..... moves to amend S.F. No. 3656, the second engrossment, in conference committee, as follows:

Page 438, delete article 27 and insert:

"ARTICLE 27

ELDERCARE AND VULNERABLE ADULT PROTECTIONS

Section 1. **CITATION.**

Sections 1 to 61 may be cited as the "Eldercare and Vulnerable Adult Protection Act of 2018."

Sec. 2. Minnesota Statutes 2016, section 144.6501, subdivision 3, is amended to read:

Subd. 3. **Contracts of admission.** (a) A facility shall make complete unsigned copies of its admission contract available to potential applicants and to the state or local long-term care ombudsman immediately upon request.

(b) A facility shall post conspicuously within the facility, in a location accessible to public view, either a complete copy of its admission contract or notice of its availability from the facility.

(c) An admission contract must be printed in black type of at least ten-point type size. The facility shall give a complete copy of the admission contract to the resident or the resident's legal representative promptly after it has been signed by the resident or legal representative.

(d) The admission contract must contain the name, address, and contact information of the current owner, manager, and if different from the owner, license holder of the facility, and the name and physical mailing address of at least one natural person who is authorized to accept service of process.

~~(d)~~ (e) An admission contract is a consumer contract under sections 325G.29 to 325G.37.

~~(e)~~ (f) All admission contracts must state in bold capital letters the following notice to applicants for admission: "NOTICE TO APPLICANTS FOR ADMISSION. READ YOUR ADMISSION CONTRACT. ORAL STATEMENTS OR COMMENTS MADE BY THE FACILITY OR YOU OR YOUR REPRESENTATIVE ARE NOT PART OF YOUR ADMISSION CONTRACT UNLESS THEY ARE ALSO IN WRITING. DO NOT RELY ON ORAL STATEMENTS OR COMMENTS THAT ARE NOT INCLUDED IN THE WRITTEN ADMISSION CONTRACT."

Sec. 3. Minnesota Statutes 2016, section 144.6501, is amended by adding a subdivision to read:

Subd. 3a. **Changes to contracts of admission.** Within 30 days of a change in ownership, management, or license holder, the facility must provide prompt written notice to the resident or resident's legal representative of a new owner, manager, and if different from the owner, license holder of the facility, and the name and physical mailing address of any new or additional natural person not identified in the admission contract who is newly authorized to accept service of process.

Sec. 4. **[144.6502] AUTHORIZED ELECTRONIC MONITORING IN CERTAIN HEALTH CARE FACILITIES.**

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

(b) "Authorized electronic monitoring" means the placement and use of an electronic monitoring device by a resident in the resident's room or private living space in accordance with this section.

(c) "Commissioner" means the commissioner of health.

(d) "Department" means the Department of Health.

(e) "Electronic monitoring device" means a surveillance instrument with a fixed position video camera or an audio recording device, or both, that is installed in a resident's room or private living space and broadcasts or records activity or sounds occurring in the room or private living space.

(f) "Facility" means a facility that is licensed as a nursing home under chapter 144A or as a boarding care home under sections 144.50 to 144.56, or registered as a housing with services establishment under chapter 144D that is also subject to chapter 144G.

(g) "Legal representative" means a court-appointed guardian or other representative with legal authority to make decisions about health care services for the resident, including a health care agent or an attorney-in-fact authorized through a health care directive or a power of attorney.

(h) "Resident" means a person 18 years of age or older residing in a facility.

Subd. 2. **Authorized electronic monitoring.** (a) A resident or a resident's legal representative may conduct authorized electronic monitoring of the resident's room or private living space through the use of electronic monitoring devices placed in the room or private living space as provided in this section.

(b) Nothing in this section allows the use of an electronic monitoring device to take still photographs or for the nonconsensual interception of private communications.

(c) Nothing in this section precludes the use of electronic monitoring of health care allowed under other law.

(d) Electronic monitoring authorized under this section, for the purpose of monitoring the actions of individuals other than the resident or to verify the delivery of services, is not a covered service under home and community-based waivers under sections 256B.0913, 256B.0915, 256B.092, and 256B.49.

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 space in writing on a notification and consent form prescribed by the ombudsman for long-term care, in consultation with the department and representatives of facilities. If the resident has not affirmatively objected to electronic monitoring and the resident's physician determines that the resident lacks the ability to understand and appreciate the nature and consequences of electronic monitoring, the resident's legal 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's legal representative consenting on behalf of a resident, the resident must be asked by the resident's legal guardian in the presence of a facility employee if the resident wants electronic monitoring to be conducted. The resident's legal 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 5;

(3) with whom the recording may be shared under subdivision 9 or 10; and

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

(c) A resident or roommate may consent to electronic monitoring with any conditions of the resident's or roommate's choosing, including the list of standard conditions provided in subdivision 5. A resident or roommate 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 must obtain the written consent of any other resident residing in the room or private living space on the notification and consent form prescribed by the ombudsman for long-term care. Except as otherwise provided in this subdivision, a roommate must consent in writing to electronic monitoring in the resident's room or private living space. If the roommate has not affirmatively objected to electronic monitoring in accordance with this subdivision and the roommate's physician determines that the roommate lacks the ability to understand and appreciate the nature and consequences of electronic monitoring, the roommate's legal representative may consent on behalf of the roommate. Consent by a roommate under this paragraph authorizes the resident's use of any recording obtained under this section, as provided under subdivision 9 or 10.

(e) Any resident conducting authorized electronic monitoring must obtain consent from any new roommate before the resident may resume authorized electronic monitoring. If a new roommate does not consent to electronic monitoring and the resident conducting the electronic monitoring does not remove or disable the electronic monitoring device, the facility must remove the electronic monitoring device.

Subd. 4. **Withdrawal of consent; refusal of roommate to consent.** (a) Consent may be withdrawn by the resident or roommate at any time and the withdrawal of consent must be documented in the resident's clinical record. If a roommate withdraws consent and the resident conducting the electronic monitoring does not remove or disable the electronic monitoring device, the facility must remove the electronic monitoring device.

(b) If a resident of a nursing home or boarding care home who is residing in a shared room wants to conduct electronic monitoring and another resident living in or moving into the same shared room refuses to consent to the use of an electronic monitoring device, the facility shall make a reasonable attempt to accommodate the resident who wants to conduct

electronic monitoring. A nursing home or boarding care home has met the requirement to make a reasonable attempt to accommodate a resident who wants to conduct electronic monitoring when, upon notification that a roommate has not consented to the use of an electronic monitoring device in the resident's room, the nursing home or boarding care home offers to move either resident to another shared room that is available at the time of the request. If a resident chooses to reside in a private room in a nursing home or boarding care home in order to accommodate the use of an electronic monitoring device, the resident must pay the private room rate. If a nursing home or boarding care home is unable to accommodate a resident due to lack of space, the nursing home or boarding care home must reevaluate the request every two weeks until the request is fulfilled. A nursing home or boarding care home is not required to provide a private room or a single-bed room to a resident who is not a private-pay resident.

Subd. 5. **Notice to facility; form requirements.** (a) Authorized electronic monitoring may begin only after the resident who intends to install an electronic monitoring device completes the notification and consent form prescribed by the ombudsman for long-term care and submits the form to the facility and the facility places the form in the resident's and any roommate's clinical records.

(b) The notification and consent form completed by the resident must include, at a minimum, the following information:

(1) the resident's signed consent to electronic monitoring or the signature of the resident's legal representative, if applicable. If a person other than the resident signs the consent form, the form must document the following:

(i) the date the resident was asked if the resident wants electronic monitoring to be conducted;

(ii) who was present when the resident was asked; and

(iii) an acknowledgment that the resident did not affirmatively object;

(2) the resident's roommate's signed consent or the signature of the roommate's legal representative, if applicable. If a roommate's legal representative signs the consent form, the form must document the following:

(i) the date the roommate was asked if the roommate wants electronic monitoring to be conducted;

(ii) who was present when the roommate was asked; and

(iii) an acknowledgment that the roommate did not affirmatively object;

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

(4) any installation needs, such as mounting of a device to a wall or ceiling;

(5) the proposed date of installation for scheduling purposes;

(6) a list of standard conditions or restrictions that the resident or a roommate may elect to place on the use of the electronic monitoring device, including, but not limited to:

(i) prohibiting audio recording;

(ii) prohibiting video recording;

(iii) prohibiting broadcasting of audio or video;

(iv) turning off the electronic monitoring device or blocking the visual recording component of the electronic monitoring device for the duration of an exam or procedure by a health care professional;

(v) turning off the electronic monitoring device or blocking the visual recording component of the electronic monitoring device while dressing or bathing is performed; and

(vi) turning off the electronic monitoring device for the duration of a visit with a spiritual advisor, ombudsman, attorney, financial planner, intimate partner, or other visitor;

(7) any other condition or restriction elected by the resident or roommate on the use of an electronic monitoring device; and

(8) a signature box for documenting that the resident or roommate has withdrawn consent.

(c) A copy of the completed notification and consent form must be placed in the resident's and any roommate's clinical records and a copy must be provided to the resident and the resident's roommate, if applicable.

(d) The ombudsman for long-term care shall prescribe the notification and consent form required in this section no later than January 1, 2019. The commissioner shall make the form available on the department's Web site.

(e) Beginning January 1, 2019, facilities must make the notification and consent form available to the residents and inform residents of their option to conduct electronic monitoring of their rooms or private living spaces.

(f) Any resident, legal representative of a resident, or other person conducting electronic monitoring of a resident's room prior to enactment of this section must comply with the requirements of this section by January 1, 2019.

Subd. 6. **Cost and installation.** (a) A resident choosing to conduct authorized electronic monitoring must do so at the resident's own expense, including paying purchase, installation, maintenance, and removal costs.

(b) If a resident chooses to install an electronic monitoring device that uses Internet technology for visual or audio monitoring, the resident may be responsible for contracting with an Internet service provider.

(c) The facility shall make a reasonable attempt to accommodate the resident's installation needs, including allowing access to the facility's telecommunications or equipment room. A facility has the burden of proving that a requested accommodation is not reasonable.

(d) All electronic monitoring device installations and supporting services must be UL-listed.

Subd. 7. **Notice to visitors.** (a) A facility shall post a sign at each facility entrance accessible to visitors that states "Security cameras and audio devices may be present to record persons and activities."

(b) The facility is responsible for installing and maintaining the signage required in this subdivision.

Subd. 8. **Obstruction of electronic monitoring devices.** (a) A person must not knowingly hamper, obstruct, tamper with, or destroy an electronic monitoring device installed in a resident's room or private living space without the permission of the resident or the resident's legal representative.

(b) It is not a violation of paragraph (a) if a person turns off the electronic monitoring device or blocks the visual recording component of the electronic monitoring device at the direction of the resident or the resident's legal representative, or if consent has been withdrawn.

Subd. 9. **Dissemination of recordings.** (a) A facility may not access any video or audio recording created through authorized electronic monitoring without the written consent of the resident or the resident's legal representative.

(b) Except as required under other law, a recording or copy of a recording made as provided in this section may only be disseminated for the purpose of addressing health, safety, or welfare concerns of a resident or residents.

