MINNESOTA
ELDER JUSTICE
CENTER

January 16, 2017

The Honorable Peggy Scott
Chair, Civil Law & Data Practices Policy

The Honorable John Lesch
Ranking Member, Civil Law& Data Practices Policy

The Honorable Matt Dean
Chair, HHS Finance

The Honorable Erin Murphy
Ranking Member, HHS Finance

The Honorable Joe Schomacker
Chair, HHS Reform

The Honorable Tina Liebling
Ranking Member, HHS Reform

The Honorable Debra Kiel
Chair, Subcommittee on Aging and Long-Term Care

The Honorable Susan Allen
Ranking Member, Subcommittee on Aging and Long-Term Care

The Honorable Karin Housley
Chair, Aging and Long-Term Care Policy

The Honorable Kent Eken
Ranking Member, Aging and Long-Term Care Policy

The Honorable Michelle Benson
Chair, Health and Human Services Finance and Policy

The Honorable Tony Lourey
Ranking Member, HHS Finance and Policy

The Honorable Jim Abeler
Chair, Human Services Reform Finance and Policy

The Honorable Jeff Hayden
Ranking Member, Human Services Reform Finance & Policy

The Honorable Warren Limmer
Chair, Judiciary and Public Safety Finance and Policy

The Honorable Ron Latz
Ranking Member, Judiciary & Public Safety Finance & Policy

Committee Chairs and Ranking Members,

Attached you will find the Residential Care and Services Electronic Monitoring Work Group Final Report. The Residential Care and Services Electronic Monitoring Work Group was established during the 2016 legislative session (Laws of Minnesota 2016, Chapter 179, section 39; https://www.revisor.mn.gov/laws/?year=2016&type=0&doctype=Chapter&id=179).

The work group was established to create recommendations for legislation that authorizes the use of voluntary electronic monitoring to protect vulnerable adults and hold accountable perpetrators of abuse. Per statute, the work group submits this report to the chairs and ranking minority members of the legislative committees with jurisdiction over civil law, judiciary, and health and human services.

Sincerely,

Amanda Vickstrom

Amanda Vickstrom
Chair, Residential Care and Services Electronic Monitoring Work Group
Executive Director, Minnesota Elder Justice Center

Work Group Recommendation and Executive Summary

The Residential Care and Services Electronic Monitoring Work Group was established to create recommendations for legislation that authorizes the use of voluntary electronic monitoring to protect vulnerable adults and hold accountable perpetrators of abuse.

Electronic monitoring to protect vulnerable adults involves many important and complex policy issues. In recognition of these complexities, this report does not make a recommendation regarding any specific legislation, but rather identifies key issues that lawmakers should consider if developing a legislative proposal. The report provides an overview of electronic monitoring, current law in Minnesota, laws in other states, and recommendations around the key issues identified by the work group. The work group had broad representation with varying viewpoints, which allowed for rich discussion of the issues the group researched and analyzed. As the report reflects, the group reached consensus on some but not all of the issues it debated, and the group identified several other issues that it viewed as important but did not have time available to analyze in detail.

While this report does not recommend any specific legislation, there are key issues that lawmakers should consider if developing a legislative proposal. Details and recommendations on those key issues are found on the subsequent pages. Overall, the work group desires to define an easy process for residents and families to utilize voluntary electronic surveillance. No member of the work group advocated for electronic monitoring to be prohibited. The work group did not meet consensus that specific legislation should be passed, however there was consensus that if legislation is drafted, lawmakers should consider the issues detailed in this report. Some families and advocates fear that creating legislation, while intended to specifically allow for electronic monitoring, may limit the abilities individuals and families currently have to monitor the care their loved one is receiving. However, others feel that not creating specific legislative authority around this issue may allow for ambiguity to continue, specifically around consent and privacy.

In addition, the work group recommends that the creation of an educational guide would clarify for residents and families, as well as for facilities and other advocates, what is allowed under law related to electronic monitoring. This guide could outline the responsibilities of anyone wishing to install an electronic monitoring device as well as some best-use practices. In addition, the guide could more broadly include information on how to address concerns related to maltreatment, the options available to report suspected maltreatment, information about the Ombudsman program, and information about long term care services. Several members of the public, as well as work group members, noted that the long term care system is complex, with systems and regulations difficult to navigate and understand.

Purpose and Approach

The Residential Care and Services Electronic Monitoring Group was established during the 2016 legislative session (See Attachment A; Laws of Minnesota 2016, Chapter 179, section 39; https://www.revisor.mn.gov/laws/?year=2016&type=0&doctype=Chapter&id=179).

The work group was established to create recommendations for legislation that authorizes the use of voluntary electronic monitoring to protect vulnerable children and adults and hold accountable perpetrators of abuse. The work group consulted with the legislation's author, and confirmed the intent was to focus specifically on vulnerable adults. Therefore, the work group addressed recommended guidelines for electronic monitoring of vulnerable adults, and not children. The work group felt necessary representation and expertise regarding children was absent from the work group, and that topic should be explored through a different work group.

The work group began meeting on June 22, 2016 and met 10 times over a period of 6 months. Meetings included expert presentations, group conversation and debate, and public comment.

It is important to note that this work group's recommendations are not related to other statutes (Minn. Stat. section 245A.11, subdivision 7, paragraph (3), and subdivision 7a) that authorize the Minnesota Department of Human Services to allow certain DHS-licensed providers to use voluntary electronic monitoring technology as an alternative to overnight staff supervision, under specified conditions.

Work group membership was established in legislation, and includes:

- Amanda Vickstrom, Minnesota Elder Justice Center (work group chair/non-voting member);
- Rep. Debra Hilstrom;
- Rep. Nick Zerwas;
- Sen. Michelle Benson;
- Sen. Alice Johnson;
- Asst. Commissioner Gil Acevedo, Minnesota Department of Health;
- Asst. Commissioner Loren Coleman, Minnesota Department of Human Services;
- Jean Peters, Family Advocate/Public Representative;
- Cheryl Hennen, Ombudsman from Long Term Care;
- Doug Beardsley, Care Providers of Minnesota;
- Jonathan Lips, LeadingAge Minnesota;
- Skip Valusek, Minnesota Home Care Association;
- Mary Jo George, AARP;
- Beth McMullen, Alzheimer's Association;
- Tony Palumbo, Anoka County Attorney;
- Becky Coffin, Voigt, Rode and Boxeth; and
- Rick Varco, SEIU Healthcare MN

Attachments

The work group conducted research to inform its discussion, which the report references in various places. For ease of reference, the following attachments are included with this report:

Attachment A -	Authorizing Legislation
Attachment B -	Minnesota Statute 626.5572 Subd. 21- Vulnerable Adult Definition
Attachment C -	Summary of Current Applicable State and Federal Laws and Regulations
Attachment D -	Summary of State Electronic Monitoring Laws
Attachment E -	Electronic Monitoring Facility Descriptions

Definitions and Acronyms

For purposes of this report:

DHS-MAARC is defined as the Minnesota Department of Human Services' Minnesota Adult Abuse Reporting Center, Minnesota's statewide common entry point to report any suspected maltreatment of a vulnerable adult.

Electronic monitoring is defined as the placement of an electronic monitoring device (video, webcam) in the room of a resident of a nursing facility, in a client's living space in an assisted living community, or in a home-care client's living space. The device could be a video surveillance camera, monitoring system, or web-based camera. Some devices allow for two-way communication, some for audio and/or video, and some record sound while others do not. Some record and some stream images and/or sound over the internet or cell phone signals.

Facility is defined as nursing homes licensed under Minnesota Statutes Chapter 144A, boarding care homes licensed under Minnesota Statutes Chapter 144, home care providers licensed under Minnesota chapter 144A, Housing with Services Establishments registered under Minnesota Chapter 144D, and Housing with Services Establishments with Assisted Living Designation under Minnesota Chapter 144G.

Maltreatment can include physical abuse, sexual abuse, emotional abuse, financial exploitation (such as theft), or neglect as defined in the Minnesota Vulnerable Adult Act, 626.5572 Subd. 17. (https://www.revisor.leg.state.mn.us/statutes/?id=626.5572) In general, we use the term maltreatment in this report.

MDH-OHFC is defined as Minnesota Department of Health's Office of Health Facility Complaints, the unit that investigates reports of maltreatment in MDH-licensed facilities.

Vulnerable Adult is defined in 626.5572 Subd. 21.
(https://www.revisor.leg.state.mn.us/statutes/?id=626.5572) (See Attachment B)

Introduction and Issue Background

Elder abuse and maltreatment is a serious problem around the country and in Minnesota. About 1 in 10 adults over the age of 60 are victims of elder abuse or maltreatment[1]. The U.S. Centers for Disease Control describes elder abuse and related maltreatment as a growing public health crisis[2]. The National Center on Elder Abuse identifies dementia as a significant risk factor, with one study showing that up to half of adults with an Alzheimer's or dementia-type disease experience some form of abuse or other maltreatment.[3] Particularly vulnerable to abuse, adults with Alzheimer's and dementia-type diseases may have trouble identifiying or verbalizing maltreatment they are experiencing; additionally, vulnerable adults with diminished capacity may not be believed when disclosing maltreatment.

