

## CHAPTER 144A

### NURSING HOMES

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#### 144A.05 LICENSE RENEWAL.

Unless the license expires in accordance with section 144A.06 or is suspended or revoked in accordance with section 144A.11, a nursing home license shall remain effective for a period of one year from the date of its issuance. The commissioner of health by rule shall establish forms and procedures for the processing of license renewals. The commissioner of health shall approve a license renewal application if the facility continues to satisfy the requirements, standards and conditions prescribed by sections 144A.01 to 144A.17 and the rules promulgated thereunder. The commissioner shall not approve the renewal of a license for a nursing home bed in a resident room with more than four beds. Except as provided in section 144A.08, a facility shall not be required to submit with each application for a license renewal additional copies of the architectural and engineering plans and specifications of the facility. Before approving a license renewal, the commissioner of health shall determine that the facility's most recent balance sheet and its most recent statement of revenues and expenses, as audited by the state auditor, by a certified public accountant licensed by this state or by a public accountant as defined in section 412.222, have been received by the department of human services.

**History:** 1987 c 403 art 4 s 2

**NOTE:** This section, as amended by Laws 1987, chapter 403, article 4, section 2, is effective July 1, 1989. See Laws 1987, chapter 403, article 4, section 15.

#### 144A.071 MORATORIUM ON CERTIFICATION OF NURSING HOME BEDS.

*[For text of subs 1 and 2, see M.S.1986]*

**Subd. 3. Exceptions.** The commissioner of health, in coordination with the commissioner of human services, may approve the addition of a new certified bed or the addition of a new licensed nursing home bed, under the following conditions:

(a) to replace a bed decertified after May 23, 1983 or to address an extreme hardship situation, in a particular county that, together with all contiguous Minnesota counties, has fewer nursing home beds per 1,000 elderly than the number that is ten percent higher than the national average of nursing home beds per 1,000 elderly individuals. For the purposes of this section, the national average of nursing home beds shall be the most recent figure that can be supplied by the federal health care financing administration and the number of elderly in the county or the nation shall be determined by the most recent federal census or the most recent estimate of the state demographer as of July 1, of each year of persons age 65 and older, whichever is the most recent at the time of the request for replacement. In allowing replacement of a decertified bed, the commissioners shall ensure that the number of added or recertified beds does not exceed the total number of decertified beds in the state in that level of care. An extreme hardship situation can only be found after the county documents the existence of unmet medical needs that cannot be addressed by any other alternatives;

(b) to certify a new bed in a facility that commenced construction before May 23, 1983. For the purposes of this section, "commenced construction" means that all of the following conditions were met: the final working drawings and specifications were approved by the commissioner of health; the construction contracts were let; a timely construction schedule was developed, stipulating dates for beginning, achieving various stages, and completing construction; and all zoning and building permits were secured;

(c) to certify beds in a new nursing home that is needed in order to meet the special dietary needs of its residents, if: the nursing home proves to the commissioner's satisfaction that the needs of its residents cannot otherwise be met; elements of the special diet are not available through most food distributors; and proper preparation of the special diet requires incurring various operating expenses, including extra food preparation or serving items, not incurred to a similar extent by most nursing homes;

(d) to license a new nursing home bed in a facility that meets one of the exceptions contained in clauses (a) to (c);

(e) to license nursing home beds in a facility that has submitted either a completed licensure application or a written request for licensure to the commissioner before March 1, 1985, and has either commenced any required construction as defined in clause (b) before May 1, 1985, or has, before May 1, 1985, received from the commissioner approval of plans for phased-in construction and written authorization to begin construction on a phased-in basis. For the purpose of this clause, "construction" means any erection, building, alteration, reconstruction, modernization, or improvement necessary to comply with the nursing home licensure rules;

(f) to certify or license new beds in a new facility that is to be operated by the commissioner of veterans' affairs or when the costs of constructing and operating the new beds are to be reimbursed by the commissioner of veterans' affairs or the United States Veterans Administration;

(g) to license or certify beds in a new facility constructed to replace a facility that was destroyed after June 30, 1987, by fire, lightning, or other hazard provided:

(1) destruction was not caused by the intentional act of or at the direction of a controlling person of the facility;

(2) at the time the facility was destroyed the controlling persons of the facility maintained insurance coverage for the type of hazard that occurred in an amount that a reasonable person would conclude was adequate;

(3) the net proceeds from an insurance settlement for the damages caused by the hazard are applied to the cost of the new facility;

(4) the new facility is constructed on the same site as the destroyed facility or on another site subject to the restrictions in section 144A.073, subdivision 5; and

(5) the number of licensed and certified beds in the new facility does not exceed the number of licensed and certified beds in the destroyed facility;

(h) to license or certify beds that are moved from one location to another within a nursing home facility, provided the total costs of remodeling performed in conjunction with the relocation of beds does not exceed ten percent of the appraised value of the facility or \$200,000, whichever is less, or to license or certify beds in a facility for which the total costs of remodeling or renovation exceed ten percent of the appraised value of the facility or \$200,000, whichever is less, if the facility makes a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate by reason of the remodeling or renovation;

(i) to license or certify beds in a facility that has been involuntarily delicensed or decertified for participation in the medical assistance program, provided that an application for relicensure or recertification is submitted to the commissioner within 120 days after delicensure or decertification;

(j) to license or certify beds in a project recommended for approval by the interagency board for quality assurance under section 144A.073;

(k) to license nursing home beds in a hospital facility that are relocated from a

different hospital facility under common ownership or affiliation, provided: (1) the hospital in which the nursing home beds were originally located ceases to function as an acute care facility, or necessary support services for nursing homes as required for licensure under sections 144A.02 to 144A.10, such as dietary service, physical plant, housekeeping, physical therapy, occupational therapy, and administration, are no longer available from the original hospital site; and (2) the nursing home beds are not certified for participation in the medical assistance program;

