# CHAPTER 144A

# NURSING HOMES AND HOME CARE



## 144A.03 LICENSE APPLICATION.

*[For text of subd 1 see M.S.2000]*

Subd. 2. **Agents.** Each application for a nursing home license or for renewal of a nursing home license shall specify one or more controlling persons or managerial employees as agents:

(a) Who shall be responsible for dealing with the commissioner of health on all matters provided for in sections 144A.01 to 144A.155; and

(b) On whom personal service of all notices and orders shall be made, and who shall be authorized to accept service on behalf of all of the controlling persons of the facility, in proceedings under sections 144A.06; 144A.10, subdivisions 4, 5, and 7; 144A.11, subdivision 3; and 144A.15. Notwithstanding any law to the contrary, personal service on the designated person or persons named in an application shall be deemed to be service on all of the controlling persons or managerial employee of the facility, and it shall not be a defense to any action arising under sections 144A.06; 144A.10, subdivisions 4, 5 and 7; 144A.11, subdivision 3; and 144A.15, that personal service was not made on each controlling person or managerial employee of the facility. The designation of one or more controlling persons or managerial employees pursuant to this subdivision shall not affect the legal responsibility of any other controlling person or managerial employee under sections 144A.01 to 144A.155.

**History:** *1Sp2001 c 9 art 5 s 40*

## 144A.04 QUALIFICATIONS FOR LICENSE.

*[For text of subds 1 to 4a, see M.S.2000]*

Subd. 5. **Administrators.** (a) Each nursing home must employ an administrator who must be licensed or permitted as a nursing home administrator by the board of examiners for nursing home administrators. The nursing home may share the services of a licensed administrator. The administrator must maintain a sufficient on-site presence in the facility to effectively manage the facility in compliance with applicable rules and regulations. The administrator must establish procedures and delegate authority for on-site operations in the administrator's absence, but is ultimately responsible for the management of the facility. Each nursing home must have posted at all times the name of the administrator and the name of the person in charge on the premises in the absence of the licensed administrator.

(b) Notwithstanding sections 144A.18 to 144A.27, a nursing home with a director of nursing serving as an unlicensed nursing home administrator as of March 1, 2001, may continue to have a director of nursing serve in that capacity, provided the director

of nursing has passed the state law and rules examination administered by the board of examiners for nursing home administrators and maintains evidence of completion of 20 hours of continuing education each year on topics pertinent to nursing home administration.

Subd. 5a. [Repealed, 2001 c 69 s 2]

*[For text of subds 6 and 7, see M.S.2000]*

Subd. 7a. [Repealed, 2001 c 69 s 2]

*[For text of subds 8 to 10, see M.S.2000]*

**History:** *2001 c 69 s 1*

**144A.05 LICENSE RENEWAL.**

Unless the license expires in accordance with section 144A.06 or is suspended or revoked in accordance with section 144A.11, a nursing home license shall remain effective for a period of one year from the date of its issuance. The commissioner of health by rule shall establish forms and procedures for the processing of license renewals. The commissioner of health shall approve a license renewal application if the facility continues to satisfy the requirements, standards and conditions prescribed by sections 144A.01 to 144A.155 and the rules promulgated thereunder. The commissioner shall not approve the renewal of a license for a nursing home bed in a resident room with more than four beds. Except as provided in section 144A.08, a facility shall not be required to submit with each application for a license renewal additional copies of the architectural and engineering plans and specifications of the facility. Before approving a license renewal, the commissioner of health shall determine that the facility's most recent balance sheet and its most recent statement of revenues and expenses, as audited by the state auditor, by a certified public accountant licensed by this state or by a public accountant as defined in section 412.222, have been received by the department of human services.

**History:** *1Sp2001 c 9 art 5 s 40*

**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 $1,000,000 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.

Subd. 1a. **Definitions.** For purposes of sections 144A.071 to 144A.073, the following terms have the meanings given them:

(a) "attached fixtures" has the meaning given in Minnesota Rules, part 9549.0020, subpart 6.

(b) "buildings" has the meaning given in Minnesota Rules, part 9549.0020, subpart 7.

(c) "capital assets" has the meaning given in section 256B.421, subdivision 16.

(d) "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 applied for.

(e) "completion date" means the date on which a certificate of occupancy is issued for a construction project, or if a certificate of occupancy is not required, the date on which the construction project is available for facility use.

(f) "construction" means any erection, building, alteration, reconstruction, modernization, or improvement necessary to comply with the nursing home licensure rules.

(g) "construction project" means:

(1) a capital asset addition to, or replacement of a nursing home or certified boarding care home that results in new space or the remodeling of or renovations to existing facility space;

(2) the remodeling or renovation of existing facility space the use of which is modified as a result of the project described in clause (1). This existing space and the project described in clause (1) must be used for the functions as designated on the construction plans on completion of the project described in clause (1) for a period of not less than 24 months; or

(3) capital asset additions or replacements that are completed within 12 months before or after the completion date of the project described in clause (1).

(h) "new licensed" or "new certified beds" means:

(1) newly constructed beds in a facility or the construction of a new facility that would increase the total number of licensed nursing home beds or certified boarding care or nursing home beds in the state; or

(2) newly licensed nursing home beds or newly certified boarding care or nursing home beds that result from remodeling of the facility that involves relocation of beds but does not result in an increase in the total number of beds, except when the project involves the upgrade of boarding care beds to nursing home beds, as defined in section 144A.073, subdivision 1. "Remodeling" includes any of the type of conversion, renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1.

(i) "project construction costs" means the cost of the facility capital asset additions, replacements, renovations, or remodeling projects, construction site preparation costs, and related soft costs. Project construction costs include the cost of any remodeling or renovation of existing facility space which is modified as a result of the construction project. Project construction costs also includes the cost of new technology implemented as part of the construction project.

(j) "technology" means information systems or devices that make documentation, charting, and staff time more efficient or encourage and allow for care through alternative settings including, but not limited to, touch screens, monitors, hand-helds, swipe cards, motion detectors, pagers, telemedicine, medication dispensers, and equipment to monitor vital signs and self-injections, and to observe skin and other conditions.