Technological advances have made monitoring devices cheaper, smaller, and more accessible. Cameras are used by residents and families for several reasons, most notably to:

- observe or monitor the care of a loved one in a facility or home setting;
- allow connection or communication between residents and long-distance loved ones; and/or
- provide evidence when families suspect a resident's health or safety is at risk due to maltreatment by facility staff, residents, families, friends or others.

In addition, electronic monitoring may exonerate staff from allegations of maltreatment.

The number of Minnesotans turning 65 in this decade – 285,000 people - will be greater than the past four decades combined. By 2020, 1 in 5 Minnesotans will be over age 65, surpassing the number of Minnesotans aged 5-17.[4] Currently, the older adult services system works to meet the needs of a growing aging population. As the population ages, and as the number and availability of family members to provide long-term services and supports decreases, there will be additional pressures placed on caregivers and health care professionals.

In Minnesota, we have:

- Just over 35,000 people residing in assisted living settings
- An estimated 61,000 admissions to nursing homes each year
- 1,419 licensed home care providers

Reports of suspected maltreatment of vulnerable adults are made by the public and mandated reporters to the Minnesota Department of Human Services' Minnesota Adult Abuse Reporting

[1] 14. Lachs, M., & Pillemer, K. (2015). Elder abuse. *New England Journal of Medicine, 373*, 1947–56. doi: 10.1056/NEJMra1404688
[2] http://www.cdc.gov/features/elderabuse/
[3] https://ncea.acl.gov/whatwedo/research/statistics.html#30
[4] Minnesota State Demographic Center, Department of Administration. http://mn.gov/admin/demography/data-by-topic/aging/

Center (DHS-MAARC) and Minnesota Department of Health's Office of Health Facility Complaints (MDH-OHFC). Alleged perpetrators can include facility staff, family members, visitors, other residents, clients, or tenants, or can be the vulnerable adult neglecting their own needs.

MDH-OHFC receives referrals from DHS-MAARC for all allegations of suspected maltreatment involving the licensed providers for residents in hospitals, nursing homes, boarding care homes, and assisted living and home care providers. All federally-certified providers, including hospitals, nursing homes, boarding care homes and federally-certified home care providers also have requirements to self-report suspected maltreatment incidents (as defined by the Centers for Medicare and Medicaid Services) to MDH-OHFC.

DHS-MAARC reports include maltreatment reports of individuals in all settings – in the community and in facilities. In 2015, DHS received **38,717** total reports of suspected maltreatment of a vulnerable adult. In 2016, DHS received **51,408** total reports of suspected maltreatment of a vulnerable adult. Beginning July 1, 2015, Minnesota launched MAARC, the statewide reporting center for suspected maltreatment of a vulnerable adult. Prior to that, reports were made to individual county common entry points.

Recent MDH-OHFC reports indicate an increase in reports of alleged maltreatment statewide in facilities licensed by MDH. In Fiscal Year 2015, MDH-OHFC received 16,954 allegations of suspected maltreatment for assessment; 746 allegations were assigned to MDH-OHFC staff for out-of-office maltreatment investigations. MDH-OHFC completed 653 maltreatment investigations; 16 % had a finding of substantiated maltreatment; 67% had a finding of maltreatment not substantiated; 17% had a finding of inconclusive. MDH-OHFC findings are based on the preponderance of the evidence. MDH-OHFC disqualified 74 individuals found responsible for serious or recurring maltreatment from providing direct contact services according to the Human Services Background Study Act.[5] MDH-OHFC reports that video recordings have been given to their staff in investigations to substantiate maltreatment of vulnerable adults, but does not have data to identify how many cases were substantiated or not substantiated using electronic monitoring evidence.

Reports of allegations of suspected abuse to MDH and DHS have increased by 20% between 2014 and 2015. Reports of allegations of abuse have increased by 92% over the past five years. Reports of maltreatment allegations received as complaints from vulnerable adults, family or community members have increased by 134% in the past 5 years. Maltreatment allegations received from provider self-reports have increased by 22% in the past 5 years. [6]

[5] Minnesota Department of Health Minnesota Department of Human Services, *Maltreatment Report: Vulnerable Adults & Minors Served by Minnesota Licensed Providers Joint Biennial Report to the Minnesota Legislature summarizing allegations and investigations of maltreatment for State Fiscal Years 2014-2015*. Page IX.
[6] Minnesota Department of Health Minnesota Department of Human Services, *Maltreatment Report: Vulnerable Adults & Minors Served by Minnesota Licensed Providers Joint Biennial Report to the Minnesota Legislature summarizing allegations and investigations of maltreatment for State Fiscal Years 2014-2015*. Page X.

Current Law

Currently, Minnesota law does not specifically permit or prohibit electronic monitoring of vulnerable adults. However, several Minnesota statutes provide guidance on the issue.

- Minnesota's criminal wiretapping statute, Section 626A.02 prohibits interception of any wire, electronic, or oral communication and prohibits intentional disclosure to another person of the contents of any wire, electronic, or oral communication obtained in violation of the statute unless one of the parties to the communication has given prior consent to such interception and the purpose of the interception is not for committing any criminal or tortious act. This statute is generally interpreted to allow for one-party of the communication to consent to audio recording. The statutory definition of "electronic communication" in Section 626A.01 includes the transfer of "images" so the one-party consent statute, Section 626A.02, could be interpreted to include video images without sound.

- The Minnesota Home Care Bill of Rights and the Minnesota Resident Bill of Rights, Sections 144A.44 and 144.651 address the right of privacy, the right of self-determination, as well as the right to be free from maltreatment.

- Minnesota has several methods to legally allow an alternate-decision maker to make one's health and financial decisions such as attorney in fact under Power of Attorney, health care agent, guardian and conservator. See attached list of state and federal laws and rules reviewed by the workgroup that impact electronic monitoring of vulnerable adults.

Other States - Summary Information Regarding Cameras in Facilities

Currently only 6 states (Illinois, New Mexico, Oklahoma, Texas, Utah and Washington) have enacted specific legislation or issued formal agency rules to authorize and regulate electronic monitoring in older adult services settings, such as nursing homes, assisted living, or other facility types. In addition, the Maryland Department of Health and Mental Hygiene (http://dhmh.maryland.gov/ohcq/ltc/docs/Reports/149report.pdf) and the Virginia Department of Health have issued guidelines for the conduct of electronic monitoring in nursing homes. In 2016, the Virginia Department of Health convened a work group to develop recommendations regarding electronic monitoring and intends to promulgate regulations on this topic in 2017.

A table summarizing the laws, rules and guidance materials from the eight states listed above is included with this report as Attachment D. As the table shows, the laws of other states address similar issues (informed consent, for example) but vary in their approaches to those issues.

This does not mean that electronic monitoring does not occur in states other than those researched and detailed in Attachment D. Rather, Attachment D shows the group of states that the work group has identified as taking specific action with respect to electronic monitoring in older adult service settings. Other states may have laws that apply broadly to recording someone, such as wiretapping, eavesdropping, or unauthorized recordings, but the work group did not research those laws. Also, the work group notes that officials in other states have taken an interest in electronic monitoring, outside of the legislative process. The New Jersey Office of the Attorney General, for example, recently announced a “Safe Care Cam” program, under which that office will lend, for 30-day time periods, micro-surveillance cameras, which are designed to be embedded in household objects, to anyone who suspects someone receiving in-home home care might be experiencing abuse.

While the work group reviewed the other state laws to identify policy considerations applicable to electronic monitoring, the work group did not research the experience other states have had since enacting their laws. Anecdotally, the work group understands that stakeholders in some of those states are working on proposals to amend their existing laws or rules.

See Attachment D for a compilation of the laws.

Key Issues and Recommendations

While this report does not recommend any specific legislation, there are key issues that lawmakers should consider if developing a legislative proposal. Details and recommendations on those key issues are found on the subsequent pages. Overall, the work group desires to define an easy process for residents and families to utilize voluntary electronic surveillance. The group did not reach consensus that specific legislation should be passed, but there was consensus that, if lawmakers choose to bring legislation forward, they should address the topics identified below.

- Facility Types
- Informed Consent of Resident/Client/Patient/Tenant Being Monitored
- Informed Consent of Roommates Residing in Shared Living Spaces
- Conditions or Limitations On Monitoring
- Notification When Electronic Monitoring is Occurring
- Retaliation Considerations
- Additional Considerations

Key Issue 1: *Facility Types*

Recommendation: Any legislation concerning electronic monitoring of vulnerable adults should include nursing homes licensed under Minnesota Statutes Chapter 144A, boarding care homes licensed under Minnesota Statutes Chapter 144, home care providers licensed under Minnesota chapter 144A, Housing with Services Establishments Registered under Minnesota Chapter 144D, and Housing with Services Establishments with Assisted Living Designation under Minnesota Chapter 144G. Defining settings would clarify what provider types would be obligated to comply with the law's requirements, restrictions and/or requirements pertaining to individuals conducting electronic monitoring, and the state agency or agencies that would be charged with oversight regarding the law's implementation and potential enforcement.