(c) The resident or the resident's legal representative must provide a copy of any video or audio recording to parties involved in a civil, criminal, or administrative proceeding,

upon a party's request, if the video or audio recording was made during the time period that the conduct at issue in the proceeding allegedly occurred.

Subd. 10. **Admissibility of evidence.** Subject to applicable rules of evidence and procedure, any video or audio recording created through authorized electronic monitoring under this section may be admitted into evidence in a civil, criminal, or administrative proceeding if the contents of the recording have not been edited or artificially enhanced and the video recording includes the date and time the events occurred.

Subd. 11. **Liability.** (a) A facility is not civilly or criminally liable for the inadvertent or intentional disclosure of a recording by a resident or a resident's legal representative for any purpose not authorized by this section.

(b) A facility is not civilly or criminally liable for a violation of a resident's right to privacy arising out of any electronic monitoring conducted as provided in this section.

Subd. 12. **Resident protections.** A facility must not:

(1) refuse to admit a potential resident or remove a resident because the facility disagrees with the potential resident's or the resident's decisions regarding electronic monitoring;

(2) intentionally retaliate or discriminate against any resident for consenting or refusing to consent to electronic monitoring under this section; or

(3) prevent the installation or use of an electronic monitoring device by a resident who has provided the facility with notice and consent as required under this section.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 5. Minnesota Statutes 2016, section 144.651, subdivision 1, is amended to read:

Subdivision 1. **Legislative intent.** It is the intent of the legislature and the purpose of this section to promote the interests and well being of the patients and residents of health care facilities. It is the intent of this section that every patient's and resident's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, must not be infringed and that the facility must encourage and assist in the fullest possible exercise of these rights. The rights provided under this section are established for the benefit of patients and residents. No health care facility may require or request a patient or resident to waive any of these rights at any time or for any reason including as a condition of admission to the facility. Any guardian or conservator of a patient or resident or, in the absence of a guardian or conservator, an interested person, may seek enforcement of these rights on behalf of a patient or resident. An interested person may also

seek enforcement of these rights on behalf of a patient or resident who has a guardian or conservator through administrative agencies or in district court having jurisdiction over guardianships and conservatorships. Pending the outcome of an enforcement proceeding the health care facility may, in good faith, comply with the instructions of a guardian or conservator. ~~It is the intent of this section that every patient's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and that the facility shall encourage and assist in the fullest possible exercise of these rights.~~

Sec. 6. Minnesota Statutes 2016, section 144.651, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Patient" means:

(1) a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person~~.~~;

(2) a minor who is admitted to a residential program as defined in section 253C.01;

(3) for purposes of subdivisions 1, 4 to 9, 12, 13, 15, 16, ~~and~~ 18 to 20, ~~"patient" also means~~ and 34, a person who receives health care services at an outpatient surgical center or at a birth center licensed under section 144.615~~. "Patient" also means a minor who is admitted to a residential program as defined in section 253C.01.~~; and

(4) for purposes of subdivisions 1, 3 to 16, 18, 20 ~~and~~, 30, ~~"patient" also means~~ and 34, any person who is receiving mental health treatment on an outpatient basis or in a community support program or other community-based program.

(c) "Resident" means a person who is admitted to:

(1) a nonacute care facility including extended care facilities~~.~~;

(2) a nursing ~~homes, and~~ home;

(3) a boarding care ~~homes~~ home for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age~~.~~; and

(4) for purposes of ~~all subdivisions except~~ subdivisions ~~28 and 29~~ 1 to 27~~, "resident" also means a person who is admitted to~~ and 30 to 34, a facility licensed as a board and lodging facility under Minnesota Rules, ~~parts 4625.0100 to 4625.2355~~ chapter 4625, or a supervised living facility under Minnesota Rules, ~~parts 4665.0100 to 4665.9900~~ chapter

4665, and which operates a rehabilitation program licensed under Minnesota Rules, parts ~~9530.6405~~ 9530.6510 to 9530.6590.

(d) "Health care facility" or "facility" means:

(1) an acute care inpatient facility;

(2) a residential program as defined in section 253C.01;

(3) for the purposes of subdivisions 1, 4 to 9, 12, 13, 15, 16, 18 to 20, and 34, an outpatient surgical center or a birth center licensed under section 144.615;

(4) for the purposes of subdivisions 1, 3 to 16, 18, 20, 30, and 34, a setting in which outpatient mental health services are provided, or a community support program or other community-based program providing mental health treatment;

(5) a nonacute care facility, including extended care facilities;

(6) a nursing home;

(7) a boarding care home for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age; or

(8) for the purposes of subdivisions 1 to 27 and 30 to 34, a facility licensed as a board and lodging facility under Minnesota Rules, chapter 4625, or a supervised living facility under Minnesota Rules, chapter 4665, and which operates a rehabilitation program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590.

Sec. 7. Minnesota Statutes 2016, section 144.651, subdivision 4, is amended to read:

Subd. 4. **Information about rights.** (a) Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement in plain language and in terms patients and residents can understand of the applicable rights and responsibilities set forth in this section. The written statement must be developed by the commissioner, in consultation with stakeholders, and must also include the name, address, and telephone number of the state or county agency to contact for additional information or assistance. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs.

(b) Reasonable accommodations shall be made for people who have communication disabilities and those who speak a language other than English.

(c) Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.

Sec. 8. Minnesota Statutes 2016, section 144.651, subdivision 6, is amended to read:

Subd. 6. **Appropriate health care.** Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning~~.~~, provided by persons who are properly trained and competent to perform their duties. This right is limited where the service is not reimbursable by public or private resources.

Sec. 9. Minnesota Statutes 2016, section 144.651, subdivision 14, is amended to read:

Subd. 14. **Freedom from maltreatment.** (a) Patients and residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Patients and residents who reside in or receive care from a facility for which the Department of Health is the lead investigative agency shall receive notification from the Department of Health regarding a report of alleged maltreatment, disposition of a report, and appeal rights, as provided under section 626.557, subdivision 9c.

(b) Every patient and resident shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a patient's or resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.

Sec. 10. Minnesota Statutes 2016, section 144.651, subdivision 16, is amended to read:

Subd. 16. **Confidentiality of records.** Patients and residents shall be assured confidential treatment of their personal, financial, and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal

records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Patients and residents have a right to access their personal, financial, and medical records and written information from those records. Copies of records and written information from the records shall be made available in accordance with this subdivision and sections 144.291 to 144.298. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third-party payment contracts, or where otherwise provided by law.

Sec. 11. Minnesota Statutes 2016, section 144.651, subdivision 17, is amended to read:

Subd. 17. **Disclosure of services available.** Patients and residents shall be informed, prior to or at the time of admission and during their stay, of services which are included in the facility's basic per diem or daily room rate and that other services are available at additional charges. Residents have the right to 30 days' advance notice of changes in charges that are unrelated to a resident's change in condition or change of care needs. A facility that is subject to section 504B.178 may not collect a nonrefundable security deposit unless it is applied to the first month's charges. Nursing facilities enrolled as medical assistance providers are prohibited from charging, soliciting, accepting, or receiving a deposit. Facilities and providers are prohibited from charging fees because a resident exercises the right to refuse treatment or medication, or when the resident chooses pharmacies or other health professionals other than the ones selected or preferred by the facility or provider. Facilities shall make every effort to assist patients and residents in obtaining information regarding whether the Medicare or medical assistance program will pay for any or all of the aforementioned services.

Sec. 12. Minnesota Statutes 2016, section 144.651, subdivision 20, is amended to read:

Subd. 20. **Grievances.** (a) Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances, assert the rights granted under this section personally, and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, retaliation, or reprisal, including threat of discharge. ~~Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place.~~

(b) Patients and residents have the right to complain about services that are provided, services that are not being provided, and the lack of courtesy or respect to the patient or resident or the patient's or resident's property. The facility must investigate and attempt resolution of the complaint or grievance. The patient or resident has the right to be informed of the name and contact information of the individual who is responsible for handling grievances.

(c) Notice must be posted in a conspicuous place of the facility's or program's grievance procedure, as well as telephone numbers and, where applicable, addresses for the common entry point, as defined in section 626.5572, subdivision 5, the protection and advocacy agency, and the state long-term care ombudsman pursuant to United States Code, title 42, sections 3058f and 3058g.

(d) Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.

Sec. 13. Minnesota Statutes 2016, section 144.651, subdivision 21, is amended to read:

Subd. 21. **Communication privacy.** Patients and residents may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Patients and residents shall have access, at their own expense, unless provided by the facility, to writing instruments, stationery, ~~and~~ postage, and Internet service. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician in the medical record. There shall be access to a telephone where patients and residents can make and receive calls as well as speak privately. Facilities which are unable to provide a private area shall make reasonable arrangements to accommodate the privacy of patients' or residents' calls. Upon admission to a facility where federal law prohibits unauthorized disclosure of patient or resident identifying information

to callers and visitors, the patient or resident, or the legal guardian or conservator of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian or conservator of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility. This right is limited where medically inadvisable, as documented by the attending physician in a patient's or resident's care record. Where programmatically limited by a facility abuse prevention plan pursuant to section 626.557, subdivision 14, paragraph (b), this right shall also be limited accordingly.

Sec. 14. Minnesota Statutes 2016, section 144.651, is amended by adding a subdivision to read:

Subd. 34. **Retaliation prohibited.** (a) A facility or person must not retaliate against a patient, resident, employee, or interested person who in good faith:

(1) files a complaint or grievance or asserts any rights on behalf of the patient or resident;

(2) submits a maltreatment report, whether mandatory or voluntary, on behalf of the patient or resident under section 626.557, subdivision 3, 4, or 4a;

(3) advocates on behalf of the patient or resident for necessary or improved care and services or enforcement of rights under this section or other law; or

(4) contracts to receive services from a service provider of the resident's choice.

(b) Adverse action may be considered retaliation. For purposes of this section, "adverse action" means any action taken in bad faith by a facility or person against the patient, resident, employee, or interested person that includes but is not limited to:

(1) discharge or transfer from the facility;

(2) discharge from or termination of employment;

(3) demotion or reduction in remuneration for services;

(4) any restriction of any of the rights set forth in state or federal law;

(5) removal, tampering with, or deprivation of technology, communication, or electronic monitoring devices of the patient or resident;

(6) one of the following actions if unrelated to a patient's or resident's change in condition or change of care needs:

(i) restriction or prohibition of access either to the facility or to the patient or resident;

(ii) any restriction of access to or use of communities or services;

(iii) termination of services or lease agreement, or both; or

(iv) a sudden increase in costs for services not already contemplated at the time of the action taken;

(7) reporting maltreatment in bad faith; or

(8) making any oral or written communication of false information about a person advocating on behalf of the patient or resident.

Sec. 15. Minnesota Statutes 2016, section 144.651, is amended by adding a subdivision to read:

Subd. 35. **Electronic monitoring.** A resident has the right to install and use electronic monitoring, provided the requirements of section 144.6502 are met.

