

CHAPTER 144A

NURSING HOMES AND HOME CARE

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

Subdivision 1. **Findings.** The legislature declares that a moratorium on the licensure and medical assistance certification of new nursing home beds and construction projects that exceed \$750,000 is necessary to control nursing home expenditure growth and enable the state to meet the needs of its elderly by providing high quality services in the most appropriate manner along a continuum of care.

[For text of subd 1a, see M.S.1996]

Subd. 2. **Moratorium.** The commissioner of health, in coordination with the commissioner of human services, shall deny each request for new licensed or certified nursing home or certified boarding care beds except as provided in subdivision 3 or 4a, or section 144A.073. "Certified bed" means a nursing home bed or a boarding care bed certified by the commissioner of health for the purposes of the medical assistance program, under United States Code, title 42, sections 1396 et seq.

The commissioner of human services, in coordination with the commissioner of health, shall deny any request to issue a license under section 252.28 and chapter 245A to a nursing home or boarding care home, if that license would result in an increase in the medical assistance reimbursement amount.

In addition, the commissioner of health must not approve any construction project whose cost exceeds \$750,000 unless:

(a) any construction costs exceeding \$750,000 are not added to the facility's appraised value and are not included in the facility's payment rate for reimbursement under the medical assistance program; or

(b) the project:

(1) has been approved through the process described in section 144A.073;

(2) meets an exception in subdivision 3 or 4a;

(3) is necessary to correct violations of state or federal law issued by the commissioner of health;

(4) is necessary to repair or replace a portion of the facility that was damaged by fire, lightning, groundshifts, or other such hazards, including environmental hazards, provided that the provisions of subdivision 4a, clause (a), are met;

(5) as of May 1, 1992, the facility has submitted to the commissioner of health written documentation evidencing that the facility meets the "commenced construction" definition as specified in subdivision 1a, clause (d), or that substantial steps have been taken prior to April 1, 1992, relating to the construction project. "Substantial steps" require that the facility has made arrangements with outside parties relating to the construction project and include the hiring of an architect or construction firm, submission of preliminary plans to the department of health or documentation from a financial institution that financing arrangements for the construction project have been made; or

(6) is being proposed by a licensed nursing facility that is not certified to participate in the medical assistance program and will not result in new licensed or certified beds.

Prior to the final plan approval of any construction project, the commissioner of health shall be provided with an itemized cost estimate for the project construction costs. If a construction project is anticipated to be completed in phases, the total estimated cost of all

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phases of the project shall be submitted to the commissioner and shall be considered as one construction project. Once the construction project is completed and prior to the final clearance by the commissioner, the total project construction costs for the construction project shall be submitted to the commissioner. If the final project construction cost exceeds the dollar threshold in this subdivision, the commissioner of human services shall not recognize any of the project construction costs or the related financing costs in excess of this threshold in establishing the facility's property-related payment rate.

The dollar thresholds for construction projects are as follows: for construction projects other than those authorized in clauses (1) to (6), the dollar threshold is \$750,000. For projects authorized after July 1, 1993, under clause (1), the dollar threshold is the cost estimate submitted with a proposal for an exception under section 144A.073, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a). For projects authorized under clauses (2) to (4), the dollar threshold is the itemized estimate project construction costs submitted to the commissioner of health at the time of final plan approval, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a).

The commissioner of health shall adopt rules to implement this section or to amend the emergency rules for granting exceptions to the moratorium on nursing homes under section 144A.073.

[For text of subs 3 and 4, see M.S.1996]

Subd. 4a. Exceptions for replacement beds. It is in the best interest of the state to ensure that nursing homes and boarding care homes continue to meet the physical plant licensing and certification requirements by permitting certain construction projects. Facilities should be maintained in condition to satisfy the physical and emotional needs of residents while allowing the state to maintain control over nursing home expenditure growth.