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 $1,000,000, unless:

(a) any construction costs exceeding $1,000,000 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 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 $1,000,000. 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 subds 3 and 4, see M.S.2000]*

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 $1,000,000;

(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 $1,000,000. 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 acquired by the Minneapolis community development agency as part of redevelopment activities in a city of the first class, provided the new facility is located within three miles of the site of the old facility. Operating and property costs for the new facility must be determined and allowed under section 256B.431 or 256B.434;

(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 $1,000,000;

(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 proposal 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 (c). 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 (c). 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;

(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;

(z) to license and certify up to 150 nursing home beds to replace an existing 285 bed nursing facility located in St. Paul. The replacement project shall include both the renovation of existing buildings and the construction of new facilities at the existing site. The reduction in the licensed capacity of the existing facility shall occur during the construction project as beds are taken out of service due to the construction process. Prior to the start of the construction process, the facility shall provide written information to the commissioner of health describing the process for bed reduction, plans for the relocation of residents, and the estimated construction schedule. The relocation of residents shall be in accordance with the provisions of law and rule;

(aa) to allow the commissioner of human services to license an additional 36 beds to provide residential services for the physically handicapped under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that the total number of licensed and certified beds at the facility does not increase;

(bb) to license and certify a new facility in St. Louis county with 44 beds constructed to replace an existing facility in St. Louis county with 31 beds, which has resident rooms on two separate floors and an antiquated elevator that creates safety concerns for residents and prevents nonambulatory residents from residing on the second floor. The project shall include the elimination of three- and four-bed rooms;

(cc) to license and certify four beds in a 16-bed certified boarding care home in Minneapolis to replace beds that were voluntarily delicensed and decertified on or before March 31, 1992. The licensure and certification is conditional upon the facility periodically assessing and adjusting its resident mix and other factors which may contribute to a potential institution for mental disease declaration. The commissioner

of human services shall retain the authority to audit the facility at any time and shall require the facility to comply with any requirements necessary to prevent an institution for mental disease declaration, including delicensure and decertification of beds, if necessary;

(dd) to license and certify 72 beds in an existing facility in Mille Lacs county with 80 beds as part of a renovation project. The renovation must include construction of an addition to accommodate ten residents with beginning and midstage dementia in a self-contained living unit; creation of three resident households where dining, activities, and support spaces are located near resident living quarters; designation of four beds for rehabilitation in a self-contained area; designation of 30 private rooms; and other improvements;

(ee) to license and certify beds in a facility that has undergone replacement or remodeling as part of a planned closure under section 256B.437;

(ff) to license and certify a total replacement project of up to 124 beds located in Wilkin county that are in need of relocation from a nursing home significantly damaged by flood. 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 section 256B.431, 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;

(gg) to allow the commissioner of human services to license an additional nine beds to provide residential services for the physically handicapped under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 240-bed nursing home located in Duluth, provided that the total number of licensed and certified beds at the facility does not increase;

(hh) to license and certify up to 120 new nursing facility beds to replace beds in a facility in Anoka county, which was licensed for 98 beds as of July 1, 2000, provided the new facility is located within four miles of the existing facility and is in Anoka county. Operating and property rates shall be determined and allowed under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, or section 256B.434 or 256B.435. The provisions of section 256B.431, subdivision 26, paragraphs (a) and (b), do not apply until the second rate year following settle-up; or

(ii) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka county that, as of March 25, 2001, is in the active process of closing, to a 122-licensed bed nonprofit nursing facility located in the city of Columbia Heights or its affiliate. The transfer is effective when the receiving facility notifies the commissioner in writing of the number of beds accepted. The commissioner shall place all transferred beds on layaway status held in the name of the receiving facility. The layaway adjustment provisions of section 256B.431, subdivision 30, do not apply to this layaway. The receiving facility may only remove the beds from layaway for recertification and relicensure at the receiving facility's current site, or at a newly constructed facility located in Anoka county. The receiving facility must receive statutory authorization before removing these beds from layaway status.

*[For text of subds 4b to 8, see M.S.2000]*

**History:** *1Sp2001 c 9 art 5 s 3-6*

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

*[For text of subd 1, see M.S.2000]*

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 commissioner 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 commissioner. The notice must describe the information that must accompany a request and state that proposals must be submitted to the commissioner 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 commissioner shall publish a notice to that effect, and no proposals shall be requested. If money is appropriated, the commissioner 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; technology 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 commissioner of health may grant exceptions to the nursing home licensure or certification moratorium for proposals that satisfy the requirements of this section. The commissioner of health shall approve or disapprove a project. The commissioner of health shall base 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).

*[For text of subd 3b, see M.S.2000]*

Subd. 3c. **Cost neutral relocation projects.** (a) Notwithstanding subdivision 3, the commissioner may at any time accept proposals, or amendments to proposals previously approved under this section, for relocations that are cost neutral with respect to state costs as defined in section 144A.071, subdivision 5a. The commissioner, in consultation with the commissioner of human services, shall evaluate proposals according to subdivision 4, clauses (1), (2), and (3), and other criteria established in rule. The commissioner shall approve or disapprove a project within 90 days. Proposals and amendments approved under this subdivision are not subject to the six-mile limit in subdivision 5, paragraph (e).

(b) For the purposes of paragraph (a), cost neutrality shall be measured over the first three 12-month periods of operation after completion of the project.

Subd. 4. **Criteria for review.** The following criteria shall be used in a consistent manner to compare, evaluate, and rank all proposals submitted. Except for the criteria specified in clause (3), the application of criteria listed under this subdivision shall not reflect any distinction based on the geographic location of the proposed project:

(1) the extent to which the proposal furthers state long-term care goals, including the goal of enhancing the availability and use of alternative care services and the goal of reducing the number of long-term care resident rooms with more than two beds;

(2) the proposal's long-term effects on state costs including the cost estimate of the project according to section 144A.071, subdivision 5a;

(3) the extent to which the proposal promotes equitable access to long-term care services in nursing homes through redistribution of the nursing home bed supply, as measured by the number of beds relative to the population 85 or older, projected to the year 2000 by the state demographer, and according to items (i) to (iv):

(i) reduce beds in counties where the supply is high, relative to the statewide mean, and increase beds in counties where the supply is low, relative to the statewide mean;

(ii) adjust the bed supply so as to create the greatest benefits in improving the distribution of beds;

(iii) adjust the existing bed supply in counties so that the bed supply in a county moves toward the statewide mean; and

(iv) adjust the existing bed supply so that the distribution of beds as projected for the year 2020 would be consistent with projected need, based on the methodology outlined in the interagency long-term care committee's nursing home bed distribution study;

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

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

(6) the extent to which the applicant demonstrates the delivery of quality care, as defined in state and federal statutes and rules, to residents as evidenced by the two most recent state agency certification surveys and the applicants' response to those surveys;

(7) the extent to which the project removes the need for waivers or variances previously granted by either the licensing agency, certifying agency, fire marshal, or local government entity;

(8) the extent to which the project increases the number of private or single bed rooms; and

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

*[For text of subds 5 to 9, see M.S.2000]*

**History:** *2001 c 161 s 22-24; 1Sp2001 c 9 art 5 s 7,8*

**144A.08 PHYSICAL STANDARDS; PENALTY.**

*[For text of subds 1 to 1b, see M.S.2000]*

Subd. 2. **Report.** The controlling persons of a nursing home shall, in accordance with rules established by the commissioner of health, within 14 days of the occurrence, notify the commissioner of health of any change in the physical structure of a nursing home, which change would affect compliance with the rules of the commissioner of health or with sections 144A.01 to 144A.155.