Sec. 16. **[144.6511] DECEPTIVE MARKETING AND BUSINESS PRACTICES.**

(a) For purposes of this section, "facility" means a facility listed in section 144.651, subdivision 2, paragraph (d), clauses (2) to (8); a housing with services establishment registered under chapter 144D; or an assisted living setting regulated under chapter 144G.

(b) Deceptive marketing and business practices by a facility or by a home care provider licensed under sections 144A.43 to 144A.482, are prohibited.

(c) For the purposes of this section, it is a deceptive practice for a facility or home care provider to:

(1) make any false, fraudulent, deceptive, or misleading statements in marketing, advertising, or written description or representation of care or services, whether in written or electronic form;

(2) arrange for or provide health care or services other than those contracted for;

(3) fail to deliver any care or services the provider or facility promised that the facility was able to provide;

(4) fail to inform the patient, resident, or client in writing of any limitations to care services available prior to executing a contract for admission;

(5) discharge or terminate the lease or services of a patient or resident following a required period of private pay who then receives benefits under the medical assistance elderly waiver program after the facility has made a written promise to continue the same services provided

under private pay and accept medical assistance elderly waiver payments after the expiration of the private pay period;

(6) fail to disclose in writing the purpose of a nonrefundable community fee or other fee prior to contracting for services with a patient, resident, or client;

(7) advertise or represent, in writing, that the facility is or has a special care unit, such as for dementia or memory care, without complying with training and disclosure requirements under sections 144D.065 and 325F.72, and any other applicable law; or

(8) define the terms "facility," "contract of admission," "admission contract," "admission agreement," "legal representative," or "responsible party" to mean anything other than the meanings of those terms under section 144.6501.

Sec. 17. Minnesota Statutes 2016, section 144.652, is amended by adding a subdivision to read:

Subd. 3. **Fines.** Notwithstanding section 144.653 or 144A.10, the commissioner may impose a fine in an amount equal to the amount listed in Minnesota Rules, part 4658.0193, item F, upon a finding that the facility has violated section 144.651, subdivision 34.

Sec. 18. Minnesota Statutes 2016, section 144A.10, subdivision 1, is amended to read:

Subdivision 1. **Enforcement authority.** The commissioner of health is the exclusive state agency charged with the responsibility and duty of inspecting all facilities required to be licensed under section 144A.02, and issuing correction orders and imposing fines as provided in this section, Minnesota Rules, chapter 4658, or any other applicable law. The commissioner of health shall enforce the rules established pursuant to sections 144A.01 to 144A.155, subject only to the authority of the Department of Public Safety respecting the enforcement of fire and safety standards in nursing homes and the responsibility of the commissioner of human services under sections 245A.01 to 245A.16 or 252.28.

The commissioner may request and must be given access to relevant information, records, incident reports, or other documents in the possession of a licensed facility if the commissioner considers them necessary for the discharge of responsibilities. For the purposes of inspections and securing information to determine compliance with the licensure laws and rules, the commissioner need not present a release, waiver, or consent of the individual. A nursing home's refusal to cooperate in providing lawfully requested information is grounds for a correction order, a fine according to Minnesota Rules, part 4658.0190, item EE, or

both. The identities of patients or residents must be kept private as defined by section 13.02, subdivision 12.

Sec. 19. Minnesota Statutes 2016, section 144A.44, subdivision 1, is amended to read:

Subdivision 1. **Statement of rights.** A person who receives home care services has these rights:

(1) the right to receive written information in plain language about rights before receiving services, including what to do if rights are violated;

(2) the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards, to take an active part in developing, modifying, and evaluating the plan and services;

(3) the right to be told before receiving services the type and disciplines of staff who will be providing the services, the frequency of visits proposed to be furnished, other choices that are available for addressing home care needs, and the potential consequences of refusing these services;

(4) the right to be told in advance of any recommended changes by the provider in the service plan and to take an active part in any decisions about changes to the service plan;

(5) the right to refuse services or treatment;

(6) the right to know, before receiving services or during the initial visit, any limits to the services available from a home care provider;

(7) the right to be told before services are initiated what the provider charges for the services; to what extent payment may be expected from health insurance, public programs, or other sources, if known; and what charges the client may be responsible for paying;

(8) the right to know that there may be other services available in the community, including other home care services and providers, and to know where to find information about these services;

(9) 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, or other health programs;

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

(11) the right to access the client's own records and written information from those records in accordance with sections 144.291 to 144.298;

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

(13) the right to be treated with courtesy and respect, and to have the client's property treated with respect;

(14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act;

(15) the right to reasonable, advance notice of changes in services or charges;

(16) the right to know the provider's reason for termination of services;

(17) the right to at least ~~ten~~ 15 days' advance notice of the termination of a service by a provider, except in cases where:

(i) the client engages in conduct that significantly alters the terms of the service plan with the home care provider;

(ii) the client, person who lives with the client, or others create an abusive or unsafe work environment for the person providing home care services; ~~or~~

(iii) an emergency or a significant change in the client's condition has resulted in service needs that exceed the current service plan and that cannot be safely met by the home care provider; or

(iv) the client's condition has improved to a point where home care services are deemed by the client's medical provider to no longer be medically necessary;

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

(19) the right to complain to staff about services that are provided, or fail to be provided, and the lack of courtesy or respect to the client or the client's property, and the right to recommend changes in policies and services, free from retaliation, including the threat of termination of services or a service agreement;

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

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

(22) the right to assert these rights personally, or have them asserted by the client's representative or by anyone on behalf of the client, without retaliation~~.~~

(23) the right to notification from the Department of Health regarding a report of alleged maltreatment, disposition of a report, and appeal rights, as provided under section 626.557, subdivision 9c;

(24) the right to Internet service at the person's own expense, unless it is provided by the provider; and

(25) the right to place an electronic monitoring device in the person's own private space, provided the requirements in section 144.6502 are met.

The commissioner shall develop and make available to providers a standard form explaining in plain language the rights specified in this subdivision.

Sec. 20. Minnesota Statutes 2016, section 144A.441, is amended to read:

144A.441 ASSISTED LIVING BILL OF RIGHTS ADDENDUM.

Assisted living clients, as defined in section 144G.01, subdivision 3, shall be provided with the home care bill of rights required by section 144A.44, except that the home care bill of rights provided to these clients must include the following provision in place of the provision in section 144A.44, subdivision 1, clause (17):

"(17) the right to reasonable, advance notice of changes in services or charges, including at least 30 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 as specified in the employment contract between the home care provider and the individual providing home care services, or~~ creates and the home care provider can document an abusive or unsafe work environment for the individual providing home care services;

(ii) a doctor or treating physician, certified nurse practitioner, physician assistant, or registered nurse documents that 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 home care provider; or

(iii) the provider has not received payment for services, for which at least ten days' advance notice of the termination of a service shall be provided."

For participants receiving medical assistance waiver services, the provider must immediately notify the participant's case manager of any termination of services.

Sec. 21. Minnesota Statutes 2016, section 144A.442, is amended to read:

144A.442 ~~ASSISTED LIVING CLIENTS; SERVICE~~ ARRANGED HOME CARE PROVIDER RESPONSIBILITIES; TERMINATION OF SERVICES.

Subdivision 1. **Definition.** For the purposes of this section, "coordinated transfer" means a plan to transfer an assisted living client, as defined in section 144G.01, subdivision 3, to another home care provider that:

(1) considers the needs and wants of the client;

(2) is based on the comprehensive assessment and individual needs of the client;

(3) includes the client, the client's case manager, and the client's representative, if any; and

(4) includes relevant information that allows the new home care provider to successfully meet the needs of the client.

Subd. 2. **Permissible reasons to terminate services; notice required.** (a) An arranged home care provider may terminate services if the home care provider is implementing a plan consistent with the client's assessed needs and a client:

(1) engages in conduct that significantly alters the terms of the service agreement with the home care provider and does not significantly alter the client's conduct within 30 days of receiving written notice of the conduct; or

(2) fails to pay the provider for services that are agreed to in the service agreement.

(b) An arranged home care provider must provide at least 30 days' advanced written notice prior to terminating a service agreement for a reason specified in paragraph (a), clause (1), and at least 10 days' advanced notice for the reason specified in paragraph (a), clause (2).

(c) Notwithstanding paragraphs (a) and (b), the arranged home care provider may terminate services if the client:

(1) creates, and the provider can document, an abusive or unsafe environment for the individual providing home care services or for other residents; or

(2) has a comprehensive assessment by a treating physician, advanced practice registered nurse, or physician assistant that documents, and shows, that an emergency or a significant

change in the client's condition has resulted in service needs that exceed the current service agreement and that cannot be safely met by the home care provider.

An arranged home care provider may not terminate services under this paragraph until the provider has assisted a client with a coordinated transfer.

(d) For participants receiving medical assistance waiver services the provider must immediately notify the participant's case manager of any termination of services.

Subd. 3. **Contents of service termination notice.** If an arranged home care provider, as defined in section 144D.01, subdivision 2a, who is not also Medicare certified terminates a service agreement ~~or service plan~~ with an assisted living client, as defined in section 144G.01, subdivision 3, the home care provider shall provide the assisted living client and the legal or designated representatives of the client, if any, with ~~a~~ advanced written notice of termination ~~which~~, as provided under subdivision 2, that includes the following information:

(1) the effective date of termination;

(2) a detailed explanation of the reason for termination;

(3) without extending the termination notice period, an affirmative offer to meet with the assisted living client or client representatives ~~within no more than five business days of the date of the termination notice~~ to discuss the termination;

(4) contact information for a reasonable number of other home care providers in the geographic area of the assisted living client, as required by section 144A.4791, subdivision 10;

(5) a statement that the provider will participate in a coordinated transfer of the care of the client to another provider or caregiver, as required by section 144A.44, subdivision 1, clause (18);

(6) the name and contact information of a representative of the home care provider with whom the client may discuss the notice of termination;

(7) a copy of the home care bill of rights; ~~and~~

(8) a statement that the notice of termination of home care services by the home care provider does not constitute notice of termination of the housing with services contract with a housing with services establishment;

(9) a statement that the client has the right to avoid termination of services by paying the past due service charges or by curing the alteration of the terms of the service agreement prior to the effective date of service termination;

(10) a statement that the recipient of the notice may contact the Office of the Ombudsman for Long-Term Care for assistance regarding service termination and the address and telephone number of the Office of Ombudsman for Long-Term Care, the Office of Administrative Hearings, and the protection and advocacy agency; and

(11) a statement of the client's right to appeal the service termination to the Office of Administrative Hearings and an explanation about how to request an appeal.

Subd. 4. **Right to appeal service termination.** (a) At any time prior to the expiration of the notice period provided under subdivision 2, paragraph (b), a client may appeal the service termination by making a written request for a hearing to the Office of Administrative Hearings, which must schedule the hearing no later than 14 days after receiving the appeal request. The hearing must be held in the establishment in which the client resides, unless impractical or the parties agree otherwise. A client may not appeal a service termination for the reason specified in subdivision 2, paragraph (a), clause (2). A client may appeal a termination of services for a reason specified in subdivision 2, paragraph (a), clause (1), beginning July 1, 2018, and may appeal a termination of services for a reason specified in subdivision 2, paragraph (c), clause (1) or (2), beginning January 1, 2020.

