CHAPTER 144A
NURSING HOMES AND HOME CARE

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144A.001 MS 2006 [Renumbered 15.001]

144A.01 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of sections 144A.01 to 144A.27, the terms defined in this section have the meanings given them.

Subd. 2. **Commissioner of health.** "Commissioner of health" means the state commissioner of health established by section 144.011.

Subd. 3. **Board of examiners.** "Board of examiners" means the Board of Examiners for Nursing Home Administrators established by section 144A.19.

Subd. 3a. **Certified.** "Certified" means certified for participation as a provider in the Medicare or Medicaid programs under title XVIII or XIX of the Social Security Act.

Subd. 4. **Controlling person.** "Controlling person" means any public body, governmental agency, business entity, officer, nursing home administrator, or director whose responsibilities include the direction of the management or policies of a nursing home. "Controlling person" also means any person who, directly or indirectly, beneficially owns any interest in:

(a) Any corporation, partnership or other business association which is a controlling person;

(b) The land on which a nursing home is located;

(c) The structure in which a nursing home is located;

(d) Any mortgage, contract for deed, or other obligation secured in whole or part by the land or structure comprising a nursing home; or

(e) Any lease or sublease of the land, structure, or facilities comprising a nursing home.

"Controlling person" does not include:

(a) A bank, savings bank, trust company, savings association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity directly or through a subsidiary operates a nursing home;

(b) An individual state official or state employee, or a member or employee of the governing body of a political subdivision of the state which operates one or more nursing homes, unless the individual is also an officer or director of a nursing home, receives any remuneration from a nursing home, or owns any of the beneficial interests not excluded in this subdivision;

(c) A natural person who is a member of a tax-exempt organization under section 290.05, subdivision 1, clause (i), unless the individual is also an officer or director of a nursing home, or owns any of the beneficial interests not excluded in this subdivision; and

(d) A natural person who owns less than five percent of the outstanding common shares of a corporation:

(1) whose securities are exempt by virtue of section 80A.45, clause (6); or

(2) whose transactions are exempt by virtue of section 80A.46, clause (7).

Subd. 4a. **Emergency.** "Emergency" means a situation or physical condition that creates or probably will create an immediate and serious threat to a resident's health or safety.

Subd. 5. **Nursing home.** "Nursing home" means a facility or that part of a facility which provides nursing care to five or more persons. "Nursing home" does not include a facility or that part of a facility which is a hospital, a hospital with approved swing beds as defined in section 144.562, clinic, doctor's office, diagnostic or treatment center, or a residential program licensed pursuant to sections 245A.01 to 245A.16 or 252.28.

Subd. 6. **Nursing care.** "Nursing care" means health evaluation and treatment of patients and residents who are not in need of an acute care facility but who require nursing supervision on an inpatient basis. The commissioner of health may by rule establish levels of nursing care.

Subd. 7. **Uncorrected violation.** "Uncorrected violation" means a violation of a statute or rule or any other deficiency for which a notice of noncompliance has been issued and fine assessed and allowed to be recovered pursuant to section 144A.10, subdivision 8.

Subd. 8. **Managerial employee.** "Managerial employee" means an employee of a nursing home whose duties include the direction of some or all of the management or policies of the nursing home.

Subd. 9. **Nursing home administrator.** "Nursing home administrator" means a person who administers, manages, supervises, or is in general administrative charge of a nursing home, whether or not the individual has an ownership interest in the home, and whether or not the person's functions and duties are shared with one or more individuals, and who is licensed

pursuant to section 144A.21.

Subd. 10. **Repeated violation.** "Repeated violation" means the issuance of two or more correction orders, within a 12-month period, for a violation of the same provision of a statute or rule.

History: *1976 c 173 s 1; 1977 c 305 s 45; 1980 c 509 s 43; 1Sp1981 c 4 art 1 s 79; 1982 c 633 s 1; 1Sp1985 c 3 s 5-7; 1986 c 444; 1989 c 282 art 2 s 24; art 3 s 6,7; 1995 c 202 art 1 s 25; 2006 c 196 art 1 s 52; art 2 s 4*

144A.02 LICENSURE; PENALTY.

Subdivision 1. **License required.** No facility shall be used as a nursing home to provide nursing care unless the facility has been licensed as a nursing home. The commissioner of health may license a facility as a nursing home if the facility meets the criteria established by sections 144A.02 to 144A.10, and the rules promulgated thereunder. A license shall describe the facility to be licensed by address and by legal property description. The license shall specify the location and square footage of the floor space constituting the facility and shall incorporate by reference the plans and specifications of the facility, which plans and specifications shall be kept on file with the commissioner of health. The license may also specify the level or levels of nursing care which the facility is licensed to provide and shall state any conditions or limitations imposed on the facility in accordance with the rules of the commissioner of health.

Subd. 2. **Penalty.** A controlling person of a nursing home in violation of this section is guilty of a misdemeanor. The provisions of this subdivision shall not apply to any controlling person who had no legal authority to affect or change decisions related to the operation of the nursing home.

History: *1976 c 173 s 2; 1977 c 305 s 45*

144A.03 LICENSE APPLICATION.

Subdivision 1. **Form; requirements.** The commissioner of health by rule shall establish forms and procedures for the processing of nursing home license applications. An application for a nursing home license shall include the following information:

(a) The names and addresses of all controlling persons and managerial employees of the facility to be licensed;

(b) The address and legal property description of the facility;

(c) A copy of the architectural and engineering plans and specifications of the facility as prepared and certified by an architect or engineer registered to practice in this state; and

(d) Any other relevant information which the commissioner of health by rule or otherwise may determine is necessary to properly evaluate an application for license.

A controlling person which is a corporation shall submit copies of its articles of incorporation and bylaws and any amendments thereto as they occur, together with the names and addresses of its officers and directors. A controlling person which is a foreign corporation shall furnish the commissioner of health with a copy of its certificate of authority to do business in this state. An application on behalf of a controlling person which is a corporation, association or a governmental unit or instrumentality shall be signed by at least two officers or managing agents of that entity.

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: *1976 c 173 s 3; 1977 c 305 s 45; 1987 c 384 art 2 s 1; 1Sp2001 c 9 art 5 s 40*

144A.04 QUALIFICATIONS FOR LICENSE.

Subdivision 1. **Compliance required.** No nursing home license shall be issued to a facility unless the commissioner of health determines that the facility complies with the requirements of this section.

Subd. 2. **Application.** The controlling persons of the facility must comply with the application requirements specified by section 144A.03 and the rules of the commissioner of health.

Subd. 2a. **Rules; locks.** The commissioner shall not adopt any rule unconditionally prohibiting locks on patient room doors in nursing homes. The commissioner may adopt a rule requiring locks to be consistent with the applicable rules enforced by the state fire marshal.

Subd. 3. **Standards.** (a) The facility must meet the minimum health, sanitation, safety and comfort standards prescribed by the rules of the commissioner of health with respect to the

construction, equipment, maintenance and operation of a nursing home. The commissioner of health may temporarily waive compliance with one or more of the standards if the commissioner determines that:

(1) temporary noncompliance with the standard will not create an imminent risk of harm to a nursing home resident; and

(2) a controlling person on behalf of all other controlling persons:

(i) has entered into a contract to obtain the materials or labor necessary to meet the standard set by the commissioner of health, but the supplier or other contractor has failed to perform the terms of the contract and the inability of the nursing home to meet the standard is due solely to that failure; or

(ii) is otherwise making a diligent good faith effort to meet the standard.

The commissioner shall make available to other nursing homes information on facility-specific waivers related to technology or physical plant that are granted. The commissioner shall, upon the request of a facility, extend a waiver granted to a specific facility related to technology or physical plant to the facility making the request, if the commissioner determines that the facility also satisfies clauses (1) and (2) and any other terms and conditions of the waiver.

The commissioner of health shall allow, by rule, a nursing home to provide fewer hours of nursing care to intermediate care residents of a nursing home than required by the present rules of the commissioner if the commissioner determines that the needs of the residents of the home will be adequately met by a lesser amount of nursing care.

(b) A facility is not required to seek a waiver for room furniture or equipment under paragraph (a) when responding to resident-specific requests, if the facility has discussed health and safety concerns with the resident and the resident request and discussion of health and safety concerns are documented in the resident's patient record.

Subd. 3a. **Rules; double beds.** The commissioner shall not adopt any rule which unconditionally prohibits double beds in a nursing home. The commissioner may adopt rules setting criteria for when double beds will be allowed.

Subd. 4. **Controlling person restrictions.** (a) The controlling persons of a nursing home may not include any person who was a controlling person of another nursing home during any period of time in the previous two-year period:

(1) during which time of control that other nursing home incurred the following number of uncorrected or repeated violations:

(i) two or more uncorrected violations or one or more repeated violations which created an imminent risk to direct resident care or safety; or

(ii) four or more uncorrected violations or two or more repeated violations of any nature for which the fines are in the four highest daily fine categories prescribed in rule; or

(2) who was convicted of a felony or gross misdemeanor that relates to operation of the nursing home or directly affects resident safety or care, during that period.

(b) The provisions of this subdivision shall not apply to any controlling person who had no legal authority to affect or change decisions related to the operation of the nursing home which incurred the uncorrected violations.

Subd. 4a. **Stay of adverse action required by controlling person restrictions.** (a) In lieu of revoking, suspending, or refusing to renew the license of a nursing home with a controlling person disqualified by subdivision 4, paragraph (a), clause (1), the commissioner may issue an order staying the revocation, suspension, or nonrenewal of the nursing home license. The order may, but need not, be contingent upon the nursing home's compliance with restrictions and conditions imposed on the license to ensure the proper operation of the nursing home and to protect the health, safety, comfort, treatment, and well-being of the residents in the home. The decision to issue an order for stay must be made within 90 days of the commissioner's determination that a controlling person is disqualified by subdivision 4, paragraph (a), clause (1), from operating a nursing home.

(b) In determining whether to issue a stay and to impose conditions and restrictions, the commissioner shall consider the following factors:

(1) the ability of the controlling persons to operate other nursing homes in accordance with the licensure rules and laws;

(2) the conditions in the facility that received the number and type of uncorrected or repeated violations described in subdivision 4, paragraph (a), clause (1); and

(3) the conditions and compliance history of each of the nursing homes operated by the controlling persons.

(c) The commissioner's decision to exercise the authority under this subdivision in lieu of revoking, suspending, or refusing to renew the license of the nursing home is not subject to administrative or judicial review.

(d) The order for the stay of revocation, suspension, or nonrenewal of the nursing home license must include any conditions and restrictions on the nursing home license that the commissioner deems necessary based upon the factors listed in paragraph (b).

(e) Prior to issuing an order for stay of revocation, suspension, or nonrenewal, the commissioner shall inform the controlling persons, in writing, of any conditions and restrictions that will be imposed. The controlling persons shall, within ten working days, notify the commissioner in writing of their decision to accept or reject the conditions and restrictions. If

the nursing home rejects any of the conditions and restrictions, the commissioner shall either modify the conditions and restrictions or take action to suspend, revoke, or not renew the nursing home license.

(f) Upon issuance of the order for stay of revocation, suspension, or nonrenewal, the controlling persons shall be responsible for compliance with the conditions and restrictions contained therein. Any time after the conditions and restrictions have been in place for 180 days, the controlling persons may petition the commissioner for removal or modification of the conditions and restrictions. The commissioner shall respond to the petition within 30 days of the receipt of the written petition. If the commissioner denies the petition, the controlling persons may request a hearing under the provisions of chapter 14. Any hearing shall be limited to a determination of whether the conditions and restrictions shall be modified or removed. At the hearing, the controlling persons will have the burden of proof.

(g) The failure of the controlling persons to comply with the conditions and restrictions contained in the order for stay shall result in the immediate removal of the stay and the commissioner shall take action to suspend, revoke, or not renew the license.

(h) The conditions and restrictions are effective for two years after the date they are imposed.

(i) Nothing in this subdivision shall be construed to limit in any way the commissioner's ability to impose other sanctions against a nursing home license under the standards set forth in state or federal law whether or not a stay of revocation, suspension, or nonrenewal is issued.

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]

Subd. 6. **Managerial employee or licensed administrator; employment prohibitions.** A nursing home may not employ as a managerial employee or as its licensed administrator any person who was a managerial employee or the licensed administrator of another facility during any period of time in the previous two-year period:

(a) during which time of employment that other nursing home incurred the following number of uncorrected violations which were in the jurisdiction and control of the managerial employee or the administrator:

(1) two or more uncorrected violations or one or more repeated violations which created an imminent risk to direct resident care or safety; or

(2) four or more uncorrected violations or two or more repeated violations of any nature for which the fines are in the four highest daily fine categories prescribed in rule; or

(b) who was convicted of a felony or gross misdemeanor that relates to operation of the nursing home or directly affects resident safety or care, during that period.

Subd. 7. **Minimum nursing staff requirement.** Notwithstanding the provisions of Minnesota Rules, part 4655.5600, the minimum staffing standard for nursing personnel in certified nursing homes is as follows:

(a) The minimum number of hours of nursing personnel to be provided in a nursing home is the greater of two hours per resident per 24 hours or 0.95 hours per standardized resident day. Upon transition to the 34 group, RUG-III resident classification system, the 0.95 hours per standardized resident day shall no longer apply.

(b) For purposes of this subdivision, "hours of nursing personnel" means the paid, on-duty, productive nursing hours of all nurses and nursing assistants, calculated on the basis of any given 24-hour period. "Productive nursing hours" means all on-duty hours during which nurses and nursing assistants are engaged in nursing duties. Examples of nursing duties may be found in Minnesota Rules, parts 4655.5900, 4655.6100, and 4655.6400. Not included are vacations, holidays, sick leave, in-service classroom training, or lunches. Also not included are the nonproductive nursing hours of the in-service training director. In homes with more than 60 licensed beds, the hours of the director of nursing are excluded. "Standardized resident day" means the sum of the number of residents in each case mix class multiplied by the case mix weight for that resident class, as found in Minnesota Rules, part 9549.0059, subpart 2, calculated on the basis of a facility's census for any given day. For the purpose of determining a facility's census, the commissioner of health shall exclude the resident days claimed by the facility for resident therapeutic leave or bed hold days.

(c) Calculation of nursing hours per standardized resident day is performed by dividing total hours of nursing personnel for a given period by the total of standardized resident days for that same period.

(d) A nursing home that is issued a notice of noncompliance under section 144A.10, subdivision 5, for a violation of this subdivision, shall be assessed a civil fine of $300 for each day of noncompliance, subject to section 144A.10, subdivisions 7 and 8.

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

Subd. 8. **Residents with AIDS or hepatitis.** A nursing home must accept as a resident a person who is infected with the human immunodeficiency virus or the hepatitis B virus unless the facility cannot provide appropriate care for the person under Minnesota Rules, part 4655.1500, subpart 2, or the person is otherwise not eligible for admission under state laws and rules.

Subd. 9. **Cardiopulmonary resuscitation training.** Effective October 1, 1989, a nursing home must have on duty at all times at least one staff member who is trained in single rescuer adult cardiopulmonary resuscitation and who has completed the initial training or a refresher course within the previous two years.

Subd. 10. **Assessments for short-stay residents.** Upon federal approval, a nursing home is not required to perform a resident assessment on a resident expected to remain in the facility for 30 days or less. A short-stay resident transferring from a hospital to a nursing home must have a plan of care developed at the hospital before admission to the nursing home. If a short-stay resident remains in the nursing home longer than 30 days, the nursing home must perform the resident assessment in accordance with sections 144.072 to 144.0722 within 40 days of the resident's admission.

Subd. 11. **Incontinent residents.** Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.

History: *1976 c 173 s 4; 1977 c 305 s 45; 1977 c 326 s 2; 1978 c 536 s 1; 1981 c 23 s 3; 1981 c 24 s 2; 1982 c 614 s 3; 1982 c 633 s 2,3; 1983 c 312 art 1 s 17; 1Sp1985 c 3 s 8,9; 1986 c 444; 1988 c 689 art 2 s 35; 1989 c 282 art 3 s 8-10; 1990 c 498 s 1,2; 1991 c 169 s 1; 1993 c 326 art 13 s 1,2; 1Sp1993 c 1 art 9 s 53; 1995 c 81 s 1; 1996 c 296 s 1; 1996 c 352 s 1; 1996 c 451 art 4 s 21; 1998 c 407 art 3 s 1; 1999 c 17 s 1,2; 2000 c 294 s 1; 2001 c 69 s 1; 2002 c 276 s 5; 2003 c 55 s 1,2; 1Sp2003 c 14 art 2 s 7,8,57*

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: *1976 c 173 s 5; 1977 c 305 s 45; 1977 c 326 s 3; 1984 c 654 art 5 s 58; 1987 c 384 art 2 s 1; 1987 c 403 art 4 s 2; 1Sp2001 c 9 art 5 s 40*

144A.06 TRANSFER OF INTERESTS.