*[For text of subd 3, see M.S.2000]*

**History:** *1Sp2001 c 9 art 5 s 40*

**144A.09 FACILITIES EXCLUDED.**

Subdivision 1. **Spiritual means for healing.** Sections 144A.04, subdivision 5, and 144A.18 to 144A.27, and rules adopted under sections 144A.01 to 144A.155 other than a rule relating to sanitation and safety of premises, to cleanliness of operation, or to physical equipment do not apply to a nursing home conducted by and for the adherents of any recognized church or religious denomination for the purpose of providing care and treatment for those who select and depend upon spiritual means through prayer alone, in lieu of medical care, for healing.

*[For text of subd 2, see M.S.2000]*

**History:** *1Sp2001 c 9 art 5 s 40*

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

Subdivision 1. **Enforcement authority.** The commissioner of health is the exclusive state agency charged with the responsibility and duty of inspecting all facilities required to be licensed under section 144A.02. The commissioner of health shall enforce the rules established pursuant to sections 144A.01 to 144A.155, subject only to the authority of the department of public safety respecting the enforcement of fire and safety standards in nursing homes and the responsibility of the commissioner of human services under sections 245A.01 to 245A.16 or 252.28.

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

*[For text of subd 1a, see M.S.2000]*

Subd. 2. **Inspections.** The commissioner of health shall inspect each nursing home to ensure compliance with sections 144A.01 to 144A.155 and the rules promulgated to implement them. The inspection shall be a full inspection of the nursing home. If upon a reinspection provided for in subdivision 5 the representative of the commissioner of health finds one or more uncorrected violations, a second inspection of the facility shall be conducted. The second inspection need not be a full inspection. No prior notice

shall be given of an inspection conducted pursuant to this subdivision. Any employee of the commissioner of health who willfully gives or causes to be given any advance notice of an inspection required or authorized by this subdivision shall be subject to suspension or dismissal in accordance with chapter 43A. An inspection required by a federal rule or statute may be conducted in conjunction with or subsequent to any other inspection. Any inspection required by this subdivision may be in addition to or in conjunction with the reinspections required by subdivision 5. Nothing in this subdivision shall be construed to prohibit the commissioner of health from making more than one unannounced inspection of any nursing home during its license year. The commissioner of health shall coordinate inspections of nursing homes with inspections by other state and local agencies consistent with the requirements of this section and the Medicare and Medicaid certification programs.

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

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

*[For text of subd 3, see M.S. 2000]*

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.155, or 626.557 or the rules promulgated thereunder, 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 15, see M.S.2000]*

**History:** *1Sp2001 c 9 art 5 s 40*

## 144A.11 LICENSE SUSPENSION OR REVOCATION; HEARING; RELICENSING.

Subdivision 1. **Optional proceedings.** The commissioner of health may institute proceedings to suspend or revoke a nursing home license, or may refuse to grant or renew the license of a nursing home if any action by a controlling person or employee of the nursing home:

(a) Violates any of the provisions of sections 144A.01 to 144A.08, 144A.13 or 144A.155, or the rules promulgated thereunder;

(b) Permits, aids, or abets the commission of any illegal act in the nursing home;

(c) Performs any act contrary to the welfare of a patient or resident of the nursing home; or

(d) Obtains, or attempts to obtain, a license by fraudulent means or misrepresentation.

*[For text of subds 2 to 3a, see M.S.2000]*

Subd. 4. **Relicensing.** If a nursing home license is revoked a new application for license may be considered by the commissioner of health when the conditions upon which revocation was based have been corrected and satisfactory evidence of this fact has been furnished to the commissioner of health. A new license may be granted after an inspection has been made and the facility has been found to comply with all provisions of sections 144A.01 to 144A.155 and the rules promulgated thereunder.

**History:** *1Sp2001 c 9 art 5 s 40*

**144A.12 INJUNCTIVE RELIEF; SUBPOENAS.**

Subdivision 1. **Injunctive relief.** In addition to any other remedy provided by law, the commissioner of health may bring an action in the district court in Ramsey or Hennepin county or in the district in which a nursing home is located to enjoin a controlling person or an employee of the nursing home from illegally engaging in activities regulated by sections 144A.01 to 144A.155. A temporary restraining order may be granted by the court in the proceeding if continued activity by the controlling person or employee would create an imminent risk of harm to a resident of the facility.

Subd. 2. **Subpoenas.** In all matters pending before the commissioner under sections 144A.01 to 144A.155, the commissioner of health shall have the power to issue subpoenas and compel the attendance of witnesses and the production of all necessary papers, books, records, documents and other evidentiary material. Any person failing or refusing to appear or testify regarding any matter about which that person may be lawfully questioned or to produce any papers, books, records, documents or evidentiary materials in the matter to be heard, after having been required by order of the commissioner of health or by a subpoena of the commissioner of health to do so may, upon application by the commissioner of health to the district court in any district, be ordered by the court to comply therewith. The commissioner of health may issue subpoenas and may administer oaths to witnesses, or take their affirmation. Depositions may be taken within or without the state in the manner provided by law for the taking of depositions in civil actions. A subpoena or other process or paper may be served upon any named person anywhere within the state by any officer authorized to serve subpoenas in civil actions, with the same fees and mileage and in the same manner as prescribed by law for process issued out of the district court of this state. Fees and mileage and other costs of persons subpoenaed by the commissioner of health shall be paid in the same manner as for proceedings in district court.