(b) The arranged home care provider may not discontinue services to a client who makes a timely appeal of a notice of service termination until the Office of Administrative Hearings makes a final determination on the appeal in favor of the arranged home care provider.

(c) Clients are not required to request a meeting as provided under subdivision 3, clause (3), prior to submitting an appeal hearing request.

(d) The commissioner of health may order the arranged home care provider to rescind the service termination if:

(1) the service termination was in violation of state or federal law; or

(2) the client cures the conduct that allegedly altered the terms of the service agreement on or before the date of the administrative hearing.

(e) Nothing in this section limits the right of a client or the client's representative to request or receive assistance from the Office of Ombudsman for Long-Term Care and the protection and advocacy agency concerning the proposed service termination.

Subd. 5. **Assistance with coordinated transfer.** A housing with services establishment with which the client has a contract and the arranged home care provider must assist a client with a coordinated transfer.

EFFECTIVE DATE. This section is effective for all contracts for services entered into or renewed on or after July 1, 2018.

Sec. 22. Minnesota Statutes 2016, section 144A.45, subdivision 1, is amended to read:

Subdivision 1. **Regulations.** The commissioner shall regulate home care providers pursuant to sections 144A.43 to 144A.482. The regulations shall include the following:

(1) provisions to assure, to the extent possible, the health, safety, well-being, and appropriate treatment of persons who receive home care services while respecting a client's autonomy and choice;

(2) requirements that home care providers furnish the commissioner with specified information necessary to implement sections 144A.43 to 144A.482;

(3) standards of training of home care provider personnel;

(4) standards for provision of home care services;

(5) standards for medication management;

(6) standards for supervision of home care services;

(7) standards for client evaluation or assessment;

(8) requirements for the involvement of a client's health care provider, the documentation of health care providers' orders, if required, and the client's service plan;

(9) standards for the maintenance of accurate, current client records;

(10) the establishment of basic and comprehensive levels of licenses based on services provided; and

(11) provisions to enforce these regulations and the home care bill of rights, including provisions for issuing penalties and fines according to section 144A.474, subdivision 11, for violations of sections 144A.43 to 144A.482, and of the home care bill of rights under sections 144A.44 to 144A.441.

Sec. 23. Minnesota Statutes 2016, section 144A.45, subdivision 2, is amended to read:

Subd. 2. **Regulatory functions.** The commissioner shall:

(1) license, survey, and monitor without advance notice, home care providers in accordance with sections 144A.43 to 144A.482;

(2) survey every temporary licensee within one year of the temporary license issuance date subject to the temporary licensee providing home care services to a client or clients;

(3) survey all licensed home care providers on an interval that will promote the health and safety of clients;

(4) with the consent of the client, visit the home where services are being provided;

(5) issue correction orders and assess civil penalties in accordance with ~~section~~ sections 144.653, subdivisions 5 to 8, 144A.474, and 144A.475, for violations of sections 144A.43 to 144A.482, and sections 144A.44 to 144A.441;

(6) take action as authorized in section 144A.475; and

(7) take other action reasonably required to accomplish the purposes of sections 144A.43 to 144A.482.

Sec. 24. Minnesota Statutes 2016, section 144A.474, subdivision 8, is amended to read:

Subd. 8. **Correction orders.** (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a home care provider, a managerial official, or an employee of the provider is not in compliance with sections 144A.43 to 144A.482. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. In addition to issuing a correction order, the commissioner may impose an immediate fine as provided in subdivision 11.

(b) The commissioner shall mail copies of any correction order to the last known address of the home care provider, or electronically scan the correction order and e-mail it to the last known home care provider e-mail address, within 30 calendar days after the survey exit date. A copy of each correction order, the amount of any immediate fine issued, the correction plan, and copies of any documentation supplied to the commissioner shall be kept on file by the home care provider, and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically.

(c) By the correction order date, the home care provider must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed.

Sec. 25. Minnesota Statutes 2016, section 144A.474, subdivision 9, is amended to read:

Subd. 9. **Follow-up surveys.** For providers that have Level 3 or Level 4 violations under subdivision 11, or any violations determined to be widespread, the department shall conduct a follow-up survey within 90 calendar days of the survey. When conducting a follow-up survey, the surveyor will focus on whether the previous violations have been corrected and may also address any new violations that are observed while evaluating the corrections that have been made. If a new violation is identified on a follow-up survey, ~~no fine will be imposed unless it is not corrected on the next follow-up survey~~ the surveyor shall issue a correction order for the new violation and may impose an immediate fine for the new violation.

Sec. 26. Minnesota Statutes 2017 Supplement, section 144A.474, subdivision 11, is amended to read:

Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be assessed based on the level and scope of the violations described in paragraph (c) as follows:

(1) Level 1, no fines or enforcement;

(2) Level 2, fines ranging from $0 to $500, in addition to any of the enforcement mechanisms authorized in section 144A.475 for widespread violations;

(3) Level 3, fines ranging from $500 to $1,000, in addition to any of the enforcement mechanisms authorized in section 144A.475; and

(4) Level 4, fines ranging from $1,000 to $5,000, in addition to any of the enforcement mechanisms authorized in section 144A.475.

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

(1) level of violation:

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

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

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

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

(2) scope of violation:

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

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

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

(c) If the commissioner finds that the applicant or a home care provider required to be licensed under sections 144A.43 to 144A.482 has not corrected violations by the date specified in the correction order or conditional license resulting from a survey or complaint investigation, the commissioner may impose ~~a~~ an additional fine for noncompliance with a correction order. A notice of noncompliance with a correction order must be mailed to the applicant's or provider's last known address. The ~~noncompliance~~ notice of noncompliance with a correction order must list the violations not corrected and any fines imposed.

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

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

(f) A home care provider that has been assessed a fine under this subdivision or subdivision 8 has a right to a reconsideration or a hearing under this section and chapter 14.

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

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

(i) Fines collected under this subdivision shall be deposited in the state government special revenue fund and credited to an account separate from the revenue collected under section 144A.472. Subject to an appropriation by the legislature, the revenue from the fines collected must be used by the commissioner for special projects to improve home care in Minnesota as recommended by the advisory council established in section 144A.4799.

Sec. 27. Minnesota Statutes 2016, section 144A.479, is amended by adding a subdivision to read:

Subd. 2a. **Deceptive marketing and business practices.** Deceptive marketing and business practices by a home care provider are prohibited. For purposes of this subdivision, it is a deceptive practice for a home care provider to engage in any conduct listed in section 144.6511.

Sec. 28. Minnesota Statutes 2016, section 144A.4791, subdivision 10, is amended to read:

Subd. 10. **Termination of service plan.** (a) Except as provided in section 144A.442, if a home care provider terminates a service plan with a client, and the client continues to need home care services, the home care provider shall provide the client and the client's representative, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the reason for termination;

(3) a list of known licensed home care providers in the client's immediate geographic area;

(4) a statement that the home care provider will participate in a coordinated transfer of care of the client to another home care provider, health care provider, or caregiver, as required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);

(5) the name and contact information of a person employed by the home care provider with whom the client may discuss the notice of termination; and

(6) if applicable, a statement that the notice of termination of home care services does not constitute notice of termination of the housing with services contract with a housing with services establishment.

(b) When the home care provider voluntarily discontinues services to all clients, the home care provider must notify the commissioner, lead agencies, and ombudsman for long-term care about its clients and comply with the requirements in this subdivision.

Sec. 29. Minnesota Statutes 2016, section 144A.53, subdivision 1, is amended to read:

Subdivision 1. **Powers.** The director may:

(a) Promulgate by rule, pursuant to chapter 14, and within the limits set forth in subdivision 2, the methods by which complaints against health facilities, health care providers, home care providers, ~~or residential care homes,~~ or administrative agencies are to be made, reviewed, investigated, and acted upon; provided, however, that a fee may not be charged for filing a complaint.

(b) Recommend legislation and changes in rules to the state commissioner of health, governor, administrative agencies or the federal government.

(c) Investigate, upon a complaint or upon initiative of the director, any action or failure to act by a health care provider, home care provider, ~~residential care home,~~ or a health facility.

(d) Request and receive access to relevant information, records, incident reports, or documents in the possession of an administrative agency, a health care provider, a home care provider, ~~a residential care home,~~ or a health facility, and issue investigative subpoenas to individuals and facilities for oral information and written information, including privileged information which the director deems necessary for the discharge of responsibilities. For purposes of investigation and securing information to determine violations, the director need not present a release, waiver, or consent of an individual. The identities of patients or residents must be kept private as defined by section 13.02, subdivision 12.

(e) Enter and inspect, at any time, a health facility ~~or residential care home~~ and be permitted to interview staff; provided that the director shall not unduly interfere with or disturb the provision of care and services within the facility ~~or home~~ or the activities of a patient or resident unless the patient or resident consents.

(f) Issue correction orders and assess civil fines ~~pursuant to section~~ for violations of sections 144.651, 144.653, 144A.10, 144A.44, 144A.45, and 626.557, Minnesota Rules, chapters 4655, 4658, 4664, and 4665, or any other law ~~which~~ that provides for the issuance of correction orders to health facilities or home care provider, or under section 144A.45. The director may use the authority in section 144A.474, subdivision 11, to calculate the fine amount. A facility's or home's refusal to cooperate in providing lawfully requested information within the requested time period may also be grounds for a correction order or fine at a Level 2 fine pursuant to section 144A.474, subdivision 11.

(g) Recommend the certification or decertification of health facilities pursuant to Title XVIII or XIX of the United States Social Security Act.

(h) Assist patients or residents of health facilities ~~or residential care homes~~ in the enforcement of their rights under Minnesota law.

(i) Work with administrative agencies, health facilities, home care providers, residential care homes, and health care providers and organizations representing consumers on programs designed to provide information about health facilities to the public and to health facility residents.

Sec. 30. Minnesota Statutes 2016, section 144A.53, subdivision 4, is amended to read:

Subd. 4. **Referral of complaints.** (a) If a complaint received by the director relates to a matter more properly within the jurisdiction of law enforcement, an occupational licensing board, or other governmental agency, the director shall promptly forward the complaint ~~to that agency~~ appropriately and shall inform the complaining party of the forwarding. ~~The~~

(b) An agency shall promptly act in respect to the complaint, and shall inform the complaining party and the director of its disposition. If a governmental agency receives a complaint which is more properly within the jurisdiction of the director, it shall promptly forward the complaint to the director, and shall inform the complaining party of the forwarding.

(c) If the director has reason to believe that an official or employee of an administrative agency, a home care provider, ~~residential care home, or~~ health facility, or a client or resident of any of these entities has acted in a manner warranting criminal or disciplinary proceedings, the director shall refer the matter to the state commissioner of health, the commissioner of human services, an appropriate prosecuting authority, or other appropriate agency.