Subdivision 1. **Notice; expiration of license.** Any controlling person who makes any transfer of a beneficial interest in a nursing home shall notify the commissioner of health of the transfer within 14 days of its occurrence. The notification shall identify by name and address the transferor and transferee and shall specify the nature and amount of the transferred interest. On determining that the transferred beneficial interest exceeds ten percent of the total beneficial interest in the nursing home facility, the structure in which the facility is located, or the land upon which the structure is located, the commissioner may, and on determining that the transferred beneficial interest exceeds 50 percent of the total beneficial interest in the facility, the structure in which the facility is located, or the land upon which the structure is located, the commissioner shall require that the license of the nursing home expire 90 days after the date of transfer. The commissioner of health shall notify the nursing home by certified mail of the expiration of the license at least 60 days prior to the date of expiration.

Subd. 2. **Relicensure.** The commissioner of health by rule shall prescribe procedures for relicensure under this section. The commissioner of health shall relicense a nursing home if the facility satisfies the requirements for license renewal established by section 144A.05. A facility shall not be relicensed by the commissioner if at the time of transfer there are any uncorrected violations. The commissioner of health may temporarily waive correction of one or more violations if the commissioner determines that:

(a) Temporary noncorrection of the violation will not create an imminent risk of harm to a nursing home resident; and

(b) A controlling person on behalf of all other controlling persons:

(1) Has entered into a contract to obtain the materials or labor necessary to correct the violation, but the supplier or other contractor has failed to perform the terms of the contract and the inability of the nursing home to correct the violation is due solely to that failure; or

(2) Is otherwise making a diligent good faith effort to correct the violation.

History: *1976 c 173 s 6; 1977 c 305 s 45; 1986 c 444*

144A.07 FEES.

Each application for a license to operate a nursing home, or for a renewal of license, except an application by the Minnesota Veterans Home or the commissioner of human services for the licensing of state institutions, shall be accompanied by a fee to be prescribed by the commissioner of health pursuant to section 144.122. No fee shall be refunded.

History: *1976 c 173 s 7; 1977 c 305 s 45; 1984 c 654 art 5 s 58*

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 clearance for the construction project is issued, or if a clearance for the construction project is not required, the date on which the construction project assets are 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; and

(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.

(h) "Depreciation guidelines" means the most recent publication of "The Estimated Useful Lives of Depreciable Hospital Assets," issued by the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois, 60611.

(i) "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.

(j) "Project construction costs" means the cost of the following items that have a completion date within 12 months before or after the completion date of the project described in item (g), clause (1):

(1) facility capital asset additions;

(2) replacements;

(3) renovations;

(4) remodeling projects;

(5) construction site preparation costs;

(6) related soft costs; and

(7) the cost of new technology implemented as part of the construction project and depreciable equipment directly identified to the project, if the construction costs for clauses (1) to (6) exceed the threshold for additions and replacements stated in section 256B.431, subdivision 16. Technology and depreciable equipment shall be included in the project construction costs unless a written election is made by the facility, to not include it in the facility's appraised value for purposes of Minnesota Rules, part 9549.0020, subpart 5. Debt incurred for purchase of technology and depreciable equipment shall be included as allowable debt for purposes of Minnesota Rules, part 9549.0060, subpart 5, items A and C, unless the written election is to not include it. Any new technology and depreciable equipment included in the project construction costs that the facility elects not to include in its appraised value and allowable debt shall be treated as provided in section 256B.431, subdivision 17, paragraph (b). Written election under this paragraph must be included in the facility's request for the rate change related to the project, and this election may not be changed.

(k) "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, ground shifts, 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.

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

(a) to license or certify a new bed in place of one decertified after July 1, 1993, as long as the number of certified plus newly certified or recertified beds does not exceed the number of beds licensed or certified on July 1, 1993, or to address an extreme hardship situation, in a particular county that, together with all contiguous Minnesota counties, has fewer nursing home beds per 1,000 elderly than the number that is ten percent higher than the national average of nursing home beds per 1,000 elderly individuals. For the purposes of this section, the national average of nursing home beds shall be the most recent figure that can be supplied by the federal Centers for Medicare and Medicaid Services and the number of elderly in the county or the nation shall be determined by the most recent federal census or the most recent estimate of the state demographer as of July 1, of each year of persons age 65 and older, whichever is the most recent at the time of the request for replacement. An extreme hardship situation can only be found after the county documents the existence of unmet medical needs that cannot be addressed by any other alternatives;

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

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

(d) to certify two existing beds in a facility with 66 licensed beds on January 1, 1994, that had an average occupancy rate of 98 percent or higher in both calendar years 1992 and 1993, and which began construction of four attached assisted living units in April 1993; or

(e) to certify four existing beds in a facility in Winona with 139 beds, of which 129 beds are certified.

Subd. 3a. [Repealed, 1992 c 513 art 7 s 135]

Subd. 4. **Monitoring exceptions for replacement beds.** The commissioner of health, in coordination with the commissioner of human services, shall implement mechanisms to monitor and analyze the effect of the moratorium in the different geographic areas of the state. The commissioner of health shall submit to the legislature, no later than January 15, 1984, and

annually thereafter, an assessment of the impact of the moratorium by geographic area, with particular attention to service deficits or problems and a corrective action plan.

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 disabled 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 disabled 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, or may remove these beds from layaway status if removal from layaway status is part of a moratorium exception project approved by the commissioner under section 144A.073.

Subd. 4b. **Licensed beds on layaway status.** A licensed and certified nursing facility may lay away, upon prior written notice to the commissioner of health, up to 50 percent of its licensed and certified beds. A nursing facility may not discharge a resident in order to lay away a bed. Notice to the commissioner shall be given 60 days prior to the effective date of the layaway. Beds on layaway shall have the same status as voluntarily delicensed and decertified beds and shall not be subject to license fees and license surcharge fees. In addition, beds on layaway may be removed from layaway at any time on or after one year after the effective date of layaway in the facility of origin, with a 60-day notice to the commissioner. A nursing facility that removes beds from layaway may not place beds on layaway status for one year after the effective date of the removal from layaway. The commissioner may approve the immediate removal of beds from layaway if necessary to provide access to those nursing home beds to residents relocated from other nursing homes due to emergency situations or closure. In the event approval is granted, the one-year restriction on placing beds on layaway after a removal of beds from layaway shall not apply. Beds may remain on layaway for up to five years. The commissioner may approve placing and removing beds on layaway at any time during renovation or construction related to a moratorium project approved under this section or section 144A.073.

Subd. 4c. **Exceptions for replacement beds after June 30, 2003.** (a) 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:

(1) to license and certify an 80-bed city-owned facility in Nicollet County to be constructed on the site of a new city-owned hospital to replace an existing 85-bed facility attached to a hospital that is also being replaced. The threshold allowed for this project under section 144A.073 shall be the maximum amount available to pay the additional medical assistance costs of the new facility;

(2) to license and certify 29 beds to be added to an existing 69-bed facility in St. Louis County, provided that the 29 beds must be transferred from active or layaway status at an existing facility in St. Louis County that had 235 beds on April 1, 2003.

The licensed capacity at the 235-bed facility must be reduced to 206 beds, but the payment rate at that facility shall not be adjusted as a result of this transfer. The operating payment rate of the facility adding beds after completion of this project shall be the same as it was on the day prior to the day the beds are licensed and certified. This project shall not proceed unless it is approved and financed under the provisions of section 144A.073;

(3) to license and certify a new 60-bed facility in Austin, provided that: (i) 45 of the new beds are transferred from a 45-bed facility in Austin under common ownership that is closed and 15 of the new beds are transferred from a 182-bed facility in Albert Lea under common ownership; (ii) the commissioner of human services is authorized by the 2004 legislature to negotiate budget-neutral planned nursing facility closures; and (iii) money is available from planned closures of facilities under common ownership to make implementation of this clause budget-neutral to the state. The bed capacity of the Albert Lea facility shall be reduced to 167 beds following the transfer. Of the 60 beds at the new facility, 20 beds shall be used for a special care unit for persons with Alzheimer's disease or related dementias;

(4) to license and certify up to 80 beds transferred from an existing state-owned nursing facility in Cass County to a new facility located on the grounds of the Ah-Gwah-Ching campus. The operating cost payment rates for the new 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. The property payment rate for the first three years of operation shall be $35 per day. For subsequent years, the property payment rate of $35 per day shall be adjusted for inflation as provided in section 256B.434, subdivision 4, paragraph (c), as long as the facility has a contract under section 256B.434; and

(5) to initiate a pilot program to license and certify up to 80 beds transferred from an existing county-owned nursing facility in Steele County relocated to the site of a new acute care facility as part of the county's Communities for a Lifetime comprehensive plan to create innovative responses to the aging of its population. Upon relocation to the new site, the nursing facility shall delicense 28 beds. The property payment rate for the first three years of operation of the new facility shall be increased by an amount as calculated according to items (i) to (v):

(i) compute the estimated decrease in medical assistance residents served by the nursing facility by multiplying the decrease in licensed beds by the historical percentage of medical assistance resident days;

(ii) compute the annual savings to the medical assistance program from the delicensure of 28 beds by multiplying the anticipated decrease in medical assistance residents, determined in item (i), by the existing facility's weighted average payment rate multiplied by 365;

(iii) compute the anticipated annual costs for community-based services by multiplying the anticipated decrease in medical assistance residents served by the nursing facility, determined in item (i), by the average monthly elderly waiver service costs for individuals in Steele County multiplied by 12;

(iv) subtract the amount in item (iii) from the amount in item (ii);

(v) divide the amount in item (iv) by an amount equal to the relocated nursing facility's occupancy factor under section 256B.431, subdivision 3f, paragraph (c), multiplied by the historical percentage of medical assistance resident days.

For subsequent years, the adjusted property payment rate shall be adjusted for inflation as provided in section 256B.434, subdivision 4, paragraph (c), as long as the facility has a contract under section 256B.434.

(b) Projects approved under this subdivision shall be treated in a manner equivalent to projects approved under subdivision 4a.

Subd. 5. [Repealed, 1Sp2003 c 14 art 2 s 57]

Subd. 5a. **Cost estimate of a moratorium exception project.** (a) For the purposes of this section and section 144A.073, the cost estimate of a moratorium exception project shall include the effects of the proposed project on the costs of the state subsidy for community-based services, nursing services, and housing in institutional and noninstitutional settings. The commissioner of health, in cooperation with the commissioner of human services, shall define the method for estimating these costs in the permanent rule implementing section 144A.073. The commissioner of human services shall prepare an estimate of the total state annual long-term costs of each moratorium exception proposal.

(b) The interest rate to be used for estimating the cost of each moratorium exception project proposal shall be the lesser of either the prime rate plus two percentage points, or the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation plus two percentage points as published in the Wall Street Journal and in effect 56 days prior to the application deadline. If the applicant's proposal uses this interest rate, the commissioner of human services, in determining the facility's actual property-related payment rate to be established

upon completion of the project must use the actual interest rate obtained by the facility for the project's permanent financing up to the maximum permitted under subdivision 6.

The applicant may choose an alternate interest rate for estimating the project's cost. If the applicant makes this election, the commissioner of human services, in determining the facility's actual property-related payment rate to be established upon completion of the project, must use the lesser of the actual interest rate obtained for the project's permanent financing or the interest rate which was used to estimate the proposal's project cost. For succeeding rate years, the applicant is at risk for financing costs in excess of the interest rate selected.

Subd. 6. **Property-related payment rates of new beds.** The property-related payment rates of nursing home or boarding care home beds certified or recertified under subdivision 3 or 4a, shall be adjusted according to Minnesota nursing facility reimbursement laws and rules unless the facility has made a commitment in writing to the commissioner of human services not to seek adjustments to these rates due to property-related expenses incurred as a result of the certification or recertification. Any licensure or certification action authorized under repealed statutes which were approved by the commissioner of health prior to July 1, 1993, shall remain in effect. Any conditions pertaining to property rate reimbursement covered by these repealed statutes prior to July 1, 1993, remain in effect.

Subd. 7. **Submission of cost information.** Before approval of final construction plans for a nursing home or a certified boarding care home construction project, the licensee shall submit to the commissioner of health an itemized statement of the project construction cost estimates.

If the construction project includes a capital asset addition, replacement, remodeling, or renovation of space such as a hospital, apartment, or shared or common areas, the facility must submit to the commissioner an allocation of capital asset costs, soft costs, and debt information prepared according to Minnesota Rules, chapter 9549.

Project construction cost estimates must be prepared by a contractor or architect and other licensed participants in the development of the project.

Subd. 8. **Final approval.** Before conducting the final inspection of the construction project required by Minnesota Rules, part 4660.0100, and issuing final clearances for use, the licensee shall provide to the commissioner of health the total project construction costs of the construction project. If total costs are not available, the most recent cost figures shall be provided. Final cost figures shall be submitted to the commissioner when available. The commissioner shall provide a copy of this information to the commissioner of human services.

History: *1983 c 199 s 1; 1983 c 289 s 115 subd 1; 1984 c 654 art 5 s 58; 1984 c 655 art 1 s 28; 1Sp1985 c 3 s 10-12; 1987 c 186 s 15; 1987 c 403 art 4 s 3; 1Sp1987 c 4 art 2 s 1; 1988 c 689 art 2 s 36; 1989 c 209 art 2 s 1; 1989 c 282 art 3 s 11; 1990 c 472 s 1; 1990 c 612 s 6; 1991 c 93 s*

1; 1991 c 292 art 4 s 1,2; art 7 s 25 subd 1,3; 1992 c 513 art 7 s 2,3; 1993 c 4 s 22; 1Sp1993 c 1 art 5 s 2; 1994 c 625 art 8 s 46; 1995 c 207 art 7 s 9-12; 1995 c 263 s 2; 1996 c 305 art 2 s 28; 1996 c 451 art 3 s 1,2; 1997 c 105 s 1; 1997 c 203 art 3 s 1,2,15; 1998 c 407 art 3 s 2; 2000 c 449 s 16; 2000 c 488 art 9 s 2,; 1Sp2001 c 9 art 5 s 3-6; 2002 c 240 s 1; 2002 c 277 s 32; 2002 c 375 art 2 s 1; 2002 c 379 art 1 s 113; 2003 c 16 s 1; 1Sp2003 c 14 art 2 s 9; 2004 c 218 s 1; 2005 c 56 s 1; 2005 c 68 art 1 s 1; 2006 c 282 art 20 s 3-5; 2008 c 285 s 1

144A.073 EXCEPTIONS TO MORATORIUM; REVIEW.

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

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

(b) "Relocation" means the movement of licensed nursing home beds or certified boarding care beds as permitted under subdivision 4, clause (3), and subdivision 5.

(c) "Renovation" means extensive remodeling of an existing facility with a total cost exceeding ten percent of the appraised value of the facility or $200,000, whichever is less. A renovation may include the replacement or upgrade of existing mechanical or electrical systems.

(d) "Replacement" means the construction of a complete new facility.

(e) "Addition" means the construction of new space to an existing facility.

(f) "Upgrading" means a change in the level of licensure of a bed from a boarding care bed to a nursing home bed in a certified boarding care facility.

(g) "Phased project" means a proposal that identifies construction occurring with more than one distinct completion date. To be considered a distinct completion, each phase must have construction that is ready for resident use, as determined by the commissioner, that is not dependent on similar commissioner approval for future phases of construction. The commissioner of human services shall only allow rate adjustments for construction projects in phases if the proposal from a facility identifies construction in phases and each phase can be approved for use independent of the other phases.

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 and certified boarding care home projects for conversion, relocation, renovation, replacement, upgrading, or addition. 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 150 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 money is appropriated, the commissioner shall initiate the application and review process described in this section at least once each biennium. A second application and review process must occur if remaining funds are either greater than $300,000 or more than 50 percent of the baseline appropriation for the biennium. Authorized funds may be awarded in full in the first review process of the biennium. Appropriated funds not encumbered within a biennium shall carry forward to 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, addition, or relocation;

(2) a description of the problems the project is designed to address;

(3) a description of the proposed project;

(4) an analysis of projected costs of the nursing facility proposed project, including:

(i) initial construction and remodeling costs;

(ii) site preparation costs;

(iii) equipment and technology costs;

(iv) financing costs, the current estimated long-term financing costs of the proposal, which is to include details of any proposed funding mechanism already arranged or being considered, including estimates of the amount and sources of money, reserves if required, annual payments schedule, interest rates, length of term, closing costs and fees, insurance costs, any completed marketing study or underwriting review; and

(v) 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 according to section 144A.161; 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).

Subd. 3a. [Repealed, 1995 c 207 art 7 s 43]

Subd. 3b. **Amendments to approved projects.** (a) Nursing facilities that have received approval on or after July 1, 1993, for exceptions to the moratorium on nursing homes through the process described in this section may request amendments to the designs of the projects by writing the commissioner within 15 months of receiving approval. Applicants shall submit supporting materials that demonstrate how the amended projects meet the criteria described in paragraph (b).

(b) The commissioner shall approve requests for amendments for projects approved on or after July 1, 1993, according to the following criteria:

(1) the amended project designs must provide solutions to all of the problems addressed by the original application that are at least as effective as the original solutions;

(2) the amended project designs may not reduce the space in each resident's living area or in the total amount of common space devoted to resident and family uses by more than five percent;

(3) the costs recognized for reimbursement of amended project designs shall be the threshold amount of the original proposal as identified according to section 144A.071, subdivision 2, except under conditions described in clause (4); and

(4) total costs up to ten percent greater than the cost identified in clause (3) may be recognized for reimbursement if the proposer can document that one of the following circumstances is true:

(i) changes are needed due to a natural disaster;

(ii) conditions that affect the safety or durability of the project that could not have reasonably been known prior to approval are discovered;

(iii) state or federal law require changes in project design; or

(iv) documentable circumstances occur that are beyond the control of the owner and require changes in the design.