**History:** *1Sp2001 c 9 art 5 s 40*

**144A.155 PLACEMENT OF MONITOR.**

Subdivision 1. **Authority.** The commissioner may place a person to act as a monitor in a nursing home or certified boarding care home in any of the circumstances listed in clause (1) or (2):

(1) in any situation for which a receiver may be appointed under section 144A.15; or

(2) when the commissioner determines that violations of sections 144.651, 144A.01 to 144A.155, 626.557, or section 1919(b), (c), or (d), of the Social Security Act, or rules or regulations adopted under those provisions, require extended surveillance to enforce compliance or protect the health, safety, or welfare of the residents.

*[For text of subds 2 to 4, see M.S.2000]*

**History:** *1Sp2001 c 9 art 5 s 40*

**144A.16** [Repealed, 1Sp2001 c 9 art 5 s 41]

## 144A.161 NURSING FACILITY RESIDENT RELOCATION.

Subdivision 1. **Definitions.** The definitions in this subdivision apply to subdivisions 2 to 10.

(a) "Closure" means the cessation of operations of a facility and the delicensure and decertification of all beds within the facility.

(b) "Curtailment," "reduction," or "change" refers to any change in operations which would result in or encourage the relocation of residents.

(c) "Facility" means a nursing home licensed pursuant to this chapter, or a certified boarding care home licensed pursuant to sections 144.50 to 144.56.

(d) "Licensee" means the owner of the facility or the owner's designee or the commissioner of health for a facility in receivership.

(e) "Local agency" means the county or multicounty social service agency authorized under sections 393.01 and 393.07, as the agency responsible for providing social services for the county in which the nursing home is located.

(f) "Plan" means a process developed under subdivision 3, paragraph (b), for the closure, curtailment, reduction, or change in operations in a facility and the subsequent relocation of residents.

(g) "Relocation" means the discharge of a resident and movement of the resident to another facility or living arrangement as a result of the closing, curtailment, reduction, or change in operations of a nursing home or boarding care home.

Subd. 2. **Initial notice from licensee.** (a) A licensee shall notify the following parties in writing when there is an intent to close or curtail, reduce, or change operations which would result in or encourage the relocation of residents:

(1) the commissioner of health;

(2) the commissioner of human services;

(3) the local agency;

(4) the office of the ombudsman for older Minnesotans; and

(5) the office of the ombudsman for mental health and mental retardation.

(b) The written notice shall include the names, telephone numbers, facsimile numbers, and e-mail addresses of the persons in the facility responsible for coordinating the licensee's efforts in the planning process, and the number of residents potentially affected by the closure or curtailment, reduction, or change in operations.

Subd. 3. **Planning process.** (a) The local agency shall, within five working days of receiving initial notice of the licensee's intent to close or curtail, reduce, or change operations, provide the licensee and all parties identified in subdivision 2, paragraph (a), with the names, telephone numbers, facsimile numbers, and e-mail addresses of those persons responsible for coordinating local agency efforts in the planning process.

(b) Within ten working days of receipt of the notice under paragraph (a), the local agency and licensee shall meet to develop the relocation plan. The local agency shall inform the departments of health and human services, the office of the ombudsman for older Minnesotans, and the office of the ombudsman for mental health and mental retardation of the date, time, and location of the meeting so that their representatives may attend. The relocation plan must be completed within 45 days of receipt of the initial notice. However, the plan may be finalized on an earlier schedule agreed to by all parties. To the extent practicable, consistent with requirements to protect the safety and health of residents, the commissioner may authorize the planning process under this subdivision to occur concurrent with the 60-day notice required under subdivision 5a. The plan shall:

(1) identify the expected date of closure, curtailment, reduction, or change in operations;

(2) outline the process for public notification of the closure, curtailment, reduction, or change in operations;

(3) identify efforts that will be made to include other stakeholders in the relocation process;

(4) outline the process to ensure 60-day advance written notice to residents, family members, and designated representatives;

(5) present an aggregate description of the resident population remaining to be relocated and the population's needs;

(6) outline the individual resident assessment process to be utilized;

(7) identify an inventory of available relocation options, including home and community-based services;

(8) identify a timeline for submission of the list identified in subdivision 5c, paragraph (b); and

(9) identify a schedule for the timely completion of each element of the plan.

(c) All parties to the plan shall refrain from any public notification of the intent to close or curtail, reduce, or change operations until a relocation plan has been established. If the planning process occurs concurrently with the 60-day notice period, this requirement does not apply once 60-day notice is given.

Subd. 4. **Responsibilities of licensee for resident relocations.** The licensee shall provide for the safe, orderly, and appropriate relocation of residents. The licensee and facility staff shall cooperate with representatives from the local agency, the department of health, the department of human services, the office of ombudsman for older Minnesotans, and ombudsman for mental health and mental retardation in planning for and implementing the relocation of residents.

Subd. 5. **Licensee responsibilities prior to relocation.** (a) The licensee shall establish an interdisciplinary team responsible for coordinating and implementing the plan. The interdisciplinary team shall include representatives from the local agency, the office of ombudsman for older Minnesotans, facility staff that provide direct care services to the residents, and facility administration.

(b) The licensee shall provide a list to the local agency that includes the following information on each resident to be relocated:

(1) name;

(2) date of birth;

(3) social security number;

(4) medical assistance identification number;

(5) all diagnoses; and

(6) the name and contact information for the resident's family or other designated representative.

(c) The licensee shall consult with the local agency on the availability and development of available resources and on the resident relocation process.

Subd. 5a. **Licensee responsibilities to provide notice.** At least 60 days before the proposed date of closing, curtailment, reduction, or change in operations as agreed to in the plan, the licensee shall send a written notice of closure or curtailment, reduction, or change in operations to each resident being relocated, the resident's family member or designated representative, and the resident's attending physician. The notice must include the following:

(1) the date of the proposed closure, curtailment, reduction, or change in operations;

(2) the name, address, telephone number, facsimile number, and e-mail address of the individual or individuals in the facility responsible for providing assistance and information;

(3) notification of upcoming meetings for residents, families and designated representatives, and resident and family councils to discuss the relocation of residents;

(4) the name, address, and telephone number of the local agency contact person; and

(5) the name, address, and telephone number of the office of ombudsman for older Minnesotans and the ombudsman for mental health and mental retardation.

The notice must comply with all applicable state and federal requirements for notice of transfer or discharge of nursing home residents.

Subd. 5b. **Licensee responsibility regarding medical information.** The licensee shall request the attending physician provide or arrange for the release of medical information needed to update resident medical records and prepare all required forms and discharge summaries.