The commissioner of health in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

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

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

(ii) at the time the facility was destroyed or damaged 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;

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

(iv) 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;

(v) 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; and

(vi) the commissioner determines that the replacement beds are needed to prevent an inadequate supply of beds.

Project construction costs incurred for repairs authorized under this clause shall not be considered in the dollar threshold amount defined in subdivision 2;

(b) 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 \$750,000;

(c) to license or certify beds in a project recommended for approval under section 144A.073;

(d) 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;

(e) 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, or in a facility that was

granted an exception to the moratorium under section 144A.073, and if the cost of any remodeling of the facility does not exceed \$750,000. If boarding care beds are licensed as nursing home beds, the number of boarding care beds in the facility must not increase beyond the number remaining at the time of the upgrade in licensure. The provisions contained in section 144A.073 regarding the upgrading of the facilities do not apply to facilities that satisfy these requirements;

(f) 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 St. 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 paragraph;

(g) 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;

(h) 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;

(i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home beds in a facility that was licensed and in operation prior to January 1, 1992;

(j) to license and certify new nursing home beds to replace beds in a facility condemned as part of an economic redevelopment plan in a city of the first class, provided the new facility is located within one mile of the site of the old facility. Operating and property costs for the new facility must be determined and allowed under existing reimbursement rules;

(k) to license and certify up to 20 new nursing home beds in a community-operated hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991, that suspended operation of the hospital in April 1986. The commissioner of human services shall provide the facility with the same per diem property-related payment rate for each additional licensed and certified bed as it will receive for its existing 40 beds;

(l) to license or certify beds in renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's remodeling projects do not exceed \$750,000;

(m) to license and certify beds that are moved from one location to another for the purposes of converting up to five four-bed wards to single or double occupancy rooms in a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity of 115 beds;

(n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing facility located in Minneapolis to layaway all of its licensed and certified nursing home beds. These beds may be relicensed and recertified in a newly-constructed teaching nursing home facility affiliated with a teaching hospital upon approval by the Legislature. The pro-

posal must be developed in consultation with the interagency committee on long-term care planning. The beds on layaway status shall have the same status as voluntarily delicensed and decertified beds, except that beds on layaway status remain subject to the surcharge in section 256.9657. This layaway provision expires July 1, 1998;

(o) to allow a project which will be completed in conjunction with an approved moratorium exception project for a nursing home in southern Cass county and which is directly related to that portion of the facility that must be repaired, renovated, or replaced, to correct an emergency plumbing problem for which a state correction order has been issued and which must be corrected by August 31, 1993;

(p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to the commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed wards to single or double occupancy. Beds on layaway status shall have the same status as voluntarily delicensed and decertified beds except that beds on layaway status remain subject to the surcharge in section 256.9657, remain subject to the license application and renewal fees under section 144A.07 and shall be subject to a \$100 per bed reactivation fee. In addition, at any time within three years of the effective date of the layaway, the beds on layaway status may be:

(1) relicensed and recertified upon relocation and reactivation of some or all of the beds to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or International Falls; provided that the total project construction costs related to the relocation of beds from layaway status for any facility receiving relocated beds may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073;

(2) relicensed and recertified, upon reactivation of some or all of the beds within the facility which placed the beds in layaway status, if the commissioner has determined a need for the reactivation of the beds on layaway status.

The property-related payment rate of a facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (d). The property-related payment rate for a facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than three years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(q) to license and certify beds in a renovation and remodeling project to convert 12 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey county; had a licensed capacity of 154 beds; and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(r) to license and certify up to 117 beds that are relocated from a licensed and certified 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds located in South St. Paul, provided that the nursing facility and hospital are owned by the same or a related organization and that prior to the date the relocation is completed the hospital ceases operation of its inpatient hospital services at that hospital. After relocation, the nursing facility's status under section 256B.431, subdivision 2j, shall be the same as it was prior to relocation. The nursing facility's property-related payment rate resulting from the project authorized in this paragraph shall become effective no earlier than April 1, 1996. For purposes of calculating the incremental change in the facility's rental per diem resulting from this project, the allowable appraised value of the nursing facility portion of the existing health care facility physical plant prior to the renovation and relocation may not exceed \$2,490,000.