(c) Approval of a request for an amendment does not alter the expiration of approval of the project according to subdivision 3.

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), (3), and (9) 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. 3d. [Repealed by amendment, 2008 c 230 s 3]

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 using data published according to requirements in section 144A.351;

(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; 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;

(9) the extent to which the applicant demonstrates the continuing need for nursing facility care in the community and adjacent communities; and

(10) 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.

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

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

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

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

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

(f) The relocation of part of an existing first facility to a second location, under paragraphs (d) and (e), may include the relocation to the second location of up to four beds from part of an existing third facility located in a township contiguous to the location of the first facility. The six-mile limit in paragraph (e) does not apply to this relocation from the third facility.

(g) For proposals approved on January 13, 1994, under this section involving the replacement of 102 licensed and certified beds, the relocation of the existing first facility to the new location under paragraphs (d) and (e) may include the relocation of up to 75 beds of the existing facility. The six-mile limit in paragraph (e) does not apply to this relocation.

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

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

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

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

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

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

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

(a) The facility must meet minimum nursing home licensure requirements.

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

Subd. 8. **Rulemaking.** The commissioner of health shall adopt rules to implement this section. The permanent rules must be in accordance with and implement only the criteria listed in this section.

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

Subd. 10. [Repealed by amendment, 2008 c 230 s 3]

Subd. 11. **Funding from expired and canceled proposals.** The commissioner shall monitor the status of projects approved under this section to identify, in consultation with each facility with an approved project, if projects will be canceled or will expire. For projects that have been canceled or have expired, if originally approved after June 30, 2001, the commissioner's approval authority for the estimated annual state cost to medical assistance shall carry forward and shall be available for the issuance of a new moratorium round later in that fiscal year or in either of the following two fiscal years.

History: *1987 c 403 art 4 s 4; 1988 c 689 art 2 s 37-39; 1989 c 282 art 3 s 12; 1990 c 568 art 3 s 4; 1992 c 292 art 7 s 25; 1992 c 513 art 7 s 4-6; 1Sp1993 c 1 art 5 s 3-5; 1995 c 207 art 7 s*

13-19; 1996 c 305 art 2 s 29; 1997 c 7 art 5 s 11; 1997 c 203 art 3 s 3,4; 1999 c 245 art 3 s 1; 2001 c 161 s 22-24; 1Sp2001 c 9 art 5 s 7,8; 2002 c 379 art 1 s 113; 2003 c 72 s 1,2; 1Sp2005 c 4 art 7 s 1,2; 2007 c 147 art 7 s 1; 2008 c 230 s 3

144A.08 PHYSICAL STANDARDS; PENALTY.

Subdivision 1. **Establishment.** The commissioner of health by rule shall establish minimum standards for the construction, maintenance, equipping and operation of nursing homes. The rules shall to the extent possible assure the health, treatment, comfort, safety and well being of nursing home residents.

Subd. 1a. **Corridor doors.** Nothing in the rules of the commissioner of health shall require that each door entering a sleeping room from a corridor in a nursing home with an approved complete standard automatic fire extinguishing system be constructed or maintained as self-closing or automatically closing.

Subd. 1b. **Summer temperature and humidity.** A nursing home, or part of a nursing home that includes resident-occupied space, constructed after June 30, 1988, must meet the interior summer design temperature and humidity recommendations in chapter 7 of the 1982 applications of the handbook published by the American Society of Heating, Refrigerating and Air-Conditioning Engineers, Inc., as amended.

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.

Subd. 3. **Penalty.** Any controlling person who establishes, conducts, manages or operates a nursing home which incurs the following number of uncorrected or repeated violations, in any two-year period:

(a) two or more uncorrected violations or one or more repeated violations which created an imminent risk to direct resident care or safety; or

(b) four or more uncorrected violations or two or more repeated violations of any nature for which the fines are in the four highest daily fine categories prescribed in rule, is guilty of a misdemeanor.

The provisions of this subdivision shall not apply to any controlling person who had no legal authority to affect or change decisions as to the operation of the nursing home which incurred the uncorrected or repeated violations.

History: *1976 c 173 s 8; 1977 c 305 s 45; 1981 c 360 art 2 s 5; 1982 c 633 s 4; 1Sp1985 c*

3 s 13; 1987 c 384 art 2 s 1; 1988 c 689 art 2 s 40; 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.

Subd. 2. **Religious society or order.** The provisions of sections 144A.01 to 144A.27 shall not apply to a facility operated by a religious society or order to provide nursing care to 20 or fewer nonlay members of the order or society.

History: *1976 c 173 s 9; 1987 c 384 art 2 s 1; 1996 c 451 art 4 s 22; 1998 c 407 art 3 s 3; 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.

Subd. 1a. **Training and education for nursing facility providers.** The commissioner of health must establish and implement a prescribed process and program for providing training and education to providers licensed by the Department of Health, in conjunction with the industry trade associations, before using any new regulatory guideline, regulation, interpretation, program letter or memorandum, or any other materials used in surveyor training to survey licensed providers. The process should include, but is not limited to, the following key components:

(1) facilitate the implementation of immediate revisions to any course curriculum for nursing assistants which reflect any new standard of care practice that has been adopted or referenced by the Health Department concerning the issue in question;

(2) conduct training of long-term care providers and health department survey inspectors jointly on the department's new expectations; and

(3) the commissioner shall consult with experts in the field to develop or make available training resources on current standards of practice and the use of technology.

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.

Subd. 3. **Reports; posting.** After each inspection or reinspection required or authorized by this section, the commissioner of health shall, by certified mail, send copies of any correction order or notice of noncompliance to the nursing home. A copy of each correction order and notice of noncompliance, and copies of any documentation supplied to the commissioner of health or the commissioner of human services under section 144A.03 or 144A.05 shall be kept on file at the nursing home and shall be made available for viewing by any person upon request. Except as otherwise provided by this subdivision, a copy of each correction order and notice of noncompliance received by the nursing home after its most recent inspection or reinspection shall be posted in a conspicuous and readily accessible place in the nursing home. No correction order or notice of noncompliance need be posted until any appeal, if one is requested by the facility, pursuant to subdivision 8, has been completed. All correction orders and notices of noncompliance issued to a nursing home owned and operated by the state or political subdivision of the state shall be circulated and posted at the first public meeting of the governing body after the order or notice is issued. Confidential information protected by section 13.05 or 13.46, shall not be made available or posted as provided in this subdivision unless it may be made available or posted in a manner authorized by chapter 13.

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, 144.6503, 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.

Subd. 4a. [Repealed, 1989 c 282 art 3 s 98]

Subd. 5. **Reinspections.** A nursing home issued a correction order under this section shall be reinspected at the end of the period allowed for correction. The reinspection may be made in conjunction with the next annual inspection or any other scheduled inspection. If upon reinspection the representative of the commissioner of health determines that the facility has not corrected a violation identified in the correction order, a notice of noncompliance with the correction order shall be mailed by certified mail to the nursing home. The notice shall specify the

violations not corrected and the fines assessed in accordance with subdivision 6.

Subd. 6. **Fines.** A nursing home which is issued a notice of noncompliance with a correction order shall be assessed a civil fine in accordance with a schedule of fines established by the commissioner of health before December 1, 1983. In establishing the schedule of fines, the commissioner shall consider the potential for harm presented to any resident as a result of noncompliance with each statute or rule. The fine shall be assessed for each day the facility remains in noncompliance and until a notice of correction is received by the commissioner of health in accordance with subdivision 7. No fine for a specific violation may exceed $500 per day of noncompliance.

Subd. 6a. [Repealed, 1989 c 155 s 5]

Subd. 6b. **Fines for federal certification deficiencies.** If the commissioner determines that a nursing home or certified boarding care home does not meet a requirement of section 1919(b), (c), or (d), of the Social Security Act, or any regulation adopted under that section of the Social Security Act, the nursing home or certified boarding care home may be assessed a civil fine for each day of noncompliance and until a notice of correction is received by the commissioner under subdivision 7. Money collected because of these fines must be applied to the protection of the health or property of residents of nursing facilities the commissioner finds deficient. A fine for a specific deficiency may not exceed $500 for each day of noncompliance. The commissioner shall adopt rules establishing a schedule of fines.

Subd. 6c. **Overlap of fines.** If a nursing home is subject to fines under both subdivisions 6 and 6b for the same requirement, condition, situation, or practice, the commissioner shall assess either the fine provided by subdivision 6 or the fine provided by subdivision 6b.

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

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

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

Subd. 6e. **Use of fines.** When the commissioner of health determines the use of, or provides recommendations on the use of fines collected under subdivision 6 or 6b, two representatives of the nursing home industry, appointed by nursing home trade associations, and two consumer

representatives as appointed by the commissioner must be included in the process of developing or preparing any information, reviews, or recommendations on the use of the fines. This includes, but is not limited to, including two representatives of the nursing home industry in any committee designed to provide information and recommendations for the use of the fines.

Subd. 7. **Accumulation of fines.** A nursing home shall promptly notify the commissioner of health in writing when a violation noted in a notice of noncompliance is corrected. Upon receipt of written notification by the commissioner of health, the daily fine assessed for the deficiency shall stop accruing. The facility shall be reinspected within three working days after receipt of the notification. If upon reinspection the representative of the commissioner of health determines that a deficiency has not been corrected as indicated by the notification of compliance the daily fine assessment shall resume and the amount of fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment due from the nursing home. The commissioner of health shall notify the nursing home of the resumption by certified mail. The nursing home may challenge the resumption as a contested case in accordance with the provisions of chapter 14. Recovery of the resumed fine shall be stayed if a controlling person or a legal representative on behalf of the nursing home makes a written request for a hearing on the resumption within 15 days of receipt of the notice of resumption. The cost of a reinspection conducted pursuant to this subdivision shall be added to the total assessment due from the nursing home.

Subd. 8. **Recovery of fines; hearing.** Fines assessed under this section shall be payable 15 days after receipt of the notice of noncompliance and at 15 day intervals thereafter, as the fines accrue. Recovery of an assessed fine shall be stayed if a controlling person or a legal representative on behalf of the nursing home makes a written request for a hearing on the notice of noncompliance within 15 days after the home's receipt of the notice. A hearing under this subdivision shall be conducted as a contested case in accordance with chapter 14. If a nursing home, after notice and opportunity for hearing on the notice of noncompliance, or on the resumption of the fine, does not pay a properly assessed fine in accordance with this subdivision, the commissioner of health shall notify the commissioner of human services who shall deduct the amount from reimbursement moneys due or to be due the facility under chapter 256B. The commissioner of health may consolidate the hearings provided for in subdivisions 7 and 8 in cases in which a facility has requested hearings under both provisions. The hearings provided for in subdivisions 7 and 8 shall be held within 30 days after the request for the hearing. If a consolidated hearing is held, it shall be held within 30 days of the request which occurred last.

Subd. 8a. **Fine for misallocation of nursing staff.** Upon issuing a correction order to a nursing home under subdivision 4 for a violation of Minnesota Rules, part 4655.5600, because of nursing staff performing duties such as washing wheelchairs or beds of discharged residents,

or other housekeeping or laundry duties not related to the direct nursing care of residents, the commissioner shall impose a civil fine of $500 per day. A fine under this subdivision accrues in accordance with subdivision 6 and is subject to subdivision 8 for purposes of recovery and hearings.

Subd. 8b. **Resident advisory council.** Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. A nursing home or boarding care home that is issued a notice of noncompliance with a correction order for violation of this subdivision shall be assessed a civil fine of $100 for each day of noncompliance.

Subd. 9. **Nonlimiting.** Nothing in this section shall be construed to limit the powers granted to the commissioner of health by section 144A.11.

Subd. 10. **Reporting to a medical examiner or coroner.** Whenever a duly authorized representative of the commissioner of health has reasonable cause to believe that a resident has died as a direct or indirect result of abuse or neglect, the representative shall report that information to the appropriate medical examiner or coroner and police department or county sheriff. The medical examiner or coroner shall complete an investigation as soon as feasible and report the findings to the police department or county sheriff, and to the commissioner of health.

Subd. 11. **Facilities cited for immediate jeopardy.** (a) The provisions of this subdivision apply to Minnesota nursing facilities:

(1) that received immediate jeopardy citations between April 1, 1998, and January 13, 1999, for violations of regulations governing the use of physical restraints; and

(2) on whose behalf the commissioner recommended to the federal government that fines for these citations not be imposed or be rescinded.

(b) The commissioner:

(1) shall grant all possible waivers for the continuation of an approved nurse aide training program, an approved competency evaluation program, or an approved nurse aide training and competency evaluation program conducted by or on the site of a facility referred to in this subdivision; and

(2) shall notify the Board of Nursing Home Administrators by June 1, 1999, that the commissioner has recommended to the federal government that fines not be imposed on the facilities referred to in this subdivision or that any fines imposed on these facilities for violations of regulations governing use of physical restraints be rescinded.

Subd. 12. **Data on follow-up surveys.** (a) If requested, and not prohibited by federal law, the commissioner shall make available to the nursing home associations and the public photocopies of statements of deficiencies and related letters from the department pertaining to federal certification surveys. The commissioner may charge for the actual cost of reproduction of these documents.

(b) The commissioner shall also make available on a quarterly basis aggregate data for all statements of deficiencies issued after federal certification follow-up surveys related to surveys that were conducted in the quarter prior to the immediately preceding quarter. The data shall include the number of facilities with deficiencies, the total number of deficiencies, the number of facilities that did not have any deficiencies, the number of facilities for which a resurvey or follow-up survey was not performed, and the average number of days between the follow up or resurvey and the exit date of the preceding survey.

Subd. 13. **Nurse aide training waivers.** Because any disruption or delay in the training and registration of nurse aides may reduce access to care in certified facilities, the commissioner shall grant all possible waivers for the continuation of an approved nurse aide training and competency evaluation program or nurse aide training program or competency evaluation program conducted by or on the site of any certified nursing facility or skilled nursing facility that would otherwise lose approval for the program or programs. The commissioner shall take into consideration the distance to other training programs, the frequency of other training programs, and the impact that the loss of the on-site training will have on the nursing facility's ability to recruit and train nurse aides.

Subd. 14. **Immediate jeopardy.** When conducting survey certification and enforcement activities related to regular, expanded, or extended surveys under Code of Federal Regulations, title 42, part 488, the commissioner may not issue a finding of immediate jeopardy unless the specific event or omission that constitutes the violation of the requirements of participation poses an imminent risk of life-threatening or serious injury to a resident. The commissioner may not issue any findings of immediate jeopardy after the conclusion of a regular, expanded, or extended survey unless the survey team identified the deficient practice or practices that constitute immediate jeopardy and the residents at risk prior to the close of the exit conference.

Subd. 15. **Informal dispute resolution.** The commissioner shall respond in writing to a request from a nursing facility certified under the federal Medicare and Medicaid programs for an informal dispute resolution within 30 days of the exit date of the facility's survey. The commissioner's response shall identify the commissioner's decision regarding the continuation of each deficiency citation challenged by the nursing facility, as well as a statement of any changes in findings, level of severity or scope, and proposed remedies or sanctions for each deficiency citation.

Subd. 16. **Independent informal dispute resolution.** (a) Notwithstanding subdivision 15, a facility certified under the federal Medicare or Medicaid programs may request from the commissioner, in writing, an independent informal dispute resolution process regarding any deficiency citation issued to the facility. The facility must specify in its written request each deficiency citation that it disputes. The commissioner shall provide a hearing under sections 14.57 to 14.62. Upon the written request of the facility, the parties must submit the issues raised to arbitration by an administrative law judge.

(b) Upon receipt of a written request for an arbitration proceeding, the commissioner shall file with the Office of Administrative Hearings a request for the appointment of an arbitrator and simultaneously serve the facility with notice of the request. The arbitrator for the dispute shall be an administrative law judge appointed by the Office of Administrative Hearings. The disclosure provisions of section 572.10 and the notice provisions of section 572.12 apply. The facility and the commissioner have the right to be represented by an attorney.

(c) The commissioner and the facility may present written evidence, depositions, and oral statements and arguments at the arbitration proceeding. Oral statements and arguments may be made by telephone.

(d) Within ten working days of the close of the arbitration proceeding, the administrative law judge shall issue findings regarding each of the deficiencies in dispute. The findings shall be one or more of the following:

(1) Supported in full. The citation is supported in full, with no deletion of findings and no change in the scope or severity assigned to the deficiency citation.

(2) Supported in substance. The citation is supported, but one or more findings are deleted without any change in the scope or severity assigned to the deficiency.

(3) Deficient practice cited under wrong requirement of participation. The citation is amended by moving it to the correct requirement of participation.

(4) Scope not supported. The citation is amended through a change in the scope assigned to the citation.

(5) Severity not supported. The citation is amended through a change in the severity assigned to the citation.