Subd. 5c. **Licensee responsibility regarding placement information.** (a) The licensee shall provide sufficient preparation to residents to ensure safe, orderly, and appropriate discharge and relocation. The licensee shall assist residents in finding placements that respond to personal preferences, such as desired geographic location.

(b) The licensee shall prepare a resource list with several relocation options for each resident. The list must contain the following information for each relocation option, when applicable:

(1) the name, address, and telephone and facsimile numbers of each facility with appropriate, available beds or services;

(2) the certification level of the available beds;

(3) the types of services available; and

(4) the name, address, and telephone and facsimile numbers of appropriate available home and community-based placements, services, and settings or other options for individuals with special needs.

The list shall be made available to residents and their families or designated representatives, and upon request to the office of ombudsman for older Minnesotans, the ombudsman for mental health and mental retardation, and the local agency.

(c) The Senior LinkAge line may make available via a Web site the name, address, and telephone and facsimile numbers of each facility with available beds, the certification level of the available beds, the types of services available, and the number of beds that are available as updated daily by the listed facilities. The licensee must provide residents, their families or designated representatives, the office of the ombudsman for older Minnesotans, the office of the ombudsman for mental health and mental retardation, and the local agency with the toll-free number and Web site address for the Senior LinkAge line.

Subd. 5d. **Licensee responsibility to meet with residents and families.** Following the establishment of the plan, the licensee shall conduct meetings with residents, families and designated representatives, and resident and family councils to notify them of the process for resident relocation. Representatives from the local county social services agency, the office of ombudsman for older Minnesotans, the ombudsman for mental health and mental retardation, the commissioner of health, and the commissioner of human services shall receive advance notice of the meetings.

Subd. 5e. **Licensee responsibility for site visits.** The licensee shall assist residents desiring to make site visits to facilities with available beds or other appropriate living options to which the resident may relocate, unless it is medically inadvisable, as documented by the attending physician in the resident's care record. The licensee shall provide or arrange transportation for site visits to facilities or other living options within a 50-mile radius to which the resident may relocate, or within a larger radius if no suitable options are available within 50 miles. The licensee shall provide available written materials to residents on a potential new facility or living option.

Subd. 5f. **Licensee responsibility for personal property, personal funds, and telephone service.** (a) The licensee shall complete an inventory of resident personal possessions and provide a copy of the final inventory to the resident and the resident's designated representative prior to relocation. The licensee shall be responsible for the transfer of the resident's possessions for all relocations within a 50-mile radius of the facility, or within a larger radius if no suitable options are available within 50 miles. The licensee shall complete the transfer of resident possessions in a timely manner, but no later than the date of the actual physical relocation of the resident.

(b) The licensee shall complete a final accounting of personal funds held in trust by the facility and provide a copy of this accounting to the resident and the resident's family or the resident's designated representative. The licensee shall be responsible for the transfer of all personal funds held in trust by the facility. The licensee shall complete the transfer of all personal funds in a timely manner.

(c) The licensee shall assist residents with the transfer and reconnection of service for telephones or, for residents who are deaf or blind, other personal communication devices or services. The licensee shall pay the costs associated with reestablishing service for telephones or other personal communication devices or services, such as connection fees or other one-time charges. The transfer or reconnection of personal communication devices or services shall be completed in a timely manner.

Subd. 5g. **Licensee responsibilities for final notice and records transfer.** (a) The licensee shall provide the resident, the resident's family or designated representative, and the resident's attending physician final written notice prior to the relocation of the resident. The notice must:

(1) be provided seven days prior to the actual relocation, unless the resident agrees to waive the right to advance notice; and

(2) identify the date of the anticipated relocation and the destination to which the resident is being relocated.

(b) The licensee shall provide the receiving facility or other health, housing, or care entity with complete and accurate resident records including information on family members, designated representatives, guardians, social service caseworkers, or other contact information. These records must also include all information necessary to provide appropriate medical care and social services. This includes, but is not limited to, information on preadmission screening, Level I and Level II screening, minimum data set (MDS), and all other assessments, resident diagnoses, social, behavioral, and medication information.

(c) For residents with special care needs, the licensee shall consult with the receiving facility or other placement entity and provide staff training or other preparation as needed to assist in providing for the special needs.

Subd. 6. **Responsibilities of the licensee during relocation.** (a) The licensee shall make arrangements or provide for the transportation of residents to the new facility or placement within a 50-mile radius, or within a larger radius if no suitable options are available within 50 miles. The licensee shall provide a staff person to accompany the resident during transportation, upon request of the resident, the resident's family, or designated representative. The discharge and relocation of residents must comply with all applicable state and federal requirements and must be conducted in a safe, orderly, and appropriate manner. The licensee must ensure that there is no disruption in providing meals, medications, or treatments of a resident during the relocation process.

(b) Beginning the week following development of the initial relocation plan, the licensee shall submit biweekly status reports to the commissioners of health and human services or their designees and to the local agency. The initial status report must identify:

(1) the relocation plan developed;

(2) the interdisciplinary team members; and

(3) the number of residents to be relocated.

(c) Subsequent status reports must identify:

(1) any modifications to the plan;

(2) any change of interdisciplinary team members;

(3) the number of residents relocated;

(4) the destination to which residents have been relocated;

(5) the number of residents remaining to be relocated; and

(6) issues or problems encountered during the process and resolution of these issues.

Subd. 7. **Responsibilities of the licensee following relocation.** The licensee shall retain or make arrangements for the retention of all remaining resident records for the period required by law. The licensee shall provide the department of health access to these records. The licensee shall notify the department of health of the location of any resident records that have not been transferred to the new facility or other health care entity.

Subd. 8. **Responsibilities of local agency.** (a) The local agency shall participate in the meeting as outlined in subdivision 3, paragraph (b), to develop a relocation plan.

(b) The local agency shall designate a representative to the interdisciplinary team established by the licensee responsible for coordinating the relocation efforts.

(c) The local agency shall serve as a resource in the relocation process.

(d) Concurrent with the notice sent to residents from the licensee as provided in subdivision 5a, the local agency shall provide written notice to residents, family, or designated representatives describing:

(1) the county's role in the relocation process and in the follow-up to relocations;

(2) a local agency contact name, address, and telephone number; and

(3) the name, address, and telephone number of the office of ombudsman for older Minnesotans and the ombudsman for mental health and mental retardation.