(s) to license and certify two beds in a facility to replace beds that were voluntarily delicensed and decertified on June 28, 1991;

(t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed nursing home and 21-bed boarding care home facility in Minneapolis, notwithstanding the licensure and certification after July 1, 1995, of the Minneapolis facility as a 147-bed nursing home facility after completion of a construction project approved in 1993 under section 144A.073, to be laid away upon 30 days' prior written notice to the commissioner. Beds on layaway status shall have the same status as voluntarily delicensed or decertified beds except that they shall remain subject to the surcharge in section 256.9657. The 16 beds on layaway status may be relicensed as nursing home beds and recertified at any time within five years of the effective date of the layaway upon relocation of some or all of the beds to a licensed and certified facility located in Watertown, provided that the total project construction costs related to the relocation of beds from layaway status for the Watertown facility may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073.

The property-related payment rate of the facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (d). The property-related payment rate for the facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than five years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(u) to license and certify beds that are moved within an existing area of a facility or to a newly constructed addition which is built for the purpose of eliminating three- and four-bed rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed capacity of 129 beds;

(v) to relocate 36 beds in Crow Wing county and four beds from Hennepin county to a 160-bed facility in Crow Wing county, provided all the affected beds are under common ownership;

(w) to license and certify a total replacement project of up to 49 beds located in Norman county that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431, except that subdivision 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost report is filed. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;

(x) to license and certify a total replacement project of up to 129 beds located in Polk county that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431, except that subdivision 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost report is filed. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility; or

(y) to license and certify beds in a renovation and remodeling project to convert 13 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey county, was not owned by a hospital corporation, had a licensed capacity of 64 beds, and had been ranked among the top 15 applicants by the

1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process.

[For text of subs 5 to 8, see M.S.1996]

History: 1997 c 105 s 1; 1997 c 203 art 3 s 1,2,15

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

[For text of subd 1, see M.S.1996]

Subd. 2. Request for proposals. At the authorization by the legislature of additional medical assistance expenditures for exceptions to the moratorium on nursing homes, the interagency committee shall publish in the State Register a request for proposals for nursing home projects to be licensed or certified under section 144A.071, subdivision 4a, clause (c). The public notice of this funding and the request for proposals must specify how the approval criteria will be prioritized by the advisory review panel, the interagency long-term care planning committee, and the commissioner. The notice must describe the information that must accompany a request and state that proposals must be submitted to the interagency committee 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 interagency committee shall publish a notice to that effect, and no proposals shall be requested. If money is appropriated, the interagency committee shall initiate the application and review process described in this section at least twice each biennium and up to four times each biennium, according to dates established by rule. Authorized funds shall be allocated proportionally to the number of processes. Funds not encumbered by an earlier process within a biennium shall carry forward to subsequent iterations of the process. Authorization for expenditures does not carry forward into the following biennium. To be considered for approval, a proposal must include the following information:

- (1) whether the request is for renovation, replacement, upgrading, conversion, or relocation;
- (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 of the nursing facility proposal, which are not required to exceed the cost threshold referred to in section 144A.071, subdivision 1, to be considered under this section, including initial construction and remodeling costs; site preparation costs; financing costs, including the current estimated long-term financing costs of the proposal, which consists of estimates of the amount and sources of money, reserves if required under the proposed funding mechanism, annual payments schedule, interest rates, length of term, closing costs and fees, insurance costs, and any completed marketing study or underwriting review; 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;
- (8) a statement of any licensure or certification issues, such as certification survey deficiencies;
- (9) the proposed relocation plan for current residents if beds are to be closed so that the department of human services can estimate the total costs of a proposal; and
- (10) other information required by permanent rule of the commissioner of health in accordance with subdivisions 4 and 8.

