STATEMENT OF NEED AND REASONABLENESS FOR ASSISTED LIVING LICENSURE

Proposed Rules Governing Assisted Living Licensure and Consumer Protections for Assisted Living Residents

Minnesota Rules, Chapter 4659

Revisor's ID Number 4605

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STATUTORY AUTHORITY

The Minnesota Department of Health (department) received authority to adopt the proposed rules in Minnesota Statutes, section 144G.09, subdivision 3. The legislature directed the department to adopt rules governing assisted living facilities by December 31, 2020. The legislature required the department to adopt rules on the following topics:

1. staffing appropriate for each licensure category to best protect the health and safety of residents no matter their vulnerability;
2. training prerequisites and ongoing training, including dementia care training and standards for demonstrating competency;
3. procedures for discharge planning and ensuring resident appeal rights;
4. initial assessments, continuing assessments, and a uniform assessment tool;
5. emergency disaster and preparedness plans;
6. uniform checklist disclosure of services;
7. a definition of serious injury that results from maltreatment;
8. conditions and fine amounts for planned closures;
9. procedures and timelines for the commissioner regarding termination appeals between facilities and the Office of Administrative Hearings;
10. establishing base fees and per-resident fees for each category of licensure;
11. considering the establishment of a maximum amount for any one fee;
12. procedures for relinquishing an assisted living facility with dementia care license and fine amounts for noncompliance; and
13. procedures to efficiently transfer existing housing with services registrants and home care licensees to the new assisted living facility licensure structure.[1]

With this statutory authority, the department intends to adopt the assisted living rules.

ADVISORY COMMITTEE

Starting in October 2019, a department advisory committee met monthly to collaborate on developing the assisted living rules, including the process and timeline for drafting the rules along with discussions on the rulemaking language. The department posted the agendas and minutes of each meeting and recommendations from advisory-committee members on the department's assisted living web page. In addition to the formal meetings, advisory-committee

[1] Minn. Stat. § 144G.09, subd. 3(c). The law's assisted living provisions were initially codified in chapter 144I, but are now codified in chapter 144G.

members met informally to discuss issues that were in turn presented to the full advisory committee and department at each meeting.

Committee Members

- Doug Beardsley – Care Providers of Minnesota
- Sean Burke – Minnesota Elder Justice Center
- Aisha Elmquist - Office of Ombudsman for Long-Term Care
- Ron Elwood – Mid-Minnesota Legal Aid
- Mary Jo George – AARP
- Wendy Hulsebus – Administrator/Owner Cherrywood Advanced Living
- Beth McMullen – Alzheimer's Association
- Dr. Rajean Moone – Minnesota Leadership Council on Aging
- Roberta Opheim – Office of Ombudsman for Mental Health & Developmental Disabilities
- Karen Peterson – Minnesota HomeCare Association
- Dr. Tetyana Shippee – University of Minnesota School of Public Health
- Kari Thurlow – LeadingAge Minnesota

INTRODUCTION

The department proposes rules under Minnesota Statutes, section 144G.09, that will govern licensure, operations, and the provision of assisted living services at assisted living facilities.[2] These rules, and the statute that authorizes them, will protect residents' rights, choices, and their health and safety.[3] The law and proposed rules intend to address the inconsistent regulatory oversight of assisted living services and housing and to protect the vulnerable adults who call these facilities home.

Under the current laws that govern assisted living, a resident's housing and services are separately regulated. Facilities providing resident housing are called "housing with services establishments."[4] These establishments must be registered with the state but are subject to

[2] These are new rules, as opposed to revisions or additions to existing rules.
[3] Minn. Stat. § 144G.09, subd. 3(a).
[4] Minn. Stat. § 144D.01, subd. 4 (defining "housing with service establishment" to mean "an establishment providing sleeping accommodations to one or more adult residents, at least 80 percent of which are 55 years of age or older, and offering or providing, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services, whether offered or provided directly by the establishment or by another entity arranged for by the establishment…").

only minimal oversight and regulation by the department.[5] The housing they provide is generally governed by landlord-tenant law.[6] Residents receive services from "arranged home care providers"[7] that are regulated under the state's home care licensure laws.[8]

Currently, 41,000 people live in 1,345 assisted living settings in Minnesota.[9] As of 2014, 58% of these residents were over the age of 85, and 39% had dementia.[10] Minnesota law does not restrict the level or complexity of the care these providers offer. As a result, residents with more severe and increasing care needs are choosing to live in assisted living settings, and receive complex health and specialty services that can be similar to the services provided at a nursing home.[11]

The regulatory framework separating assisted living housing from assisted living services was meant to enhance flexibility and choice for residents by allowing them to tailor their housing and services to fit their unique care needs. Over time, however, it created consumer confusion over expectations for the provision of housing and services. It also left critical gaps in regulatory oversight.[12] For example, despite the fact that vulnerable adults reside in assisted living settings, the department does not regulate the housing with services establishment building, the non-licensed services that the establishment providers, nor the people employed by the establishment.[13]

These gaps in regulatory oversight must be addressed to allow the state to more effectively identify and prevent abuse and maltreatment in assisted living settings. In fiscal year 2017, the Office of Health Facility Complaints received 18,400 maltreatment allegation reports from providers, 35% more than it received in fiscal year 2012.[14] The new law and proposed rules

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[5] *See* Minn. Stat. §§ 144D.02 (requiring registration of housing with services establishments); 144D.04 (setting minimum standards for housing with services establishment contracts); 144D.05 (providing that the commissioner has standing to seek injunctive relief to "compel the housing with services establishment to meet the requirements of this chapter or other requirements of the state or of any county or local governmental unit to which the establishment is otherwise subject"); 144D.065–.066 (establishing dementia care training requirements for certain establishments and providing that the commissioner may levy fines for failure to comply with these training requirements).

[6] Minn. Stat. §§ 144D.01–.11; 504B.0001–.471.

[7] Minn. Stat. § 144D.01, subd. 2a (defining "arranged home care provider" to mean "a home care provider licensed under chapter 144A that provides services to some or all of the residents of a housing with services establishment and that is either the establishment itself or another entity with which the establishment has an arrangement.").

[8] *See* Minn. Stat. §§ 144A.43–.484 (governing the regulation of home care providers).

[9] *See* *Minnesota Department of Health Fact Sheet: Assisted Living Licensure in Minnesota* (PDF) (www.health.state.mn.us/facilities/regulation/assistedliving/docs/factsheet.pdf). Version 3.0 (Mar. 8, 2020)

[10] *Id*.

[11] Minn. Stat. §§ 144A.471, subd. 7(7) (including in the definition of home care services "complex or specialty health care services"); 144G.08, subd. 9(12) (including in the definition of assisted living services "complex or specialty health care services").

[12] Office of the Legislative Auditor, *Office of Health Facility Complaints 2018 Evaluation Report*, p. 78 (PDF) (www.auditor.leg.state.mn.us/ped/pedrep/ohfc.pdf).

[13] *Id.* at 82.

[14] *Id.* at 27.

intend to prevent these incidents of abuse and maltreatment. Publicly reported stories illustrate the magnitude of the problem:

- In October 2017, a 92-year old resident of an assisted living facility in Eagan was found dead in her apartment by her daughter.[15] An investigation indicated that the resident had died in her apartment two days earlier and the staff had failed to perform daily wellness checks.[16]
- In 2016, a resident was found dead in his apartment in an assisted living facility north of the Twin Cities and his body was not discovered for seven days, as staff apparently did not perform regular wellness checks.[17]
- In 2019, the state charged the staff and former owner of an assisted living facility in Hill City with more than 70 criminal counts, including manslaughter, racketeering, theft, and multiple counts of criminal neglect of the assisted living residents.[18]
- In 2019, a 70-year old Vietnam War veteran suffering from dementia died after consuming a cleaning chemical.[19] He had been living in a secured memory care unit when he reportedly entered his assisted living facility's kitchen and drank a caustic cleaning chemical that caused severe burns to his esophagus and stomach before killing him three days later.[20]
- In 2017, the department cited an Orono assisted living facility for failing to respond to an activated bed alarm and failing to make regular checks on a resident who was suffering from Alzheimer's disease.[21] The resident apparently fell in her room but was not found by staff for 10 hours.[22] The resident's health deteriorated and she later died.[23]

The present chaos of the pandemic has only exacerbated the problem of inappropriate and unsafe resident discharges in assisted living facilities. Since the onset of Covid-19, "complaints about involuntary discharges and transfers from senior care homes statewide have risen nearly

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[15] Serres, Chris, "State Faults Eagan Senior Home After Resident Found Dead in Room", *StarTribune* (April 4, 2018) (www.startribune.com/state-faults-eagan-senior-home-after-resident-found-dead-in-room/478778913/).
[16] *Id*.
[17] *Id*.
[18] Serres, Chris, "Assisted-living Home in Northern Minnesota Faces 76 Criminal Charges Alleging Abuse", *StarTribune* (Sept. 24, 2019) (www.startribune.com/ellison-brings-76-criminal-charges-alleging-abuse-at-minnesota-care-home/561253872/).
[19] Walsh, Paul, "Duluth Facility's Neglect Allowed Resident to Drink Fatal Dose of Cleaning Chemical, State Says", *StarTribune*, (May 1, 2019) (www.startribune.com/duluth-senior-care-resident-dies-after-swallowing-cleaning-chemical/509328211/).
[20] *Id*.
[21] Serres, Chris, "Orono Senior Home Cited in Death of Woman who Fell And Wasn't Found for 10 Hours, Later Died", *StarTribune*, (Jan. 27, 2018) (www.startribune.com/minneapolis-senior-home-cited-in-death-of-woman-who-fell-and-wasn-t-found-for-10-hours-later-died/471290174/).
[22] *Id*.
[23] *Id*.

30% over the same four-month period a year ago, according to the state Office of Ombudsman for Long-Term Care, the state's official advocate for senior care residents."[24]

In 2017, reporting of the state's handling of elder abuse allegations, including in assisted living settings, gained Governor Dayton's attention.[25] In response, he called for a workgroup led by consumer stakeholder groups to recommend changes to current regulations of long-term care settings.[26] In March 2018, both the governor and the legislature announced a bipartisan plan to protect the health and safety of seniors and vulnerable adults in Minnesota, which included strengthening licensing requirements for assisted living and dementia care facilities.[27]

In the fall of 2018, the Commissioner of Health convened six informal workgroups to develop recommendations around assisted living and protection of consumer rights. The assisted living licensure workgroup recommended a single licensing structure combining housing and assisted living services; a graduated license based on the complexity of services offered and additional certification for memory care units; minimum criteria for physical plant requirements; trained and licensed assisted living administrators; and lease and service termination protections.[28]

During the 2019 legislative session, a group of stakeholders representing consumer and provider interests, the department, and the Department of Human Services (DHS) worked as a group to develop consensus language around assisted living licensure and consumer protections for vulnerable adults. The stakeholders included individuals from the Alzheimer's Association, American Association of Retired Persons (AARP), Minnesota Elder Justice Center, ElderVoice Family Advocates, Mid-Minnesota Legal Aid, LeadingAge Minnesota, and Care Providers of Minnesota. DHS's colleagues from the Aging & Adult Services Division and the Office of Ombudsman for Long-Term Care were also involved.

In May 2019, the Minnesota Legislature passed the Elder Care and Vulnerable Adult Protection Act of 2019, a comprehensive package of reforms strengthening consumer protections for vulnerable adults and mandating state licensure of assisted living facilities. The Act is a landmark agreement that is the "most significant reform to state law for elder care in decades."[29] The new assisted living licensure law is housed in Minnesota Statutes 144G and the bulk of its requirements become effective on August 1, 2021.

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[24] Serres, Chris, "Complaints of Evictions in Senior Care Homes up Nearly 30% During Pandemic", *StarTribune* (July 3, 2020) (www.startribune.com/complaints-of-evictions-in-minn-senior-care-homes-up-nearly-30-during-pandemic/571609422/).

[25] Serres, Chris, "Left to Suffer a 5-Part Series", *StarTribune* (Nov. 2017) (www.startribune.com/senior-home-residents-are-abused-and-ignored-across-minnesota/450623913/).

[26] Serres, Chris, "Governor Dayton calls for new elder-abuse work group", *StarTribune* (Nov. 30, 2017) (www.startribune.com/dayton-calls-for-new-elder-abuse-work-group/461111583/).

[27] Office of Governor Mark Dayton, "A Bipartisan Plan to Protect the Health and Safety of Senior and Vulnerable Adults in Minnesota" (PDF) (https://mn.gov/gov-stat/pdf/2018_03_13_FACT_SHEET_Senior_Safety_Proposals.pdf)

[28] "Minnesota Department of Health, Elder and Vulnerable Adult Abuse Prevention Working Group Summary Report", January 24, 2019 (PDF) (www.health.state.mn.us/facilities/regulation/ohfc/prevworkgroups/finalrpt0119.pdf)

[29] *See* Minnesota Senate Republican Caucus, Landmark elder care protections, assisted living license signed into law (www.mnsenaterepublicans.com/elder-care-assisted-living-signed-into-law/).

The new assisted living licensure law resolves the regulatory gap of housing and services by streamlining housing and services under a single, integrated license, where the facility is directly responsible to the resident for all housing and service-related matters.[30] The new licensure model includes two categories of licensure: the assisted living facility license and assisted living facility with dementia care license.[31]

The law also enhances consumer protections for residents during relocations between facilities,[32] transfers within facilities,[33] and when their services are reduced or terminated,[34] and strengthens consumer protections through an augmented assisted living bill of rights.[35]

Under this new law, the legislature has directed the Commissioner of Health to "adopt rules for all assisted living facilities that promote person-centered planning and service delivery and optimal quality of life, and that ensure resident rights are protected, resident choice is allowed, and public health and safety is ensured."[36] These rules should address a list of topics that include but are not limited to facility staffing and training, assessments of the needs of new residents, ensuring resident appeal rights, emergency preparedness and missing person procedures, and health and safety protections for residents during relocations out of or within facilities.[37] The department proposes these rules in furtherance of this mandate.

REGULARTORY ANALYSIS

As part of its SONAR, the department must analyze eight factors.[38]

[30] Minn. Stat. §§ 144G.08, subd. 7 (defining assisted living facility as "a licensed facility that provides sleeping accommodations and assisted living services to one or more adults"); 144G.10 ("no assisted living facility may operate in Minnesota unless it is licensed under this chapter"); 144G.40, subd. 1 ("The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract.").
[31] See Minn. Stat. § 144G.10, subd. 2.
[32] See Minn. Stat. § 144G.55.
[33] See Minn. Stat. § 144G.56.
[34] *Compare* Minn. Stat. §§ 144A.441; *and* 144A.442; *with* 144G.52 (restricting facilities' rights to terminate services or housing); 144G.54 (contract termination hearing rights); 144G.55 (coordinated move requirements); 144G.57 (planned closure law and protections); *and* 144G.80, subd. 3 (protections for residents when facilities relinquish dementia care license).
[35] *Compare* Minn. Stat. §§ 144A.44 and 144A.441 (housing with services bill of rights); *with* 144G.91 (assisted living facility bill of rights).
[36] Minn. Stat. § 144G.09, subd. 3(a).
[37] Minn. Stat. § 144G.09, subd. 3(c).
[38] Minn. Stat. § 14.131.

1. A description of the classes of persons who probably will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule

Chapter 144G will require certain entities that provide sleeping accommodations and assisted living services,[39] such as housing with services establishments,[40] to obtain licenses and become assisted living facilities upon the chapter's effective date. These facilities and their owners (including certain cities that own and operate such facilities), licensees, managers, directors, administrators, contractors, and employees will be affected by the proposed rules. In addition, entities that provide services at these facilities, such as arranged home care providers,[41] will be affected.

The proposed assisted living rules will likely also affect:

- current residents of housing with services establishments who receive services from home care providers
- future assisted living residents and their families or representatives
- current and future volunteers who work at assisted living facilities
- state agencies that license health professionals
- DHS, which develops and operates social-service programs such as home and community-based service programs that assist residents on Medicaid who are on Elderly Waiver
- state agencies that process maltreatment reports and complaints about services and facilities, including the Minnesota Adult Abuse Reporting Center (under DHS), the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities
- The Senior LinkAge Line under the Minnesota Board on Aging[42] and Disability Hub MN (previously, the Disability Linkage Line[43])
- Minnesota lead agencies such as county social-service agencies, managed-care organizations, and tribal nations
- facility staff, registered nurses, and licensed health professionals that facilities hire to comply with or whose responsibilities will be altered by these rules
- local law-enforcement agencies, local units of government, and emergency-preparedness-and-response departments
- trade associations, including LeadingAge MN and Care Providers MN

[39] Minn. Stat. § 144G.08, subd. 9 (defining "assisted living services").
[40] Minn. Stat. § 144D.01, subd. 4 (defining "Housing with services establishment").
[41] Minn. Stat. § 144D.01, subd. 2a (defining "Arranged home care provider").
[42] Minn. Stat. § 256.975, subd. 7.
[43] Minn. Stat. § 256.01, subd. 24.

- consumer-advocacy organizations, including AARP Minnesota, the Alzheimer's Association, Mid-Minnesota Legal Aid, Elder Voice Family Advocates, the Minnesota Elder Justice Center, and other related organizations

Classes that will bear costs from the proposed rules include:

- assisted living facilities
- residents
- ombudsman offices to carry out assigned duties under the rules

Classes that will benefit from the proposed rule include:

- assisted living residents and their families
- caregivers
- facilities
- Minnesotans who will eventually reside in assisted living facilities

2. The probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues

The Department

The department has estimated that costs for implementing the proposed assisted living facility rules will be minimal. The estimated costs will be borne by the department using the money appropriated to the department under Laws 2019, chapter 60, article 5, section 2. The department will then implement the proposed rules with money collected through fees as provided under statute.[44]

Other State Agencies, Offices and Boards

The department has determined that no other state agencies, offices or boards will incur costs related to the proposed assisted living facility rules.

3. A determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule

The purpose of the rules is to comply with the legislature's mandate that the department "regulate assisted living facilities pursuant to" Minnesota Statutes, chapter 144G, including by "adopt[ing] rules for all assisted living facilities that promote person-centered planning and service delivery and optimal quality of life, and that ensure resident rights are protected,

[44] *See* Minn. Stat. § 144.122.

resident choice is allowed, and public health and safety is ensured."[45] The legislature provided a non-exhaustive list of subjects that these rules must address and generally laid out prescriptive requirements related to these subjects throughout chapter 144G.[46]

As described below, the department reviewed assisted living regulations of other jurisdictions when developing these rules. These proposed rules are similar to the regulations in place throughout the country for assisted living facilities and nursing homes that provide similar levels of care as assisted living facilities. The department knows no less costly or intrusive method for regulating and licensing assisted living facilities in compliance with this mandate other than the proposed rules. To limit costs and intrusiveness, however, the proposed rules allow facilities to apply for rule variances.[47]

4. A description of any alternative methods for achieving the purpose of the proposed rule that were seriously considered by the agency and the reasons why they were rejected in favor of the proposed rule

The department convened an advisory committee to assist with developing these rules. The department solicited advice from the committee regarding alternative methods of meeting the objectives of chapter 144G and thus the proposed rules. The committee was convened on three occasions. Despite limitations related to the COVID-19 pandemic on the ability to engage in face-to-face meetings, department staff kept in regular contact with committee members regarding rule development. To that end, the department posted rule drafts to its Assisted Living Licensure Rulemaking website. Most recently, the department posted the proposed rules to the website on October 13, 2020. No committee members, stakeholders, or members of the public have presented to the department an alternative method for achieving the purpose of the rules.

