a state plan for combating the spread of SARS-CoV-2 or similar severe acute respiratory syndrome-related coronavirus infections and COVID-19 disease or similar severe acute respiratory syndromes among residents of long-term care settings. For the purposes of this section, "long-term care setting" or "setting" means: (1) an assisted living facility licensed under Minnesota Statutes, chapter 144G; (2) a nursing home licensed under Minnesota Statutes, chapter 144A; (3) a boarding care home licensed under Minnesota Statutes, sections 144.50 to 144.58; or (4) independent senior living. For the purposes of this section, "resident" means any individual residing in a long-term care setting. The commissioner must consult with the Long-Term Care Severe Acute Respiratory Syndrome-Related Coronavirus Task Force regarding the creation of and modifications or amendments to the state plan.

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

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

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

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

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

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

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

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

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

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

(8) compassionate care visitation;

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

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

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

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

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

(14) taking into account dementia-related concerns.

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

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

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

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

Sec. 31. **LONG-TERM CARE COVID-19-RELATED TESTING PROGRAMS.**

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

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

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

(d) "Facility" means a nursing home licensed under Minnesota Statutes, section 144A.02; a boarding care home licensed under Minnesota Statutes, sections 144.50 to 144.58; an assisted living facility licensed under Minnesota Statutes, chapter 144G; and independent senior living settings.

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

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

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

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

Subd. 3. **Baseline testing grants.** Within the limits of money specifically appropriated to the commissioner of human services under section 33, paragraph (a), the commissioner of human services shall make COVID-19 baseline screening grants to any facility that has not completed COVID-19 baseline testing. The commissioner shall determine the amount of each baseline screening grant, and shall award a grant only if funds are not otherwise available.

Subd. 4. **Serial screening reimbursement.** (a) Within the limits of money specifically appropriated to the commissioner of human services under section 33, paragraph (b), the commissioner of human services shall reimburse each facility for the allowable costs of eligible COVID-19-related screening services that a facility cannot otherwise afford upon submission by a facility of a COVID-19-related testing services cost report.

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

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

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

Sec. 32. **CONSUMER PROTECTIONS FOR ASSISTED LIVING CLIENTS.**

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

(b) "Appropriate service provider" means an assisted living facility or home care provider that can adequately provide to a client the services agreed to in the service agreement.

(c) "Client" means a resident who receives assisted living that is subject to Minnesota Statutes, chapter 144G.

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

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

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

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

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

(5) a person who:

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

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

(e) "Facility" means an assisted living facility licensed under Minnesota Statutes, chapter 144G.

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

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

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

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

Subd. 2. **Prerequisite to termination; meeting.** (a) A facility must schedule and participate in a meeting with the client and the client representative before a notice of termination of services is issued.

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

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

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

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

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

Subd. 3. **Pretermination meeting; notice.** (a) The facility must provide written notice of the meeting to the client and the client's representative at least five business days in advance.

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

(c) The meeting must be scheduled to take place at least seven calendar days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the client and the client's representative are able to attend the meeting.

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

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

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

(3) a list of facility representatives who will attend the meeting;

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

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

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

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

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

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

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

Subd. 4. **Pretermination meeting requirements; identifying and offering accommodations, modifications, and alternatives.** (a) At the meeting described in subdivision 2, the facility must:

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

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

(b) Within 24 hours after the conclusion of the meeting, the facility must provide the client with a written summary of the meeting, including any agreements reached about any accommodation, modification, intervention, or alternative that will be used to avoid termination.

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

(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:

(1) the reason for the relocation;

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

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

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

(5) a statement that, if the facility refuses to provide either housing or services after a relocation, the client has a right to appeal under subdivision 10. The facility must provide contact information for the agency to which the resident may submit an appeal.

(c) The notice required under paragraph (b) must be delivered as soon as practicable to:

(1) the client and the client's representative;

(2) for residents who receive home and community-based waiver services under Minnesota Statutes, section 256B.49, and chapter 256S, the client's case manager; and

(3) the Office of Ombudsman for Long-Term Care if the client has been relocated and has not returned to the facility within four days.

(d) Following an emergency relocation, a facility's refusal to provide housing or services, respectively, constitutes a termination and triggers the termination process in this section.