(1) to license or certify beds that are moved from one location to another within an existing identifiable complex of hospital buildings, from a hospital-attached nursing home to the hospital building, or from a separate nursing home under common ownership with or control of a hospital to the hospital when a hospital-attached nursing home is moved simultaneously to the hospital. As a condition of receiving a license or certification under this clause, the facility must make a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate as a result of the relocation. At the time of the licensure and certification of the nursing home beds, the commissioner of health shall delicense the same number of acute care beds within the existing complex of hospital buildings or building. When a separate nursing home and a hospital-attached nursing home under common ownership or control are simultaneously relocated to a hospital building, a combined cost report must be submitted for the cost reporting year ending September 30, 1987, and the freestanding nursing home limits apply. Relocation of nursing home beds under this clause is subject to the limitations in section 144A.073, subdivision 5;

(m) to license or certify beds that are moved from an existing state nursing home to a different state facility, provided there is no net increase in the number of state nursing home beds;

(n) to license new nursing home beds in a continuing care retirement community affiliated with a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its residents from outside the state for the purpose of meeting contractual obligations to residents of the retirement community, provided the facility makes a written commitment to the commissioner of human services that it will not seek medical assistance certification for the new beds; or

(o) to certify or license new beds in a new facility on the Red Lake Indian reservation for which payments will be made under the Indian Health Care Improvement Act, Public Law Number 94-437, at the rates specified in United States Code, title 42, section 1396d(b).

*[For text of subds 4 and 5, see M.S.1986]*

**History:** 1987 c 403 art 4 s 3; 1Sp1987 c 4 art 2 s 1

#### **144A.073 REVIEW OF PROPOSALS REQUIRING EXCEPTIONS TO THE MORATORIUM.**

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

(a) "Conversion" means the relocation of a nursing home bed from a nursing home to an attached hospital.

(b) "Renovation" means extensive remodeling of, or construction of an addition to, a facility on an existing site with a total cost exceeding ten percent of the appraised value of the facility or \$200,000, whichever is less.

(c) "Replacement" means the demolition and reconstruction of all or part of an existing facility.

(d) "Upgrading" means a change in the level of licensure of a bed from a boarding care bed to a nursing home bed in a certified boarding care facility that is attached to a nursing home or a boarding care bed in a freestanding boarding care facility that currently meets all health department standards for a nursing home.

**Subd. 2. Request for proposals.** At the intervals specified in rules, the interagency board shall publish in the State Register a request for proposals for nursing home projects to be licensed or certified under section 144A.071, subdivision 3, clause (j). The notice must describe the information that must accompany a request and state that proposals must be submitted to the interagency board within 90 days of the date of publication. The notice must include the amount of the legislative appropriation available for the additional costs to the medical assistance program of projects approved under this section. If no money is appropriated for a year, the notice for that year must state that proposals will not be requested because no appropriations were made. To be considered for approval, a proposal must include the following information:

- (1) whether the request is for renovation, replacement, upgrading, or conversion;
- (2) a description of the problem the project is designed to address;
- (3) a description of the proposed project;
- (4) an analysis of projected costs, including initial construction and remodeling costs, site preparation costs, financing costs, and estimated operating costs during the first two years after completion of the project;
- (5) for proposals involving replacement of all or part of a facility, the proposed location of the replacement facility and an estimate of the cost of addressing the problem through renovation;
- (6) for proposals involving renovation, an estimate of the cost of addressing the problem through replacement;
- (7) the proposed timetable for commencing construction and completing the project; and
- (8) other information required by rule of the commissioner of health.

**Subd. 3. Review and approval of proposals.** Within the limits of money specifically appropriated to the medical assistance program for this purpose, the interagency board for quality assurance may recommend that the commissioner of health grant exceptions to the nursing home licensure or certification moratorium for proposals that satisfy the requirements of this section. The interagency board shall appoint an advisory review panel composed of representatives of consumers and providers to review proposals and provide comments and recommendations to the board. The commissioners of human services and health shall provide staff and technical assistance to the board for the review and analysis of proposals. The interagency board shall hold a public hearing before submitting recommendations to the commissioner of health on project requests. The board shall submit recommendations within 150 days of the date of the publication of the notice, based on a comparison and ranking of proposals using the criteria in subdivision 4. The commissioner of health shall approve or disapprove a project within 30 days after receiving the board's recommendations. The cost to the medical assistance program of the proposals approved must be within the limits of the appropriations specifically made for this purpose. Approval of a proposal expires 12 months after approval by the commissioner of health unless the facility has commenced construction as defined in section 144A.071, subdivision 3, paragraph (b). The board's report to the legislature, as required under section 144A.31, must include the projects approved, the criteria used to recommend proposals for approval, and the estimated costs of the projects, including the costs of initial construction and remodeling, and the estimated operating costs during the first two years after the project is completed.

**Subd. 4. Criteria for review.** (a) The following criteria must be used to compare and evaluate all proposals submitted:

- (1) the extent to which the average occupancy rate of the facility supports the need for the proposed project;
- (2) the extent to which the average occupancy rate of all facilities in the county in which the applicant is located, together with all contiguous Minnesota counties, supports the need for the proposed project;
- (3) the extent to which the proposal furthers state long-term care goals, including the goal of enhancing the availability and use of alternative care services and the goal of reducing the number of long-term care resident rooms with more than two beds;

(4) the cost effectiveness of the proposal, including the proposal's long-term effects on the costs of the medical assistance program, as determined by the commissioner of human services; and

(5) other factors developed in rule by the commissioner of health that evaluate and assess how the proposed project will further promote or protect the health, safety, comfort, treatment, or well-being of the facility's residents.