Subd. 3. Review and approval of proposals. Within the limits of money specifically appropriated to the medical assistance program for this purpose, the interagency long-term care planning committee 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 committee shall appoint an advisory review panel composed of representatives of consumers and providers to review proposals and provide comments and recommendations to the committee. The commissioners of human services and health shall provide staff and technical assistance to the committee for the review and analysis of proposals. The interagency committee shall hold a public hearing before submitting recommendations to the commissioner of health on project requests. The committee shall submit recommendations within 150 days of the date of the publication of the notice. The commissioner of health shall approve or disapprove a project within 30 days after receiving the committee's recommendations. The advisory review panel, the committee, and the commissioner of health shall base their recommendations, approvals, or disapprovals on a comparison and ranking of proposals using only the criteria in subdivision 4 and in rules adopted by the commissioner. 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 18 months after approval by the commissioner of health unless the facility has commenced construction as defined in section 144A.071, subdivision 1a, paragraph (d). The committee'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.

[For text of subs 3b to 8, see M.S.1996]

Subd. 9. Budget request. The commissioner of human services, in consultation with the commissioner of finance, shall include in each biennial budget request a line item for the nursing home moratorium exception process. If the commissioner of human services does not request funding for this item, the commissioner of human services must justify the decision in the budget pages.

History: 1997 c 7 art 5 s 11; 1997 c 203 art 3 s 3,4

144A.33 RESIDENT AND FAMILY ADVISORY COUNCIL EDUCATION.

[For text of subs 1 to 4, see M.S.1996]

Subd. 5. Evaluation. Each year the Minnesota board on aging shall evaluate the programs and funding sources established under this section.

History: 1997 c 7 art 2 s 16

144A.43 DEFINITIONS.

[For text of subs 1 to 3, see M.S.1996]

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 employee of a nursing home licensed under this chapter or an employee of a boarding care home licensed under sections 144.50 to 144.56 who responds to occasional emergency calls from individuals residing in a residential setting that is attached to or located on property contiguous to the nursing home or boarding care home;

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

(9) 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 317A, a partnership organized under chapter 323, or any other entity determined by the commissioner;

(10) 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;

(11) an individual licensed under chapter 147; or

(12) an individual who provides home care services to a person with a developmental disability who lives in a place of residence with a family, foster family, or primary caregiver.

History: 1997 c 22 art 2 s 2; 1997 c 113 s 1

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 for medication management which may vary according to the nature of the services provided, the setting in which the services are provided, or the status of the consumer. Medication management includes the central storage, handling, distribution, and administration of medications;

(e) standards for supervision of home care services requiring supervision by a registered nurse or other appropriate health care professional which must occur on site at least every 62 days, or more frequently if indicated by a clinical assessment, and in accordance with sections 148.171 to 148.285 and rules adopted thereunder;

(f) standards for client evaluation or assessment which may vary according to the nature of the services provided or the status of the consumer;

(g) 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;

(h) 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

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

[For text of subd 2, see M.S.1996]

Subd. 3. [Repealed, 1997 c 113 s 22]

Subd. 4. **Medicaid reimbursement.** Notwithstanding the provisions of section 256B.071 or state plan requirements to the contrary, certification by the federal Medicare program must not be a requirement of Medicaid payment for services delivered under section 144A.4605.

History: 1997 c 113 s 2,3

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. A home care provider may hold a separate license for each class of home care licensure.

(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.