When developing the assisted living rules, moreover, the department analyzed and researched assisted living regulations from 49 states, including currently proposed legislation. In addition, the department analyzed best practices in assisted living facilities by researching academic articles and journals and contacting other states to find out about their experiences licensing assisted living facilities and to learn more about their regulations. These proposed rules reflect the practices employed and proven effective in other jurisdictions.

The department knows of no alternative method to achieve the purpose of the proposed rules, as the department has been directed by the legislature to adopt specific rule requirements for assisted living facilities. Accordingly, the department's proposed rules are the only means to license and regulate assisted living facilities.

[45] Minn. Stat. § 144G.09, subds. 1, 3.
[46] *See* Minn. Stat. ch. 144G and § 144G.09, subd. 3.
[47] *See* Proposed Minn. R. 4659.0080.

5. The probable costs of complying with the proposed rule, including the portion of the total costs that will be borne by identifiable categories of affected parties, such as separate classes of governmental units, businesses, or individuals

The vast majority of compliance costs associated with the new assisted living licensure framework originate in Minnesota Statutes, chapter 144G, not in the proposed rules. As described below, the proposed rules only clarify the requirements already imposed on facilities by statute by adding detail where it is lacking in chapter 144G. By making facilities' legal obligations clear, these rules should reduce administrative costs that facilities would otherwise incur deciphering the new regulatory framework around assisted living facility operation and licensure. The department anticipates that the total annual cost to comply with the proposed rules is approximately $5,000 per facility on average.

4659.0010 Applicability and Purpose

There are no anticipated costs of complying with this proposed rule part because it does not broaden the scope of responsibilities upon an assisted living facility or licensee. The proposed rule clarifies that the licensee is responsible for ensuring compliance with the proposed rules and chapter 144G by any individual or entity, acting on behalf of the facility. The rule is consistent with Minnesota Statute, section 144G.08, subdivision 32, establishing that the licensee is the person or legal entity who is responsible for the management, control, and operation of a facility.

4659.0020 Definitions

There are no anticipated costs of complying with this proposed rule part because the definitions do not broaden the scope of responsibilities upon an assisted living facility or licensee.

4659.0030 Responsibility to Meet Standards

There are no costs associated with this proposed rule part because it does not broaden the scope of responsibilities imposed under chapter 144G.

4659.0040 Licensing in General

There are no anticipated additional costs of complying with this proposed rule part because it does not increase costs on licensees beyond what is required by statute.

Subpart 2, item B, reduces license costs for campus settings by issuing one license for two or more buildings that are located on either the same property with a single property identification number, or adjoining properties with different property identification numbers.

4659.0060 Assisted Living Licensure; Conversion of Existing Assisted Living Providers

There are no anticipated costs from this proposed rule part. Instead, this rule part should provide economic benefits by exempting certain current housing with services establishments from the provisional license requirements of chapter 144G. As described in the Rule By Rule analysis below, this exemption should strengthen the financial stability of the exempted establishments.

4659.0070 Assisted Living Licensure: Initial License Renewal

There are no additional costs associated with this rule part. Instead, it should reduce licensees' economic burdens. For example, under item B, paragraphs 3 and 4, licensees receive financial flexibility in paying their renewal fees. This is because the rule part allows them to request a change in their randomly assigned renewal period based on financial hardship, and allows licensees with more than one license to consolidate all of the renewal dates in the same month or in different months.

4659.0080 Variance

This rule part does not create any additional costs. It may decrease costs by providing a way for licensees to obtain variances from the proposed rules, including where a rule part poses an undue burden on a licensee.

4659.0090 Uniform Checklist Disclosure of Services

There are only minor administrative costs associated with this rule part. Minnesota Statutes, section 144G.40, subdivision 2, already requires each licensee to provide each prospective resident with a disclosure of its license category and a written checklist indicating all of the permitted services it offers to provide, and does not provide.

Subpart 3 of the rule part requires licensees to submit the completed checklist forms to the commissioner and make paper copies of the forms available to prospective residents inquiring about the facility's services. The printing costs associated with this requirement will be minimal.

4659.0100 Emergency Disaster and Preparedness Plan; Incorporation by Reference

There are costs for facilities implementing this proposed rule part. The proposed rule requires facilities to comply with the federal emergency preparedness regulations for long-term care facilities as outlined in the federal register and the Centers for Medicare and Medicaid Services Appendix Z. The Centers for Medicare and Medicaid Services estimates the total cost for a long-term care facility to comply with these federal requirement to be $4,383.[48]

[48] Emergency Preparedness Regulations for Long Term Care Facilities, 81 Fed. Reg. 63,965 table 56 (Sept. 16, 2016) (codified at 42 C.F.R. 483.73(a)-(d)).

4659.0110 Missing Resident Plan

There are no substantial anticipated costs for this proposed rule part as missing-resident plans are required under Minnesota Statute, section 144G.42, subdivision 10. The proposed rule part merely sets a broad outline of what the plan must include and requires senior facility staff to conduct quarterly reviews of their facility's plan. At most, this will require a facility to pay a senior staff member's hourly wage for 1-3 hours per quarter.

4659.0120 Procedures for Resident Termination and Discharge Planning

There are minimal costs for implementing this rule part; however, it largely reflects the department's interpretation of what chapter 144G already requires of facilities during resident terminations and discharges. The process of terminating a resident's assisted living contract is governed by Minnesota Statutes, sections 144G.52, 144G.54, and 144G.55. Subparts 1-3 of the proposed rule clarify how a facility can comply with the pretermination meeting requirement set forth in section 144G.52.

Subpart 4 requires facilities to summarize the meeting and any agreements reached between the parties in the pretermination meeting, and to provide a copy of the summary to the resident within 24 hours. The anticipated cost of meeting this requirement is approximately one hour of administrative staff time to draft and mail the summary to the resident.

For residents who are relocating after receiving a written termination notice, Minnesota Statutes, section 144G.55, subdivisions 1 and 3, require the facility to develop a resident relocation plan and participate in a coordinated move of the resident to a safe location and appropriate service provider. Subparts 6 through 9 explain the coordinated-move process, which includes: (1) evaluating the resident's needs and preferences; (2) identifying at least two alternative service providers with a room available for the resident; (3) holding a planning conference with the resident to finalize the details of the move; and (4) verifying the resident has safely relocated.

4659.0160 Relinquishing an Assisted Living Facility with Dementia Care License.

There are no anticipated costs for assisted living facilities to implement this rule part because the rule part only makes specific what facilities must do to comply with statutory requirements.

- Subparts 1-2 clarify the contents of the transitional plans that are required by Minnesota Statutes, section 144G.80, subdivision 3;
- Subpart 3 explains the contents of the written notice to residents that section 144G.80, subdivision 3, requires;
- Subparts 4-5 and 7-9 flag requirements already imposed on facilities under statute as provided in the Procedures for Resident Termination and Discharge Planning Rule, 4659.0120, when terminating resident contracts as a result of a relinquishment;
- Subpart 6 reiterates Minnesota Statutes, section 144G.55, subdivision 1's, requirement that facilities verify that the resident has safely relocated to a new location; and

- Subpart 8 flags a facility's obligation to comply with Minnesota Statutes, section 144G.42, subdivision 5's, requirement that the facility to return any monies that the resident had entrusted in the facility's safe keeping during their residency.

4659.0200 Non-Renewal of Housing, Reduction in Services; Required Notices

There are no anticipated costs of compliance with this rule because it merely clarifies existing statutory requirements. Subparts 1 and 2 specify the notice and discharge process for non-renewal of housing and reduction of services, as required by Minnesota Statutes, sections 144G.53, and 144G.55. Subpart 3 clarifies what is required in the notice to the ombudsman for change in facility operations, as required under Minnesota Statute, section 144G.56, subdivision 5, paragraph (a)(4).

4659.0130 Conditions for Planned Closures

There are no anticipated costs for assisted living facilities in implementing this rule. Minnesota Statutes, section 144G.57, subdivisions 1-3, require the licensee to notify the commissioner and ombudsman in advance of an intent to close and submit a proposed closure plan to the commissioner for approval. Once the commissioner approves the closure plan, the law requires the licensee to give at least 60 days advance notice to the residents and residents' representatives, and ensure that a coordinated move of each resident to a safe location and, if applicable, an appropriate service provider.[49] The rule lays out the contents of the proposed closure plan, how long the commissioner has to approval the proposed closure plan, and repeats the coordinated-move process found in subparts 6-9 in the Procedures for Resident Termination and Discharge Planning Rule, 4659.0120.

4659.0140 Initial Assessments and Continuing Assessments

There are no anticipated costs for assisted living facilities in implementing this rule part. Instead, it specifies how to comply with existing statutory requirements.

Minnesota Statutes, section 144G.70, subdivision 1, prohibits facilities from accepting a resident unless the facility has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the assisted living contract. Subpart 1 clarifies that the facility must explain to the individual why the individual was not admitted to the facility, in light of the facility's staffing constraints.

Minnesota Statutes, section 144G.09, subdivision 3(c), requires the commissioner to develop a uniform assessment tool. Subparts 2-4 clarify how and when the tool must be used and who must conduct the assessments.

Minnesota Statute, section 144G.70, subdivision 3, limits a temporary service plan to 72 hours when a facility has initiated services, but an individualized assessment as required under subdivision 2 has not been completed. Subpart 5 clarifies that the facility necessarily must

[49] Minnesota Statutes, section 144G.57, subdivision 5, Minnesota Statutes, section 144G.55, subdivision 1.

conduct the nursing assessment within 72 hours of initiating services in order to comply with this statutory requirement.

Subpart 6, imposes no additional costs as it merely clarifies that individuals who are admitted under temporary service plans are afforded the full array of consumer protections that residents receive under Minnesota Chapter 144G and rules.[50]

Subpart 7 provides that a registered nurse must be available to conduct an assessment during the weekend when hospital staff want to discharge and transfer a resident back to the assisted living facility. This subpart merely expresses a necessary step that facilities must take to ensure their compliance with statutory requirements that obligate facilities to conduct timely reassessments of residents and thus imposes no additional costs to those already imposed under statute. For example, Minnesota Statutes, section 144G.70, subdivision 2(c), requires resident reassessments to be "conducted as needed based on changes in the needs of the resident." A resident needs to be reassessed after being hospitalized so that the direct-care staff can develop an up-to-date plan of care.

4659.0150 Uniform Assessment Tool.

There are no anticipated costs for assisted living facilities in implementing this rule part. It clarifies how to comply with existing statutory requirements, while providing flexibility to facilities in meeting these requirements. Chapter 144G requires the commissioner to adopt a rule on a uniform assessment tool that can be used by facilities to determine the physical and cognitive needs of residents to ensure that facilities have adequate staff and resources to provide contracted for services to their residents.[51] The legislature did not specifically define what information a facility needs to collect during an assessment or individualized initial review, but facilities will need to address the items identified in subpart 2 in order to comply with their contractual and statutory obligations to meet their resident's needs. Facilities are free to use any uniform assessment tool so long as it covers the enumerated elements in subpart 2.

4659.0170 Disease Prevention and Infection Control.

There are no anticipated costs for assisted living facilities in implementing this rule part because it explains how to comply with existing requirements. Minnesota Statute section 144G.41, subdivisions 2(8) and 3, require that facilities "establish and maintain an infection control program" and implement up-to-date infection control practices. The rule clarifies the sources of information apprising the facility's infection control programs and practices.

[50] A temporary service plan is an agreement between the facility and individual for the provision of housing and services, which meets the definition of "assisted living contract" under Minnesota Statute, section 144G.08, subdivision 5. An individual also meets the definition of "resident", which means "a person living in an assisted living facility who has executed an assisted living contract." Minnesota Statute, section 144G.08, subdivision 59.
[51] Minn. Stat. §§ 144G.09, subd. 3(c)(4); 144G.70.

4659.0180 Staffing

There are no anticipated costs for assisted living facilities in implementing this rule because it clarifies existing requirements under chapter 144G. Minnesota Statutes, section 144G.41, subdivision 1(11)(ii), requires all facilities to have sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the resident's assessments and service plans on a 24-hour per day basis. Subparts 3 and 4 identify necessary steps in meeting this statutory requirement.

Minnesota Statutes, section 144G.91 subdivision 4(b), vests residents with the right to receive assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract. Subpart 5 enforces this requirement by requiring a minimum of two direct-care staff to be scheduled and available at all times whenever a resident requires the assistance of two direct-care staff for scheduled and unscheduled needs. Accordingly, any costs incurred in complying with subpart 5 are the product of the resident's needs in light of the statute, not the rule itself.

Minnesota Statutes section 144G.41, subdivision 1(12), requires that one or more persons be available 24 hours per day, awake, and located either in the same building, attached building, or on a contiguous campus who can respond to the requests of residents for assistance with health or safety needs within a reasonable amount of time. Subpart 6 reflects the department's interpretation that a reasonable amount of time to respond to a resident's request for assistance with health or safety needs is 10 minutes.

4659.0190 Training Requirements

The proposed rule creates minimal costs for assisted living facilities because it does not impose any new requirements in addition to those provided under statute. Subparts 2 and 3 require a facility to add a few additional topics for orientation and training on dementia to those that are required by Minnesota Statutes, sections 144G.63 and 144G.81. At the most, these topics will require a few hours of additional training per each unlicensed staff member. The average unlicensed staff member makes $12.18 per hour.[52] According to surveys conducted by the department, the average facility employs seven unlicensed staff members. Thus, the average cost of complying with this rule will be less than $300 per facility.

4659.0210 Termination appeals; Procedures and Timelines for Appeals

The proposed rule creates no new costs because it does not impose any new requirements on facilities. Minnesota Statute, section 144G.54, allows a resident to appeal the termination of the resident's assisted living contract before an administrative law judge. Subparts 1 and 2 identify the appeal timelines and how a resident must contact the department to initiate an appeal. Subpart 3 clarify the processes for conducting an informal and formal hearing. Subpart

[52] *See* US Bureau of Labor Statistics, Occupational Employment and Wages, May 2019, 31-1120 Home Health and Personal Care Aides (www.bls.gov/oes/current/oes311120.htm)

4 provides the timeline for the commissioner to issue a final decision after receiving the administrative law judge's recommendation, and that the parties may appeal the commissioner's decision to the Minnesota Court of Appeals. The department will assume all costs associated with the hearing process before the administrative law judge and the issuance of the commissioner's decision.[53]

4659.0050 Fines for Noncompliance

The proposed rule adds no new costs because it incorporates the existing statutory structure for assessing fines for violations of the rules or chapter 144G.

Total annual compliance costs

The total estimated costs of compliance with the proposed rule is approximately $5,000 per facility. The department estimates that facilities will incur $4,383 on average to comply with the emergency preparedness plan requirements, and that they will also have to invest 4-12 hours of senior staff time in conducting quarterly reviews of their missing person plans. The department estimates that facilities will incur the costs associated with three additional hours of training for each unlicensed staff member under the proposed rule's additional training requirements. Finally, the discharge planning rule (part 4659.0120) will require facilities to dedicate about 1 hour of administrative time per pretermination meeting held.

Local building code officials

Assisted living facilities will be required to comply with local building code requirements.[54] There are no physical plant or occupancy requirements in the proposed rules. Therefore the department has determined that there will not be increased costs to local building code officials as a result of the proposed rules.

6. The probable costs or consequences of not adopting the proposed rule, including those costs or consequences borne by identifiable categories of affected parties, such as separate classes of government units, businesses, or individuals

Residents and Facilities

The proposed rules clarify how facilities must comply with chapter 144G, and how and to whom residents may report concerns with facilities' noncompliance with chapter 144G and the proposed rules. The topics addressed by these rules include licensure of facilities, health and safety and consumer protections that govern the initial transactions that place residents in assisted living facilities, procedures that must be followed to protect residents during relocations, facility staffing and training requirements, and standards for responding to and

[53] Minn. Stat. § 14.53.
[54] *See* Minn. Stat. § 144G.45.

planning for emergencies. The consequence of not adopting the proposed rules will be to inject uncertainty into each of these situations, placing unnecessary burdens on residents and facilities alike who will otherwise have to parse through statutes to understand facilities' obligations and residents' options for redressing grievances. For a discussion of the human costs these rules and the statute were designed to address, see the introduction to this SONAR.

Department

Without the proposed rules, the department would face a public that is confused about the regulation of assisted living facilities under chapter 144G. The clarity provided by the rules should limit these burdens and costs placed on the department.

In addition, not adopting these rules would result in a failure to satisfy the legislative mandate requiring the department to issue the proposed rules.

7. An assessment of any differences between the proposed rule and existing federal regulations and a specific analysis of the need for and reasonableness of each difference

Because there are no federal regulations for assisted living facilities, the proposed rules do not conflict with federal law.

8. An assessment of the cumulative effect of the rule with other federal and state regulations related to the specific purpose of the rule

Assisted living facilities are established under chapter 144G and will not be separate licensed facilities until August 1, 2021. Accordingly, like the facilities themselves, there are no existing federal or state regulations related to them. Thus, there is no cumulative effect of the rules with other federal and state regulations.

PERFORMANCE BASED RULES

Minnesota Statutes, sections 14.002 and 14.131, require that the SONAR describe how the agency, in developing its rules, considered and implemented performance-based standards that emphasize superior achievement in meeting the agency's regulatory objectives and maximum flexibility for the regulated party and the agency in meeting those goals.

A true performance-based rule would establish specific outcomes, and the regulated party would be able to select the approach or manner to achieve the outcomes. In much of public health regulation, this is not possible without putting the public's health in danger. In this case, it is not possible to split the assisted living facility population into separate groups to try different regulatory approaches because, if an approach does not work, it may cause significant and possibly fatal outcomes for residents.

The objective of the proposed rules is to carry out the legislature's mandate that the department make rules that regulate a non-exhaustive list of subject areas in a manner that

"promote[s] person-centered planning and service delivery and optimal quality of life, and that ensure[s] resident rights are protected, resident choice is allowed, and public health and safety is ensured."[55] Chapter 144G gives clear and detailed guidance regarding the requirements that must be placed on assisted living facilities, leaving little room for flexibility in these rules.

Nonetheless, a few areas of the proposed rules give facilities and their owners, licensees, directors, staff, residents and their families, and the department some flexibility.

- The rules provide a process for facilities to request variances from a rule requirement. A common state-agency tool, a variance or waiver procedure gives a regulated party, such as an assisted living facility, flexibility in achieving the department's regulatory objectives without sacrificing the health, safety, or welfare of those the department seeks to protect; and
- The department must establish a Resident Quality of Care and Outcomes Improvement Task Force (Quality Task Force) under Minnesota Statutes, section 144G.9999. The Quality Task Force will include various stakeholders, including residents, consumer advocates, providers, and department staff.[56] "The task force shall periodically provide recommendations to the commissioner and the legislature on changes needed to promote safety and quality improvement practices in long-term care settings and with long-term care providers."[57] To the extent the proposed rules are too prescriptive or inflexible in their practical effect, the Quality Task Force is positioned to alert the department and make recommendations to address such problems, including through rule revisions.