(b) In addition to the criteria in paragraph (a), the following criteria must be used to evaluate, compare, and rank proposals involving renovation or replacement:

(1) the extent to which the project improves conditions that affect the health or safety of residents, such as narrow corridors, narrow door frames, unenclosed fire exits, and wood frame construction, and similar provisions contained in fire and life safety codes and licensure and certification rules;

(2) the extent to which the project improves conditions that affect the comfort or quality of life of residents in a facility or the ability of the facility to provide efficient care, such as a relatively high number of residents in a room; inadequate lighting or ventilation; poor access to bathing or toilet facilities; a lack of available ancillary space for dining rooms, day rooms, or rooms used for other activities; problems relating to heating, cooling, or energy efficiency; inefficient location of nursing stations; narrow corridors; or other provisions contained in the licensure and certification rules.

**Subd. 5. Replacement restrictions.** (a) Proposals submitted or approved under this section involving replacement must provide for replacement of the facility on the existing site except as allowed in this subdivision.

(b) Facilities located in a metropolitan statistical area other than the Minneapolis-St. Paul seven-county metropolitan area may relocate to a site within the same census tract or a contiguous census tract.

(c) Facilities located in the Minneapolis-St. Paul seven-county metropolitan area may relocate to a site within the same or contiguous health planning area as adopted in March 1982 by the metropolitan council.

(d) Facilities located outside a metropolitan statistical area may relocate to a site within the same city or township, or within a contiguous township.

(e) A facility relocated to a different site under paragraph (b), (c), or (d) must not be relocated to a site more than six miles from the existing site.

**Subd. 6. Conversion restrictions.** Proposals submitted or approved under this section involving conversion must satisfy the following conditions:

(a) Conversion is limited to a total of five beds.

(b) An equivalent number of hospital beds must be delicensed.

(c) The average occupancy rate in the existing nursing home beds must be greater than 96 percent according to the most recent annual statistical report of the department of health.

(d) The cost of remodeling the hospital rooms to meet current nursing home construction standards must not exceed ten percent of the appraised value of the nursing home or \$200,000, whichever is less.

(e) The conversion must not result in an increase in operating costs.

**Subd. 7. Upgrading restrictions.** Proposals submitted or approved under this section involving upgrading must satisfy the following conditions:

(a) No proposal for upgrading may be approved after June 30, 1989.

(b) No more than one proposal for upgrading may be approved for a facility.

(c) Upgrading is limited to a total of ten beds.

(d) The facility must meet minimum nursing home care standards.

(e) Upgrading must not result in an increase in per diem operating costs, except for the upgrading of those freestanding boarding care facilities which currently meet existing nursing home building and space standards.

(f) If beds are upgraded to nursing home beds, the number of boarding care beds in a facility must not increase in the future.

(g) The average occupancy rate in the existing nursing home beds must be greater than 96 percent according to the most recent annual statistical report of the department of health.

(h) The cost of remodeling the facility to meet current nursing home construction standards must not exceed ten percent of the appraised value of the facility or \$200,000, whichever is less.

**Subd. 8. Rulemaking.** The commissioner of health shall adopt emergency or permanent rules to implement this section.

**History:** 1987 c 403 art 4 s 4

#### **144A.10 INSPECTION; COMMISSIONER OF HEALTH; FINES.**

**Subdivision 1. Enforcement authority.** The commissioner of health is the exclusive state agency charged with the responsibility and duty of inspecting all facilities required to be licensed under section 144A.02. The commissioner of health shall enforce the rules established pursuant to sections 144A.01 to 144A.17, subject only to the authority of the department of public safety respecting the enforcement of fire and safety standards in nursing homes and the responsibility of the commissioner of human services under sections 245.781 to 245.821 or 252.28.

The commissioner may request and must be given access to relevant information, records, incident reports, or other documents in the possession of a licensed facility if the commissioner considers them necessary for the discharge of responsibilities. For the purposes of inspections and securing information to determine compliance with the licensure laws and rules, the commissioner need not present a release, waiver, or consent of the individual. The identities of patients or residents must be kept private as defined by section 13.02, subdivision 12.

**Subd. 2. Inspections.** The commissioner of health shall inspect each nursing home to ensure compliance with sections 144A.01 to 144A.17 and the rules promulgated to implement them. The inspection shall be a full inspection of the nursing home. If upon a reinspection provided for in subdivision 5 the representative of the commissioner of health finds one or more uncorrected violations, a second inspection of the facility shall be conducted. The second inspection need not be a full inspection. No prior notice shall be given of an inspection conducted pursuant to this subdivision. Any employee of the commissioner of health who willfully gives or causes to be given any advance notice of an inspection required or authorized by this subdivision shall be subject to suspension or dismissal in accordance with chapter 43A. An inspection required by a federal rule or statute may be conducted in conjunction with or subsequent to any other inspection. Any inspection required by this subdivision may be in addition to or in conjunction with the reinspections required by subdivision 5. Nothing in this subdivision shall be construed to prohibit the commissioner of health from making more than one unannounced inspection of any nursing home during its license year. The commissioner of health shall coordinate inspections of nursing homes with inspections by other state and local agencies consistent with the requirements of this section and the Medicare and Medicaid certification programs.

The commissioner shall conduct inspections and reinspections of health facilities with a frequency and in a manner calculated to produce the greatest benefit to residents within the limits of the resources available to the commissioner. In performing this function, the commissioner may devote proportionately more resources to the inspection of those facilities in which conditions present the most serious concerns with respect to resident health, treatment, comfort, safety, and well-being.

These conditions include but are not limited to: change in ownership; frequent change in administration in excess of normal turnover rates; complaints about care, safety, or rights; where previous inspections or reinspections have resulted in correction orders related to care, safety, or rights; and, where persons involved in ownership or administration of the facility have been indicted for alleged criminal activity. Any facility that has none of the above conditions or any other condition established by the

commissioner that poses a risk to resident care, safety, or rights shall be inspected once every two years.