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 to only one individual 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 to only one individual 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 provider that is licensed by the commissioner of human services to provide semi-independent living services under Minnesota Rules, parts 9525.0500 to 9525.0660 when providing home care services to a person with a developmental disability;

(6) a provider that is licensed by the commissioner of human services to provide home and community-based services under Minnesota Rules, parts 9525.2000 to 9525.2140 when providing home care services to a person with a developmental disability;

(7) a person or organization that provides only home management services, if the person or organization is registered under section 144A.461; or

(8) a person who is licensed as a social worker under sections 148B.18 to 148B.289 and who provides social work services in the home independently and not through any contractual or employment relationship with a home care provider or other organization.

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.** (a) 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 14.69. 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.

(b) The owner and managerial officials, as defined in the home care licensure rules, Minnesota Rules, chapter 4668, of a home care provider whose Minnesota license has not been renewed or has been revoked because of noncompliance with applicable law or rule shall not be eligible to apply for nor will be granted a license for five years following the effective date of the nonrenewal or revocation.

(c) The commissioner shall not issue a license to a home care provider if an owner or managerial official includes any individual who was an owner or managerial official of a home care provider whose Minnesota license was not renewed or was revoked as described in paragraph (b) for five years following the effective date of nonrenewal or revocation.

(d) Notwithstanding the provisions of paragraph (a), the commissioner shall not renew, or shall suspend or revoke the license of any home care provider which includes any individual as an owner or managerial official who was an owner or managerial official of a home care provider whose Minnesota license was not renewed or was revoked as described in paragraph (b) for five years following the effective date of the nonrenewal or revocation. The commissioner shall notify the home care provider 30 days in advance of the date of nonrenewal, suspension, or revocation of the license. Within ten days after the receipt of this notification, the home care provider may request, in writing, that the commissioner stay the nonrenewal, revocation, or suspension of the license. The home care provider shall specify the reasons for requesting the stay; the steps that will be taken to attain or maintain compliance with the licensure laws and regulations; any limits on the authority or responsibility of the owners or managerial officials whose actions resulted in the notice of nonrenewal, revocation, or suspension; and any other information to establish that the continuing affiliation with these individuals will not jeopardize client health, safety, or well being. The commissioner shall determine whether the stay will be granted within 30 days of receiving the provider's request. The commissioner may propose additional restrictions or limitations on the provider's license and require that the granting of the stay be contingent upon compliance with those provisions. The commissioner shall take into consideration the following factors when determining whether the stay should be granted:

- (1) the threat that continued involvement of the owners and managerial officials in the home care provider poses to client health, safety, and well being;
- (2) the compliance history of the home care provider; and
- (3) the appropriateness of any limits suggested by the home care provider.

If the commissioner grants the stay, the order shall include any restrictions or limitation on the provider's license. The failure of the provider to comply with any restrictions or limitations shall result in the immediate removal of the stay and the commissioner shall take immediate action to suspend, revoke, or not renew the license.

(e) The provisions contained in paragraphs (b) and (c) shall apply to any nonrenewal or revocation of a home care license occurring after June 1, 1993, the effective date of the home care licensure rules.

(f) For the purposes of this subdivision, owners of a home care provider are those individuals whose ownership interest provides sufficient authority or control to affect or change decisions related to the operation of the home care provider. An owner includes a sole proprietor, a general partner, or any other individual whose individual ownership interest can affect the management and direction of the policies of the home care provider. For the purposes of this subdivision, managerial officials are those individuals who had the responsibility for the ongoing management or direction of the policies, services, or employees of the home care provider relating to the areas of noncompliance which led to the license revocation or nonrenewal.

[For text of subs 3a to 4, see M.S.1996]

Subd. 5. Prior criminal convictions. (a) Before the commissioner issues an initial or renewal license, an owner or managerial official shall be required to complete a background study under section 144.057. No person may be involved in the management, operation, or control of a provider, if the person has been disqualified under the provisions of chapter 245A. Individuals disqualified under these provisions can request a reconsideration, and if the disqualification is set aside are then eligible to be involved in the management, operation or control of the provider. For purposes of this section, owners of a home care provider subject to the background check requirement are those individuals whose ownership interest provides sufficient authority or control to affect or change decisions related to the operation of the home care provider. An owner includes a sole proprietor, a general partner, or any other individual whose individual ownership interest can affect the management and direction of the policies of the home care provider. For the purposes of this section, managerial officials subject to the background check requirement are those individuals who provide "direct contact" as defined in section 245A.04 or those individuals who have the responsibility for the ongoing management or direction of the policies, services, or employees of the home care provider. Data collected under this subdivision shall be classified as private data under section 13.02, subdivision 12.