(6) No deficient practice. The citation is deleted because the findings did not support the citation or the negative resident outcome was unavoidable. The findings of the arbitrator are not binding on the commissioner.

(e) The commissioner shall reimburse the Office of Administrative Hearings for the costs incurred by that office for the arbitration proceeding. The facility shall reimburse the commissioner for the proportion of the costs that represent the sum of deficiency citations supported in full under

paragraph (d), clause (1), or in substance under paragraph (d), clause (2), divided by the total number of deficiencies disputed. A deficiency citation for which the administrative law judge's sole finding is that the deficient practice was cited under the wrong requirements of participation shall not be counted in the numerator or denominator in the calculation of the proportion of costs.

Subd. 17. **Agency quality improvement program; annual report on survey process.** (a) The commissioner shall establish a quality improvement program for the nursing facility survey and complaint processes. The commissioner must regularly consult with consumers, consumer advocates, and representatives of the nursing home industry and representatives of nursing home employees in implementing the program. The commissioner, through the quality improvement program, shall submit to the legislature an annual survey and certification quality improvement report, beginning December 15, 2004, and each December 15 thereafter.

(b) The report must include, but is not limited to, an analysis of:

(1) the number, scope, and severity of citations by region within the state;

(2) cross-referencing of citations by region within the state and between states within the Centers for Medicare and Medicaid Services region in which Minnesota is located;

(3) the number and outcomes of independent dispute resolutions;

(4) the number and outcomes of appeals;

(5) compliance with timelines for survey revisits and complaint investigations;

(6) techniques of surveyors in investigations, communication, and documentation to identify and support citations;

(7) compliance with timelines for providing facilities with completed statements of deficiencies; and

(8) other survey statistics relevant to improving the survey process.

(c) The report must also identify and explain inconsistencies and patterns across regions of the state; include analyses and recommendations for quality improvement areas identified by the commissioner, consumers, consumer advocates, and representatives of the nursing home industry and nursing home employees; and provide action plans to address problems that are identified.

History: *1976 c 173 s 10; 1977 c 305 s 45; 1977 c 326 s 4,5; 1980 c 509 s 44; 1981 c 210 s 54; 1981 c 311 s 39; 1Sp1981 c 4 art 1 s 12; 1982 c 424 s 130; 1982 c 545 s 24; 1982 c 633 s 5; 1983 c 199 s 2-4; 1983 c 312 art 1 s 18; 1984 c 654 art 5 s 58; 1Sp1985 c 3 s 14-16; 1986 c 444; 1987 c 209 s 26,27; 1987 c 384 art 2 s 1; 1989 c 209 art 2 s 1; 1989 c 282 art 3 s 13-17; 1991 c 286 s 5,6; 1991 c 292 art 4 s 3; 1999 c 83 s 2; 1999 c 245 art 3 s 2-6; 1Sp2001 c 9 art 5 s 40; 1Sp2003 c 14 art 2 s 10; 2004 c 247 s 1,2; 2006 c 282 art 20 s 6; 2008 c 230 s 4*

144A.101 PROCEDURES FOR FEDERALLY REQUIRED SURVEY PROCESS.

Subdivision 1. **Applicability.** This section applies to survey certification and enforcement activities by the commissioner related to regular, expanded, or extended surveys under Code of Federal Regulations, title 42, part 488.

Subd. 2. **Statement of deficiencies.** The commissioner shall provide nursing facilities with draft statements of deficiencies at the time of the survey exit process and shall provide facilities with completed statements of deficiencies within 15 working days of the exit process.

Subd. 3. **Surveyor notes.** The commissioner, upon the request of a nursing facility, shall provide the facility with copies of formal surveyor notes taken during the survey, with the exception of interview forms, at the time of the exit conference or at the time the completed statement of deficiency is provided to the facility. The survey notes shall be redacted to protect the confidentiality of individuals providing information to the surveyors. A facility requesting formal surveyor notes must agree to pay the commissioner for the cost of copying and redacting.

Subd. 4. **Posting of statements of deficiencies.** The commissioner, when posting statements of a nursing facility's deficiencies on the agency Web site, must include in the posting the facility's response to the citations. The Web site must also include the dates upon which deficiencies are corrected and the date upon which a facility is considered to be in compliance with survey requirements. If deficiencies are under dispute, the commissioner must note this on the Web site using a method that clearly identifies for consumers which citations are under dispute.

Subd. 5. **Survey revisits.** The commissioner shall conduct survey revisits within 15 calendar days of the date by which corrections will be completed, as specified by the provider in its plan of correction, in cases where category 2 or category 3 remedies are in place. The commissioner may conduct survey revisits by telephone or written communications for facilities at which the highest scope and severity score for a violation was level E or lower.

Subd. 6. **Family councils.** Nursing facility family councils shall be interviewed as part of the survey process and invited to participate in the exit conference.

History: *2004 c 247 s 3*

144A.102 WAIVER FROM FEDERAL RULES AND REGULATIONS; PENALTIES.

By January 2000, the commissioner of health shall work with providers to examine state and federal rules and regulations governing the provision of care in licensed nursing facilities and apply for federal waivers and identify necessary changes in state law to:

(1) allow the use of civil money penalties imposed upon nursing facilities to abate any deficiencies identified in a nursing facility's plan of correction; and

(2) stop the accrual of any fine imposed by the Health Department when a follow-up inspection survey is not conducted by the department within the regulatory deadline.

History: *1999 c 245 art 3 s 7*

144A.103 [Repealed, 2000 c 312 s 7]

144A.105 SUSPENSION OF ADMISSIONS.

Subdivision 1. **Circumstances for suspensions.** The commissioner of health may suspend admissions to a nursing home or certified boarding care home when:

(1) the commissioner has issued a penalty assessment or the nursing home has a repeated violation for noncompliance with section 144A.04, subdivision 7, or the portion of Minnesota Rules, part 4655.5600, subpart 2, that establishes minimum nursing personnel requirements;

(2) the commissioner has issued a penalty assessment or the nursing home or certified boarding care home has repeated violations for not maintaining a sufficient number or type of nursing personnel to meet the needs of the residents, as required by Minnesota Rules, parts 4655.5100 to 4655.6200;

(3) the commissioner has determined that an emergency exists;

(4) the commissioner has initiated proceedings to suspend, revoke, or not renew the license of the nursing home or certified boarding care home; or

(5) the commissioner determines that the remedy of denial of payment, as provided by subparagraph 1919(h)(2)(A)(i) of the Social Security Act, is to be imposed under section 1919(h) of the Social Security Act, or regulations adopted under that section of the Social Security Act.

Subd. 2. **Order.** If the commissioner suspends admissions under subdivision 1, the commissioner shall notify the nursing home or certified boarding care home, by written order, that admissions to the nursing home or certified boarding care home will be suspended beginning at a time specified in the order. The suspension is effective no earlier than 48 hours after the nursing home or certified boarding care home receives the order, unless the order is due to an emergency under subdivision 1, clause (3). The order may be served on the administrator of the nursing home or certified boarding care home, or the designated agent in charge of the home, by personal service or by certified or registered mail with a return receipt of delivery. The order shall specify the reasons for the suspension, the corrective action required to be taken by the nursing home or certified boarding care home, and the length of time the suspension will be in effect. The nursing home or certified boarding care home shall not admit any residents after the effective time of the order. In determining the length of time for the suspension, the commissioner shall consider the reasons for the suspension, the performance history of the nursing home, and the needs of the residents.

Subd. 3. **Conference.** After receiving the order for suspension, the nursing home or certified boarding care home may request a conference with the commissioner to present reasons why the suspension should be modified or should not go into effect. The request need not be in writing. If a conference is requested within 24 hours after receipt of the order, the commissioner shall hold the conference before the effective time of the suspension, unless the order for suspension is due to an emergency under subdivision 1, clause (3). If a conference is not requested within 24 hours after receipt of the order, the nursing home or certified boarding care home may request a conference and the commissioner shall schedule the conference as soon as practicable. The conference may be held in person or by telephone. After a conference, the commissioner may affirm, rescind, or modify the order.

Subd. 4. **Correction.** The nursing home or certified boarding care home shall notify the commissioner, in writing, when any required corrective action has been completed. The commissioner may verify the corrective action by inspection under section 144A.10. The commissioner may extend the initial suspension period by written notice to the nursing home or certified boarding care home.

Subd. 5. **Notification of commissioner of human services.** Whenever the commissioner suspends admissions to a nursing home or certified boarding care home, the commissioner shall notify the commissioner of human services of the order and of any modifications to the order.

Subd. 6. **Hearing.** A nursing home or certified boarding care home may appeal from an order for suspension of admissions issued under subdivision 1. To appeal, the nursing home or certified boarding care home shall file with the commissioner a written notice of appeal. The appeal must be received by the commissioner within ten days after the date of receipt of the order for suspension by the nursing home or certified boarding care home. Within 15 calendar days after receiving an appeal, the commissioner shall request assignment of an administrative law judge under sections 14.48 to 14.56 to conduct the hearing as soon as possible or according to agreement of the parties. Regardless of any appeal, the order for suspension of admissions remains in effect until final resolution of the appeal.

History: *1989 c 282 art 3 s 19*

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.

Subd. 2. **Mandatory proceedings.** (a) The commissioner of health shall initiate proceedings within 60 days of notification to suspend or revoke a nursing home license or shall refuse to renew a license if within the preceding two years the nursing home has incurred the following number of uncorrected or repeated violations:

(1) two or more uncorrected violations or one or more repeated violations which created an imminent risk to direct resident care or safety; or

(2) four or more uncorrected violations or two or more repeated violations of any nature for which the fines are in the four highest daily fine categories prescribed in rule.

(b) Notwithstanding paragraph (a), the commissioner is not required to revoke, suspend, or refuse to renew a facility's license if the facility corrects the violation.

Subd. 2a. **Notice to residents.** Within five working days after proceedings are initiated by the commissioner to revoke, suspend, or not renew a nursing home license, the controlling person of the nursing home or a designee must provide to the commissioner and the ombudsman for long-term care the names of residents and the names and addresses of the residents' guardians, representatives, and designated family contacts. The controlling person or designees must provide updated information each month until the proceeding is concluded. If the controlling person or designee fails to provide the information within this time, the nursing home is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the facility immediately comply with the request for information and that as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100 fine the first day of noncompliance and an increase in the $100 fine by $50 increments for each day the noncompliance continues. Information provided under this subdivision may be used by the commissioner or the ombudsman only for the purpose of providing affected consumers information about the status of the proceedings. Within ten working days after the commissioner initiates proceedings to revoke, suspend, or not renew a nursing home license, the commissioner of health shall send a written notice of the action and the process involved to each resident of the nursing home and the resident's legal guardian, representative, or designated family contact. The commissioner shall provide the ombudsman with monthly information on the department's actions and the status of the proceedings.

Subd. 3. **Hearing.** No nursing home license may be suspended or revoked, and renewal may not be denied, without a hearing held as a contested case in accordance with chapter 14. The hearing must commence within 60 days after the proceedings are initiated. If the controlling

person designated under section 144A.03, subdivision 2, as an agent to accept service on behalf of all of the controlling persons of the nursing home has been notified by the commissioner of health that the facility will not receive an initial license or that a license renewal has been denied, the controlling person or a legal representative on behalf of the nursing home may request and receive a hearing on the denial. This hearing shall be held as a contested case in accordance with chapter 14.

Subd. 3a. **Mandatory revocation.** Notwithstanding the provisions of subdivision 3, the commissioner shall revoke a nursing home license if a controlling person is convicted of a felony or gross misdemeanor that relates to operation of the nursing home or directly affects resident safety or care. The commissioner shall notify the nursing home 30 days in advance of the date of revocation.

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: *1976 c 173 s 11; 1977 c 305 s 45; 1982 c 424 s 130; 1982 c 633 s 6,7; 1Sp1985 c 3 s 17,18; 1986 c 444; 1987 c 384 art 2 s 1; 1989 c 282 art 3 s 20,21; 1993 c 326 art 13 s 3; 1Sp2001 c 9 art 5 s 40; 2007 c 147 art 7 s 75; 2008 c 230 s 5*

144A.115 VIOLATIONS; PENALTIES.

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

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

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

History: *1987 c 209 s 28*

144A.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: *1976 c 173 s 12; 1977 c 305 s 45; 1986 c 444; 1987 c 384 art 2 s 1; 1989 c 282 art 3 s 22; 1Sp2001 c 9 art 5 s 40*

144A.13 COMPLAINTS; RESIDENT'S RIGHTS.

Subdivision 1. **Processing.** All matters relating to the operation of a nursing home which are the subject of a written complaint from a resident and which are received by a controlling person or employee of the nursing home shall be delivered to the facility's administrator for evaluation and action. Failure of the administrator within seven days of its receipt to resolve the complaint, or alternatively, the failure of the administrator to make a reply within seven days after its receipt to the complaining resident stating that the complaint did not constitute a valid objection to the nursing home's operations, shall be a violation of section 144A.10. If a complaint directly involves the activities of a nursing home administrator, the complaint shall be resolved in accordance with this section by a person, other than the administrator, duly authorized by the nursing home to investigate the complaint and implement any necessary corrective measures.

Subd. 2. **Resident's rights.** The administrator of a nursing home shall inform each resident in writing at the time of admission of the right to complain to the administrator about facility accommodations and services. A notice of the right to complain shall be posted in the

nursing home. The administrator shall also inform each resident of the right to complain to the commissioner of health. No controlling person or employee of a nursing home shall retaliate in any way against a complaining nursing home resident and no nursing home resident may be denied any right available to the resident under chapter 504B.

History: *1976 c 173 s 13; 1977 c 305 s 45; 1986 c 444; 1999 c 199 art 2 s 4*

144A.135 TRANSFER AND DISCHARGE APPEALS.

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

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

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

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

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

(f) Nothing in this section limits the right of a resident or the resident's representative to request or receive assistance from the Office of Ombudsman for Long-Term Care or the Office of Health Facility Complaints with respect to an intended discharge or transfer.

(g) A person required to inform a health care facility of the person's status as a registered predatory offender under section 243.166, subdivision 4b, who knowingly fails to do so shall

be deemed to have endangered the safety of individuals in the facility under Code of Federal Regulations, chapter 42, section 483.12. Notwithstanding paragraph (d), any appeal of the notice and discharge shall not constitute a stay of the discharge.

History: *1989 c 282 art 3 s 26; 1991 c 286 s 7; 2005 c 136 art 3 s 2; 2007 c 147 art 7 s 75*

144A.14 VOLUNTARY RECEIVERSHIP.

A majority in interest of the controlling persons of a nursing home may at any time request the commissioner of health to assume the operation of the nursing home through appointment of a receiver. Upon receiving a request for a receiver, the commissioner of health may, if the commissioner deems receivership desirable, enter into an agreement with a majority in interest of the controlling persons, providing for the appointment of a receiver to take charge of the facility under conditions deemed appropriate by both parties. The agreement shall specify all terms and conditions of the receivership and shall preserve all rights of the facility residents as granted by law. A receivership initiated in accordance with this section shall terminate at the time specified by the parties or at the time when either party notifies the other in writing that the party wishes to terminate the receivership agreement.

History: *1976 c 173 s 14; 1977 c 305 s 45; 1986 c 444*

144A.15 INVOLUNTARY RECEIVERSHIP.

Subdivision 1. **Petition, notice.** In addition to any other remedy provided by law, the commissioner of health may petition the district court in Ramsey or Hennepin County or in the district in which a nursing home or certified boarding care home is located for an order directing the controlling persons of the nursing home or certified boarding care home to show cause why the commissioner of health or a designee should not be appointed receiver to operate the facility. The petition to the district court shall contain proof by affidavit that the commissioner of health has either commenced license suspension or revocation proceedings, suspended or revoked a license, or decided not to renew the nursing home license, or that violations of section 1919(b), (c), or (d), of the Social Security Act, or the regulations adopted under that section, or violations of state law or rules, create an emergency. The order to show cause shall be returnable not less than five days after service is completed and shall provide for personal service of a copy to the nursing home administrator and to the persons designated as agents by the controlling persons to accept service on their behalf pursuant to section 144A.03, subdivision 2.

Subd. 2. **Appointment of receiver, rental.** If, after hearing, the court finds that involuntary receivership is necessary as a means of protecting the health, safety or welfare of a resident of a nursing home, the court shall appoint the commissioner of health, or any other person designated by the commissioner of health, as a receiver to take charge of the facility. The court shall determine a fair monthly rental for the facility, taking into account all relevant factors including

the condition of the facility. This rental fee shall be paid by the receiver to the appropriate controlling persons for each month that the receivership remains in effect. Notwithstanding any other law to the contrary, no payment made to a controlling person by any state agency during a period of involuntary receivership shall include any allowance for profit or be based on any formula which includes an allowance for profit.

Subd. 2a. **Emergency procedure.** If it appears from the petition filed under subdivision 1, or from an affidavit or affidavits filed with the petition, or from testimony of witnesses under oath when the court determines that this is necessary, that there is probable cause to believe that an emergency exists in a nursing home or certified boarding care home, the court shall issue a temporary order for appointment of a receiver within five days after receipt of the petition. Notice of the petition shall be served personally on the nursing home administrator and on the persons designated as agents by the controlling persons to accept service on their behalf according to section 144A.03, subdivision 2. A hearing on the petition shall be held within five days' after notice is served unless the administrator or designated agent consents to a later date. After the hearing, the court may continue, modify, or terminate the temporary order.