*[For text of subds 3 to 10, see M.S.1986]*

**History:** 1987 c 209 s 26,27

#### **144A.115 VIOLATIONS; PENALTIES.**

**Subdivision 1. Operating without a license.** The operation of a facility providing services required to be licensed under sections 144A.02 to 144A.10 without a license is a misdemeanor punishable by a fine of not more than \$300.

**Subd. 2. Advertising without a license.** A person or entity that advertises a facility required to be licensed under sections 144A.02 to 144A.10 before obtaining a license is guilty of a misdemeanor.

**Subd. 3. Other sanctions.** The sanctions in this section do not restrict other available sanctions.

**History:** 1987 c 209 s 28

#### **144A.16 CESSATION OF OPERATIONS.**

If a nursing home voluntarily plans to cease operations or to curtail operations to the extent that relocation of residents is necessary, the controlling persons of the facility shall notify the commissioner of health at least 90 days prior to the scheduled cessation or curtailment. The commissioner of health shall cooperate with and advise the controlling persons of the nursing home in the resettlement of residents. Failure to comply with this section shall be a violation of section 144A.10.

**History:** 1987 c 209 s 29

#### **144A.27 ACTING ADMINISTRATORS.**

If a licensed nursing home administrator is removed from the position by death or other unexpected cause, the controlling persons of the nursing home suffering the removal may designate an acting nursing home administrator who shall secure an acting administrator's license within 30 days of appointment as the acting administrator.

**History:** 1987 c 403 art 4 s 5

#### **144A.31 INTERAGENCY BOARD FOR QUALITY ASSURANCE.**

**Subdivision 1. Interagency board.** The commissioners of health and human services shall establish, by July 1, 1983, an interagency board of employees of their respective departments who are knowledgeable and employed in the areas of long-term care, geriatric care, long-term care facility inspection, or quality of care assurance. The number of interagency board members shall not exceed eight; three members each to represent the commissioners of health and human services and one member each to represent the directors of state planning and housing finance. The board shall identify long-term care issues requiring coordinated interagency policies and shall conduct analyses, coordinate policy development, and make recommendations to the commissioners for effective implementation of these policies. The commissioner of human services and the commissioner of health or their designees shall annually alternate chairing and convening the board. The board may utilize the expertise and time of other individuals employed by either department as needed. The board may recommend that the commissioners contract for services as needed. The board shall meet as often as necessary to accomplish its duties, but at least quarterly. The board shall establish procedures, including public hearings, for allowing regular opportunities for input from residents, nursing homes, and other interested persons.

**Subd. 2. Inspections.** No later than January 1, 1988, the board shall develop and recommend implementation and enforcement of an effective system to ensure quality of care in each nursing home in the state. Quality of care includes evaluating, using

the resident's care plan, whether the resident's ability to function is optimized and should not be measured solely by the number or amount of services provided.

The board shall assist the commissioner of health in developing methods to ensure that inspections and reinspections of nursing homes are conducted with a frequency and in a manner calculated to most effectively and appropriately fulfill its quality assurance responsibilities and achieve the greatest benefit to nursing home residents. The board shall identify and recommend criteria and methods for identifying those nursing homes that present the most serious concerns with respect to resident health, treatment, comfort, safety, and well-being. The commissioner of health shall require a higher frequency and extent of inspections with respect to those nursing homes that present the most serious concerns with respect to resident health, treatment, comfort, safety, and well-being. These concerns include but are not limited to: complaints about care, safety, or rights; situations where previous inspections or reinspections have resulted in correction orders related to care, safety, or rights; instances of frequent change in administration in excess of normal turnover rates; and situations where persons involved in ownership or administration of the nursing home have been convicted of engaging in criminal activity. A nursing home that presents none of these concerns or any other concern or condition recommended by the board and established by the commissioner that poses a risk to resident care, safety, or rights shall be inspected once every two years for compliance with key requirements as determined by the board.

The board shall develop and recommend to the commissioners mechanisms beyond the inspection process to protect resident care, safety, and rights, including but not limited to coordination with the office of health facility complaints and the nursing home ombudsman program.

**Subd. 3. Methods for determining resident care needs.** The board shall develop and recommend to the commissioners definitions for levels of care and methods for determining resident care needs for implementation on July 1, 1985, in order to adjust payments for resident care based on the mix of resident needs in a nursing home. The methods for determining resident care needs shall include assessments of ability to perform activities of daily living and assessments of medical and therapeutic needs.

**Subd. 4. Enforcement.** The board shall develop and recommend for implementation effective methods of enforcing quality of care standards. The board shall develop and monitor, and the commissioner of human services shall implement, a resident relocation plan that instructs a county in which a nursing home or certified boarding care home is located of procedures to ensure that the needs of residents in nursing homes or certified boarding care homes about to be closed are met. The duties of a county under the relocation plan also apply when residents are to be discharged from a nursing home or certified boarding care home as a result of a change in certification, closure, or loss or termination of the facility's medical assistance provider agreement. The resident relocation plans and county duties required in this subdivision apply to the voluntary or involuntary closure, or reduction in services or size of, an intermediate care facility for the mentally retarded. The relocation plan for intermediate care facilities for the mentally retarded must conform to Minnesota Rules, parts 4655.6810 to 4655.6830, 9525.0015 to 9525.0165, and 9546.0010 to 9546.0060, or their successors. The commissioners of health and human services may waive a portion of existing rules that the commissioners determine does not apply to persons with mental retardation or related conditions. The county shall ensure appropriate placement of residents in licensed and certified facilities or other alternative care such as home health care and foster care placement. In preparing for relocation, the board shall ensure that residents and their families or guardians are involved in planning the relocation.

