Minnesota Statutes and Rules – Board of Examiners for Nursing Home Administrators

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CLEAN INDOOR AIR ACT

144.411 CITATION.

Sections 144.411 to 144.417 may be cited as the "Minnesota Clean Indoor Air Act."

History: 1975 c 211 s 1

144.412 PUBLIC POLICY.

The purpose of sections 144.411 to 144.417 is to protect employees and the general public from the hazards of secondhand smoke by eliminating smoking in public places, places of employment, public transportation, and at public meetings.

History: 1975 c 211 s 2; 1987 c 399 s 1; 2007 c 82 s 2

144.413 DEFINITIONS.

Subdivision 1. Scope. As used in sections 144.411 to 144.416, the terms defined in this section have the meanings given them.

Subd. 1a. Indoor area. "Indoor area" means all space between a floor and a ceiling that is bounded by walls, doorways, or windows, whether open or closed, covering more than 50 percent of the combined surface area of the vertical planes constituting the perimeter of the area. A wall includes any retractable divider, garage door, or other physical barrier, whether temporary or permanent. A 0.011 gauge window screen with an 18 by 16 mesh count is not a wall.

Subd. 1b. Place of employment. "Place of employment" means any indoor area at which two or more individuals perform any type of a service for consideration of payment under any type of contractual relationship, including, but not limited to, an employment relationship with or for a private corporation, partnership, individual, or government agency. Place of employment includes any indoor area where two or more individuals gratuitously perform services for which individuals are ordinarily paid. A place of employment includes, but is not limited to, public conveyances, factories, warehouses, offices, retail stores, restaurants, bars, banquet facilities, theaters, food stores, banks, financial institutions, employee cafeterias, lounges, auditoriums, gymnasiums, restrooms, elevators, hallways, museums, libraries, bowling
establishments, employee medical facilities, and rooms or areas containing photocopying equipment or other office equipment used in common. Vehicles used in whole or in part for work purposes are places of employment during hours of operation if more than one person is present. An area in which work is performed in a private residence is a place of employment during hours of operation if:

(1) the homeowner uses the area exclusively and regularly as a principal place of business and has one or more on-site employees; or

(2) the homeowner uses the area exclusively and regularly as a place to meet or deal with patients, clients, or customers in the normal course of the homeowner's trade or business.

Subd. 2. **Public place.** "Public place" means any enclosed, indoor area used by the general public, including, but not limited to, restaurants; bars; any other food or liquor establishment; retail stores and other commercial establishments; educational facilities other than public schools, as defined in section 120A.05, subdivisions 9, 11, and 13; hospitals; nursing homes; auditoriums; arenas; meeting rooms; and common areas of rental apartment buildings.

Subd. 3. **Public meeting.** "Public meeting" includes all meetings open to the public pursuant to section 13D.01.

Subd. 4. **Smoking.** "Smoking" means inhaling or exhaling smoke from any lighted cigar, cigarette, pipe, or any other lighted tobacco or plant product. Smoking also includes carrying a lighted cigar, cigarette, pipe, or any other lighted tobacco or plant product intended for inhalation.

Subd. 5. **Public transportation.** "Public transportation" means public means of transportation, including light and commuter rail transit; buses; enclosed bus and transit stops; taxis, vans, limousines, and other for-hire vehicles other than those being operated by the lessee; and ticketing, boarding, and waiting areas in public transportation terminals.

**History:** 1975 c 211 s 3; 1992 c 576 s 1; 1994 c 520 s 1; 1998 c 397 art 11 s 3; 1999 c 245 art 2 s 24; 2007 c 82 s 3-7

**144.414 PROHIBITIONS.**

Subdivision 1. **Public places, places of employment, public transportation, and public meetings.** Smoking shall not be permitted in and no person shall smoke in a public place, at a public meeting, in a place of employment, or in public transportation, except as provided in this section or section 144.4167.

Subd. 2. **Day care premises.** (a) Smoking is prohibited in a day care center licensed under Minnesota Rules, parts 9503.0005 to 9503.0170, or in a family home or in a group family day care provider home licensed under Minnesota Rules, parts 9502.0300 to 9502.0445, during its hours of operation. The proprietor of a family home or group family day care provider must disclose to parents or guardians of children cared for on the premises if the proprietor permits smoking outside of its hours of operation. Disclosure must include posting on the premises a conspicuous written notice and orally informing parents or guardians.

(b) For purposes of this subdivision, the definition of smoking includes the use of electronic cigarettes, including the inhaling and exhaling of vapor from any electronic delivery device as defined in section 609.685, subdivision 1.

Subd. 3. **Health care facilities and clinics.** (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for
adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws.

(b) Except as provided in section 246.0141, smoking by patients in a locked psychiatric unit may be allowed in a separated well-ventilated area in the unit under a policy established by the administrator of the program that allows the treating physician to approve smoking if, in the opinion of the treating physician, the benefits to be gained in obtaining patient cooperation with treatment outweigh the negative impacts of smoking.

(c) For purposes of this subdivision, the definition of smoking includes the use of electronic cigarettes, including the inhaling and exhaling of vapor from any electronic delivery device as defined in section 609.685, subdivision 1.

Subd. 4. Public transportation vehicles. Smoking is prohibited in public transportation vehicles except that the driver of a public transportation vehicle may smoke when the vehicle is being used for personal use. For purposes of this subdivision, "personal use" means that the public transportation vehicle is being used by the driver for private purposes and no for-hire passengers are present. If a driver smokes under this subdivision, the driver must post a conspicuous sign inside the vehicle to inform passengers.

Subd. 5. Electronic cigarettes. (a) The use of electronic cigarettes, including the inhaling or exhaling of vapor from any electronic delivery device, as defined in section 609.685, subdivision 1, is prohibited in the following locations:

(1) any building owned or operated by the state, home rule charter or statutory city, county, township, school district, or other political subdivision;

(2) any facility owned by Minnesota State Colleges and Universities and the University of Minnesota;

(3) any facility licensed by the commissioner of human services; or

(4) any facility licensed by the commissioner of health, but only if the facility is also subject to federal licensing requirements.

(b) Nothing in this subdivision shall prohibit political subdivisions or businesses from adopting more stringent prohibitions on the use of electronic cigarettes or electronic delivery devices.

History: 1975 c 211 s 4; 1977 c 305 s 45; 1984 c 654 art 2 s 113; 1987 c 399 s 2; 1992 c 576 s 2; 1993 c 14 s 1; 1995 c 165 s 2; 1999 c 245 art 2 s 25; 1Sp2003 c 14 art 7 s 41; 2007 c 82 s 8; 2014 c 291 art 6 s 4-6; 2016 c 158 art 1 s 53

144.415 [Repealed, 2007 c 82 s 15]

144.416 RESPONSIBILITIES OF PROPRIETORS.

(a) The proprietor or other person, firm, limited liability company, corporation, or other entity that owns, leases, manages, operates, or otherwise controls the use of a public place, public transportation, place of employment, or public meeting shall make reasonable efforts to prevent smoking in the public place, public transportation, place of employment, or public meeting by:

(1) posting appropriate signs or by any other means which may be appropriate; and

(2) asking any person who smokes in an area where smoking is prohibited to refrain from smoking and, if the person does not refrain from smoking after being asked to do so, asking the person to leave. If the
person refuses to leave, the proprietor, person, or entity in charge shall handle the situation consistent with lawful methods for handling other persons acting in a disorderly manner or as a trespasser.

(b) The proprietor or other person or entity in charge of a public place, public meeting, public transportation, or place of employment must not provide smoking equipment, including ashtrays or matches, in areas where smoking is prohibited. Nothing in this section prohibits the proprietor or other person or entity in charge from taking more stringent measures than those under sections 144.414 to 144.417 to protect individuals from secondhand smoke. The proprietor or other person or entity in charge of a restaurant or bar may not serve an individual who is in violation of sections 144.411 to 144.417.

History: 1975 c 211 s 6; 2007 c 82 s 9

144.4165 TOBACCO PRODUCTS PROHIBITED IN PUBLIC SCHOOLS.

No person shall at any time smoke, chew, or otherwise ingest tobacco or a tobacco product, or inhale or exhale vapor from an electronic delivery device as defined in section 609.685, subdivision 1, in a public school, as defined in section 120A.05, subdivisions 9, 11, and 13, and no person under the age of 18 shall possess any of these items. This prohibition extends to all facilities, whether owned, rented, or leased, and all vehicles that a school district owns, leases, rents, contracts for, or controls. Nothing in this section shall prohibit the lighting of tobacco by an adult as a part of a traditional Indian spiritual or cultural ceremony. For purposes of this section, an Indian is a person who is a member of an Indian tribe as defined in section 260.755 subdivision 12.

History: 1992 c 576 s 3; 1993 c 224 art 9 s 42; 1996 c 412 art 13 s 30; 1998 c 397 art 11 s 3; 1999 c 139 art 4 s 2; 1999 c 245 art 2 s 26; 2014 c 291 art 6 s 7

144.4167 PERMITTED SMOKING.

Subdivision 1. Scientific study participants. Smoking by participants in peer reviewed scientific studies related to the health effects of smoking may be allowed in a separated room ventilated at a rate of 60 cubic feet per minute per person pursuant to a policy that is approved by the commissioner and is established by the administrator of the program to minimize exposure of nonsmokers to smoke.

Subd. 2. Traditional Native American ceremonies. Sections 144.414 to 144.417 do not prohibit smoking by a Native American as part of a traditional Native American spiritual or cultural ceremony. For purposes of this section, a Native American is a person who is a member of an Indian tribe as defined in section 260.755, subdivision 12.

Subd. 3. Private places. Except as provided in section 144.414, subdivision 2, nothing in sections 144.411 to 144.417 prohibits smoking in:

(1) private homes, private residences, or private automobiles when they are not in use as a place of employment, as defined in section 144.413, subdivision 1b; or

(2) a hotel or motel sleeping room rented to one or more guests.

Subd. 4. Tobacco products shop. Sections 144.414 to 144.417 do not prohibit the lighting of tobacco in a tobacco products shop by a customer or potential customer for the specific purpose of sampling tobacco products. For the purposes of this subdivision, a tobacco products shop is a retail establishment with an entrance door opening directly to the outside that derives more than 90 percent of its gross revenue from the sale of loose tobacco, plants, or herbs and cigars, cigarettes, pipes, and other smoking devices for burning tobacco and related smoking accessories and in which the sale of other products is merely incidental. "Tobacco
products shop" does not include a tobacco department or section of any individual business establishment with any type of liquor, food, or restaurant license.

Subd. 5. **Heavy commercial vehicles.** Sections 144.414 to 144.417 do not prohibit smoking in the cabs of motor vehicles registered under section 168.013, subdivision 1e, with a total gross weight of 26,001 pounds or greater.

Subd. 6. **Farm vehicles and construction equipment.** Sections 144.414 to 144.417 do not prohibit smoking in farm trucks, as defined in section 168.002, subdivision 8; implements of husbandry, as defined in section 168A.01, subdivision 8; and special mobile equipment, as defined in section 168.002, subdivision 31. This subdivision applies to farm trucks, implements of husbandry, and special mobile equipment, when being used for their intended purposes.

Subd. 7. **Family farms.** Sections 144.414 to 144.417 do not prohibit smoking in the house, garage, barns, and other buildings on a family farm that meet the following criteria: (1) the family farm is engaged in farming, as defined in section 500.24, subdivision 2, paragraph (a); (2) the family farm meets the definition of family farm under section 500.24, subdivision 2, paragraph (b), (c), (j), or (l); and (3) the family farm employs two or fewer persons who are not family members.

Subd. 8. **Disabled veterans rest camp.** Sections 144.414 to 144.417 do not prohibit smoking in the disabled veterans rest camp located in Washington County, established as of January 1, 2007.

Subd. 9. **Theatrical productions.** Sections 144.414 to 144.417 do not prohibit smoking by actors and actresses as part of a theatrical performance conducted in compliance with section 366.01. Notice of smoking in a performance shall be given to theater patrons in advance and shall be included in performance programs.

**History:** 2007 c 82 s 10

### 144.417 COMMISSIONER OF HEALTH, ENFORCEMENT, PENALTIES.

Subdivision 1. **Rules.** The state commissioner of health shall adopt rules necessary and reasonable to implement the provisions of sections 144.411 to 144.417.

Subd. 2. **Violations.** (a) Any proprietor, person, or entity that owns, leases, manages, operates, or otherwise controls the use of an area in which smoking is prohibited under sections 144.414 to 144.417, and that knowingly fails to comply with sections 144.414 to 144.417, is guilty of a petty misdemeanor.

(b) Any person who smokes in an area where smoking is prohibited or restricted under sections 144.414 to 144.417 is guilty of a petty misdemeanor.

(c) A proprietor, person, or entity in charge of a public place, public meeting, place of employment, or public transportation must not retaliate or take adverse action against an employee or anyone else who, in good faith, reports a violation of sections 144.414 to 144.417 to the proprietor or person in charge of the public place, public meeting, place of employment, or public transportation, or to the commissioner of health or other designee responsible for enforcing sections 144.414 to 144.417.

(d) No person or employer shall discharge, refuse to hire, penalize, discriminate against, or in any manner retaliate against any employee, applicant for employment, or customer because the employee, applicant, or customer exercises any right to a smoke-free environment provided by sections 144.414 to 144.417 or other law.
Subd. 3. **Injunction.** The state commissioner of health, a community health board as defined in section 145A.02, subdivision 5, or any affected party may institute an action in any court with jurisdiction to enjoin repeated violations of sections 144.414 to 144.417.

Subd. 4. **Local government ordinances.** (a) Nothing in sections 144.414 to 144.417 prohibits a statutory or home rule charter city or county from enacting and enforcing more stringent measures to protect individuals from secondhand smoke.

(b) Except as provided in sections 144.411 to 144.417, smoking is permitted outside of restaurants, bars, and bingo halls unless limited or prohibited by restrictions adopted in accordance with paragraph (a).

**History:** 1975 c 211 s 7; 1977 c 305 s 45; 1985 c 248 s 70; 1986 c 444; 1987 c 309 s 24; 1992 c 576 s 4,5; 1995 c 165 s 3; 2002 c 375 art 3 s 7; 2007 c 82 s 11; 2014 c 291 art 7 s 28

Subd. 5. **Directly transmitted.** "Directly transmitted" means predominately:

(1) sexually transmitted;

(2) bloodborne; or
NURSING HOME ADMISSION CONTRACTS; CARE OF RESIDENTS

144.6501 NURSING HOME ADMISSION CONTRACTS.

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

(a) "Facility" means a nursing home licensed under chapter 144A or a boarding care facility licensed under sections 144.50 to 144.58.

(b) "Contract of admission," "admission contract," or "admission agreement," includes, but is not limited to, all documents that a resident or resident's representative must sign at the time of, or as a condition of, admission to the facility. Oral representations and statements between the facility and the resident or resident's representative are not part of the contract of admission unless expressly contained in writing in those documents. The contract of admission must specify the obligations of the resident or the responsible party.

(c) "Legal representative" means an attorney-in-fact under a valid power of attorney executed by the prospective resident, or a conservator or guardian appointed for the prospective resident, or a representative payee appointed for the prospective resident, or other agent of limited powers.

(d) "Responsible party" means a person who has access to the resident's income and assets and who agrees to apply the resident's income and assets to pay for the resident's care or who agrees to make and complete an application for medical assistance on behalf of the resident.

Subd. 2. Waivers of liability prohibited. An admission contract must not include a waiver of facility liability for the health and safety or personal property of a resident while the resident is under the facility's supervision. An admission contract must not include a provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor any provision that requires or implies a lesser standard of care or responsibility than is required by law.

Subd. 3. Contracts of admission. (a) A facility shall make complete unsigned copies of its admission contract available to potential applicants and to the state or local long-term care ombudsman immediately upon request.

(b) A facility shall post conspicuously within the facility, in a location accessible to public view, either a complete copy of its admission contract or notice of its availability from the facility.

(c) An admission contract must be printed in black type of at least ten-point type size. The facility shall give a complete copy of the admission contract to the resident or the resident's legal representative promptly after it has been signed by the resident or legal representative.

(d) An admission contract is a consumer contract under sections 325G.29 to 325G.37.

(e) All admission contracts must state in bold capital letters the following notice to applicants for admission: "NOTICE TO APPLICANTS FOR ADMISSION. READ YOUR ADMISSION CONTRACT."
ORAL STATEMENTS OR COMMENTS MADE BY THE FACILITY OR YOU OR YOUR REPRESENTATIVE ARE NOT PART OF YOUR ADMISSION CONTRACT UNLESS THEY ARE ALSO IN WRITING. DO NOT RELY ON ORAL STATEMENTS OR COMMENTS THAT ARE NOT INCLUDED IN THE WRITTEN ADMISSION CONTRACT."

Subd. 4. Resident and facility obligations. (a) Before or at the time of admission, the facility shall make reasonable efforts to communicate the content of the admission contract to, and obtain on the admission contract the signature of, the person who is to be admitted to the facility and the responsible party. The admission contract must be signed by the prospective resident unless the resident is legally incompetent or cannot understand or sign the admission contract because of the resident's medical condition.

(b) If the resident cannot sign the admission contract, the reason must be documented in the resident's medical record by the admitting physician.

(c) If the determination under paragraph (b) has been made, the facility may request the signature of another person on behalf of the applicant, subject to the provisions of paragraph (d). The facility must not require the person to disclose any information regarding the person's personal financial assets, liabilities, or income, unless the person voluntarily chooses to become financially responsible for the resident's care. The facility must issue timely billing, respond to questions, and monitor timely payment.

(d) A person who desires to assume financial responsibility for the resident's care may contract with the facility to do so. A person other than the resident or a financially responsible spouse who signs an admission contract must not be required by the facility to assume personal financial liability for the resident's care. However, if the responsible party has signed the admission contract and fails to make timely payment of the facility obligation, or knowingly fails to spend down the resident's assets appropriately for the purpose of obtaining medical assistance, then the responsible party shall be liable to the facility for the resident's costs of care which are not paid for by medical assistance. A responsible party shall be personally liable only to the extent the resident's income or assets were misapplied.

(e) The admission contract must include written notice in the signature block, in bold capital letters, that a person other than the resident or financially responsible spouse may not be required by the facility to assume personal financial liability for the resident's care.

(f) This subdivision does not preclude the facility from obtaining the signature of a legal representative, if applicable.

Subd. 5. Public benefits eligibility. An admission contract must clearly and explicitly state whether the facility participates in the Medicare, medical assistance, or Veterans Administration programs. If the facility's participation in any of those programs is limited for any reason, the admission contract must clearly state the limitation and whether the facility is eligible to receive payment from the program for the person who is considering admission or who has been admitted to the facility.