ADDITIONAL SONAR REQUIREMENTS

Consulting with MMB on local government impact

As required by Minnesota Statutes, section 14.131, the department is in the process of consulting with Minnesota Management and Budget (MMB) to evaluate the fiscal impact and fiscal benefits of the proposed rule on units of local government. The department sent MMB the documents for review on October 27, 2020. This was done before the department caused the Notice of Hearing to be published in the State Register. The documents provided include: the Governor's Office Proposed Rule and SONAR Form; the proposed rules; and the SONAR. The Department will submit a copy of the cover correspondence and any response received from Minnesota Management and Budget at the hearing for review by Administrative Law Judge Ann C. O'Reilly. *Please see Appendix A for the department's correspondence with MMB.*

Cost of complying for small business or small city

As required by Minnesota Statutes, section 14.127, the department has determined that the cost of complying with the proposed rules in the first year after the rules are effective will not

[55] Minn. Stat. § 144G.09, subd. 3
[56] Minn. Stat. § 144G.9999, subd. 2.
[57] Minn. Stat. § 144G.9999, subd. 3.

exceed $25,000 for (1) a business that has less than 50 full time employees, or (2) a statutory or home rule charter city that has less than ten full time employees.[58]

Determination about rules requiring local implementation

As required by Minnesota Statutes, section 14.128, the department must determine if a local government will be required to adopt or amend an ordinance or other regulation to comply with the department's proposed rules. If an agency determines that a proposed rule requires adoption or amendment of an ordinance or regulation, or if the administrative law judge disapproves an agency's determination that the rule does not have this effect, the effective date of the rules is generally altered.[59] Because the department has been directed by law to commence the rulemaking process,[60] however, the effective date of these proposed rules will not be altered by the determination of whether they require adoption or amendment of ordinances or regulations.[61] Nonetheless, the department has determined that local governments will not need to amend or adopt any ordinances or regulations as a result of these rules.

Impact on farming operations

The proposed rule does not affect farming operations.

List of witnesses

The department will hold a hearing under Minn. Stat. § 14.14.

The department anticipates the following non-agency individual will be present to answer questions on behalf of the agency at the hearing. Jeremy Peichel, Principal with Civic Intelligence LLC, will be present to discuss the department's survey of providers.

ADDITIONAL NOTICE PLAN

Minnesota Statutes, section 14.131 requires the department to describe its efforts to provide additional notice to persons who may be affected by the proposed rule. The department provided this notice through its Additional Notice Plan. The department's Additional Notice Plan was reviewed by OAH and approved in an order by Administrative Law Judge O'Reilly.

The department has given additional notice through various ways:

- The department's initial notice of rulemaking was published through its Request for Comments in the *State Register* on August 12, 2019.

[58] For a breakdown of the estimated costs of compliance with these proposed rules see item (5) of the Regulatory Analysis section.
[59] *See* Minn. Stat. § 14.128, subd. 2.
[60] *See* Minn. Stat. § 144G.09, subd. 3.
[61] *See* Minn. Stat. § 14.128, subd. 3(2).

- The department convened an advisory committee, which met six times between October 2019 and November 2020. During the first five in-person meetings, the department invited interested members of the public to attend and comment, including by calling into the meeting via a conference line. During the final virtual meeting the department invited interested members of the public to attend and comment through the online meeting application, WebEx.
- The new assisted living regulations and its planned rulemaking were discussed and presented by the department between June 2019 through September 2020 at various care provider forums and at the quarterly meeting for the Home Care Provider Advisory Council under Minn. Stat. § 144A.4799, including:
  - MDH HRD Brown Bag Lunch June 2019
  - Odyssey Conference July 2019
  - LeadingAge Conference September 2019
  - Community Health Services Conference September 2019
  - Home Care Advisory Council September 2019
  - Home Care Advisory Council December 2019, September 2020
  - MSBA Elder Care Section April 2020
- The department created a dedicated webpage for Assisted Living Licensure (ALL) Minnesota Department of Health Assisted Living Home Page (www.health.state.mn.us/facilities/regulation/assistedliving/index.html), in October 2019 to provide providers, consumers, and the public with updates on ALL, including the rulemaking process. The department posts drafts of proposed rules, comments from the rules advisory committee and invites readers to submit comments on proposed rules.[62]
- Utilizing an electronic communications platform called GovDelivery, the department emailed a fact sheet providing an overview of the Assisted Living Licensure law, including information on rulemaking, to over 6,000 home care providers, housing with services registrants, and other related provider types about the proposed rules and statutory changes on March 20, 2020. This electronic platform connects people with accessible, relevant, and important government information. This was also posted on the ALL website and the notices directed readers to the website as a source of more information.
- The department mailed notices to over 3,900 housing with services registrants and licensed home care providers about the proposed rules and statutory changes on March 31, 2020. These were also posted on the website and the notices directed readers to the website as a source of more information.

[62] *See* Minnesota Department of Health Assisted Living Home Page (www.health.state.mn.us/facilities/regulation/assistedliving/index.html)

- A second fact sheet, Assisted Living Licensure in Minnesota: Making the Transition, was sent out via GovDelivery on July 27, 2020, to over 7,200 homecare providers, housing with services registrants and other stakeholders and interested parties. This was also posted on the ALL website and the notices directed readers to the website as a source of more information.
- The department sent out a survey to all housing with services registrants between July 2, 2020, and July 16, 2020. The department also sent a survey to all home care providers between July 9, 2020, and July 23, 2020. In the survey, the department asked registrants and providers questions about their intent to convert to an Assisted Living Facility license. The department is using the data from the survey to assist with planning implementation activities to support a successful transition for providers. The surveys asked about provider:
  - intent to apply for an assisted living license
  - concerns about applying for an assisted living license
  - concerns about how the COVID-19 pandemic has affected their programs
- The department testified at six legislative hearings for both the house and senate to give periodic updates on Long Term Care and Assisted Living Licensure, including the proposed rules and its implementation of the statutory requirements under chapter 144G.
- In April 2020, Governor Walz and Commissioner Malcolm held discussions with key stakeholders on assisted living licensure, including the assisted living rules:
  - On April 9, they met with representatives from Care Providers MN and LeadingAge MN.
  - On April 14, they met with representatives from consumer advocacy groups, Minnesota Alzheimer's Association, Minnesota Elder Justice Center, Minnesota Legal Aid, AARP, Elder Voices Family Advocates, and the Office of Ombudsman for Long Term Care.
- On July 30, 2020, the commissioner sent a letter on assisted living licensure to Minnesota Legislators, Senator Karin Housley, Chair, Family Care and Aging Committee, and Representative Jennifer Schultz, Chair, Long-Term Care Division. The letter was copied to Governor Tim Walz, Lieutenant Governor Peggy Flanagan, Senator Michelle Benson, Senator John Marty, Senator Kent Eken, Senator Scott Dibble, Representative Tina Liebling, Representative Joe Schomacker, Representative Deb Kiel, and Representative Ginny Klevorn.
- On October 13, 2020, the department sent an email announcing the availability of the proposed rules for review and comment with an update on the rulemaking process to a total 9,819 individuals and organizations via GovDelivery to the following:
  - all members of the rules advisory committee
  - members of the public who signed up for rule updates on the department's website via GovDelivery
  - all housing with services registrants and licensed home care providers

  - state ombudsman offices for long-term care and mental health and developmental disabilities
  - county social services agencies
  - managed-care organizations, such as Blue Cross Blue Shield and HealthPartners
  - tribal nations
  - various health-care-related nonprofits, private and public organizations, and local-government associations
  - city community health boards, county health directors, local health departments, and managed-care county advocates
  - Minnesota Nurses Association and Service Employee International Union (SEIU) Healthcare Minnesota
  - major state volunteer organizations

- On October 19, 2020, the department published an announcement of the proposed rules in the MDH Center for Health Equity Bulletin which is sent to more than 5,300 subscribers every other week; and to the MN Immigrant and Refugee Health Announcements MIRHA Bi-Weekly Update which reaches an additional 3,000 individuals and organizations.
- On October 20, 2020, the department sent an email announcement via GovDelivery of the final rules advisory committee meeting scheduled for November 5, 2020, to the same individuals and organizations receiving the October 13 email. An announcement of the meeting was also posted on the ALL webpage. The email invited the public to join the meeting being conducted via WebEx. Comments and questions received as a result of the meeting are being compiled into "Frequently Asked Questions" or "FAQs" that will be posted on the ALL webpage. The FAQs will be updated periodically to assure they remain a resource of current information on ALL for providers, consumers and the public.

Our Additional Notice Plan also includes giving all of the notice required by statute. We will mail the rule and Notice of Intent to Adopt with a Public Hearing (Notice) to everyone who has registered to be on the departments' rulemaking mailing list under *Minnesota Statutes*, section 14.14, subdivision 1a.

We also will email the Notice to interested groups utilizing an electronic communications platform called GovDelivery. This will include all the groups that received the proposed rules on October 13, 2020. Among these groups receiving the Notice will be:

- Care Providers of Minnesota
- Leading Age MN
- Minnesota Alzheimer's Association
- Minnesota Elder Justice Center
- Minnesota Legal Aid
- AARP
- Elder Voices Family Advocates

Combined, these groups reach over 9,000 people and organizations.

If we do not have email addresses for any of the above listed persons or organizations, we will mail the Notice to them via USPS.

The Notice, the draft proposed rule amendments, and Statement of Need and Reasonableness (SONAR) will posted on the dedicated Assisted Living Licensure website.

The department will present and discuss the proposed rules, SONAR and Notice of Intent to Adopt at:

- Quarterly Home Care Advisory Council meetings
- One or more provider organization meetings
- One more assisted living licensure work group meetings convened by MDH to coordinate implementation efforts across State agencies and offices
- Individual follow up meetings with members of the rules advisory committee will be offered and conducted when requested
- Upcoming legislative meetings with legislators and key stakeholders, including provider and consumer advocate meetings
- Upcoming legislative hearings on Long Term Care and Assisted Living Licensure

The department will issue a press release announcing the Notice of Hearing and invite people to review and comment on the proposed rules at the Assisted Living Licensure webpage. We will ask and encourage other organizations to publicize the public hearing on their websites and in their print newsletters.

We will give notice to the Legislature per Minnesota Statutes, section 14.116. Our Notice Plan does not include notifying the Commissioner of Agriculture because the rules do not affect farming operations.

RULE-BY-RULE ANALYSIS

4659.0010 APPLICABILITY AND PURPOSE.

This part makes clear to stakeholders that the rules do not replace the requirements of chapter 144G. The part instead explains that these rules establish criteria and procedures for the enforcement of chapter 144G. In addition, this rule part clarifies that, as with chapter 144G, licensees bear the responsibility for their facilities' compliance with these rules, in addition to individuals acting on each facility's behalf.

It is necessary and reasonable to include this information at the beginning of the rule so there is not misunderstanding by the affected parties. Further, this part is reasonable because it does not place any additional burdens on licensees that do not already exist by operation of law.[63]

[63] *See* Minn. Stat. § 144G.10, subd. 1 ("The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.").

For example, chapter 144G defines licensee as a person "who is responsible for the management, control, and operation of a facility"[64] and makes licensees responsible for paying fines and correcting violations.[65]

4659.0020 DEFINITIONS.

This part defines the terms used throughout these rules to ensure that department and regulated and affected parties share a common vocabulary. Definitions are needed to provide consistency, clarity, and understanding when reading and interpreting the proposed rules.

Many of the terms defined in this part simply incorporate existing terms and definitions in Minnesota Statutes, chapter 144G.[66] In addition, at least two terms are derived from concepts referenced in Minnesota Statutes, chapter 144G.[67] These terms are used throughout the rules and, wherever possible, the department reasonably opted to use vocabulary and concepts already established in statute for convenience and consistency. These references to statutory definitions are a necessary means of signaling to the reader that certain terms have an established meaning. This definitions part also creates shorthand references to commonly utilized and understood terms for conciseness and clarity, including the Ombudsman for Long-Term Care, the Board of Executives for Long Term Services and Supports, and the department and its commissioner.

Similarly, the department needs to define the term "case manager" because many residents receive services under federally-approved medical assistance waiver programs that require case management services from assigned case managers. To define the term, the department reasonably referred to existing statutory sections that require case management services under these waiver programs.

Finally, the department created definitions for several terms that are utilized in this rule part but do not have a complete existing statutory definition. Definitions to these terms are necessary because they define critical concepts, and include:

- "Elopement," which means when a resident leaves the premises or a safe area without authorization or necessary supervision. This needed definition comes from the Centers for

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[64] Minn. Stat. § 144G.08, subd. 32.

[65] *See, e.g.*, Minn. Stat. § 144G.31, subd. 5.

[66] *See* Minn. Stat. §§ 144G.08, subds 6, 7, 8, 9, 16, 29, 32, 37, 59, 68, 69, 70, and 73 (defining assisted living director; assisted living facility—with and without dementia care; assisted living services; dementia; licensed health professional; licensee; medication; legal and designated representatives; resident; resident record; service plan; supportive services; survey and surveyor; and unlicensed personnel); 144G.41, subd. 4 (referencing the "clinical nurse supervisor" that a facility is required to have on staff); 144G.55, subd. 2 (clarifying term "safe location"); and 144G.61 (addressing required competency evaluations). In addition, "person-centered planning and service delivery" is defined in Minnesota Statutes, chapter 144G by reference to Minnesota Statutes, section 245D.07, subdivision 1a(b), so this section directly references the latter statute so readers do not have to encounter multiple cross references to locate the definition.

[67] Specifically, the rule defines "investigator" as the person who conducts investigations under Minn. Stat. § 144.30. In addition, "competency" is a term that is derived, in part, from various statutory requirements that staff be appropriately trained and able to provide services. *See, e.g.,* Minn. Stat. §§ 144G.60 to 144G.64.

Medicare and Medicaid Services' federal regulation guidelines for nursing homes.[68] It is reasonable to use this existing definition because nursing homes care for a similar resident population (including those with dementia) and also must address elopement risk.[69]

- "Prospective resident," which is a term that is referenced but not clearly defined in statute. This definition is needed because facilities are required throughout Minnesota Statutes, chapter 144G to provide certain disclosures and assessments to these prospective residents, and this rule part clarifies that a prospective resident is someone who is seeking to become a resident of an assisted living facility.
- "Wandering," which means random or repetitive locomotion by a resident. This movement may be goal-directed (for example, a resident who appears to be searching for something such as an exit) or may be non-goal-directed or aimless. The definition is also needed for the "missing resident" section of these rules and comes from the Centers for Medicare and Medicaid Services' federal regulation guidelines for nursing homes.[70] A wandering resident can go missing, and wandering occurs in a variety of long-term care settings, including assisted living facilities, adult day-care programs, and nursing homes. It is reasonable to use this definition because it is a widely accepted definition used by nurse surveyors of skilled nursing facilities and nursing facilities participating in the Medicare and Medicaid program.[71]

4659.0030 RESPONSIBILITY TO MEET STANDARDS.

This part simply recites the requirement that facilities must comply with the rules and chapter 144G when providing housing and assisted living services. It is needed to make this point clear, and reasonable because the department knows no other way to make this point clear without stating it in rule.

4659.0040 LICENSING IN GENERAL.

Subp. 1. ***License required.***

Subpart 1 bars people and entities from providing assisted living services or advertising specialized care for individuals with Alzheimer's disease or dementia without first becoming licensed to do these things pursuant to the rules and chapter 144G. This subpart is necessary to effectuate the policies stated in chapter 144G and to assure that the legislative intent of protecting residents and potential residents from abuse and misleading advertising is carried

[68]Appendix PP—"Guidance to Surveyors for Long Term Care Facilities", *CMS State Operations Manual*, § 483.25(d), Rev. Nov. 22, 2017 (PDF) (www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.
[69]42 CFR § 483.1(a)(1)(i).
[70]Appendix PP—"Guidance to Surveyors for Long Term Care Facilities", *CMS State Operations Manual*, § 483.25(d), Rev. Nov. 22, 2017 (PDF) (www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
[71]42 CFR § 483.1(a)(1)(i).

out.[72] This requirement is reasonable because it prohibits only unauthorized conduct. To ensure that it poses no undue burden on stakeholders, the department developed this subpart with input and agreement from key members of the Assisted Living Licensure Rules Advisory Committee as part of a package of proposed amendments to chapter 144G.

Subp. 2. ***Issuance of assisted living facility license.***

Subpart 2 clarifies that separate licenses are required for facilities operated at separate premises, but allows for one license to cover one licensee's operation of multiple buildings on one property or two adjacent properties. Providing clear direction to providers that operate large facilities about their licensure requirements was necessary to prevent confusion and is a reasonable approach. This requirement was developed with input and agreement from key members of the Assisted Living Licensure Rules Advisory Committee as part of a package of proposed amendments to chapter 144G.

Subp. 3. ***License to be posted***.

Subpart 3 requires each facility to post its license at its main entrance. It is necessary and reasonable to require an assisted living facility to post its license at a predictable location where people (the public, facility staff, and government regulators) expect to find it. This helps residents and prospective residents determine whether a facility is licensed and what type of license it has.

Subp. 4. ***Required submissions to ombudsman.***

Subpart 4 is needed to clarify that a facility must provide its contract to the ombudsman under Minnesota Statute, section 144G.50, subdivision 1(c)(1) within 30 days of receiving a license or provisional license. This contract disclosure must include each standard contract that the facility will use, and updates must be provided to the ombudsman within the same timelines as the original contract disclosure. Similarly, disclosures dementia care licensed facilities are required to make under Minnesota Statutes, section 325F.72, subdivision 1 must be made within 30 days of licensure. These clear and reasonable timelines are necessary to establish consistency and ensure compliance.

Subp. 5. ***Location for submissions to ombudsman.***

Subpart 5 acknowledges that these rules or relevant statutes may govern how submissions must be made to the ombudsman. This rule reasonably defers to the ombudsman for the form and content of the submission when rule or state does not set clear requirements.

4659.0050 FINES FOR NONCOMPLIANCE.

This part makes clear to licensees how the department will assess fines for violations of the proposed rule parts regarding planned closures (proposed rule part 4659.0130) and

[72]*See* Minn. Stat. §§ 144G.10, subd. 1 (prohibiting operation of a facility without a license and placing legal responsibility for facility management, control, and operation on licensees); 144G.80, subd. 3 (requiring facilities to "remove any reference that the facility is an assisted living facility with dementia care" when relinquishing an assisted facility with dementia care license).

relinquishment of assisted living facility with dementia care licenses (proposed rule part 4659.0160). Specifically, it provides that the structure already established under chapter 144G will govern such fines.