(e) When an emergency relocation triggers the termination process and an in-person meeting is impractical or impossible, the facility may use telephonic, video, or other electronic format.

(f) If the meeting is held through telephone, video, or other electronic format, the facility must ensure that the client, the client's representative, and any case manager or representative of an ombudsman's office are able to participate in the meeting. The facility must make reasonable efforts to ensure that any person the client invites to the meeting is able to participate.

(g) The facility must issue the notice in this subdivision at least 24 hours in advance of the meeting. The notice must include detailed instructions on how to access the means of communication for the meeting.

(h) If notice to the ombudsman is required under paragraph (c), clause (3), the facility must provide the notice no later than 24 hours after the notice requirement is triggered.

Subd. 6. **Restrictions on housing terminations.** (a) A facility may not terminate housing except as provided in this subdivision.

(b) Upon 30 days' prior written notice, a facility may initiate a termination of housing only for:

(1) nonpayment of rent, provided the facility informs the client that public benefits may be available and provides contact information for the Senior LinkAge Line under Minnesota Statutes, section 256.975, subdivision 7. An interruption to a client's public benefits that lasts for no more than 60 days does not constitute nonpayment; or

(2) a violation of a lawful provision of housing if the client does not cure the violation within a reasonable amount of time after the facility provides written notice to the client of the ability to cure. Written notice of the ability to cure may be provided in person or by first class mail. A facility is not required to provide a client with written notice of the ability to cure for a violation that threatens the health or safety of the client or another individual in the facility or for a violation that constitutes illegal conduct.

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

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

(2) engaged in conduct that substantially and intentionally interferes with the safety or physical health of the staff of the facility; or

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

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

Subd. 7. **Restrictions on terminations of services.** (a) A facility may not terminate services of a client in a facility except as provided in this subdivision.

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

(c) Upon 15 days' prior written notice, a facility may terminate services only if:

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

(2) the client's assessed needs exceed the scope of services agreed upon in the service plan and are not otherwise offered by the facility; or

(3) extraordinary circumstances exist, causing the facility to be unable to provide the client with the services agreed to in the service plan that are necessary to meet the client's needs.

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

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

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

(d) A facility terminating services under subdivision 7, paragraph (b), must provide a written termination notice at least 30 days before the effective date of the termination to the client and the client's representative.

(e) A facility terminating services under subdivision 7, paragraph (c), must provide a written termination notice at least 15 days before the effective date of the termination to the client and the client's representative.

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

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

(1) the effective date of the termination;

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

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

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

(5) a statement that the facility must participate in a coordinated move as described in this section;

(6) the name and contact information of the person employed by the facility with whom the client may discuss the termination;

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

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

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

(b) A facility must provide written notice of the client's termination of housing or services, respectively, in person or by first-class mail. Service of the notice must be proved by affidavit of the person making it.

(c) If sent by mail, the facility must mail the notice to the client's last known address.

(d) A facility providing a notice to the ombudsman of a client's termination of housing or services must provide the ombudsman with a copy of the written notice that is provided to the client. The facility must provide notice to the ombudsman as soon as practicable, but

in any event no later than two business days after notice is provided to the client. The notice must include a telephone number for the client, or, if the client does not have a telephone number, the telephone number of the client's representative or case manager.

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

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

(1) there is a factual dispute as to whether the facility had a permissible basis to initiate the termination;

(2) the termination would result in great harm or the potential for great harm to the client as determined by the totality of the circumstances, except in circumstances where there is a greater risk of harm to other clients or staff of the facility;

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

(4) the facility has terminated housing, services, or both, in violation of state or federal law.

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

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

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

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

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

(e) The administrative law judge shall make a transcript of the hearing.

(f) The informal hearing will allow the client to provide an opportunity to present written or oral objections or defenses to the termination.

(g) If either party is represented by an attorney, the administrative law judge shall emphasize the informality of the hearing.

(h) If the client is unable to represent themselves at the hearing, the resident may present the client's appeal to the administrative law judge on the client's behalf.

(i) Parties may be, but are not required to be, represented by counsel. The appearance of a party without counsel does not constitute the unauthorized practice of law.

(j) The facility bears the burden of proof to establish by a preponderance of the evidence that the termination was permissible if the appeal is brought on the ground listed in subdivision 12.