Subd. 3. **Powers and duties of receiver.** A nursing home receiver appointed pursuant to this section shall with all reasonable speed, but in any case, within 18 months after the receivership order, provide for the orderly transfer of all the nursing home's residents to other facilities or make other provisions for their continued safety and health care. The receiver may correct or eliminate those deficiencies in the facility which seriously endanger the life, health or safety of the residents unless the correction or elimination of deficiencies involves major alterations in the physical structure of the nursing home. The receiver shall, during this period, operate the nursing home in a manner designed to guarantee the safety and adequate health care of the residents. The receiver shall take no action which impairs the legal rights of a resident of the nursing home. The receiver shall have power to make contracts and incur lawful expenses. The receiver shall collect incoming payments from all sources and apply them to the cost incurred in the performance of the receiver's functions. No security interest in any real or personal property comprising the nursing home or contained within it, or in any fixture of the facility, shall be impaired or diminished in priority by the receiver. The receiver shall pay all valid obligations of the nursing home and shall deduct these expenses, if appropriate, from rental payments owed to any controlling person by virtue of the receivership.

Subd. 4. **Receiver's fee; liability; commissioner assistance.** A nursing home receiver appointed pursuant to this section shall be entitled to a reasonable receiver's fee as determined by the court. The receiver shall be liable only in an official capacity for injury to person and property by reason of the conditions of the nursing home. The receiver shall not be personally liable, except for gross negligence and intentional acts. The commissioner of health shall assist

the receiver in carrying out these duties.

Subd. 5. **Termination.** An involuntary receivership imposed pursuant to this section shall terminate 18 months after the date on which it was ordered or at any other time designated by the court or upon the occurrence of any of the following events:

(a) A determination by the commissioner of health that the nursing home's license should be renewed or should not be suspended or revoked;

(b) The granting of a new license to the nursing home; or

(c) A determination by the commissioner of health that all of the residents of the nursing home have been provided alternative health care, either in another facility or otherwise.

Subd. 6. [Repealed, 1992 c 513 art 8 s 59]

History: *1976 c 173 s 15; 1977 c 305 s 45; 1986 c 444; 1989 c 282 art 3 s 23-25*

144A.154 RATE RECOMMENDATION.

The commissioner may recommend to the commissioner of human services a review of the rates for a nursing home or boarding care home that participates in the medical assistance program that is in voluntary or involuntary receivership, and that has needs or deficiencies documented by the Department of Health. If the commissioner of health determines that a review of the rate under section 256B.495 is needed, the commissioner shall provide the commissioner of human services with:

(1) a copy of the order or determination that cites the deficiency or need; and

(2) the commissioner's recommendation for additional staff and additional annual hours by type of employee and additional consultants, services, supplies, equipment, or repairs necessary to satisfy the need or deficiency.

History: *1992 c 513 art 7 s 7*

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.

Subd. 2. **Duties of monitor.** The monitor shall observe the operation of the home, provide advice to the home on methods of complying with state and federal rules and regulations, where

documented deficiencies from the regulations exist, and periodically shall submit a written report to the commissioner on the ways in which the home meets or fails to meet state and federal rules and regulations.

Subd. 3. **Selection of monitor.** The commissioner may select as monitor an employee of the department or may contract with any other individual to serve as a monitor. The commissioner shall publish a notice in the State Register that requests proposals from individuals who wish to be considered for placement as monitors and that sets forth the criteria for selecting individuals as monitors. The commissioner shall maintain a list of individuals who are not employees of the department who are interested in serving as monitors. The commissioner may contract with those individuals determined to be qualified.

Subd. 4. **Payment of monitor.** A nursing home or certified boarding care home in which a monitor is placed shall pay to the department the actual costs associated with the placement, unless payment would create an undue hardship for the home.

History: *1989 c 282 art 3 s 27; 1Sp2001 c 9 art 5 s 40*

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

144A.161 NURSING HOME AND BOARDING CARE HOME 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) "County social services 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. 1a. **Scope.** Where a facility is undertaking closure, curtailment, reduction, or change in operations, the facility and the county social services agency must comply with the requirements of this section.

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 county social services agency;

(4) the Office of Ombudsman for Long-Term Care; and

(5) the Office of Ombudsman for Mental Health and Developmental Disabilities.

(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.

(c) After providing written notice under this section, and prior to admission, the facility must fully inform prospective residents and their families of the intent to close or curtail, reduce, or change operations, and of the relocation plan.

Subd. 3. **Planning process.** (a) The county social services 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 county social services agency efforts in the planning process.

(b) Within ten working days of receipt of the notice under paragraph (a), the county social services agency and licensee shall meet to develop the relocation plan. The county social services agency shall inform the Departments of Health and Human Services, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities 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);

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

(10) identify the steps the licensee and the county social services agency will take to address the relocation needs of individual residents who may be difficult to place due to specialized care needs such as behavioral health problems.

(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 county social services agency, the Department of Health, the Department of Human Services, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities 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 county social services agency, the Office of Ombudsman for Long-Term Care, facility staff that provide direct care services to the residents, and facility administration.

(b) The licensee shall provide a summary document to the county social services agency that includes the following information on each resident to be relocated:

(1) name;

(2) date of birth;

(3) Social Security number;

(4) payment source and medical assistance identification number, if applicable;

(5) county of financial responsibility;

(6) date of admission to the facility;

(7) all diagnoses;

(8) the name of and contact information for the resident's physician;

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

(10) the names of and contact information for any case managers, if known; and

(11) information on the resident's status related to commitment and probation.

(c) The licensee shall consult with the county social services 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 county social services agency contact person; and

(5) the name, address, and telephone number of the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.

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 Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, and the county social services 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 Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, and the county social services 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 Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, 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 responsible for resident property, 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 onetime 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 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 weekly status reports to the commissioners of health and human services or their designees and to the county social services 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 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 county social services agency.** (a) The county social services agency shall participate in the meeting as outlined in subdivision 3, paragraph (b), to develop a

relocation plan.

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

(c) The county social services 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 county social services 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 county social services agency contact name, address, and telephone number; and

(3) the name, address, and telephone number of the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.

(e) The county social services 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 county social services agency shall monitor compliance with all components of the plan. If the licensee is not in compliance, the county social services 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 county social services agency may halt a relocation that it deems inappropriate or dangerous to the health or safety of a resident. The county social services 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 county social services agency staff shall visit residents relocated within 100 miles of the county within 30 days after the relocation. This requirement does not apply to changes in operation where the facility moved to a new location and residents chose to move to that new location. The requirement also does not apply to residents admitted after the notice of closure and discharged prior to the actual closure. County social services 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 county social services 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 county social services 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 county social services 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 county social services 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; 2002 c 379 art 1 s 113; 2005 c 56 s 1; 2006 c 282 art 20 s 7-16; 2007 c 147 art 7 s 75*

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 Long-Term Care and, when appropriate, the Office of Ombudsman for Mental Health and Developmental Disabilities, 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; 2002 c 379 art 1 s 113; 2005 c 56 s 1; 2007 c 147 art 7 s 75*

144A.17 [Repealed, 1983 c 260 s 68]

144A.18 ADMINISTRATOR'S LICENSES; PENALTY.

No person shall act as a nursing home administrator or purport to be a nursing home administrator unless that person is licensed by the Board of Examiners for Nursing Home Administrators. A violation of this section is a misdemeanor.

History: *1976 c 173 s 18; 1986 c 444*

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; 2002 c 379 art 1 s 113*

BOARD OF EXAMINERS FOR ADMINISTRATORS

144A.19 BOARD OF EXAMINERS FOR ADMINISTRATORS.

Subdivision 1. **Creation; membership.** There is hereby created the Board of Examiners for Nursing Home Administrators which shall consist of the following members:

(a) a designee of the commissioner of health who shall be a nonvoting member;

(b) a designee of the commissioner of human services who shall be a nonvoting member; and

(c) the following members appointed by the governor:

(1) two members actively engaged in the management, operation, or ownership of proprietary nursing homes;

(2) two members actively engaged in the management or operation of nonprofit nursing homes;

(3) one member actively engaged in the practice of medicine;

(4) one member actively engaged in the practice of professional nursing; and

(5) three public members as defined in section 214.02.

Subd. 2. **Provisions.** Membership terms, compensation of members, removal of members, the filling of membership vacancies, fiscal year and reporting requirements, the provision of staff, administrative services and office space, the review and processing of complaints, the setting of board fees and other provisions relating to board operations for the board of examiners shall be as provided in chapter 214.

Subd. 3. [Repealed, 1999 c 102 s 7]

History: *1976 c 173 s 19; 1977 c 305 s 45; 1977 c 347 s 24; 1977 c 444 s 10; 1984 c 654 art 5 s 58; 1986 c 444; 1999 c 102 s 1*

144A.20 ADMINISTRATOR QUALIFICATIONS.

Subdivision 1. **Criteria.** The board of examiners may issue licenses to qualified persons as nursing home administrators, and shall establish qualification criteria for nursing home administrators. No license shall be issued to a person as a nursing home administrator unless that person:

(a) is at least 21 years of age and otherwise suitably qualified;

(b) has satisfactorily met standards set by the board of examiners, which standards shall be designed to assure that nursing home administrators will be individuals who, by training or experience are qualified to serve as nursing home administrators; and

(c) has passed an examination approved by the board and designed to test for competence in the subject matters referred to in clause (b), or has been approved by the board of examiners through the development and application of other appropriate techniques.

Subd. 2. [Repealed, 1999 c 102 s 7]

History: *1976 c 173 s 20; 1986 c 444; 1996 c 451 art 4 s 23; 1999 c 102 s 2*

144A.21 ADMINISTRATOR LICENSES.

Subdivision 1. **Transferability.** A nursing home administrator's license shall not be transferable.

Subd. 2. **Rules; renewal.** The board of examiners by rule shall establish forms and procedures for the processing of license renewals. A nursing home administrator's license may be renewed only in accordance with the standards adopted by the board of examiners pursuant to section 144A.24.

Subd. 3. [Repealed, 1977 c 444 s 21]

Subd. 4. [Repealed, 1977 c 444 s 21]

History: *1976 c 173 s 21; 1977 c 444 s 11*

144A.22 ORGANIZATION OF BOARD.

The board of examiners shall elect from its membership a chair, vice-chair and secretary-treasurer, and shall adopt rules to govern its proceedings. Except as otherwise provided by law the board of examiners shall employ and fix the compensation and duties of an executive director and other necessary personnel to assist it in the performance of its duties. The executive director shall be in the unclassified service and shall not be a member of the board of examiners.

History: *1976 c 173 s 22; 1985 c 247 s 25; 1986 c 444; 1999 c 102 s 3*

144A.23 JURISDICTION OF BOARD.

Except as provided in section 144A.04, subdivision 5, the board of examiners shall have exclusive authority to determine the qualifications, skill and fitness required of any person to serve as an administrator of a nursing home. The holder of a license shall be deemed fully qualified to serve as the administrator of a nursing home.

History: *1976 c 173 s 23*

144A.24 DUTIES OF THE BOARD.

The board of examiners shall:

(a) develop and enforce standards for nursing home administrator licensing, which standards shall be designed to assure that nursing home administrators will be individuals of good character who, by training or experience, are suitably qualified to serve as nursing home administrators;

(b) develop appropriate techniques, including examinations and investigations, for determining whether applicants and licensees meet the board's standards;

(c) issue licenses and permits to those individuals who are found to meet the board's standards;

(d) establish and implement procedures designed to assure that individuals licensed as nursing home administrators will comply with the board's standards;

(e) receive and investigate complaints and take appropriate action consistent with chapter 214, to revoke or suspend the license or permit of a nursing home administrator or acting administrator who fails to comply with sections 144A.18 to 144A.27 or the board's standards;

(f) conduct a continuing study and investigation of nursing homes, and the administrators of nursing homes within the state, with a view to the improvement of the standards imposed for the licensing of administrators and improvement of the procedures and methods used for enforcement of the board's standards; and

(g) approve or conduct courses of instruction or training designed to prepare individuals for licensing in accordance with the board's standards. Courses designed to meet license renewal requirements shall be designed solely to improve professional skills and shall not include classroom attendance requirements exceeding 50 hours per year. The board may approve courses conducted within or without this state.

History: *1976 c 173 s 24; 1980 c 509 s 45; 1999 c 102 s 4*

144A.25 [Repealed, 1977 c 444 s 21]

144A.251 MANDATORY PROCEEDINGS.

In addition to its discretionary authority to initiate proceedings under section 144A.24 and chapter 214, the board of examiners shall initiate proceedings to suspend or revoke a nursing home administrator license or shall refuse to renew a license if within the preceding two year period the administrator was employed at a nursing home which during the period of employment incurred the following number of uncorrected violations, which violations were in the jurisdiction and control of the administrator and for which a fine was assessed and allowed to be recovered:

(a) Two or more uncorrected violations which created an imminent risk of harm to a nursing home resident; or

(b) Ten or more uncorrected violations of any nature.

History: *1976 c 173 s 26; 1977 c 444 s 12; 1986 c 444*

144A.2511 COSTS; PENALTIES.

If the Board of Examiners has initiated proceedings under section 144A.24 or 144A.251 or chapter 214, and upon completion of the proceedings has found that a nursing home administrator has violated a provision or provisions of sections 144A.18 to 144A.27, it may impose a civil penalty not exceeding $10,000 for each separate violation, with all violations related to a single event or incident considered as one violation. The amount of the civil penalty shall be fixed so as to deprive the nursing home administrator of any economic advantage gained by reason of the violation charged or to reimburse the board for the cost of the investigation and proceeding. For purposes of this section, the cost of the investigation and proceeding may include, but is not limited to, fees paid for services provided by the Office of Administrative Hearings, legal and investigative services provided by the Office of the Attorney General, court reporters, witnesses, and reproduction of records.

History: *2003 c 66 s 1*

144A.252 IMMUNITY.

Members of the Board of Examiners for Nursing Home Administrators and persons employed by the board or engaged in the investigation of violations and in the preparation and management of charges of violations of sections 144A.18 to 144A.27, or of rules adopted pursuant to sections 144A.18 to 144A.27 on behalf of the board, are immune from civil liability and criminal prosecution for any actions, transactions, or publication in execution of, or relating to, their duties under sections 144A.18 to 144A.27 provided they are acting in good faith.

History: *1999 c 102 s 5*

144A.26 RECIPROCITY WITH OTHER STATES.

The board of examiners may issue a nursing home administrator's license, without examination, to any person who holds a current license as a nursing home administrator from another jurisdiction if the board finds that the standards for licensure in the other jurisdiction are at least the substantial equivalent of those prevailing in this state and that the applicant is otherwise qualified.

History: *1976 c 173 s 27*

144A.27 ACTING ADMINISTRATORS.

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

History: *1976 c 173 s 28; 1986 c 444; 1987 c 403 art 4 s 5; 1999 c 102 s 6*

144A.28 SEVERABILITY.

Any part of sections 144A.18 to 144A.27 which is in conflict with any act of Congress of the United States or any rule of a federal agency, so as to deprive nursing homes of this state of federal funds, shall be deemed void without affecting the remaining provisions of sections 144A.18 to 144A.27.

History: *1976 c 173 s 29*

144A.29 [Repealed, 1999 c 102 s 7]

144A.30 PETS IN NURSING HOMES.

Nursing homes may keep pet animals on the premises subject to reasonable rules as to the care, type and maintenance of the pet.

History: *1979 c 38 s 1*

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

144A.33 RESIDENT AND FAMILY ADVISORY COUNCIL EDUCATION.

Subdivision 1. **Educational program.** Each resident and family council authorized under section 144.651, subdivision 27, shall be educated and informed about the following:

(1) care in the nursing home or board and care home;

(2) resident rights and responsibilities;

(3) resident and family council organization and maintenance;

(4) laws and rules that apply to homes and residents;

(5) human relations; and

(6) resident and family self-help methods to increase quality of care and quality of life in a nursing home or board and care home.

Subd. 2. **Providing educational services.** The Minnesota Board on Aging shall provide a grant-in-aid to a statewide, independent, nonprofit, consumer-sponsored agency to provide educational services to councils.

Subd. 3. **Funding of advisory council education.** A license application or renewal fee for nursing homes and boarding care homes under section 144.53 or 144A.07 must be increased by $5 per bed to fund the development and education of resident and family advisory councils.

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

Subd. 5. **Evaluation.** Each year the Minnesota Board on Aging shall evaluate the programs and funding sources established under this section.

History: *1985 c 267 s 1; 1987 c 403 art 2 s 13,14; 1995 c 207 art 9 s 19; 1997 c 7 art 2 s 16*

144A.35 [Repealed, 1Sp2003 c 14 art 2 s 57]

144A.351 BALANCING LONG-TERM CARE: REPORT REQUIRED.