The work group spent time acknowledging and discussing the complexity and challenges of the various settings. This report focuses on nursing homes and housing with services with assisted living designation and/or settings that specialize in care or special programs for individuals with Alzheimer's disease. See Attachment E for a list of facilities/settings with the statutory reference for further understanding. For the purposes of this report and based on the settings discussed, the term "resident" will be used for nursing homes and "clients" will be used for housing with services with an assisted living designation. Home care services were also discussed by the work group. Home care services can be provided in a variety of settings including housing with services. Supportive services is another term discussed by the group that should not be confused with licensed home care services. The work group specifically recommends that any legislation should include nursing homes licensed under Minnesota Statutes Chapter 144A, boarding care homes licensed under Minnesota Statutes Chapter 144, home care providers licensed under Minnesota chapter 144A, Housing with Services Establishments registered under Minnesota Chapter 144D, and Housing with Services Establishments with Assisted Living Designation under Minnesota Chapter 144G. The work group recognizes that many vulnerable adults also reside in congregate, residential settings licensed by the Minnesota Department of Human Services, and other settings, such as hospitals, licensed by the Minnesota Department of Health, but the group chose to focus its discussion on the common adult senior congregate settings and provider types identified above.

Key Issue 2*: Informed Consent of Resident/Client/Patient/Tenant Being Monitored*

Recommendation: Electronic monitoring should only be conducted with the informed consent of the resident, or of a representative who gives consent on behalf of the resident.

In order to uphold a vulnerable adult's rights to privacy, to self-determination, and to be from maltreatment, (see Attachment C for a Summary of Existing Laws on Privacy that establish these rights), the use of electronic monitoring should always flow from the choice of the resident as the resident expresses. The other states that have addressed electronic monitoring have addressed consent. Consent means the authorization, in advance, of recording or streaming video and/or audio of the resident in their private living space using electronic monitoring techniques. (See Attachment D.)

If legislation is developed, the work group recommends that lawmakers consider both who can give the necessary consent and what form or process requirements should apply to consent.

On the subject of who consents, the work group's consensus is that a hierarchy should apply:

1. If a resident is able to provide consent, he or she should do so directly.
2. If a resident is unable to provide consent due to incapacity or incompetence, a legal representative of the resident (guardian, attorney-in-fact, or health care agent) should provide the consent (within the parameters of their legal responsibilities)
3. If a resident is unable to provide consent and has no legal representative, the work group recommends that lawmakers recognize the authority of another designated representative to provide the consent.
   - Existing federal (in the case of nursing homes) and state (in the case of home care) regulations recognize the following individuals as having a role in a resident's care, and the work group recommends that lawmakers recognize their authority to provide the necessary consent to electronic monitoring:
     - Nursing Homes: Resident Representative - An individual chosen by or acting on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; or
     - Home Care: Client Representative - A person who, because of the client's needs, makes decisions about the client's care on behalf of the client. A client representative may be a guardian, health care agent, family member, or other agent of the client.

If the legislature desires to expand the list beyond this, lawmakers should develop a clear list of hierarchy or provide further guidance for those adults that don't have specific people selected to serve in these roles.

The third step in this hierarchy raises important policy questions, including the need to balance an individual's rights to privacy and self-determination with the need to protect vulnerable adults from maltreatment. Information presented to the work group indicates that electronic monitoring can be especially beneficial to protect individuals who lack capacity or are incompetent as a result of dementia, and who may be unable to recognize, resist, or report maltreatment as a result. If such a person does not have a legal representative, it is especially important to know who can consent to electronic monitoring on behalf of the resident for the purpose of preventing maltreatment.

When reviewing other states' legislation affirmatively enacting electronic monitoring, requirements are similar in that the resident and/or their legal representative must provide consent.

In terms of what form or process must be used or followed when consent is given, the work group did not address this issue in detail, but noted from its research that other states have established a range of requirements. Other states generally require that consent be documented in writing prior to any electronic monitoring activity; some states require the use of specific forms, others do not; states vary in terms of other details and requirements.

The work group recommends that any legislation on this topic should reflect the goal of ensuring that informed consent is provided, without creating a process that is so complex or burdensome that it creates a barrier to electronic monitoring.

Key Issue 3: *Informed Consent of Roommates Residing in Shared Living Spaces*

Recommendation: If a resident who wishes to conduct electronic monitoring shares a private living space with another resident, the roommate must also provide informed consent before the use of any electronic monitoring in the private living space.

In order to protect a roommate's rights to privacy and self-determination, he or she must have the right to provide consent to electronic monitoring before it begins. If the roommate objects and does not consent, the resident should not be permitted to conduct electronic monitoring. If a resident's roommate consents to allow a camera or recording/streaming device in the room, the roommate has the right to provide restrictions or conditions as to what is recorded or transmitted, and where the electronic monitoring occurs. For example, the roommate may require that the camera be positioned in such a way that will keep the roommate out of view or recording of audio or video, or that the camera be turned off at certain times.

Here too, if legislation is developed, the work group recommends that lawmakers consider both who can consent for a roommate and what form or process requirements should apply. If a roommate is unable to provide consent due to incapacity or incompetence, consent must be obtained from the roommate's legal guardian or representative using the same process as described in obtaining consent on behalf of a resident (detailed under Informed Consent of Resident/Client/Patient Being Monitored).

The work group also noted that a resident who wishes to conduct electronic monitoring may wish to move into a private room if his or her roommate refuses to consent, but did not discuss this issue in detail. For examples of how other states have addressed this issue, see Attachment D.

Key Issue 4: *Conditions or Limitations on Monitoring*

Recommendation – A resident or roommate has a right to condition when and where electronic monitoring occurs. A person who has the right to consent to the electronic monitoring device, whether a resident or a roommate, also has the right to condition that consent.

Other states that have enacted legislation or rules relating to electronic monitoring have recognized that an individual who consents to electronic monitoring may wish to place conditions or restrictions on the monitoring that occurs.

Many electronic monitoring devices give the user (whether a resident or substitute decision maker) the power to turn the camera/device on and off as needed, and this creates the opportunity to turn off the device during private moments such as the delivery of cares, or during private meetings with persons such as the Ombudsman, attorney, faith leader or advocate or any other reason. The resident or substitute decision maker may request the camera/device to be turned off for reasons or privacy, modesty, certain treatments or services, or any other reason. Another condition or limitation a person might wish to have in place is consenting to video recording but not audio. There are a number of practical questions and issues that will arise regarding conditions or limitations on recording. Further review and analysis is needed to adequately address these issues.

Key Issue 5: *Notification When Electronic Monitoring is Occurring*

Recommendation: This issue as a whole remains unresolved, as the work group did not reach consensus on whether notification from a resident or substitute decision maker to the provider or regulating authority should be required. Notification is letting the provider or facility know that informed consent was received to utilize electronic monitoring devices or technology, not necessarily letting the provider know the electronic monitoring is occurring. However, if legislation is created, consensus was achieved that it should include a requirement to notify a provider and/or regulating authority that consent was received by the roommate, if applicable. The issue of notification should be evaluated in terms of what impact it would have on the use of electronic monitoring to prevent maltreatment and to hold perpetrators accountable, whether notification is needed to ensure that a resident has provided consent, and to assist the provider or regulating authority to initiate actions to prevent or stop any suspected maltreatment

The work group devoted considerable time to the question of whether a resident or substitute decision maker should be required to notify the resident's service provider that consent for electronic monitoring has been received, and/or of any recording/transmission restrictions. The work group agrees that:

- Current Minnesota law permits individuals to conduct electronic monitoring without notification, and any proposed change must be evaluated for whether it will serve the goal of preventing maltreatment and holding perpetrators accountable.

- Lawmakers should consider whether notification is or is not important to ensuring that a resident has consented to electronic monitoring. If determining notification is important, a separate question is whether notification to a person, agency or entity other than a service provider could achieve the same goal of preventing maltreatment, while providing protection of the service provider absent notification, and reducing the fear of retaliation.

- Absent notification, if a facility or service provider finds an electronic monitoring device installed in a resident's private living space, the service provider should be entitled to evidence that proper consent was obtained. The work group did not agree what that evidence of informed consent would consist of, such as a verbal or written confirmation of consent. In the six states that have statutes addressing electronic monitoring, they all require some sort of written consent to the regulating authority or to the facility. (See Attachment D).

- If maltreatment is seen or captured by electronic monitoring, the person authorized to conduct electronic monitoring is encouraged to report it to DHS-MAARC or MDH-OHFC.