This proposed rule part is necessary to fulfill the department's obligation to "enforce all sections of [chapter 144G] and the rules adopted under" it,[73] including by issuing "correction orders and assess[ing] civil penalties under sections 144G.30 and 144G.31 . . . "[74] This part also satisfies the legislative directive that these proposed rules include fine amounts for noncompliance with requirements related to planned closure and assisted living facility with dementia care license relinquishments.[75]

The department determined that the most reasonable way to set fines for noncompliance with these rule parts would be to use the process that the legislature already established in Minnesota Statutes section 144G.31, and which is already applicable to facilities for violations of assisted living regulations generally. Under this fine structure, violations of the closure and relinquishment rule parts will be characterized based on the level of harm the violations have caused to residents, the portion of residents within a facility that the violations affect, and the regularity with which the violations have occurred.[76]

4659.0060 ASSISTED LIVING LICENSURE; CONVERSION OF EXISTING ASSISTED LIVING PROVIDERS.

When enacting chapter 144G, the legislature required that "all existing housing with services establishments providing home care services[77] under Minnesota Statutes, chapter 144A [(legacy facilities)], must convert their registration to licensure under" chapter 144G.[78] The legislature tasked the department with adopting rules that include "procedures to efficiently transfer" these legacy facilities to the new assisted living facility licensure structure.[79] This part is necessary to comply with the legislature's mandate.

Subpart. 1. ***License application required.***

Item A communicates to the existing housing with services providers that they must convert their registrations to assisted living licensure to continue providing assisted living services after August 1, 2021. Under Item A, legacy facilities must be providing assisted living services to residents on August 1, 2021, to convert. MDH determined that it is necessary to include the conversion requirement from the 2019 law in the rules to make providers aware of it because this language is not in the text of chapter 144G.

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[73] Minn. Stat. § 144G.30, subd. 1(a).
[74] Minn. Stat. § 144G.09, subd. 2(a)(1) and (5).
[75] Minn. Stat. § 144G.09, subd. 3(c)(8) and (12).
[76] Minn. Stat. § 144G.31, subds. 2–4.
[77] "Housing with services establishments providing home care services" are referred to throughout this SONAR as "legacy facilities."
[78] Laws 2019, chapter 60, art. 1, § 45.
[79] Minn. Stat. § 144G.09, subd. 3(c)(13).

Requiring legacy facilities to be providing services when chapter 144G takes affect is consistent with the legislative policy reflected in the provisional license statute, which requires provisional licensees to reapply if they cease providing services during the provisional period.[80]

Item B, lays out the process that legacy facilities must follow to convert. It reasonably requires facilities to apply for assisted living facility licensure under Minnesota Statutes, section 144G.12, to convert. Under **Item C**, legacy facilities whose applications the commissioner approves, will be issued a full license, as opposed to a provisional license. Accordingly, the rule exempts converting legacy facilities from chapter 144G's provisional license requirements.

Legacy facilities are currently providing what chapter 144G defines as "assisted living services."[81] The procedures MDH created under this rule protect residents by giving the department the information it needs to fulfil its oversight role without endangering legacy facilities' ability to continue operating and providing housing and services to their residents.

Submitting converting legacy facilities to the general licensure application process outlined in statute is necessary to ensure that MDH receives the information the legislature determined the department should have regarding all licensed facilities.[82] This includes documentation of compliance with background study requirements and information about the criminal histories and financial liabilities of owners, managers, and controlling individuals.[83]

To maintain continuity of operations within the assisted living industry, this rule part exempts converting legacy facilities from the provisional license requirements. Provisional licenses are temporary,[84] and a provisional licensee is not entitled to a formal hearing to contest the commissioner's decision to deny the licensee a full license at the end of the provisional period.[85] Non-provisional licensees, however, are entitled to notice and a hearing under the Administrative Procedure Act before the commissioner may suspend, revoke, or refuse to renew their license.[86] These are the same hearing rights that legacy facilities currently have with regard to the arranged home care provider licenses.[87] To convert legacy facilities to provisional license status would strip them of their business stability and, in turn, would leave their residents less secure in their housing situations.

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[80] *See* Minn. Stat. § 144G.16, subd. 2 (c) ("If the provisional licensee does not provide services during the provisional license period, the provisional license shall expire at the end of the period and the applicant must reapply.").
[81] *Compare* Minn. Stat. §144G.08, subd. 9 (defining "assisted living services"), *with* Minn. Stat. § 144A.43, subd. 3 (defining "home care services").
[82] *See* Minn. Stat. § 144G.12, subd. 1 (providing a non-exhaustive list of items needed to show that each assisted living facility license "applicant meets the requirements of licensure").
[83] *See* Minn. Stat. § 144G.12.
[84] *See* Minn. Stat. § 144G.16, subd. 1.
[85] *See* Minn. Stat. § 144G.16, subd. 4.
[86] *See* Minn. Stat. § 144G.20, subd. 13.
[87] *See* Minn. Stat. § 144A.475, subd. 3.

4659.0070 ASSISTED LIVING LICENSURE; INITIAL LICENSE RENEWAL.

This rule part applies only to licenses issued with an initial effective date in August 2021. It sets out the process for the initial renewal of these licenses and provides the information that licensees need to renew their licenses. Having the process in the rule is necessary to make it accessible and understandable to licensees. This process allows the department to focus its systems infrastructure development on supporting the initial license application process to effectively move all legacy facilities through the conversion process and to avoid gaps between the expiration of housing with services registrations and the effective dates of facility licenses. It also allows the time needed to develop the system capacity to generate the new license renewal periods that will be assigned under this rule part.

Under **Item A**, all licenses with an initial effective date in August 2021, will expire on July 31, 2022. This item clarifies the timing and duration of these licenses, and it is necessary and reasonable to provide clear information to licensees about their licensing periods. The department expects that most will seek licensure on August 1, 2021, or shortly thereafter, because August 1, 2021 is the first date licensure under chapter 144G is required.[88] These licenses will be effective for one year, a reasonable period that corresponds with other state administered licensing programs, and must be renewed for the first time on August 1, 2022.[89]

Under **Item B**, MDH will issue notices for renewal by May, 1, 2022. This date is reasonable because it gives facilities time to prepare for renewal on August 1, 2022. Each notice will include renewal instructions, a randomly-assigned license renewal period, and instructions for requesting changes to license renewal periods. Providing a renewal notice to all of the licensed facilities is needed to remind them they need to renew. Licensees need to be able to anticipate what this license renewal process will require as this is different than the renewal process in Minnesota Statutes, section 144G.17.

This system of random assignment of renewal dates stems from MDH's need to balance the renewal workload throughout the year due to staffing constraints. This approach will prevent processing backlogs, as the expiration date for these initial renewals are spread out over 12 months (*see* Item C), preventing a surge of license renewals each August. Prorating license fees is a practice that already is used for hospitals and other medical facilities. It is reasonable to use this method because it has been used for some time and is well tested.

Item B, Subitems 3 and 4, establish that MDH will provide instructions to licensees on how they may request new renewal periods under two conditions. It is reasonable to include notice of the availability of these options in the rule so all facilities are aware of them. First, licensees may request changes to their renewal periods because of financial hardship. This is necessary because there may be some facilities that will not have the money needed to pay for a renewal on their randomly assigned renewal date. MDH needs to ensure facilities, especially those in rural areas, do not have to close due to this situation.

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[88] *See* Minn. Stat. § 144G.10, subd. 1 ("Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter.")

[89] *See, e.g.,* the food, pools and lodging licensing program in Minn. Stat. § 157.16, which requires annual licensure.

Second, licensees with multiple facilities may request a change to their renewal periods so that all facilities renew in the same month or in different months throughout the year. There are some organizations that own or manage more than one facility. Providing this option helps these facilities keep track of their renewal dates and stagger the costs so they are more manageable.

Items C and D illustrate how license renewals will be staggered and describe how the fees for these renewals will be prorated based on the randomly assigned renewal periods.[90] This schedule clarifies the prorated renewal periods and allows providers to see the range of prorated periods that may be assigned. It is necessary to explain how the prorated license fee will be calculated to help licensees understand the basis for their fees during this initial license renewal period.

Under **Item E**, this rule part expires on December 31, 2023, because at the time of these licensees' second license renewals their license renewal periods will last twelve months and will be governed by the licensing renewal provisions of chapter 144G,[91] without the need for supplementation by this rule part.

4659.0080 VARIANCE.

The APA provides licensees and license applicants the right to request variances from rule requirements and authorizes agencies to develop variance standards in rule. Minn. Stat. §§ 14.055 and 14.056. This rule is needed to spell out, among other things, the procedures for requesting a variance, the factors the commissioner must consider in granting or denying a variance, the conditions associated with variances, and appeal procedures.

Subp. 1. ***Request for variance.***

The application criteria in subpart 1 are reasonably derived from the requirements in Minnesota Statute, section 144G.33 for "innovation" variances, with minor tweaks to comply with the requirements of the APA and other minor revisions for clarity. For example, the APA implies that the department should consider a broader range of rule variance requests than chapter 144G—which requires a nexus to "innovation"—so the rule authorizes licensees or license applicants to request a variance at any time and on any grounds, as long as the criteria under subpart 2 favor granting a variance.

Subp. 2. ***Criteria for evaluation.***

Subpart 2 reasonably details standards for the commissioner to consider to provide consistency and clarity to variance applicants and the commissioner in evaluating a variance request. This requirement (coupled with the denial and revocation criteria in subpart 7) also ensures that an

[90] *See* Minn. Stat. § 144.122(d) (setting base fees for assisted facility licenses) and (f) (allowing the commissioner to "adjust the fees assessed on assisted living facilities and assisted living facilities with dementia care under paragraph (d), in a revenue-neutral manner…")

[91] *See* Minn. Stat. §§ 144G.12 (setting license renewal application requirements and providing that renewal fees will be in the amount specified in section 144.122); 144G.17 (establishing certain procedures for renewal of non-provisional licenses); 144.122 (setting licensing fees).

administrative law judge can adequately review the commissioner's decision on appeal. These criteria are adapted from the procedures for requesting rule variances in the nursing home context, and it is reasonable to draw on the nursing home example because those rules require consideration of the health and safety of a similar and often vulnerable population of residents. *See* Minn. R. 4658.0040, subp. 2.

Subp. 3. ***Duration and Conditions.***

Subpart 3 is needed and reasonable because the commissioner is permitted to place conditions and limitations on variances under the APA, and this subpart is also consistent with the department's innovation variance procedure. *See* Minn. Stat. § 144G.33, subds. 3 and 4; Minn. Stat. § 14.055, subd. 2.

Subp. 4. ***Granting a variance.***

Subpart 4 simply requires, for self-explanatory reasons, that any conditions and time limitations on a granted variance be clearly laid out in writing to the licensee or license applicant.

Subp. 5. ***Renewal****.*

Subpart 5 sets a standard, derived from the nursing home variance rules, that requires a variance applicant to request renewal of a variance 45 days in advance of its expiration date. *See* Minn. R. 4658.0040, subp. 5. This reasonable requirement ensures that the commissioner can adequately consider and decide a renewal request before the variance expires.

Subp. 6. ***Violation of variances****.*

Subpart 6 is pulled from Minnesota Statutes, section 144G.33, subdivision 6, which treats violations of a variance as a violation of the statute. Ensuring a variance is enforceable is a reasonable means of achieving compliance, and is consistent with variance procedures in other department rules, including the nursing home rules. *See* Minn. R. 4658.0040, subp. 4.

Subp. 7. ***Denial, revocation, or refusal to renew****.*

Subpart 7 sets out the various scenarios that require the commissioner to deny or revoke a variance. Consistent with Minnesota Statute, section 144G.33, subd. 7, it is reasonable to require that a variance be denied any time it is infringing upon the health, safety, welfare, or rights of residents. Further, it is also reasonable to deny a variance when a facility otherwise fails to show the department that a variance is appropriate under the criteria established in subpart 2 of this rule, any time a facility violates the terms of a variance in effect, any time a facility wishes to give up a variance, or whenever a change in law requires that the variance be denied or revoked. As a reasonable due process measure, the department must notify a facility of the reasons for a denial or revocation, and point facility's to their rights to appeal the department's decision under this part.

Subp. 8. ***Appeal procedure****.*

Lastly, subpart 8 establishes facility appeal rights to challenge department variance decisions. Because it is beneficial to facilities, residents, and the commissioner to swiftly resolve variance disputes, this subpart adopts the Revenue Recapture Act procedures used elsewhere in this chapter (for example, resident termination appeals) where a streamlined appeal process is

needed. For identical reasons of expediency and efficiency, facilities are provided 10 days from the date of receiving the commissioner's determination to appeal the decision, and it is reasonable to require the facility's appeal notice to include reasoning for challenging the department's decision as a notice measure. Finally, it is reasonable and consistent with the department's nursing home rules to place the burden of proof on the facility challenging a denial, and to place the burden on the department when it affirmatively revokes a variance.

4659.0090 UNIFORM CHECKLIST DISCLOSURE OF SERVICES.

Subpart 1. ***Definition.***

Subpart 1 is needed because Minnesota Statutes, section 144G.40, subdivision 2, describes a uniform checklist disclosure of services that must be provided to prospective residents, but the checklist is not formally defined in Minnesota Statutes, chapter 144G or in rule.[92] This definition reasonably clarifies that the uniform checklist is a specific form developed and posted online by the commissioner that facilities must complete and disclose to prospective residents under this part and 144G.40, subdivision 2.

Subp. 2. ***Uniform checklist disclosure of services.***

Regarding Subpart 2, an assisted living facility's array of services will naturally evolve over time with technological advancements, changing philosophies about service delivery models, and changing consumer expectations. It is essential that the checklist incorporate these changes and advancements in a timely manner so that potential residents receive comprehensive information about the services currently provided by facilities. The department initially considered including all of the services permitted under a facility license in this rule, but ultimately abandoned this approach because it would impede the department's ability to make timely updates to the uniform checklist by necessitating costly and time consuming rule amendments when new services arise or when certain services become obsolete.

Members of the Assisted Living Rules Advisory Committee submitted sample checklists outlining the full complement of assisted living services that are generally provided by an assisted living facility. The department incorporated all of the services recommended by the committee into a sample checklist, which is available for review in Appendix B. As demonstrated by Appendix B, there are over one hundred different services that are typically provided under a facility license. Due to the complexity of this checklist and its likely evolution over time, it is reasonable for this subpart to state that the department will post the checklist form it developed with interested stakeholders (consistent with Minnesota Statute, section 144G.40, subdivision 2(c)) online and update the form as needed.

Subp. 3. ***Submission of checklist to commissioner.***

Subpart 3 is necessary because it explains the facility's obligation to submit a completed checklist to the department, which is a reasonable means of ensuring compliance with this

[92] Minnesota Statute, section 144G.09, subdivision 3(c)(6) authorizes the commissioner to make rules clarifying this uniform checklist requirement.

important disclosure obligation. Under **Item A**, it is necessary to require applicants or licensees to submit a completed checklist at the time of license application or renewal so that the department has up-to-date information about the services the facility offers. The department provides this information to DHS, which is charged with the important task of providing consumer information on long-term housing and service options in Minnesota.[93] **Item B** is needed to ensure that the department's and DHS's information on the facility remains current, and provides facilities a reasonable amount of time (30 days) to update the department with changes in services.

Subp. 4. ***Use of uniform checklist disclosure of services.***

As noted in subpart 3 and as recognized in Minnesota Statute, section 144G.40, subdivision 2, it is critical that consumers receive timely information about the services provided by a facility so they can make informed choices about their long-term care options. Subpart 4, **Item A** is needed because it clarifies the facility's responsibility to provide up-to-date information to *both* prospective residents and their representatives seeking information about the facility. The statute is silent on whether checklists must be provided to representatives, and this minor clarification is reasonable because a resident's representative often assists the resident in evaluating information and making key decisions.
Item B is necessary to signify the importance of a facility's scope of services, and to avoid the risk that this critical disclosure is lost in the volume of paperwork that can accompany a move to a new residence. This separate form requirement is also reasonable because facilities are already required to use the standardized, separate checklist template under item C. And the requirement in **Item C** is needed to ensure that prospective residents receive a standardized set of information they can use to easily compare services provided and not provided by various facilities. To this end, it is reasonable to notify facilities that they cannot create their own checklist.

4659.0100 EMERGENCY DISASTER AND PREPAREDNESS PLAN; INCORPORATION BY REFERENCE.

Chapter 144G requires an assisted living facility to have "a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency . . . ."[94] The statute also requires an assisted living facility to post its written plan prominently, train its staff on the plan, and "meet any additional requirements adopted in rule."[95] These items are addressed by the federal emergency preparedness regulations as set forth by the Public Health

[93] DHS's Board on Aging uses the information furnished by the department to update its MinnesotaHelp.info network long-term care database and SeniorLinkAge line, both of which are statewide services used to assist older Minnesotans and their families in making informed choices about long-term care options and health care benefits. *See* Minn. Stat. § 256.975, subd. 7.
[94] Minn. Stat. § 144G.42, subd. 10(a).
[95] *See* Minn. Stat. § 144G.42, subd. 10.

Section of Title 42 of the Code of Federal Regulations.[96] The department chose to require assisted living facilities to comply with these federal emergency preparedness standards for several reasons.[97]

First, given the variation in facility size, resident population, and breadth of assisted living services offered by an assisted living facility, an emergency preparedness rule must give a facility flexibility to develop an effective preparedness plan that is uniquely tailored to the facility. The federal requirements eschew a one-size-fits-all approach to emergency planning and instead focus on building a facility's capacities and capabilities to ensure that it has sufficient training, supplies, and leadership to address a broad range of emergencies. The federal requirements stress the importance of facility staff developing a standard protocol to follow in case of any emergency. This approach allows a facility to develop cost-effective emergency plans that are scalable given their resident population, community assets, and facility size.

Second, 17 different provider and supplier types currently follow CMS's emergency preparedness rule,[98] including long-term care facilities where vulnerable adults reside,[99] nursing homes, hospices, and intermediate care facilities for individuals with intellectual disabilities. As assisted living facilities also provide long-term care and complex health-related services to vulnerable adults,[100] it is reasonable to subject them to the same level of rigor for emergency preparedness planning that CMS requires of similar long-term care settings.

Third, the agency's emergency preparedness subject matter experts recommended that the department adopt federal requirements. Judy Seaberg, a program manager in the Center for Emergency Preparedness and Response at the department, recommended that the department require assisted living facilities to follow federal emergency preparedness regulations. The program manager for the Licensing and Certification program, which surveys nursing homes and long-term care facilities throughout Minnesota, also recommended that assisted living facilities follow federal emergency preparedness regulations.

Fourth, long-term care associations such as Care Providers of Minnesota and LeadingAge MN currently provide training and workshops for its members on how to comply with federal emergency preparedness laws, including CMS's Appendix Z requirements. By adopting this rule,

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[96] *See* 42 C.F.R. § 483.73, (www.ecfr.gov/cgi-bin/text-idx?SID=cda8d477c2ad7c4a7a642ec8676c2313&mc=true&node=pt42.5.483&rgn=div5#se42.5.483_173).

[97] A previous draft of this rule was shared with the advisory committee in December 2019 (December draft) and is available online at MDH Assisted Living Emergency Disaster and Preparedness Plan (PDF) (www.health.state.mn.us/facilities/regulation/assistedliving/docs/epplandraft.pdf). The December draft was influenced by and borrowed from the federal regulations now incorporated by reference into proposed Rule Part 4659.0100.

[98] "Providers/Suppliers Facilities Impacted by the Emergency Preparedness Rule, Centers for Medicaid and Medicaid Services" (PDF) (www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/17-Facility-Provider-Supplier-Types-Impacted.pdf.

[99] Minn. Stat. § 626.5572, subd. 21(a) (Vulnerable adult means "any person 18 years or older who is a resident or inpatient of a facility").