Subd. 6. Medical assistance payment. (a) An admission contract for a facility that is certified for participation in the medical assistance program must state that neither the prospective resident, nor anyone on the resident's behalf, is required to pay privately any amount for which the resident's care at the facility has been approved for payment by medical assistance or to make any kind of donation, voluntary or otherwise. Except as permitted under section 6015 of the Deficit Reduction Act of 2005, Public Law 109-171, an admission contract must state that the facility does not require as a condition of admission, either in its admission contract or by oral promise before signing the admission contract, that residents remain in private pay status for any period of time.
(b) The admission contract must state that upon presentation of proof of eligibility, the facility will submit a medical assistance claim for reimbursement and will return any and all payments made by the resident, or by any person on the resident's behalf, for services covered by medical assistance, upon receipt of medical assistance payment.

(c) A facility that participates in the medical assistance program shall not charge for the day of the resident's discharge from the facility or subsequent days.

(d) If a facility's charges incurred by the resident are delinquent for 30 days, and no person has agreed to apply for medical assistance for the resident, the facility may petition the court under chapter 524 to appoint a representative for the resident in order to apply for medical assistance for the resident.

(e) The remedy provided in this subdivision does not preclude a facility from seeking any other remedy available under other laws of this state.

Subd. 7. Consent to treatment. An admission contract must not include a clause requiring a resident to sign a consent to all treatment ordered by any physician. An admission contract may require consent only for routine nursing care or emergency care. An admission contract must contain a clause that informs the resident of the right to refuse treatment.

Subd. 8. Written acknowledgment. An admission contract must contain a written acknowledgment that the resident has been informed of the patient's bill of rights, as required in section 144.652.

Subd. 9. Violations; penalties. (a) Violation of this section is grounds for issuance of a correction order, and if uncorrected, a penalty assessment issued by the commissioner of health, under section 144A.10. The civil fine for noncompliance with a correction order issued under this section is $250 per day.

(b) Unless otherwise expressly provided, the remedies or penalties provided by this subdivision do not preclude a resident from seeking any other remedy and penalty available under other laws of this state.

Subd. 10. Applicability. This section applies to new admissions to facilities on and after October 1, 1989. This section does not require the execution of a new admission contract for a resident who was residing in a facility before June 1, 1989. However, provisions of the admission contract that are inconsistent with or in conflict with this section are voidable at the sole option of the resident. Residents must be given notice of the changes in admission contracts according to this section and must be given the opportunity to execute a new admission contract that conforms to this section.

History: 1989 c 285 s 2; 1990 c 426 art 1 s 19; 1995 c 136 s 1,2; 2005 c 10 art 4 s 1; 2006 c 282 art 17 s 23; 2009 c 86 art 1 s 17

144.6503 FACILITIES FOR ALZHEIMER'S DISEASE OR RELATED DISORDER.

(a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, 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 facility 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.

(d) The facility shall document compliance with this section.

(e) The commissioner of health has enforcement authority under section 144A.10, subdivision 1, to ensure compliance of the training requirements in this section.

(f) At each facility inspection under section 144A.10, subdivision 2, if the facility is not in compliance, the commissioner has authority to issue a correction order under section 144A.10, subdivision 4.

History: 2003 c 37 s 1; 2008 c 230 s 2

SUBACUTE CARE WAIVERS

144.6505 SUBACUTE CARE WAIVERS.

Subdivision 1. Subacute care; waiver from state and federal rules and regulations. The commissioners of health and human services shall work with providers to examine state and federal rules and regulations governing the provision of care in nursing facilities and apply for federal waivers and pursue state law changes to any impediments to the provision of subacute care in skilled nursing facilities.

Subd. 2. Definition of subacute care. (a) For the purpose of this section, "subacute care" means comprehensive inpatient care, as further defined in this subdivision, designed for persons who:

(1) have or have had an acute illness or accident, or an acute exacerbation of a chronic illness, and who require a moderate level of service intensity;

(2) do not require, or no longer require, technologically intensive diagnosis or management;

(3) have concurrent medical, nursing, and discharge and/or nondischarge oriented rehabilitation objectives that are expected to be achieved within a specified time; and

(4) require interdisciplinary management.

(b) Subacute care includes goal-oriented treatment rendered immediately after, or as an appropriate alternative to, acute hospitalization with the goal of transitioning patients towards increased independence or lower acuity level in a cost-effective environment, to treat one or more specific active complex medical conditions or to administer one or more technically complex treatments, in the context of a patient's underlying long-term conditions and overall situation.

(c) Subacute care does not generally depend heavily on high technology monitoring or complex diagnostic procedures.

(d) Subacute care requires the coordinated services of an interdisciplinary team including physicians, nurses, and other relevant professional disciplines, who are trained and knowledgeable to assess and manage these specific conditions and perform the necessary procedures.

(e) Subacute care is provided as part of a specifically defined program.

(f) Subacute care includes more intensive care than traditional nursing facility care and less intensive care than acute care and may be provided at a variety of sites, including hospitals and skilled nursing facilities.
(g) Subacute care requires recurrent patient assessment on a daily to weekly basis and review of the clinical course and treatment plan for a limited time period ranging from several days to several months, until the condition is stabilized or a predetermined treatment course is completed.

**History:** 1995 c 207 art 7 s 8; 1995 c 263 s 14

## PATIENTS BILL OF RIGHTS

### 144.651 HEALTH CARE BILL OF RIGHTS.

Subdivision 1. **Legislative intent.** It is the intent of the legislature and the purpose of this section to promote the interests and well being of the patients and residents of health care facilities. No health care facility may require a patient or resident to waive these rights as a condition of admission to the facility. Any guardian or conservator of a patient or resident or, in the absence of a guardian or conservator, an interested person, may seek enforcement of these rights on behalf of a patient or resident. An interested person may also seek enforcement of these rights on behalf of a patient or resident who has a guardian or conservator through administrative agencies or in district court having jurisdiction over guardianships and conservatorships. Pending the outcome of an enforcement proceeding the health care facility may, in good faith, comply with the instructions of a guardian or conservator. It is the intent of this section that every patient's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and that the facility shall encourage and assist in the fullest possible exercise of these rights.

Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person. For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a person who receives health care services at an outpatient surgical center or at a birth center licensed under section 144.615. "Patient" also means a minor who is admitted to a residential program as defined in section 253C.01. For purposes of subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving mental health treatment on an outpatient basis or in a community support program or other community-based program. "Resident" means a person who is admitted to a nonacute care facility including extended care facilities, nursing homes, and boarding care homes for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age. For purposes of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, or a supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates a rehabilitation program licensed under Minnesota Rules, parts 9530.6405 to 9530.6590.

Subd. 3. **Public policy declaration.** It is declared to be the public policy of this state that the interests of each patient and resident be protected by a declaration of a patients' bill of rights which shall include but not be limited to the rights specified in this section.

Subd. 4. **Information about rights.** Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients.
in residential programs. Reasonable accommodations shall be made for people who have communication
disabilities and those who speak a language other than English. Current facility policies, inspection findings
of state and local health authorities, and further explanation of the written statement of rights shall be available
to patients, residents, their guardians or their chosen representatives upon reasonable request to the
administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section
626.557, relating to vulnerable adults.

Subd. 5. **Courteous treatment.** Patients and residents have the right to be treated with courtesy and
respect for their individuality by employees of or persons providing service in a health care facility.

Subd. 6. **Appropriate health care.** Patients and residents shall have the right to appropriate medical
and personal care based on individual needs. Appropriate care for residents means care designed to enable
residents to achieve their highest level of physical and mental functioning. This right is limited where the
service is not reimbursable by public or private resources.

Subd. 7. **Physician's identity.** Patients and residents shall have or be given, in writing, the name, business
address, telephone number, and specialty, if any, of the physician responsible for coordination of their care.
In cases where it is medically inadvisable, as documented by the attending physician in a patient's or resident's
care record, the information shall be given to the patient's or resident's guardian or other person designated
by the patient or resident as a representative.

Subd. 8. **Relationship with other health services.** Patients and residents who receive services from an
outside provider are entitled, upon request, to be told the identity of the provider. Residents shall be informed,
in writing, of any health care services which are provided to those residents by individuals, corporations, or
organizations other than their facility. Information shall include the name of the outside provider, the address,
and a description of the service which may be rendered. In cases where it is medically inadvisable, as
documented by the attending physician in a patient's or resident's care record, the information shall be given
to the patient's or resident's guardian or other person designated by the patient or resident as a representative.

Subd. 9. **Information about treatment.** Patients and residents shall be given by their physicians complete
and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required
by the physician's legal duty to disclose. This information shall be in terms and language the patients or
residents can reasonably be expected to understand. Patients and residents may be accompanied by a family
member or other chosen representative, or both. This information shall include the likely medical or major
psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as
documented by the attending physician in a patient's or resident's medical record, the information shall be
given to the patient's or resident's guardian or other person designated by the patient or resident as a
representative. Individuals have the right to refuse this information.

Every patient or resident suffering from any form of breast cancer shall be fully informed, prior to or at
the time of admission and during her stay, of all alternative effective methods of treatment of which the
treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or
combinations of treatments and the risks associated with each of those methods.

Subd. 10. **Participation in planning treatment; notification of family members.** (a) Patients and
residents shall have the right to participate in the planning of their health care. This right includes the
opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and
participate in formal care conferences, and the right to include a family member or other chosen representative,
or both. In the event that the patient or resident cannot be present, a family member or other representative
chosen by the patient or resident may be included in such conferences. A chosen representative may include a doula of the patient's choice.

(b) If a patient or resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the patient as the person to contact in an emergency that the patient or resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the patient or resident has an effective advance directive to the contrary or knows the patient or resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the patient or resident has executed an advance directive relative to the patient or resident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

1. examining the personal effects of the patient or resident;
2. examining the medical records of the patient or resident in the possession of the facility;
3. inquiring of any emergency contact or family member contacted under this section whether the patient or resident has executed an advance directive and whether the patient or resident has a physician to whom the patient or resident normally goes for care; and
4. inquiring of the physician to whom the patient or resident normally goes for care, if known, whether the patient or resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to the patient or resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the patient or resident and the medical records of the patient or resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the patient or resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the patient or resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

Subd. 11. **Continuity of care.** Patients and residents shall have the right to be cared for with reasonable regularity and continuity of staff assignment as far as facility policy allows.

Subd. 12. **Right to refuse care.** Competent patients and residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a patient or resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit
the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the patient's or resident's medical record.

Subd. 13. Experimental research. Written, informed consent must be obtained prior to a patient's or resident's participation in experimental research. Patients and residents have the right to refuse participation. Both consent and refusal shall be documented in the individual care record.

Subd. 14. Freedom from maltreatment. Patients and residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every patient and resident shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a patient's or resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.

Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance.

Subd. 16. Confidentiality of records. Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Copies of records and written information from the records shall be made available in accordance with this subdivision and sections 144.291 to 144.298. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third-party payment contracts, or where otherwise provided by law.

Subd. 17. Disclosure of services available. Patients and residents shall be informed, prior to or at the time of admission and during their stay, of services which are included in the facility's basic per diem or daily room rate and that other services are available at additional charges. Facilities shall make every effort to assist patients and residents in obtaining information regarding whether the Medicare or medical assistance program will pay for any or all of the aforementioned services.

Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests.

Subd. 19. Personal privacy. Patients and residents shall have the right to every consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Facility staff shall respect the privacy of a resident's room by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable.

Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place.
Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.

Subd. 21. **Communication privacy.** Patients and residents may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Patients and residents shall have access, at their expense, to writing instruments, stationery, and postage. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician in the medical record. There shall be access to a telephone where patients and residents can make and receive calls as well as speak privately. Facilities which are unable to provide a private area shall make reasonable arrangements to accommodate the privacy of patients’ or residents’ calls. Upon admission to a facility where federal law prohibits unauthorized disclosure of patient or resident identifying information to callers and visitors, the patient or resident, or the legal guardian or conservator of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian or conservator of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility. This right is limited where medically inadvisable, as documented by the attending physician in a patient's or resident's care record. Where programmatically limited by a facility abuse prevention plan pursuant to section 626.557, subdivision 14, paragraph (b), this right shall also be limited accordingly.

Subd. 22. **Personal property.** Patients and residents may retain and use their personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients or residents, and unless medically or programmatically contraindicated for documented medical, safety, or programmatic reasons. The facility must either maintain a central locked depository or provide individual locked storage areas in which residents may store their valuables for safekeeping. The facility may, but is not required to, provide compensation for or replacement of lost or stolen items.

Subd. 23. **Services for the facility.** Patients and residents shall not perform labor or services for the facility unless those activities are included for therapeutic purposes and appropriately goal-related in their individual medical record.

Subd. 24. **Choice of supplier.** Residents may purchase or rent goods or services not included in the per diem rate from a supplier of their choice unless otherwise provided by law. The supplier shall ensure that these purchases are sufficient to meet the medical or treatment needs of the residents.

Subd. 25. **Financial affairs.** Competent residents may manage their personal financial affairs, or shall be given at least a quarterly accounting of financial transactions on their behalf if they delegate this responsibility in accordance with the laws of Minnesota to the facility for any period of time.

Subd. 26. **Right to associate.** (a) Residents may meet with and receive visitors and participate in activities of commercial, religious, political, as defined in section 203B.11 and community groups without interference.
at their discretion if the activities do not infringe on the right to privacy of other residents or are not programmatically contraindicated. This includes:

(1) the right to join with other individuals within and outside the facility to work for improvements in long-term care;

(2) the right to visitation by an individual the patient has appointed as the patient's health care agent under chapter 145C;

(3) the right to visitation and health care decision making by an individual designated by the patient under paragraph (c).

(b) Upon admission to a facility where federal law prohibits unauthorized disclosure of patient or resident identifying information to callers and visitors, the patient or resident, or the legal guardian or conservator of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian or conservator of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility.

(c) Upon admission to a facility, the patient or resident, or the legal guardian or conservator of the patient or resident, must be given the opportunity to designate a person who is not related who will have the status of the patient's next of kin with respect to visitation and making a health care decision. A designation must be included in the patient's health record. With respect to making a health care decision, a health care directive or appointment of a health care agent under chapter 145C prevails over a designation made under this paragraph. The unrelated person may also be identified as such by the patient or by the patient's family.

Subd. 27. Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies.

Subd. 28. Married residents. Residents, if married, shall be assured privacy for visits by their spouses and, if both spouses are residents of the facility, they shall be permitted to share a room, unless medically contraindicated and documented by their physicians in the medical records.

Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments.

Subd. 30. Protection and advocacy services. Patients and residents shall have the right of reasonable access at reasonable times to any available rights protection services and advocacy services so that the patient
may receive assistance in understanding, exercising, and protecting the rights described in this section and in other law. This right shall include the opportunity for private communication between the patient and a representative of the rights protection service or advocacy service.

Subd. 31. Isolation and restraints. A minor patient who has been admitted to a residential program as defined in section 253C.01 has the right to be free from physical restraint and isolation except in emergency situations involving a likelihood that the patient will physically harm the patient's self or others. These procedures may not be used for disciplinary purposes, to enforce program rules, or for the convenience of staff. Isolation or restraint may be used only upon the prior authorization of a physician, psychiatrist, or licensed psychologist, only when less restrictive measures are ineffective or not feasible and only for the shortest time necessary.

Subd. 32. Treatment plan. A minor patient who has been admitted to a residential program as defined in section 253C.01 has the right to a written treatment plan that describes in behavioral terms the case problems, the precise goals of the plan, and the procedures that will be utilized to minimize the length of time that the minor requires inpatient treatment. The plan shall also state goals for release to a less restrictive facility and follow-up treatment measures and services, if appropriate. To the degree possible, the minor patient and the minor patient's parents or guardian shall be involved in the development of the treatment and discharge plan.

Subd. 33. Restraints. (a) Competent nursing home residents, family members of residents who are not competent, and legally appointed conservators, guardians, and health care agents as defined under section 145C.01, have the right to request and consent to the use of a physical restraint in order to treat the medical symptoms of the resident.

(b) Upon receiving a request for a physical restraint, a nursing home shall inform the resident, family member, or legal representative of alternatives to and the risks involved with physical restraint use. The nursing home shall provide a physical restraint to a resident only upon receipt of a signed consent form authorizing restraint use and a written order from the attending physician that contains statements and determinations regarding medical symptoms and specifies the circumstances under which restraints are to be used.

(c) A nursing home providing a restraint under paragraph (b) must:

(1) document that the procedures outlined in that paragraph have been followed;

(2) monitor the use of the restraint by the resident; and

(3) periodically, in consultation with the resident, the family, and the attending physician, reevaluate the resident's need for the restraint.

(d) A nursing home shall not be subject to fines, civil money penalties, or other state or federal survey enforcement remedies solely as the result of allowing the use of a physical restraint as authorized in this subdivision. Nothing in this subdivision shall preclude the commissioner from taking action to protect the health and safety of a resident if:

(1) the use of the restraint has jeopardized the health and safety of the resident; and

(2) the nursing home failed to take reasonable measures to protect the health and safety of the resident.

(e) For purposes of this subdivision, "medical symptoms" include:

(1) a concern for the physical safety of the resident; and
(2) physical or psychological needs expressed by a resident. A resident's fear of falling may be the basis of a medical symptom.

A written order from the attending physician that contains statements and determinations regarding medical symptoms is sufficient evidence of the medical necessity of the physical restraint.

(f) When determining nursing facility compliance with state and federal standards for the use of physical restraints, the commissioner of health is bound by the statements and determinations contained in the attending physician's order regarding medical symptoms. For purposes of this order, "medical symptoms" include the request by a competent resident, family member of a resident who is not competent, or legally appointed conservator, guardian, or health care agent as defined under section 145C.01, that the facility provide a physical restraint in order to enhance the physical safety of the resident.

History: 1973 c 688 s 1; 1976 c 274 s 1; 1982 c 504 s 1; 1983 c 248 s 1; 1984 c 654 art 5 s 8; 1984 c 657 s 1; 1986 c 326 s 1-6; 1986 c 444; 1989 c 186 s 1; 1989 c 282 art 3 s 5; 1991 c 255 s 19; 1993 c 54 s 1-3; 1995 c 136 s 3,4; 1995 c 189 s 8; 1995 c 229 art 4 s 5,6; 1996 c 277 s 1; 1998 c 254 art 2 s 10; 1999 c 83 s 1; 2004 c 198 s 10; 2007 c 147 art 9 s 18-20; art 10 s 15; 1Sp2010 c 1 art 20 s 15; 2013 c 62 s 4; 2016 c 158 art 1 s 55

144.652 BILL OF RIGHTS NOTICE TO PATIENT OR RESIDENT; VIOLATION.

Subdivision 1. Distribution; posting. Except as provided below, section 144.651 shall be posted conspicuously in a public place in all facilities licensed under the provisions of sections 144.50 to 144.58, or 144A.02. Copies of the law shall be furnished the patient or resident and the patient or resident's guardian or conservator upon admittance to the facility. Facilities providing services to patients may delete section 144.651, subdivisions 24 to 29, and those portions of other subdivisions that apply only to residents, from copies posted or distributed to patients with appropriate notation that residents have additional rights under law. The policy statement shall include the address and telephone number of the Board of Medical Practice and/or the name and phone number of the person within the facility to whom inquiries about the medical care received may be directed. The notice shall include a brief statement describing how to file a complaint with the Office of Health Facility Complaints established pursuant to section 144A.52 concerning a violation of section 144.651 or any other state statute or rule. This notice shall include the address and phone number of the Office of Health Facility Complaints.