The following are examples of issues that work group members feel are important for lawmakers to consider in relation to notification:

Families and advocates, including those present on the work group, believe the prevention of maltreatment can be fostered through open communication involving all parties who provide care for the resident. Families and advocates, including those present on the work group, strongly oppose requiring notification to facilities or staff that electronic monitoring is occurring. Families reported that if they were required to notify a facility that they were using electronic monitoring, or obtained consent for electronic monitoring, they fear retaliation, or that the maltreatment would be moved to an area not monitored by the electronic monitoring device. Families and advocates, with the belief that open communication between all parties can prevent maltreatment, stated to the work group that cameras frequently were used as a last resort to validate concerns when they felt the care or safety of their loved one was at risk. These advocates have a firm belief that notification will impair the right to conduct electronic monitoring and prevent maltreatment. Families and advocates suggest that it should be sufficient to have the resident or substitute decision maker generally notify a facility upon admission that authorized consent has been received for electronic monitoring, should the resident or substitute decision maker decide to utilize it at some point in the future.

Ombudsman representatives have mixed reactions in regards to notification. Ombudsman work to resolve concerns to the satisfaction of the resident and/or resident representative, and this includes engaging the provider and the family. When problems persist, in spite of engaging provider staff, trust erodes between all parties. Families and some residents may turn to electronic monitoring as a means to establish proof of concerns and protect their loved ones. Ombudsman believe the prevention of abuse, neglect and maltreatment can be fostered through open communication involving all parties invested in quality of care for the resident.

MDH-OHFC would like to ensure that the rights of residents'/patients' under the Minnesota Health Records Act and the Minnesota Health Care Bill of Rights are maintained. The question of notification is closely tied to the issue of consent. Like the Ombudsman, MDH believes that the prevention of abuse, neglect and maltreatment can also be fostered through open communication involving the various parties invested in quality of care for the resident.

Provider/facility representatives expressed that providers are required to uphold residents' rights to privacy and are concerned that they may be found in violation of regulatory requirements if electronic monitoring devices are used in facilities without proper consent. Providers feel it is important that monitoring should not occur unless the person being monitored, or a substitute decision maker, has given informed consent to such monitoring activities; and without notification, it may be impossible for a provider to know if proper consent has been provided. They also expressed that notification provides an opportunity for

communication about concerns the resident/family may have about the provider's services and treatments, including fears that maltreatment is or may be occurring. In addition, notification could, depending on the circumstances, trigger the provider to initiate an OHFC or MAARC external investigation regarding maltreatment.

Public Notification of Monitoring

Minnesota does not require that facilities notify persons that there is or may be electronic monitoring in the common or public areas within a facility. Apart from the issue of individual notification from the resident/family to the facility or service provider, lawmakers will note that some other states require a notice be posted when monitoring is occurring. For example, Texas requires that a notice be posted outside of the individual resident's room, while Oklahoma requires a notice be posted at the entrance of a facility that cameras are in use within, and it is optional about posting a notice outside of the individual resident's room. Notification may also include public notice at the entrance of a facility informing those that enter the premises that recording may be utilized in public areas of the building. The work group did not develop a position on these sort of public posting requirements.

Key Issue 6: *Retaliation Considerations*

Recommendation: All members of the work group believe that should legislation be created, it should specifically prohibit retaliation if electronic monitoring is utilized.

Retaliation can be defined as action taken by a facility or person involved in providing care, against the person using electronic monitoring, and can include, but is not limited to:

- not accepting or admitting a resident because of planned use of electronic monitoring;
- discharge/eviction because of use of electronic monitoring;
- nonrenewal of lease because of use of electronic monitoring;
- restriction of or refusal of care because of use of electronic monitoring; or
- other restriction of a resident's rights.

There are several anti-retaliation laws and regulations already in place in both Minnesota and federal law, including: Federal Nursing Home Reform law, the Minnesota Vulnerable Adult Act, Home Care Bill of Rights, Resident's Rights and Prohibition on Retaliation, and State Ombudsman law on prohibition on discrimination and retaliation. (See Attachment C.) In general, these laws prohibit providers from retaliating against residents and clients, and discuss penalties if retaliation occurs. The work group did hear concerns of lack of enforcement of retaliation laws.

More analysis would need to be done to determine the extent to which retaliation occurs, the effectiveness of current retaliation laws, the reporting process, enforcement of current laws, and penalties associated with retaliation. However, family advocates participating in or testifying to the work group stated that they experienced retaliation in supportive housing situations, with limited options to address the retaliation they believed had occurred. Family advocates expressed that those who depend on others for their care, and who have mental or physical vulnerabilities, worry that, if they report maltreatment to the provider or to a regulatory agency, the care and services they depend upon may decline as a result of retaliation by the provider. Further, they reported that the process to report retaliation to government agencies is unclear and confusing. Clear communication and guidelines regarding retaliation and reporting process would be beneficial to persons considering electronic monitoring.

Additional Considerations

1. Technology

Technology related to electronic monitoring will continue to advance and evolve. The work group recognizes this inevitable technological advancement and attempted to keep recommendations broad to encompass future possibilities. While the work group did not research the many types and capabilities of current monitoring technologies, should legislation be created, lawmakers should consider technological issues such as audio vs. video capabilities, streaming vs. non-streaming, as well as other technological capabilities.

2. Communication

The work group recommends that the creation of an educational guide would clarify for residents and families, as well as for facilities and other advocates, what is allowed under law related to electronic monitoring. This guide could outline the responsibilities of anyone wishing to install an electronic monitoring device as well as some best-use practices. In addition, the guide could more broadly include information on how to address concerns related to maltreatment, the options available to report suspected maltreatment, information about the Ombudsman program, and information about long term care services.

3. Cost

Currently, the cost of installation, operation and maintenance of electronic monitoring is covered by whoever places the device. However, the cost of electronic monitoring equipment and operation may be a deterrent for some individuals interested in or considering the use of electronic monitoring. Many individuals do not have financial means creating a barrier to electronic monitoring. The New Jersey Office of the Attorney General lends, for up to 30 days, micro-surveillance cameras to anyone who suspects their loved one receiving in-home home care might be suffering abuse. The cameras are designed to be embedded in household objects. Illinois currently requires the user of electronic monitoring to contract with an internet provider if internet services are required for the electronic monitoring. Subject to appropriation, Illinois also requires a fund be created for the purchase and installation of authorized electronic monitoring devices for persons receiving Medical Assistance.

4. Access, Retention and Dissemination

The work group identified but did not analyze various issues relating to access, retention and dissemination of recordings made by electronic monitoring devices. Issues that lawmakers might consider in this category include the utilization of recordings in the case of civil, criminal or administrative proceedings, or for internal facility investigations/allegations, or addressing quality of care concerns. Persons conducting electronic monitoring should be encouraged to share recordings and information upon request of a facility to address these investigations/concerns. A separate issue to consider is whether and how to address an instance where someone intentionally hampers, obstructs, tampers with or destroys an electronic monitoring device. Persons conducting electronic monitoring must provide copies of electronic monitoring recordings to parties in civil, criminal or administrative proceeding upon request. Issues surrounding admissibility of electronic monitoring evidence or liability were not addressed by the work group. Finally, the work group identified the privacy and security of health information as a key issue for lawmaker consideration.

ATTACHMENT A:
Authorizing Legislation

CHAPTER 179--H.F.No. 3142

An act relating to health; requiring a health carrier to update its Web site; amending provisions for the all-payer claims data, statewide trauma system, home care, assisted living, body art, hearing instrument dispensers, and food, beverage, and lodging establishments; directing activities for response to the Zika virus; adopting requirements for a medical faculty license; changing provisions in the medical cannabis program; establishing a residential care and services electronic monitoring work group; appropriating money and canceling a specific appropriation;amending Minnesota Statutes 2014, sections 144.605, subdivision 5; 144.608, subdivision 1; 144A.471, subdivision 9; 144A.473, subdivision 2; 144A.475, subdivisions 3, 3b, by adding a subdivision; 144A.4791, by adding a subdivision; 144A.4792, subdivision 13; 144A.4799, subdivisions 1, 3; 144A.482; 144D.01, subdivision 2a; 144G.03, subdivisions 2, 4; 146B.01, subdivision 28; 146B.03, subdivisions 4, 6, 7, by adding a subdivision; 146B.07, subdivisions 1, 2; 152.22, subdivision 14; 152.25, subdivisions 3, 4; 152.29, subdivision 3, by adding a subdivision; 152.36, subdivision 2, by adding a subdivision; 153A.14, subdivisions 2d, 2h; 153A.15, subdivision 2a; 157.15, subdivision 14; 157.16, subdivision 4; Minnesota Statutes 2015 Supplement, section 62U.04, subdivision 11; proposing coding for new law in Minnesota Statutes, chapters 62K; 144; 147.

Sec. 39.

RESIDENTIAL CARE AND SERVICES ELECTRONIC MONITORING WORK GROUP.

(a) A residential care and services electronic monitoring work group is established to create recommendations for legislation that authorizes the use of voluntary electronic monitoring to protect vulnerable children and adults and hold accountable perpetrators of abuse.