Sec. 31. Minnesota Statutes 2016, section 144A.53, is amended by adding a subdivision to read:

Subd. 5. **Safety and quality improvement technical panel.** The director shall establish an expert technical panel to examine and make recommendations, on an ongoing basis, on how to apply proven safety and quality improvement practices and infrastructure to settings and providers that provide long-term services and supports. The technical panel must include representation from nonprofit Minnesota-based organizations dedicated to patient safety or innovation in health care safety and quality, Department of Health staff with expertise in issues related to adverse health events, the University of Minnesota, organizations representing long-term care providers and home care providers in Minnesota, national patient safety experts, and other experts in the safety and quality improvement field. The technical panel shall periodically provide recommendations to the legislature on legislative changes needed to promote safety and quality improvement practices in long-term care settings and with long-term care providers.

Sec. 32. Minnesota Statutes 2016, section 144A.53, is amended by adding a subdivision to read:

Subd. 6. **Training and operations panel.** (a) The director shall establish a training and operations panel within the Office of Health Facility Complaints to examine and make recommendations, on an ongoing basis, on continual improvements to the operation of the office. The training and operations panel shall be composed of office staff, including investigators and intake and triage staff, one or more representatives of the commissioner's office, and employees from any other divisions in the Department of Health with relevant knowledge or expertise. The training and operations panel may also consult with employees from other agencies in state government with relevant knowledge or expertise.

(b) The training and operations panel shall examine and make recommendations to the director and the commissioner regarding introducing or refining office systems, procedures, and staff training in order to improve office and staff efficiency; enhance communications between the office, health care facilities, home care providers, and residents or clients; and provide for appropriate, effective protection for vulnerable adults through rigorous investigations and enforcement of laws. Panel duties include but are not limited to:

(1) developing the office's training processes to adequately prepare and support investigators in performing their duties;

(2) developing clear, consistent internal policies for conducting investigations as required by federal law, including policies to ensure staff meet the deadlines in state and federal laws

for triaging, investigating, and making final dispositions of cases involving maltreatment, and procedures for notifying the vulnerable adult, reporter, and facility of any delays in investigations; communicating these policies to staff in a clear, timely manner; and developing procedures to evaluate and modify these internal policies on an ongoing basis;

(3) developing and refining quality control measures for the intake and triage processes, through such practices as reviewing a random sample of the triage decisions made in case reports or auditing a random sample of the case files to ensure the proper information is being collected, the files are being properly maintained, and consistent triage and investigations determinations are being made;

(4) developing and maintaining systems and procedures to accurately determine the situations in which the office has jurisdiction over a maltreatment allegation;

(5) developing and maintaining audit procedures for investigations to ensure investigators obtain and document information necessary to support decisions;

(6) developing and maintaining procedures to, following a maltreatment determination, clearly communicate the appeal or review rights of all parties upon final disposition; and

(7) continuously upgrading the information on and utility of the office's Web site through such steps as providing clear, detailed information about the appeal or review rights of vulnerable adults, alleged perpetrators, and providers and facilities.

Sec. 33. Minnesota Statutes 2016, section 144A.53, is amended by adding a subdivision to read:

Subd. 7. **Posting maltreatment reports.** (a) The director shall post on the Department of Health Web site the following information for the past five years:

(1) the public portions of all substantiated reports of maltreatment of a vulnerable adult at a facility or by a provider for which the Department of Health is the lead investigative agency under section 626.557; and

(2) whether the facility or provider has requested reconsideration or initiated any type of dispute resolution or appeal of a substantiated maltreatment report.

(b) Following a reconsideration, dispute resolution, or appeal, the director must update the information posted under this subdivision to reflect the results of the reconsideration, dispute resolution, or appeal.

(c) The information posted under this subdivision must be posted in coordination with other divisions or sections at the Department of Health and in a manner that does not duplicate

information already published by the Department of Health, and must be posted in a format that allows consumers to search the information by facility or provider name and by the physical address of the facility or the local business address of the provider.

Sec. 34. Minnesota Statutes 2016, section 144D.01, subdivision 1, is amended to read:

Subdivision 1. **Scope.** As used in ~~sections 144D.01 to 144D.06~~ this chapter, the following terms have the meanings given them.

Sec. 35. Minnesota Statutes 2016, section 144D.02, is amended to read:

144D.02 REGISTRATION REQUIRED.

No entity may establish, operate, conduct, or maintain a housing with services establishment in this state without registering and operating as required in ~~sections 144D.01 to 144D.06~~ this chapter.

Sec. 36. Minnesota Statutes 2017 Supplement, section 144D.04, subdivision 2, is amended to read:

Subd. 2. **Contents of contract.** A housing with services contract, which need not be entitled as such to comply with this section, shall include at least the following elements in itself or through supporting documents or attachments:

(1) the name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;

(4) the name and physical mailing address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;

(5) a statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;

(6) the term of the contract;

(7) a description of the services to be provided to the resident in the base rate to be paid by the resident, including a delineation of the portion of the base rate that constitutes rent and a delineation of charges for each service included in the base rate;

(8) a description of any additional services, including home care services, available for an additional fee from the establishment directly or through arrangements with the establishment, and a schedule of fees charged for these services;

(9) a conspicuous notice informing the tenant of the policy concerning the conditions under which and the process through which the contract may be modified, amended, or terminated, including whether a move to a different room or sharing a room would be required in the event that the tenant can no longer pay the current rent;

(10) a description of the establishment's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;

(11) the resident's designated representative, if any;

(12) the establishment's referral procedures if the contract is terminated;

(13) requirements of residency used by the establishment to determine who may reside or continue to reside in the housing with services establishment;

(14) billing and payment procedures and requirements;

(15) a statement regarding the ability of a resident to receive services from service providers with whom the establishment does not have an arrangement;

(16) a statement regarding the availability of public funds for payment for residence or services in the establishment; ~~and~~

(17) a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the establishment is located;

(18) a statement that a resident has the right to request a reasonable accommodation; and

(19) a statement describing the conditions under which a contract may be amended.

Sec. 37. Minnesota Statutes 2016, section 144D.04, is amended by adding a subdivision to read:

Subd. 2b. **Changes to contract.** The housing with services establishment must provide prompt written notice to the resident or resident's legal representative of a new owner or

manager of the housing with services establishment, and the name and physical mailing address of any new or additional natural person not identified in the admission contract who is authorized to accept service of process.

Sec. 38. **[144D.041] DECEPTIVE MARKETING AND BUSINESS PRACTICES.**

Housing with services establishments are subject to the same prohibitions against deceptive practices as are health care facilities under section 144.6511.

Sec. 39. **[144D.044] INFORMATION REQUIRED TO BE POSTED.**

A housing with services establishment must post conspicuously within the establishment, in a location accessible to public view, the following information:

(1) the name, mailing address, and contact information of the current owner or owners of the establishment and, if the owner or owners are not natural persons, identification of the type of business entity of the owner or owners;

(2) the name, mailing address, and contact information of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners, and the name and contact information of the on-site manager, if any; and

(3) the name and mailing address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent.

Sec. 40. Minnesota Statutes 2016, section 144D.09, is amended to read:

144D.09 TERMINATION OF LEASE.

Subdivision 1. **Notice required.** ~~The~~ (a) A housing with services establishment ~~shall include with notice of termination of lease information about how to contact the ombudsman for long-term care, including the address and telephone number along with a statement of how to request problem-solving assistance.~~that terminates a resident's lease must provide the resident with a notice that includes:

(1) a detailed explanation of the reason for the termination;

(2) the date termination will occur;

(3) the location to which the resident will relocate, if known;

(4) a statement that the resident may contact the Office of the Ombudsman for Long-Term Care regarding the lease termination issues and the address and telephone number of the Office of Ombudsman for Long-Term Care and the protection and advocacy agency;

(5) a statement that the resident has the right to request a meeting with the owner or manager of the housing with services establishment to discuss the lease termination and attempt to avoid termination of the lease; and

(6) a statement that the resident has the right to avoid termination of the lease for nonpayment of rent by paying the rent in full within ten days of receiving written notice of nonpayment.

Subd. 2. **Transfer of information to new residence.** Prior to a resident's involuntary relocation due to a termination of a lease, the housing with services establishment must provide to the facility or establishment to which the resident is relocating, all information known to the establishment and related to the resident that is necessary to ensure continuity of care and services, provided the resident consents to the transfer of information. At a minimum, the information transferred must include:

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

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

(3) the resident's current documented diagnoses;

(4) the resident's known allergies;

(5) the name and telephone number of the resident's physician, advanced practice registered nurse, or physician assistant and their current medical orders, if known;

(6) all medication administration records;

(7) the most recent resident assessment; and

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

Sec. 41. **[144D.095] TERMINATION OF SERVICES.**

A termination of services initiated by an arranged home care provider is governed by section 144A.442.

Sec. 42. Minnesota Statutes 2016, section 144G.01, subdivision 1, is amended to read:

Subdivision 1. **Scope; other definitions.** For purposes of ~~sections 144G.01 to 144G.05~~ this chapter, the following definitions apply. In addition, the definitions provided in section 144D.01 also apply to ~~sections 144G.01 to 144G.05~~ this chapter.

Sec. 43. **[144G.07] TERMINATION OF LEASE.**

A lease termination initiated by a registered housing with services establishment using "assisted living" is governed by section 144D.09.

Sec. 44. **[144G.08] TERMINATION OF SERVICES.**

A termination of services initiated by an arranged home care provider as defined in section 144D.01, subdivision 2a, is governed by section 144A.442.

Sec. 45. Minnesota Statutes 2016, section 325F.71, is amended to read:

325F.71 SENIOR CITIZENS, VULNERABLE ADULTS, AND ~~DISABLED~~ PERSONS WITH DISABILITIES; ADDITIONAL CIVIL PENALTY FOR DECEPTIVE ACTS.

Subdivision 1. **Definitions.** For the purposes of this section, the following words have the meanings given them:

(a) "Senior citizen" means a person who is 62 years of age or older.

(b) "~~Disabled~~ Person with a disability" means a person who has an impairment of physical or mental function or emotional status that substantially limits one or more major life activities.

(c) "Major life activities" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

(d) "Vulnerable adult" has the meaning given in section 626.5572, subdivision 21, except that vulnerable adult does not include an inpatient of a hospital licensed under sections 144.50 to 144.58.

Subd. 2. **Supplemental civil penalty.** (a) In addition to any liability for a civil penalty pursuant to sections 325D.43 to 325D.48, regarding deceptive trade practices; 325F.67, regarding false advertising; and 325F.68 to 325F.70, regarding consumer fraud; a person who engages in any conduct prohibited by those statutes, and whose conduct is perpetrated against one or more senior citizens, vulnerable adults, or ~~disabled~~ persons with a disability, is liable for an additional civil penalty not to exceed $10,000 for each violation, if one or more of the factors in paragraph (b) are present.