Subd. 2. Correction order; emergencies. A substantial violation of the rights of any patient or resident as defined in section 144.651, shall be grounds for issuance of a correction order pursuant to section 144.653 or 144A.10. The issuance or nonissuance of a correction order shall not preclude, diminish, enlarge, or otherwise alter private action by or on behalf of a patient or resident to enforce any unreasonable violation of the patient's or resident's rights. Compliance with the provisions of section 144.651 shall not be required whenever emergency conditions, as documented by the attending physician in a patient's medical record or a resident's care record, indicate immediate medical treatment, including but not limited to surgical procedures, is necessary and it is impossible or impractical to comply with the provisions of section 144.651 because delay would endanger the patient's or resident's life, health, or safety.

History: 1973 c 688 s 2; 1976 c 173 s 41; 1976 c 222 s 28; 1976 c 274 s 2; 1977 c 326 s 1; 1983 c 248 s 2; 1986 c 444; 1991 c 106 s 6
144.6521 DISCLOSURE OF FINANCIAL INTEREST.

Subdivision 1. Disclosure. No health care provider with a financial or economic interest in, or an employment or contractual arrangement that limits referral options with, a hospital, outpatient surgical center or diagnostic imaging facility, or an affiliate of one of these entities, shall refer a patient to that hospital, center, or facility, or an affiliate of one of these entities, unless the health care provider discloses in writing to the patient, in advance of the referral, the existence of such an interest, employment, or arrangement.

The written disclosure form must be printed in letters of at least 12-point boldface type and must read as follows: "Your health care provider is referring you to a facility or service in which your health care provider has a financial or economic interest."

Hospitals, outpatient surgical centers, and diagnostic imaging facilities shall promptly report to the commissioner of health any suspected violations of this section by a health care provider who has made a referral to such hospital, outpatient surgical center, or diagnostic imaging facility without providing the written notice.

Subd. 2. Posting of notice. In addition to the requirement in subdivision 1, each health care provider who makes referrals to a hospital, outpatient surgical center or diagnostic imaging facility, or an affiliate of one of these entities in which the health care provider has a financial or economic interest, or has an employment or contractual arrangement with one of these entities that limits referral options, shall post a notice of this interest, employment, or arrangement in a patient reception area or waiting room or other conspicuous public location within the provider's facility.

Subd. 3. Definition. (a) For purposes of this section, the following definitions apply.

(b) "Affiliate" means an entity that controls, is controlled by, or is under common control with another entity.

(c) "Diagnostic imaging facility" has the meaning provided in section 144.565, subdivision 4.

(d) "Employment or contractual arrangement that limits referral options" means a requirement of, or a financial incentive, provided to a health care provider to refer a patient to a specific hospital, outpatient surgical center or diagnostic imaging facility, or an affiliate of one of these entities even if other options exist for the patient.

(e) "Freestanding" has the meaning provided in section 144.565, subdivision 4.

(f) "Financial or economic interest" means a direct or indirect:

(1) equity or debt security issued by an entity, including, but not limited to, shares of stock in a corporation, membership in a limited liability company, beneficial interest in a trust, units or other interests in a partnership, bonds, debentures, notes or other equity interests or debt instruments, or any contractual arrangements;

(2) membership, proprietary interest, or co-ownership with an individual, group, or organization to which patients, clients, or customers are referred to; or

(3) employer-employee or independent contractor relationship, including, but not limited to, those that may occur in a limited partnership, profit-sharing arrangement, or other similar arrangement with any facility to which patients are referred, including any compensation between a facility and a health care provider,
the group practice of which the provider is a member or employee or a related party with respect to any of them.

(g) "Health care provider" means an individual licensed by a health licensing board as defined in section 214.01, subdivision 2, who has the authority, within the individual's scope of practice, to make referrals to a hospital, outpatient surgical center, or diagnostic imaging facility.

(h) "Mobile" has the meaning provided in section 144.565, subdivision 4.

History: 2004 c 198 s 11

144.6522 DESIGNATION OF A CAREGIVER.

Subdivision 1. Definitions. For purposes of this section:

(a) "Aftercare" means any assistance provided to a patient in the patient's residence by a caregiver designated by the patient in accordance with this section after the patient's discharge from a hospital. Assistance may include, but is not limited to, assisting with basic activities of daily living (ADLs), instrumental activities of daily living (IADLs), or carrying out medical or nursing tasks, such as managing wound care, assisting in administering medications, and operating medical equipment.

(b) "Agent" means a court-appointed guardian, the parent of a minor child whose authority to act on behalf of the patient as to health care decisions has not been restricted by the court, or a health agent authorized to act on behalf of the patient under chapter 145C.

(c) "Designated caregiver" means any individual 18 years of age or older who is designated as a caregiver by a patient to provide aftercare assistance to the patient in the patient's residence after the patient's discharge from a hospital and who, in the professional opinion of the patient's health care provider, is capable of providing aftercare assistance. A designated caregiver may include, but is not limited to, a relative, partner, friend, or neighbor who has a relationship with the patient.

(d) "Discharge" means a patient's exit or release from a hospital to the patient's residence following an inpatient admission.

(e) "Entry" means a patient's admission to a hospital for the purposes of inpatient medical care.

(f) "Hospital" means a facility licensed under sections 144.50 to 144.56.

(g) "Residence" means a dwelling that the patient considers to be the patient's home. For the purposes of this section, a residence does not include a rehabilitation facility, hospital, nursing facility, or other health care or residential facility where health care staff are responsible for performing necessary medical and nursing tasks for the patient.

Subd. 2. Opportunity to designate a caregiver. (a) A hospital shall provide each patient or, if applicable, the patient's agent with an opportunity to designate at least one caregiver no later than 24 hours upon the patient's entry into a hospital and before the patient is discharged from the hospital or transferred to another health care facility. If the patient is unconscious or otherwise incapacitated upon entry into the hospital, the hospital shall provide the patient or the patient's agent with an opportunity to designate a caregiver within 24 hours following the patient's recovery of consciousness or capacity.

(b) If the patient or the patient's agent designates an individual as a caregiver, the hospital shall record the patient's designation of caregiver, the relationship of the designated caregiver to the patient, and the name, telephone number, and address of the patient's designated caregiver in the patient's medical record.
If the patient or the patient's agent declines to designate a caregiver, the hospital shall document this in the patient's medical record.

(c) If the patientdesignates a caregiver, the hospital shall be deemed to have obtained the written consent of the patient to release medical information to the designated caregiver following the hospital's established procedures for releasing personal health information and in compliance with all federal and state laws. The patient or the patient's agent may revoke prior consent to release medical information to the designated caregiver at any time and, if consent is revoked, the hospital is not required to provide notice to the designated caregiver under subdivision 3 or provide information contained in the patient's discharge plan under subdivision 4.

(d) A patient may elect to change their designated caregiver at any time, and the hospital shall record the change in the patient's medical record within 24 hours.

(e) A designation of a caregiver by a patient or a patient's agent does not obligate the designated caregiver to perform any aftercare tasks for the patient.

Subd. 3. Notice to designated caregiver. (a) A hospital shall notify, as soon as practicable, the patient's designated caregiver of the patient's discharge or transfer to another hospital or health care facility after the patient's health care provider issues a discharge or transfer order.

(b) Failure to contact a designated caregiver or failure of the designated caregiver to be present at the hospital to receive the discharge plan and aftercare instructions described in subdivision 4 shall not interfere with or delay the discharge or transfer of the patient so long as the hospital has made a good faith effort to contact the designated caregiver within a reasonable time period. The hospital shall document the efforts made to contact the designated caregiver in the patient's medical record.

(c) This subdivision shall not apply if the patient is transferred to another health care facility due to an emergency situation.

Subd. 4. Discharge plan and aftercare instructions to designated caregiver. (a) Prior to a patient's discharge from the hospital to the patient's residence, the hospital shall consult with the designated caregiver and the patient, and issue a discharge plan that describes the patient's aftercare needs and instructions for all aftercare tasks described in the discharge plan.

(b) At a minimum, a discharge plan must include:

(1) the name and contact information of the designated caregiver;

(2) a description of and instructions for all aftercare tasks necessary to maintain the patient's ability to reside at home, taking into account the capabilities and limitations of the designated caregiver;

(3) contact information for any health care, community resources, and long-term services and supports necessary to successfully carry out the patient's discharge plan; and

(4) contact information of a hospital representative who can respond to questions about the discharge plan and instructions that are required to be provided under this subdivision after the patient has been discharged.

(c) At a minimum, the instructions for aftercare tasks included in the discharge plan must include:

(1) a live demonstration or video instruction of the aftercare tasks performed by a hospital employee, or an individual with whom the hospital has a contractual relationship who has the appropriate education
and competency in the task to be performed and is authorized to perform the task, in a culturally competent manner and in accordance with the hospital's requirements to provide language access services under state and federal law; and

(2) an opportunity for the designated caregiver and patient to ask questions about the aftercare tasks, and to provide answers to any questions in a culturally competent manner and in accordance with the hospital's requirements to provide language access services under state and federal law.

(d) The hospital shall document the discharge plan and a description of the instructions provided in the patient's medical record, including, at a minimum, the date, time, and content of the instructions provided.

Subd. 5. Limitations. (a) Nothing in this section shall be construed to create a separate private cause of action against a hospital, a hospital employee, or an individual with whom a hospital has a contractual relationship, or to otherwise supersede or replace existing duties, rights, or remedies under any other provision of state or federal law. This section does not establish a separate standard of care for use in an action against a hospital, health care facility, or health care provider.

(b) Nothing in this section shall be construed to require a patient or a patient's agent to designate a caregiver.

(c) Nothing in this section shall be construed to interfere with the powers of a health care agent operating under a valid health care directive in compliance with chapter 145C.

History: 2016 c 103 s 1

144.653 RULES; PERIODIC INSPECTIONS; ENFORCEMENT.

Subdivision 1. Rules. The state commissioner of health is the exclusive state agency charged with the responsibility and duty of inspecting all facilities required to be licensed under the provisions of sections 144.50 to 144.58. The state commissioner of health shall enforce its rules subject only to the authority of the Department of Public Safety respecting the enforcement of fire and safety standards in licensed health care facilities and the responsibility of the commissioner of human services pursuant to sections 245A.01 to 245A.16 and 252.28.

Subd. 2. Periodic inspection. All facilities required to be licensed under the provisions of sections 144.50 to 144.58 shall be periodically inspected by the state commissioner of health to ensure compliance with rules and standards. Inspections shall occur at different times throughout the calendar year. The commissioner of health may enter into agreements with political subdivisions providing for the inspection of such facilities by locally employed inspectors.

The commissioner of health shall conduct inspections and reinspections of facilities licensed under the provisions of sections 144.50 to 144.56 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 health
care 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. Enforcement. With the exception of the Department of Public Safety which has the exclusive jurisdiction to enforce state fire and safety standards, the state commissioner of health is the exclusive state agency charged with the responsibility and duty of inspecting facilities required to be licensed under the provisions of sections 144.50 to 144.58 and enforcing the rules and standards prescribed by it.

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. 4. Without notice. One or more unannounced inspections of each facility required to be licensed under the provisions of sections 144.50 to 144.58 or Minnesota Rules, chapter 4675, shall be made annually.

Subd. 5. Correction orders. Whenever a duly authorized representative of the state commissioner of health finds upon inspection of a facility required to be licensed under the provisions of sections 144.50 to 144.58 that the licensee of such facility is not in compliance with sections 144.411 to 144.417, 144.50 to 144.58, 144.651, or 626.557, or the applicable rules promulgated under those sections, a correction order shall be issued to the licensee. The correction order shall state the deficiency, cite the specific rule violated, and specify the time allowed for correction.

Subd. 6. Reinspections; fines. If upon reinspection it is found that the licensee of a facility required to be licensed under the provisions of sections 144.50 to 144.58 has not corrected deficiencies specified in the correction order, a notice of noncompliance with a correction order shall be issued stating all deficiencies not corrected. Unless a hearing is requested under subdivision 8, the licensee shall forfeit to the state within 15 days after receipt by the licensee of such notice of noncompliance with a correction order up to $1,000 for each deficiency not corrected. For each subsequent reinspection, the licensee may be fined an additional amount for each deficiency which has not been corrected. All forfeitures shall be paid into the general fund. The commissioner of health shall promulgate by rule a schedule of fines applicable for each type of uncorrected deficiency.

Subd. 7. Recovery. Any unpaid forfeitures may be recovered by the attorney general.

Subd. 8. Hearings. A licensee of a facility required to be licensed under the provisions of sections 144.50 to 144.58 is entitled to a hearing on any notice of noncompliance with a correction order issued to the licensee as a result of a reinspection, provided that the licensee makes a written request therefor within 15 days of receipt by the licensee of the notice of noncompliance with a correction order. Failure to request a hearing shall result in the forfeiture of a penalty as determined by the commissioner of health in accordance with subdivision 6. A request for a hearing shall operate as a stay during the hearing and review process of the payment of any forfeiture provided for in this section. Upon receipt of the request for a hearing, a hearing officer, who shall not be an employee of the state commissioner of health, shall be appointed by the state commissioner of health, and the hearing officer shall promptly schedule a hearing on the matter, giving at least ten days' notice of the date, time, and place of the hearing to the licensee. Upon determining that the licensee of a facility required to be licensed under sections 144.50 to 144.58 has not corrected the deficiency specified in the correction order, the hearing officer shall impose a penalty as determined by the commissioner.
of health in accordance with subdivision 6. The hearing and review thereof shall be in accordance with the relevant provisions of the Administrative Procedure Act.

Subd. 9. **Nonlimiting.** Nothing in this section shall be construed to limit the powers granted to the state commissioner of health in section 144.55.

**History:** 1973 c 688 s 3; 1975 c 310 s 6,7,37; 1976 c 173 s 42; 1977 c 305 s 45; 1Sp1981 c 4 art 1 s 76; 1983 c 312 art 1 s 16; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1986 c 444; 1987 c 209 s 23; 1989 c 209 art 2 s 1; 1991 c 286 s 4; 2004 c 198 s 12

144.6535 VARIANCE OR WAIVER.

Subdivision 1. **Request for variance or waiver.** A hospital may request that the commissioner grant a variance or waiver from the provisions of Minnesota Rules, chapter 4640 or 4645. A request for a variance or waiver must be submitted to the commissioner in writing. Each request must contain:

(1) the specific rule or rules for which the variance or waiver is requested;

(2) the reasons for the request;

(3) the alternative measures that will be taken if a variance or waiver is granted;

(4) the length of time for which the variance or waiver is requested; and

(5) other relevant information deemed necessary by the commissioner to properly evaluate the request for the variance or waiver.

Subd. 2. **Criteria for evaluation.** The decision to grant or deny a variance or waiver must be based on the commissioner's evaluation of the following criteria:

(1) whether the variance or waiver will adversely affect the health, treatment, comfort, safety, or well-being of a patient;

(2) whether the alternative measures to be taken, if any, are equivalent to or superior to those prescribed in Minnesota Rules, chapter 4640 or 4645; and

(3) whether compliance with the rule or rules would impose an undue burden upon the applicant.

Subd. 3. **Notification of variance.** The commissioner must notify the applicant in writing of the decision. If a variance or waiver is granted, the notification must specify the period of time for which the variance or waiver is effective and the alternative measures or conditions, if any, to be met by the applicant.

Subd. 4. **Effect of alternative measures or conditions.** (a) Alternative measures or conditions attached to a variance or waiver have the same force and effect as the rules under Minnesota Rules, chapter 4640 or 4645, and are subject to the issuance of correction orders and penalty assessments in accordance with section 144.55.

(b) Fines for a violation of this section shall be in the same amount as that specified for the particular rule for which the variance or waiver was requested.

Subd. 5. **Renewal.** A request for renewal of a variance or waiver must be submitted in writing at least 45 days before its expiration date. Renewal requests must contain the information specified in subdivision 1. A variance or waiver must be renewed by the commissioner if the applicant continues to satisfy the criteria in subdivision 2 and the alternative measures or conditions, if any, specified under subdivision 3 and...
demonstrates compliance with the alternative measures or conditions imposed at the time the original variance or waiver was granted.

Subd. 6. Denial, revocation, or refusal to renew. The commissioner must deny, revoke, or refuse to renew a variance or waiver if it is determined that the criteria in subdivision 2 or the alternative measures or conditions, if any, specified under subdivision 3 are not met. The applicant must be notified in writing of the reasons for the decision and informed of the right to appeal the decision.

Subd. 7. Appeal procedure. An applicant may contest the denial, revocation, or refusal to renew a variance or waiver by requesting a contested case hearing under chapter 14. The applicant must submit, within 15 days of the receipt of the commissioner's decision, a written request for a hearing. The request for hearing must set forth in detail the reasons why the applicant contends the decision of the commissioner should be reversed or modified. At the hearing, the applicant has the burden of proving that it satisfied the criteria specified in subdivision 2 or the alternative measures or conditions, if any, specified under subdivision 3, except in a proceeding challenging the revocation of a variance or waiver.

History: 2001 c 29 s 1

144.654 EXPERTS MAY BE EMPLOYED.

The state commissioner of health may employ experts in the field of health care to assist the staffs of facilities required to be licensed under the provisions of sections 144.50 to 144.58, or 144A.02, in programming and providing adequate care of the patients and residents of the facility. Alternate methods of care for patients and residents of the facilities shall be researched by the state commissioner of health using the knowledge and experience of experts employed therefor.

History: 1973 c 688 s 4; 1976 c 173 s 43; 1977 c 305 s 45

144.655 PROGRAM FOR VOLUNTARY MEDICAL AID.

Licensed physicians may visit a facility required to be licensed under the provisions of sections 144.50 to 144.58, or 144A.02, and examine patients and residents thereof under a program which shall be established by the state commissioner of health and regulated and governed by rules promulgated by the state commissioner of health pursuant to the Administrative Procedure Act. The rules shall protect the privacy of patients and residents of facilities. No patient or resident of any facility shall be required to submit to an examination under the program. The state commissioner of health shall consult with medical schools and other experts for the purpose of establishing the program. The state commissioner of health shall encourage the active participation of all licensed physicians on a voluntary basis in the program.

History: 1973 c 688 s 5; 1976 c 173 s 44; 1977 c 305 s 45

144.656 EMPLOYEES TO BE COMPENSATED.

All employees of facilities required to be licensed under the provisions of sections 144.50 to 144.58, or 144A.02, participating in orientation programs or in in-service training provided by the facility shall be compensated therefor at their regular rate of pay, provided, however, that this section will be effective only to the extent that facilities are reimbursed for the compensation by the commissioner of human services in the proportion of welfare to total residents and patients in the facility.

History: 1973 c 688 s 6; 1976 c 173 s 45; 1984 c 654 art 5 s 58
144.657 VOLUNTEER EFFORTS ENCOURAGED.

The state commissioner of health, through the dissemination of information to appropriate organizations, shall encourage citizens to promote improved care in facilities required to be licensed under the provisions of sections 144.50 to 144.58, or 144A.02, throughout the state.

History: 1973 c 688 s 7; 1976 c 173 s 46; 1977 c 305 s 45

EPIDEMIOLOGICAL DATA

144.658 EPIDEMIOLOGICAL DATA DISCOVERY.

Notwithstanding any law to the contrary, health data on an individual collected by public health officials conducting an epidemiologic investigation to reduce morbidity or mortality is not subject to discovery in a legal action.

History: 1985 c 298 s 41

144.6581 DETERMINATION OF WHETHER DATA IDENTIFIES INDIVIDUALS.

The commissioner of health may: (1) withhold access to health or epidemiologic data if the commissioner determines the data are data on an individual, as defined in section 13.02, subdivision 5; or (2) grant access to health or epidemiologic data, if the commissioner determines the data are summary data as defined in section 13.02, subdivision 19. In the exercise of this discretion, the commissioner shall consider whether the data requested, alone or in combination, may constitute information from which an individual subject of data may be identified using epidemiologic methods. In making this determination, the commissioner shall consider disease incidence, associated risk factors for illness, and similar factors unique to the data by which it could be linked to a specific subject of the data. This discretion is limited to health or epidemiologic data maintained by the commissioner of health or a community health board, as defined in section 145A.02.

History: 1993 c 351 s 26; 2014 c 291 art 7 s 28

144.6585 IDENTIFICATION OF HEALTH CARE PROVIDERS.

Any health care provider who is licensed, credentialed, or registered by a health-related licensing board as defined under section 214.01, subdivision 2, must wear a name tag that indicates by words, letters, abbreviations, or insignia the profession or occupation of the individual. The name tag must be worn whenever the health care provider is rendering health services to a patient, unless wearing the name tag would create a safety or health risk to the patient. The failure to wear a name tag is not reportable under chapter 214.

History: 1997 c 237 s 15

SEXUAL ASSAULT VICTIMS RIGHTS

144.6586 NOTICE OF RIGHTS TO SEXUAL ASSAULT VICTIM.

Subdivision 1. Notice required. A hospital shall give a written notice about victim rights and available resources to a person seeking medical services in the hospital who reports to hospital staff or presents evidence of a sexual assault or other unwanted sexual contact or sexual penetration. The hospital shall make a good faith effort to provide this notice prior to medical treatment or the examination performed for the purpose of gathering evidence, subject to applicable federal and state laws and regulations regarding the
### CHAPTER 144A.01-144A.37

**NURSING HOMES AND HOME CARE**

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144A.001 MS 2006 [Renumbered 15.001]

144A.01 DEFINITIONS.

Subd. 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. (a) "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:

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

(2) the land on which a nursing home is located;

(3) the structure in which a nursing home is located;

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

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

(b) "Controlling person" does not include:
(1) 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;

(2) 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;

(3) a natural person who is a member of a tax-exempt organization under section 290.05, subdivision 2, 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

(4) a natural person who owns less than five percent of the outstanding common shares of a corporation:
   (i) whose securities are exempt by virtue of section 80A.45, clause (6); or
   (ii) 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; 2012 c 187 art 1 s 22
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. 3b. Nursing homes; tuberculosis prevention and control. (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

(b) Written compliance with this subdivision must be maintained by the nursing home.

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.

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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. 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, part 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 144.0721 and 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 treated according to the comprehensive assessment and care plan.

Subd. 12. **Resident positioning.** Notwithstanding Minnesota Rules, part 4658.0525, subpart 4, the position of residents unable to change their own position must be changed based on the comprehensive assessment and 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; 2009 c 174 art 2 s 2,3; 2013 c 43 s 15; 2014 c 192 art 4 s 2; 2016 c 158 art 1 s 56

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 in accordance with chapter 326A 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; 2010 c 191 s 4

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. Certified beds in facilities which do not allow medical assistance intake shall be deemed to be decertified for purposes of this section only.

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 increase in beds; hardship areas. (a) The commissioner of health, in coordination with the commissioner of human services, may approve the addition of new licensed and Medicare and Medicaid certified nursing home beds, using the criteria and process set forth in this subdivision.

(b) The commissioner, in cooperation with the commissioner of human services, shall consider the following criteria when determining that an area of the state is a hardship area with regard to access to nursing facility services:

(1) a low number of beds per thousand in a specified area using as a standard the beds per thousand people age 65 and older, in five year age groups, using data from the most recent census and population projections, weighted by each group's most recent nursing home utilization, of the county at the 20th percentile, as determined by the commissioner of human services;

(2) a high level of out-migration for nursing facility services associated with a described area from the county or counties of residence to other Minnesota counties, as determined by the commissioner of human services, using as a standard an amount greater than the out-migration of the county ranked at the 50th percentile;

(3) an adequate level of availability of noninstitutional long-term care services measured as public spending for home and community-based long-term care services per individual age 65 and older, in five year age groups, using data from the most recent census and population projections, weighted by each group's most recent nursing home utilization, as determined by the commissioner of human services using as a standard an amount greater than the 50th percentile of counties;

(4) there must be a declaration of hardship resulting from insufficient access to nursing home beds by local county agencies and area agencies on aging; and

(5) other factors that may demonstrate the need to add new nursing facility beds.
(c) On August 15 of odd-numbered years, the commissioner, in cooperation with the commissioner of human services, may publish in the State Register a request for information in which interested parties, using the data provided under section 144A.351, along with any other relevant data, demonstrate that a specified area is a hardship area with regard to access to nursing facility services. For a response to be considered, the commissioner must receive it by November 15. The commissioner shall make responses to the request for information available to the public and shall allow 30 days for comment. The commissioner shall review responses and comments and determine if any areas of the state are to be declared hardship areas.

(d) For each designated hardship area determined in paragraph (c), the commissioner shall publish a request for proposals in accordance with section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The request for proposals must be published in the State Register by March 15 following receipt of responses to the request for information. The request for proposals must specify the number of new beds which may be added in the designated hardship area, which must not exceed the number which, if added to the existing number of beds in the area, including beds in layaway status, would have prevented it from being determined to be a hardship area under paragraph (b), clause (1). Beginning July 1, 2011, the number of new beds approved must not exceed 200 beds statewide per biennium. After June 30, 2019, the number of new beds that may be approved in a biennium must not exceed 300 statewide. For a proposal to be considered, the commissioner must receive it within six months of the publication of the request for proposals. The commissioner shall review responses to the request for proposals and shall approve or disapprove each proposal by the following July 15, in accordance with section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The commissioner shall base approvals or disapprovals on a comparison and ranking of proposals using only the criteria in subdivision 4a. Approval of a proposal expires after 18 months unless the facility has added the new beds using existing space, subject to approval by the commissioner, or has commenced construction as defined in section 144A.071, subdivision 1a, paragraph (d). If, after the approved beds have been added, fewer than 50 percent of the beds in a facility are newly licensed, the operating payment rates previously in effect shall remain. If, after the approved beds have been added, 50 percent or more of the beds in a facility are newly licensed, operating payment rates shall be determined according to Minnesota Rules, part 9549.0057, using the limits under sections 256R.23, subdivision 5, and 256R.24, subdivision 3. External fixed costs payment rates must be determined according to section 256R.25. Property payment rates for facilities with beds added under this subdivision must be determined in the same manner as rate determinations resulting from projects approved and completed under section 144A.073.

(e) The commissioner may:

(1) 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; and

(2) 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 by an organization that is not a related organization as defined in section 256R.02, subdivision 43, to the prior licensee within 120 days after delicensure or decertification.

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 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

(v) 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 clause;

(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 or chapter 256R;

(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 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 chapter 256R. Property-related reimbursement rates shall be determined under section 256R.26, taking
into account any federal or state flood-related loans or grants provided to the facility;
(x) to license and certify to the licensee of a nursing home in Polk County that was destroyed by flood in 1997 replacement projects with a total of up to 129 beds, with at least 25 beds to be located in Polk County and up to 104 beds distributed among up to three other counties. These beds may only be distributed to counties with fewer than the median number of age intensity adjusted beds per thousand, as most recently published by the commissioner of human services. If the licensee chooses to distribute beds outside of Polk County under this paragraph, prior to distributing the beds, the commissioner of health must approve the location in which the licensee plans to distribute the beds. The commissioner of health shall consult with the commissioner of human services prior to approving the location of the proposed beds. The licensee may combine these beds with beds relocated from other nursing facilities as provided in section 144A.073, subdivision 3c. The operating payment rates for the new nursing facilities shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, parts 9549.0010 to 9549.0080. Property-related reimbursement rates shall be determined under section 256R.26. If the replacement beds permitted under this paragraph are combined with beds from other nursing facilities, the rates shall be calculated as the weighted average of rates determined as provided in this paragraph and section 256R.50;

(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 256R.40;

(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 chapter 256R. Property-related reimbursement rates shall be determined under section 256R.26, 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 chapter 256R and Minnesota Rules, parts 9549.0010 to 9549.0080; 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, 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 six months 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 six months 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 six-month restriction on placing beds on layaway after a removal of beds from layaway shall not apply. Beds may remain on layaway for up to ten 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. Nursing facilities are not required to comply with any licensure or certification requirements for beds on layaway status.

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 chapter 256R. 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;

(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 payment rate for external fixed costs for 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; and

(6) to consolidate and relocate nursing facility beds to a new site in Goodhue County and to integrate these services with other community-based programs and services under a communities for a lifetime pilot program and comprehensive plan to create innovative responses to the aging of its population. Two nursing facilities, one for 84 beds and one for 65 beds, in the city of Red Wing licensed on July 1, 2015, shall be consolidated into a newly renovated 64-bed nursing facility resulting in the delicensure of 85 beds. Notwithstanding the carryforward of the approval authority in section 144A.073, subdivision 11, the funding approved in April 2009 by the commissioner of health for a project in Goodhue County shall not carry forward. The closure of the 85 beds shall not be eligible for a planned closure rate adjustment under section 256R.40. The construction project permitted in this clause shall not be eligible for a threshold project rate adjustment under section 256B.434, subdivision 4f. The payment rate for external fixed costs for the new facility shall be increased by an amount as calculated according to items (i) to (vi):

(i) compute the estimated decrease in medical assistance residents served by both nursing facilities by multiplying the difference between the occupied beds of the two nursing facilities for the reporting year ending September 30, 2009, and the projected occupancy of the facility at 95 percent occupancy by the historical percentage of medical assistance resident days;

(ii) compute the annual savings to the medical assistance program from the delicensure by multiplying the anticipated decrease in the medical assistance residents, determined in item (i), by the hospital-owned nursing facility 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 facilities, determined in item (i), by the average monthly elderly waiver service costs for individuals in Goodhue County multiplied by 12;

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

(v) multiply the amount in item (iv) by 57.2 percent; and

(vi) divide the difference of the amount in item (iv) and the amount in item (v) 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.

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

[See Note.]
Subd. 4d. **Consolidation of nursing facilities.** (a) The commissioner of health, in consultation with the commissioner of human services, may approve a request for consolidation of nursing facilities which includes the closure of one or more facilities and the upgrading of the physical plant of the remaining nursing facility or facilities, the costs of which exceed the threshold project limit under subdivision 2, clause (a). The commissioners shall consider the criteria in this section, section 144A.073, and section 256R.40, in approving or rejecting a consolidation proposal. In the event the commissioners approve the request, the commissioner of human services shall calculate an external fixed costs rate adjustment according to clauses (1) to (3):

1. the closure of beds shall not be eligible for a planned closure rate adjustment under section 256R.40, subdivision 5;
2. the construction project permitted in this clause shall not be eligible for a threshold project rate adjustment under section 256B.434, subdivision 4f, or a moratorium exception adjustment under section 144A.073; and
3. the payment rate for external fixed costs for a remaining facility or facilities shall be increased by an amount equal to 65 percent of the projected net cost savings to the state calculated in paragraph (b), divided by the state's medical assistance percentage of medical assistance dollars, and then divided by estimated medical assistance resident days, as determined in paragraph (c), of the remaining nursing facility or facilities in the request in this paragraph. The rate adjustment is effective on the first day of the month of January or July, whichever date occurs first following both the completion of the construction upgrades in the consolidation plan and the complete closure of the facility or facilities designated for closure in the consolidation plan. If more than one facility is receiving upgrades in the consolidation plan, each facility's date of construction completion must be evaluated separately.

(b) For purposes of calculating the net cost savings to the state, the commissioner shall consider clauses (1) to (7):

1. the annual savings from estimated medical assistance payments from the net number of beds closed taking into consideration only beds that are in active service on the date of the request and that have been in active service for at least three years;
2. the estimated annual cost of increased case load of individuals receiving services under the elderly waiver;
3. the estimated annual cost of elderly waiver recipients receiving support under housing support under chapter 256I;
4. the estimated annual cost of increased case load of individuals receiving services under the alternative care program;
5. the annual loss of license surcharge payments on closed beds;
6. the savings from not paying planned closure rate adjustments that the facilities would otherwise be eligible for under section 256R.40; and
7. the savings from not paying external fixed costs payment rate adjustments from submission of renovation costs that would otherwise be eligible as threshold projects under section 256B.434, subdivision 4f.

(c) For purposes of the calculation in paragraph (a), clause (3), the estimated medical assistance resident days of the remaining facility or facilities shall be computed assuming 95 percent occupancy multiplied by

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the historical percentage of medical assistance resident days of the remaining facility or facilities, as reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, multiplied by 365.

(d) For purposes of net cost of savings to the state in paragraph (b), the average occupancy percentages will be those reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, and the average payment rates shall be calculated based on the approved payment rates in effect at the time the consolidation request is submitted.

(e) To qualify for the external fixed costs payment rate adjustment under this subdivision, the closing facilities shall:

1. submit an application for closure according to section 256R.40, subdivision 2; and
2. follow the resident relocation provisions of section 144A.161.

(f) The county or counties in which a facility or facilities are closed under this subdivision shall not be eligible for designation as a hardship area under subdivision 3 for five years from the date of the approval of the proposed consolidation. The applicant shall notify the county of this limitation and the county shall acknowledge this in a letter of support.

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 Minnesota Rules, part 9549.0060, subpart 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; 2010 c 329 art 1 s 1; 2010 c 352 art 1 s 2; 2011 c 22 art 1 s 2,3; art 2 s 1; 2012 c 216 art 9 s 1,2; art 14 s 1; 2013 c 63 s 3; 2013 c 108 art 7 s 2; 2015 c 71 art 6 s 2; 2016 c 99 art 2 s 1; 2016 c 140 s 1,2; 2017 c 40 art 1 s 22-25; 1Sp2017 c 6 art 2 s 39; art 3 s 4; art 14 s 2-4

NOTE: The amendment to subdivision 4c by Laws 2016, chapter 140, section 1, is effective for rate years beginning on or after January 1, 2017, except that the amendment to paragraph (a), clause (6), transferring the rate adjustment in items (i) to (vi) from the property payment rate to the payment rate for external fixed costs, is effective for rate years beginning on or after January 1, 2017, or upon completion of the closure and new construction authorized in paragraph (a), clause (6), whichever is later. The commissioner of human services shall notify the revisor of statutes when the subdivision is effective.

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;

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(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 4a, clauses (1), (4), (5), (6), and (8), and other criteria established in rule or law. The commissioner of human services shall determine the allowable payment rates of the facility receiving the beds in accordance with section 256R.50. The commissioner shall approve or disapprove a project within 90 days.

(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. [Repealed, 2011 c 22 art 1 s 8]

Subd. 4a. Criteria for review. In reviewing the application materials and submitted costs by an applicant to the moratorium process, the review panel shall consider the following criteria in recommending proposals:

(1) the extent to which the proposed nursing home project is integrated with other health and long-term care services for older adults;

(2) the extent to which the project provides for the complete replacement of an outdated physical plant;

(3) the extent to which the project results in a reduction of nursing facility beds in an area that has a relatively high number of beds per thousand occupied by persons age 85 and over;

(4) the extent to which the project produces improvements in health; safety, including life safety code corrections; quality of life; and privacy of residents;

(5) the extent to which, under the current facility ownership and management, the provider has shown the ability to provide good quality of care based on health-related findings on certification surveys, quality indicator scores, and quality-of-life scores, including those from the Minnesota nursing home report card;

(6) the extent to which the project integrates the latest technology and design features in a way that improves the resident experience and improves the working environment for employees;

(7) the extent to which the sustainability of the nursing facility can be demonstrated based on the need for services in the area and the proposed financing of the project; and

(8) the extent to which the project provides or maintains access to nursing facility services needed in the community.
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. [Repealed, 2012 c 247 art 4 s 51]

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.

Subd. 12. **Extension of approval of moratorium exception projects.** Notwithstanding subdivision 3, the commissioner of health shall extend project approval by an additional 18 months for an approved proposal for an exception to the nursing home licensure and certification moratorium if the proposal was approved under this section between July 1, 2007, and June 30, 2009.

Subd. 13. **Moratorium exception funding.** In fiscal year 2013, the commissioner of health may approve moratorium exception projects under this section for which the full annualized state share of medical assistance costs does not exceed $1,000,000 plus any carryover of previous appropriations for this purpose.

Subd. 14. **Moratorium exception funding.** In fiscal year 2015, the commissioner of health may approve moratorium exception projects under this section for which the full annualized state share of medical assistance costs does not exceed $1,000,000 plus any carryover of previous appropriations for this purpose.
Subd. 15. Moratorium exception funding. In fiscal year 2017, the commissioner may approve moratorium exception projects under this section for which the full annualized state share of medical assistance costs does not exceed $1,000,000 plus any carryover of previous appropriations for this purpose.

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; 2009 c 79 art 8 s 6; 2009 c 101 art 2 s 109; 2011 c 22 art 1 s 4,5; 2012 c 247 art 4 s 2; 2014 c 312 art 27 s 3; 2016 c 189 art 18 s 1-3; 2017 c 40 art 1 s 26

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.

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. [Repealed, 2017 c 40 art 1 s 122]

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 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 572B.12 and the notice provisions of section 572B.15, subsection (c), 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; 2014 c 275 art 1 s 23; 2015 c 21 art 1 s 28; 2016 c 158 art 1 s 57; 1Sp2017 c 6 art 14 s 5

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

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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.

(a) 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.

(b) By January 2012, the commissioner of health shall work with providers and the ombudsman for long-term care 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. eliminate the requirement for written plans of correction from nursing homes for federal deficiencies issued at a scope and severity that is not widespread, harmful, or in immediate jeopardy; and
2. issue the federal survey form electronically to nursing homes.

The commissioner shall issue a report to the legislative chairs of the committees with jurisdiction over health and human services by January 31, 2012, on the status of implementation of this paragraph.

**History:** 1999 c 245 art 3 s 7; 1Sp2011 c 9 art 2 s 19

### 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;
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 4655.5400;
(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; 2016 c 158 art 1 s 58
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 designee 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 [Repealed, 2015 c 74 s 13]

144A.15 STATE RECEIVERSHIP.

Subd. 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 should not be appointed receiver to operate the facility. The petition to the district court shall contain proof by affidavit that one or more of the following exists:

1. the commissioner of health has commenced proceedings to suspend or revoke the state license, or refuses to renew a license;

2. violations of section 1919(b), (c), or (d), of the Social Security Act, or the regulations adopted under that section, or violations of state laws or rules, create an emergency for the residents of the facility;

3. there is a threat of imminent abandonment by the owner or operator;

4. there is a pattern of failure to meet ongoing financial obligations such as failing to pay for food, pharmaceuticals, personnel, or required insurance;

5. the Centers for Medicare and Medicaid Services (CMS) has appointed a temporary manager to oversee the operation of the facility; or

6. notice by CMS has been given that the federal Medicare or Medicaid provider agreement will be terminated, revoked, canceled, or not renewed.

The order to show cause shall be personally served to either the nursing home administrator or to the person designated as the agent 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 receivership is necessary as a means of protecting the health, safety, or welfare of a resident of the facility, the court shall appoint the commissioner of health as a receiver to take charge of the facility. The commissioner may enter into an
agreement for a managing agent to work on the commissioner's behalf in operating the facility during the
receivership. 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 person for each month that the receivership remains in effect but shall be reduced by the amount
that the costs of the receivership provided under section 256R.52 are in excess of the facility rate. The
controlling person may agree to waive the fair monthly rent by affidavit to the court. Notwithstanding any
other law to the contrary, no payment made to a controlling person by any state agency during a period of
receivership shall include any allowance for profit or be based on any formula which includes an allowance
for profit.

Notwithstanding state contracting requirements in chapter 16C, the commissioner shall establish and
maintain a list of qualified licensed nursing home administrators, or other qualified persons or organizations
with experience in delivering skilled health care services and the operation of long-term care facilities for
those interested in being a managing agent on the commissioner's behalf during a state receivership of a
facility. This list will be a resource for choosing a managing agent and the commissioner may update the
list at any time. A managing agent cannot be someone who: (1) is the owner, licensee, or administrator of
the facility; (2) has a financial interest in the facility at the time of the receivership or is a related party to
the owner, licensee, or administrator; or (3) has owned or operated any nursing facility or boarding care
home that has been ordered into receivership.

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 requiring the receivership, the court shall issue a temporary order for
appointment of a receiver within two days after receipt of the petition. Notice of the petition shall be served
personally on the nursing home administrator or on the person designated as the agent by the controlling
person 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) 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, determine
whether to close the facility or to make other provisions intended to keep it open. If facility closure is the
determination, the commissioner shall provide for the orderly transfer of all the nursing home's residents to
other facilities pursuant to the relocation procedures required in section 144A.161. During the receivership,
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 use the building, fixtures, furnishings,
and any accompanying consumable goods in the provision of care and services to the residents during the
receivership period. The receiver shall take action as is reasonably necessary to protect or conserve the
tangible assets or property during receivership. 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
the facility incurred during the course of the receivership and may pay obligations incurred prior to the
receivership if, in the judgment of the commissioner, these payments must be made to ensure the health,
safety, or welfare of the residents and shall deduct these expenses from rental payments owed to any controlling person by virtue of the receivership. The receiver has authority to hire, direct, manage, and discharge any employees of the facility including the administrator, director of nursing, medical director, or manager of the facility.

(b) Nothing in this section shall relieve any owner, operator, or controlling person of a facility placed in receivership of any civil or criminal liability incurred, or any duty imposed by law, by reason of acts or omissions of the owner, licensee, or controlling person prior to the order for receivership under this section, nor shall anything contained in this section be construed to suspend during the receivership any obligation of the owner, licensee, or controlling person for payment of taxes or other operating and maintenance expenses of the facility nor of the owner, licensee, or controlling person or any other person for the payment of mortgages or liens.

Subd. 4. Receiver's fee; liability; commissioner assistance. The commissioner of health, as receiver appointed by the court, may hire a managing agent to work on the commissioner's behalf to operate the facility during the receivership, and that managing agent is entitled to a reasonable fee. The receiver and its managing agent 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 and its managing agent shall not be personally liable, except for gross negligence and intentional acts. The commissioner of health shall assist the managing agent in carrying out its duties.

Subd. 5. Termination. 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:

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

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

(3) 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. Postreceivership period; facility remaining open. If a facility remains open after the receivership is concluded, a new operator is only legally responsible under state law for its actions after the receivership has concluded.

History: 1976 c 173 s 15; 1977 c 305 s 45; 1986 c 444; 1989 c 282 art 3 s 23-25; 2015 c 74 s 1; 2016 c 99 art 2 s 2; 2017 c 40 art 1 s 28

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 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 256R.52 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; 2017 c 40 art 1 s 29

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) "Change in operations" means any alteration in operations which would require or encourage the relocation of residents.

(b) "Closure" or "closing" means the cessation of operations of a facility.

(c) "Contact information" means name, address, and telephone number and, when available, e-mail address and facsimile number.

(d) "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 facility is located.
(e) "Facility" means a nursing home licensed pursuant to this chapter, or a boarding care home licensed pursuant to sections 144.50 to 144.56.

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

(g) "Plan" or "relocation plan" means a description of the process developed under subdivision 3, paragraph (b), for the relocation of residents in cases of a facility closure, reduction, or change in operations.

(h) "Reduction" means a decrease in the number of beds that would require or encourage the relocation of residents.

(i) "Relocation" means the movement of the resident to another facility or living arrangement as a result of the closing, reduction, or change in operations of a facility.

(j) "Responsible party" means an individual acting as a legal representative for the resident.

Subd. 1a. **Scope.** Where a facility is undertaking a closure, reduction, or change in operations, or where a housing with services unit registered under chapter 144D is closed because the space that it occupies is being replaced by a nursing facility bed that is being reactivated from layaway status, 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, reduce, or change operations that would require 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;
5. the Office of Ombudsman for Mental Health and Developmental Disabilities; and
6. the managed care organizations contracting with Minnesota health care programs within the county where the nursing facility is located.

(b) The written notice shall include the contact information 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, reduction, or change in operations. Only the copy of the notice provided to the county social services agency shall include a complete resident census, including resident name, date of birth, Social Security number, and medical assistance identification number if it is available.

(c) For a facility that is reducing or changing operations, after providing written notice under subdivision 5a, and prior to admission, the facility must fully inform prospective residents and their responsible parties of the intent to reduce or change operations, and of the relocation plan.

(d) A closing facility is prohibited from admitting any new residents on or after the date of the written notice provided under subdivision 5a.

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, reduce, or change operations, provide the licensee
and all parties identified in subdivision 2, paragraph (a), with the contact information 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 subdivision 2, paragraph (a), the county social services agency and licensee shall meet to develop the relocation plan. The county social services agency shall inform the Department of Health and the Department of 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 no later than 45 days after receipt of the initial notice in subdivision 2, paragraph (a). The plan shall:

1. identify the expected date of closure, reduction, or change in operations;
2. outline the process for public notification of the closure, 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 and resources, including home and community-based services;
8. identify a schedule for the timely completion of each element of the plan;
9. 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; and
10. identify the steps needed to share information and coordinate relocation efforts with managed care organizations.

(c) All parties to the plan shall refrain from any public notification of the intent to close, reduce, or change operations until a relocation plan has been established and the notice in subdivision 5a 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 related to sending the notice in subdivision 5a.** (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, the Office of the Ombudsman for Mental Health and Developmental Disabilities, facility staff that provide direct care services to the residents, and facility administration.
(b) Concurrent with the notice provided in subdivision 5a, the licensee shall provide an updated resident census summary document to the county social services agency, the Ombudsman for Long-Term Care, and the Ombudsman for Mental Health and Developmental Disabilities that includes the following information on each resident to be relocated:

1. resident name;
2. date of birth;
3. Social Security number;
4. payment source and medical assistance identification number, if applicable;
5. county of financial responsibility if the resident is enrolled in a Minnesota health care program;
6. date of admission to the facility;
7. all current diagnoses;
8. the name of and contact information for the resident's physician;
9. the name and contact information for the resident's responsible party;
10. the name of and contact information for any case manager, managed care coordinator, or other care coordinator, if known;
11. information on the resident's status related to commitment and probation; and
12. the name of the managed care organization in which the resident is enrolled, if known.

Subd. 5a. **Administrator and licensee responsibility to provide notice.** At least 60 days before the proposed date of closing, reduction, or change in operations as agreed to in the plan, the administrator shall send a written notice of closure, reduction, or change in operations to each resident being relocated, the resident's responsible party, the resident's managed care organization if it is known, the county social services agency, the commissioner of health, the commissioner of human services, the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, the resident's attending physician, and, in the case of a complete facility closure, the Centers for Medicare and Medicaid Services regional office designated representative. The notice must include the following:

1. the date of the proposed closure, reduction, or change in operations;
2. the contact information of the individual or individuals in the facility responsible for providing assistance and information;
3. notification of upcoming meetings for residents, responsible parties, and resident and family councils to discuss the plan for relocation of residents;
4. the contact information of the county social services agency contact person; and
5. the contact information of the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.

Subd. 5b. [Repealed by amendment, 2013 c 63 s 4]
Subd. 5c. **Licensee responsibility regarding placement information.** The licensee shall provide sufficient preparation to each resident to ensure safe and orderly discharge and relocation. The licensee shall assist each resident in finding placements that take into consideration quality, services, location, the resident's needs and choices, and the best interests of each resident.

Subd. 5d. **Licensee responsibility to meet with residents and responsible parties.** Following the establishment of the plan, the licensee shall conduct meetings with residents, families and responsible parties, 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, managed care organizations with residents in the facility, 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 make available to the resident at no charge transportation for up to three site visits to facilities or other living options within the county or contiguous counties.

Subd. 5f. **Licensee responsibility for resident property, funds, and communication devices.** (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 responsible party prior to relocation. The licensee shall be responsible for the transfer of the resident's possessions to a selected new location within the county or contiguous counties. The licensee shall complete the transfer of resident possessions in a timely manner.

(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 responsible party. 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 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 and reconnection of personal communication devices or services shall be completed in a timely manner.

Subd. 5g. **Licensee responsibilities for final written discharge notice and records transfer.** (a) The licensee shall provide the resident, the resident's responsible parties, the resident's managed care organization, if known, and the resident's attending physician with a final written discharge notice prior to the relocation of the resident. The notice must:

(1) be provided prior to the actual relocation; and

(2) identify the effective 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 contact information for family members, responsible parties, social service or other caseworkers, and managed care coordinators. 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), all other...
assessments, current resident diagnoses, social, behavioral, and medication information, required forms, and discharge summaries.

(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, at no charge to the resident, make arrangements or provide for the transportation of residents to the new facility or location within the county or contiguous counties. The licensee shall provide a staff person to accompany the resident during transportation to the new location within the county or contiguous counties, upon request of the resident, the resident's family, or responsible party. The discharge and relocation of residents must be conducted in a safe and orderly 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 the announcement in subdivision 5a, the licensee shall submit weekly status reports to the commissioner of health and the commissioner of human services or their designees, the Ombudsman for Long-Term Care and Ombudsman for Mental Health and Developmental Disabilities, and to the county social services agency. The status reports must be submitted in the format required by the commissioner of health and the commissioner of human services. 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 and responsible parties describing:

1. the county's role in the relocation process and in the follow-up to relocations;
2. the county social services agency contact information; and
3. the contact information for 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 responsible parties to explain the relocation process.

(f) Beginning from the initial notice given in subdivision 2, the county social services agency shall monitor compliance with all components of this section and the plan developed under subdivision 3, paragraph (b). If the licensee is not in compliance, the county social services agency shall notify the commissioner of the Department of Health and the commissioner of the Department of Human Services.

(g) Except as requested by the resident or responsible party and within the parameters of the Vulnerable Adults Act, the county social services agency, in coordination with the commissioner of health and the commissioner of human services, may halt a relocation that it deems inappropriate or dangerous to the health or safety of a resident. In situations where a resident relocation is halted, the county social services agency must notify the resident, family, responsible parties, Office of the Ombudsman for Long-Term Care and Office of the Ombudsman for Mental Health and Developmental Disabilities, and resident's managed care organization, of this action. 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 follow up with relocated residents 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 in subdivision 5a is given and discharged prior to the actual change in facility operations or reduction. County social services agency staff shall interview the resident or responsible party 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 shall conduct subsequent follow-up visits on site 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 under paragraphs (h) and (i), the county social services agency shall submit a written summary of the follow-up work to the Department of Health and the Department of Human Services in a manner approved by the commissioners.

(k) The county social services agency shall submit to the Department of Health and the Department of 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 256R.40, subdivisions 5 and 6, to offset the cost of this rate adjustment.

Subd. 11. [Repealed by amendment, 2013 c 63 s 4]

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; 2010 c 352 art 1 s 3; 2013 c 63 s 4; 2017 c 40 art 1 s 30

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 256R.40 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; 2017 c 40 art 1 s 31

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 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; 2014 c 312 art 27 s 4

144A.351 **LONG-TERM CARE SERVICES AND SUPPORTS REPORT REQUIRED.**

**Subdivision 1. Report requirements.** The commissioners of health and human services, with the cooperation of counties and in consultation with stakeholders, including persons who need or are using long-term care services and supports, lead agencies, regional entities, senior, disability, and mental health organization representatives, service providers, and community members shall prepare a report to the legislature by August 15, 2013, and biennially thereafter, regarding the status of the full range of long-term care services and supports for the elderly and children and adults with disabilities and mental illnesses in Minnesota. Any amounts appropriated for this report are available in either year of the biennium. The report shall address:

(1) demographics and need for long-term care services and supports 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 and related mental health services, housing options, and supports by county and region including:

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

   (ii) access problems, including access to the least restrictive and most integrated services and settings, regarding long-term care services; and
(iii) comparative measures of long-term care services availability, including serving people in their home
areas near family, and changes over time; and

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

Subd. 2. [Repealed, 1Sp2017 c 6 art 1 s 54]

**History:** 1Sp2003 c 14 art 2 s 11; 2007 c 147 art 6 s 1; 2012 c 247 art 4 s 3; 2012 c 298 s 2; 2013 c
108 art 2 s 2,44; art 15 s 3,4; 1Sp2017 c 6 art 1 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.37 [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.482.

Subd. 1a. Agent. "Agent" means the person upon whom all notices and orders shall be served and who is authorized to accept service of notices and orders on behalf of the home care provider.
CHAPTER 6400
BOARD OF EXAMINERS FOR NURSING HOME ADMINISTRATORS
LICENSING OF NURSING HOME ADMINISTRATORS

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Published Electronically: June 11, 2008
(4) hold permits issued by the board to serve as acting administrators under Minnesota Statutes, section 144A.27;

B. individuals and organizations which sponsor continuing education programs to enable licensees to update their knowledge and meet license renewal requirements; and

C. academic institutions which offer courses to meet the academic course requirements for nursing home administrator licensure.

**Statutory Authority:** MS s 16A.1285; 144A.21; 144A.24; 214.06

**History:** 21 SR 1564; 24 SR 1780

**Published Electronically:** June 11, 2008

6400.5100 DEFINITIONS.

Subpart 1. **Scope.** The terms used in this chapter have the meanings given them in this part.

Subp. 2. **Accredited.** "Accredited" means approved by a regional accrediting organization for higher education.

Subp. 3. **Acting administrator.** "Acting administrator" means an individual, designated by the controlling persons of the employing nursing facility, who has been issued a permit by the board under part 6400.6770.

Subp. 4. **Assistant administrator.** "Assistant administrator" means an individual who reports to the nursing home administrator, assumes charge of the facility in the administrator's absence, and has ongoing managerial and supervisory authority over both administrative and resident care functions, operations, and staff in a nursing facility.

Subp. 5. **Board.** "Board" means the Minnesota Board of Examiners for Nursing Home Administrators.

Subp. 6. **CE credit.** "CE credit" means a unit of measurement of continuing education activity.

Subp. 7. **Clock hour.** "Clock hour" means an instructional session of 60 consecutive minutes, excluding breaks, registration, meals, and social activities.

Subp. 8. **Director of nurses.** "Director of nurses" means the individual designated by a nursing facility to perform duties consistent with the responsibilities of the director of nursing services under part 4658.0505, whether in Minnesota or another jurisdiction.

Subp. 9. **Domains of practice.** "Domains of practice" means the tasks performed by nursing home administrators and the knowledge, skills, and abilities identified as necessary to perform those tasks by NAB in its job analysis of nursing home administrator. The NAB domains of practice for nursing home administrator are found in the Final Report of the Job Analysis of the Practice of Nursing Home Administrators prepared for the National Association of Boards of Examiners for Long-Term Care Administrators. This document is incorporated by reference. It is available at the State Law Library and on the board's website and is subject to change every five years.
Subp. 9a. **Hospital.** "Hospital" means a facility in which accommodation is furnished or offered for the reception and care of sick or injured patients for a continuous period longer than 24 hours for the purpose of diagnosis or treatment bearing on the physical or mental health of the patients. It does not mean a clinic or day surgery center.

Subp. 10. **License.** "License" means a written document issued by the board to indicate that the bearer has been found by the board to meet all requirements for practice as a licensed nursing home administrator in Minnesota. It includes an original license issued for meeting the requirements of part 6400.6000, a renewal license issued for meeting the requirements of part 6400.6700, and a reinstated license issued under part 6400.6750. It does not include a permit to serve as an acting administrator.

Subp. 11. **Licensee.** "Licensee" means an individual who holds a valid license to practice as a nursing home administrator granted by the board under this chapter.

Subp. 12. **NAB.** "NAB" means the National Association of Boards of Examiners for Long-Term Care Administrators, Inc.

Subp. 13. **Nursing facility.** "Nursing facility" means a facility licensed as a nursing home to provide nursing care to five or more persons under Minnesota Statutes, sections 144A.02 to 144A.10, by the Minnesota Department of Health or a similar facility licensed under similar provisions in another jurisdiction.

Subp. 14. **Nursing home administrator.** "Nursing home administrator" means an individual who has the responsibilities outlined in part 4658.0060 in a nursing facility in Minnesota or another jurisdiction and is licensed by the licensing authority of the jurisdiction responsible for the facility.

Subp. 15. **Permit.** "Permit" means the acting license referred to in Minnesota Statutes, section 144A.27, which, for purposes of this chapter, is a temporary authorization issued by the board to an individual who meets the qualifications of part 6400.6770.

Subp. 16. **Preceptor.** "Preceptor" means a nursing home administrator who meets the standards in part 6400.6600, subpart 3, and supervises an applicant for licensure during the practicum course.

Subp. 17. **Related individual.** "Related individual" means a spouse, natural or adoptive parent, stepparent, natural or adoptive grandparent, stepgrandparent, natural or adoptive child, sibling, guardian, stepbrother, stepsister, aunt, uncle, niece, nephew, first cousin, or spouse of any person named in the above groups even after the marriage ends by death or divorce.

**Statutory Authority:** *M.S. s 16A.1285; 144A.20; 144A.21; 144A.23; 144A.24; 214.06*

**History:** *21 SR 1564; 24 SR 1780; 41 SR 599*

**Published Electronically:** *September 10, 2018*

**6400.5200 USE OF TITLE.**

Only an individual who is qualified as a licensed nursing home administrator and who holds a valid license under this chapter for the current licensure period may use the title "Licensed Nursing Home Administrator" and the abbreviation "L.N.H.A." after the individual's name.
6400.6000 LICENSURE REQUIREMENTS.

The board shall issue an individual a license to practice as a nursing home administrator in Minnesota upon determining that the individual:

A. has filed a completed application for licensure under part 6400.6100;
B. meets the requirements specified in Minnesota Statutes, section 144A.20;
C. has obtained a bachelor's degree from an accredited postsecondary institution;
D. has passed the national examination for nursing home administrator developed by NAB to test knowledge of subjects pertinent to the domains of practice of nursing home administration as identified in the NAB job analysis for nursing home administrator;
E. has passed the state examination given by the board to test knowledge of Minnesota laws and rules governing nursing facility operations in Minnesota;
F. has presented evidence, as specified in part 6400.6570, that the applicant has satisfactorily completed courses in each of the areas specified in part 6400.6500, or qualifies for waivers under part 6400.6560;
G. has not had an application rejected by the board under part 6400.6100, subpart 5; and
H. has paid the fees required under part 6400.6970.

6400.6100 APPLYING FOR LICENSURE.

Subpart 1. Application contents. An individual applying for licensure shall do so on forms provided by the board. The information requested shall include personal identifying and locating data including name, home and work addresses and telephone numbers, and social security number; education and degree information; employment and practice history; licensure and disciplinary history; and information relating to criminal convictions, use of alcohol and drugs, and other issues which may reflect on ability and fitness to practice. The application shall also include a recent full-face two-inch by three-inch photograph affixed to the application as indicated and notarized as a true likeness. The notary seal shall be placed next to the picture and shall fall partly upon the photograph and partly upon the application.

Subp. 2. Applicant responsibility. An applicant must provide the board with all information, documents, and fees necessary to meet licensure requirements.
Subp. 3. **Application expiration.** Applications expire 18 months after the date the application form is filed with the board. If the applicant does not fulfill all licensure requirements within the 18-month application period, the applicant must resubmit the application and another application fee to continue to seek licensure.

Subp. 4. **Examination attempts and score expiration.**

A. If an applicant does not pass the NAB or state examination on the second attempt, the applicant must submit to the board a study plan and wait six months from the date of the examination attempt to sit for the examination a third time. If an applicant does not pass the NAB or state examination on the third attempt, the applicant must submit a revised study plan and wait one year from the date of the third examination attempt to sit for the examination a fourth time. The applicant may also be required to reapply in order to comply with subpart 3.

B. Examination scores expire two years after the date the examination was taken if the applicant has not become fully licensed within that two years.

Subp. 5. **Grounds for rejection.** The board shall reject an applicant who does not meet the requirements of part 6400.6000 within the time period of application validity. The board may reject an applicant who has been found to have committed acts in this or any other jurisdiction which, if performed by a licensee of the Minnesota board, would be grounds for discipline under part 6400.6900, subpart 1, taking into account the considerations in part 6400.6900, subpart 3.

Subp. 6. **Notice of rejection.** An applicant for licensure whose application has been rejected by the board shall be given written notice of the disqualification and the reasons for it and of the right to a hearing under Minnesota Statutes, chapter 14.

**Statutory Authority:** MS s 16A.1285; 144A.20; 144A.21; 144A.23; 144A.24; 214.06

**History:** 21 SR 1564; 41 SR 599

**Published Electronically:** December 20, 2016

**COURSE REQUIREMENTS**

**6400.6400** **GENERAL COURSE REQUIREMENTS.**

An applicant for licensure must satisfactorily complete courses to prepare the applicant to perform the duties of a nursing home administrator. The courses must include those specified in part 6400.6500.

**Statutory Authority:** MS s 16A.1285; 144A.21; 144A.24; 214.06

**History:** 21 SR 1564

**Published Electronically:** June 11, 2008
6400.6500 SPECIFIC COURSE REQUIREMENTS FOR APPLICANTS WHO APPLY BEFORE SEPTEMBER 1, 2017.

Subpart 1. Organizational management. An applicant must complete a course in organizational management covering the basic management functions of:

A. planning and objective setting;
B. organizing and delegating; and
C. observing, monitoring, and evaluating outcomes, including customer satisfaction.

Subp. 2. Managerial accounting. An applicant must complete a course in managerial accounting, beyond introductory accounting, covering:

A. budgeting and fiscal resource allocation; and
B. interpreting financial information to monitor financial performance and position and to make managerial decisions.

Subp. 3. Gerontology. An applicant must complete a course in gerontology covering:

A. the physical, social, and psychological aspects of the aging process; and
B. programs and services designed to meet the needs of the aged population.

Subp. 4. Health care and medical needs. An applicant must complete a course in health care and medical needs of nursing facility residents covering:

A. differentiation between the aging process and the disease process;
B. common conditions, issues, diseases, illnesses, disabilities, and treatments of nursing facility residents including dementia (cognitive decline including Alzheimer's disease); AIDS; pressure sores; infections; mobility, falls, and restraints; incontinence and constipation; sensory impairments; depression; nutrition; iatrogenesis (health care system induced medical problems); drug use; and end-of-life pain management; and
C. medical and pharmacological terminology.

Subp. 5. Nursing facility services, programs, and issues. An applicant must complete a course in the organization, operations, functions, services, and programs of nursing facilities covering:

A. governing and oversight bodies and their relationship to the administrator;
B. administrative responsibilities and structures;
C. operations and functions of each facility department;
D. functions and roles of professional and nonprofessional staff and consulting personnel; and
E. issues of cultural diversity and human relationships between and among employees and residents of nursing facilities and their family members.

Subp. 6. **Human resources.** An applicant must complete a course in human resource management covering:

A. staffing;
B. equal employment opportunity, affirmative action, and workforce diversity;
C. compensation and benefits;
D. coaching and performance management;
E. training and development;
F. labor relations, including union contract negotiation and administration; and
G. employment law.

Subp. 7. **Regulatory management.** An applicant must complete a course in regulatory management covering the legal, regulatory, and funding provisions and requirements governing operation of nursing facilities and health care programs including:

A. resident rights and protection from maltreatment;
B. professional and biomedical ethics, including advance directives;
C. guardianship and conservatorship;
D. liability, negligence, and malpractice;
E. data confidentiality, privacy, and practices;
F. professional licensing, certification, and reporting for staff and consulting personnel;
G. health and safety codes including OSHA and the National Life Safety Code;
H. Medicare and Medicaid, standards for managed care and subacute care, and third-party payer requirements and reimbursement;
I. federal and state nursing home survey and compliance regulations and processes;
J. requirements affecting the quality of care and life of residents, including measurement of outcomes from clinical and resident-satisfaction perspectives;
K. resident acuity and assessment methodology; and
L. quality assessment and assurance.

Subp. 8. **Information uses.** An applicant must complete a course in the accumulation and analysis of data to inform management decision making including:

A. strategic uses of data and information;
B. data accumulation, storage, integration from multiple sources, manipulation, and presentation;
C. needs assessment and analysis methodologies; and
D. measures, analysis, and assessment of outcomes including customer satisfaction and quality improvement.

Subp. 9. Practicum. An applicant must complete or have waived, based upon prior experience under part 6400.6650, subpart 1, item A, a practicum course as described in part 6400.6600.

Subp. 10. Effective date. An applicant who applies before September 1, 2017, must follow the requirements in this part.

Statutory Authority: MS s 16A.1285; 144A.20; 144A.21; 144A.23; 144A.24; 214.06
History: 21 SR 1564; 24 SR 1780; 41 SR 599
Published Electronically: December 20, 2016

6400.6550 SPECIFIC COURSE REQUIREMENTS FOR APPLICANTS WHO APPLY ON OR AFTER SEPTEMBER 1, 2017.

Subpart 1. Organizational management. An applicant must complete a course in organizational management covering the basic management functions of:

A. planning and objective setting;
B. organizing and delegating; and
C. observing, monitoring, and evaluating outcomes, including customer satisfaction.

Subp. 2. Managerial accounting. An applicant must complete a course in managerial accounting, beyond introductory accounting, covering:

A. budgeting and fiscal resource allocation; and
B. interpreting financial information to monitor financial performance and position and to make managerial decisions.

Subp. 3. Gerontology. An applicant must complete a course in gerontology covering:

A. the physical, social, and psychological aspects of the aging process; and
B. programs and services designed to meet the needs of the aged population.

Subp. 4. Health care and medical needs. An applicant must complete a course in health care and medical needs of nursing facility residents covering:

A. the anatomic and physiologic changes that are associated with the aging process;
B. the impact and management of common syndromes associated with aging, including vision and hearing impairment, nutrition and malnutrition, and balance and mobility impairment;
C. basic medical and pharmacological terminology;
D. prevention and management of conditions such as pressure ulcers and delirium;
E. common psychiatric and neurodegenerative disorders such as dementias (including Alzheimer's), depression, anxiety, psychotic disorders, and alcohol and drug abuse;
F. advance care planning and the role of palliative care and end-of-life care; and
G. emerging medical trends and technology used in the long-term care setting.

Subp. 5. **Long-term care supports and services.** An applicant must complete a course in the organization, operations, functions, services, and programs of long-term care supports and services covering:

A. governing and oversight bodies and their relationship to the administrator;
B. administrative responsibilities and structures;
C. operations and functions of each facility department;
D. functions and roles of professional and nonprofessional staff and consulting personnel; and
E. issues of cultural diversity and human relationships between and among employees and residents of nursing facilities and their family members.

Subp. 6. **Human resources.** An applicant must complete a course in human resource management covering:

A. staffing;
B. equal employment opportunity, affirmative action, and workforce diversity;
C. compensation and benefits;
D. coaching and performance management;
E. training and development;
F. labor relations, including union contract negotiation and administration;
G. employment law; and
H. workplace culture, accountability and fairness, just culture and learning concepts.

Subp. 7. **Regulatory management.** An applicant must complete a course in regulatory management covering the legal, regulatory, and funding provisions and requirements governing operations of long-term care supports and services and health care programs including:

A. resident rights, resident choice, resident risk, and protection from maltreatment;
B. professional and biomedical ethics, including advance directives;
C. guardianship and conservatorship;
D. liability, negligence, and malpractice;
E. data confidentiality, privacy, and practices;
F. professional licensing, certification, and reporting for staff and consulting personnel;
G. health and safety codes, including OSHA and the National Life Safety Code;
H. Medicare and Medicaid, standards for managed care and subacute care, and third-party payer requirements and reimbursement;
I. federal and state nursing home survey and compliance regulations and processes;
J. requirements affecting the quality of care and life of residents, including measurement of outcomes from clinical and resident-satisfaction perspectives;
K. resident acuity and assessment methodology;
L. quality assessment and assurance; and
M. customer choice.

Subp. 8. **Quality measurement and performance improvement.** An applicant must complete a course in the accumulation and analysis of data to inform management decision making including:

   A. strategic uses of data and information;
   B. data accumulation, storage, integration from multiple sources, manipulation, and presentation;
   C. needs assessment and analysis methodologies;
   D. measures, analysis, and assessment of outcomes, including customer satisfaction and quality improvement;
   E. utilizing quality measurement and performance improvement tools and methodologies; and
   F. problem-solving skills.

Subp. 9. **Practicum.** An applicant must complete or have waived, based upon prior experience under part 6400.6650, subpart 1, item A, a practicum course as described in part 6400.6600.

Subp. 10. **Effective date.** An applicant who applies on or after September 1, 2017, must follow the requirements in this part.

**Statutory Authority:**  MS s 144A.20; 144A.21; 144A.23; 144A.24; 214.06

**History:**  41 SR 599

**Published Electronically:**  December 20, 2016
**6400.6560 WAIVER OF ALL COURSE REQUIREMENTS.**

Subpart 1. **Waiver of all course requirements.** The board shall waive part 6400.6500 if the applicant meets all other licensure requirements and submits satisfactory evidence of having actively and effectively served full time for a minimum of two continuous years within the immediate past five years as the licensed nursing home administrator and chief executive officer of one or more nursing facilities in a single jurisdiction regulated by the licensing board of that jurisdiction. Time working as an acting administrator under an acting license or permit or as an administrator-in-training does not count to meet this requirement. To determine the effectiveness of the applicant's service, the board shall review the results of the two most recent regulatory inspections of the nursing facilities administered by the applicant.

Subp. 2. [Repealed, 24 SR 1780]

**Statutory Authority:** MS s 16A.1285; 144A.21; 144A.24; 214.06

**History:** 21 SR 1564; 24 SR 1780

**Published Electronically:** June 11, 2008

**6400.6570 EVIDENCE OF COURSE COMPLETION.**

Subpart 1. **Types of evidence.** Evidence to verify satisfactory completion of requirements specified in part 6400.6500 must consist of one or more of the following:

A. transcripts showing completion at an accredited academic institution of a course of study approved by NAB as providing coverage of the domains of practice identified in the job analysis performed by NAB for nursing home administrator;

B. transcripts or attestation of the program director showing completion of an academic program designated by the board as an approved academic program under part 6400.6660; or

C. transcripts and other supporting documentation such as course outlines, course catalog descriptions, and text coverage information, showing completion of individual academic courses taken for credit at an accredited postsecondary institution which meet the requirements of part 6400.6500, provided that applicants may supplement evidence of completion of an accredited academic course which covers at least two-thirds of the topics listed in part 6400.6500, subpart 1, 4, 5, 6, 7, or 8, with evidence of completion of continuing education courses for the remaining topics. The continuing education courses must be approved by the board in the same manner as the board reviews and approves clock hours for continuing education courses for licensees under part 6400.6870, subparts 2 and 3.

Subp. 2. **Supplementing evidence older than seven years.** Evidence presented under subpart 1 for completion of academic programs or academic courses taken more than seven years prior to the submittal of the information to the board must be supplemented by either:

A. evidence that the applicant has been employed within the immediate past seven years in activities requiring use of the knowledge gained in the course; or

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B. evidence that the applicant has completed continuing education within the past two years to renew and update knowledge gained in any academic course taken more than seven years prior.

Subp. 3. **No additional fees required.** No fees in excess of fees associated with the standard application process may be charged to applicants for review of continuing education courses submitted as evidence to meet course requirements.

**Statutory Authority:** MS s 16A.1285; 144A.21; 144A.24; 214.06

**History:** 21 SR 1564

**Published Electronically:** June 11, 2008

### 6400.6600 PRACTICUM COURSE.

Subpart 1. **Requirements and content.** The practicum course must be approved by the board and taken for academic credit at an accredited postsecondary institution. It must provide practical learning experiences to complement the student's academic training and work or volunteer experience in long-term care, general health care, and management. Except as provided in this subpart, the practicum must include, but need not be limited to, the following:

A. a rotation through the departments of the nursing facility to provide the student exposure to and knowledge of all functions of the nursing facility. Whenever possible, the student shall be assigned to perform tasks not requiring special skill or licensure within each department. The time to be spent in each department for a student with prior experience shall vary in relation to the prior experience of the student. The time to be spent by a student without prior experience in management, health care, or long-term care must be divided approximately equally between administrative and resident care departments. The rotation experience of every student must include time at the facility during all work shifts;

B. participation in or review of the findings and results of regulatory inspections of the facility;

C. observation of the integrative and administrative role of the administrator through attendance with the administrator at meetings with staff, governing bodies, community groups, resident councils, and other groups;

D. observation of the relationships between the facility and community and other health care providers and organizations operating in the continuum of health care;

E. participation in an in-service education session; and

F. completion of a major project, study, or research effort designed to improve operations at the facility or provide information upon which a major decision facing the facility and its management can be made.

Items B and E need not be included in the practicum of a student taking a practicum of 200 hours or less if the student has participated in the specified activities during prior health care work experience.
Subp. 2. **Facility requirements.** The practicum course must be conducted within a nursing facility and require the student's attention to practicum activities at the facility for at least 20 hours per week. Upon mutual agreement of the academic institution and nursing facility preceptor, a licensed nursing facility may serve as the practicum site for a student who is employed by the nursing facility, provided that the student is relieved of all previous duties during the time of the practicum experience.

Subp. 3. **Preceptor requirements.** The practicum must be supervised by a preceptor who is a currently licensed nursing home administrator who has been licensed and practicing as a nursing home administrator for at least two years. A preceptor may not supervise a student who is a related individual or who resides in the immediate household of the preceptor.

Subp. 4. **Faculty requirements.** Each student practicum must be coordinated with a faculty advisor from an academic institution. The faculty advisor shall work cooperatively with the preceptor to review results of student practicum experiences in the preceptor's facility. The faculty advisor shall consult periodically with each student enrolled in the practicum to review the student's experience and assist the student in relating the facility practicum experience to the other required academic courses.

**Statutory Authority:** MS s 16A.1285; 144A.21; 144A.24; 214.06

**History:** 21 SR 1564

**Published Electronically:** June 11, 2008

6400.6650 **PRACTICUM DURATION FOR APPLICANTS WHO APPLY BEFORE SEPTEMBER 1, 2017.**

Subpart 1. **Waiver and minimum number of hours.** The minimum number of hours to be spent by each individual in the practicum experience shall vary according to the following schedule:

A. waived for an individual who has one year of continuous full-time employment as the licensed administrator and chief executive officer or the assistant administrator of a nursing facility, provided that the individual presents the board evidence that the individual's employment as assistant administrator included items A to F of part 6400.6600, subpart 1. Time working as an acting administrator under an acting license or permit in the same nursing facility where the individual also served as the licensed administrator or assistant administrator is counted in meeting this standard if the individual's employment under both titles combined was one continuous year;

B. 80 hours for an individual who has served one year or more full time as a hospital administrator or hospital assistant administrator with responsibility for both resident care and administrative functions, or who has served two or more years full time as the director of nurses in a nursing facility;

C. 200 hours for an individual who has served two or more years as a department manager with supervisory and budgetary responsibility in a hospital or nursing facility. This also applies to:
(1) an individual not meeting the requirements for assistant administrator under item B or the definition in part 6400.5100, but who has otherwise held that title in a nursing facility or hospital and performed under the title for two or more years;

(2) an individual who has served as director of nurses in a hospital for two or more years; and

(3) an individual who has served two or more years as an administrator or assistant administrator of one or more long-term care facilities for 25 or more developmentally disabled residents;

D. 300 hours for an individual who has two or more years of employment in a hospital or nursing facility in any professional capacity or in any direct patient care capacity;

E. 300 hours for an individual with two or more years of managerial or administrative employment experience, including supervision of at least 25 employees and responsibility for an annual budget of at least $250,000; or

F. 400 hours for an individual with none of the experience specified in items A to E.

The amount of experience required to qualify for a practicum reduction under items C, D, and E shall be measured in full-time equivalency at the rate of 35 hours per week.

Subp. 2. Duration of individual student practicums. Each applicant must complete a 400-hour practicum unless presenting evidence to the board that the applicant has experience as described in subpart 1, items A to E, for a reduction in the number of practicum hours. The board shall determine the minimum number of hours of practicum to be completed by an applicant by comparing the applicant's experience to the requirements in subpart 1 and shall notify the applicant of the board's decision.

Subp. 3. Effective date. An applicant who applies before September 1, 2017, must follow the requirements in this part.

Statutory Authority: MS s 16A.1285; 144A.20; 144A.21; 144A.23; 144A.24; 214.06

History: 21 SR 1564; 24 SR 1780; 41 SR 599

Published Electronically: December 20, 2016

6400.6655 PRACTICUM DURATION FOR APPLICANTS WHO APPLY ON OR AFTER SEPTEMBER 1, 2017.

Subpart 1. Duration of individual student practicums. An applicant must complete a 1,000-hour practicum unless the applicant presents evidence to the board that the applicant has experience as described in subpart 2 for a reduction in the number of practicum hours. The board shall determine the minimum number of hours of practicum to be completed by an applicant by comparing the applicant's expertise to the requirements in subpart 2 and shall notify the applicant of the board's decision.
Subp. 2. Waiver and minimum number of hours. An individual may qualify for a reduction in hours or waiver of the 1,000-hour practicum by providing evidence of the following documented health care experience and satisfying the board-approved assessment tool:

A. 750 hours for an individual with two or more years of managerial or administrative employment experience, including supervision of at least 25 employees and responsibility for an annual budget of at least $1,000,000;

B. 750 hours for an individual who has two or more years of employment in a hospital or nursing facility in any professional capacity or in any direct patient care capacity;

C. 500 hours for an individual who has served two or more years as a department manager with supervisory and budgetary responsibility and meets one or more of the following criteria:

   (1) the individual does not meet the requirements for assistant administrator under item D or the definition in part 6400.5100, but has otherwise held that title in a nursing facility or hospital and has performed under the title for two or more years;

   (2) the individual has served, for two or more years, as director of nurses in a hospital or registered housing with services establishment that has an arranged comprehensive home care license; or

   (3) the individual has served as a housing manager in a registered housing with services establishment that has an arranged comprehensive home care license;

D. 200 hours for an individual who has served one or more years as a full-time hospital administrator or hospital assistant administrator with responsibility for both resident care and administrative functions, or who has served two or more years as a full-time director of nurses in a nursing facility; or

E. the documented experience requirement is waived for an individual who has one year of continuous full-time employment as the assistant administrator, chief executive officer, or equivalent role with responsibility for both resident care and administrative functions. Time working as an acting administrator under an acting license or permit in the same nursing facility where the individual also served as the assistant administrator, chief executive officer, or equivalent role meets this requirement if the individual's employment under both titles combined was one continuous year.

Subp. 3. Method of measuring experience. The amount of experience required to qualify for a practicum reduction under subpart 2, items C, D, and E, shall be measured in full-time equivalency at the rate of 35 hours per week.

Subp. 4. Effective date. An applicant who applies on or after September 1, 2017, must follow the requirements in this part.

Statutory Authority: MS s 144A.20; 144A.21; 144A.23; 144A.24; 214.06

History: 41 SR 599

Published Electronically: December 20, 2016
6400.6660  ACADEMIC PROGRAM REVIEW.

Subpart 1.  Program review and approval.  Upon request of an academic institution, the board shall review courses offered by the institution, and upon finding conformity between the proposed program and the requirements of this chapter, shall approve the institution as offering courses which meet all or some portion of the course requirements for licensure. If the institution offers courses which are approved by the board to meet all course requirements of part 6400.6500, the board shall designate the institution as an approved academic program. If the institution offers courses approved by the board to meet five or more of the courses required in part 6400.6500, the board shall designate the institution as an approved course provider.

Subp. 2.  Requesting course review.  In submitting a program of study offered by an academic institution to meet all or some of the course requirements, the institution shall provide the following information in an application package for review by the board:

A.  indication of whether the institution is requesting designation as an approved program or as an approved course provider;

B.  evidence of the institution's current accreditation by a regional accrediting organization for higher education;

C.  designation of a faculty member to serve as program director to coordinate the institution's program or course offerings with the board. The program director shall have authority to accept courses of equivalent content to those accepted by the board to fulfill academic course requirements specified in part 6400.6500 from students transferring to the institution and the program and from students enrolled in the program who cannot arrange class schedules to permit timely completion of the board-approved courses. The program director must report approval of courses so substituted to the board for each affected student who makes application for licensure to the board;

D.  evidence of the establishment and use of an advisory group of administrators and others in the long-term care industry, including names and experience of group members and frequency of meetings, to review course requirements and practicum activities in order to provide guidance to keep courses current and make student experiences reality based and practical;

E.  a description of the course of study offered or recommended by the institution for those interested in licensure as a nursing home administrator in Minnesota. Nothing in this chapter restricts institutions from designing or implementing curricula, or establishing requirements for courses, majors, or other designations offered by the institution, more comprehensive than required under this chapter for licensure;

F.  a topic-by-topic review of all course requirements outlined in part 6400.6500 showing where and how within the institution's course offerings the outlined topics are covered;

G.  an outline of each course offered by the institution to fulfill one or more of the licensure course requirements listing texts and materials used in the course; and

H.  identification of one or more qualified faculty members to:
(1) coordinate practicum experiences for students;

(2) ensure that all practicums are conducted according to the requirements of part 6400.6600;

(3) provide instruction to any administrator becoming a preceptor for the first time after September 1, 1997, regarding objectives for the practicum and procedures to follow to structure and supervise a successful practicum experience for a student; and

(4) ensure that each practicum is initiated with a signed learning agreement between the student, faculty advisor, and preceptor outlining the roles and responsibilities of all three parties, the time to be spent by the student in each facility department in relation to the student's prior experience, and the learning outcomes expected for the student.

Subp. 3. **Review and approval process.** Upon receipt of an application package for approval of an academic institution program to meet board course requirements, the board shall acknowledge receipt of the request and identify any missing requirements to the program director. Upon receipt of all required information, the board shall review all materials presented and may conduct an on-site visit or request an appearance by one or more representatives of the institution at a meeting to review all material for conformance to requirements. Board members shall base their decision to approve or reject an academic institution program on whether or not the application materials presented provide assurance that students completing the program at the institution will cover the course topics outlined in part 6400.6500 with sufficient depth to enable the board to infer student attainment of the knowledge, skills, and abilities to begin work as a nursing home administrator. If the application package and discussion with program officials fail to show compliance with the rules or to provide sufficient evidence to satisfy the board members that they can infer beginning level competency among students completing the proposed course offerings, the board shall notify the program director in writing of the deficiencies the institution must remedy. Once all deficiencies are satisfactorily remedied, the board shall grant approval to the program or courses in writing and include reference to the institution's offerings in its correspondence with students interested in learning where courses approved by the board to meet licensure requirements are available. If the deficiencies are not corrected, the board shall deny approval for the program by written notice to the program director.

Subp. 4. **Annual update.** Annually on or before September 1, the program director of an institution with an approved program or courses shall file with the board on forms prescribed by the board for that purpose a report indicating the following:

A. number of students with known intent to pursue licensure as nursing home administrators in Minnesota enrolled during the past academic year in courses meeting board requirements;

B. any changes in any of the information presented to satisfy the requirements outlined in this part and part 6400.6500 since the initial application or since the update report of the preceding year; and

C. to the extent available, a schedule of when throughout the academic year the approved courses will be offered by the institution.
Subp. 5. Five-year program review.

A. Every fifth year following the board’s initial approval of an academic institution's program or courses, the program director shall provide a complete review of the institution's program by submitting to the board by September 1 of the fifth year, a review application package in the same format and incorporating the same information as required in subpart 2 for a new program approval application. Where no change has occurred since the initial application, the program director may submit a copy of the initially submitted information with an updated date and attestation that the information is current.

B. The board shall review the five-year program review package submitted by the institution and approve or deny continued board approval for the program as provided in subpart 3. Where the board finds it necessary to deny continued approval to a program or to specific courses, the board shall provide information to the program director about ways in which students currently enrolled in the program may obtain supplementary or alternative courses to complete the requirements for licensure in view of the revocation of approval for courses offered by the institution. The program director shall provide the information to all students enrolled in the previously approved program or courses and shall work with the students to provide a smooth transition to alternative institutions offering approved courses.

C. In addition to the five-year program review, if the board receives information that the success rates fall below the national average for candidates from the program who, during any January 1 through December 31 period, wrote for the first time the national examination for nursing home administrators developed by NAB, the board must take one of the actions described in subitems (1) to (3).

   (1) If success rates are below the national average for one period, the board shall require the director to identify factors that are potentially affecting the low success rate on the licensure examination. The director shall submit a plan of corrective action by a specified date. The plan of action must be on a board-supplied form and include the signature of the director and another institutional administrative academic representative. If the following year the success rate is above the national average, no action by the board is required.

   (2) If success rates are below the national average for any two consecutive periods, the board shall notify the director of a survey to identify additional factors affecting the low success rate and review progress on the plan for corrective action submitted the previous year. The survey must include the director, faculty, students, and an institutional administrative academic representative. The director shall submit a revised plan of corrective action by a specified date. The plan of corrective action must be on a board-supplied form and include the signature of the director and another institutional administrative academic representative. If the following year the success rate is above the national average, no action is required by the board.

   (3) If success rates are below the national average for any three consecutive periods, the board shall require the director and another institutional administrative academic representative to meet with a committee of board members and board staff for a survey for compliance with all
applicable rules and for the implementation of the plan for corrective action submitted the previous year. Upon completion of the survey, the board shall take action in compliance with subpart 3.

Subp. 6. [Repealed, 41 SR 599]

Statutory Authority:  MS s 16A.1285; 144A.20; 144A.21; 144A.23; 144A.24; 214.06
History: 21 SR 1564; 41 SR 599

Published Electronically: December 20, 2016

LICENSES AND PERMITS

6400.6700 RECIPROCITY.

The board shall issue a license to a nursing home administrator who has been issued and currently holds a license as a nursing home administrator in another jurisdiction provided that:

A. the other jurisdiction maintains requirements for nursing home administrator licensure which are substantially equivalent to those required under part 6400.6000 or the applicant is currently certified as a nursing home administrator and provides the board evidence of having successfully completed a professional certification program in nursing facility administration endorsed by NAB;

B. the applicant has passed the Minnesota state examination within the immediate past two years;

C. the applicant is in good standing as a nursing home administrator in each jurisdiction from which the applicant has ever received a nursing home administrator license; and

D. the applicant has made application for licensure under part 6400.6100 and paid the applicable fees under part 6400.6970.

Statutory Authority:  MS s 16A.1285; 144A.21; 144A.24; 214.06
History: 21 SR 1564; 24 SR 1780
Published Electronically: June 11, 2008

6400.6710 LICENSEE RESPONSIBILITIES.

Each licensee shall:

A. comply with the laws of Minnesota and the rules of the board and other Minnesota state agencies regarding licensure as a nursing home administrator and operation of a nursing facility in Minnesota;

B. provide notice to the board within five working days of any change in mailing address or telephone number pursuant to Minnesota Statutes, section 13.41, subdivision 2, paragraph (b);

C. provide notice to the board within five working days of any change in employment as a nursing home administrator for a nursing facility;
D. provide notice to the board within five working days of the occurrence of any reprimand, restriction, limitation, condition, revocation, suspension, surrender, or other disciplinary action or the bringing of charges against any license the licensee holds as a nursing home administrator or other health care professional in Minnesota or any other jurisdiction; and

E. cooperate with the board by providing data, reports, or information requested by the board and complying with requests to attend conferences, meetings, or hearings scheduled by the board concerning license renewal or complaint investigation and discipline.

Statutory Authority: MS s 16A.1285; 144A.20; 144A.21; 144A.23; 144A.24; 214.06
History: 21 SR 1564; 24 SR 1780; 41 SR 599
Published Electronically: December 20, 2016

6400.6720 DISPLAYING LICENSES.

A licensee actively practicing as a nursing home administrator shall display the board-issued license, not a photocopy, in a conspicuous place in the facility which the licensee administers, visible to residents and visitors.

Statutory Authority: MS s 16A.1285; 144A.20; 144A.21; 144A.23; 144A.24; 214.06
History: 21 SR 1564; 41 SR 599
Published Electronically: December 20, 2016

6400.6730 DUPLICATE LICENSES.

Upon receipt of a notarized statement from a licensee that the licensee's license has been lost, mutilated, or destroyed, or that the licensee has had a name change, the board shall issue a duplicate license. Licensees obtaining duplicate licenses are subject to the applicable fee under part 6400.6970.

Statutory Authority: MS s 16A.1285; 144A.21; 144A.24; 214.06
History: 21 SR 1564
Published Electronically: June 11, 2008

6400.6740 RENEWING LICENSES.

Subpart 1. Forms, time for renewal. Every individual who holds a valid license as a nursing home administrator issued by the board shall annually apply to the board on or before June 1 for renewal of the individual's license and shall report any information pertinent to continued licensure requested by the board on forms provided for that purpose. The applicant shall submit evidence satisfactory to the board and subject to audit under part 6400.6800, subpart 3, that during the annual period immediately preceding the renewal application the licensee has complied with the rules of the board and completed continuing education requirements for license renewal.

Subp. 2. Fees. Upon making an application for license renewal, the licensee shall pay the annual fee as specified under part 6400.6970. If submitting CE credits which include clock hours for workshops, seminars, institutes, or home study courses which have not been preapproved by
the board, the licensee shall also pay a fee for review of clock hours based upon the total number of nonpreapproved clock hours being submitted for CE credit to meet renewal requirements. If the application for renewal has not been received by June 30 of each year, the license shall lapse and the holder of a lapsed license shall be subject to the reinstatement procedure and late renewal fees.

Subp. 3. **Exemption from renewal.** Pursuant to Minnesota Statutes, section 326.56, a licensee who is in active military service, as defined in Minnesota Statutes, section 190.05, for the armed forces of the United States or is employed outside the United States in employment that is essential to the prosecution of any war or the national defense, as defined in Minnesota Statutes, section 326.56, and whose license was in effect at the time of entry into the armed forces or engagement in employment outside the United States, is not obligated to renew licensure. The board must be notified in writing by the licensee regarding the qualifications for this exemption. The exemption ceases six months after discharge from active service or termination of the aforementioned employment. A license renewal notice shall be sent to the licensee at the time that a license renewal notice would normally be sent to the licensee. The licensee may be requested to reconfirm exempt status. If the licensee no longer qualifies for the exemption, the requirements for license renewal must be met.

**Statutory Authority:** MS s 16A.1285; 144A.20; 144A.21; 144A.23; 144A.24; 214.06

**History:** 21 SR 1564; 41 SR 599

**Published Electronically:** December 20, 2016

### 6400.6750 LICENSE REINSTATEMENT.

A nursing home administrator previously licensed in this state whose license has lapsed may apply under items A to C for reinstatement of a license within five years of the date the individual was last licensed. If an individual's license has been revoked or if the individual has not been licensed for five years or more, the license cannot be reinstated but the former licensee may apply for relicensure under the requirements in part 6400.6000.

A. If a license has been lapsed in Minnesota for less than two years prior to the date of the application for reinstatement, the board must reinstate the license if the former licensee has not had disciplinary action against a license in Minnesota or another jurisdiction during the time the Minnesota license was lapsed and the former licensee:

(1) files with the board a completed application for reinstatement;

(2) provides evidence of having completed the continuing education requirements under part 6400.6800, subpart 2, for each of the years the license has lapsed; and

(3) pays the license renewal and late fees in part 6400.6970 for each of the years the license has lapsed.

B. If a license has been lapsed in Minnesota for more than two years but less than five years prior to the date of the application for reinstatement and the former licensee has been continuously licensed as a nursing home administrator in one or more other jurisdictions since the date the license lapsed in Minnesota, the board must reinstate the license if the former licensee has not had
disciplinary action against a license in Minnesota or another jurisdiction during the time the Minnesota license was lapsed and the former licensee:

(1) files with the board a completed application for reinstatement;

(2) provides evidence of having completed the continuing education requirements under part 6400.6800, subpart 2, for each of the years the license has lapsed;

(3) pays the license renewal and late fees specified in part 6400.6970 for each of the years the license has lapsed; and

(4) successfully completes the state examination.

C. If a license has been lapsed in Minnesota for more than two years but less than five years prior to the date of the application for reinstatement and the former licensee has not been continuously licensed in one or more jurisdictions since the date the license lapsed in Minnesota, the board must reinstate the license if the former licensee has not had disciplinary action against a license in Minnesota or another jurisdiction during the time the Minnesota license was lapsed and the former licensee:

(1) files with the board a completed application for reinstatement;

(2) provides evidence of having completed the continuing education requirements under part 6400.6800, subpart 2, for each of the years the license has lapsed;

(3) pays the license renewal and late fees specified in part 6400.6970 for each of the years the license has lapsed;

(4) successfully completes the state examination; and

(5) successfully completes the NAB examination.

Statutory Authority:  MS s 16A.1285; 144A.21; 144A.24; 214.06

History:  21 SR 1564

Published Electronically:  June 11, 2008

6400.6760 VERIFICATION OF MINNESOTA LICENSE.

Upon request and payment of a fee under part 6400.6970 by the licensee, the board shall issue a certified statement of the licensee's licensure status and examination scores to another jurisdiction.

Statutory Authority:  MS s 16A.1285; 144A.21; 144A.24; 214.06

History:  21 SR 1564

Published Electronically:  June 11, 2008

6400.6770 ACTING ADMINISTRATOR PERMITS.

Subpart 1. Board to issue permits. When the controlling persons of a nursing home designate an acting nursing home administrator under Minnesota Statutes, section 144A.27, the designee
must secure an acting administrator's permit within 30 days of the termination of the previous licensed administrator. The board shall issue a permit to serve a facility as an acting administrator for up to six months from the termination of the facility's previous licensed administrator to an individual who meets the qualifications specified in subpart 2. A permit to serve a facility as an acting administrator is valid only for the holder's work with that facility and shall not be transferable to another facility. A permit to serve as acting administrator is not renewable beyond the six months for which it was issued. The board may issue a second permit to serve a facility as an acting administrator for up to six months from the expiration of the original acting administrator permit when the board finds the second permit to be in the best interests of the public. In no event shall the board issue successive permits for a total duration of longer than one year.

Subp. 2. Qualifications. An applicant for a permit to serve a facility as an acting nursing home administrator must furnish satisfactory evidence that the applicant:

A. has graduated from high school or holds a commissioner of education-selected high school equivalency certification or has completed an associate or higher degree from an accredited postsecondary institution;

B. is at least 21 years of age;

C. has experience in the management of a nursing home or related facility or program or has completed a majority of the courses required for licensure under part 6400.6500;

D. has passed within the last two years the state examination under parts 6400.6000, item E, and 6400.6100, subpart 4; and

E. is in good standing in each jurisdiction from which the applicant has ever received a nursing facility administrator license.

Statutory Authority: MS s 16A.1285; 144A.20; 144A.21; 144A.23; 144A.24; 214.06

History: 21 SR 1564; 24 SR 1780; 41 SR 599; L 2017 1Sp5 art 10 s 7

Published Electronically: August 21, 2017

CONTINUING EDUCATION

6400.6800 CONTINUING EDUCATION REQUIREMENTS.

Subpart 1. Renewal requirements. At the time of license renewal, each licensee shall provide evidence satisfactory to the board that the licensee has completed in the preceding year 20 CE credits of acceptable continuing education activities as specified in this part and part 6400.6850. Licensees in their first year of licensure shall have the number of CE credits required for license renewal prorated for the number of months they were licensed during the preceding year. For purposes of obtaining and presenting CE credits, a year shall run from May 1 to April 30.

Subp. 2. Evidence of CE requirement completion. Licensees must maintain proof as described in part 6400.6850 of having completed the number of CE credits claimed at the time of renewal and shall, upon request of the board, make that proof available for audit to verify completion of the
Subp. 3. **Audit.** The board shall annually select on a random basis at least five percent of the licensees applying for renewal to have their claims of CE credits audited for compliance with board requirements. Nothing in this subpart shall prevent the board from requiring any individual licensee to provide evidence satisfactory to the board of having completed the CE credits required for license renewal.

Subp. 4. **Acceptable content for CE activities.** Unless otherwise specified in part 6400.6850, the content of continuing education activities must relate to one or more of the following:

A. administration of services for persons needing long-term care;

B. current issues and trends in long-term care;

C. the relationship of long-term care to other aspects of the health care continuum; and

D. responsibilities, tasks, knowledges, skills, and abilities required to perform nursing home administrator functions as outlined in the NAB domains of practice.

Subp. 5. **Unacceptable content for CE activities.** Subjects for continuing education which will not be accepted to meet license renewal requirements include, but are not limited to, general personal development including stress management, facility or company orientation, facility or company policies or procedural issues, organizational functions such as business meetings and election of officers, and medical treatment at a clinical level beyond that required for licensure as a nursing home administrator.

Statutory Authority:  MS s 16A.1285; 144A.21; 144A.24; 214.06

History: 21 SR 1564

Published Electronically: June 11, 2008

6400.6850  NUMBER OF CE CREDITS FOR ACTIVITIES.

Acceptable activities to meet continuing education requirements for license renewal and the number of CE credits that licensees may obtain for each are described in items A to K.

A. A licensee who attends board-approved seminars, webinars, institutes, or workshops shall receive CE credit on a clock-hour basis for the actual amount of time spent in the seminar rounded to the nearest lower one-quarter hour. To verify clock hours of attendance at seminars, institutes, or workshops, a licensee must maintain an attendance certificate provided by the sponsoring organization.

B. A licensee who completes board-approved home study courses, including correspondence work, televised courses, and audio or video tapes, shall receive CE credit for the number of clock hours reasonably required to complete the home study course as determined by the board. To verify completion of the course, the licensee must maintain a certificate of course completion from the
sponsor which must include evidence of successful completion of a test corrected by the sponsor to ascertain attainment of the knowledge conveyed in the course.

C. A licensee who attends seminars, webinars, institutes, or workshops, or completes home study courses approved by the NAB/National Continuing Education Review Service (NCERS), shall receive CE credit on the basis of clock hours assigned by NAB/NCERS. To verify clock hours of attendance at NAB approved seminars, institutes, or workshops, or completion of NAB approved home study courses, the licensee must maintain a certificate provided by the NAB approved sponsor.

D. A licensee who attends, in another state, seminars, webinars, institutes, or workshops approved by the nursing home administrator licensing authority of the other state shall receive CE credit on the basis of the number of clock hours attended. To verify clock hours of attendance at seminars, institutes, or workshops approved by another state licensing authority, the licensee must maintain a certificate of attendance from the sponsor including verification of the approval from the state licensing authority.

E. A licensee who completes academic courses applicable to the domains of practice taken at an accredited postsecondary institution shall receive nine CE credits per quarter credit and 12 CE credits per semester credit. To verify completion of academic courses the licensee must maintain a copy of an academic transcript showing the course grade and date it was awarded.

F. A licensee who writes an article on a topic related to long-term care that is published in a national periodical shall receive two CE credits for an article of 500 to 1,000 words and one additional CE credit for each additional 500 words to a maximum of ten credits per year. To verify publication the licensee must maintain a copy of the periodical containing the published article.

G. A licensee who presents a paper or lecture of at least one hour at a national or statewide meeting shall receive two CE credits per one hour of initially presented lectures and one CE credit per hour of lectures repeating earlier presented material to a maximum of ten CE credits per year. To verify presentation the licensee must maintain a copy of the text of the information delivered and a copy of the program for the conference or workshop at which the paper or lecture was delivered.

H. A licensee who delivers a lecture of at least one hour at an academic institution shall receive two CE credits per one hour of initially presented lecture and one CE credit per hour of lecture repeating earlier developed material to a maximum of ten CE credits per year. To verify lecture delivery the licensee shall maintain corroboration from the participating academic institution.

I. A licensee who serves as a member of a board, committee, council, or work group which includes members from several nursing facilities or organizations and deals primarily with issues in nursing facility operation or long-term care shall receive one clock hour per membership position provided the group meets at least quarterly or for at least four hours of work in a year to a maximum of six CE credits per year for all membership positions combined. Where the licensee verifies that the licensee's participation on a single board, committee, council, or work group exceeded the minimum specified for a single CE credit by double the amount of hours of attendance, the licensee shall receive two CE credits per membership position to a maximum of six CE credits per year for all membership positions combined. To verify board, committee, council, or work group participation...
the licensee must maintain written verification of membership and attendance from an officer of
the group and must provide the learning objectives of the meeting.

J. A licensee who serves as a preceptor for a student's nursing facility administration
practicum shall receive two CE credits per month spent serving as a preceptor to a maximum of 16
CE credits per year. To verify preceptor service the licensee must maintain corroboration of service
from the participating academic institution. A licensee who attends training sessions to prepare
administrators to be preceptors shall receive CE credit on the same clock-hour basis as for seminars,
institutes, and workshops under item A.

K. Other continuing education activities not specified in items A to J may be approved for
up to ten CE credits per year on an individual basis upon submission of information to the board
concerning the activity in which the licensee has engaged, the results of the learning, the number
of hours involved, the number of CE credits requested, and some means of verifying completion
of the activity. The board shall consider the information submitted and determine whether to approve
the activity and, if so, what number of CE credits to award for the activity and shall notify the
requesting licensee of the board's determination. In making its determination, the board shall consider
whether the activity contributed to the advancement and extension of professional skill and
knowledge of the licensee in matters related to the practice of nursing facility administration.

Statutory Authority:  MS s 16A.1285; 144A.20; 144A.21; 144A.23; 144A.24; 214.06
History:  21 SR 1564; 41 SR 599
Published Electronically:  December 20, 2016

6400.6870 SPONSORING CONTINUING EDUCATION.

Subpart 1. Applying for program approval. Individuals, groups, or organizations wishing
to sponsor educational seminars, institutes, workshops, or home study programs shall submit the
following, in writing, to the board to obtain review and approval for clock hours of CE credit for
licensees to use in meeting continuing education requirements for license renewal:

A. date, time, and location of presentation;

B. presentation content, showing specific time periods, topic titles, and speakers including
their professional qualifications;

C. number of clock hours requested to be approved;

D. a statement indicating the sponsor's willingness to maintain a means of verifying
attendance and provide each attendee a certificate of attendance or other appropriate means of
attesting to the number of clock hours actually attended by each attendee;

E. for home study programs, evidence of a testing process to measure the participant's
attainment of knowledge and information provided in study materials; and

F. a fee under part 6400.6970 based on the number of clock hours requested to be reviewed
and approved.

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Subp. 2. **Licensee sponsored programs and courses.** A licensed administrator who attends a seminar, institute, or workshop, or participates in a home study course which has not been reviewed and approved by the board for a sponsor, may serve as the sponsor of a program and obtain review of the program and assignment of clock hours by submitting to the board office:

A. a copy of the seminar program or other document identifying the program content and other information required of program sponsors under subpart 1, items A to C; and

B. a fee in the same amount as would be charged to a sponsor under part 6400.6970, based on the total number of clock hours requested to be reviewed and approved.

Subp. 3. **Review of sponsor requests.** The board shall review sponsor requests and approve CE credit clock hours for programs with acceptable content, qualified presenters, and acceptable means of verifying attendance or measuring knowledge attainment under subpart 1 and part 6400.6800, subpart 4, and notify the requesting sponsor of the decision.

Subp. 4. **Designation of registered continuing education sponsors.** An organization which annually sponsors many educational seminars, institutes, workshops, or home study courses, may request designation by the board as a registered continuing education sponsor on an annual basis beginning May 1 and ending April 30. Registered continuing education sponsors may assign CE credit clock hours to their own program offerings applying the provisions of this chapter. The board shall review and approve requests for designation and authority as a registered continuing education sponsor provided the requesting agency meets the following requirements:

A. the sponsor is a regionally accredited university or college or division thereof or a state or national membership organization in the field of health care;

B. the sponsor has been a proven sponsor of continuing education programs acceptable to the board under subpart 3, for the two years preceding the request to be named a registered sponsor;

C. the sponsor has complied fully with the board's criteria for sponsors of continuing education programming;

D. the sponsor has made application on forms prescribed by the board and paid a nonrefundable filing fee of ten percent of the registered continuing education sponsor fee as specified in part 6400.6970;

E. the sponsor has signed an agreement to comply with the rules of the board in assigning clock hours to continuing education programs, providing certificates of attendance to participants, and providing the board with pertinent information concerning sponsored programs; and

F. the sponsor has paid the balance of the registered sponsor fee specified in part 6400.6970 within 30 days of notification by the board of approval of the organization as a registered continuing education sponsor.

Subp. 5. **Performance review of registered sponsors.** The board shall review performance of registered sponsors annually upon the sponsor's request to renew the one-year sponsor agreement with the board or more frequently if determined necessary in the judgment of the board and may
remove registered sponsor status from an organization upon 30 days' notice if the sponsor has been found to violate the terms of the agreement with the board.

**Statutory Authority:**  MS s 16A.1285; 144A.21; 144A.24; 214.06

**History:**  21 SR 1564

**Published Electronically:**  June 11, 2008

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**DISCIPLINE**

**6400.6900  GROUNDS FOR DISCIPLINE.**

Subpart 1. **Criteria.** The board may impose disciplinary action as described in subpart 2 against an applicant, the holder of a permit to serve as an acting administrator, or a licensee, when the board determines, by a preponderance of the evidence and after due notice and an opportunity to be heard at a contested case hearing, that the applicant, permit holder, or licensee:

A. has been convicted of a felony or gross misdemeanor, including a finding or verdict of guilt, whether or not the adjudication of guilt has been withheld or not entered, an admission of guilt, or a no contest plea, when the felony or gross misdemeanor is reasonably related to the practice of nursing home administration, as evidenced by a certified copy of the conviction;

B. has been convicted of a crime against a minor, including a finding or verdict of guilt, whether or not adjudication of guilt has been withheld or not entered, an admission of guilt, or a no contest plea;

C. is not eligible to be employed as a nursing home administrator under Minnesota Statutes, section 144A.04, subdivision 6;

D. has failed to comply with Minnesota Statutes, section 626.557, the Vulnerable Adult Act;

E. has violated a statute, rule, or order that the board issued or is empowered to enforce or that pertains to administration of a nursing facility or to the responsibilities of a nursing home administrator;

F. has discriminated against any resident or employee, based on age, race, sex, religion, color, creed, national origin, marital status, status with regard to public assistance, sexual orientation, or disability;

G. has committed acts of misconduct substantially related to the qualifications, function, or duties of a nursing home administrator and evidenced unfitness to perform as a nursing home administrator in a manner consistent with protecting resident health, safety, and welfare;

H. has engaged in fraudulent, deceptive, or dishonest conduct, whether or not the conduct relates to the practice of nursing home administration, that adversely affects the individual's ability or fitness to practice as a nursing home administrator;
I. has engaged in unprofessional conduct or any other conduct with potential for causing harm to the public or facility residents including any departure from or failure to conform to the minimum standards of acceptable and prevailing practice, as specified in state and federal statutes and rules concerning administration of nursing home facilities, without actual injury having to be established;

J. has failed to exercise true regard for the safety, health, or life of a resident;

K. has willfully permitted the unauthorized or illegal disclosure of information relating to a resident;

L. has engaged in sexual harassment, made sexual advances toward, or engaged in sexual contact with any resident, student, or trainee under the licensee's supervision, or engaged in sexual harassment of an employee, consultant, or visitor to the facility in which the licensee practices;

M. has practiced fraud, deceit, cheating, or misrepresentation, or provided misleading omission or material misstatement of fact, in securing, procuring, renewing, or maintaining a nursing home administrator license;

N. has used the licensee's professional status, title, position, or relationship as a nursing home administrator or licensee to coerce, improperly influence, or obtain money, property, or services from a resident, resident's family member or visitor, employee, or any person served by or doing business with the nursing facility that the licensee administers or is employed by;

O. has paid, given, has caused to be paid or given, or offered to pay or give to any person, a commission or other consideration for solicitation or procurement either directly or indirectly for nursing home patronage. Nothing in this item shall be construed to limit or restrict commercial advertisement;

P. has knowingly aided, advised, or allowed an unlicensed person to engage in the unlicensed practice of nursing home administration;

Q. has practiced fraudulent, misleading, or deceptive advertising with respect to the facility of which the licensee is administrator;

R. has wrongfully transmitted or surrendered possession of the licensee's license to any other person, either temporarily or permanently;

S. has falsely impersonated another licensee;

T. has practiced without current licensure;

U. has made a false statement or knowingly provided false or misleading information to the board, failed to submit reports as required by the board, failed to cooperate with an investigation of the board, the Office of the Attorney General, or the Minnesota Department of Health, or violated an order of the board;
V. has been the subject of a reprimand, restriction, limitation, condition, revocation, suspension, surrender, or other disciplinary action against the person's nursing home administrator license in another jurisdiction;

W. has failed to report a reprimand, restriction, limitation, condition, revocation, suspension, surrender, or other disciplinary action against the person's license as a nursing home administrator in another jurisdiction or failed to report the existence of a complaint or other charges against the person's nursing home administrator license in this or another jurisdiction or has been refused a license as a nursing home administrator by any other jurisdiction for reasons not related strictly to a difference in academic or experience requirements among jurisdictions; or

X. has abused or is dependent on alcohol, a legend drug as defined in Minnesota Statutes, chapter 151, a chemical as defined in Minnesota Statutes, chapter 151, or a controlled substance as defined in Minnesota Statutes, chapter 152, and this abuse or dependency has affected the performance of the licensee's duties.

Subp. 2. **Actions.** If grounds for disciplinary action exist under subpart 1, the board shall take one or more of the following actions:

A. refuse to grant a permit;

B. refuse to grant or renew a license;

C. revoke a license or permit;

D. suspend a license or permit;

E. impose limitations or conditions on a license or permit;

F. censure or reprimand the licensee or permit holder;

G. refuse to permit an applicant to take the licensure examination or refuse to release an applicant's examination score; or

H. any other action authorized by statute.

Subp. 3. **Considerations.** In determining what action to take under subpart 2, the board shall consider:

A. responsibility and response of the individual prior to, during, and after the occurrence;

B. extenuating circumstances;

C. repeat complaints against the individual; and

D. severity of or potential harm to residents.

**Statutory Authority:**  MS s 16A.1285; 144A.21; 144A.24; 214.06

**History:**  21 SR 1564

**Published Electronically:**  December 15, 2015
Subpart 1. **Payment types and nonrefundability.** The fees imposed in this part shall be paid by cash, personal check, bank draft, cashier's check, or money order made payable to the Board of Examiners for Nursing Home Administrators. All fees are nonrefundable.

Subp. 2. **Amounts.** The amount of fees may be set by the board with the approval of the Department of Management and Budget up to the limits provided in this part depending upon the total amount required to sustain board operations under Minnesota Statutes, section 16A.1285, subdivision 2. Information about fees in effect at any time is available from the board office. The maximum amounts of fees are:

A. application for licensure, $150;

B. for a prospective applicant for a review of education and experience advisory to the license application, $50, to be applied to the fee for application for licensure if the latter is submitted within one year of the request for review of education and experience;

C. state examination, $75;

D. initial license, $200 if issued between July 1 and December 31, $100 if issued between January 1 and June 30;

E. acting administrator permit, $250;

F. renewal license, $200;

G. duplicate license, $10;

H. fee to a sponsor for review of individual continuing education seminars, institutes, workshops, or home study courses:
   (1) for less than seven clock hours, $30; and
   (2) for seven or more clock hours, $50;

I. fee to a licensee for review of continuing education seminars, institutes, workshops, or home study courses not previously approved for a sponsor and submitted with an application for license renewal:
   (1) for less than seven clock hours total, $30; and
   (2) for seven or more clock hours total, $50;

J. late renewal fee, $50;

K. fee to a licensee for verification of licensure status and examination scores, $30; and

L. registration as a registered continuing education sponsor, $1,000.
Statutory Authority:  MS s 16A.1285; 144A.21; 144A.24; 214.06
History:  21 SR 1564; 24 SR 1780; L 2009 c 101 art 2 s 109
Published Electronically:  August 7, 2009