(b) Employees, contractors, and volunteers of a home care provider or hospice are subject to the background study required by section 144.057. These individuals shall be disqualified under the provisions of chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090. Nothing in this section shall be construed to prohibit a home care provider from requiring self-disclosure of criminal conviction information.

(e) Termination of an employee in good faith reliance on information or records obtained under paragraph (a) or (b) regarding a confirmed conviction does not subject the home care provider to civil liability or liability for reemployment insurance benefits.

History: 1997 c 113 s 4,5; 1997 c 193 s 47; 1997 c 195 s 1; 1997 c 248 s 2

144A.4605 ASSISTED LIVING HOME CARE PROVIDER.

Subdivision 1. Definitions. For purposes of this section, the term "assisted living home care provider" means a home care provider who provides nursing services, delegated nursing services, other services performed by unlicensed personnel, or central storage of medications solely for residents of one or more housing with services establishments registered under chapter 144D.

Subd. 2. Assisted living home care license established. A home care provider license category entitled assisted living home care provider is hereby established. A home care provider may obtain an assisted living license if the program meets the following requirements:

(a) nursing services, delegated nursing services, other services performed by unlicensed personnel, or central storage of medications under the assisted living license are provided solely for residents of one or more housing with services establishments registered under chapter 144D;

(b) unlicensed personnel perform home health aide and home care aide tasks identified in Minnesota Rules, parts 4668.0100, subparts 1 and 2, and 4668.0110, subpart 1. Qualifications to perform these tasks shall be established in accordance with subdivision 3;

(c) periodic supervision of unlicensed personnel is provided as required by rule;

(d) notwithstanding Minnesota Rules, part 4668.0160, subpart 6, item D, client records shall include:

- (1) a weekly summary of the client's status and home care services provided;
- (2) documentation each time medications are administered to a client; and
- (3) documentation on the day of occurrence of any significant change in the client's status or any significant incident, such as a fall or refusal to take medications.

All entries must be signed by the staff providing the services and entered into the record no later than two weeks after the end of the service day, except as specified in clauses (2) and (3);

(e) medication and treatment orders, if any, are included in the client record and are renewed at least every 12 months, or more frequently when indicated by a clinical assessment;

(f) the central storage of medications in a housing with services establishment registered under chapter 144D is managed under a system that is established by a registered nurse and addresses the control of medications, handling of medications, medication containers, medication records, and disposition of medications; and

(g) in other respects meets the requirements established by rules adopted under sections 144A.45 to 144A.48.

Subd. 3. Training or competency evaluations required. (a) Unlicensed personnel must:

(1) satisfy the training or competency requirements established by rule under sections 144A.45 to 144A.48; or

(2) be trained or determined competent by a registered nurse in each task identified under Minnesota Rules, part 4668.0100, subparts 1 and 2, when offered to clients in a housing with services establishment as described in paragraphs (b) to (e).

(b) Training for tasks identified under Minnesota Rules, part 4668.0100, subparts 1 and 2, shall use a curriculum which meets the requirements in Minnesota Rules, part 4668.0130.

(c) Competency evaluations for tasks identified under Minnesota Rules, part 4668.0100, subparts 1 and 2, must be completed and documented by a registered nurse.