**Subd. 5. Reports.** The board shall prepare a report and the commissioners of health and human services shall deliver this report to the legislature no later than January 15, 1984, on the board's proposals and progress on implementation of the methods required under subdivision 2. The commissioners shall recommend changes in or additions to legislation necessary or desirable to fulfill their responsibilities. The



board shall prepare an annual report and the commissioners shall deliver this report annually to the legislature, beginning in January 1985, on the implementation of the provisions of this section.

Subd. 6. **Data.** The interagency board may have access to data from the commissioners of health, human services, and public safety for carrying out its duties under this section. The commissioner of health and the commissioner of human services may each have access to data on persons, including data on vendors of services, from the other to carry out the purposes of this section. If the interagency board, the commissioner of health, or the commissioner of human services receives data on persons, including data on vendors of services, that is collected, maintained, used or disseminated in an investigation, authorized by statute and relating to enforcement of rules or law, the board or the commissioner shall not disclose that information except:

- (a) pursuant to section 13.05;
- (b) pursuant to statute or valid court order; or
- (c) to a party named in a civil or criminal proceeding, administrative or judicial, for preparation of defense.

Data described in this subdivision is classified as public data upon its submission to an administrative law judge or court in an administrative or judicial proceeding.

**History:** 1987 c 209 s 30

#### 144A.33 RESIDENT AND FAMILY ADVISORY COUNCIL EDUCATION.

*[For text of subds 1 and 2, see M.S.1986]*

Subd. 3. **Funding of advisory council education.** A license application or renewal fee for nursing homes and boarding care homes under section 144.53 or 144A.07 must be increased by \$2.75 per bed to fund the development and education of resident and family advisory councils.

Subd. 4. **Special account.** All money collected by the commissioner of health under subdivision 3 must be deposited in the state treasury and credited to a special account called the nursing home advisory council fund. Money credited to the fund is appropriated to the Minnesota board on aging for the purposes of this section.

*[For text of subd 5, see M.S.1986]*

**History:** 1987 c 403 art 2 s 13,14

### HOME CARE HOSPICE PROGRAM

#### 144A.43 DEFINITIONS.

Subdivision 1. **Applicability.** The definitions in this section apply to sections 144.699, subdivision 2, and 144A.43 to 144A.48.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 3. **Home care service.** "Home care service" means any of the following services when delivered in a place of residence to a person whose illness, disability, or physical condition creates a need for the service:

- (1) nursing services, including the services of a home health aide;
- (2) personal care services not included under sections 148.171 to 148.299;
- (3) physical therapy;
- (4) speech therapy;
- (5) respiratory therapy;
- (6) occupational therapy;
- (7) nutritional services;
- (8) home management services when provided to a person who is unable to perform these activities due to illness, disability, or physical condition. Home manage-

ment services include at least two of the following services: housekeeping, meal preparation, laundry, shopping, and other similar services;

(9) medical social services;

(10) the provision of medical supplies and equipment when accompanied by the provision of a home care service;

(11) the provision of a hospice program as specified in section 144A.48; and

(12) other similar medical services and health-related support services identified by the commissioner in rule.

**Subd. 4. Home care provider.** "Home care 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 home care services for a fee. At least one home care service must be provided directly, although additional home care services may be provided by contractual arrangements. "Home care provider" includes a hospice program defined in section 144A.48. "Home care provider" does not include:

(1) any home care or nursing services conducted by and for the adherents of any recognized church or religious denomination for the purpose of providing care and services for those who depend upon spiritual means, through prayer alone, for healing;

(2) an individual who only provides services to a relative;

(3) an individual not connected with a home care provider who provides assistance with home management services or personal care needs if the assistance is provided primarily as a contribution and not as a business;

(4) an individual not connected with a home care provider who shares housing with and provides primarily housekeeping or homemaking services to an elderly or disabled person in return for free or reduced-cost housing;

(5) an individual or agency providing home-delivered meal services;

(6) an agency providing senior companion services and other older American volunteer programs established under the Domestic Volunteer Service Act of 1973, Public Law Number 98-288;

(7) an individual or agency that only provides chore, housekeeping, or child care services which do not involve the provision of home care services;

(8) an employee of a nursing home licensed under this chapter who provides emergency services to individuals residing in an apartment unit attached to the nursing home;

(9) a member of a professional corporation organized under sections 319A.01 to 319A.22 that does not regularly offer or provide home care services as defined in subdivision 3;

(10) the following organizations established to provide medical or surgical services that do not regularly offer or provide home care services as defined in subdivision 3: a business trust organized under sections 318.01 to 318.04, a nonprofit corporation organized under chapter 317, a partnership organized under chapter 323, or any other entity determined by the commissioner;

(11) an individual or agency that provides medical supplies or durable medical equipment, except when the provision of supplies or equipment is accompanied by a home care service; or

(12) an individual licensed under chapter 147.

**History:** 1987 c 378 s 3

#### 144A.44 HOME CARE BILL OF RIGHTS.

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

(1) the right to receive written information about rights, including what to do if rights are violated;

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

(3) the right to be told about the services that are being provided or suggested, about other choices that are available, and about the consequences of these choices including the consequences of refusing these services;

(4) the right to refuse services or treatment;

(5) the right to know, in advance, any limits to the services available from a provider, whether the services are covered by health insurance, medical assistance, or other health programs, and the provider's grounds for a termination of services;

(6) the right to know what the charges are for services, no matter who will be paying the bill;

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

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

(9) the right to have personal, financial, and medical information kept private;

(10) the right to be allowed access to records and written information from records in accordance with section 144.335;

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

(12) the right to be treated with courtesy and respect;

(13) the right to be free from physical and verbal abuse;

(14) the right to reasonable notice of changes in services or charges;

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

(16) the right to know how to contact an individual associated with the provider who is responsible for handling problems and the name and address of the state or county agency to contact for additional information or assistance; and

(17) the right to assert these rights without retaliation.