[100] *See, e.g.*, Minn. Stat. § 144G.08, subd. 9(12) (assisted living services include "complex or specialty health care services").

assisted living facility leadership will be able to immediately tap into the resources and support within the long-term care community that follow federal emergency preparedness guidelines.

Fifth, CMS regularly updates its federal emergency preparedness requirements in order to better serve and protect resident populations. By incorporating the federal regulations and associated guidance by reference, assisted living facilities will always follow the most up-to-date requirements.

Item B is necessary to clarify that facilities must follow the final rule interpretative guidelines developed by the Centers for Medicaid and Medicaid services (CMS) found in Appendix Z. The Centers for Medicaid and Medicaid Services (CMS) regulates provider and supplier compliance with federal emergency preparedness regulations and provides survey procedures and final rule interpretative guidelines in Appendix Z.[101] Appendix Z lays out the step-by-step guidance for complying with each element of federal regulation. It is reasonable to direct facilities to use Appendix Z because it is the framework that state surveyors will use to assess whether the facility is complying with this rule part. CMS regularly updates Appendix Z to reflect best practices for emergency preparedness.

4659.0110 MISSING RESIDENT PLAN.

Subpart 1. ***Applicability*.**

Minnesota Statute, section 144G.09, subdivision 3(c)(5) authorizes the commissioner to adopt rules relating to emergency preparedness, which subdivision 10 of Minnesota Statute, section 144G.42 clarifies includes missing resident planning. Subpart 1 is needed to define the scope of this rule part. Under **Item A**, it is necessary to acknowledge that some residents only receive and pay for housing, without additional services and supervision. Notably, these residents do not undergo an assessment that would reveal to the facility any cognitive or physical deficits that heighten a resident's risk to go missing. Thus, this subpart reasonably states that a facility's missing resident plan only applies to residents who are receiving assisted living services, and who also meet one or both of subitems 1 or 2.

Subitem 1 is necessary to address the unique risks that emergencies pose to residents who cannot take appropriate action to protect themselves. When emergency situations occur, such as a fire or natural disaster, these residents are at significant risk of going missing because they may not be able to ambulate or evacuate when necessary. Similarly, a resident who is unable to take appropriate action to protect themselves may be more likely to go missing due to caregiver error, as these residents require a higher level of direct staff supervision and care. Accordingly, it is reasonable to include these clients within the class of residents covered by facility missing resident policies.

Subitem 2 is necessary because facilities must identify which residents are likely to wander or elope from a facility in order to protect these residents from serious injury or death. More than

[101], "Appendix Z—Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance", *State Operations Manual*, Rev. Feb. 21, 2020 PDF) (www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_z_emergprep.pdf).

60% of individuals with dementia will wander,[102] which can lead to elopement. Elopement is very dangerous for older adults with dementia. An academic study of nursing home claims found 70% of elopement incidents end in resident death, and 80% of elopement incidents involve chronic wanderers.[103] A resident is most likely to elope shortly after admission to a long-term care facility, as 45% of elopements occur within 48 hours of admission.[104] It is reasonable to require facilities that care for residents who wander or are at risk of elopement—as identified by the facility's assessment of the resident—to plan to protect these vulnerable residents from risks to their health and safety.[105]

Item B is necessary to define which residents are covered by this rule on the grounds that they are incapable of taking appropriate action for self-preservation under emergency conditions. The department reasonably adopted DHS's adult day-care rules to describe the applicable criteria.[106] Because both adult day-care centers and assisted living facilities serve vulnerable adults in a congregate care setting, it is reasonable for this proposed rule to look to the adult day-care rule for guidance on drafting this item.

Subp. 2. ***Missing resident policies and procedures.***

This subpart is needed to provide the minimum elements of the facility's missing resident plan, all of which are designed to ensure resident safety and to be straightforward and easy to implement in order to ensure a consistent and comprehensive response. Further, this subpart reasonably provides that facilities continue to bear responsibility for providing appropriate care to residents when a missing resident emergency occurs, and this plan requirement eliminates confusion and chaos, allowing the facility and its staff to continue to carry out its essential duties.

Notably, most of these timelines require "immediate" action. The department elected not to set a formal timeline to avoid the impression that it is acceptable to delay action when a resident is missing, even for a short period of time. Minnesota law recognizes the critical importance of locating missing individuals without delay, and whether the facility acted

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[102] Neubauer, et al., "What do we know about strategies to manage dementia-related wandering? A scoping review", *Alzheimer's & Dementia: Diagnosis, Assessment and Monitoring*, 2018; 10: 615–628 (Aug. 31, 2018) (www.ncbi.nlm.nih.gov/pmc/articles/PMC6234917/).

[103] Aud, Myra, "Dangerous wandering: Elopements of older adults with dementia from long-term care facilities", *American Journal of Alzheimer's Disease and Other Dementias*, Vol. 19, No. 6, p. 362, (Nov./Dec. 2004) (https://journals.sagepub.com/doi/pdf/10.1177/153331750401900602).

[104] *Id*.

[105] *See* Minn. R. 4659.0150, subps. 2 (E), (F), and (M) (7) and (8) (uniform assessment tool, which requires assessment of cognitive status and history of elopement and wandering).

[106] Minn. R. 9555.9600, subp. 8 ("Capable of taking appropriate action for self-preservation under emergency conditions" is defined as an adult who meets the following criteria: "The person is ambulatory or mobile; and The person has the combined physical and mental capability to: (1) recognize a danger, signal, or alarm requiring evacuation from the center; (2) initiate and complete the evacuation without requiring more than sporadic assistance from another person, such as help in opening a door or getting into a wheelchair; (3) select an alternative means of escape or take other appropriate action if the primary escape route is blocked; and (4) remain at a designated location outside the center until further instruction is given.")

immediately will need to be judged on the surrounding circumstances. *See* Minn. Stat. § 299C.53, subd. 1(b).

Item A

Subitem 1 is needed to clarify who is directly responsible for implementing the missing resident plan. A resident can go missing at any time of the day or night. Accordingly, the plan must identify the staff person in charge of implementing the plan when facility staff suspect a resident is missing. It is reasonable that the facility identify a particular staff member for each shift to fulfill this role so that there is always a staff member on site and available 24-hours a day, seven-days a week, to implement the missing resident plan in a timely fashion. When a resident is suspected missing, it is imperative that the facility waste no time in implementing the plan, as the resident may be in grave physical danger.

Under **subitem 2**, the facility's policies and procedures need to explain how facility staff must act when they suspect that a resident may be missing in order to protect a resident from the risk of serious injury. Emergency situations can induce panic and lead to inconsistent and uncoordinated responses, impacting resident safety. It is reasonable for the staff member to notify immediately the individual identified in Item A so the responsible staff member can organize and begin a comprehensive, coordinated, and timely search for the resident.

Under **subitem 3**, missing resident plans must identify staff roles during the search for a missing resident. To conduct a timely and comprehensive search for the resident, it is essential that staff members are aware before a resident goes missing that they will be participating in the search of the resident. As staff schedules vary by shift, identifying staff by position description is reasonable because it eliminates any potential confusion as to who is supposed to search for the missing resident. As noted above, facilities must also ensure through this planning process that they have appropriate staff to care for residents during the period in which a resident is missing.

Subitem 4, reflects the need for the facility to act immediately and conduct a comprehensive search. Time is of the essence when a facility suspects that a resident is missing because the resident may be at serious risk for harm. This item reasonably requires staff to thoroughly search the areas where the missing resident may have walked to, which includes the facility, the facility premises, and the surrounding neighborhood. This rule is reasonable because it clarifies for staff the scope of their responsibilities in searching for the resident, and that the search must be conducted without delay.

Subitems 5 through 8 are needed to emphasize that facilities are obligated to engage outside resources and notify the resident's formal supports if the immediate search required under subitem 4 does not locate the resident. It is reasonable to require a facility to engage law enforcement and notify the resident's formal supports if the resident cannot be promptly located, as the resident may be in serious jeopardy and time is of the essence. Minnesota law recognizes that the first few hours after a person is deemed missing are critical, and law enforcement must accept all credible missing person reports, even if a relatively short amount of time has passed since staff or others suspect the resident missing. *See* Minn. Stat. § 299C.53. Law enforcement will conduct an immediate preliminary investigation and assessment of risk to

the person, and have formal resources, training, and experience in locating missing persons beyond that of a facility. *Id*. Further, the resident's formal supports may have insight into the resident's schedule, habits, and likely location, so it is also reasonable that they be contacted without delay once a resident is deemed missing.

Finally, **Item B** explains that the staff's responsibility for finding the missing resident does not end after completing the immediate search for the resident and contacting law enforcement for assistance. Staff must be available to respond to any requests of law enforcement to aid in identifying and locating the missing resident.

Subp. 3. ***Additional notification required.***

Once a missing resident is found, facility staff must immediately contact the various individuals and entities it notified in Subpart 2, Item A, subitems 6 and 7, about the resident so they are aware that the resident is no longer missing and they can cease all search-related efforts.

Subp. 4. ***Review missing resident plan.***

This subpart is needed to establish that an assisted living director and clinical nurse supervisor must review the missing resident plan at least quarterly and document any changes to the plan. This subpart is reasonable because all of the facility's residents receiving assisted living services undergo quarterly assessments and review of their cognitive and physical health.[107] Given the importance of the missing resident plan to protecting the health and safety of a facility's most vulnerable residents, the clinical nurse supervisor must review the plan at least quarterly to identify the residents who are at risk for becoming missing and update the plan, if needed.

4659.0120 PROCEDURES FOR RESIDENT TERMINATION AND DISCHARGE PLANNING.

Minnesota Statute, section 144G.09, subdivision 3 authorizes the commissioner to adopt rules that establish "procedures for discharge planning and ensuring appeal rights." *See also* Minn. Stat. § 144G.55, subd. 3 (requiring, without further detail, that the facility prepare a "relocation plan" when discharging residents to a new location or service provider). This part implements a number of reasonable and necessary clarifications to the termination process. In addition, this part develops a process and safeguards for ensuring that facilities discharge and relocate residents in a safe and efficient manner, and, consistent with the requirements of Minnesota Statutes, chapter 144G, involve the resident, the resident's representatives, and the resident's case manager in the discharge and relocation process. Minn. Stat. § 144G.09, subd. 3 (requiring assisted living rules to emphasize "person-centered planning and service delivery" and ensure that "resident choice is allowed").

Subp. 1. ***Pretermination meeting notice.***

[107] Minn. Stat. § 144G.70, subd. 2(c), (d).

Minnesota Statute, section 144G.52, subdivision 2 requires an interactive meeting[108] between resident, resident representatives, case managers, and facility representatives prior to a termination of an assisted living contract. **Items A** and **C** are needed to clarify that a resident and the resident's representatives and case manager, if any, are entitled to notice of the pretermination meeting—a necessary due process measure that allows residents a sufficient amount of time to prepare for and address the issues raised in the meeting. Minnesota Statute, section 144G.52, subdivision 2 already requires notice of the meeting to case managers and requires facilities to "schedule" a meeting with residents and their representatives, but does not elaborate on what this notice and scheduling process requires. The department determined that 5 business days is reasonable advance notice that recognizes: (1) that these meetings must be conducted swiftly, as they typically relate to contract violations, resident nonpayment, and, occasionally, health and safety issues; and (2) that these meetings can result in substantial consequences to residents in the form of contract termination, and that residents may need to arrange for representation, gather evidence, and otherwise prepare their case to present to the facility.

This rule also clarifies under **Item B** that the facility must ensure that the meeting is scheduled on a date that allows the resident to participate, and the reasonableness of this requirement is self-explanatory. **Item D** addresses the need for a resident, and where applicable, the resident's representatives and case manager to be notified of key issues such as the time and location of the meeting, the reasons for the proposed termination, the parties involved, and a contact person at the facility for information and accommodation requests. Further, Item D requires the facility to provide the resident key disclosures about the resident's rights, including:

- The fact that residents may invite others to participate in the meeting under Minnesota Statute, section 144G.52, subdivision 2;
- The resident's right to request accommodations needed to participate in the meeting, consistent with Title III of the Americans With Disabilities Act;[109]
- Contact information for the Offices of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities and notice that these Offices may be able to provide advocacy services, to aid the resident in obtaining a representative, if needed, consistent with Minnesota Statute, section 144G.52, subd. 2(c); and
- The resident's right to appeal under these rules and Minnesota Statute, section 144G.54 if the facility terminates the resident's contract, in order to notify residents and others—who may not be familiar with the law—of the appeals process and applicable timelines.

[108] For reader clarity, this meeting is referred to throughout the rule as a "pretermination" meeting to distinguish this meeting from the appeals process that residents are entitled to under Minnesota Statute, section 144G.54 after a facility issues a termination notice.

[109] Assisted living facilities are generally deemed to be places of public accommodation because they are social service center establishments. See Americans with Disabilities Act, Title III Technical Assistance Manual 1994 Supplement, § III-1.2000 (www.ada.gov/taman3up.html).

Finally, **Item E** reasonably requires notification if changes are made to the date, time, and location of the meeting, and requires notice under this subpart in writing to ensure that all individuals involved have consistent information and to preserve the record for a potential termination appeal.

Subp. 2. ***Emergency relocation notice.***

Under the statute, a facility may remove a resident from the facility in an emergency if the resident experiences an urgent medical need or is an imminent health or safety risk to another resident or staff member.[110] Residents in these situations are often residing temporarily in another setting, such as a hospital or jail. Accordingly, **Item A** reasonably requires pretermination meetings to be conducted through a range of technical alternatives to an in-person meeting if an in-person meeting is impossible or impractical under the circumstances. This requirement strengthens the language in Minnesota Statute, section 144G.52, subdivision 2(d) (which allows the facility to "attempt to schedule and participate" in a remote meeting) by guaranteeing the resident a right to alternative technology when a meeting cannot be held in person.

Item B is needed to require that the notice under subpart 1 be provided to the same parties to ensure that the resident and the resident's representatives can adequately prepare for the meeting. In addition, this item reasonably guarantees relocated residents, who are often in crisis situations, the right to have their formal supports (case managers, representatives, and ombudsman officials) present during any remote meetings. These individuals can assist the resident with presenting at a meeting and with making key decisions about the resident's future plan of care. This rule also requires facilities to make reasonable efforts to ensure others are able to participate, acknowledging that it is difficult to guarantee participation for a wide range of persons depending on the technological means available.

Item C imposes a shorter pretermination meeting notice period of 24 hours, which reasonably balances the resident's right to notice and the exigencies that are often involved when an emergency relocation takes place. Finally, if the resident has been relocated away from the facility premises and has not returned to the facility in four days, the facility must notify the Office of Ombudsman for Long-Term Care.[111] **Item D** is needed to clarify that facilities make that notification within 24 hours, which is reasonable to ensure that the ombudsman can assist the resident in a timely fashion by informing the resident about his or her rights under federal and state law, including the right to return to the facility, and that a facility's refusal to provide housing or services constitutes a termination of the resident's assisted living contract. The ombudsman may also be able to attend the emergency pretermination meeting.

Subp. 3. ***Identifying and offering accommodations, modifications, and alternatives***.

This subpart clarifies an essential requirement in Minnesota Statute, section 144G.52, subdivision 2, which requires facilities to identify and offer reasonable accommodations or modifications, interventions, or alternatives to avoid termination or to allow the resident to

[110] *See* Minn. Stat. § 144G.52, subd. 9(a).
[111] Minn, Stat. § 144G.52, subd. 9(b).

remain in the facility. This rule clarifies that the reasonable accommodation process is not "top down," but instead requires the facility to collaborate with the resident (and the resident's representatives and case manager) to ensure that the parties mutually identify an accommodation that will work for the facility and the resident.

Subp. 4. ***Summarizing pretermination meeting outcomes.***

It is essential for the facility to memorialize any agreements reached by the parties at a pretermination meeting in writing and provide them to the resident in a timely fashion in order to eliminate future confusion, conflict, and ambiguity about each party's responsibilities and to establish a record for any potential appeal. It is also reasonable for the facility to provide a summary of the meeting and any agreements reached within 24 hours of the meeting so that the parties can review the information while the details of the meeting are fresh in their minds.

Subp 5. ***Providing notice.***

This subpart is needed to describe how a facility must provide notice to a resident that the facility is terminating a resident's housing or services in order to preserve the resident's due process right to appeal the termination.

To ensure that the resident receives timely notice, **Item A** reasonably requires that the facility provide the written notice either in person or by first-class mail. A facility terminating a resident's housing and or services must provide a written termination notice to the resident at least 15 or 30 days before the effective date of the termination to the resident, depending on the grounds for the termination, and the resident must exercise their right to appeal within those timelines. Minn. Stat. § 144G.52, subds. 3-5. Accordingly, it is critically important that the facility accurately document when it served the notice and, for the same reason, it is necessary and reasonable to require that a facility be able to prove service through an affidavit of service.

Normally, the resident's last known address will be the resident's residence at the assisted living facility. However, there are circumstances where a resident has been relocated due to an emergency, or has left the premises for a short period of time and may not be residing at the facility. Thus, under **Item B**, it necessary and reasonable for the termination notice to be sent to the resident's last known address if the notice is served by mail.

Lastly, when a resident receives a termination notice from the facility, an ombudsman can help the resident understand his or her rights under the law and also advocate on behalf of the resident. Thus, it is necessary to clarify under **Item C** that the facility must provide the ombudsman with a copy of the written notice in a timely fashion, no later than two business days after it was provided to the resident. Because a resident only has 15 or 30 days to relocate after termination, it is reasonable for the ombudsman to receive contemporaneous information about the termination in order to effectively assist and resident. In order to allow the ombudsman to contact the resident and gather additional information about the resident and the circumstances of the termination, it is also reasonable for the written notice to include the resident's phone number, or if the resident does not have a phone, the phone number of the resident's representative or case manager.

Subp. 6. ***Resident-relocation evaluation.***

Minnesota Statute, section 144G.55 imposes certain duties on facilities who terminate a resident's contract and relocate resident. Among these obligations, a facility must develop a relocation plan, but the statute is largely silent on what that plan entails. In the spirit of person-centered planning and service delivery, one of the hallmarks of the assisted living law, these rules reasonably require a facility to conduct a limited, individualized relocation evaluation to ensure that the resident's needs and goals are considered in identifying a new facility or service provider. This subpart also borrows language from the California Residential Care Facilities for the Elderly Act, which requires a relocation evaluation for the resident with the goal of ensuring a safe transfer and minimizing trauma.[112]

Item A clarifies that this subpart is applicable in situations where the facility has either initiated the pretermination or termination process. This clarification is needed to recognize that residents are often vulnerable and do not have equal bargaining power with facilities when a facility initiates the steps that lead to termination, and can often feel persuaded or compelled to leave the facility before receiving a formal termination notice. Whether or not the facility has sent out a termination notice, it is reasonable for facilities to follow discharge and relocation steps in this rule when they have taken steps towards terminating a resident, as these rules are drafted to protect resident health, safety, and well-being when involuntary or compelled relocation occurs.

Subitem 1 requires consideration of the resident's current service plan, which is a written document outlining information necessary to identify an appropriate placement, including a resident's health status, cognition and behaviors, activities of daily living and the resident's personal interests, desired activities and desired community involvement.