(b) Members of the work group shall include:

(1) two members of the house of representatives, one appointed by the speaker of the house and one appointed by the minority leader;

(2) two members of the senate, one appointed by the majority leader and one appointed by the minority leader;

(3) the commissioner of health or a designee;

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

(5) one representative of consumers or victims;

(6) the ombudsman for long-term care established under Minnesota Statutes, section 256.974;

(7) one representative from Care Providers of Minnesota;

(8) one representative from LeadingAge Minnesota;

(9) one representative from the Minnesota Home Care Association;

(10) one representative from the Minnesota chapter of AARP;

(11) one representative of a nonprofit organization with a focus on Alzheimer's disease;

(12) one representative of county attorneys;

(13) one representative with legal expertise on medical privacy; and

(14) one representative of direct-care workers.

The commissioner of health shall appoint the work group chair and convene its first meeting no later than July 1, 2016.

(c) The work group shall be exempt from the appointment requirements in Minnesota Statutes, section 15.0597.

(d) The work group may accept donated services from a nonprofit organization that prevents abuse, neglect, and financial exploitation of vulnerable adults.

(e) Work group members shall serve without compensation or expense reimbursement.

(f) The work group shall issue a report to the chairs and ranking minority members of the legislative committees with jurisdiction over civil law, judiciary, and health and human services by January 15, 2017.

(g) The work group expires 30 days following the completion of the work required by this section.

EFFECTIVE DATE.

This section is effective the day following final enactment.

ATTACHMENT B
Definition: Vulnerable Adult

2016 Minnesota
Statutes

626.5572 DEFINITIONS.

Subd. 21.**Vulnerable adult.**

(a) "Vulnerable adult" means any person 18 years of age or older who:

(1) is a resident or inpatient of a facility;

(2) receives services required to be licensed under chapter 245A, except that a person receiving outpatient services for treatment of chemical dependency or mental illness, or one who is served in the Minnesota sex offender program on a court-hold order for commitment, or is committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253B, is not considered a vulnerable adult unless the person meets the requirements of clause (4);

(3) receives services from a home care provider required to be licensed under sections 144A.43 to 144A.482; or from a person or organization that offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under section 256B.0625, subdivision 19a, 256B.0651, 256B.0653, 256B.0654, 256B.0659, or 256B.85; or

(4) regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

(ii) because of the dysfunction or infirmity and the need for care or services, the individual has an impaired ability to protect the individual's self from maltreatment.

(b) For purposes of this subdivision, "care or services" means care or services for the health, safety, welfare, or maintenance of an individual.

ATTACHMENT C
Summary of Current Applicable State and Federal Laws and Regulations

Regulation/Statute	Citation	Brief Description
One-party consent statute	Minn. Stat. § 626A.02 subd.2(d)	"It is not unlawful under this chapter for a person not acting under color of law to intercept a wire, electronic, or oral communication where such person is a party to the communication or where one of the parties to the communication has given prior consent to such interception unless such communication is intercepted for the purpose of committing any criminal or tortious act in violation of the constitution or laws of the United States or of any state." Note: Wiretapping law does not apply to silent videos.
Criminal statute	Minn. Stat. § 609.746 subd.1(d)	A person is guilty of a gross misdemeanor if the person: (1) "surreptitiously installs or uses any device for observing, photographing, recording, amplifying, or broadcasting sounds or events . . .[in a] place where a reasonable person would have an expectation of privacy and has exposed or is likely to expose their intimate parts . . . or the clothing covering the immediate area of the intimate parts; and

		(2) does so with the intent to intrude upon or interfere with the privacy of the occupant.
Criminal Statute- crimes against vulnerable adults	Minn. Stat. §§ 609.232, 609.233, 609.2325 and 609.234	Criminal abuse, criminal neglect, and failure to report for a mandated reporter
MN Home Care Bill of Rights	Minn. Stat. § 144A.44	The right to have personal, financial, and medical information kept private, and to be advised on the provider's policies and procedures regarding disclosure of such information Provides several rights for self-determination on care provided Provides the client has the right to assert all rights without retaliation
MN Home Care Bill of Rights; Notification to Client and client complaint and investigative process	Minn. Stat. § 144A.4791	Subd.1 Providers must provide the client with written notice of the home care bill of rights in Section 144A.44 including a statement that the home care provider will not retaliate because of a complaint Subd. 11 Home care provider must have a policy for clients to file a complaint and an explicit statement that the home care provider will not discriminate or retaliate against a client for expressing concerns or complaints

MN Resident Bill of Rights	Minn. Stat. § 144.651	Residents shall be assured confidential treatment of their personal and medical records and shall be notified when personal records are requested by any individual outside the facility Residents have rights to associate and communicate privately with people of their choice. Residents have the right to information about their treatment and the right to participate in planning their treatment. (Note: Patients and residents may waive these rights, and these rights can be limited when needed to ensure patient or resident safety.)
Minnesota law on Resident's Rights and Prohibition on Retaliation	Minn. Stat. § 144A.13	Nursing home must inform each resident in writing of the right to complain about the facility and services. No controlling person or employee of a nursing home shall retaliate in any way against a complaining resident
Minnesota law on Rights of Patients under Minnesota Commitment and Treatment Act	Minn. Stat. § 253B.03	Outlines several rights of civilly committed patients including right to correspondence, visitors and phone calls, consenting to procedures and treatment
MN Landlord Tenant Law on Tenant's Right to Privacy	Minn. Stat. § 504B.211	Explains entry by landlord and need for a reasonable business purpose to enter premises and after making a

		good faith effort to give the tenant reasonable notice
MN Health Records Act	Minn. Stat. § 144.293	Requires patient to have a signed and dated consent form to release health records; Note that MN law is stricter than Federal HIPAA law and does require written authorization even for payment, treatment, health care operations.
MN Government Data Practices Act- disclosures	Minn. Stat. § 13.384	Medical data is private but can be disclosed with certain exceptions including court order, or to certain family members or health care agents, or as allowed by law
MN Government Data Practices Act	Minn. Stat. §13.43	Governs access to "personnel data" including investigations of complaints against public employees.
MN Government Data Practices Act	Minn. Stat. §13.46 (3)	Governs access to "investigative data" in enforcement actions within the welfare system.
MN Government Data Practices Act	Minn. Stat. §13.82 (7), (10), (11)	Governs "law enforcement data" and includes specific provisions related to handling of data involving vulnerable adults who are victims of maltreatment.
MN Maltreatment of Vulnerable Adult Act	Minn. Stat. § 626.557 and § 626.5572 (definitions)	A mandated reporter who believes a vulnerable adult is being or has been maltreated (including financial) or who has sustained an injury that is not reasonably explained shall immediately report the incident. Prohibits retaliation by a facility or person against any person who reports in good

		faith suspected maltreatment. Remedies for a violation include actual damages, and punitive damages up to $10,000, and attorney fees. Section 626.5572: Defines facilities. Defines vulnerable adult as, "any person 18 years of age or older who: (1) is a resident or inpatient of a facility; (2) receives services required to be licensed under chapter 245A, except that a person receiving outpatient services for treatment of chemical dependency or mental illness, or one who is served in the Minnesota sex offender program on a court-hold order for commitment, or is committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253B, is not considered a vulnerable adult unless the person meets the requirements of clause (4); (3) receives services from a home care provider required to be licensed under sections 144A.43 to 144A.482; or from a person or organization that offers, provides, or arranges for personal care assistance

		services under the medical assistance program as authorized under section 256B.0625, subdivision 19a, 256B.0651, 256B.0653, 256B.0654, 256B.0659, or 256B.85; or (4) regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction: (i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and (ii) because of the dysfunction or infirmity and the need for care or services, the individual has an impaired ability to protect the individual's self from maltreatment. VA law also states lead investigative agency has right to enter facility, inspect, review and copy records, including access to not-public data and medical records.
MN Guardianship Powers and Duties	Minn. Stat. § 524.5-313	Lists powers of guardian including providing for care, health care (needs court approval)
MN Conservatorship Powers and Duties	Minn. Stat. § 524.5-417	Lists powers of conservator including paying for support

		and maintenance (needs court approval)
MN Duties of an attorney-in-fact	Minn. Stat. § 523.21; 523.23	Lists duties and sample short form (does not need court approval)
MN Health Care directive	Minn. Stat. § 145C.05	Includes decision-making powers for a health care agent
Federal definition of "Resident Representative" (for nursing homes)	45 CFR § 1324.1	An individual chosen by the resident to act on behalf of the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; also includes a person authorized by law to act on behalf of the resident (POA, legal representative, guardian, conservator)
MN Special Considerations for Overnight Programs – Alternate Overnight Supervision Technology	Minn. Stat. § 245.A11 Sub 7.3; Sub7a	Pertinent to DHS-licensed homes, ordinarily found in small houses in residential neighborhoods (adult foster care, etc).Provision allows certain facilities in some cases to use technology to monitor in the evenings in lieu of paid staff.
Federal Resident Bill of Rights (for nursing home)	42 CFR § 483.10	The right to personal privacy and confidentiality of personal and clinical records Note F-164 guidance for the right to privacy, "should include full visual, and to the extent desired, for visits or other activities, auditory privacy." SOM, Appendix PP at 30. The right to refuse treatment