**Subd. 2. Interpretation and enforcement of rights.** These rights are established for the benefit of persons who receive home care services. "Home care services" means home care services as defined in section 144A.43, subdivision 3. A home care provider may not require a person to surrender these rights as a condition of receiving services. A guardian or conservator or, when there is no guardian or conservator, a designated person, may seek to enforce these rights. This statement of rights does not replace or diminish other rights and liberties that may exist relative to persons receiving home care services, persons providing home care services, or providers licensed under Laws 1987, chapter 378. A copy of these rights must be provided to an individual at the time home care services are initiated. The copy shall also contain the address and phone number of the office of health facility complaints and a brief statement describing how to file a complaint with that office.

**History:** 1987 c 378 s 4

#### **144A.45 REGULATION OF HOME CARE SERVICES.**

**Subdivision 1. Rules.** The commissioner shall adopt rules for the regulation of home care providers pursuant to sections 144A.43 to 144A.49. The rules shall include the following:

(a) provisions to assure, to the extent possible, the health, safety and well-being, and appropriate treatment of persons who receive home care services;

(b) requirements that home care providers furnish the commissioner with specified information necessary to implement sections 144A.43 to 144A.49;

(c) standards of training of home care provider personnel, which may vary according to the nature of the services provided or the health status of the consumer;

(d) standards of supervision by a registered nurse or other appropriate health care professionals of personnel providing home care services, which may vary according to the nature of the services provided or the health status of the consumer;

(e) requirements for the involvement of a consumer's physician, the documentation of physicians' orders, if required, and the consumer's treatment plan, and the maintenance of accurate, current clinical records;

(f) the establishment of different classes of licenses for different types of providers and different standards and requirements for different kinds of home care services; and

(g) operating procedures required to implement the home care bill of rights.

**Subd. 2. Regulatory functions.** (a) The commissioner shall:

(1) evaluate, monitor, and license home care providers in accordance with sections 144A.45 to 144A.49;

(2) inspect the office and records of a provider during regular business hours, provided that when conducting routine office visits or inspections, the commissioner shall provide at least 48 hours advance notice to the home care provider;

(3) with the consent of the consumer, visit the home where services are being provided;

(4) issue correction orders and assess civil penalties in accordance with section 144.653, subdivisions 5 to 8; and

(5) take other action reasonably required to accomplish the purposes of sections 144A.43 to 144A.49.

(b) In the exercise of the authority granted in sections 144A.43 to 144A.49, the commissioner shall comply with the applicable requirements of section 144.122, the government data practices act, and the administrative procedure act.

**Subd. 3. Advisory task force.** The commissioner of health shall establish and appoint a home care advisory task force consisting of 15 members representing the various kinds of home care providers, including a hospice program, health care professionals, community health services agencies, and consumers. The appointment, removal, and compensation of members is as provided in section 15.059, subdivision 6. The task force shall provide advice and recommendations to the commissioner regarding the development of rules required by subdivision 1.

**History:** 1987 c 378 s 5

#### **144A.46 LICENSURE.**

**Subdivision 1. License required.** (a) A home care provider may not operate in the state without a current license issued by the commissioner of health.

(b) Within ten days after receiving an application for a license, the commissioner shall acknowledge receipt of the application in writing. The acknowledgement must indicate whether the application appears to be complete or whether additional information is required before the application will be considered complete. Within 90 days after receiving a complete application, the commissioner shall either grant or deny the license. If an applicant is not granted or denied a license within 90 days after submitting a complete application, the license must be deemed granted. An applicant whose license has been deemed granted must provide written notice to the commissioner before providing a home care service.

**Subd. 2. Exemptions.** The following individuals or organizations are exempt from the requirement to obtain a home care provider license:

(1) a person who is licensed under sections 148.171 to 148.285 and who independently provides nursing services in the home without any contractual or employment relationship to a home care provider or other organization;

(2) a personal care assistant who provides services under the medical assistance program as authorized under section 256B.02, subdivision 8, paragraph (17), and section 256B.04, subdivision 16;

(3) a person or organization that exclusively offers, provides, or arranges for personal care assistant services under the medical assistance program as authorized under section 256B.02, subdivision 8, paragraph (17), and section 265B.04, subdivision 16;

(4) a person who is registered under sections 148.65 to 148.78 and who independently provides physical therapy services in the home without any contractual or employment relationship to a home care provider or other organization;

(5) a person who provides services to a person with mental retardation under a program of semi-independent living services regulated by Minnesota Rules, parts 9525.0500 to 9525.0660; or

(6) a person who provides services to a person with mental retardation under contract with a county to provide home and community-based services that are reimbursed under the medical assistance program, chapter 256B, and regulated by Minnesota Rules, parts 9525.1800 to 9525.1930.

An exemption under this subdivision does not excuse the individual from complying with applicable provisions of the home care bill of rights.

**Subd. 3. Enforcement.** The commissioner may refuse to grant or renew a license, or may suspend or revoke a license, for violation of statutes or rules relating to home care services or for conduct detrimental to the welfare of the consumer. Prior to any suspension, revocation, or refusal to renew a license, the home care provider shall be entitled to notice and a hearing as provided by sections 14.57 to 14.70. In addition to any other remedy provided by law, the commissioner may, without a prior contested case hearing, temporarily suspend a license or prohibit delivery of services by a provider for not more than 60 days if the commissioner determines that the health or safety of a consumer is in imminent danger, provided (1) advance notice is given to the provider; (2) after notice, the provider fails to correct the problem; (3) the commissioner has reason to believe that other administrative remedies are not likely to be effective; and (4) there is an opportunity for a contested case hearing within the 60 days. The process of suspending or revoking a license must include a plan for transferring affected clients to other providers.

**Subd. 4. Relation to other regulatory programs.** In the exercise of the authority granted under sections 144A.43 to 144A.49, the commissioner shall not duplicate or replace standards and requirements imposed under another state regulatory program. The commissioner shall not impose additional training or education requirements upon members of a licensed or registered occupation or profession, except as necessary to address or prevent problems that are unique to the delivery of services in the home or to enforce and protect the rights of consumers listed in section 144A.44. For home care providers certified under the Medicare program, the state standards must not be inconsistent with the Medicare standards for Medicare services. To the extent possible, the commissioner shall coordinate the inspections required under sections 144A.45 to 144A.48 with the health facility licensure inspections required under sections 144.50 to 144.58 or 144A.10 when the health care facility is also licensed under the provisions of Laws 1987, chapter 378.

**Subd. 5. Prior criminal convictions.** An applicant for a home care provider license shall disclose to the commissioner all criminal convictions of persons involved in the management, operation, or control of the provider. A home care provider shall require employees of the provider and applicants for employment to disclose all criminal convictions. No person may be employed by a home care provider or involved in the management, operation, or control of a provider, if the person has been convicted of a crime that relates to the provision of home care services or to the position, duties, or responsibilities undertaken by that person in the operation of the home care provider, unless the person can provide sufficient evidence of rehabilitation. The commissioner shall adopt rules for determining whether a crime relates to home care services and what constitutes sufficient evidence of rehabilitation. The rules must require consideration of the nature and seriousness of the crime; the relationship of the crime to the purposes of home care licensure and regulation; the relationship of the

crime to the ability, capacity, and fitness required to perform the duties and discharge the responsibilities of the person's position; mitigating circumstances or social conditions surrounding the commission of the crime; the length of time elapsed since the crime was committed; the seriousness of the risk to the home care client's person or property; and other factors the commissioner considers appropriate. Data collected under this subdivision shall be classified as private data under section 13.02, subdivision 12.

**History:** 1987 c 378 s 6

#### **144A.47 INFORMATION AND REFERRAL SERVICES.**

The commissioner shall ensure that information and referral services relating to home care are available in all regions of the state. The commissioner shall collect and make available information about available home care services, sources of payment, providers, and the rights of consumers. The commissioner may require home care providers to provide information requested for the purposes of this section, including price information, as a condition of registration or licensure. Specific price information furnished by providers under this section is not public data and must not be released without the written permission of the agency. The commissioner may publish and make available:

- (1) general information and a summary of the range of prices of home care services in the state;
- (2) limitations on hours, availability of services, and eligibility for third-party payments, applicable to individual providers; and
- (3) other information the commissioner determines to be appropriate.

**History:** 1987 c 378 s 7

#### **144A.48 HOSPICE PROGRAMS.**

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

(1) "Core services" means physician services, registered nursing services, medical social services, pastoral care or other counseling services, and volunteer services that are provided either directly by the hospice program or through a service contract or other arrangement;

(2) "Hospice patient" means an individual who has been diagnosed as terminally ill with a probable life expectancy of under one year, as documented by the individual's attending physician, and who alone or, when unable, through the hospice patient's family has voluntarily consented to and received admission to a hospice program;

(3) "Hospice patient's family" means relatives of the hospice patient, the hospice patient's guardian, primary caregivers, or persons identified by the hospice patient as having significant personal ties;

(4) "Hospice program" means palliative and supportive care and other services provided by an interdisciplinary team under the direction of an identifiable hospice administration to terminally ill hospice patients and their families to meet the physical, nutritional, emotional, social, spiritual, and special needs experienced during the final stages of illness, dying, and bereavement, through a centrally coordinated program that ensures continuity and consistency of home and inpatient care provided directly or through an agreement;

(5) "Interdisciplinary team" means a group of qualified individuals with expertise in meeting the special needs of hospice patients and their families, including, at a minimum, those individuals who are providers of core services;

(6) "Palliative care" means care directed at managing the symptoms experienced by the hospice patient and intended to enhance the quality of life for the hospice patient and the patient's family, but not directed at curing the illness; and

(7) "Volunteer services" means services by volunteers who provide a personal

presence that augments a variety of professional and nonprofessional services available to the hospice patient, the patient's family, and the hospice program.

**Subd. 2. License requirements.** A hospice program may not operate in the state or use the words "hospice" or "hospice program" without a current license issued by the commissioner of health. The commissioner shall license hospice programs using the powers and authorities contained in sections 144A.43 to 144A.47 and 144A.49. In addition a hospice program must provide:

- (1) centrally coordinated hospice core services in the home and inpatient settings;
- (2) that the medical components of the hospice program are under the direction of a licensed physician who serves as medical director;
- (3) that the palliative medical care provided to a hospice patient is under the direction of the attending physician;
- (4) an interdisciplinary team that meets regularly to develop, implement, and evaluate the hospice program's plan of care for each hospice patient and the patient's family;
- (5) accessible hospice care, 24 hours a day, seven days a week;
- (6) an ongoing system of quality assurance;
- (7) that volunteer services are provided by individuals who have completed a hospice training program and are qualified to provide the services;
- (8) a planned program of supportive services available to patients' families during the bereavement period; and
- (9) that inpatient services are provided directly or by arrangement in a licensed hospital or nursing home.

**Subd. 3. Required inspections.** The commissioner shall inspect the hospice program, the home care and the inpatient care provided by the hospice program to determine if the requirements of sections 144A.45 to 144A.48 are met.

**Subd. 4. Rule authority.** The commissioner shall promulgate rules to implement the provisions of this section.

**Subd. 5. License designation.** A license issued to a home care provider meeting the requirements contained in this section shall indicate that the provider is qualified to offer hospice care.

**History:** 1987 c 378 s 8

#### 144A.49 TEMPORARY PROCEDURES.

For purposes of this section, "home care providers" shall mean the providers described in section 144A.43, subdivision 4, including hospice programs described in section 144A.48. Home care providers are exempt from the licensure requirement in section 144A.46, subdivision 1, until 90 days after the effective date of the licensure rules. Beginning July 1, 1987, no home care provider, as defined in section 144A.43, subdivision 4, except a provider exempt from licensure under section 144A.46, subdivision 2, may provide home care services in this state without registering with the commissioner. A home care provider is registered with the commissioner when the commissioner has received in writing the provider's name; the name of its parent corporation or sponsoring organization, if any; the street address and telephone number of its principal place of business; the street address and telephone number of its principal place of business in Minnesota; the counties in Minnesota in which it may render services; the street address and telephone number of all other offices in Minnesota; and the name, educational background, and ten-year employment history of the person responsible for the management of the agency. A registration fee must be submitted with the application for registration. The fee must be established pursuant to section 144.122 and must be based on a consideration of the following factors: the number of clients served by the home care provider, the number of employees, the number of services offered, and annual revenues of the provider. The registration is effective until 90 days after licensure rules are effective. In order to maintain its

registration and provide services in Minnesota, a home care provider must comply with section 144A.44 and comply with requests for information under section 144A.47. A registered home care provider is subject to sections 144A.51 to 144A.54. Registration under this section does not exempt a home care provider from the licensure and other requirements later adopted by the commissioner.

Within 90 days after the effective date of the licensure rules under section 144A.45, the commissioner of health shall issue provisional licenses to all home care providers registered with the department as of that date. The provisional license shall be valid until superseded by a license issued under section 144A.46 or for a period of one year, whichever is shorter. Applications for licensure as a home care provider received on or after the effective date of the home care licensure rules, shall be issued under section 144A.46, subdivision 1.

**History:** 1987 c 378 s 14

#### **144A.51 DEFINITIONS.**

*[For text of subds 1 to 5, see M.S.1986]*

Subd. 6. "Resident" means any resident or patient of a health facility or a consumer of services provided by a home care provider, or the guardian or conservator of the resident, patient, or consumer, if one has been appointed.

Subd. 7. "Home care provider" means a home care provider as defined in section 144A.43, subdivision 4.

**History:** 1987 c 378 s 9,10

#### **144A.52 OFFICE OF HEALTH FACILITY COMPLAINTS; CREATION.**

*[For text of subds 1 and 2, see M.S.1986]*

Subd. 3. The director may delegate to members of the staff any of the authority or duties of the director except the duty of formally making recommendations to the legislature, administrative agencies, health facilities, health care providers, home care providers, and the state commissioner of health.

*[For text of subd 4, see M.S.1986]*

**History:** 1987 c 378 s 11

#### **144A.53 DIRECTOR; POWERS AND DUTIES.**

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

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

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

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

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



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

(f) Issue a correction order pursuant to section 144.653 or any other law which provides for the issuance of correction orders to health care facilities or home care provider, or under section 144A.45. A facility's refusal to cooperate in providing lawfully requested information may also be grounds for a correction order.

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

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

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

**Subd. 2. Complaints.** The director may receive a complaint from any source concerning an action of an administrative agency, a health care provider, a home care provider, or a health facility. The director may require a complainant to pursue other remedies or channels of complaint open to the complainant before accepting or investigating the complaint.

The director shall keep written records of all complaints and any action upon them. After completing an investigation of a complaint, the director shall inform the complainant, the administrative agency having jurisdiction over the subject matter, the health care provider, the home care provider, and the health facility of the action taken.

**Subd. 3. Recommendations.** If, after duly considering a complaint and whatever material the director deems pertinent, the director determines that the complaint is valid, the director may recommend that an administrative agency, a health care provider, a home care provider, or a health facility should:

- (a) Modify or cancel the actions which gave rise to the complaint;
- (b) Alter the practice, rule or decision which gave rise to the complaint;
- (c) Provide more information about the action under investigation; or
- (d) Take any other step which the director considers appropriate.

If the director requests, the administrative agency, a health care provider, a home care provider, or health facility shall, within the time specified, inform the director about the action taken on a recommendation.

**Subd. 4. Referral of complaints.** If a complaint received by the director relates to a matter more properly within the jurisdiction of an occupational licensing board or other governmental agency, the director shall forward the complaint to that agency and shall inform the complaining party of the forwarding. The agency shall promptly act in respect to the complaint, and shall inform the complaining party and the director of its disposition. If a governmental agency receives a complaint which is more properly within the jurisdiction of the director, it shall promptly forward the complaint to the director, and shall inform the complaining party of the forwarding. If the director has reason to believe that an official or employee of an administrative agency, a home care provider, or health facility has acted in a manner warranting criminal or disciplinary proceedings, the director shall refer the matter to the state commissioner of health, the commissioner of human services, an appropriate prosecuting authority, or other appropriate agency.

**History:** 1987 c 209 s 31; 1987 c 378 s 12

#### **144A.54 PUBLICATION OF RECOMMENDATIONS; REPORTS.**

**Subdivision 1.** Except as otherwise provided by this section, the director may determine the form, frequency, and distribution of the conclusions and recommenda-

tions. The director shall transmit the conclusions and recommendations to the state commissioner of health and the legislature. Before announcing a conclusion or recommendation that expressly or by implication criticizes an administrative agency, a health care provider, a home care provider, or a health facility, the director shall consult with that agency, health care provider, home care provider, or facility. When publishing an opinion adverse to an administrative agency, a health care provider, a home care provider, or a health facility, the director shall include in the publication any statement of reasonable length made to the director by that agency, health care provider, home care provider, or health facility in defense or explanation of the action.

*[For text of subds 2 and 3, see M.S.1986]*

**History:** 1987 c 378 s 13