Second, Minnesota Statutes, section 144G.55, subdivision 1, requires a facility to find safe housing and an appropriate service provider for residents during a facility-initiated termination. **Subitem 2** requires the facility to provide the resident a list of choices, where possible, so the resident can elect their preferred option. The proposed rule uses a reasonableness standard for the geographic proximity of the alternative housing and service providers, as the alternatives available will vary for urban and rural facilities. It is likely that some residents in rural areas may have to relocate longer distances to find appropriate care than a resident in an urban area.

Third, consistent with resident-centered care and Minnesota Statutes, section 144G.55, subdivision 1(3), the resident's goals must be considered under **Subitem 3** in the evaluation of relocation options.

Fourth, a resident may tour any of the suggested locations and providers prior to moving, and it is important that a written evaluation notify a resident of that right under **Subitem 4**. Encouraging a resident to be actively engaged in the relocation process lowers the likelihood

[112] Cal. H.S.C. § 1569.682 (https://codes.findlaw.com/ca/health-and-safety-code/hsc-sect-1569-682.html#:~:text=in%20this%20section.-,Any%20person%2C%20firm%2C%20partnership%2C%20or%20corporation%20who%20owns%2C,for%20costs%20and%20attorney's%20fees).

that the resident will experience relocation stress.[113] Visiting a facility will help the resident gain a better sense of the staff, residents, and facility environment, and whether the facility is a good fit for the resident's needs and choices.

Finally, under **Item B**, it is necessary and reasonable for the resident, resident representatives, and case manager to review the relocation evaluation prior to or during the planning conference in order to ascertain the evaluation's completeness and discuss any follow-up questions or concerns raised by the evaluation with the facility.

Subp. 7. ***Resident-relocation plan.***

Under **Item A**, in order to transition of the resident out of the facility in a safe, timely, and resident-centered fashion, the facility must hold a planning conference with the resident, as well as the resident's formal supports and any other individual invited by the resident to finalize plans for the resident's relocation. Like the evaluation requirement discussed in the above subpart, this conference is required when the facility initiates the termination or pretermination process, and the reasonableness of this requirement is discussed under subpart 6.

The relocation process must focus on the resident's preferences and choices for an alternate living environment. To that end, it is reasonable to require that facilities collaborate with the resident in developing the relocation plan. It is also important for representatives, case managers, and persons invited by the resident to attend the planning conference, as they play an important role in assisting the resident with formulating a relocation plan with the facility. At the planning conference, the group will discuss the assistance the resident will need to prepare, arrange, and finance the move, and the actions needed to ensure the resident's medications, meals, and communication are not disrupted during the relocation.

The relocation plan requirements, like the resident relocation evaluation in subpart 6, are drafted to ensure that facilities appropriately carry out Minnesota Statutes, section 144G.55, subdivision 3. **Item B** reasonably requires that the resident relocation evaluation referenced in the above subpart 6 be incorporated in the resident's discharge plan because the evaluation contains key information about potential placements, resident preferences, and service needs.

Item C contains the additional relocation plan requirements, some of which ask for basic information—like the date and time of the move and the contact information of the receiving facility. These requirements ensure the facility and resident both understand when the move will take place and allow resident to easily reach out to their future housing provider. This item also reasonably requires facilities and residents to plan ahead for how the resident will be transported to their new residence, and how resident's belongings will be handled and moved to set expectations, avoid misunderstandings, and to eliminate disruption and stress for residents. Finally, in addition to these basic, logistical requirements, this item requires that the resident relocation plan include:

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[113] *See* Jackson, Kate, "Prevent Elder Transfer Trauma: Tips to Ease Relocation Stress", *Social Work Today*, Vol. 15, No. 1, p. 10 (Jan./Feb. 2015) (www.socialworktoday.com/archive/011915p10.shtml).

- *Recommendations to assist the resident to adjust to the new living environment*

It is difficult for vulnerable adults to adjust to a new routine, especially when they have no desire to move.[114] A resident's health or cognitive status may deteriorate from moving to a different care facility. To prevent relocation stress, this rule part reasonably requires the facility to draft recommendations that will assist the resident in adjusting to the new living environment.

- *Recommendations for addressing the stress that a resident with dementia may experience when moving to a new living environment, if applicable.*

Over forty percent of assisted living residents have some form of moderate or severe cognitive impairment, including many with recognized dementias.[115] Relocating to a new living environment can trigger "transfer trauma" for residents with dementia. Transfer trauma is stress experienced by a person with dementia that is triggered by changing living environments. Transfer trauma can precipitate a decline in a resident's health or cognitive status.[116] Residents with dementia may even suffer increased likelihood of death as a result of the move.[117] This rule part addresses the very real potential for transfer trauma by requiring the facility to develop recommendations for residents with dementia that address the added stresses that comes from moving and adapting to a new living environment.

- *Recommendations for ensuring the safe and proper transfer of the resident's medications and durable medical equipment.*

Continuity of medication management during the relocation process is essential for the health and well-being of the assisted living resident. Minnesota Statutes, section 144G.71, subdivision 22, states that any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends. A resident's medications may require special care to retain potency, such as refrigeration, and a resident's durable medical equipment may also require special care. As medications and medical equipment will be transferred to the assisted living resident on the day the resident relocates, the facility must develop recommendations ensuring that the resident's medications and any durable medical equipment are not lost, diverted, or damaged during the relocation.

- *Arrangements that have been made for the resident's follow-up care and meals.*

The facility must consider arrangements for the resident's follow-up care and dietary needs after relocation, as gaps in these services could be detrimental to the resident. The arrangements may include suggested follow up to ensure the resident's well-being, and making

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[114] *See* Jackson, Kate, "Prevent Elder Transfer Trauma: Tips to Ease Relocation Stress", *Social Work Today*, Vol. 15, No. 1, p. 10 (Jan./Feb. 2015) (www.socialworktoday.com/archive/011915p10.shtml).
[115] *See* Zimmerman, Sheryl, et al., "Dementia Prevalence and Care in Assisted Living", *Health Affairs*, Vol. 33, No. 4 (April 2014) (www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.1255?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed).
[116] *See* Jackson, Kate, "Prevent Elder Transfer Trauma: Tips to Ease Relocation Stress", *Social Work Today*, Vol. 15. No. 1, P. 10 (Jan./Feb. 2015) (www.socialworktoday.com/archive/011915p10.shtml).
[117] *Id.*

staff available to answer the receiving facility's questions. Depending on the resident, the facility could also suggest that the regional ombudsman check in with the resident to observe the relocation process and ensure that resident rights are being protected. The resident may also have a new case manager that can check in with the resident after the move.

- *A plan for transferring and reconnecting phone and internet services.*

It is necessary for the transition plan to detail how the resident's phone and internet services as well as any electronic monitoring equipment will be transferred and reconnected in the new setting. This requirement is reasonable because the assisted living licensure law protects access to these services. Minn. Stat. § 144G.91, subds. 14, 19; Minn. Stat. § 144G.07, subd. 3(8); Minn. Stat. § 144G.92, subd. 1(9); Minn. Stat. § 144.6502, subds. 2(a), 7(a).

- *Who is responsible for paying moving expenses and how the expenses will be paid.*

Unlike nursing home relocations, it is incumbent upon the resident to plan for the move, as the resident bears the cost of the relocation, not the facility. This process can be complicated with assisted living residents, as these residents may have a guardian, conservator, or other representative that has to weigh in. Accordingly, it is necessary to identify who will pay these expenses in advance to avoid potential disputes between facilities, residents, and persons hired to assist with the move.

Finally, after the facility and resident hold the planning conference and draft the written relocation plan, it is incumbent on the facility to implement the relocation plan with the resident and provide a copy of the plan to the resident, the resident's representative, and the resident's case manager, if applicable. These reasonable requirements, detailed in **Item D**, emphasize to facilities and residents that they must adhere to the agreed-upon relocation plan and ensure that all parties have copies of the plan. It is also necessary and reasonable to include reference to Minnesota Statute, section 144G.55 so facilities can find the full scope of coordinated move requirements in one place.

Subp. 8. ***Providing resident-relocation information to receiving facility or other service provider.***

This subpart is largely derived from Wisconsin's community based residential facility code.[118] Minnesota Statute, section 144G.43, subdivision 4 already requires a transferring facility to send records to a resident's new facility, but this subpart is needed to fill several important gaps in that requirement. Under **Item A**, it is reasonable for the facility to provide the name and address of the facility to the receiving facility, as well as the dates of resident's admission and discharge in case the receiving facility has any questions about the resident's care or medical history during a certain period that could be answered by facility staff.

Under **Item B**, one way to assist the resident in mitigating relocation stress is to inquire with the resident about whether they have contacted the resident's significant social or community contacts after relocating. Because the relocation process is resident centered, it is reasonable to make the facility staff aware of the resident's significant social or community contacts, if the

[118] *See* Wisconsin DHS 83.31(7) (https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/83/V/31).

resident consents, and see if the resident needs any assistance in maintaining these relationships after the relocation.

Under **Item C**, Minnesota Statutes, section 144G.44, subdivision 4(7), requires the facility to transfer the resident's most recent assessment to the receiving facility or service provider. To that end, it is reasonable for the facility to also send the resident's most recent service or care plan, with the resident's consent, so the receiving facility has an up-to-date and accurate understanding of the resident's needs and the care that the resident was receiving from the previous facility.

Finally, Minnesota Statutes, section 144G.44, subdivision 4(8), requires the facility to transfer copies of the resident's health care directives, "do not resuscitate" orders, and any guardianship orders or power of attorney, but does not include a requirement that the facility send any orders for life sustaining treatment. Unlike a health care directive, which is typically prepared by the resident in advance of medical issues, a physician order for life sustaining treatment form is completed by a physician when a new critical medical condition arises or when changes to a current condition take place. It is reasonable to clarify through **Item D** that the facility is required to send such orders to a receiving facility along with the information in Minnesota Statutes, section 144G.44, subdivision 4(8).

Subp. 9. Resident discharge summary.

Items A through D originate from the federal language relating to the transfer and discharges for nursing homes.[119] As previously stated, it is reasonable to derive requirements from nursing home regulations due to the similarity of the resident populations in Minnesota's assisted living facilities. Further, it is standard practice for a long-term care provider to give a resident a discharge summary upon the resident's departure from a provider. The discharge summary serves as the primary document communicating a patient's care plan to the resident's post-discharge care providers. Facilities may choose their own method of communicating transfer or discharge information, such as a universal transfer form or an electronic health record summary, as long as the method contains the required elements and the information is provided at the time of discharge.

Under **Item A**, it is essential that the resident and the resident's formal supports receive a summary of the resident's stay, including the resident's medical history, treatments, medical diagnoses, courses of illnesses, therapies, and pertinent lab, radiology, and consultation results. This post discharge summary can reduce the risk of complications and adverse events during the resident's transition to a new setting by informing the resident, the resident's formal supports, and future care providers about the resident's medical and service history.

Under **Item B**, it is necessary for the resident and the resident's formal supports to have a copy of the final summary of the resident' status from the resident's latest assessment or review.

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[119] *See* Appendix PP—"Guidance to Surveyors for Long Term Care Facilities", *CMS State Operations Manual*, § 483.21(c)(2), Rev. Nov. 22, 2017 (www.cms.gov/Regulations-and Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf).

This is requirement is also necessary and reasonable to accurately describe the current clinical status of the resident.

Under **Item C**, a resident's discharge medications may differ from what the resident was receiving while residing in the facility. It is critical for facility staff to compare the medications listed in the discharge summary to medications the resident was taking while residing in the assisted living facility. Any discrepancies or differences found during the reconciliation must be assessed and resolved, and the resolution documented in the discharge summary, along with a rationale for any changes. The discontinuation of the medication should also be documented in the discharge summary. Discharge instructions and accompanying prescriptions provided to the resident and, if applicable, the resident representatives must accurately reflect the reconciled medication list in the discharge summary.

Finally, under **Item D**, the post-discharge plan of care is needed to detail the arrangements that facility staff have made to address the resident's needs after discharge, and includes instructions given to the resident and his or her representative, if applicable. These reasonable requirements ensure that residents and representatives are aware of necessary follow-up care and services that the resident needs, and where that care will be provided.

Subp. 10. ***Services pending appeal.***

This subpart applies to instances where a resident appeals a facility-initiated termination and the resident has a case manager. In this situation, the proposed rule requires the facility to contact and inform a resident's case manager to let them know the resident needs additional services and that it is the resident's responsibility to contract for and ensure payment of the services pending appeal under Minnesota Statute, section 144G.54, subdivision 6. The purpose of this rule is to ensure that the case manager is informed about the resident's new need for services during the appeal process, as the case manager is responsible for identifying payment sources for resident services.

Subp. 11. ***Expedited termination.***

The intent of **Item A** is to clarify that an expedited termination, which has a shortened 15-day written notice period before the effective date of termination, must comply with all of the requirements of the rule part. It is reasonable to clarify that the expedited termination does not allow a facility to skip the essential due process and planning requirements of this rule, such as the pretermination meeting, resident relocation evaluation, and resident relocation plan.

Item B applies to instances where the facility initiates a termination based on the facility's conclusion that the resident's assessed needs exceed the scope of the services detailed in assisted living facility contract and the facility's uniform checklist. This item reasonably requires the facility to provide the resident a copy of the assessment that formed the basis for this conclusion so the resident can determine whether the facility's conclusions have merit.

4659.0130 CONDITIONS FOR PLANNED CLOSURES.

Chapter 144G requires the department to set conditions for planned closures through

rulemaking.[120] The proposed closure rule provides licensees step-by-step guidance for developing a comprehensive closure plan and safely transferring residents to a new service provider. The rule stresses the importance of giving the resident and the resident's representatives, case managers, and other interested parties timely information about the closure and relocation process, and giving the resident as much choice as possible in deciding where he or she will relocate. It is necessary and reasonable to prioritize these things in order to enforce residents' rights under chapter 144G.[121]

Subpart 1. ***Planned closure; notifying commissioner and ombudsman*.**

Under Subpart 1**, Item A**, before voluntarily closing, each facility must submit to the commissioner and ombudsman a "proposed closure plan" and contact information for an individual responsible for management of the facility other than the facility's director. Chapter 144G already requires facilities to notify the commissioner and ombudsman when they plan to close by submitting a proposed closure plan.[122] This item makes clear that the submission must take place before closure, which the legislature clearly intended by also requiring commissioner approval of a closure plan before a facility may take any "action to close the residence."[123] It is reasonable and necessary to communicate this requirement in rule to ensure compliance.

Subitem 2 requires facilities to provide contact information of a senior staff member other than the director who is responsible for management of the facility during the closure process. This requirement is necessary to ensure that the department can maintain contact with a facility throughout the closure process so that the department can fulfill its statutory obligation "to assist in the proper relocation of residents."[124] It is rare for a licensee, especially of larger assisted living facilities, to be an owner/operator who resides on the facility premises. Smaller facilities are also likely to share the services of a licensed assisted living director as a cost-saving measure, as is typically the case in nursing homes. Given the fact that neither the licensee nor the assisted living director may be present at the facility on a full-time basis, it is reasonable for the licensee to identify an alternative contact person with supervisory responsibilities that the department can contact about questions and concerns. Similar requirements exist under federal regulations of nursing homes.[125]

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[120] Minn. Stat. § 144G.09, subd. 3(c)(8).

[121] *See* Minn. Stat. §§ 144G.09, subd. 1(1) and (12) (requiring the commissioner to enforce regulations that include "provisions to assure, to the extent possible, the health, safety, well-being, and appropriate treatment of residents while respecting individual autonomy and choice . . . and the assisted living bill of rights"); 144G.91 (assisted living bill of rights), subds. 21-24 (giving residents rights to immediate access by advocates, information about charges for and limits on services, information about staff, and information about available providers from which the resident can obtain services).

[122] *See* Minn. Stat. § 144G.57, subd. 1.

[123] *See* Minn. Stat. § 144G.57, subd. 3(a).

[124] *See* Minn. Stat. § 144G.57, subd. 3(b).

[125] *See Appendix PP—*"Guidance to Surveyors for Long Term Care Facilities", *CMS State Operations Manual*, § 483.70(m), Rev. Nov. 22, 2017 (PDF) (www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf). Federal regulations for nursing home facility closures require the licensee identify a contact person other than the nursing home administrator that acts as the department's contact through the closure process.

Item B prohibits facilities from entering new contracts or accepting new residents once they have submitted their closure plans for approval. This is necessary and reasonable to allow the department to fulfill its review and assistance obligations under statute. Chapter 144G requires the proposed closure plan to include "assessments of the needs and preferences of individual residents."[126] The commissioner uses this information to determine what resources are needed to "assist in the proper relocation of [these] residents."[127] The commissioner also must approve the proposed closure plan before the facility can begin taking actions to close.[128] Accordingly, admission of new residents would be unworkable under the statute. Plans would be rendered incomplete each time a new resident was admitted. For facilities whose plans have been approved, admission of new residents would undermine that approval and arguably retroactively render unlawful whatever steps the facility had taken toward closure. Even where commissioner approval had not yet occurred, the admission of new residents would complicate the department's plan review and risk creating a backlog that could hold up approval of the subject plan and those of other facilities.

If facilities were allowed to admit residents after submitting their proposed closure plans, this would also create unnecessary burdens for these newly admitted residents. They would be forced to relocate soon after moving in. Because the facility is under no obligation to inform residents of the closure until after the commissioner has approved the plan, the newly-admitted residents would potentially be blindsided by the closure and left with as little as 60 days to find new housing all over again.[129]

Item C requires licensees to comply with this rule part when they decide to not renew the housing contracts of all of their residents. This is to prevent licensees from avoiding the planned closure law by issuing blanket nonrenewal-of-housing notices to all of the residents in the facility. A nonrenewal of housing does not provide residents all of the closure safeguards, such as preparing a closure plan for review by the commissioner, following resident notice requirements, and verifying the safe relocation of residents after closure.[130] It is necessary to prohibit this conduct in order to protect residents who are experiencing the functional equivalent of a closure by ensuring they have the same safeguards as planned closures. This requirement is reasonable because it merely prohibits attempts by licensees to end run protections for residents that were put in place to deal with the exact circumstances that the closure statute and rules are designed to address.

Subp. 2. ***Proposed closure plan; contents.***

Subpart 2 lays out the required contents of proposed closure plans. Several requirements in this

[126] *See* Minn. Stat. § 144G.57, subd. 2(3).
[127] *See* Minn. Stat. § 144G.57, subd. 3(b).
[128] *See* Minn. Stat. § 144G.57, subd. 3.
[129] *See* Minn. Stat. § 144G.57, subd. 5 ("After the commissioner has approved the relocation plan and at least 60 calendar days before closing, except as provided under subdivision 6, the facility must notify residents, designated representatives, and legal representatives of the closure").
[130] *Compare* Minn. Stat. § 144G.53 (nonrenewal of housing), *with* § 144G.57 (planned closures).

subpart are informed by federal nursing home facility closure regulations.[131] The closure plan provides key information concerning the procedures and actions needed to assess, notify, and relocate residents to other settings.[132]

Item A requires the plan to include the proposed closure date and the reason for the closure. As resident safety is of paramount concern through the closure process, it is necessary for the commissioner and ombudsman to know when and why the licensee is voluntarily closing the facility. Voluntary closure of a facility can occur for a multitude of reasons, some of which may warrant greater scrutiny by the department. For example, a licensee may want to close a facility in anticipation of further enforcement actions by the state due to chronic poor performance on surveys. A licensee may not have sufficient capital to continue operations, or may face chronic staffing shortages and be unable to provide necessary services, staffing, and resources. The department must carefully assess the licensee's business rationale for closing the facility to determine if resident safety and care is in jeopardy. Knowing the licensee's rationale for closing will help MDH monitor the health and safety risks to residents during the closure process.