(e) The local agency designee shall meet with appropriate facility staff to coordinate any assistance in the relocation process. This coordination shall include participating in group meetings with residents, families, and designated representatives to explain the relocation process.

(f) The local agency shall monitor compliance with all components of the plan. If the licensee is not in compliance, the local agency shall notify the commissioners of the departments of health and human services.

(g) Except as requested by the resident, family member, or designated representative and within the parameters of the Vulnerable Adults Act, the local agency may halt a relocation that it deems inappropriate or dangerous to the health or safety of a resident. The local agency shall pursue remedies to protect the resident during the relocation process, including, but not limited to, assisting the resident with filing an appeal of transfer or discharge, notification of all appropriate licensing boards and agencies, and other remedies available to the county under section 626.557, subdivision 10.

(h) A member of the local agency staff shall visit residents relocated within 100 miles of the county within 30 days after the relocation. Local agency staff shall interview the resident and family or designated representative, observe the resident on site, and review and discuss pertinent medical or social records with appropriate facility staff to:

(1) assess the adjustment of the resident to the new placement;

(2) recommend services or methods to meet any special needs of the resident; and

(3) identify residents at risk.

(i) The local agency may conduct subsequent follow-up visits in cases where the adjustment of the resident to the new placement is in question.

(j) Within 60 days of the completion of the follow-up visits, the local agency shall submit a written summary of the follow-up work to the departments of health and human services in a manner approved by the commissioners.

(k) The local agency shall submit to the departments of health and human services a report of any issues that may require further review or monitoring.

(l) The local agency shall be responsible for the safe and orderly relocation of residents in cases where an emergent need arises or when the licensee has abrogated its responsibilities under the plan.

Subd. 9. **Penalties.** Upon the recommendation of the commissioner of health, the commissioner of human services may eliminate a closure rate adjustment under subdivision 10 for violations of this section.

Subd. 10. **Facility closure rate adjustment.** Upon the request of a closing facility, the commissioner of human services must allow the facility a closure rate adjustment equal to a 50 percent payment rate increase to reimburse relocation costs or other costs related to facility closure. This rate increase is effective on the date the facility's occupancy decreases to 90 percent of capacity days after the written notice of closure is distributed under subdivision 5 and shall remain in effect for a period of up to 60 days. The commissioner shall delay the implementation of rate adjustments under section 256B.437, subdivisions 3, paragraph (b), and 6, paragraph (a), to offset the cost of this rate adjustment.

Subd. 11. **County costs.** The commissioner of human services shall allocate up to $450 in total state and federal funds per nursing facility bed that is closing, within the limits of the appropriation specified for this purpose, to be used for relocation costs incurred by counties for resident relocation under this section or planned closures under section 256B.437. To be eligible for this allocation, a county in which a nursing facility closes must provide to the commissioner a detailed statement in a form provided by the commissioner of additional costs, not to exceed $450 in total state and federal funds per bed closed, that are directly incurred related to the county's role in the relocation process.

**History:** *1Sp2001 c 9 art 5 s 9*

## 144A.162 TRANSFER OF RESIDENTS WITHIN FACILITIES.

The licensee shall provide for the safe, orderly, and appropriate transfer of residents within the facility. In situations where there is a curtailment, reduction, capital improvement, or change in operations within a facility, the licensee shall minimize the number of intrafacility transfers needed to complete the project or change in operations, consider individual resident needs and preferences, and provide reasonable accommodation for individual resident requests regarding their room transfer. The licensee shall provide notice to the office of ombudsman for older Minnesotans and, when appropriate, the office of ombudsman for mental health and mental retardation, in advance of any notice to residents and family, when all of the following circumstances apply:

(1) the transfers of residents within the facility are being proposed due to curtailment, reduction, capital improvements or change in operations;

(2) the transfers of residents within the facility are not temporary moves to accommodate physical plan upgrades or renovation; and

(3) the transfers involve multiple residents being moved simultaneously.

**History:** *1Sp2001 c 9 art 5 s 10*

## 144A.1888 REUSE OF FACILITIES.

Notwithstanding any local ordinance related to development, planning, or zoning to the contrary, the conversion or reuse of a nursing home that closes or that curtails, reduces, or changes operations shall be considered a conforming use permitted under local law, provided that the facility is converted to another long-term care service approved by a regional planning group under section 256B.437 that serves a smaller number of persons than the number of persons served before the closure or curtailment, reduction, or change in operations.

**History:** *1Sp2001 c 9 art 5 s 11*

**144A.31** [Repealed, 2001 c 161 s 58]

## 144A.35 EXPANSION OF BED DISTRIBUTION STUDY.

The commissioner of human services shall monitor and analyze the distribution of older adult services, including, but not limited to, nursing home beds, senior housing, housing with services units, and home and community-based services in the different geographic areas of the state. The study shall include an analysis of the impact of amendments to the nursing home moratorium law which would allow for transfers of

nursing home beds within the state. The commissioner of human services shall submit to the legislature, beginning June 1, 2002, and each January 15 thereafter, an assessment of the distribution of long-term health care services by geographic area, with particular attention to service deficits or problems, and corrective action plans.

**History:** *1Sp2001 c 9 art 4 s 1*

## 144A.36 TRANSITION PLANNING GRANTS.

Subdivision 1. **Definitions.** "Eligible nursing home" means any nursing home licensed under sections 144A.01 to 144A.155 and certified by the appropriate authority under United States Code, title 42, sections 1396-1396p, to participate as a vendor in the medical assistance program established under chapter 256B.

Subd. 2. **Grants authorized.** (a) The commissioner shall establish a program of transition planning grants to assist eligible nursing homes in implementing the provisions in paragraphs (b) and (c).

(b) Transition planning grants may be used by nursing homes to develop strategic plans which identify the appropriate institutional and noninstitutional settings necessary to meet the older adult service needs of the community.

(c) At a minimum, a strategic plan must consist of:

(1) a needs assessment to determine what older adult services are needed and desired by the community;

(2) an assessment of the appropriate settings in which to provide needed older adult services;

(3) an assessment identifying currently available services and their settings in the community; and

(4) a transition plan to achieve the needed outcome identified by the assessment.

Subd. 3. **Allocation of grants.** (a) Eligible nursing homes must apply to the commissioner no later than September 1 of each fiscal year for grants awarded in that fiscal year. A grant shall be awarded upon signing of a grant contract.

(b) The commissioner must make a final decision on the funding of each application within 60 days of the deadline for receiving applications.