(b) In determining whether to impose a civil penalty pursuant to paragraph (a), and the amount of the penalty, the court shall consider, in addition to other appropriate factors, the extent to which one or more of the following factors are present:

(1) whether the defendant knew or should have known that the defendant's conduct was directed to one or more senior citizens, vulnerable adults, or ~~disabled~~ persons with a disability;

(2) whether the defendant's conduct caused one or more senior citizens, vulnerable adults, or ~~disabled~~ persons with a disability to suffer: loss or encumbrance of a primary residence, principal employment, or source of income; substantial loss of property set aside for retirement or for personal or family care and maintenance; substantial loss of payments received under a pension or retirement plan or a government benefits program; or assets essential to the health or welfare of the senior citizen, vulnerable adult, or ~~disabled~~ person with a disability;

(3) whether one or more senior citizens, vulnerable adults, or ~~disabled~~ persons with a disability are more vulnerable to the defendant's conduct than other members of the public because of age, poor health or infirmity, impaired understanding, restricted mobility, or disability, and actually suffered physical, emotional, or economic damage resulting from the defendant's conduct; or

(4) whether the defendant's conduct caused senior citizens, vulnerable adults, or ~~disabled~~ persons with a disability to make an uncompensated asset transfer that resulted in the person being found ineligible for medical assistance.

Subd. 3. **Restitution to be given priority.** Restitution ordered pursuant to the statutes listed in subdivision 2 shall be given priority over imposition of civil penalties designated by the court under this section.

Subd. 4. **Private remedies.** A person injured by a violation of this section may bring a civil action and recover damages, together with costs and disbursements, including costs of investigation and reasonable attorney's fees, and receive other equitable relief as determined by the court.

Sec. 46. Minnesota Statutes 2016, section 609.2231, subdivision 8, is amended to read:

Subd. 8. **Vulnerable adults.** (a) As used in this subdivision, "vulnerable adult" has the meaning given in section 609.232, subdivision 11.

(b) Whoever assaults ~~and inflicts demonstrable bodily harm on~~ a vulnerable adult, knowing or having reason to know that the person is a vulnerable adult, is guilty of a gross misdemeanor.

(c) A person who uses restraints on a vulnerable adult does not violate this subdivision if (1) the person complies with applicable requirements in state and federal law regarding the use of restraints; and (2) any force applied in imposing restraints is reasonable.

EFFECTIVE DATE. This section is effective August 1, 2018, and applies to crimes committed on or after that date.

Sec. 47. Minnesota Statutes 2016, section 626.557, subdivision 3, is amended to read:

Subd. 3. **Timing of report.** (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall ~~immediately~~ report the information to the common entry point as soon as possible but in no event longer than 24 hours. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency

shall consider this information when making an initial disposition of the report under subdivision 9c.

Sec. 48. Minnesota Statutes 2016, section 626.557, subdivision 4, is amended to read:

Subd. 4. **Reporting.** (a) Except as provided in paragraph (b), a mandated reporter shall immediately make an oral report to the common entry point. The common entry point may accept electronic reports submitted through a Web-based reporting system established by the commissioner. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. The common entry point must provide a way to record that the reporter has electronic evidence to submit. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, to the extent necessary to comply with this subdivision.

(b) A boarding care home that is licensed under sections 144.50 to 144.58 and certified under Title 19 of the Social Security Act, a nursing home that is licensed under section 144A.02 and certified under Title 18 or Title 19 of the Social Security Act, or a hospital that is licensed under sections 144.50 to 144.58 and has swing beds certified under Code of Federal Regulations, title 42, section 482.66, may submit a report electronically to the common entry point instead of submitting an oral report. ~~The report may be a duplicate of the initial report the facility submits electronically to the commissioner of health to comply with the reporting requirements under Code of Federal Regulations, title 42, section 483.13.~~ The commissioner of health may modify these reporting requirements to include items required under paragraph (a) that are not currently included in the electronic reporting form.

(c) All reports must be directed to the common entry point, including reports from federally licensed facilities.

Sec. 49. Minnesota Statutes 2016, section 626.557, subdivision 9a, is amended to read:

Subd. 9a. **Evaluation and referral of reports made to common entry point.** (a) The common entry point must screen the reports of alleged or suspected maltreatment for immediate risk and make all necessary referrals as follows:

(1) if the common entry point determines that there is an immediate need for emergency adult protective services, the common entry point agency shall immediately notify the appropriate county agency;

(2) if the common entry point determines an immediate need exists for response by law enforcement or if the report contains suspected criminal activity against a vulnerable adult, the common entry point shall immediately notify the appropriate law enforcement agency;

(3) the common entry point shall refer all reports of alleged or suspected maltreatment to the appropriate lead investigative agency as soon as possible, but in any event no longer than two working days;

(4) if the report contains information about a suspicious death, the common entry point shall immediately notify the appropriate law enforcement agencies, the local medical examiner, and the ombudsman for mental health and developmental disabilities established under section 245.92. Law enforcement agencies shall coordinate with the local medical examiner and the ombudsman as provided by law; and

(5) for reports involving multiple locations or changing circumstances, the common entry point shall determine the county agency responsible for emergency adult protective services and the county responsible as the lead investigative agency, using referral guidelines established by the commissioner.

(b) If the lead investigative agency receiving a report believes the report was referred by the common entry point in error, the lead investigative agency shall immediately notify the common entry point of the error, including the basis for the lead investigative agency's belief that the referral was made in error. The common entry point shall review the information submitted by the lead investigative agency and immediately refer the report to the appropriate lead investigative agency.

Sec. 50. Minnesota Statutes 2016, section 626.557, subdivision 9b, is amended to read:

Subd. 9b. **Response to reports.** Law enforcement is the primary agency to conduct investigations of any incident in which there is reason to believe a crime has been committed. Law enforcement shall initiate a response immediately. If the common entry point notified a county agency for emergency adult protective services, law enforcement shall cooperate with that county agency when both agencies are involved and shall exchange data to the extent authorized in subdivision 12b, paragraph ~~(g)~~ (k). County adult protection shall initiate a response immediately. Each lead investigative agency shall complete the investigative process for reports within its jurisdiction. A lead investigative agency, county, adult protective

agency, licensed facility, or law enforcement agency shall cooperate with other agencies in the provision of protective services, coordinating its investigations, and assisting another agency within the limits of its resources and expertise and shall exchange data to the extent authorized in subdivision 12b, paragraph ~~(g)~~ (k). The lead investigative agency shall obtain the results of any investigation conducted by law enforcement officials, and law enforcement shall obtain the results of any investigation conducted by the lead investigative agency to determine if criminal action is warranted. The lead investigative agency has the right to enter facilities and inspect and copy records as part of investigations. The lead investigative agency has access to not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, that are maintained by facilities to the extent necessary to conduct its investigation. Each lead investigative agency shall develop guidelines for prioritizing reports for investigation. Nothing in this subdivision alters the duty of the lead investigative agency to serve as the agency responsible for investigating reports made under this section.

Sec. 51. Minnesota Statutes 2016, section 626.557, subdivision 9c, is amended to read:

Subd. 9c. **Lead investigative agency; notifications, dispositions, determinations.** (a) ~~Upon request of the reporter,~~ The lead investigative agency shall notify the reporter that it has received the report, and provide information on the initial disposition of the report within five business days of receipt of the report, provided that the notification will not endanger the vulnerable adult or hamper the investigation.

(b) Except to the extent prohibited by federal law, when the Department of Health is the lead investigative agency, the agency must provide the following information to the vulnerable adult or the vulnerable adult's guardian or health care agent, if known, within five days after the initiation of an investigation, provided that the provision of the information will not hamper the investigation or harm the vulnerable adult:

(1) the maltreatment allegations by types: abuse, neglect, financial exploitation, and drug diversion;

(2) the name of the facility or other location at which alleged maltreatment occurred;

(3) the dates of the alleged maltreatment if identified in the report at the time of the lead investigative agency disclosure;

(4) the name and contact information for the investigator or other information as requested and allowed under law; and

(5) confirmation of whether the lead investigative agency is investigating the matter and, if so:

(i) an explanation of the process;

(ii) an estimated timeline for the investigation;

(iii) a notification that the vulnerable adult or the vulnerable adult's guardian or health care agent may electronically submit evidence to support the maltreatment report, including but not limited to photographs, videos, and documents; and

(iv) a statement that the lead investigative agency will provide an update on the investigation upon request by the vulnerable adult or the vulnerable adult's guardian or health care agent and a report when the investigation is concluded.

(c) If the Minnesota Department of Health is the lead investigative agency, the Department of Health shall provide maltreatment information, to the extent allowed under state and federal law, including any reports, upon request of the vulnerable adult that is the subject of a maltreatment report or upon request of that vulnerable adult's guardian or health care agent.

(d) If the common entry point data indicates that the reporter has electronic evidence, the lead investigative agency shall seek to receive such evidence prior to making a determination that the lead investigative agency will not investigate the matter. Nothing in this provision requires the lead investigative agency to stop investigating prior to receipt of the electronic evidence nor prevents the lead investigative agency from closing the investigation prior to receipt of the electronic evidence if, in the opinion of the investigator, the evidence is not necessary to the determination.

(e) The lead investigative agency may assign multiple reports of maltreatment for the same or separate incidences related to the same vulnerable adult to the same investigator, as deemed appropriate.

(f) Reports related to the same vulnerable adult, the same incident, or the same alleged perpetrator, facility, or licensee must be cross-referenced.

(g) Upon conclusion of every investigation it conducts, the lead investigative agency shall make a final disposition as defined in section 626.5572, subdivision 8.

~~(e)~~ (h) When determining whether the facility or individual is the responsible party for substantiated maltreatment or whether both the facility and the individual are responsible for substantiated maltreatment, the lead investigative agency shall consider at least the following mitigating factors:

(1) whether the actions of the facility or the individual caregivers were in accordance with, and followed the terms of, an erroneous physician order, prescription, resident care plan, or directive. This is not a mitigating factor when the facility or caregiver is responsible for the issuance of the erroneous order, prescription, plan, or directive or knows or should have known of the errors and took no reasonable measures to correct the defect before administering care;

(2) the comparative responsibility between the facility, other caregivers, and requirements placed upon the employee, including but not limited to, the facility's compliance with related regulatory standards and factors such as the adequacy of facility policies and procedures, the adequacy of facility training, the adequacy of an individual's participation in the training, the adequacy of caregiver supervision, the adequacy of facility staffing levels, and a consideration of the scope of the individual employee's authority; and

(3) whether the facility or individual followed professional standards in exercising professional judgment.

~~(d)~~ (i) When substantiated maltreatment is determined to have been committed by an individual who is also the facility license holder, both the individual and the facility must be determined responsible for the maltreatment, and both the background study disqualification standards under section 245C.15, subdivision 4, and the licensing actions under section 245A.06 or 245A.07 apply.

~~(e)~~ (j) The lead investigative agency shall complete its final disposition within 60 calendar days. If the lead investigative agency is unable to complete its final disposition within 60 calendar days, the lead investigative agency shall notify the following persons provided that the notification will not endanger the vulnerable adult or hamper the investigation: (1) the vulnerable adult or the vulnerable adult's guardian or health care agent, when known, if the lead investigative agency knows them to be aware of the investigation; and (2) the facility, where applicable. The notice shall contain the reason for the delay and the projected completion date. If the lead investigative agency is unable to complete its final disposition by a subsequent projected completion date, the lead investigative agency shall again notify the vulnerable adult or the vulnerable adult's guardian or health care agent, when known if the lead investigative agency knows them to be aware of the investigation, and the facility, where applicable, of the reason for the delay and the revised projected completion date provided that the notification will not endanger the vulnerable adult or hamper the investigation. The lead investigative agency must notify the health care agent of the vulnerable adult only if the health care agent's authority to make health care decisions for the vulnerable adult is currently effective ~~under section 145C.06~~ and not suspended under

section 524.5-310 ~~and the investigation relates to a duty assigned to the health care agent by the principal~~. A lead investigative agency's inability to complete the final disposition within 60 calendar days or by any projected completion date does not invalidate the final disposition.