(k) The client bears the burden of proof to establish by a preponderance of the evidence that the termination was permissible if the appeal is brought on the grounds listed in subdivision 12.

(l) The hearing shall be limited to the amount of time necessary for the participants to expeditiously present the facts about the proposed termination. The administrative law judge shall issue a final decision as soon as practicable, but no later than ten business days after the hearing.

(m) The administrative law judge's decision may contain any conditions that may be placed on the client's continued residency or receipt of services, including but not limited to changes to the service plan or a required increase in services.

(n) The client's termination must be rescinded if the client prevails in the appeal.

(o) The facility or client may appeal the administrative law judge's decision to the Minnesota Court of Appeals.

Subd. 12. **Service provision while appeal pending.** A termination of housing or services shall not occur while an appeal is pending. If additional services are needed to meet the

health or safety needs of the client while an appeal is pending, the client is responsible for contracting for those additional services from the facility or another home care provider licensed under Minnesota Statutes, chapter 144A, and for ensuring the costs for those additional services are covered.

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

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

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

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

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

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

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

Subd. 16. **Coordinated moves.** (a) A facility must arrange a coordinated move for a client according to this subdivision if:

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

(2) a facility reduces or eliminates services to the extent that the client needs to move.

(b) If an event listed in paragraph (a) occurs, the facility must:

(1) ensure a coordinated move to a safe location that is appropriate for the client;

(2) ensure a coordinated move to an appropriate service provider, provided services are still needed and desired by the client; and

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

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

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

(e) Sixty days before one or more services are reduced or eliminated for a particular client, the provider must provide written notice of the reduction or elimination. If the facility, client, or client's representative determines that the reduction or elimination of services will force the client to move to a new location, the facility must ensure a coordinated move in accordance with this subdivision, and must provide notice to the Office of Ombudsman for Long-Term Care.

(f) The facility must prepare a client-relocation evaluation and client-relocation plan as described in this section to prepare for the move to the new location or service provider.

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

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

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

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

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

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

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

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

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

Subd. 17. **Client-relocation evaluation.** If the client plans to move out of the facility due to termination of housing or services, or nonrenewal of housing, the facility must work in coordination to prepare a written client-relocation evaluation. The evaluation must include:

(a) the client's current service plan;

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

(c) the client's needs and choices.

Subd. 18. **Client-relocation plan.** (a) The facility must hold a planning conference to develop a relocation plan with the client, the client's representative and case manager, if any, and other individuals invited by the client.

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

(c) The client-relocation plan must include:

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

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

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

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

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

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

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

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

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

(d) The facility must implement the relocation plan and comply with the coordinated move requirements in this section.

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

(1) the name and address of the facility, the dates of the client's admission and discharge, and the name and address of a person at the facility to contact for additional information;

(2) the client's most recent service plan, if the client has received services from the facility; and

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

Subd. 20. **Client discharge summary.** At the time of discharge, the facility must provide the client, and, with the client's consent, the client's representative and case manager, if applicable, with a written discharge summary that includes:

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

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

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

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

Subd. 21. **Services pending appeal.** If a client needs additional services during a pending termination appeal, the facility must contact and inform the client's case manager, if applicable, of the client's responsibility to contract and ensure payment for those services.

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

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

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

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

EFFECTIVE DATE. This section is effective for contracts entered into on or after the date of enactment for this section and expires July 31, 2024.

Sec. 33. **APPROPRIATION; COVID-19 SCREENING PROGRAM.**

(a) $..... in fiscal year 2024 is appropriated from the coronavirus relief fund to the commissioner of human services for COVID-19 baseline screening grants under section 1. This is a onetime appropriation.

(b) $..... in fiscal year 2024 is appropriated from the coronavirus relief fund to the commissioner of human services for cost-based reimbursement for COVID-19 serial screening under section 1. This is a onetime appropriation.

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

Sec. 34. **APPROPRIATION; BOARD OF EXECUTIVES FOR LONG TERM SERVICES AND SUPPORTS.**

$..... in fiscal year 2024 and $..... in fiscal year 2025 are appropriated from the state government special revenue fund to the Board of Executives for Long Term Services and Supports for operations and is effective the day following final enactment. The base for this appropriation is $..... in fiscal year 2026 and $..... in fiscal year 2027.

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