Subd. 4. **Evaluation.** The commissioner shall evaluate the overall effectiveness of the grant program. The commissioner may collect, from the nursing homes receiving grants, the information necessary to evaluate the grant program. Information related to the financial condition of individual nursing homes shall be classified as nonpublic data.

**History:** *1Sp2001 c 9 art 5 s 12,40*

## 144A.37 ALTERNATIVE NURSING HOME SURVEY PROCESS.

Subdivision 1. **Alternative nursing home survey schedules.** (a) The commissioner of health shall implement alternative procedures for the nursing home survey process as authorized under this section.

(b) These alternative survey process procedures seek to: (1) use department resources more effectively and efficiently to target problem areas; (2) use other existing or new mechanisms to provide objective assessments of quality and to measure quality improvement; (3) provide for frequent collaborative interaction of facility staff and surveyors rather than a punitive approach; and (4) reward a nursing home that has performed very well by extending intervals between full surveys.

(c) The commissioner shall pursue changes in federal law necessary to accomplish this process and shall apply for any necessary federal waivers or approval. If a federal waiver is approved, the commissioner shall promptly submit, to the house and senate committees with jurisdiction over health and human services policy and finance, fiscal estimates for implementing the alternative survey process waiver. The commissioner shall also pursue any necessary federal law changes during the 107th Congress.

(d) The alternative nursing home survey schedule and related educational activities shall not be implemented until funding is appropriated by the legislature.

Subd. 2. **Survey intervals.** The commissioner of health must extend the time period between standard surveys up to 30 months based on the criteria established in subdivision 4. In using the alternative survey schedule, the requirement for the statewide average to not exceed 12 months does not apply.

Subd. 3. **Compliance history.** The commissioner shall develop a process for identifying the survey cycles for skilled nursing facilities based upon the compliance history of the facility. This process can use a range of months for survey intervals. At a minimum, the process must be based on information from the last two survey cycles and shall take into consideration any deficiencies issued as the result of a survey or a complaint investigation during the interval. A skilled nursing facility with a finding of substandard quality of care or a finding of immediate jeopardy is not entitled to a survey interval greater than 12 months. The commissioner shall alter the survey cycle for a specific skilled nursing facility based on findings identified through the completion of a survey, a monitoring visit, or a complaint investigation. The commissioner must also take into consideration information other than the facility's compliance history.

Subd. 4. **Criteria for survey interval classification.** (a) The commissioner shall provide public notice of the classification process and shall identify the selected survey cycles for each skilled nursing facility. The classification system must be based on an analysis of the findings made during the past two standard survey intervals, but it only takes one survey or complaint finding to modify the interval.

(b) The commissioner shall also take into consideration information obtained from residents and family members in each skilled nursing facility and from other sources such as employees and ombudsmen in determining the appropriate survey intervals for facilities.

Subd. 5. **Required monitoring.** (a) The commissioner shall conduct at least one monitoring visit on an annual basis for every skilled nursing facility which has been selected for a survey cycle greater than 12 months. The commissioner shall develop protocols for the monitoring visits which shall be less extensive than the requirements for a standard survey. The commissioner shall use the criteria in paragraph (b) to determine whether additional monitoring visits to a facility will be required.

(b) The criteria shall include, but not be limited to, the following:

(1) changes in ownership, administration of the facility, or direction of the facility's nursing service;

(2) changes in the facility's quality indicators which might evidence a decline in the facility's quality of care;

(3) reductions in staffing or an increase in the utilization of temporary nursing personnel; and

(4) complaint information or other information that identifies potential concerns for the quality of the care and services provided in the skilled nursing facility.

Subd. 6. **Survey requirements for facilities not approved for extended survey intervals.** The commissioner shall establish a process for surveying and monitoring of facilities which require a survey interval of less than 15 months. This information shall identify the steps that the commissioner must take to monitor the facility in addition to the standard survey.

Subd. 7. **Impact on survey agency's budget.** The implementation of an alternative survey process for the state must not result in any reduction of funding that would have been provided to the state survey agency for survey and enforcement activity based upon the completion of full standard surveys for each skilled nursing facility in the state.

Subd. 8. **Educational activities.** The commissioner shall expand the state survey agency's ability to conduct training and educational efforts for skilled nursing facilities, residents and family members, residents and family councils, long-term care ombudsman programs, and the general public.

Subd. 9. **Evaluation.** The commissioner shall develop a process for the evaluation of the effectiveness of an alternative survey process conducted under this section.

**History:** *1Sp2001 c 9 art 5 s 13*

## 144A.38 INNOVATIONS IN QUALITY DEMONSTRATION GRANTS.

Subdivision 1. **Program established.** The commissioners of health and human services shall establish a long-term care grant program that demonstrates best practices and innovation for long-term care service delivery and housing. The grants must fund demonstrations that create new means and models for serving the elderly or demonstrate creativity in service provision through the scope of their program or service.

Subd. 2. **Eligibility.** Grants may only be made to those who provide direct service or housing to the elderly within the state. Grants may only be made for projects that show innovations and measurable improvement in resident care, quality of life, use of technology, or customer satisfaction.

Subd. 3. **Awarding of grants.** (a) Applications for grants must be made to the commissioners on forms prescribed by the commissioners.

(b) The commissioners shall review applications and award grants based on the following criteria:

(1) improvement in direct care to residents;

(2) increase in efficiency through the use of technology;

(3) increase in quality of care through the use of technology;

(4) increase in the access and delivery of service;

(5) enhancement of nursing staff training;

(6) the effectiveness of the project as a demonstration; and

(7) the immediate transferability of the project to scale.

(c) In reviewing applications and awarding grants, the commissioners shall consult with long-term care providers, consumers of long-term care, long-term care researchers, and staff of other state agencies.

(d) Grants for eligible projects may not exceed $100,000.

**History:** *1Sp2001 c 9 art 5 s 14*

## 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, including at least ten days' advance notice of the termination of a service by a provider, except in cases where:

(i) the recipient of services engages in conduct that alters the conditions of employment as specified in the employment contract between the home care provider and the individual providing home care services, or creates an abusive or unsafe work environment for the individual providing home care services; or

(ii) an emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the home care provider;

(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.2000]*

**History:** *1Sp2001 c 9 art 1 s 39*

**144A.46 LICENSURE.**

*[For text of subds 1 to 4, see M.S.2000]*

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. Nothing in this section shall be construed to prohibit a home care provider from requiring self-disclosure of criminal conviction information.

(c) [Repealed by amendment, 1997 c 248 s 2]

(d) [Repealed by amendment, 1997 c 248 s 2]

(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 unemployment benefits.

**History:** *1Sp2001 c 9 art 14 s 35*

## 144A.4605 ASSISTED LIVING HOME CARE PROVIDER.

*[For text of subds 1 to 3, see M.S.2000]*

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 or class E license according to rule. A housing with services establishment that obtains a class E license under this subdivision remains subject to the payment limitations in sections 256B.0913, subdivision 5, paragraph (h), and 256B.0915, subdivision 3, paragraph (g).

(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.48, 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.

(d) An assisted living home care provider licensed under this section must comply with the disclosure provisions of section 325F.72 to the extent they are applicable.

*[For text of subds 5 and 6, see M.S.2000]*

**History:** *1Sp2001 c 9 art 1 s 40*

## 144A.70 REGISTRATION OF SUPPLEMENTAL NURSING SERVICES AGENCIES; DEFINITIONS.

Subdivision 1. **Scope.** As used in sections 144A.70 to 144A.74, the terms defined in this section have the meanings given them.

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

Subd. 3. **Controlling person.** "Controlling person" means a business entity, officer, program administrator, or director whose responsibilities include the direction of the management or policies of a supplemental nursing services agency. Controlling person also means an individual who, directly or indirectly, beneficially owns an interest in a corporation, partnership, or other business association that is a controlling person.

Subd. 4. **Health care facility.** "Health care facility" means a hospital, boarding care home, or outpatient surgical center licensed under sections 144.50 to 144.58; a nursing home or home care agency licensed under this chapter; a housing with services establishment registered under chapter 144D; or a board and lodging establishment that is registered to provide supportive or health supervision services under section 157.17.

Subd. 5. **Person.** "Person" includes an individual, firm, corporation, partnership, or association.

Subd. 6. **Supplemental nursing services agency.** "Supplemental nursing services agency" means a person, firm, corporation, partnership, or association engaged for hire in the business of providing or procuring temporary employment in health care facilities for nurses, nursing assistants, nurse aides, and orderlies. Supplemental nursing services agency does not include an individual who only engages in providing the individual's services on a temporary basis to health care facilities. Supplemental nursing services agency also does not include any nursing service agency that is limited to providing temporary nursing personnel solely to one or more health care facilities owned or operated by the same person, firm, corporation, or partnership.

**History:** *1Sp2001 c 9 art 7 s 2*

## 144A.71 SUPPLEMENTAL NURSING SERVICES AGENCY REGISTRATION.

Subdivision 1. **Duty to register.** A person who operates a supplemental nursing services agency shall register the agency with the commissioner. Each separate location of the business of a supplemental nursing services agency shall register the agency with the commissioner. Each separate location of the business of a supplemental nursing services agency shall have a separate registration.

Subd. 2. **Application information and fee.** The commissioner shall establish forms and procedures for processing each supplemental nursing services agency registration application. An application for a supplemental nursing services agency registration must include at least the following:

(1) the names and addresses of the owner or owners of the supplemental nursing services agency;

(2) if the owner is a corporation, copies of its articles of incorporation and current bylaws, together with the names and addresses of its officers and directors;

(3) any other relevant information that the commissioner determines is necessary to properly evaluate an application for registration; and

(4) the annual registration fee for a supplemental nursing services agency, which is $891.

Subd. 3. **Registration not transferable.** A registration issued by the commissioner according to this section is effective for a period of one year from the date of its issuance unless the registration is revoked or suspended under section 144A.72, subdivision 2, or unless the supplemental nursing services agency is sold or ownership or management is transferred. When a supplemental nursing services agency is sold or ownership or management is transferred, the registration of the agency must be voided and the new owner or operator may apply for a new registration.

**History:** *1Sp2001 c 9 art 7 s 3*

## 144A.72 REGISTRATION REQUIREMENTS; PENALTIES.

Subdivision 1. **Minimum criteria.** The commissioner shall require that, as a condition of registration:

(1) the supplemental nursing services agency shall document that each temporary employee provided to health care facilities currently meets the minimum licensing, training, and continuing education standards for the position in which the employee will be working;

(2) the supplemental nursing services agency shall comply with all pertinent requirements relating to the health and other qualifications of personnel employed in health care facilities;

(3) the supplemental nursing services agency must not restrict in any manner the employment opportunities of its employees;

(4) the supplemental nursing services agency, when supplying temporary employees to a health care facility, and when requested by the facility to do so, shall agree that at least 30 percent of the total personnel hours supplied are during night, holiday, or weekend shifts;

(5) the supplemental nursing services agency shall carry medical malpractice insurance to insure against the loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in the provision of health care services by the supplemental nursing services agency or by any employee of the agency; and

(6) the supplemental nursing services agency must not, in any contract with any employee or health care facility, require the payment of liquidated damages, employment fees, or other compensation should the employee be hired as a permanent employee of a health care facility.

Subd. 2. **Penalties.** A pattern of failure to comply with this section shall subject the supplemental nursing services agency to revocation or nonrenewal of its registration. Violations of section 144A.74 are subject to a fine equal to 200 percent of the amount billed or received in excess of the maximum permitted under that section.

**History:** *1Sp2001 c 9 art 7 s 4*

### 144A.73 COMPLAINT SYSTEM.

The commissioner shall establish a system for reporting complaints against a supplemental nursing services agency or its employees. Complaints may be made by any member of the public. Written complaints must be forwarded to the employer of each person against whom a complaint is made. The employer shall promptly report to the commissioner any corrective action taken.

**History:** *1Sp2001 c 9 art 7 s 5*

### 144A.74 MAXIMUM CHARGES.

A supplemental nursing services agency must not bill or receive payments from a nursing home licensed under this chapter at a rate higher than 150 percent of the weighted average wage rate for the applicable employee classification for the geographic group to which the nursing home is assigned under Minnesota Rules, part 9549.0052. The weighted average wage rates must be determined by the commissioner of human services and reported to the commissioner of health on an annual basis. Facilities shall provide information necessary to determine weighted average wage rates to the commissioner of human services in a format requested by the commissioner. The maximum rate must include all charges for administrative fees, contract fees, or other special charges in addition to the hourly rates for the temporary nursing pool personnel supplied to a nursing home.

**History:** *1Sp2001 c 9 art 7 s 6*