~~(f)~~ (k) Within ten calendar days of completing the final disposition, the lead investigative agency shall provide a copy of the public investigation memorandum under subdivision 12b, paragraph ~~(b), clause (1)~~ (d), when required to be completed under this section, to the following persons:

(1) the vulnerable adult, or the vulnerable adult's guardian or health care agent, if known, unless the lead investigative agency knows that the notification would endanger the well-being of the vulnerable adult;

(2) the reporter, ~~if~~ unless the reporter requested ~~notification~~ otherwise when making the report, provided this notification would not endanger the well-being of the vulnerable adult;

(3) the alleged perpetrator, if known;

(4) the facility; ~~and~~

(5) the ombudsman for long-term care, or the ombudsman for mental health and developmental disabilities, as appropriate;

(6) law enforcement; and

(7) the county attorney, as appropriate.

~~(g)~~ (l) If, as a result of a reconsideration, review, or hearing, the lead investigative agency changes the final disposition, or if a final disposition is changed on appeal, the lead investigative agency shall notify the parties specified in paragraph ~~(f)~~ (h).

~~(h)~~ (m) The lead investigative agency shall notify the vulnerable adult who is the subject of the report or the vulnerable adult's guardian or health care agent, if known, and any person or facility determined to have maltreated a vulnerable adult, of their appeal or review rights under this section or section 256.021.

~~(i)~~ (n) The lead investigative agency shall routinely provide investigation memoranda for substantiated reports to the appropriate licensing boards. These reports must include the names of substantiated perpetrators. The lead investigative agency may not provide investigative memoranda for inconclusive or false reports to the appropriate licensing boards unless the lead investigative agency's investigation gives reason to believe that there may have been a violation of the applicable professional practice laws. If the investigation

memorandum is provided to a licensing board, the subject of the investigation memorandum shall be notified and receive a summary of the investigative findings.

~~(j)~~ (o) In order to avoid duplication, licensing boards shall consider the findings of the lead investigative agency in their investigations if they choose to investigate. This does not preclude licensing boards from considering other information.

~~(k)~~ (p) The lead investigative agency must provide to the commissioner of human services its final dispositions, including the names of all substantiated perpetrators. The commissioner of human services shall establish records to retain the names of substantiated perpetrators.

Sec. 52. Minnesota Statutes 2016, section 626.557, subdivision 12b, is amended to read:

Subd. 12b. **Data management.** (a) In performing any of the duties of this section as a lead investigative agency, the county social service agency shall maintain appropriate records. Data collected by the county social service agency under this section are welfare data under section 13.46. Notwithstanding section 13.46, subdivision 1, paragraph (a), data under this paragraph that are inactive investigative data on an individual who is a vendor of services are private data on individuals, as defined in section 13.02. The identity of the reporter may only be disclosed as provided in paragraph ~~(c)~~ (g).

(b) Data maintained by the common entry point are ~~confidential~~ private data on individuals or ~~protected~~ nonpublic data as defined in section 13.02, provided that the name of the reporter is confidential data on individuals. Notwithstanding section 138.163, the common entry point shall maintain data for three calendar years after date of receipt and then destroy the data unless otherwise directed by federal requirements.

~~(b)~~ (c) The commissioners of health and human services shall prepare an investigation memorandum for each report alleging maltreatment investigated under this section. County social service agencies must maintain private data on individuals but are not required to prepare an investigation memorandum. During an investigation by the commissioner of health or the commissioner of human services, data collected under this section are confidential data on individuals or protected nonpublic data as defined in section 13.02, provided that data, other than data on the reporter, may be shared with the vulnerable adult or guardian or health care agent if the lead investigative agency determines that sharing of the data is needed to protect the vulnerable adult. Upon completion of the investigation, the data are classified as provided in ~~clauses (1) to (3) and paragraph (c)~~ paragraphs (d) to (g).

~~(1)~~ (d) The investigation memorandum must contain the following data, which are public:

~~(i)~~ (1) the name of the facility investigated;

~~(ii)~~ (2) a statement of the nature of the alleged maltreatment;

~~(iii)~~ (3) pertinent information obtained from medical or other records reviewed;

~~(iv)~~ (4) the identity of the investigator;

~~(v)~~ (5) a summary of the investigation's findings;

~~(vi)~~ (6) statement of whether the report was found to be substantiated, inconclusive, false, or that no determination will be made;

~~(vii)~~ (7) a statement of any action taken by the facility;

~~(viii)~~ (8) a statement of any action taken by the lead investigative agency; and

~~(ix)~~ (9) when a lead investigative agency's determination has substantiated maltreatment, a statement of whether an individual, individuals, or a facility were responsible for the substantiated maltreatment, if known.

The investigation memorandum must be written in a manner which protects the identity of the reporter and of the vulnerable adult and may not contain the names or, to the extent possible, data on individuals or private data on individuals listed in ~~clause (2)~~ paragraph (e).

~~(2)~~ (e) Data on individuals collected and maintained in the investigation memorandum are private data on individuals, including:

~~(i)~~ (1) the name of the vulnerable adult;

~~(ii)~~ (2) the identity of the individual alleged to be the perpetrator;

~~(iii)~~ (3) the identity of the individual substantiated as the perpetrator; and

~~(iv)~~ (4) the identity of all individuals interviewed as part of the investigation.

~~(3)~~ (f) Other data on individuals maintained as part of an investigation under this section are private data on individuals upon completion of the investigation.

~~(c)~~ (g) After the assessment or investigation is completed, the name of the reporter must be confidential~~.~~, except:

(1) the subject of the report may compel disclosure of the name of the reporter only with the consent of the reporter; or

(2) upon a written finding by a court that the report was false and there is evidence that the report was made in bad faith.

This subdivision does not alter disclosure responsibilities or obligations under the Rules of Criminal Procedure, except that where the identity of the reporter is relevant to a criminal prosecution, the district court shall do an in-camera review prior to determining whether to order disclosure of the identity of the reporter.

~~(d)~~ (h) Notwithstanding section 138.163, data maintained under this section by the commissioners of health and human services must be maintained under the following schedule and then destroyed unless otherwise directed by federal requirements:

(1) data from reports determined to be false, maintained for three years after the finding was made;

(2) data from reports determined to be inconclusive, maintained for four years after the finding was made;

(3) data from reports determined to be substantiated, maintained for seven years after the finding was made; and

(4) data from reports which were not investigated by a lead investigative agency and for which there is no final disposition, maintained for three years from the date of the report.

~~(e)~~ (i) The commissioners of health and human services shall annually publish on their Web sites the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigation under this section, and the resolution of those investigations. On a biennial basis, the commissioners of health and human services shall jointly report the following information to the legislature and the governor:

(1) the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigations under this section, the resolution of those investigations, and which of the two lead agencies was responsible;

(2) trends about types of substantiated maltreatment found in the reporting period;

(3) ~~if there are upward trends for types of maltreatment substantiated,~~ recommendations for preventing, addressing, and responding to ~~them~~ substantiated maltreatment;

(4) efforts undertaken or recommended to improve the protection of vulnerable adults;

(5) whether and where backlogs of cases result in a failure to conform with statutory time frames and recommendations for reducing backlogs if applicable;

(6) recommended changes to statutes affecting the protection of vulnerable adults; and

(7) any other information that is relevant to the report trends and findings.

~~(f)~~ (j) Each lead investigative agency must have a record retention policy.

~~(g)~~ (k) Lead investigative agencies, prosecuting authorities, and law enforcement agencies may exchange not public data, as defined in section 13.02, if the agency or authority requesting the data determines that the data are pertinent and necessary to the requesting agency in initiating, furthering, or completing an investigation under this section. Data collected under this section must be made available to prosecuting authorities and law enforcement officials, local county agencies, and licensing agencies investigating the alleged maltreatment under this section. The lead investigative agency shall exchange not public data with the vulnerable adult maltreatment review panel established in section 256.021 if the data are pertinent and necessary for a review requested under that section. Notwithstanding section 138.17, upon completion of the review, not public data received by the review panel must be destroyed.

~~(h)~~ (l) Each lead investigative agency shall keep records of the length of time it takes to complete its investigations.

~~(i)~~ (m) Notwithstanding paragraph (a) or (b), a lead investigative agency may share common entry point or investigative data and may notify other affected parties, including the vulnerable adult and their authorized representative, if the lead investigative agency has reason to believe maltreatment has occurred and determines the information will safeguard the well-being of the affected parties or dispel widespread rumor or unrest in the affected facility.

~~(j)~~ (n) Under any notification provision of this section, where federal law specifically prohibits the disclosure of patient identifying information, a lead investigative agency may not provide any notice unless the vulnerable adult has consented to disclosure in a manner which conforms to federal requirements.

Sec. 53. Minnesota Statutes 2016, section 626.557, subdivision 14, is amended to read:

Subd. 14. **Abuse prevention plans.** (a) Each facility, except home health agencies and personal care ~~attendant services providers~~ assistance provider agencies, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.

(b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.

(c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.

(d) The commissioner of health must issue a correction order and may impose an immediate fine in an amount equal to the amount listed in Minnesota Rules, part 4658.0193, item E, upon a finding that the facility has failed to comply with this subdivision.

Sec. 54. Minnesota Statutes 2016, section 626.557, subdivision 17, is amended to read:

Subd. 17. **Retaliation prohibited.** (a) A facility or person shall not retaliate against any person who reports in good faith suspected maltreatment pursuant to this section, or against a vulnerable adult with respect to whom a report is made, because of the report.

(b) In addition to any remedies allowed under sections 181.931 to 181.935, any facility or person which retaliates against any person because of a report of suspected maltreatment is liable to that person for actual damages, punitive damages up to $10,000, and attorney fees.

(c) There shall be a rebuttable presumption that any adverse action, as defined below, within 90 days of a report, is retaliatory. For purposes of this ~~clause~~ paragraph, the term "adverse action" refers to action taken by a facility or person involved in a report against the person making the report or the person with respect to whom the report was made because of the report, and includes, but is not limited to:

(1) discharge or transfer from the facility;

(2) discharge from or termination of employment;

(3) demotion or reduction in remuneration for services;

(4) restriction or prohibition of access to the facility or its residents; or

(5) any restriction of rights set forth in section 144.651, 144A.44, or 144A.441.