(d) Unlicensed personnel performing tasks identified under Minnesota Rules, part 4668.0100, subparts 1 and 2, shall be trained or demonstrate competency in the following topics:

(1) an overview of sections 144A.43 to 144A.49 and rules adopted thereunder;

(2) recognition and handling of emergencies and use of emergency services;

(3) reporting the maltreatment of vulnerable minors or adults under sections 626.556 and 626.557;

(4) home care bill of rights;

(5) handling of clients' complaints and reporting of complaints to the office of health facility complaints;

(6) services of the ombudsman for older Minnesotans;

(7) observation, reporting, and documentation of client status and of the care or services provided;

(8) basic infection control;

(9) maintenance of a clean, safe, and healthy environment;

(10) communication skills;

(11) basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional; and

(12) physical, emotional, and developmental needs of clients, and ways to work with clients who have problems in these areas, including respect for the client, the client's property, and the client's family.

(e) Unlicensed personnel who administer medications must comply with rules relating to the administration of medications in Minnesota Rules, part 4668.0100, subpart 2, except that unlicensed personnel need not comply with the requirements of Minnesota Rules, part 4668.0100, subpart 5.

Subd. 4. License required. (a) A housing with services establishment registered under chapter 144D that is required to obtain a home care license must obtain an assisted living home care license according to this section or a class A license according to rule.

(b) A board and lodging establishment registered for special services as of December 31, 1996, and also registered as a housing with services establishment under chapter 144D, must deliver home care services according to sections 144A.43 to 144A.49, and may apply for a waiver from requirements under Minnesota Rules, parts 4668.0002 to 4668.0240, to operate a licensed agency under the standards of section 157.17. Such waivers as may be granted by the department will expire upon promulgation of home care rules implementing section 144A.4605.

(c) An adult foster care provider licensed by the department of human services and registered under chapter 144D may continue to provide health-related services under its foster care license until the promulgation of home care rules implementing this section.

Subd. 5. License fees. The license fees for assisted living home care providers shall be as follows:

- (1) \$125 annually for those providers serving a monthly average of 15 or fewer clients, and for assisted living providers of all sizes during the first year of operation;
- (2) \$200 annually for those providers serving a monthly average of 16 to 30 clients;
- (3) \$375 annually for those providers serving a monthly average of 31 to 50 clients; and
- (4) \$625 annually for those providers serving a monthly average of 51 or more clients.

Subd. 6. Waiver. Upon request of the home care provider, the commissioner may waive the provisions of this section relating to registered nurse duties.

History: 1997 c 113 s 6; 1Sp1997 c 5 s 2

144A.49 [Repealed, 1997 c 113 s 22]

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 residential care homes, or administrative agencies are to be made, reviewed, investigated, and acted upon; provided, however, that a fee may not be charged for filing a complaint.

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

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

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

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

(f) Issue correction orders and assess civil fines pursuant to section 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 or home'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 or residential care homes in the enforcement of their rights under Minnesota law.

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

[For text of subs 2 to 4, see M.S.1996]

History: 1997 c 7 art 2 s 17

144A.54 PUBLICATION OF RECOMMENDATIONS; REPORTS.

Subdivision 1. **Director; duties.** Except as otherwise provided by this section, the director may determine the form, frequency, and distribution of the conclusions and recommendations. The director shall transmit the conclusions and recommendations to the state commissioner of health. Before announcing a conclusion or recommendation that expressly or by implication criticizes an administrative agency, a health care provider, a home care provider, a residential care home, or a health facility, the director shall consult with that agency, health care provider, home care provider, home, or facility. When publishing an opinion adverse to an administrative agency, a health care provider, a home care provider, a residential care home, 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, residential care home, or health facility in defense or explanation of the action.

Subd. 2. **Annual report.** In addition to whatever other reports the director may make, the director shall, at the end of each year, report to the state commissioner of health concerning the exercise of the director's functions during the preceding year. The state commissioner of health may, at any time, request and receive information, other than resident records, from the director.

[For text of subd 3, see M.S.1996]

History: 1997 c 7 art 2 s 18,19