

# Meeting Notes

## Assisted Living Licensure Rulemaking Advisory Committee Meeting

Date: December 13, 2019

Time: 1:30 – 3:30 PM

Location: Minnesota State Retirement Systems Building, 60 Empire Drive, St. Paul

### Attendees

**Advisory council members:** Doug Beardsley (Care Providers of Minnesota), Kristine Sundberg (Elder Voice Family Advocates), Beth McCollum (Alzheimer’s Association), Sean Burke (Minnesota Elder Justice Center), Kari Thurlow (LeadingAge Minnesota), Aisha Elmquist (Office of Ombudsman for Long-Term Care), Roberta Opheim (Office of Ombudsman for Mental Health & Developmental Disabilities), Ron Elwood (Mid Minnesota Legal Aid), Mary Jo George (AARP Minnesota), Karen Peterson (Minnesota HomeCare Association), Rajean Moone (Minnesota Leadership Council on Aging), Dr. Tatyana Shippee (University of Minnesota School of Public Health), Wendy Hulsebus (Director, Cherrywood Advanced Living)

**Minnesota Department of Health:** Anne Peterson, Linda Prail, Toni Malanaphy-Sorg, Marilyn Etzbach

### Updates

#### Rulemaking comment process

Linda Prail led this discussion.

- There will be a public hearing scheduled; comments after the hearing, comments after that and rebuttal comments then comments to Commissioner’s Office after report with ALJ information.
- Once we have adopted the rules, comments can still be made but it is not a part of the process; comments, alternative language – is an open process
- The end date is December 2020
- Updated copies will be posted on the website; you will also receive drafts –nothing is final until the Commissioner signs the order of adoption.
- Written comments are best so we can refer back to them.
- As an Advisory Committee you have the power of persuasion, but it is helpful to have information to back up your point.
- Everyone’s comments are welcome.

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## Physical Plant Definitions

Bob Dehler, Engineering Program Manager, led the discussion.

- NFPA definition of construction activity – intertwined-ness
- Two types of repairs – look at P. (last sentence says no review by MDH)
  - Explicitly say this in the definition
  - Same with Q
  - We are getting rid of L, so when sharing with constituents, please don't share L
- How do you reconcile the different construction references between food code, international building code?
  - Current revision requires self-closing doors, not ok for our residents -- how to reconcile that language?
- NFPA 2018 edition used for these definitions
  - Recommendation: don't tie to something else that is changing, don't need hazard – include in emergency preparedness
  - Create a summary of those that do not require building plan review – that is the trigger
- Look at definition from a non-engineer perspective for readability
  - A renovation comes from NFPA 101, and in our general practice, does not require plan review
  - “replacement in kind” is confusing
  - “strengthening or upgrading building materials”
- Theme is scalability, need to consider the large provider who has architects, and a 6-unit house with limited resources
  - We have 1500 such entities in the state; user friendly is the goal
  - This clarity in rulemaking is needed in other places
- “interpretative guidance” and resources that are easy to understand, while needed, are not the purview of this group

## Definitions Subcommittee

Sean Burke led the discussion.

- No proposal for the group today
- Definitions are an extremely important issue, for MDH's enforcement and ability to carry out the statute
  - The rub is coming from the question of exactly what legal or business entanglements exist and what the relationship is between the housing provider and service provider
  - When they are the same, it is easy, but when it is not, from a legal aid standpoint the bar is pretty high
- A less complicating factor to the conversation, as we are passing statute, recognize that it was intentional in AL category regulation, but preserving independent senior housing and the two

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are related – how the market will react and who will/won't need a license, and what the risk is in terms of the market and unintended consequences

- Sean will prepare a 1-page synopsis of definitions for the group
- This covers the spectrum of living types, and places in between the two ends, for the Home Care provider to be a different company than the property owner, etc.
- Some categories need metrics for the relationships being discussed
  - Example: Brand new AL building in Eden Prairie, HC in AL will be made available for the people in the AL, how will the license be reviewed?
- need to have a related conversation about dementia care

## Emergency Preparedness

Anne Petersen led the discussion.

- missing resident, consider also “missing residents not in an emergency”
- hazard vulnerability assessment has been described as a facility analyzing need for generator based on resident need
- Definition of assessment – spell out the language about ventilators, etc.
- Subpart 2D, page 2, plan must include a facility-based and community-based assessment, need to look at not only being in tornado alley, but also own building
- Minnesota had a significant planning process after 9/11, so we need to hook up the Assisted Living facility with the emergency planning entity of the community
- Assisted Living provider has no information on the plans/services that are coming from outside vendors
  - That is not to be addressed in this rule, address it in the definition of resident
- Subpart 3 consider adding information about the patient population
- Concerns about notification of resident’s family, only if the resident authorizes it
  - Those identified as legal guardian also need to be notified
- Add clarification on “full drill” – memory care dementia residents can’t have sirens, etc., need to work with local government to fulfill requirement on both sides
- Some parts of statute do address appropriate procedures for memory care
- Definition of community based?

## Assessment/Uniform Assessment Tool Draft

Anne Petersen led the discussion.

- Emergency preparedness will also help shape
- Surveyors want more clinical data to be collected about residents in Assisted Living – more fragile population

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- Create a form that is not onerous; yet captures all services and is respectful of the person's goals/choices
- Not a lot of Medicare business in Assisted Living - new burden for 1200 providers
- Minimum data set for nursing homes, costs consumers a lot in increased fees
  - Generated to collect data or support payment, not to determine how to provide care, that is a nursing function, and board of nursing does not have a standardized tool
  - don't duplicate MnCHOICES assessment
- MDH needs better clinical data on medically fragile residents
- Nurse members will appreciate a detailed useful tool, it will be used to implement this
  - Department surveyors need more data on vulnerable individuals; nurses have requirements under the nurse practice act; that also governs this
- Subpart 4 combines basic and comprehensive home care services under Assisted Living services
  - Non-nursing services
- Research on MDS and Oasis, time consuming and challenging
- Threshold or base levels for Assisted Living areas
- Assessment creates service plan for resident, enforcement will look at plan, need accurate, reliable, verifiable metrics for this enforcement
- premier goal is safe quality care and assessment

## Dementia Care Considerations and Process

Linda Prail led the discussion.

- Workgroup resulted in good language on statute so what is this
- Training for dementia care and competency
- Focus on training and how we are assessing for competency
- Relinquishing of dementia care licenses and how to plan and prepare for shut down
- Also staffing recommendations if have two categories of licensure

## Fees and Fines

Linda Prail led the discussion.

- The legislature does not want state agencies to set fees
  - Application of fees, clarified in the rule
  - Or in definition of resident
- rulemaking process is not the right venue for the conversation on fees
  - Fines can be done in the rule; we have authority to do rulemaking on that
- Final clarification by end of December

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## Public comments

- Sue Boyd: Leading Edge, RN, comes from Long-Term Care side, average time to do an MDS is 6 hours, for payment, data collection, take it with a grain of salt, not just a good nursing assessment
  - Definition of “significant change” for assessment is important
  - Pull subparts back together
  - “Nurse has to do physical and cognitive”, so can other parts be done by others?

## Next meeting

Next meeting date February 6th to review progress

Minnesota Department of Health  
Health Regulation Division  
PO Box 64900  
St. Paul, MN 55164-0900  
[www.health.state.mn.us](http://www.health.state.mn.us)  
Phone: 651-201-4101

To obtain this information in a different format, call: 651-201-4101