Sec. 55. **ASSISTED LIVING LICENSURE AND DEMENTIA CARE TASK FORCE.**

Subdivision 1. **Creation.** (a) The Assisted Living Licensure and Dementia Care Task Force consists of 15 members, including the following:

(1) one senator appointed by the majority leader;

(2) one senator appointed by the minority leader;

(3) one member of the house of representatives appointed by the speaker of the house;

(4) one member of the house of representatives appointed by the minority leader;

(5) the ombudsman for long-term care or a designee;

(6) the ombudsman for mental health and developmental disabilities or a designee;

(7) one member appointed by ARRM;

(8) one member appointed by AARP Minnesota;

(9) one member appointed by the Alzheimer's Association Minnesota-North Dakota Chapter;

(10) one member appointed by Elder Voice Family Advocates;

(11) one member appointed by Minnesota Elder Justice Center;

(12) one member appointed by Care Providers of Minnesota;

(13) one member appointed by LeadingAge Minnesota;

(14) one member appointed by Minnesota HomeCare Association; and

(15) one member appointed by the Minnesota Commission on Disability.

(b) The appointing authorities must appoint members by July 1, 2018.

(c) The ombudsman for long-term care or a designee shall act as chair of the task force and convene the first meeting no later than August 1, 2018.

Subd. 2. **Duties; recommendations.** (a) The assisted living and dementia care licensing task force shall consider and make recommendations on a new regulatory framework for

assisted living establishments and dementia care. In developing the licensing framework, the task force must address at least the following:

(1) the appropriate level of regulation, including licensure, registration, or certification;

(2) coordination of care;

(3) the scope of care to be provided and limits on acuity levels of residents;

(4) consumer rights;

(5) building design and physical environment;

(6) dietary services;

(7) support services;

(8) transition planning;

(9) the installation and use of electronic monitoring in settings in which assisted living or dementia care services are provided;

(10) staff training and qualifications;

(11) options for the engagement of seniors and their families;

(12) notices and financial requirements;

(13) compliance with federal Medicaid waiver requirements for home and community-based services settings;

(14) policies for providing advance notice to patients and residents of changes in services or charges unrelated to changes in patient or resident service or care needs;

(15) survey frequency for home care providers;

(16) terminations of services and lease terminations;

(17) appeals of terminations of services and leases; and

(18) relocations within a housing with services establishment or assisted living setting.

(b) The task force shall also:

(1) develop standards in the following areas that nursing homes, boarding care homes, and housing with services establishments offering care for clients diagnosed with Alzheimer's disease or other dementias must meet in order to obtain dementia care certification, including staffing, egress control, access to secured outdoor spaces, specialized therapeutic activities, and specialized life enrichment programming;

(2) develop requirements for disclosing dementia care certification standards to consumers; and

(3) develop mechanisms for enforcing dementia care certification standards.

(c) Facilities and providers licensed by the commissioner of human services shall be exempt from licensing requirements for assisted living recommended under this section.

Subd. 3. **Meetings.** The commissioner of health or a designee shall convene the first meeting of the task force no later than August 1, 2018. The members of the task force shall elect a chair from among the task force's members at the first meeting, and the commissioner of health or a designee shall serve as the task force's chair until a chair is elected. Meetings of the task force shall be open to the public.

Subd. 4. **Compensation.** Members of the task force appointed under subdivision 1, paragraph (b), shall serve without compensation or reimbursement for expenses.

Subd. 5. **Administrative support.** The commissioner of health shall provide administrative support for the task force and arrange meeting space.

Subd. 6. **Report.** By February 1, 2019, the task force must submit an interim report with findings, recommendations, and draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance. By January 15, 2020, the task force must submit a final report with findings, recommendations, and draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

Subd. 7. **Expiration.** The task force expires January 16, 2020, or the day after the task force submits the final report required under subdivision 6, whichever is later.

Sec. 56. **ASSISTED LIVING REPORT CARD WORKING GROUP.**

Subdivision 1. **Establishment; membership.** (a) An assisted living report card working group, tasked with researching and making recommendations on the development of an assisted living report card, is established.

(b) The commissioner of human services shall appoint the following members of the working group:

(1) two persons who reside in senior housing with services establishments, one residing in an establishment in the seven-county metropolitan area and one residing in an establishment outside the seven-county metropolitan area;

(2) four representatives of the senior housing with services profession, two providing services in the seven-county metropolitan area and two providing services outside the seven-county metropolitan area;

(3) one family member of a person who resides in a senior housing with services establishment in the seven-county metropolitan area, and one family member of a person who resides in a senior housing with services establishment outside the seven-county metropolitan area;

(4) a representative from the Home Care and Assisted Living Program Advisory Council;

(5) a representative from the University of Minnesota with expertise in data and analytics;

(6) a representative from Care Providers of Minnesota; and

(7) a representative from LeadingAge Minnesota.

(c) The following individuals shall also be appointed to the working group:

(1) the commissioner of human services or a designee;

(2) the commissioner of health or a designee;

(3) the ombudsman for long-term care or a designee;

(4) one member of the Minnesota Board on Aging, appointed by the board; and

(5) the executive director of the Minnesota Board on Aging who shall serve on the working group as a nonvoting member.

(d) The appointing authorities under this subdivision must complete the appointments no later than July 1, 2018.

Subd. 2. **Duties.** The assisted living report card working group shall consider and make recommendations on the development of an assisted living report card. The quality metrics considered shall include, but are not limited to:

(1) an annual customer satisfaction survey measure using the CoreQ questions for assisted-living residents and family members;

(2) a measure utilizing level 3 or 4 citations from Department of Health home care survey findings and substantiated Office of Health Facility Complaints findings against a home care provider;

(3) a home care staff retention measure; and

(4) a measure that scores a provider's staff according to their level of training and education.

Subd. 3. **Meetings.** The commissioner of human services or a designee shall convene the first meeting of the working group no later than August 1, 2018. The members of the working group shall elect a chair from among the group's members at the first meeting, and the commissioner of human services or a designee shall serve as the working group's chair until a chair is elected. Meetings of the working group shall be open to the public.

Subd. 4. **Compensation.** Members of the working group shall serve without compensation or reimbursement for expenses.

Subd. 5. **Administrative support.** The commissioner of human services shall provide administrative support and arrange meeting space for the working group.

Subd. 6. **Report.** By January 15, 2019, the working group must submit a report with findings, recommendations, and draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

Subd. 7. **Expiration.** The working group expires January 16, 2019, or the day after the working group submits the report required in subdivision 6, whichever is later.

Sec. 57. **CRIMES AGAINST VULNERABLE ADULTS ADVISORY TASK FORCE.**

Subdivision 1. **Task force established; membership.** (a) The Crimes Against Vulnerable Adults Advisory Task Force consists of the following members:

(1) the commissioner of public safety or a designee;

(2) the commissioner of human services or a designee;

(3) the commissioner of health or a designee;

(4) the attorney general or a designee;

(5) a representative from the Minnesota Bar Association;

(6) a representative from the Minnesota judicial branch;

(7) one member appointed by the Minnesota County Attorneys Association;

(8) one member appointed by the Minnesota Association of City Attorneys;

(9) one member appointed by the Minnesota Elder Justice Center;

(10) one member appointed by the Minnesota Home Care Association;

(11) one member appointed by Care Providers of Minnesota;

(12) one member appointed by LeadingAge Minnesota;

(13) one member appointed by ARC Minnesota;

(14) one member appointed by AARP Minnesota; and

(15) one representative from a union that represents persons working in long-term care settings.

(b) The advisory task force may appoint additional members that it deems would be helpful in carrying out its duties under subdivision 2.

(c) The appointing authorities must complete the appointments listed in paragraph (a) by July 1, 2018.

(d) At its first meeting, the task force shall elect a chair from among the members listed in paragraph (a).

Subd. 2. **Duties; recommendations and report.** (a) The advisory task force's duties are to review and evaluate laws relating to crimes against vulnerable adults, and any other information the task force deems relevant.

(b) By December 1, 2018, the advisory task force shall submit a report to the chairs and ranking minority members of the legislative committees with primary jurisdiction over health and human services and criminal policy. The report must contain the task force's findings and recommendations, including discussion of the benefits and problems associated with proposed changes. The report must include draft legislation to implement any recommended changes to statute.

Subd. 3. **Administrative provisions.** (a) The commissioner of human services shall provide meeting space and administrative support to the advisory task force.

(b) The commissioners of human services and health and the attorney general shall provide technical assistance to the advisory task force.

(c) Advisory task force members shall serve without compensation and shall not be reimbursed for expenses.

Subd. 4. **Expiration.** The advisory task force expires on May 20, 2019.

Sec. 58. **DIRECTION TO COMMISSIONER OF HEALTH; PROGRESS IN IMPLEMENTING RECOMMENDATIONS OF LEGISLATIVE AUDITOR.**

By March 1, 2019, the commissioner of health must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health, human services, or aging on the progress toward implementing each recommendation of the Office of the Legislative Auditor with which the commissioner agreed in the commissioner's letter to the legislative auditor dated March 1, 2018. The commissioner shall include in the report existing data collected in the course of the commissioner's continuing oversight of the Office of Health Facility Complaints sufficient to demonstrate the implementation of the recommendations with which the commissioner agreed.

Sec. 59. **REPORTS; OFFICE OF HEALTH FACILITY COMPLAINTS' RESPONSE TO VULNERABLE ADULT MALTREATMENT ALLEGATIONS.**

(a) On a quarterly basis until January 2021, and annually thereafter, the commissioner of health must publish on the Department of Health Web site, a report on the Office of Health Facility Complaints' response to allegations of maltreatment of vulnerable adults. The report must include:

(1) a description and assessment of the office's efforts to improve its internal processes and compliance with federal and state requirements concerning allegations of maltreatment of vulnerable adults, including any relevant timelines;

(2)(i) the number of reports received by type of reporter; (ii) the number of reports investigated; (iii) the percentage and number of reported cases awaiting triage; (iv) the number and percentage of open investigations; (v) the number and percentage of reports that have failed to meet state or federal timelines for triaging, investigating, or making a final disposition of an investigation by cause of delay; and (vi) processes the office will implement to bring the office into compliance with state and federal timelines for triaging, investigating, and making final dispositions of investigations;

(3) a trend analysis of internal audits conducted by the office; and

(4) trends and patterns in maltreatment of vulnerable adults, licensing violations by facilities or providers serving vulnerable adults, and other metrics as determined by the commissioner.

(b) The commissioner shall maintain on the Department of Health Web site reports published under this section for at least the past three years.

Sec. 60. **REPORT; SAFETY AND QUALITY IMPROVEMENT PRACTICES.**

By January 15, 2019, the safety and quality improvement technical panel established under Minnesota Statutes, section 144A.53, subdivision 5, shall provide recommendations to the legislature on legislative changes needed to promote safety and quality improvement practices in long-term care settings and with long-term care providers. The recommendations must address:

(1) how to implement a system for adverse health events reporting, learning, and prevention in long-term care settings and with long-term care providers; and

(2) interim actions to improve systems for the timely analysis of reports and complaints submitted to the Office of Health Facility Complaints to identify common themes and key prevention opportunities, and to disseminate key findings to providers across the state for the purposes of shared learning and prevention.

Sec. 61. **REPEALER.**

Minnesota Statutes 2016, section 144A.479, subdivision 2, is repealed."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly