CHAPTER 144A

NURSING HOMES

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144A.04 QUALIFICATIONS FOR LICENSE.

[For text of subds 1 to 4a, see M.S.1990]

Subd. 5. **Administrators.** Except as otherwise provided by this subdivision, a nursing home must have a full time licensed nursing home administrator serving the facility. In any nursing home of less than 25 beds, the director of nursing services may also serve as the licensed nursing home administrator. Two nursing homes under common ownership having a total of 150 beds or less and located within 75 miles of each other may share the services of a licensed administrator if the administrator divides full-time work week between the two facilities in proportion to the number of beds in each facility. Every nursing home shall have a person-in-charge on the premises at all times in the absence of the licensed administrator. The name of the person in charge must be posted in a conspicuous place in the facility. The commissioner of health shall by rule promulgate minimum education and experience requirements for persons-in-charge, and may promulgate rules specifying the times of day during which a licensed administrator must be on the nursing home's premises. In the absence of rules adopted by the commissioner governing the division of an administrator's time between two nursing homes, the administrator shall designate and post the times the administrator will be on site in each home on a regular basis. A nursing home may employ as its administrator the administrator of a hospital licensed pursuant to sections 144.50 to 144.56 if the individual is licensed as a nursing home administrator pursuant to section 144A.20 and the nursing home and hospital have a combined total of 150 beds or less and are located within one mile of each other. A nonproprietary retirement home having fewer than 15 licensed nursing home beds may share the services of a licensed administrator with a nonproprietary nursing home, having fewer than 150 licensed nursing home beds, that is located within 25 miles of the retirement home. A nursing home which is located in a facility licensed as a hospital pursuant to sections 144.50 to 144.56, may employ as its administrator the administrator of the hospital if the individual meets minimum education and long term care experience criteria set by rule of the commissioner of health.

[For text of subds 6 to 9, see M.S.1990]

History: *1991 c 169 s 1*

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

[For text of subds 1 and 2, see M.S.1990]

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 hard-

ship 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 nursing home beds are not certified for participation in the medical assistance program; and

(2) the relocation of nursing home beds under this clause should not exceed a radius of six miles;

(l) 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 to a building formerly used as a hospital, provided the original nursing home building will no longer be operated as a nursing home and the building to which the beds are moved will no longer be operated as a 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. 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. The relocated beds need not be licensed and certified at the new location simultaneously with the delicensing and decertification of the old beds and may be licensed and certified at any time after the old beds are delicensed and decertified;

(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;

(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);

(p) to certify and license as nursing home beds boarding care beds in a certified boarding care facility if the beds meet the standards for nursing home licensure and if the cost of any remodeling of the facility does not exceed ten percent of the appraised value of the facility or $200,000, whichever is less; or to license as nursing home beds boarding care beds in a facility with an addendum to its provider agreement effective beginning July 1, 1983, if the boarding care beds to be upgraded meet the standards for nursing home licensure. If boarding care beds are licensed as nursing home beds, the number of boarding care beds in the facility must not increase in the future. The provisions contained in section 144A.073 regarding the upgrading of the facilities do not apply to facilities that satisfy these requirements;

(q) to license and certify up to 40 beds transferred from an existing facility owned and operated by the Amherst H. Wilder Foundation in the city of Saint Paul to a new unit at the same location as the existing facility that will serve persons with Alzheimer's disease and other related disorders. The transfer of beds may occur gradually or in stages, provided the total number of beds transferred does not exceed 40. At the time of licensure and certification of a bed or beds in the new unit, the commissioner of health shall delicense and decertify the same number of beds in the existing facility. 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 transfers allowed under this clause;

(r) to license and certify nursing home beds to replace currently licensed and certified boarding care beds which may be located either in a remodeled or renovated boarding care or nursing home facility or in a remodeled, renovated, newly constructed, or replacement nursing home facility within the identifiable complex of health care facilities in which the currently licensed boarding care beds are presently located, provided that the number of boarding care beds in the facility or complex are decreased by the number to be licensed as nursing home beds and further provided that, if the total costs of new construction, replacement, remodeling, or renovation exceed ten percent of the appraised value of the facility or $200,000, whichever is less, 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 new construction, replacement, remodeling, or renovation. The provisions contained in section 144A.073 regarding the upgrading of facilities do not apply to facilities that satisfy these requirements;

(s) to license or certify beds that are moved from a nursing home to a separate facility under common ownership or control that was formerly licensed as a hospital and is currently licensed as a nursing facility and that is located within eight miles of the original facility, provided the original nursing home building will no longer be operated as a nursing home. 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; or

(t) to license as a nursing home and certify as a nursing facility a facility that is licensed as a boarding care facility but not certified under the medical assistance program, but only if the commissioner of human services certifies to the commissioner of health that licensing the facility as a nursing home and certifying the facility as a nursing facility will result in a net annual savings to the state general fund of $200,000 or more.

Subd. 3a. **Certification of licensed beds in a certified facility.** Nothing in this section prohibits the commissioner of health from certifying licensed nursing home beds in a facility certified for medical assistance provided that these beds meet the certification requirements and the facility enters into a written agreement with the commissioner of human services specifying that medical assistance reimbursement shall not be requested for a greater number of residents than the facility had medical assistance certified beds on April 1, 1991.

[For text of subds 4 and 5, see M.S.1990]

History: *1991 c 93 s 1; 1991 c 292 art 4 s 1,2*

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

[For text of subds 1 to 3, see M.S.1990]

Subd. 4. **Correction orders.** Whenever a duly authorized representative of the commissioner of health finds upon inspection of a nursing home, that the facility or a controlling person or an employee of the facility is not in compliance with sections 144.411 to 144.417, 144.651, 144A.01 to 144A.16, or 626.557 or the rules promulgated thereun-

der, a correction order shall be issued to the facility. The correction order shall state the deficiency, cite the specific rule or statute violated, state the suggested method of correction, and specify the time allowed for correction. If the commissioner finds that the nursing home had uncorrected or repeated violations which create a risk to resident care, safety, or rights, the commissioner shall notify the commissioner of human services who shall require the facility to use any efficiency incentive payments received under section 256B.431, subdivision 2b, paragraph (d), to correct the violations and shall require the facility to forfeit incentive payments for failure to correct the violations as provided in section 256B.431, subdivision 2p. The forfeiture shall not apply to correction orders issued for physical plant deficiencies.

[For text of subds 5 to 6c, see M.S.1990]

Subd. 6d. **Schedule of fines.** (a) The schedule of fines for noncompliance with correction orders issued to nursing homes that was adopted under the provisions of section 144A.10, subdivision 6, and in effect on May 1, 1989, is effective until repealed, modified, or superseded by rule.

(b) By September 1, 1990, the commissioner shall amend the schedule of fines to increase to $250 the fines for violations of section 144.651, subdivisions 18, 20, 21, 22, 27, and 30, and for repeated violations.

(c) The commissioner shall adopt rules establishing the schedule of fines for deficiencies in the requirements of section 1919(b), (c), and (d), of the Social Security Act, or regulations adopted under that section of the Social Security Act.

[For text of subds 7 to 10, see M.S.1990]

History: *1991 c 286 s 5,6; 1991 c 292 art 4 s 3*

144A.135 TRANSFER AND DISCHARGE APPEALS.

(a) The commissioner shall establish a mechanism for hearing appeals on transfers and discharges of residents by nursing homes or boarding care homes licensed by the commissioner. The commissioner may adopt permanent rules to implement this section.

(b) Until federal regulations are adopted under sections 1819(f)(3) and 1919(f)(3) of the Social Security Act that govern appeals of the discharges or transfers of residents from nursing homes and boarding care homes certified for participation in Medicare or medical assistance, the commissioner shall provide hearings under sections 14.57 to 14.62 and the rules adopted by the office of administrative hearings governing contested cases. To appeal the discharge or transfer, or notification of an intended discharge or transfer, a resident or the resident's representative must request a hearing in writing no later than 30 days after receiving written notice, which conforms to state and federal law, of the intended discharge or transfer.

(c) Hearings under this section shall be held no later than 14 days after receipt of the request for hearing, unless impractical to do so or unless the parties agree otherwise. Hearings shall be held in the facility in which the resident resides, unless impractical to do so or unless the parties agree otherwise.

(d) A resident who timely appeals a notice of discharge or transfer, and who resides in a certified nursing home or boarding care home, may not be discharged or transferred by the nursing home or boarding care home until resolution of the appeal. The commissioner can order the facility to readmit the resident if the discharge or transfer was in violation of state or federal law. If the resident is required to be hospitalized for medical necessity before resolution of the appeal, the facility shall readmit the resident unless the resident's attending physician documents, in writing, why the resident's specific health care needs cannot be met in the facility.

(e) The commissioner and office of administrative hearings shall conduct the hearings in compliance with the federal regulations described in paragraph (b), when adopted.

(f) Nothing in this section limits the right of a resident or the resident's representative to request or receive assistance from the office of ombudsman for older Minnesotans or the office of health facility complaints with respect to an intended discharge or transfer.

History: *1991 c 286 s 7*

144A.29 CONTINUITY OF RULES; AUTHORITY.

[For text of subd 1, see M.S.1990]

Subd. 2. Any investigation, disciplinary hearing, court action or other proceeding affecting a nursing home or nursing home administrator heretofore initiated by the commissioner of health or board of examiners in accordance with chapter 144, shall be conducted and completed in accordance with that chapter as it existed prior to January 1, 1977. Proceedings heretofore initiated by the commissioner of health or board of examiners leading to the establishment of a rule affecting nursing homes or nursing home administrators may be continued and the rule may be promulgated in accordance with heretofore existing law, notwithstanding any other provision of Laws 1976, chapter 173.

Subd. 3. As soon as possible after April 7, 1976, the commissioner of health shall by rule establish a schedule of fines in accordance with section 144A.10, subdivision 6.

[For text of subd 4, see M.S.1990]

History: *1991 c 199 art 1 s 38,39*

144A.31 INTERAGENCY LONG-TERM CARE PLANNING COMMITTEE.

Subdivision 1. **Interagency long-term care planning committee.** The commissioners of health and human services shall establish, by July 1, 1983, an interagency committee of managerial employees of their respective departments who are knowledgeable and employed in the areas of long-term care, geriatric care, community services for the elderly, long-term care facility inspection, or quality of care assurance. The number of interagency committee members shall not exceed twelve; four members each to represent the commissioners of health and human services and one member each to represent the commissioners of state planning, housing finance, finance, and the chair of the Minnesota board on aging. The commissioner of human services and the commissioner of health or their designees shall annually alternate chairing and convening the committee. The committee may utilize the expertise and time of other individuals employed by each department as needed. The committee may recommend that the commissioners contract for services as needed. The committee shall meet as often as necessary to accomplish its duties, but at least quarterly. The committee shall establish procedures, including public hearings, for allowing regular opportunities for input from consumers of long-term care services, advocates, trade associations, facility administrators, county agency administrators, and other interested persons.

Subd. 2. [Repealed, 1991 c 292 art 7 s 26]

Subd. 2a. **Duties.** The interagency committee 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 committee shall refine state long-term goals, establish performance indicators, and develop other methods or measures to evaluate program performance, including client outcomes. The committee shall review the effectiveness of programs in meeting their objectives.

The committee shall also:

(1) facilitate the development of regional and local bodies to plan and coordinate regional and local services;

(2) recommend a single regional or local point of access for persons seeking information on long-term care services;

(3) recommend changes in state funding and administrative policies that are necessary to maximize the use of home and community-based care and that promote the use of the least costly alternative without sacrificing quality of care; and

(4) develop methods of identifying and serving seniors who need minimal services to remain independent but who are likely to develop a need for more extensive services in the absence of these minimal services.

Subd. 2b. **Goals of the committee.** The long-term goals of the committee are:

(1) to achieve a broad awareness and use of low-cost home care and other residential alternatives to nursing homes;

(2) to develop a statewide system of information and assistance to enable easy access to long-term care services;

(3) to develop sufficient alternatives to nursing homes to serve the increased number of people needing long-term care; and

(4) to maintain the moratorium on new construction of nursing home beds and to lower the percentage of elderly served in institutional settings.

These goals are designed to create a new community-based care paradigm for long-term care in Minnesota in order to maximize independence of the older adult population, and to ensure cost-effective use of financial and human resources.

Subd. 3. [Repealed, 1991 c 292 art 7 s 26]

Subd. 4. **Enforcement.** The committee shall develop and recommend for implementation effective methods of enforcing quality of care standards. The committee 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 committee shall ensure that residents and their families or guardians are involved in planning the relocation.

Subd. 5. **Reports.** The committee shall prepare a biennial report and the commissioners of health and human services shall deliver this report to the legislature beginning January 31, 1993, listing progress, achievements, and current goals and objectives. The commissioners shall recommend changes in or additions to legislation necessary or desirable to fulfill their responsibilities.

Subd. 6. **Data.** The interagency committee shall have access to data from the commissioners of health, human services, housing finance, and state planning 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 committee, 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 committee 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.

Subd. 7. **Long-term care research and data base.** The interagency long-term care planning committee shall collect and analyze state and national long-term care data and research, including relevant health data and information and research relating to long-term care and social needs, service utilization, costs, and client outcomes. The committee shall make recommendations to state agencies and other public and private agencies for methods of improving coordination of existing data, develop data needed for long-term care research, and promote new research activities. Research and data activities must be designed to:

(1) improve the validity and reliability of existing data and research information;

(2) identify sources of funding and potential uses of funding sources;

(3) evaluate the effectiveness and client outcomes of existing programs; and

(4) identify and plan for future changes in the number, level, and type of services needed by seniors.

History: *1991 c 292 art 7 s 1*

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 in advance of receiving care or during the initial evaluation visit before the initiation of treatment, 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 in advance of receiving care about the services that will be provided, the disciplines that will furnish care, the frequency of visits proposed to be furnished, other choices that are available, and the consequences of these choices including the consequences of refusing these services;

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

(5) the right to refuse services or treatment;

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

(7) the right to know in advance of receiving care whether the services are covered by health insurance, medical assistance, or other health programs, the charges for services that will not be covered by Medicare, and the charges that the individual may have to pay;

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

(9) 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;

(10) 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;

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

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

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

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

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

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

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

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

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

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

(21) the right to assert these rights personally, or have them asserted by the patient's family or guardian when the patient has been judged incompetent, without retaliation.

[For text of subd 2, see M.S.1990]

History: *1991 c 133 s 1*

144A.45 REGULATION OF HOME CARE SERVICES.

[For text of subd 1, see M.S.1990]

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 without 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, for violations of sections 144A.43 to 144A.48 or the rules adopted under those sections; 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.

[For text of subd 3, see M.S.1990]

History: *1991 c 286 s 8*

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 acknowledgment 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.

(c) Each application for a home care provider license, or for a renewal of a license, shall be accompanied by a fee to be set by the commissioner under section 144.122, except that the commissioner shall not charge a licensure fee to a home care provider operated by a statutory or home rule charter city, county, town, or other governmental entity.

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 as a registered nurse 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 sections 256B.0625, subdivision 19, and 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 sections 256B.0625, subdivision 19, and 256B.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.

[For text of subds 3 to 3b, see M.S.1990]

Subd. 3c. **Time limits for appeals.** To appeal the assessment of civil penalties under section 144A.45, subdivision 2, clause (4), a denial of a waiver or variance, and an action against a license under subdivision 3, a provider must request a hearing no later than 15 days after the provider receives notice of the action.

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. The commissioner of health shall not require a home care provider certified under the Medicare program to comply with a rule adopted under section 144A.45 if the home care provider is required to comply with any equivalent federal law or regulation relating to the same subject matter. The commissioner of health shall specify in the rules those provisions that are not applicable to certified home care providers. 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.

[For text of subd 5, see M.S.1990]

History: *1991 c 286 s 9,10; 1991 c 292 art 2 s 10; art 7 s 2*

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, except that the commissioner shall not collect a registration fee from a home care provider operated by a statutory or home rule charter city, county, town, or other governmental entity. 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: *1991 c 292 art 2 s 11*

144A.51 DEFINITIONS.

[For text of subds 1 to 4, see M.S.1990]

Subd. 5. "Health facility" means a facility or that part of a facility which is required to be licensed pursuant to sections 144.50 to 144.58, a facility or that part of a facility which is required to be licensed under any law of this state which provides for the licensure of nursing homes, and a residential care home licensed under sections 144B.10 to 144B.17.

[For text of subds 6 and 7, see M.S.1990]

History: *1991 c 292 art 2 s 12*

NOTE: Subdivision 5, as amended by Laws 1991, chapter 292, article 2, section 12, is effective upon the effective date of rules adopted by the commissioner of health for licensure of residential care homes. See Laws 1991, chapter 292, article 2, section 76.

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

Subdivision 1. The office of health facility complaints is hereby created in the department of health. The office shall be headed by a director appointed by the state commissioner of health.

The commissioner of health shall provide the office of health facility complaints with office space, administrative services and secretarial and clerical assistance.

[For text of subds 2 to 4, see M.S.1990]

History: *1991 c 238 art 1 s 8*

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 correction orders and assess civil fines pursuant to section 144.653 or any other law which provides for the issuance of correction orders to health 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.

[For text of subds 2 to 4, see M.S.1990]

History: *1991 c 286 s 11; 1991 c 292 art 2 s 13*

NOTE: Subdivision 1, as amended by Laws 1991, chapter 292, article 2, section 13, is effective upon the effective date of rules adopted by the commissioner of health for licensure of residential care homes. See Laws 1991, chapter 292, article 2, section 76.

144A.61 NURSING ASSISTANT TRAINING.

[For text of subds 1 and 2, see M.S.1990]

Subd. 3. **Curricula.** The chancellor of vocational technical education shall develop curricula to be used for nursing assistant training programs for employees of nursing homes and boarding care homes.

Subd. 3a. **Competency evaluation program.** The commissioner of health shall approve the competency evaluation program. A competency evaluation must be administered to nursing assistants who desire to be listed in the nursing assistant registry. The tests may only be administered by technical colleges, community colleges, or other organizations approved by the department of health. After January 1, 1992, a competency evaluation for a person, other than an individual enrolled in a licensed nurse education program, who has not completed an approved nursing assistant training program, must include an evaluation of all clinical skills.

[For text of subd 4, see M.S.1990]

Subd. 6a. **Nursing assistants hired in 1990 and after.** Each nursing assistant hired to work in a nursing home or in a certified boarding care home on or after January 1, 1990, must have successfully completed an approved competency evaluation or an approved nursing assistant training program and competency evaluation within four months from the date of employment.

[For text of subds 7 and 8, see M.S.1990]

History: *1991 c 286 s 12-14*

144A.611 REIMBURSABLE EXPENSES PAYABLE TO NURSING ASSISTANTS.

Subdivision 1. **Nursing homes and certified boarding care homes.** The actual costs of tuition and reasonable expenses for the competency evaluation or the nursing assistant training program and competency evaluation approved under section 144A.61, which are paid to nursing assistants pursuant to subdivision 2, are a reimbursable expense for nursing homes and certified boarding care homes under the provisions of chapter 256B and the rules promulgated thereunder.

Subd. 2. **Nursing assistants.** A nursing assistant who has completed an approved competency evaluation or an approved training program and competency evaluation shall be reimbursed by the nursing home or certified boarding care home for actual costs of tuition and reasonable expenses for the competency evaluation or the training program and competency evaluation 90 days after the date of employment, or upon completion of the approved training program, whichever is later.

[For text of subd 3, see M.S.1990]

History: *1991 c 286 s 15,16*

144A.612 APPEALS FROM FINDINGS OF ABUSE, NEGLECT, OR MISAPPROPRIATION OF PROPERTY.

(a) Until federal regulations are adopted under sections 1819(g)(1)(C) and 1919(g)(1)(C) of the Social Security Act that govern appeals from the state's findings of abuse, neglect, or misappropriation of property by nursing assistants employed by or working in a nursing home or boarding care home, the commissioner of health shall provide hearings under sections 14.57 to 14.62 and the rules adopted by the office of administrative hearings governing contested cases.

(b) The commissioner of health shall notify the nursing assistant of findings by sending written notice, by certified mail, to the last known address available from the facility or employer. The notice must contain a statement of the nature of the allegation and the time and date of the occurrence; the individual's right to a hearing; and the

commissioner's intent to report the findings to the nurse aide registry, pending the individual's appeal.

(c) To contest the finding, the nursing assistant must request a hearing in writing no later than 30 days after receiving written notice of the finding, unless federal regulations provide otherwise.

(d) The hearing must be held within 60 days from the date of receipt of the request for a hearing. The individual must be served written notice by certified mail of the time, place, and date of the hearing at least 15 days in advance. The hearing must be held in a place and time that is convenient for the individual to attend.

(e) The hearing must provide an opportunity for the individual to present evidence, either in person, in writing, or through witnesses, and to refute the allegations. The individual is entitled to have an attorney or other representative present at the hearing. The commissioner must issue a decision within 30 days after the hearing record is complete and the parties have had an opportunity to file exceptions under section 14.61. A copy of the decision shall be mailed to the individual.

(f) If a hearing is requested and held, and if the department's findings of abuse, neglect, or misappropriation of property are upheld by a preponderance of the evidence, the commissioner's decision and findings will be sent to the registry established under section 144A.61, subdivision 1. If a hearing is not requested or if the notice to the nursing assistant is returned to the department, the commissioner has no jurisdiction to hear an appeal at a later date, and the department's findings shall be sent to the registry at the end of the 30-day period with a notation that a hearing was not requested or held. The registry must include any brief statement by the individual disputing the findings.

(g) If it is determined that the individual did not neglect, abuse, or misappropriate resident property, all records and investigative reports shall be classified as private data under section 13.39.

(h) The identity of the nursing assistant and the findings of abuse, neglect, or misappropriation of property are public when sent to the registry, notwithstanding the provisions of section 626.557, subdivision 12. The identity of the reporter, the vulnerable adult, and persons interviewed are governed by section 626.557, subdivision 12.

History: *1991 c 286 s 17*