The commissioners of health and human services, with the cooperation of counties and regional entities, shall prepare a report to the legislature by August 15, 2004, and biennially thereafter, regarding the status of the full range of long-term care services for the elderly in Minnesota. The report shall address:

(1) demographics and need for long-term care in Minnesota;

(2) summary of county and regional reports on long-term care gaps, surpluses, imbalances, and corrective action plans;

(3) status of long-term care services by county and region including:

(i) changes in availability of the range of long-term care services and housing options;

(ii) access problems regarding long-term care; and

(iii) comparative measures of long-term care availability and progress over time; and

(4) recommendations regarding goals for the future of long-term care services, policy changes, and resource needs.

History: *1Sp2003 c 14 art 2 s 11; 2007 c 147 art 6 s 1*

144A.36 [Repealed, 1Sp2003 c 14 art 7 s 89]

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 of representatives 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. **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; 2002 c 379 art 1 s 113*

144A.38 [Repealed, 1Sp2003 c 14 art 7 s 89]

HOME CARE PROGRAM

144A.43 DEFINITIONS.

Subdivision 1. **Applicability.** The definitions in this section apply to sections 144.699, subdivision 2, and 144A.43 to 144A.47.

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

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

(1) nursing services, including the services of a home health aide;

(2) personal care services not included under sections 148.171 to 148.285;

(3) physical therapy;

(4) speech therapy;

(5) respiratory therapy;

(6) occupational therapy;

(7) nutritional services;

(8) home management services when provided to a person who is unable to perform these activities due to illness, disability, or physical condition. Home management services include at least two of the following services: housekeeping, meal preparation, and shopping;

(9) medical social services;

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

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

"Home care service" does not include the following activities conducted by the commissioner of health or a board of health as defined in section 145A.02, subdivision 2: communicable disease investigations or testing; administering or monitoring a prescribed therapy necessary to control or prevent a communicable disease; or the monitoring of an individual's compliance with a health directive as defined in section 144.4172, subdivision 6.

Subd. 4. **Home care provider.** "Home care provider" means an individual, organization, association, corporation, unit of government, or other entity that is regularly engaged in the delivery, directly or by contractual arrangement, of home care services for a fee. At least one home care service must be provided directly, although additional home care services may be provided by contractual arrangements. "Home care provider" does not include:

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

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

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

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

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

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

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

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

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

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

(11) an individual licensed under chapter 147; or

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

History: *1987 c 378 s 3; 1989 c 194 s 1; 1989 c 304 s 137; 1992 c 513 art 6 s 5,6; 1995 c 207 art 9 s 20; 1997 c 22 art 2 s 2,8; 1997 c 113 s 1; 2002 c 252 s 2-4,24*

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 sections 144.291 to 144.298;

(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.

Subd. 2. **Interpretation and enforcement of rights.** These rights are established for the benefit of persons who receive home care services. "Home care services" means home care services as defined in section 144A.43, subdivision 3. A home care provider may not require a person to surrender these rights as a condition of receiving services. A guardian or conservator or, when there is no guardian or conservator, a designated person, may seek to enforce these rights. This statement of rights does not replace or diminish other rights and liberties that may exist relative to persons receiving home care services, persons providing home care services, or providers licensed under Laws 1987, chapter 378. A copy of these rights must be provided to an individual at the time home care services are initiated. The copy shall also contain the address and phone number of the Office of Health Facility Complaints and the Office of Ombudsman for Long-Term Care and a brief statement describing how to file a complaint with these offices. Information about how to contact the Office of Ombudsman for Long-Term Care shall be included in notices of change in client fees and in notices where home care providers initiate transfer or discontinuation of services.

History: *1987 c 378 s 4; 1991 c 133 s 1; 1998 c 407 art 2 s 81; 1Sp2001 c 9 art 1 s 39; 2002 c 379 art 1 s 113; 2007 c 147 art 7 s 75; art 10 s 15*

144A.441 ASSISTED LIVING BILL OF RIGHTS ADDENDUM.

Assisted living clients, as defined in section 144G.01, subdivision 3, shall be provided with the home care bill of rights required by section 144A.44, except that the home care bill of rights provided to these clients must include the following provision in place of the provision in section 144A.44, subdivision 1, clause (16):

"(16) the right to reasonable, advance notice of changes in services or charges, including at least 30 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;

(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; or

(iii) the provider has not received payment for services, for which at least ten days' advance notice of the termination of a service shall be provided."

History: *2006 c 282 art 19 s 1*

144A.442 ASSISTED LIVING CLIENTS; SERVICE TERMINATION.

If an arranged home care provider, as defined in section 144D.01, subdivision 2a, who is not also Medicare certified terminates a service agreement or service plan with an assisted living client, as defined in section 144G.01, subdivision 3, the home care provider shall provide the assisted living client and the legal or designated representatives of the client, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the reason for termination;

(3) without extending the termination notice period, an affirmative offer to meet with the assisted living client or client representatives within no more than five business days of the date of the termination notice to discuss the termination;

(4) contact information for a reasonable number of other home care providers in the geographic area of the assisted living client, as required by Minnesota Rules, part 4668.0050;

(5) a statement that the provider will participate in a coordinated transfer of the care of the client to another provider or caregiver, as required by section 144A.44, subdivision 1, clause (17);

(6) the name and contact information of a representative of the home care provider with whom the client may discuss the notice of termination;

(7) a copy of the home care bill of rights; and

(8) a statement that the notice of termination of home care services by the home care provider does not constitute notice of termination of the housing with services contract with a housing with services establishment.

History: *2006 c 282 art 19 s 2*

144A.45 REGULATION OF HOME CARE SERVICES.

Subdivision 1. **Rules.** The commissioner shall adopt rules for the regulation of home care providers pursuant to sections 144A.43 to 144A.47. The rules shall include the following:

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

(2) requirements that home care providers furnish the commissioner with specified information necessary to implement sections 144A.43 to 144A.47;

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

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

(5) standards for supervision of home care services requiring supervision by a registered nurse or other appropriate health care professional which must occur on site at least every 62 days, or more frequently if indicated by a clinical assessment, and in accordance with sections 148.171 to 148.285 and rules adopted thereunder, except that, notwithstanding the provisions of Minnesota Rules, part 4668.0110, subpart 5, item B, supervision of a person performing home care aide tasks for a class B licensee providing paraprofessional services must occur only every 180 days, or more frequently if indicated by a clinical assessment;

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

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

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

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

Subd. 1a. **Home care aide tasks.** Notwithstanding the provisions of Minnesota Rules, part 4668.0110, subpart 1, item E, home care aide tasks also include assisting toileting, transfers, and ambulation if the client is ambulatory and if the client has no serious acute illness or infectious disease.

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

(1) evaluate, monitor, and license home care providers in accordance with sections 144A.45 to 144A.47;

(2) inspect the office and records of a provider during regular business hours without advance notice to the home care provider;

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

(4) issue correction orders and assess civil penalties in accordance with section 144.653, subdivisions 5 to 8, for violations of sections 144A.43 to 144A.47 or the rules adopted under those sections; and

(5) take other action reasonably required to accomplish the purposes of sections 144A.43 to 144A.47.

(b) In the exercise of the authority granted in sections 144A.43 to 144A.47, the commissioner shall comply with the applicable requirements of section 144.122, the Government Data Practices Act, and the Administrative Procedure Act.

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

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

Subd. 5. **Home care providers; services for Alzheimer's disease or related disorder.** (a) If a home care provider licensed under section 144A.46 or 144A.4605 markets or otherwise promotes services for persons with Alzheimer's disease or related disorders, the facility's direct care staff and their supervisors must be trained in dementia care.

(b) Areas of required training include:

(1) an explanation of Alzheimer's disease and related disorders;

(2) assistance with activities of daily living;

(3) problem solving with challenging behaviors; and

(4) communication skills.

(c) The licensee shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.

History: *1987 c 378 s 5; 1989 c 282 art 2 s 25; 1991 c 286 s 8; 1997 c 113 s 2,3; 1998 c 254 art 1 s 30,31; 2002 c 252 s 5,6,24; 2003 c 37 s 2; 2008 c 326 art 1 s 2,3*

144A.46 LICENSURE.

Subdivision 1. **License required.** (a) A home care provider may not operate in the state

without a current license issued by the commissioner of health. A home care provider may hold a separate license for each class of home care licensure.

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

(c) Each application for a home care provider license, or for a renewal of a license, shall be accompanied by a fee to be set by the commissioner under section 144.122.

(d) The commissioner of health, in consultation with the commissioner of human services, shall provide recommendations to the legislature by February 15, 2009, for provider standards for personal care assistant services as described in section 256B.0655.

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

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

(2) a personal care assistant who provides services to only one individual under the medical assistance program as authorized under sections 256B.0625, subdivision 19a, and 256B.04, subdivision 16;

(3) a person or organization that offers, provides, or arranges for personal care assistant services under the medical assistance program as authorized under sections 256B.0625, subdivision 19a, and 256B.04, subdivision 16, until provider standards are implemented based on the recommendations in section 144A.46, subdivision 1, paragraph (d);

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

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

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

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

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

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

Subd. 3. **Enforcement.** (a) The commissioner may refuse to grant or renew a license, or may suspend or revoke a license, for violation of statutes or rules relating to home care services or for conduct detrimental to the welfare of the consumer. Prior to any suspension, revocation, or refusal to renew a license, the home care provider shall be entitled to notice and a hearing as provided by sections 14.57 to 14.69. In addition to any other remedy provided by law, the commissioner may, without a prior contested case hearing, temporarily suspend a license or prohibit delivery of services by a provider for not more than 60 days if the commissioner determines that the health or safety of a consumer is in imminent danger, provided (1) advance notice is given to the provider; (2) after notice, the provider fails to correct the problem; (3) the commissioner has reason to believe that other administrative remedies are not likely to be effective; and (4) there is an opportunity for a contested case hearing within the 60 days. The process of suspending or revoking a license must include a plan for transferring affected clients to other providers.

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

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

(d) Notwithstanding the provisions of paragraph (a), the commissioner shall not renew, or shall suspend or revoke the license of any home care provider which includes any individual as an owner or managerial official who was an owner or managerial official of a home care provider whose Minnesota license was not renewed or was revoked as described in paragraph (b) for five years following the effective date of the nonrenewal or revocation. The commissioner shall notify

the home care provider 30 days in advance of the date of nonrenewal, suspension, or revocation of the license. Within ten days after the receipt of this notification, the home care provider may request, in writing, that the commissioner stay the nonrenewal, revocation, or suspension of the license. The home care provider shall specify the reasons for requesting the stay; the steps that will be taken to attain or maintain compliance with the licensure laws and regulations; any limits on the authority or responsibility of the owners or managerial officials whose actions resulted in the notice of nonrenewal, revocation, or suspension; and any other information to establish that the continuing affiliation with these individuals will not jeopardize client health, safety, or well being. The commissioner shall determine whether the stay will be granted within 30 days of receiving the provider's request. The commissioner may propose additional restrictions or limitations on the provider's license and require that the granting of the stay be contingent upon compliance with those provisions. The commissioner shall take into consideration the following factors when determining whether the stay should be granted:

(1) the threat that continued involvement of the owners and managerial officials in the home care provider poses to client health, safety, and well being;

(2) the compliance history of the home care provider; and

(3) the appropriateness of any limits suggested by the home care provider.

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

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

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

Subd. 3a. **Injunctive relief.** In addition to any other remedy provided by law, the commissioner may bring an action in district court to enjoin a person who is involved in the management, operation, or control of a home care provider, or an employee of the home care provider from illegally engaging in activities regulated by sections 144A.43 to 144A.47. The

commissioner may bring an action under this subdivision in the district court in Ramsey County or in the district in which a home care provider is providing services. The court may grant a temporary restraining order in the proceeding if continued activity by the person who is involved in the management, operation, or control of a home care provider, or by an employee of the home care provider, would create an imminent risk of harm to a recipient of home care services.

Subd. 3b. **Subpoena.** In matters pending before the commissioner under sections 144A.43 to 144A.47, the commissioner may issue subpoenas and compel the attendance of witnesses and the production of all necessary papers, books, records, documents, and other evidentiary material. If a person fails or refuses to comply with a subpoena or order of the commissioner to appear or testify regarding any matter about which the person may be lawfully questioned or to produce any papers, books, records, documents, or evidentiary materials in the matter to be heard, the commissioner may apply to the district court in any district, and the court shall order the person to comply with the commissioner's order or subpoena. The commissioner of health may administer oaths to witnesses, or take their affirmation. Depositions may be taken in or outside 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 a named person anywhere within the state by an 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 a district court. A person subpoenaed under this subdivision shall receive the same fees, mileage, and other costs that are paid in proceedings in district court.

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

Subd. 4. **Relation to other regulatory programs.** In the exercise of the authority granted under sections 144A.43 to 144A.47, the commissioner shall not duplicate or replace standards and requirements imposed under another state regulatory program. The commissioner shall not impose additional training or education requirements upon members of a licensed or registered occupation or profession, except as necessary to address or prevent problems that are unique to the delivery of services in the home or to enforce and protect the rights of consumers listed in section 144A.44. The commissioner of health shall not require a home care provider certified under the Medicare program to comply with a rule adopted under section 144A.45 if the home care provider is required to comply with any equivalent federal law or regulation relating to the same subject matter. The commissioner of health shall specify in the rules those provisions that are not applicable to certified home care providers. To the extent possible, the commissioner shall coordinate the inspections required under sections 144A.45 to 144A.47 with the health facility

licensure inspections required under sections 144.50 to 144.58 or 144A.10 when the health care facility is also licensed under the provisions of Laws 1987, chapter 378.

Subd. 5. **Prior criminal convictions.** (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 245C. 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 245C.02, subdivision 11, 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 245C. Nothing in this section shall be construed to prohibit a home care provider from requiring self-disclosure of criminal conviction information.

(c) 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: *1987 c 378 s 6; 1988 c 689 art 2 s 268; 1989 c 209 art 2 s 1; 1989 c 282 art 2 s 26; 1990 c 426 art 2 s 1; 1991 c 286 s 9,10; 1991 c 292 art 2 s 10; art 7 s 2; 1992 c 513 art 6 s 7-9; 1994 c 488 s 8; 1995 c 63 s 1; 1996 c 408 art 10 s 4; 1997 c 113 s 4,5; 1997 c 193 s 47; 1997 c 195 s 1; 1997 c 248 s 2; 1998 c 254 art 1 s 32; 1999 c 107 s 66; 1999 c 245 art 9 s 3; 2000 c 260 s 21; 2000 c 343 s 4; 1Sp2001 c 9 art 14 s 35; 2002 c 252 s 7-9,24; 2003 c 15 art 1 s 33; 2005 c 147 art 1 s 4; 2008 c 230 s 6,7*

144A.4605 CLASS F PROVIDER.

Subdivision 1. **Definitions.** For purposes of this section, the term "class F home care provider" means a home care provider who provides nursing services, delegated nursing services, other services performed by unlicensed personnel, or central storage of medications solely for

residents of one or more housing with services establishments registered under chapter 144D.

Subd. 2. **Class F home care license established.** A home care provider license category entitled class F home care provider is hereby established. A home care provider may obtain a class F license if the program meets the following requirements:

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

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

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

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

(1) daily records or a weekly summary of home care services provided;

(2) documentation each time medications are administered to a client; and

(3) documentation on the day of occurrence of any significant change in the client's status or any significant incident, such as a fall or refusal to take medications.

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

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

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

(g) in other respects meets the requirements established by rules adopted under sections 144A.45 to 144A.47.

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

(1) satisfy the training or competency requirements established by rule under sections 144A.45 to 144A.47; or

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

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

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

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

(1) an overview of sections 144A.43 to 144A.47 and rules adopted thereunder;

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

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

(4) home care bill of rights;

(5) handling of clients' complaints and reporting of complaints to the Office of Health Facility Complaints;

(6) services of the ombudsman for long-term care;

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

(8) basic infection control;

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

(10) communication skills;

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

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

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

Subd. 4. **License required.** (a) A housing with services establishment registered under chapter 144D that is required to obtain a home care license must obtain a class F home care license according to this section or a class A or class B license according to rule. A housing with services establishment that obtains a class B license under this subdivision remains subject to the payment limitations in sections 256B.0913, subdivision 5f, paragraph (b), and 256B.0915, subdivision 3d.

(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.47, 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) A class F home care provider licensed under this section must comply with the disclosure provisions of section 325F.72 to the extent they are applicable.

Subd. 5. **License fees.** The license fees for class F home care providers shall be as follows:

(1) $125 annually for those providers serving a monthly average of 15 or fewer clients, and for class F providers of all sizes during the first year of operation;

(2) $200 annually for those providers serving a monthly average of 16 to 30 clients;

(3) $375 annually for those providers serving a monthly average of 31 to 50 clients; and

(4) $625 annually for those providers serving a monthly average of 51 or more clients.

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

History: *1997 c 113 s 6; 1Sp1997 c 5 s 2; 1998 c 254 art 1 s 33,34; 1998 c 407 art 2 s 82; 1999 c 245 art 2 s 30; 1Sp2001 c 9 art 1 s 40; 2002 c 252 s 10-12,24; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 2 s 12; 2006 c 282 art 19 s 3; 2007 c 147 art 7 s 75*

144A.461 REGISTRATION.

A person or organization that provides only home management services defined as home care services under section 144A.43, subdivision 3, clause (8), may not operate in the state without a current certificate of registration issued by the commissioner of health. To obtain a certificate of registration, the person or organization must annually submit to the commissioner the name, address, and telephone number of the person or organization and a signed statement declaring that the person or organization is aware that the Home Care Bill of Rights applies to their clients and that the person or organization will comply with the bill of rights provisions contained in section 144A.44. A person who provides home management services under this section must, within 120 days after beginning to provide services, attend an orientation session approved by the commissioner that provides training on the bill of rights and an orientation on the aging process and the needs and concerns of elderly and disabled persons. An organization applying for a certificate must also provide the name, business address, and telephone number of each of the individuals responsible for the management or direction of the organization. The commissioner shall charge an annual registration fee of $20 for individuals and $50 for organizations. A home

care provider that provides home management services and other home care services must be licensed, but licensure requirements other than the home care bill of rights do not apply to those employees or volunteers who provide only home management services to clients who do not receive any other home care services from the provider. A licensed home care provider need not be registered as a home management service provider, but must provide an orientation on the home care bill of rights to its employees or volunteers who provide home management services. The commissioner may suspend or revoke a provider's certificate of registration or assess fines for violation of the home care bill of rights. Any fine assessed for a violation of the bill of rights by a provider registered under this section shall be in the amount established in the licensure rules for home care providers. As a condition of registration, a provider must cooperate fully with any investigation conducted by the commissioner, including providing specific information requested by the commissioner on clients served and the employees and volunteers who provide services. The commissioner may use any of the powers granted in sections 144A.43 to 144A.47 to administer the registration system and enforce the home care bill of rights under this section.

History: *1992 c 513 art 6 s 10; 2008 c 277 art 1 s 16*

144A.465 LICENSURE; PENALTY.

A person involved in the management, operation, or control of a home care provider who violates section 144A.46, subdivision 1, paragraph (a), is guilty of a misdemeanor. This section does not apply to a person who had no legal authority to affect or change decisions related to the management, operation, or control of a home care provider.

History: *1989 c 282 art 2 s 27*

144A.47 INFORMATION AND REFERRAL SERVICES.

The commissioner shall ensure that information and referral services relating to home care are available in all regions of the state. The commissioner shall collect and make available information about available home care services, sources of payment, providers, and the rights of consumers. The commissioner may require home care providers to provide information requested for the purposes of this section as a condition of registration or licensure. The commissioner may publish and make available:

(1) general information describing home care services in the state;

(2) limitations on hours, availability of services, and eligibility for third-party payments, applicable to individual providers; and

(3) other information the commissioner determines to be appropriate.

History: *1987 c 378 s 7; 1995 c 207 art 9 s 21*

144A.48 MS 2002 [Repealed, 2002 c 252 s 25]

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

HEALTH CARE FACILITY GRIEVANCES

144A.51 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of sections 144A.51 to 144A.54, the terms defined in this section have the meanings given them.

Subd. 2. **Administrative agency or agency.** "Administrative agency" or "agency" means any division, official, or employee of a state or local governmental agency, but does not include:

(a) any member of the senate or house of representatives;

(b) the governor or personal staff of the governor;

(c) any instrumentality of the federal government of the United States; or

(d) any court or judge.

Subd. 3. **Director.** "Director" means the director of the Office of Health Facility Complaints.

Subd. 4. **Health care provider.** "Health care provider" means any professional licensed by the state to provide medical or health care services who does provide the services to a resident of a health facility or a residential care home.

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

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

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

History: *1976 c 325 s 1; 1986 c 444; 1987 c 378 s 9,10; 1987 c 384 art 2 s 1; 1991 c 292 art 2 s 12; 1992 c 513 art 6 s 12-14*

144A.52 OFFICE OF HEALTH FACILITY COMPLAINTS.

Subdivision 1. **Creation; administration.** The Office of Health Facility Complaints is hereby created in the Department of Health. The office shall be headed by a director appointed by the state commissioner of health.

The commissioner of health shall provide the Office of Health Facility Complaints with office space, administrative services and secretarial and clerical assistance.

Subd. 2. **Staff.** The director may appoint a deputy director and one personal secretary to discharge the responsibilities of the office. Any deputy director or personal secretary and all other employees of the office shall be classified employees of the state commissioner of health.

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

Subd. 4. **Training.** The director shall attempt to include staff persons with expertise in areas such as law, health care, social work, dietary needs, sanitation, financial audits, health-safety requirements as they apply to health facilities, residential care homes, and any other relevant fields. To the extent possible, employees of the office shall meet federal training requirements for health facility surveyors.

History: *1976 c 325 s 2; 1977 c 305 s 45; 1982 c 560 s 48; 1986 c 444; 1987 c 378 s 11; 1991 c 238 art 1 s 8; 1992 c 513 art 6 s 15,16*

144A.53 DIRECTOR; POWERS AND DUTIES.

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

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

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

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

(d) Request and receive access to relevant information, records, incident reports, or documents in the possession of an administrative agency, a health care provider, a home care provider, a residential care home, or a health facility, and issue investigative subpoenas to individuals and facilities for oral information and written information, including privileged information which the director deems necessary for the discharge of responsibilities. For purposes of investigation and securing information to determine violations, the director need not present a

release, waiver, or consent of an individual. The identities of patients or residents must be kept private as defined by section 13.02, subdivision 12.

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

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

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

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

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

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

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

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

(a) Modify or cancel the actions which gave rise to the complaint;

(b) Alter the practice, rule or decision which gave rise to the complaint;

(c) Provide more information about the action under investigation; or

(d) Take any other step which the director considers appropriate.

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

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

History: *1976 c 325 s 3; 1977 c 305 s 45; 1982 c 424 s 130; 1983 c 289 s 98; 1984 c 654 art 5 s 58; 1986 c 444; 1987 c 209 s 31; 1987 c 378 s 12; 1991 c 286 s 11; 1991 c 292 art 2 s 13; 1992 c 513 art 6 s 17-20; 1997 c 7 art 2 s 17*

144A.54 PUBLICATION OF RECOMMENDATIONS; REPORTS.

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

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

Subd. 3. **Confidentiality.** In performing the duties under Laws 1976, chapter 325, the

director shall preserve the confidentiality of resident records. The director may release a resident's records with the written approval of the resident who is the subject of the records.

History: *1976 c 325 s 4; 1977 c 305 s 45; 1986 c 444; 1987 c 378 s 13; 1992 c 513 art 6 s 21; 1997 c 7 art 2 s 18,19*

144A.55 [Repealed, 1983 c 260 s 68]

NURSING ASSISTANTS

144A.61 NURSING ASSISTANT TRAINING.

Subdivision 1. **Authority.** The commissioner of health, in consultation with the commissioner of human services, shall implement the provisions of Public Law 100-203, the Omnibus Budget Reconciliation Act of 1987, that relate to training and competency evaluation programs, testing, and the establishment of a registry for nursing assistants in nursing homes and boarding care homes certified for participation in the medical assistance or Medicare programs. The commissioner of health may adopt permanent rules that may be necessary to implement Public Law 100-203 and provisions of this section. The commissioner of health may contract with outside parties for the purpose of implementing the provisions of this section. At the request of the commissioner, the Board of Nursing may establish training and competency evaluation standards; review, evaluate, and approve curricula; review and approve training programs; and establish a registry of nursing assistants.

Subd. 2. **Nursing assistants.** For the purposes of this section and section 144A.611 "nursing assistant" means a nursing home or certified boarding care home employee, including a nurse's aide or an orderly, who is assigned by the director of nursing to provide or assist in the provision of nursing or nursing-related services under the supervision of a registered nurse. "Nursing assistant" includes nursing assistants employed by nursing pool companies but does not include a licensed health professional.

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

Subd. 3a. **Competency evaluation program.** The commissioner of health shall approve the competency evaluation program. A competency evaluation must be administered to persons who desire to be listed in the nursing assistant registry. The tests may only be administered by technical colleges, community colleges, or other organizations approved by the Department of Health. The commissioner of health shall approve a nursing assistant for the registry without requiring a competency evaluation if the nursing assistant is in good standing on a nursing assistant registry in another state.

Subd. 4. **Technical assistance.** The chancellor of vocational technical education shall, upon request, provide necessary and appropriate technical assistance in the development of nursing assistant training programs.

Subd. 5. [Repealed, 1977 c 326 s 18]

Subd. 6. [Repealed, 1989 c 282 art 3 s 98]

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

Subd. 7. **Violation, penalty.** Violation of this section by a nursing home or certified boarding care home shall be grounds for the issuance of a correction order. Under the provisions of sections 144.653 or 144A.10, the failure of the nursing home or certified boarding care home to comply with the correction order shall result in the assessment of a fine in the amount of $300.

Subd. 8. **Exceptions.** Employees of nursing homes conducted in accordance with the teachings of the body known as the Church of Christ, Scientist, shall be exempt from the requirements of this section and section 144A.611.

History: *1976 c 310 s 1; 1977 c 305 s 45; 1977 c 326 s 6,7; 1977 c 453 s 26; 1981 c 359 s 17; 1987 c 258 s 12; 1989 c 246 s 2; 1989 c 282 art 3 s 28; 1990 c 375 s 3; 1991 c 286 s 12-14; 1992 c 513 art 6 s 22,23; 1993 c 5 s 1; 1997 c 7 art 1 s 75; 1997 c 203 art 3 s 14; 1999 c 210 s 1,2*

144A.611 REIMBURSABLE EXPENSES PAYABLE TO NURSING ASSISTANTS.

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

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

Subd. 3. **Rules.** The commissioner of human services shall promulgate any rules necessary to implement the provisions of this section. The rules shall include, but not be limited to:

(a) Provisions designed to prevent reimbursement by the commissioner under this section and section 144A.61 to a nursing home, certified boarding care home, or nursing assistant for the assistant's simultaneous training in more than one approved program;

(b) Provisions designed to prevent reimbursement by the commissioner under this section and section 144A.61 to more than one nursing home or certified boarding care home for the training of any individual nursing assistant; and

(c) Provisions permitting the reimbursement by the commissioner to nursing homes, certified boarding care homes, and nursing assistants for the retraining of a nursing assistant after an absence from the labor market of not less than 24 months.

History: *1976 c 310 s 2; 1977 c 326 s 9; 1984 c 654 art 5 s 58; 1986 c 444; 1989 c 282 art 3 s 29; 1991 c 286 s 15,16*

144A.612 [Repealed, 1995 c 229 art 4 s 22]

144A.62 RESIDENT ATTENDANTS.

Subdivision 1. **Assistance with eating and drinking.** (a) Upon federal approval, a nursing home may employ resident attendants to assist with the activities authorized under subdivision 2. The resident attendant will not be counted in the minimum staffing requirements under section 144A.04, subdivision 7.

(b) The commissioner shall submit by May 15, 2000, a request for a federal waiver necessary to implement this section.

Subd. 2. **Definition.** "Resident attendant" means an individual who assists residents in a nursing home with the activities of eating and drinking. A resident attendant does not include an individual who:

(1) is a licensed health professional or a registered dietitian;

(2) volunteers without monetary compensation; or

(3) is a registered nursing assistant.

Subd. 3. **Requirements.** (a) A nursing home may not use on a full-time or other paid basis any individual as a resident attendant in the nursing home unless the individual:

(1) has completed a training and competency evaluation program encompassing the tasks the individual provides;

(2) is competent to provide feeding and hydration services; and

(3) is under the supervision of the director of nursing.

(b) A nursing home may not use a current employee as a resident attendant unless the employee satisfies the requirements of paragraph (a) and volunteers to be used in that capacity.

Subd. 4. **Evaluation.** The training and competency evaluation program may be facility based. It must include, at a minimum, the training and competency standards for eating and drinking assistance contained in the nursing assistant training curriculum.

Subd. 5. **Criminal background check.** A person seeking employment as a resident attendant is subject to the criminal background check requirements.

Subd. 6. **Nonretaliation.** Employees shall not be subject to disciplinary action if they choose not to volunteer under this section.

Subd. 7. **Resident protections.** Resident attendants are subject to requirements for volunteer feeding assistants in Minnesota Rules, part 4658.0530.

Subd. 8. **Exceptions.** A resident attendant may not be assigned to feed any resident who:

(1) is at risk of choking while eating or drinking;

(2) presents significant behavior management challenges while eating or drinking; or

(3) presents other risk factors that may require emergency intervention.

History: *2000 c 312 s 1*

144A.65 [Expired]

144A.66 [Expired]

144A.67 [Expired]

SUPPLEMENTAL NURSING SERVICES AGENCY REGISTRATION

144A.70 REGISTRATION OF SUPPLEMENTAL NURSING SERVICES AGENCIES.

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 does not include a professional home care agency licensed as a Class A provider under section 144A.46 and rules adopted thereunder that only provides staff to other home care providers.

History: *1Sp2001 c 9 art 7 s 2; 2002 c 287 s 1; 2002 c 379 art 1 s 113; 2003 c 55 s 3*

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) satisfactory proof of compliance with section 144A.72, subdivision 1, clauses (5) to (7);

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

(5) 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; 2002 c 287 s 2; 2002 c 379 art 1 s 113*

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 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;

(5) the supplemental nursing services agency shall carry an employee dishonesty bond in the amount of $10,000;

(6) the supplemental nursing services agency shall maintain insurance coverage for workers' compensation for all nurses, nursing assistants, nurse aides, and orderlies provided or procured by the agency;

(7) the supplemental nursing services agency shall file with the commissioner of revenue: (i) the name and address of the bank, savings bank, or savings association in which the supplemental nursing services agency deposits all employee income tax withholdings; and (ii) the name and address of any nurse, nursing assistant, nurse aide, or orderly whose income is derived from placement by the agency, if the agency purports the income is not subject to withholding;

(8) 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; and

(9) the supplemental nursing services agency shall document that each temporary employee provided to health care facilities is an employee of the agency and is not an independent contractor.

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.

Subd. 3. **Revocation.** Notwithstanding subdivision 2, the registration of a supplemental nursing services agency that knowingly supplies to a health care facility a person with an illegally or fraudulently obtained or issued diploma, registration, license, certificate, or background study shall be revoked by the commissioner. The commissioner shall notify the supplemental nursing services agency 15 days in advance of the date of revocation.

Subd. 4. **Hearing.** (a) No supplemental nursing services agency's registration may be revoked without a hearing held as a contested case in accordance with chapter 14. The hearing must commence within 60 days after the proceedings are initiated.

(b) If a controlling person has been notified by the commissioner of health that the supplemental nursing services agency will not receive an initial registration or that a renewal of the registration has been denied, the controlling person or a legal representative on behalf of the supplemental nursing services agency may request and receive a hearing on the denial. This hearing shall be held as a contested case in accordance with chapter 14.

Subd. 5. **Period of ineligibility.** (a) The controlling person of a supplemental nursing services agency whose registration has not been renewed or has been revoked because of noncompliance with the provisions of sections 144A.70 to 144A.74 shall not be eligible to apply for nor will be granted a registration for five years following the effective date of the nonrenewal or revocation.

(b) The commissioner shall not issue or renew a registration to a supplemental nursing services agency if a controlling person includes any individual or entity who was a controlling person of a supplemental nursing services agency whose registration was not renewed or was revoked as described in paragraph (a) for five years following the effective date of nonrenewal or revocation.

History: *1Sp2001 c 9 art 7 s 4; 2002 c 287 s 3-6; 2002 c 379 art 1 s 113*

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; 2002 c 379 art 1 s 113*

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 sum of the weighted average wage rate, plus a factor determined by the commissioner to incorporate payroll taxes as defined in Minnesota Rules, part 9549.0020, subpart 33, 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. Wages are defined as hourly rate of pay and shift differential, including weekend shift differential and overtime. 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; 2002 c 287 s 7; 2002 c 379 art 1 s 113*

HOSPICE CARE LICENSING

144A.75 DEFINITIONS; SERVICE REQUIREMENTS.

Subdivision 1. **Applicability.** For the purposes of sections 144A.75 to 144A.756, the following terms have the meanings given them.

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

Subd. 3. **Core services.** "Core services" means physician services, registered nursing services, medical social services, and counseling services. A hospice must ensure that at least two core services are regularly provided directly by hospice employees. A hospice provider may use contracted staff if necessary to supplement hospice employees in order to meet the needs of patients during peak patient loads or under extraordinary circumstances.

Subd. 4. **Counseling services.** "Counseling services" includes bereavement counseling provided after the patient's death and spiritual and other counseling services for the individual and the family while enrolled in hospice care. Bereavement services must be provided according to a plan of care that reflects the needs of the family for up to one year following the death of the patient.

Subd. 5. **Hospice provider.** "Hospice provider" means an individual, organization, association, corporation, unit of government, or other entity that is regularly engaged in the delivery, directly or by contractual arrangement, of hospice services for a fee to terminally ill hospice patients. A hospice must provide all core services.

Subd. 6. **Hospice patient.** "Hospice patient" means an individual who has been diagnosed

as terminally ill, with a probable life expectancy of under one year, as documented by the individual's attending physician and hospice medical director, who alone or, when unable, through the individual's family has voluntarily consented to and received admission to a hospice provider.

Subd. 7. **Hospice patient's family.** "Hospice patient's family" means relatives of the hospice patient, the hospice patient's guardian or primary caregiver, or persons identified by the hospice patient as having significant personal ties.

Subd. 8. **Hospice services; hospice care.** "Hospice services" or "hospice care" means palliative and supportive care and other services provided by an interdisciplinary team under the direction of an identifiable hospice administration to terminally ill hospice patients and their families to meet the physical, nutritional, emotional, social, spiritual, and special needs experienced during the final stages of illness, dying, and bereavement. These services are provided through a centrally coordinated program that ensures continuity and consistency of home and inpatient care that is provided directly or through an agreement.

Subd. 9. **Interdisciplinary team.** "Interdisciplinary team" means a group of qualified individuals with expertise in meeting the special needs of hospice patients and their families, including, at a minimum, those individuals who are providers of core services.

Subd. 10. **Medical director.** "Medical director" means a licensed physician who is knowledgeable about palliative medicine and assumes overall responsibility for the medical component of the hospice care program.

Subd. 11. **Other services.** "Other services" means physical therapy, occupational therapy, speech therapy, nutritional counseling, and volunteers.

Subd. 12. **Palliative care.** "Palliative care" means the total active care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social, and spiritual problems is paramount. The goal of palliative care is the achievement of the best quality of life for patients and their families.

Subd. 13. **Residential hospice facility.** "Residential hospice facility" means a facility that resembles a single-family home located in a residential area that directly provides 24-hour residential and support services in a home-like setting for hospice patients as an integral part of the continuum of home care provided by a hospice and that houses:

(1) no more than eight hospice patients; or

(2) at least nine and no more than 12 hospice patients with the approval of the local governing authority, notwithstanding section 462.357, subdivision 8.

Subd. 14. **Volunteer services.** "Volunteer services" means services by volunteers who provide a personal presence that augments a variety of professional and nonprofessional services

available to the hospice patient, the hospice patient's family, and the hospice provider.

History: *2002 c 252 s 13,24*

144A.751 HOSPICE BILL OF RIGHTS.

Subdivision 1. **Statement of rights.** An individual who receives hospice care has the right to:

(1) receive written information about rights in advance of receiving hospice care or during the initial evaluation visit before the initiation of hospice care, including what to do if rights are violated;

(2) receive care and services according to a suitable hospice plan of care and subject to accepted hospice care standards and to take an active part in creating and changing the plan and evaluating care and services;

(3) 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 consequence of these choices, including the consequences of refusing these services;

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

(5) refuse services or treatment;

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

(7) know in advance of receiving care whether the hospice services may be covered by health insurance, medical assistance, Medicare, or other health programs in which the individual is enrolled;

(8) receive, upon request, a good faith estimate of the reimbursement the provider expects to receive from the health plan company in which the individual is enrolled. A good faith estimate must also be made available at the request of an individual who is not enrolled in a health plan company. This payment information does not constitute a legally binding estimate of the cost of services;

(9) know that there may be other services available in the community, including other end of life services and other hospice providers, and know where to go for information about these services;

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

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

(12) be allowed access to records and written information from records according to sections 144.291 to 144.298;

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

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

(15) 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;

(16) be free from physical and verbal abuse;

(17) 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 between the hospice provider and the individual providing hospice services, or creates an abusive or unsafe work environment for the individual providing hospice services;

(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 hospice provider; or

(iii) the recipient is no longer certified as terminally ill;

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

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

(21) assert these rights personally, or have them asserted by the hospice patient's family when the patient has been judged incompetent, without retaliation; and

(22) have pain and symptoms managed to the patient's desired level of comfort.

Subd. 2. **Interpretation and enforcement of rights.** The rights under this section are established for the benefit of individuals who receive hospice care. A hospice provider may not require a person to surrender these rights as a condition of receiving hospice care. A guardian or conservator or, when there is no guardian or conservator, a designated person, may seek to enforce these rights. This statement of rights does not replace or diminish other rights and liberties that may exist relative to persons receiving hospice care, persons providing hospice care, or hospice

providers licensed under section 144A.753.

Subd. 3. **Disclosure.** A copy of these rights must be provided to an individual at the time hospice care is initiated. The copy shall contain the address and telephone number of the Office of Health Facility Complaints and the Office of Ombudsman for Long-Term Care and a brief statement describing how to file a complaint with these offices. Information about how to contact the Office of Ombudsman for Long-Term Care shall be included in notices of change in provider fees and in notices where hospice providers initiate transfer or discontinuation of services.

History: *2002 c 252 s 14,24; 2005 c 122 s 1,2; 2007 c 147 art 7 s 75; art 10 s 15*

144A.752 REGULATION OF HOSPICE CARE.

Subdivision 1. **Rules.** The commissioner shall adopt rules for the regulation of hospice providers according to sections 144A.75 to 144A.755. The rules shall include the following:

(1) provisions to ensure, to the extent possible, the health, safety, well-being, and appropriate treatment of persons who receive hospice care;

(2) requirements that hospice providers furnish the commissioner with specified information necessary to implement sections 144A.75 to 144A.755;

(3) standards of training of hospice provider personnel;

(4) standards for medication management, which may vary according to the nature of the hospice care provided, the setting in which the hospice care is provided, or the status of the patient;

(5) standards for hospice patient and hospice patient's family evaluation or assessment, which may vary according to the nature of the hospice care provided or the status of the patient; and

(6) requirements for the involvement of a patient's physician; documentation of physicians' orders, if required, and the patient's hospice plan of care; and maintenance of accurate, current clinical records.

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

(1) evaluate, monitor, and license hospice providers according to sections 144A.75 to 144A.755;

(2) inspect the office and records of a hospice provider during regular business hours without advance notice to the hospice provider;

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

(4) issue correction orders and assess civil penalties according to section 144.653, subdivisions 5 to 8, for violations of sections 144A.75 to 144A.755 or rules adopted thereunder; and

(5) take other action reasonably required to accomplish the purposes of sections 144A.75 to 144A.755.

(b) In the exercise of the authority granted under this section, the commissioner shall comply with the applicable requirements of the Government Data Practices Act, the Administrative Procedure Act, and other applicable law.

Subd. 3. **Relation to other regulatory programs.** In the exercise of the authority granted under sections 144A.75 to 144A.755, the commissioner shall not duplicate or replace standards and requirements imposed under another regulatory program of the state. The commissioner shall not impose additional training or education requirements upon members of a licensed or registered occupation or profession, except as necessary to address or prevent problems that are unique to the delivery of hospice care or to enforce and protect the rights of patients listed under section 144A.751. The commissioner shall not require a hospice care provider certified under the Medicare program and surveyed and enforced by the Minnesota Department of Health, to comply with a rule adopted under this section if the hospice provider is required to comply with any equivalent federal law or regulation relating to the same subject matter. The commissioner shall specify in the rules those provisions that are not applicable to certified hospice providers.

Subd. 4. **Medicaid reimbursement.** Certification by the federal Medicare program must not be a requirement of Medicaid payment for room and board services delivered in a residential hospice facility.

History: *2002 c 252 s 15,24*

144A.753 LICENSURE.

Subdivision 1. **License required; application.** (a) A hospice provider may not operate in the state without a valid license issued by the commissioner.

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

(c) Each application for a hospice provider license, or for a renewal of a license, shall be accompanied by a fee as follows:

(1) for revenues no more than $25,000, $125;

(2) for revenues greater than $25,000 and no more than $100,000, $312.50;

(3) for revenues greater than $100,000 and no more than $250,000, $625;

(4) for revenues greater than $250,000 and no more than $350,000, $937.50;

(5) for revenues greater than $350,000 and no more than $450,000, $1,250;

(6) for revenues greater than $450,000 and no more than $550,000, $1,562.50;

(7) for revenues greater than $550,000 and no more than $650,000, $1,875;

(8) for revenues greater than $650,000 and no more than $750,000, $2,187.50;

(9) for revenues greater then $750,000 and no more than $850,000, $2,500;

(10) for revenues greater than $850,000 and no more than $950,000, $2,812.50;

(11) for revenues greater than $950,000 and no more than $1,100,000, $3,125;

(12) for revenues greater than $1,100,000 and no more than $1,275,000, $3,750;

(13) for revenues greater than $1,275,000 and no more than $1,500,000, $4,375; and

(14) for revenues greater than $1,500,000, $5,000.

Subd. 2. **Licensing requirements.** The commissioner shall license hospice providers using the authorities under sections 144A.75 to 144A.755. To receive a license, a hospice provider must:

(1) provide centrally coordinated core services in the home and inpatient settings and make other services available, which may be provided by employees or contracted staff;

(2) require that the medical components of the hospice care program be under the direction of a licensed physician who serves as medical director;

(3) require that the palliative care provided to a hospice patient be under the direction of a licensed physician;

(4) utilize an interdisciplinary team that meets regularly to develop, implement, and evaluate the hospice provider's plan of care for each hospice patient and the patient's family. Within 48 hours of admission, a licensee must enter a written service agreement with the patient or the patient's responsible person describing the cost of services. Services are provided in accordance to the plan of care developed by the interdisciplinary team. Changes in the services provided which do not cause a change in fees do not require a written modification of the service plan agreed to by the patient or the patient's responsible person;

(5) provide accessible hospice care, 24 hours a day, seven days a week;

(6) utilize an ongoing system of quality assurance;

(7) require that volunteer services be provided by individuals who have completed a hospice volunteer training program and are trained to provide the services required;

(8) provide a planned program of supportive services and bereavement counseling available to patients and families during hospice care and the bereavement period following the death of the hospice patient; and

(9) require that inpatient services be provided directly or by arrangement in a licensed hospital or nursing home or residential hospice.

Subd. 3. **Nomenclature.** A hospice provider may not operate in the state or use the words "hospice," "hospice care," "hospice care program," or "hospice provider" without a valid license issued by the commissioner. St. Anne Hospice in Winona County may continue to use the name "hospice."

History: *2002 c 252 s 16,24*

144A.754 ENFORCEMENT.

Subdivision 1. **Enforcement.** (a) The commissioner may refuse to grant or renew a license, or may suspend or revoke a license, for violation of statutes or rules relating to hospice or for conduct detrimental to the welfare of a patient. Prior to any suspension, revocation, or refusal to renew a license, the hospice provider is entitled to notice and a hearing as provided by chapter 14.

(b) In addition to any other remedy provided by law, the commissioner may, without a prior contested case hearing, temporarily suspend a license or prohibit delivery of hospice care by a provider for not more than 60 days if the commissioner determines that the health or safety of a patient is in imminent danger, provided:

(1) advance notice is given to the provider;

(2) after notice, the provider fails to correct the problem;

(3) the commissioner has reason to believe that other administrative remedies are not likely to be effective; and

(4) there is an opportunity for a contested case hearing within the 60 days.

(c) The process of suspending or revoking a license must include a plan for transferring affected patients to other providers.

(d) The owner and managerial officials of a hospice provider, the license of which has not been renewed or has been revoked because of noncompliance with applicable law, are not eligible to apply for and shall not be granted a license for five years following the effective date of the nonrenewal or revocation.

(e) The commissioner shall not issue a license to a hospice provider if an owner or managerial official includes an individual who was an owner or managerial official of a hospice provider or other type of licensed home care provider whose license was not renewed or was

revoked as described in paragraph (d) for five years following the effective date of nonrenewal or revocation.

(f) Notwithstanding the provisions of paragraph (a), the commissioner shall not renew or shall suspend or revoke the license of a hospice provider that includes an individual as an owner or managerial official who was an owner or managerial official of a hospice provider whose license was not renewed or was revoked as described in paragraph (d) for five years following the effective date of the nonrenewal or revocation.

(g) The commissioner shall notify the hospice provider 30 days in advance of the date of nonrenewal, suspension, or revocation of the license. Within ten days after the receipt of this notification, the hospice provider may request, in writing, that the commissioner stay the nonrenewal, revocation, or suspension of the license. The hospice provider shall specify the reasons for requesting the stay; the steps that will be taken to attain or maintain compliance with the licensure laws; any limits on the authority or responsibility of the owners or managerial officials whose actions resulted in the notice of nonrenewal, revocation, or suspension; and any other information to establish that the continuing affiliation with these individuals will not jeopardize patient health, safety, or well-being. The commissioner shall determine whether the stay will be granted within 30 days of receiving the provider's request. The commissioner may propose additional restrictions or limitations on the provider's license and require that the granting of the stay be contingent upon compliance with those provisions. The commissioner shall take into consideration the following factors when determining whether the stay should be granted:

(1) the threat that continued involvement of the owners and managerial officials in the hospice provider poses to patient health, safety, and well-being;

(2) the compliance history of the hospice provider; and

(3) the appropriateness of any limits suggested by the hospice provider.

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

(i) The provisions contained in paragraphs (d) and (e) apply to any nonrenewal or revocation of a hospice provider license occurring after the effective date of the rules adopted under section 144A.752.

(j) For the purposes of this subdivision, owners of a hospice provider are those individuals whose ownership interest provides sufficient authority or control to affect or change decisions related to the operation of the hospice 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 hospice provider. For the purposes of this subdivision, managerial officials are those individuals who had the responsibility for the ongoing management or direction of the policies, services, or employees of the hospice provider relating to the areas of noncompliance that led to the license revocation or nonrenewal.

Subd. 2. **Injunctive relief.** In addition to any other remedy provided by law, the commissioner may bring an action in district court to enjoin a person who is involved in the management, operation, or control of a hospice provider or an employee of the hospice provider from illegally engaging in activities regulated under sections 144A.75 to 144A.755. The commissioner may bring an action under this subdivision in the district court in Ramsey County or in the district in which a hospice provider is providing hospice care. The court may grant a temporary restraining order in the proceeding if continued activity by the person who is involved in the management, operation, or control of a hospice provider or an employee of the hospice provider would create an imminent risk of harm to a recipient of hospice care.

Subd. 3. **Subpoena.** In matters pending before the commissioner under sections 144A.75 to 144A.755, the commissioner may issue subpoenas and compel the attendance of witnesses and the production of all necessary papers, books, records, documents, and other evidentiary material. If a person fails or refuses to comply with a subpoena or order of the commissioner to appear or testify regarding any matter about which the person may be lawfully questioned or to produce any papers, books, records, documents, or evidentiary materials in the matter to be heard, the commissioner may apply to the district court in any district and the court shall order the person to comply with the commissioner's order or subpoena. The commissioner may administer oaths to witnesses or take their affirmation. Depositions may be taken in or outside 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 a named person anywhere within the state by an 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 a district court. A person subpoenaed under this subdivision shall receive the same fees, mileage, and other costs that are paid in proceedings in district court.

Subd. 4. **Time limits for appeals.** To appeal the assessment of civil penalties under section 144A.752, subdivision 2, clause (4), a denial of a waiver or variance, and an action against a license under subdivision 1, a hospice provider must request a hearing no later than 15 days after the provider receives notice of the action.

Subd. 5. **Prior criminal convictions.** (a) Before the commissioner issues an initial or renewal license, an owner or managerial official is required to complete a background study under section 144.057. No person may be involved in the management, operation, or control of a hospice provider if the person has been disqualified under the provisions of chapter 245C. Individuals disqualified under these provisions may 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 hospice 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 hospice 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 hospice 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 245C.02, subdivision 11, or those individuals who have the responsibility for the ongoing management or direction of the policies, services, or employees of the hospice provider. Data collected under this subdivision are classified as private data under section 13.02, subdivision 12.

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

(c) 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 hospice provider to civil liability or liability for unemployment benefits.

History: *2002 c 252 s 17,24; 2003 c 15 art 1 s 33*

144A.755 INFORMATION AND REFERRAL SERVICES.

The commissioner shall ensure that information and referral services relating to hospice care are available in all regions of the state. The commissioner shall collect and make available information about available hospice care, sources of payment, providers, and the rights of patients. The commissioner shall, as a condition of licensure, require a hospice provider to complete the sections entitled Identification and Contact Information, Program Demographics, Patient Volume, Patient Demographics, and Inpatient and Residential Facilities in the National Hospice and Palliative Care Organization National Data Set Survey and to submit the survey to the National Hospice and Palliative Care Organization once in the 12 calendar months before the hospice provider's license renewal date. If the Center for Medicare and Medicaid Services requires hospice providers to complete a different data set as a condition of certification, the commissioner shall accept the completion and submittal of such data set as compliance with this requirement. The commissioner shall not use any data or information about any hospice provider submitted to the National Hospice and Palliative Care Organization in connection with this data set in any regulatory function with respect to the hospice provider. The commissioner may publish and make available:

(1) general information describing hospice care in the state;

(2) limitations on hours, availability of services, and eligibility for third-party payments, applicable to individual providers; and

(3) other information the commissioner determines to be appropriate.

History: *2002 c 252 s 18,24; 2005 c 122 s 3,5*

144A.756 PENALTY.

A person involved in the management, operation, or control of a hospice provider who violates section 144A.753, subdivision 1, paragraph (a), is guilty of a misdemeanor. This section does not apply to a person who had no legal authority to affect or change decisions related to the management, operation, or control of a hospice provider.

History: *2002 c 252 s 19,24*