		The right to be fully informed in advance about care and treatment
Federal law on freedom from abuse, neglect and exploitation	42 CFR § 483.12	Nursing home must develop policies and procedures that prohibit mistreatment, neglect, abuse and misappropriation of resident property
Federal law on facility-operated surveillance (for nursing home)	42 CFR § 483.70(d)(1)	Nursing home resident rooms must be designed or equipped to assure full visual privacy for each resident
Federal law on confidential information (for nursing home)	42 CFR § 483.75(l)(4)	Facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required… "Keep confidential" means, "safeguarding the content of information including video, audio, or other computer stored information from unauthorized disclosure without the consent…"
HIPAA- Protected Health Information definition	45 CFR § 160.103	Information, including demographic information that relates to: -the individual's past, present, or future physical or mental health or condition -The provision of health care to the individual, or -The past, present, or future payment for the provision of health care to the individual -And that identifies the individual or which there is a reasonable basis to believe it can be used to identify the individual

HIPAA- Covered entity definition	45 CFR § 160.103	A health plan, a health care clearinghouse, or a health care provider
HIPAA- basic principle	45 CFR § 164.502(a)	A covered entity may not use or disclose protected health information except as the Privacy Rule allows or requires, or if the individual gives written authorization
HIPAA- Uses and Disclosures for which an authorization is required	45 CFR § 164.508	Authorizations required to disclose PHI with several exceptions, including for treatment, payment or health care operations
Nursing Home guidance on resident decision-makers	42 CFR § 483.10(a)(3) and (4)	If resident is adjudicated incompetent, rights of resident exercised by person appointed by state. If resident is not adjudicated incompetent, any legal surrogate may exercise rights The SOM guidance states that a facility must still protect and promote the resident's interests. (F-152)
National Labor Relations Board ruling	*Colgate-Palmolive Co*., 323 NLRB 515 (1997)	NLRB has ruled that installation and use of hidden surveillance cameras is a mandatory subject of bargaining.
4th Amendment Case Law	*State v. Buswell*, 460 N.W.2d 614 (Minn. 1990)	Private search, even if unreasonable, will not result in evidence being suppressed because there is no constitutional violation. But if the private individual acted as an agent or instrument of the state, the search is subject to the Fourth Amendment. It is only when the government takes some type of initiative or steps to

		promote the search that a private citizen is deemed to be an agent or instrument of the state.
4th Amendment Case Law	*State v. Diaz*, 706 A.2d 264 (N.J. 1998) (n.1) Note this is New Jersey law	Case involving a "nanny cam" placed in home by parents of child. The New Jersey court was reviewing the application of the state's wiretapping law but noted, "Neither the federal nor the state constitution are implicated here because the alleged unlawful conduct was performed by private individuals and not by the government or its agents."
Federal Ombudsman Regulations and Authority	45 CFR § 1327.19	Ombudsman shall support the resident, offer privacy, discuss the complaint with the resident (and/or resident's representative) in order to: determine the perspective of the resident; request informed consent in order to investigate the complaint; determine the wishes of the resident with respect to resolution of the complaint; advise the resident of his rights; work with the resident to develop a plan of action for resolution of the complaint; investigate to determine whether the complaint can be verified; and determine whether the complaint is resolved to resident's satisfaction
State Ombudsman law on prohibition on discrimination and retaliation	Minn. Stat. § 256.9742 subd. 6	Prohibits discriminatory, disciplinary, or retaliatory action against the ombudsman, a client, a

		guardian, or family member of client for filing a good faith complaint to the ombudsman. A person who violates this section is guilty of a misdemeanor.

ATTACHMENT D: Summary of State Electronic Monitoring Laws

Illinois: Authorized Electronic Monitoring in Long-Term Care Facilities Act (210 ILCS 32/1-32/99) *Effective Date: January 1, 2016*	
Settings Covered	Nursing homes; ICF/DD with 30 or more beds; and certain long-term care facilities for persons under age 22.
Device Standards	"Electronic monitoring device" means a surveillance instrument with a fixed position video camera or an audio recording device, or a combination thereof, that is installed in a resident's room under the provisions of this Act and broadcasts or records activity or sounds occurring in the room.
Consent	The resident or resident's guardian must consent. If the resident has not affirmatively objected and physician determines resident lacks ability to understand, other specified people may give consent, provided they first explain specified issues to the resident. The resident must obtain prior written consent from any roommate. If roommate objects, facility must make reasonable attempt to accommodate the resident. Consent may be withdrawn.
Limits on Recordings	The resident and roommate may place conditions or restrictions on the use of the monitoring device. See the State's form for examples.
Use of Recordings	Facility may not access any recording without the written consent of the resident. A recording (or copy) may only be disseminated for the purpose of addressing concerns relating to the health, safety, or welfare of a resident or residents. The resident must provide a copy of any recording to parties in a civil, criminal, or administrative proceeding, upon a party's request, if the recording was made during the time period that the conduct at issue in the proceeding allegedly occurred.
Notification and Signage	AEM may begin only after a notification and consent form prescribed by the State has been completed and submitted to the facility. The facility is required to post signs at building entrances and at the entrance to the resident's room.
Installation/ Accommodation of Monitoring	The facility shall make a reasonable attempt to accommodate the resident's installation needs, including, but not limited to, allowing access to the facility's telecommunications or equipment room. A facility has the burden of proving that a requested accommodation is not reasonable. The electronic monitoring device must be placed in a conspicuously visible location in the room.
Prohibitions/ Penalties	Subject to criminal penalties ranging from misdemeanor to felony, a person or entity is prohibited from knowingly hampering, obstructing, tampering with, or destroying an electronic monitoring device or a video or audio recording obtained in accordance with the Act.
Other Issues Addressed	• Subject to applicable rules of evidence and procedure, a recording 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. • A facility is not civilly or criminally liable for the inadvertent or intentional disclosure of a recording by a resident for any purpose not authorized by the Act; or for a violation of a resident's right to privacy arising out of any electronic monitoring conducted pursuant to the Act.

See also: 210 ILCS 45/2-115 and 2-116 (addressing resident rights in nursing homes and ID/DD settings); 210 ILCS 45/3-318 and 3-318 (nursing homes and ID/DD settings may not retaliate because of, or prohibit, AEM).

ATTACHMENT D: Summary of State Electronic Monitoring Laws

New Mexico: Patient Care Monitoring Act (N.M.S.A § 24-26-1 et seq; N.M. Rules 9.2.23 et seq) *Effective Date: 2004*	
Settings Covered	A long-term care facility licensed pursuant to the provisions of Section 24-1-5 NMSA 1978 (other than ICF/MR), and may also include: (1) a skilled nursing facility; (2) an intermediate care nursing facility; (3) a nursing facility; (4) an adult residential shelter care home; (5) a boarding home; (6) any adult care home or adult residential care facility; and (7) any swing bed in an acute care facility or extended care facility.
Device Standards	"Monitoring device" means a surveillance instrument that broadcasts or records activity, but does not include a still camera. If device records activity visually, it must include a record of the date and time. If the device uses the internet, it must meet specified encryption standard.
Consent	Resident and any roommate must give written consent (legal guardian or legally-appointed substitute decision maker may consent); consent must include specified content and be on forms issued by the State. If the resident or roommate has capacity, only s/he may consent. Consent may be withdrawn.
Limits on Recordings	Monitoring must comply with any limitation placed on it as a condition of consent by the resident or a roommate; facility shall accommodate limitations including the time of operation, direction, focus or volume.
Use of Recordings	In any civil action against the facility, material obtained through the use of a monitoring device may not be used if the monitoring device was installed or used without the knowledge of the facility or without the prescribed form.
Notification and Signage	Resident must notify the facility of the installation of a monitoring device. The facility shall post a notice in a conspicuous place at the entrance to a room with a monitoring device that a monitoring device is in use in that room.
Installation/ Accommodation of Monitoring	Upon admission, a resident shall be offered the option to have a monitoring device, and a record of the patient's authorization or choice not to have a monitoring device shall be kept by the facility and accessible to the Ombudsman. After authorization, consent and notice, a patient or surrogate may install, operate and maintain a monitoring device in the patient's room at the patient's expense. Facility shall cooperate to accommodate the installation of the device, provided the installation does not place undue burden on the facility; agency rules addresses this issue in more detail.
Prohibitions/ Penalties	No person or patient shall be denied admission to or discharged from a facility or be otherwise discriminated against or retaliated against because of a choice to authorize installation and use of a monitoring device; civil penalties apply. Any person other than a patient or surrogate found guilty of intentionally hampering, obstructing, tampering with or destroying a monitoring device or a recording made by a monitoring device is guilty of a fourth degree felony.
Other Issues Addressed	Compliance with the provisions of the Patient Care Monitoring Act shall be a complete defense against any civil or criminal action brought against the patient, surrogate or facility for the use or presence of a monitoring device.

See also: N/A

ATTACHMENT D: Summary of State Electronic Monitoring Laws

63 Oklahoma Statutes Annotated § 1-1953.1-1953.7 *Effective Date: November 1, 2013*	
Settings Covered	Nursing facilities.
Device Standards	"Authorized electronic monitoring" (AEM) means the placement of electronic monitoring devices in the common areas or room of a resident of a nursing facility and the tapes or recordings from such devices pursuant to the provisions of this act; "AEM devices" (AEMD) means: video surveillance cameras installed in the common areas or resident's room under the provisions of this act, or audio devices installed in the room of a resident under the provisions of this act that are designed to acquire communications or other sounds occurring in the room. A resident may conduct AEM using AEMDs.
Consent	Resident (or representative) and any roommate (or representative) must consent before AED begins. A resident who wishes to conduct AED must notify the facility on a consent form prescribed by the State, and must obtain roommate consent. Forms available on-line: resident / roommate.
Limits on Recordings	Roommate may condition consent on a camera being pointed away and/or on audio being limited or prohibited.
Use of Recordings	Subject to the provisions of law, a tape or recording created through the use of authorized electronic monitoring pursuant to this act may be admitted into evidence in a civil or criminal court action or administrative proceeding.
Notification and Signage	A resident who wishes to conduct AED must notify the facility on the consent form noted above. Facility shall provide written notice to each resident (or representative) that AEM of a resident's room is not compulsory and shall only be conducted with the written consent of the resident (or representative). A nursing facility shall post at or near its main entrances a sign that clearly states that electronic monitoring and audio devices may be in use in the facility.
Installation/ Accommodation of Monitoring	A nursing facility shall not refuse to admit an individual to residency in the facility and shall not remove a resident from a facility because of AEM of a resident's room. In the case of a roommate refusal, facility shall accommodate a room change, if requested in a reasonable time.
Prohibitions/ Penalties	Any person or entity that intentionally hampers, obstructs, tampers with, or destroys a recording or an electronic monitoring device installed in a nursing facility shall be subject to criminal penalties (see Section 1993 of Title 21). No person or entity shall intercept a communication or disclose or use an intercepted communication of an electronic monitoring device placed or installed in a common area of a nursing facility without the express written consent of the facility, or, for an electronic monitoring device installed in a resident's room, the express written consent of the resident or the representative of the resident.
Other Issues Addressed	Residents conducting monitoring prior to the law's enacted were required to comply with written consent and disclosure requirements by January 1, 2014.

See also: N/A

ATTACHMENT D: Summary of State Electronic Monitoring Laws

Texas Health and Safety Code § 242.841 et seq; 40 TX Admin. Code § 92.2 and § 19.422. *Effective Date: June 15, 2001*	
Settings Covered	Nursing facilities and assisted living facilities.
Device Standards	Authorized electronic monitoring (AEM) means the placement of an electronic monitoring device (EMD) in the room of a resident of an institution and making tapes or recordings with the device after making a request to the institution to allow electronic monitoring. EMD includes video surveillance cameras installed in the room of a resident; and audio devices installed in the room of a resident designed to acquire communications or other sounds occurring in the room; and does not include an electronic, mechanical, or other device that is specifically used for the nonconsensual interception of wire or electronic communications.
Consent	Resident and any roommate must give written consent. If the resident has capacity, only s/he may consent notwithstanding any durable POA; an appointed guardian or legal representative of the resident may consent under specified conditions. Similar provisions apply to roommate consent. Consent must include specified content and be on forms issued by State. Consent may be withdrawn.
Limits on Recordings	Residents may impose limitations and restrictions; roommates may insist that a camera be pointed away from him/her or that audio be limited or prohibited.
Use of Recordings	Subject to rules of evidence and procedure, a tape or recording created through the use of covert or authorized electronic monitoring may be admitted into evidence in a civil or criminal court action or administrative proceeding, so long as it is time/date stamped and meets two other specified conditions.
Notification and Signage	Upon admission a resident must sign a state-prescribed form that explains the right to conduct AEM and addresses issues such as procedures for requesting AEM, potential civil liability for disclosure of recordings, etc. [To locate forms, CLICK HERE and search for "monitoring" in the title field.] The resident shall post a notice at the entrance to the room. The facility shall post a notice at the entrance to the facility.
Installation/ Accommodation of Monitoring	Facility shall permit electronic monitoring and make reasonable physical accommodation for it. Facility may require device to be installed safely. If AEM is conducted, facility may require it to occur in plain view.
Prohibitions/ Penalties	Subject to civil penalties, an institution may not refuse to admit an individual to residency in the institution and may not remove a resident because of a request to conduct AEM; an institution may not remove a resident because covert electronic monitoring is being conducted. A person who intentionally hampers, obstructs, tampers with, or destroys an electronic monitoring device installed in a resident's room in accordance with this subchapter or a tape or recording made by the device commits an offense. An offense under this section is a Class B misdemeanor
Other Issues Addressed	§ 242.842 addresses criminal and civil liability issues; § 242.843 immunizes the state and institution from civil liability in instances of covert monitoring. §242.848 addresses reporting of abuse and neglect identified through viewing/listening to a recording.

See also: TX Health & Safety Code Title 7, Subtitle B, Ch. 555, and related rules in TX Admin. Code Title 40, Part 1, Ch. 3, regarding monitoring in state supervised living facilities for criminal offenders.

ATTACHMENT D: Summary of State Electronic Monitoring Laws

Utah Assisted Living Facility Surveillance Act (Utah Code Annotated § 26-21-301 et seq) *Effective Date: May 10, 2016*	
Settings Covered	Assisted living facilities.
Device Standards	"Monitoring device" means: a video surveillance camera; or a microphone or other device that captures audio; does not include: a device that is specifically intended to intercept wire, electronic, or oral communication without notice to or the consent of a party to the communication; or a device that is connected to the Internet or that is set up to transmit data via an electronic communication.
Consent	A resident or the resident's legal representative may operate or install a monitoring device in the resident's room if the resident and the resident's legal representative, if any, unless the resident is incapable of informed consent: (a) notifies the resident's facility in writing that the resident or the resident's legal representative, if any: (i) intends to operate or install a monitoring device in the resident's room; and (ii) consents to a waiver agreement, if required by a facility; (b) obtains written consent from each of the resident's roommates, and their legal representative, if any, that specifically states the hours when each roommate consents to the resident or the resident's legal representative operating the monitoring device.
Limits on Recordings	Not specifically addressed.
Use of Recordings	Not specifically addressed.
Notification and Signage	A facility may require the resident or the resident's legal representative to place a sign near the entrance of the resident's room that states that the room contains a monitoring device.
Installation/ Accommodation of Monitoring	A facility may not deny an individual admission to the facility for the sole reason that the individual or the individual's legal representative requests to install or operate a monitoring device in the individual's room. A facility may not discharge a resident for the sole reason that the resident or the resident's legal representative requests to install or operate a monitoring device in the individual's room.
Prohibitions/ Penalties	Not specifically addressed.
Other Issues Addressed	§ 26-21-303 states that an individual may not operate a monitoring device in a facility without a court order:(a) in secret; or (b) with an intent to intercept a wire, electronic, or oral communication without notice to or the consent of a party to the communication; same section provides certain civil and criminal liability protections to facilities.

See also: N/A

ATTACHMENT D: Summary of State Electronic Monitoring Laws

Washington Administrative Code §§ 388-97-0380/0400 (NFs), 388-78a-2680/2690 (ALFs), 388-76-10720/10725 (Adult Family Home), and 388-107-0780/0790 (Enhanced Service Facilities) *Effective: Nov. 1, 2008 (nursing homes); Sept. 1, 2004 (assisted living, fka boarding homes);Jan. 1, 2008 (adult family home); Oct. 13, 2014 (enhanced service facilities)*	
Settings Covered	Nursing facilities; assisted living facilities; adult family home; enhanced service facilities (scope of latter two categories not yet studied). Provisions are identical for all four settings; note they apply to what the facility itself can and cannot do.
Device Standards	Not specifically addressed.
Consent	The resident and any roommate must consent. For purposes of consenting to any audio electronic monitoring, consent must be given by resident himself/herself or the resident's court-appointed guardian or attorney-in-fact who has obtained a court order specifically authorizing the court-appointed guardian or attorney-in-fact to consent to audio electronic monitoring of the resident. For video monitoring, consent must be given by the resident or a surrogate decision maker (e.g. for NFs this means a resident representative or representatives as outlined in WAC 388-97-0240, and as authorized by RCW 7.70.065). The facility must immediately stop electronic monitoring if the: (a) Resident no longer wants electronic monitoring; (b) Roommate objects or withdraws the consent to the electronic monitoring; or (c) The resident becomes unable to give consent.
Limits on Recordings	**(1)** The facility must not use audio or video monitoring equipment to monitor any resident unless: (a) The resident has requested the monitoring; and (b) The monitoring is only used in the sleeping room of the resident who requested the monitoring. **(2)** If the resident requests audio or video monitoring, before any electronic monitoring occurs, the facility must ensure: (a) That the electronic monitoring does not violate chapter 9.73 RCW (statutes pertaining to violation of privacy rights); (b) The resident has identified a threat to the resident's health, safety or personal property; (c) The resident's roommate has provided written consent to electronic monitoring, if the resident has a roommate; and (d) The resident and the facility have agreed upon a specific duration for the electronic monitoring and the agreement is documented in writing. **(3)** The facility must: (a) Reevaluate the need for the electronic monitoring with the resident at least quarterly; and (b) Have each re-evaluation in writing, signed and dated by the resident.
Use of Recordings	Not specifically addressed.
Notification and Signage	Not specifically addressed.
Installation/ Accommodation of Monitoring	Not specifically addressed.
Prohibitions/ Penalties	Not specifically addressed.
Other Issues Addressed	In addition to the resident-requested use scenario summarized above, the regulations establish limits on a facility's broader use of monitoring. They state that the facility may video monitor on the premises, without an audio component, only in specified areas (e.g. entrances, rooms that only staff utilize, outdoor areas not commonly used by residents) and with specified conditions.

See also: N/A

ATTACHMENT D: Summary of State Electronic Monitoring Laws

OTHER RELEVANT ITEMS:

- **Maryland:** At the direction of the state legislature, the Department of Health and Mental Hygiene published Guidelines for Electronic Monitoring (December 1, 2003). This document is intended to provide guidance to facilities that voluntarily elect to use electronic monitoring at the request of a resident or the legal representative of the resident and with the consent of a resident's roommate. It addresses:
    - Handling Requests
    - Informed Consent (Required)
    - Notice (Required)
    - Cost and Maintenance (Required)
    - Custody of Recordings
    - Department Access to Recordings

- **Virginia** passed a law in April 2016 (S 553) directing its State Board of Health to promulgate regulations, by July 1, 2017, for the audio-visual recording of residents in nursing facilities. Such regulations shall include provisions related to (i) resident privacy, (ii) notice and disclosure, (iii) liability, (iv) ownership and maintenance of equipment, (v) cost, (vi) recording and data security, and (vii) nursing facility options for both nursing facility-managed recording and resident-managed recording. The Department shall convene a workgroup to make recommendations to the Board on such regulations and shall report its recommendations to the Board and the General Assembly by December 1, 2016.

  Meantime, see the Virginia Department of Health's 2004 guidance document: Electronic Monitoring of Resident's Rooms. Its introduction notes as follows: "State and federal long-term care regulations do not prohibit the placing of electronic monitoring equipment in resident rooms for the purposes of monitoring at-risk residents. However, Virginia law (§18.2- 386.1 of the Code of Virginia) prohibits the filming, videotaping or photographing of non-consenting persons if: "(i) that person is totally nude, clad in undergarments, or in a state of
  undress so as to expose the genitals, pubic area, buttocks or female breast in a restroom, dressing room, locker room, hotel room, motel room, tanning bed, tanning booth or other location and (ii) the circumstances are otherwise such that the person being videotaped, photographed or filmed would have a reasonable expectation of privacy. Facilities cannot use cameras in violation of the law based solely on a family member's request or approval.
  Therefore, facilities must have procedures in place to obtain the resident's documented consent prior to installing any monitoring equipment, including the consent of any resident sharing a room with the resident to be monitored. Residents have a right to refuse consent to be monitored. Family members cannot insist on monitoring over the objections of the residents in the room. It is not necessary to obtain consent of employees or for using monitoring equipment in community areas such as hallways, elevators, and dining rooms. This guideline is a resource tool designed to assist in the facilitation and implementation of electronic monitoring requests."

  It addresses a variety of issues, including:
  - Request procedures
  - Documentation
  - Custody / ownership of recordings

ATTACHMENT D: Summary of State Electronic Monitoring Laws

- Consent
- Notice
- Covert recording (prohibited)

ATTACHMENT E
FACILITY DESCRIPTION

MINNESOTA DEPARTMENT OF HEALTH
HEALTH REGULATION DIVISION

Minnesota Laws for settings licensed or registered by Minnesota Department of Health

Nursing homes are licensed under Minnesota Statutes 144A.01 – 144A.1888.

A "Nursing Home" means a facility or that part of a facility which provides nursing care to five or more persons. Nursing care means health evaluation and treatment of patients and residents who are not in need of an acute care facility but who require nursing supervision on an inpatient basis.

Housing with services establishments are registered under Minnesota Statutes Chapter 144D.

Housing with services establishments registered and provide Assisted Living Services are under Minnesota Statutes Chapter 144G.

Housing with services establishments registered and have special program or secured unit for persons with Alzheimer's disease or a related disorder disclose this under Minnesota Statutes 325F.72.

A housing with services establishment provides sleeping accommodations to one or more adult residents, at least 80 percent of which are 55 years of age or older and offering or providing for a fee, one or more regularly scheduled health related services or two or more regularly scheduled supportive services.

Health related services are provided through a licensed Minnesota Home Care Provider Minnesota Statute Sections 144A.43-144A.482.

Supportive services under identified in Minnesota Statutes 144D and mean help with personal laundry, handling or assisting with personal funds of residents, or arranging for medical services, health-related services, social services, or transportation to medical or social services appointments.

Housing with Services establishments may choose to be designated as providing assisted living under 144G AND/OR have a special program for individuals with Alzheimer's disease under 325F.72. See Minnesota Statutes 325F.72. https://www.revisor.mn.gov/statutes/?id=325F.72

"Assisted living" means a service or package of services advertised, marketed or otherwise described, offered or promoted under the phrase "assisted living" and which is available only to

individuals residing in a registered housing with services establishment. See Minnesota Statutes 144G.03.
https://www.revisor.mn.gov/statutes/?id=144G.03&format=pdf

Home care providers in Minnesota are licensed under Minnesota Statutes 144A.43-144A.481.

A "Home Care Provider" means an individual, organization, association, corporation, unit of government, or other entity that is regularly engaged in the delivery of at least one home care service, directly in a client's home for a fee and who has a valid license.

Basic Home Care Provider License. Home care services that can be provided with a basic home care license are assistive tasks provided by licensed or unlicensed personnel that include: (1) assisting with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing; (2) providing standby assistance; (3) providing verbal or visual reminders to the client to take regularly scheduled medication, which includes bringing the client previously set-up medication, medication in original containers, or liquid or food to accompany the medication; (4) providing verbal or visual reminders to the client to perform regularly scheduled treatments and exercises; (5) preparing modified diets ordered by a licensed health professional; and (6) assisting with laundry, housekeeping, meal preparation, shopping, or other household chores and services if the provider is also providing at least one of the activities in clauses (1) to (5).

Comprehensive Home Care Provider License. Home care services that may be provided with a comprehensive home care license include any of the basic home care services and one or more of the following: (1) services of an advanced practice nurse, registered nurse, licensed practical nurse, physical therapist, respiratory therapist, occupational therapist, speech-language pathologist, dietitian or nutritionist, or social worker; (2) tasks delegated to unlicensed personnel by a registered nurse or assigned by a licensed health professional within the person's scope of practice; (3) medication management services; (4) hands-on assistance with transfers and mobility; (5) assisting
clients with eating when the clients have complicating eating problems as identified in the client record or through an assessment such as difficulty swallowing, recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous instruments to be fed; or (6) providing other complex or specialty health care services.

Home Management Providers are registered under Minnesota Statutes 144A.482.

A provider performing only home management tasks must obtain a certificate of registration from the commissioner of health. Home management services include at least two of the following services: housekeeping, meal preparation, and shopping provided to a person who is unable to perform these activities due to illness, disability or physical condition.

Hospices are licensed under Minnesota Statutes, Section 144A.75, 144A.751-144A.756

A hospice provider means an individual, organization, association, corporation, unit of government, or other entity that is regularly engaged in the delivery, directly or by contractual arrangement, of hospice services for a fee to terminally ill hospice patients.

Residential hospice facility means a facility that resembles a single-family home located in a residential area that directly provides 24-hour residential and support services in a home-like setting for hospice patients as an integral part of the continuum of home care provided by a hospice or, is a facility that meets the requirements of a residential hospice under 144A.75 Subd. 13

Boarding care homes, and supervised living facilities are licensed under Minnesota Statutes 144.50 to 144.586.

A "boarding care home" provides personal or custodial care only. Examples of personal or custodial care include: Help with bathing, dressing, or other personal care; supervision of medications which can be safely self-administered; plus, a program of activities and supervision required by persons who are not capable of properly caring for themselves.

A "Supervised Living Facility" provides a residential, homelike setting for persons who are intellectually disabled, adult mentally ill, chemically dependent, or physically handicapped. Services include provision of meals, lodging, housekeeping services, health services, and other services provided by either staff or residents under supervision. Class A facilities include homes for ambulatory and mobile persons who are capable of taking appropriate action for self-preservation under emergency conditions as determined by program licensure provisions. Class B facilities include homes for ambulatory, non-ambulatory, mobile or non-mobile persons who are not mentally or physically capable of taking appropriate action for self-preservation under emergency conditions as determined by program licensure provisions.