Item B requires plans to include a proposed timetable for relocating residents. This is necessary so that the commissioner can assess whether the licensee has allocated reasonable amounts of time for identifying appropriate service providers for residents. It also allows the commissioner to ensure that the facility has sufficient staff and resources on hand to continue to provide quality care to the residents through the closure process.

Under **item C**, facilities must identify each resident that will need to be relocated. The statute already requires proposed closure plans to include individualized information about the needs and preferences of each resident.[133] To develop timely and comprehensive relocation plans for each resident, the closing facility needs to identify all of the residents who will need to relocate. Similarly, the department needs this information so that it can fulfill its statutory obligation to assess the closure plan and determine whether and which professionals the facility should work with to assist in the proper relocation of these residents.[134]

Item D requires proposed closure plans to include certain information about the residents that will need to be relocated. This requirement is informed by the department's experience overseeing nursing home closures. Having a baseline of information helps the department understand the magnitude of the issues the closure and attendant relocations will create. In addition to the specific reasons provided below, this information is necessary and reasonable to include in closure plans to ensure compliance by facilities with the statutory requirements for the plans and to ensure that they will be equipped to comply with chapter 144G's coordinated move requirements.[135] The department needs this information as well to fulfil its statutory duty

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[131] *See See Appendix PP—*"Guidance to Surveyors for Long Term Care Facilities", *CMS State Operations Manual*, § 483.70(m), Rev. Nov. 22, 2017 (PDF) (www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf).

[132] Minn. Stat. § 144G.57, subd. 2.

[133] *See* Minn. Stat. § 144G.57, subd. 2(3).

[134] *See* Minn. Stat. § 144G.57, subd. 3.

[135] *See, e.g*. Minn. Stat. § 144G.55, subds. 1(1)-(2) (requiring closing facilities to ensure "a coordinated move to a safe location that is appropriate for the resident . . . [and] to an appropriate service provider"); 144G.57, subd. 2.

to evaluate and approve plans and to identify whether closing facilities will require additional assistance from "department staff, staff of the Office of Ombudsman for Long-Term Care, and other professionals the commissioner deems necessary to assist in the proper relocation of residents."[136]

Subitem 1 requires information about relocating residents' care, services, and special needs and medical conditions. This is consistent with the statutory requirements for these plans,[137] and in MDH staff experience regulating nursing homes, this information is needed to understand the complications presented by a relocation. Notice of a facility closure can trigger an immediate exodus of direct-care staff, which in turn negatively impacts the quality of assisted living services provided to resident.[138] It is essential that the licensee identify residents whose service plans are affected by staffing changes during the closure process and takes immediate steps to ensure continuity in service provision for residents. This may include hiring temporary staff to fill in for staffing shortages. Further, department, county, or ombudsman staff may assist with monitoring the transition of certain individuals when necessary.

Subitem 2 requires information about residents' payment sources. It is necessary for the department to know whether a resident is receiving home and community-based services (HCBS) through one of the State's Medicaid waiver programs under Minnesota Statutes, chapter 256S, and section 256B.49. These include the Elderly Waiver (EW), Brain Injury (BI) Waiver, and the Community Access for Disability Inclusion (CADI) Waiver programs.[139] Each provide home and community-based services for people who need the level of care provided in an assisted living facility or nursing home, but who choose to live in the community.

A facility must ensure that a resident who is receiving these services is relocated to a facility that accepts reimbursement for the HCBS waiver programs. It is reasonable to require the licensee to identify the resident's payment source so the facility and MDH can verify that residents can continue to pay for housing and assisted living services at the receiving facility.

Subitem 3 requires inclusion of the names and contact information of residents' representatives and case managers. Residents will need support from many sources, both formal and informal, to successfully relocate to a safe location and appropriate service provider. Formal supports include legal representatives and case managers. Informal supports include a resident's family and friends.

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[136] *See* Minn. Stat. § 144G.57, subd. 3.
[137] *See* Minn. Stat. § 144G.57, subd. 2(3).
[138] *See* Rudder, Cynthia, "Successful Transitions: Reducing the Negative Impact of Nursing Home Closures", *The National Consumer Voice for Quality Long Term Care*, pp. 8-9 (2016) (PDF) (https://theconsumervoice.org/uploads/files/issues/CV_Closure_Report_-_FINAL_FINAL_FULL_APPENDIX.PDF) (noting staff leaving is a primary obstacle to a successful closure and transition).
[139] For a more detailed description of these programs, see DHS, Waiver and Alternative Care Programs Overview (www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ID_000852) (last visited Sept. 30, 2020); DHS, Customized Living (Including 24-Hour Customized Living) (www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_001787) (last visited Sept. 30, 2020).

Under the terms of the assisted living contract, a resident may identify anyone as a designated representative who may receive information and notices about the resident, including information relating to the resident's health care.[140] The designated representative can also advocate on the resident's behalf. Residents who are receiving public assistance for assisted living services or housing may have a case manager assigned to help them access needed services, identify potential service providers, and coordinate services.

It is reasonable that the licensee identify the individual's representatives and case manager in the proposed closure plan as they each have a vested stake in assisting and supporting the resident through the closure process and because most of this information is easily accessible to facilities via resident contracts.[141]

Subitem 4 requires identification of those residents who do not have a representative or case manager but that the facility has reason to believe may have diminished cognitive capacity. These are among the most vulnerable individuals that will be relocated during a closure. These residents will be difficult to place in a new facility because they are isolated and will struggle to make the necessary decisions and planning to successfully relocate. It is necessary that the licensee identify these residents who will need additional assistance from the facility and the department to help shepherd them through the relocation process.

The department drafted this requirement to include only residents "the facility *has reason to believe* may have diminished capacity" to limit its burden on facilities. It is necessary and reasonable to require identification of these residents early on so that the licensee, and if necessary the care team assembled by the department, can develop steps to work with the county social services agency to address the residents' relocation needs.

Item E requires identification of safe and appropriate housing and service providers that are reasonably close to the facility and may be able to accept a resident.

Minnesota Statutes, section 144G.55, subdivision 1, requires a closing facility to ensure a coordinated move for each resident to a "safe location," which means stable housing where residents can get the care they need.[142] Residents may decline to move to the location the facility identifies.[143] In the spirit of person-centered planning and service delivery, and to ensure that resident choice is allowed, the proposed rule requires the facility to identify at least two safe locations and appropriate service providers.[144] Additionally, it is reasonable for the facility to ascertain whether a potential safe location or appropriate service provider is likely to

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[140] *See* Minn. Stat. § 144G.50, subd. 3 ("Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract…").
[141] *See* Minn. Stat. § 144G.50, subd. 3.
[142] *See* Minn. Stat. § 144G.55, subd. 2 ("A safe location is not a private home where the occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel.").
[143] *See* Minn. Stat. § 144G.55, subd. 1(c).
[144] *See* Minn. Stat. § 144G.09, subd. 3(a), stating, "[t]he commissioner shall adopt rules for all assisted living facilities that promote person-centered planning and service delivery and optimal quality of life, and that ensure resident rights are protected, resident choice is allowed, and public health and safety is ensured."

have an available room for the resident.

Rather than establishing a one-size-fits-all standard, the proposed rule uses a reasonableness standard for the geographic proximity of the alternative housing and service providers. It is likely that some residents in rural areas may have to relocate longer distances to find appropriate care than a resident in an urban area.

Item F requires contact information and a description of the roles and responsibilities of the various individuals that will carry out the facilities' responsibilities during a closure, including temporary managers or monitors. It is not uncommon for an assisted living facility to hire temporary staff to assist with the winding down of a facility's operations. Larger facilities may also hire new assisted living directors or temporary managers or monitors, who were not present when the decision was made to close the facilities, to assist with their closures. In some cases, an assisted living director may not have direct control over an impending closure or the implementation of the facility's written notice and closure plan.

To ensure a safe and orderly closure of the facility, it is essential that the licensee, assisted living director, and any temporary manager or monitor understand their respective roles and responsibilities. It is reasonable for the licensee to include this information in the closure plan so that the department can assess the adequacy of the plan.

Chapter 144G requires closure plans to include "procedures and actions the facility will implement to maintain compliance with this chapter until all residents have relocated."[145] **Item G** identifies specific subjects that must be addressed to comply with this requirement. These are necessary tripwires for the department that are designed to give it advanced notice that a facility is unlikely to meet its residents' needs for the duration of a closure. Each of these items is reasonable to include in a closure plan because no facility that is unable to address them could hope to comply with the obligations imposed on facilities under statute or rule during the closure process. Moreover, the legislature empowered the commissioner to demand "any documentation related to the appropriateness of [a facility's] relocation plan, or to any assertion that the facility lacks the funds to comply with" the planned closure requirements so that the commissioner may determine whether an emergency closure is necessary.[146]

Subitems 1 through 3 require each facility to demonstrate that, for the duration of its closure, it can pay its operating expenses, maintain staffing and resources to continue providing residents with doctor-ordered medical care, and ensure residents' meals, medications, and treatments are not disrupted. These requests are reasonable and necessary as they fall squarely within the commissioner's emergency closure authority, which empowers the commissioner to request information necessary to determine whether she needs to close a facility early to protect the health and safety of its residents where it "can no longer remain open."[147] Chapter

[145] *See* Minn. Stat. § 144G.57, subd. 2(4).
[146] *See* Minn. Stat. § 144G.57, subd. 6.
[147] *See* Minn. Stat. § 144G.57, subd. 6.

144G makes clear that provision of meals, medications, and medical treatment and therapies are necessary to ensure residents' health and safety.[148]

Subitem 4 requires a facility to describe how it will provide transportation of residents during discharge and transfer. Each facility is required under statute to "ensure a coordinated move of [each of its residents] to an appropriate service provider,"[149] and, after receiving the plan, the commissioner must determine whether the facility needs assistance in relocating its residents.[150] This subitem gives the commissioner the information she needs to make that determination.

Subitem 5 requires a facility to describe how it will transfer and reconnect residents' telephone, internet services, and any electronic monitoring equipment. It is necessary for the closure plan to detail how the resident's phone and internet services as well as any electronic monitoring equipment will be transferred and reconnected in the new setting.

The assisted living licensure law protects a resident's access to telephone, internet services, and electronic monitoring equipment. Under the assisted living bill of rights, a resident has the right to access the facility's internet service at the resident's expense.[151] A resident also has the right to access a telephone to make and receive calls.[152] A resident has the right to install an electronic monitoring device in the resident's room or private living unit at the resident's own expense.[153] A facility is required to make a reasonable attempt to accommodate the resident's installation needs, including allowing access to the facility's public-use internet or wi-fi systems when available for other public uses.[154] It is reasonable to enforce these protections by requiring a facility to develop policies and procedures documenting how a resident's access to these communication tools will continue after the resident relocates to the new setting.

Subitem 6 requires a facility to describe how it will account for residents' personal funds during the closure process. Minnesota Statutes, section 144G.42, subdivision 4(b), allows the resident to deposit funds with the facility. Under subdivision 5 of this statute, the facility must provide a final accounting of these funds and return them within 30 days of termination of the resident's housing. To ensure compliance with these requirements, it is necessary that the closure plan provides that the licensee will safely handle the resident's funds as the licensee transfers custodial responsibility of the funds to the resident or resident's representatives.

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[148] *See* Minn. Stat. § 144G.41, subd. 1(13) (requiring the facility to provide at least three nutritious meals daily with snacks available seven days a week, according to the recommended dietary allowances in the United States Department of Agriculture guidelines, including seasonal fresh fruit and vegetables); § 144G.91, subd. 4(b) ("Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.).

[149] *See* Minn. Stat. § 144G.55, subd. 1(a)(2). *See also* proposed Minn. R. 4659.0120, subp. 7.C. which requires that transportation arrangements be made when a resident is relocated.

[150] *See* Minnesota Statutes, section 144G.55, subdivision 3.

[151] Minn. Stat. § 144G.91, subd. 19.

[152] Minn. Stat. § 144G.91, subd. 14.

[153] Minn. Stat. § 144.6502, subds. 2(a), 7(a).

[154] Minn. Stat. § 144G.6502, subd. 7(c).

Subitem 7 requires a facility to describe how it will label and keep residents' belongings safe, and how it will ensure that residents are given contact information for retrieving missing items after the facility has closed.

It is necessary for the closure plan to account for how a resident's belongings will be safely stored and labeled during the relocation process to avoid the loss of these important items during resident relocation. The resident's personal belongings include clothing, durable medical equipment, and furniture. During a facility closure, all of the residents will be packing their belongings and moving around the same time. During this chaotic time, it is easy for a resident's belongings to accidentally be lost or moved to the wrong location.

Under Minnesota Chapter 504B, licensees must store and care for property that is left behind for a period of time after residents vacate the facility.[155] Licensees must allow residents to reclaim this property and, under certain circumstances, residents are entitled to damages if licensees fail to make it available to them.[156] Closures commonly occur, however, because of licensees' financial insolvency. Thus, these damages provisions will have little effect in protecting resident's property. It is reasonable to require licensees to develop policies and procedures in advance of closures that would help ensure that tenants can recover their property.

Subp. 3. ***Commissioner acknowledgment of notice*.**

Subpart 3 governs the commissioner's review and approval of proposed closure plans.

Under **Item A**, the commissioner will acknowledge receipt of a facility's proposed closure plan within 14 days of receiving notice. The rule proposes 14 calendar days to give the commissioner sufficient time to verify receipt of notice. This is consistent with the timeframes set by other jurisdictions. For example, Wisconsin uses a 10 working day timeframe, for responding to receipt of proposed closure notices from assisted living facilities.[157]

Under **Item B**, the commissioner has up to 45 calendar days after acknowledging receipt of the proposed closure plan to approve the closure plan and verify the effective date of the closure. The commissioner has no statutory obligation to establish time limits on herself; instead, the commissioner need only "approve or otherwise respond to the plan as soon as practicable."[158] It is essential that the commissioner and ombudsman have adequate time to review the closure plan to ensure that the residents' health and safety are protected. These time limits give a degree of certainty to licensees and residents, while preserving the commissioner's ability to conduct the thorough review necessary to protect the health and safety of residents.

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[155] *See* Minn. Stat. §§ 144G.11; 504B.271.
[156] *See* Minn. Stat. § 504B.271.
[157] *See* Wisc. Code § 50.03(14)(d) ("The department shall notify the facility within 10 days after receiving the preliminary [closure] plan"). Wisconsin statutes compute time by "the time within which an act is to be done or proceeding had or taken shall be computed by excluding the first day and including the last . . . if the last day within which an act is to be done or proceeding had or taken falls on a Sunday or legal holiday the act may be done or the proceeding had or taken on the next secular day." *See* Wisc. Stat. § 990.001(4).
[158] *See* Minn. Stat. § 144G.57, subd. 3(a).

Upon written receipt of the closure plan, the commissioner will begin a timely review of the closure plan based on statutory criteria and in consultation with the ombudsman and staff from the Health Regulation Division overseeing the licensing and certification of assisted living facilities. The review will determine whether all statutorily required components are present and satisfactory.

The period of 45 days is informed by Minnesota's nursing home involuntary receivership law, which in many ways resembles the same process as an assisted living planned closure. That law gives licensees 45 days to develop a relocation plan in consultation with staff from MDH, DHS, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities.[159]

This 45-calendar-day time period allows the department time to contact the licensee to clarify any outstanding issues raised in the submitted information or to request additional information. The accuracy and completeness of information contained in the plan will facilitate a smooth review and timely approval.

If the commissioner takes the full forty-five calendar days to review and approve a closure plan, the timeframe from the initial written notice to the commissioner to the licensee forfeiting the license is 119 calendar days.[160] This timeframe is reasonable in comparison to a nursing home receivership, which takes 105 calendar days.[161] Note that this is the maximum amount of time that the commissioner may need to verify the effective date of closure. Most closures will be completed in a much shorter time. The facility will be notified in writing about the effective date of closure after the plan is approved.

Subitem 1 provides that the commissioner may contact the licensee about necessary amendments to the closure plan before the commissioner approves it. This is consistent with the process laid out in statute, which requires the commissioner to "approve or otherwise respond to the plan" and to consider requiring a facility to work with a team of professionals to assist in relocation of residents.[162]

Subitem 2 requires licensees to establish and maintain ongoing communication with the commissioner about the closure, including by responding to commissioner inquiries. The commissioner has statutory authority to demand information from licensees regarding their ability to relocate residents, maintain operations, or otherwise maintain the health and safety of residents throughout the closure.[163] The process laid out in this subitem is necessary to ensure that the commissioner can facilitate timely closures while ensuring the closure plan will

[159] *See* Minn. Stat. § 144A.161, subd. 3(b).
[160] The commissioner has 14 calendar days to acknowledge in writing receipt of the licensee's closure plan, and 45 calendar days to review and approve the closure plan. Residents have 60 days from receipt of notice of the closure plan to relocate to another setting.
[161] Under Minnesota Statutes, section 144A.161, subdivision 3, the nursing home and board care relocation takes around 105 calendar days: 45 calendar days for the relocation to be completed after receipt of the licensee's initial notice of closure and 60 calendar days advance written notice to residents, family members, and designated representatives.
[162] *See* Minn. Stat. § 144G.57, subd. 3.
[163] *See* Minn. Stat. § 144G.57, subd. 6.

adequately protect the health and safety of residents. Requiring licensees to maintain ongoing communications with the commissioner is a reasonable alternative to the commissioner waiting until a review is complete before addressing concerns with licensees, thereby extending the review process by losing the time that could be gained if facilities were addressing concerns on a rolling basis during the commissioner's review.

Under **Item C**, in the event a single licensee submits three or more license relinquishments or planned closures in a 30-day period, the commissioner has until 75 days after receipt of the third notice to approve and verify the effective dates of the closure(s). As described above, the commissioner has no statutory obligation to establish time limits for this review.[164] This item is necessary to account for the complexity posed where one licensee is engaged in several simultaneous closures, and accordingly, relocating their residents. This is only a maximum amount of time allowed for review and does not prevent the commissioner from completing reviews sooner where these complexities do not arise.

Item D prohibits the relocation of residents pursuant to the proposed closure plan until the commissioner has approved the plan. This is already prohibited by the statute, and is necessary to reiterate in rule to ensure compliance.[165]

Subp. 4. ***Notice to residents.***

Subpart 4 requires each facility to use the notice of closure that it provided for approval when notifying residents and further requires the notice to residents to identify a primary facility contact with whom the residents and their representatives can discuss resident relocations. The statute already implies that facilities will notify residents by providing a copy of the closure plan,[166] and this subpart simply makes this requirement clear. Subpart 1 of this rule part already requires facilities to identify a contact person in addition to the director as part of their proposed closure plans, so adding this person's contact information to the notice to residents should not burden facilities. This is necessary so that residents and their representatives can contact the facility to resolve issues that may arise as a result of the closure, including issues that affect the residents' relocation plans.

Subp. 5. ***Resident-relocation evaluation***; Subp. 6. ***Resident-relocation plan.***

With the noted exception below, Subparts 5 and 6 are substantively identical to subparts 6 and 7 of the discharge planning rule part[167] and share the same statutory authority.[168] For an explanation of the need for and reasonableness of these subparts, see the Rule-By-Rule Analysis of their counterparts, above.

[164] *See* Minn. Stat. § 144G.57, subd. 3(a).
[165] *See* Minn. Stat. § 144G.57, subd. 3(a).
[166] *See* Minn. Stat. § 144G.57, subds. 2 and 3.
[167] Proposed Minn. R. 4659.0120.
[168] *See* Minn. Stat. § 144G.57, subd. 4; § 144G.55, subd. 1(a).

Subpart 6, **Item E**, allows the department to visit facilities to monitor the closure process. Surveys of facilities to monitor compliance are authorized generally under statute.[169] This item merely informs licensees that the commissioner may choose to do so during closures.

Subp. 7. ***Resident-relocation verification.***

Subpart 7 requires licensees to notify the commissioner once the closure is complete and verify that the licensee complied with the coordinated move requirements under Minnesota Statutes, section 144G.55. The purpose of this subpart is to assist the commissioner with her oversight of the relocation of residents during a closure. Facilities are already required to implement the coordinated move requirements and ensure that arrangements for relocation and continued care are effectuated prior to closure.[170] Asking facilities to verify their compliance with this statutory requirement should pose, at most, a minimal burden on facilities. Informing the commissioner of the completed closure also helps the department ensure that it has taken the steps necessary to end any payments it is making to residents of the facility to cover the services it provides.

Subp. 8. ***Information regarding resident relocation to receiving provider.***

Subpart 8 requires closing facilities to comply with subpart 8 of proposed rule part 4659.0120. For an explanation of the need for and reasonableness of this subpart, see the Rule-By-Rule Analysis for its counterpart.

Subp. 9. ***Disbursing resident funds.***

Subpart 9 requires a facility to comply with the disbursement of resident funds statute that is currently applicable to residents undergoing a facility-initiated or resident-initiated termination.[171] As with a resident who is relocating due to a termination, facility closure necessitates the facility providing the resident with a final accounting of the resident's personal funds that were placed in the facility's care during the resident's residency at the facility. When a resident has deposited funds with the facility, it is necessary and reasonable to also require the facility to return the funds back to the resident.

Subp. 10. ***Resident discharge summary.***

Subpart 10 requires compliance with proposed rule part 4659.0120, subpart 9. For an explanation of the need for and reasonableness of this subpart, see the Rule-By-Rule Analysis for that subpart.

Subp. 11. ***License forfeiture.***

Subpart 11 sets the effective date of closure as the date upon which a closing facility forfeits its license. Once a facility is closed, it will not be providing any housing or assisted living services to any residents and thus it is reasonable to set this date for forfeiture.

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[169] *See* Minn. Stat. § 144G.30, subd. 2.
[170] *See* Minn. Stat. § 144G.57, subd. 4.
[171] *See* Minn. Stat. § 144G.42, subd. 5.

4659.0140 Initial Assessments and Continuing Assessments.

The department is authorized to implement rules and regulations that include "initial assessments, continuing assessments, and a uniform assessment tool" and "standards for resident evaluation or assessment." This part and part 4659.0150 (Uniform Assessment Tool) establish several reasonable and necessary obligations and clarifications to ensure that facilities address these important statutory goals.

Subp. 1***. Admissions.***

Item A is needed to establish responsibility for conducting resident screening, evaluation, and assessments required under Minnesota Statutes, chapter 144G. Minnesota Statutes, section 144G.41, subdivision 2(5)-(6) requires facilities to have current policies and procedures that address initial evaluations of resident needs and initial and ongoing resident assessments (including those by a registered nurse or appropriate licensed health professional) according to the requirements outlined in statute. The assisted living director "administers, manages, supervises, or is in general administrative charge of the facility." Minn. Stat. § 144G.08, subd. 6. The clinical nurse supervisor develops the direct-care staffing plan for the facility.[172] Based on their respective job responsibilities, the assisted living director and clinical nurse supervisor are well-positioned to work together in determining who should be admitted to the facility based on the facility's admission policies. This proposed rule is also reasonable as it mirrors the admission requirements in state nursing home licensing rules. *See* Minn. R. 4658.0140 ("The administrator, in cooperation with the director of nursing services and the medical director, is responsible for the admission of residents to the home according to the admission policies of the nursing home").

Item B is needed to carry out Minnesota Statutes, section 144G.70, subdivision 1, which states that an assisted living facility cannot accept a resident unless "the facility has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the assisted living contract." An assisted living facility can choose which types of assisted living services it will provide to its residents. Based on the services offered and the number and competency of the staff, as well as the physical layout of the facility, among other factors, the facility may not be able to meet the needs of every potential resident seeking admission to the facility. It is therefore necessary and reasonable for the facility to screen potential residents prior to admission to ensure that it only admits residents that it can adequately care for and provide necessary and appropriate services.

Item C is necessary to provide consumer transparency and legal protections for prospective residents who are denied admission to a facility. This rule is also reasonable because it ensures that the facility's admissions process complies with the Americans with Disabilities Act and the

[172] Proposed Minn. R. 4659.0180.

Minnesota Human Rights Act by ensuring that residents are not being denied admission on protected grounds.[173]

Subp. 2. ***Nursing assessment.***

Item A is needed to clarify which group of prospective residents must undergo a nursing assessment prior to moving into a facility or signing an assisted living contract because the statute is slightly unclear.[174] Not all assisted living residents receive health-related assisted living services from a facility's registered nurse.[175] This item states—consistent with Minnesota Statutes, section 144G.70, subdivision 2(b)-(d)–that only a prospective resident requesting health-related assisted living services must undergo a nursing assessment. Every 90 days, the facility must also conduct a nursing reassessment of the resident's cognitive and physical health.[176]

Item B, Subitem 1 is needed to clarify that a facility must conduct a nursing assessment that includes all of the elements listed in the uniform assessment tool in rule part 4659.0150. It is important that a facility examine multiple domains of a prospective resident's physical and cognitive health in order to develop an accurate and comprehensive assessment. The assessment directly affects the quality of care a resident receives as it used to develop a resident's service plan, and the reasonableness of the uniform tool is discussed in greater detail, below, in the justification of Minnesota Rule 4659.0150. In short, this "nursing assessment" reasonably requires a broader range of health-related topics to be addressed than the "individualized review" under the following subpart because the residents receiving a nursing assessment are seeking health care services.

Subitem 2 acknowledges that, ideally, a registered nurse will conduct the nurse assessment of a prospective resident in person so that the nurse can personally observe the resident's physical and cognitive health. For example, the nurse can use his or her senses to observe the resident's ambulatory ability, facial expressions, skin temperature, and pulse. The nurse may also notice potential or underlying health issues that may need to be addressed in the resident's care and service plan.

There are statutory exceptions to the in-person assessment based on geographic distance or "urgent or unexpected circumstances."[177] In these limited instances, it is necessary to have an alternative method to conduct an assessment because the prospective resident is unable to

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[173] *See* 42 USC § 12012; Minn. Stat., ch. 363A. A prospective resident seeking health-related assisted living services will undergo a comprehensive assessment that will require the resident to reveal information about a disability prior to signing an assisted living contract with the facility.

[174] Minn. Stat. § 144G.70, subd. 2 (indicating without expressly stating that residents receiving certain nonmedical services need only undergo an individualized assessment and not a nursing assessment, and further exempting residents from assessment provisions if they do not receive assisted living services).

[175] "Assisted living services" include a variety of services ranging from assistance with daily living activities, such as bathing and dressing, to more complex medical care, such as medication management, complex health-care services, and medical management, which require assistance of highly trained, licensed medical staff. Minn. Stat. § 144G.08, subd. 9.

[176] Minn. Stat. § 144G.70, subd. 2(c)

[177] Minn. Stat. § 144G.70, subd. 2(b).

travel to the facility for an in-person assessment. *See* Minn. Stat. § 144G.70, subd. 2(b). It is reasonable to note for facilities that in-person assessments represent the typical standard and draw attention to the exceptions to that requirement in the rule part governing nursing assessments.

Relevant to **Subitem 3**, commissioner is required to develop and implement rules to ensure public health and safety, including through the development of resident assessment criteria and a uniform assessment tool.[178] To that end, Subitem 3 guarantees that all residents receive a uniform, comprehensive, and individually tailored nursing assessment of their health-care needs, regardless of what assisted living facility a resident chooses to live in. Using a standard assessment tool advances health equity throughout the state as it ensures every resident of a licensed assisted living facility receives a comprehensive assessment of multiple domains of a resident's health and cognitive functioning. This tool is also a reasonable means of ensuring that facilities have information needed to develop an adequate care and service plan for the resident.

Staff who will be caring for the resident will need to review and share the assessment or reassessment with other staff and licensed health professionals at the facility, so it is reasonable and necessary for **Subitem 4** to require the assessment in writing. Because assessments are required periodically by statute, it is also reasonable to require a dated assessment so staff can ensure that they are reviewing the most up-to-date record. Finally, it is reasonable to require that the assessment be signed by the nurse so facility staff know who to contact for follow-up questions.

Subp. 3. ***Individualized review.***

Item A is needed to clarify which residents only require "individualized review" in lieu of a nursing assessment, consistent with Minnesota Statute, section 144G.70. These assisted living residents will not need or request health-related assisted living services and will instead want assistance only with activities of daily living such as dressing, bathing, and grooming, as well as supportive services such as laundry, shopping, and arranging transportation.[179] These assisted living services are equivalent to the services provided under the basic home care license provided under home care licensure law.[180] The resident will therefore not require a nursing assessment under subpart 2 and will receive an individualized initial review or follow-up review, as appropriate. Every 90 days, the facility must conduct a follow-up review.[181]

Most of the basic requirements under **Item B** are similar to those for nursing assessments under subpart 2, and the need and reasonableness of these requirements is addressed in the discussion of that subpart. The primary difference is that the individualized initial review requires the facility to address fewer elements of the uniform assessment tool because the review excludes assessment for health-related services that the resident will not be seeking.

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[178] Minn. Stat. § 144G.09, subd. 9(a).
[179] Minn. Stat. § 144G.08, subd. 9 (1)-(5) sets forth the non-health related assisted living services that can be provided by a facility.
[180] *See* Minn. Stat. § 144A.471, subd. 6.
[181] Minn. Stat. § 144G.70, subd. 2(d).

The topics covered in the review are reasonably tailored to address topics such as a resident's personal lifestyle preferences, ability to perform activities of daily living, desire for assistance with supportive services, and information regarding any advanced health-care directives and legal documents establishing a resident's substitute decision-maker.

In addition, this subpart is needed to clarify that individualized initial reviews must also be conducted in person, unless the circumstances require the assessment to be held by alternative means. This clarification is needed because the statute is silent on where and how individualized initial reviews should take place. Like nursing assessments, an in-person review is beneficial to the facility and the resident because the staff conducting the review are able to identify the type of services the resident will need (by observing things like ambulatory ability, facial expressions, and the like). This in-person review may also signal a need for health-related services (which would require the more detailed nursing assessment). For these reasons, establishing an in-person review standard, with exceptions similar to those allowed for nursing assessments, is reasonable.

Subp. 4. ***Assessor; qualifications.***

Item A is needed to clarify that a registered nurse must both complete a comprehensive assessment and any reassessments of a resident who is receiving health-related assisted living services under Minnesota Statutes, section 144G.08, subdivision 9(6)-(12). Minnesota Statutes, section 144G.70, subdivision 2(c), is silent on who must conduct reassessments. As Minnesota Statutes, section 144G.70, subdivision 2(b), requires an initial assessment to be completed by a registered nurse, it is reasonable that a registered nurse also performs quarterly reassessments of the resident's cognitive and physical health because this reassessment process requires the same level of professional nursing expertise. This item is also consistent with the Nurse Practice Act (*see* Minn. Stat. § 148.171, subd. 15), which defines such comprehensive assessments as the practice of professional nursing.

Item B is needed to clarify that a resident receiving non health-related assisted living services does not need to be evaluated by a registered nurse prior to admission to the facility or for quarterly reviews under Minnesota Statutes, section 144G.70, subdivision 2(d). The statute is silent on this topic, but it is reasonable to allow a staff member who is competent and trained in providing non health-related assisted living services (and thus meets the qualifications in Minnesota Statutes, section 144G.60, subdivision 2) to perform these reviews because these individuals have adequate expertise to perform the task.

Subp. 5. ***Temporary service plan admission.***

Residents who are admitted to a facility during the weekend are often placed on temporary service plans because the facility's clinical nurse supervisor or registered nurse is unavailable to conduct a nursing assessment. In these situations, staff may draft a temporary service plan in order to immediately start providing services to the resident until the clinical nurse supervisor or registered nurse is available to conduct the assessment. Minnesota Statutes, section 144G.70, subdivision 3, restricts the use of a temporary service plan to 72 hours because a resident can sustain physical or cognitive harm by remaining on a service plan that is not based on a comprehensive assessment of the resident's physical and cognitive status.

This subpart clarifies that within 72 hours of initiating a temporary service plan, the clinical nurse supervisor or registered nurse must conduct an initial assessment of the resident as described in Minnesota Statutes, section 144G.70, subdivision 2. This requirement is reasonable and consistent with the statutory limitation of temporary service plans, and ensures that the registered nurse comprehensively assesses the resident's physical and cognitive health and develops a service plan that accurately and holistically addresses the resident's needs.

Subp. 6. ***Consumer protections under temporary service plan.***

The assisted living contract is a binding agreement between the resident and the facility that provides the resident additional consumer protections beyond what is already provided under landlord-tenant law in Minnesota Statutes, chapter 504B. These protections include the assisted living bill of rights, Minnesota Statutes, section 144G.91, as well as appeal rights of assisted living contract terminations, under Minnesota Statutes, section 144G.54. These consumer protections are necessary to protect against any harm that might come to the resident, such as homelessness from eviction, deceptive marketing practices, or sudden, unexpected increases in the cost of housing or assisted living services.

While a temporary service plan under Minnesota Statutes, section 144G.70, subdivision 3 is not a permanent contract, it is an "assisted living contract" as defined by statute, and the statute is clear that persons receiving services under a temporary service plan are still treated as "residents" that receive the consumer protections afforded by Chapter 144G. *See* Minn. Stat. § 144G.08, subd. 5 (defining an "assisted living contract" as "the legal agreement between a resident and an assisted living facility…") and subd. 59 (defining "resident" as "a person living in an assisted living facility who has executed an assisted living contract"); Minn. Stat. § 144G.70, subd. 3 (referring to persons under 72-hour temporary service plans as "residents" and requiring the facility to have a legal agreement with the resident for services). This subpart is needed to clarify this point expressly for facilities and residents. It is reasonable to expect that facilities will exercise careful discretion before admitting residents under a temporary service plan because these facilities have represented that they can provide services to the resident, and the resident has undertaken a significant transition to move into the facility and may have terminated their prior living arrangements. Further, if a resident is terminated under a temporary service plan, the resident is still required to pay the facility for services received as the resident and facility work through the termination and appeals process.

Subp. 7. ***Weekend assessments.***

This subpart is needed to clarify that a registered nurse must be available on the weekends to conduct a nursing assessment of an existing resident who is ready to be discharged from the hospital and return to the assisted living facility where he or she resides. The assisted living law states that "resident reassessment…must be conducted *as needed* based on changes in the needs of the resident."[182] A resident who has sufficiently recovered while hospitalized needs to be reassessed by a registered nurse before the resident can be transferred back to the facility because a hospitalization often involves significant changes in resident needs. *See also* Minn.

[182] Minn. Stat. § 144G.70, subd. 2(c).

Stat. § 148.171, subd. 15(1) (requiring that comprehensive assessments conducted by a registered nurse address changes in a patient's condition).

This rule is reasonable because the Ombudsman for Long-Term Care reported receiving complaints from residents and their family members that residents unnecessarily remain in the hospital over a weekend because the facility's registered nurse is unavailable conduct an assessment. The practice of holding a resident over the weekend at the hospital is expensive for both the state and the resident, who is already paying to reside and receive services from the assisted living facility and should not also have to pay for unnecessary days in the hospital. It may also leave a resident more vulnerable to infection, transfer trauma, or other health issues. The department also received a written comment from a member of the public requesting that assisted living facilities be precluded from barring a resident's return to the facility from the hospital if the patient has sufficiently recovered.[183] Accordingly, this is a reasonable requirement, particularly considering that the number of weekend assessments needed under this subpart is likely to be limited and the facility can choose to meet this requirement through means short of having a nurse on site throughout the weekend (for example, by having a nurse on call).

4659.0150 UNIFORM ASSESSMENT TOOL.

Subp. 1. ***Definition.***

This rule is needed to define the term "uniform assessment tool," and reasonably defines the term as a tool developed in accordance with the requirements of this rule that is used by facilities to obtain a comprehensive assessment of resident needs.

Minnesota Statute, section 144G.09, subdivision 3 authorizes the commissioner to implement rules relating to resident "initial assessments, continuing assessments, and a uniform assessment tool." Further, Minnesota Statutes, section 144G.70, subdivisions 2 and 4, require a facility to conduct an initial nursing assessment and individualized initial review, as well as quarterly reassessments and reviews, to identify a prospective resident's assessed needs and develop a resident-oriented service plan. But chapter 144G does not specifically define what information a facility needs to collect during an assessment or review. This rule closes this gap by providing uniform assessment criteria to facilities for the collection of essential information about each resident's physical and cognitive needs, as well as their preferences and habits. This uniform assessment requirement also advances health equity in Minnesota as it ensures that prospective residents or residents throughout the state receive a comprehensive assessment.

Subp. 2. ***Assessment Tool Elements.***

It is necessary to list in rule the minimum components of the uniform assessment to ensure that facilities gather complete information on a resident's physical health and cognitive status as well as the resident's strengths and needs, all of which eventually form the foundation for the resident's service and care plans. It is also necessary to require that facilities develop and utilize a uniform tool for the purposes of ensuring equitable and consistent assessments across

[183] Comment from Todd Redmann, MSW, St. Luke's Hospital, Duluth, MN, received on February 24, 2020.

a wide range of facilities. Many of the uniform assessment elements are derived from the Oregon Administrative Rules for Residential Care and Assisted Living Facilities, and have been further refined for additional clarity for the reader and to address specific statutory requirements in chapter 144G (*see, e.g.,* item D, subitem 4, which addresses numerous requirements for medication management assessment detailed in Minnesota Statute, section 144G.71).[184] Further, as discussed above in part 4659.0140, facilities are permitted to apply their uniform tool in a more flexible manner than the Oregon law because residents may choose to decline health-related services at the time of admission. The department's decision to derive requirements from Oregon's existing law is reasonable for multiple reasons.

First, the department initially proposed a longer and more expansive uniform assessment tool similar to the Washington State Comprehensive Assessment Reporting Evaluation.[185] The department also considered the MnCHOICES tool, which, like the Washington State tool, is used to assess an individuals need and eligibility for home and community based services that are typically funded through Medicaid waiver programs.[186] The proposed tool would have been administered by the state, further developed by the commissioner and interested stakeholders over the fall and winter of 2020, and deployed on August 1, 2021.

The department eventually set aside its plans to create a state-administered uniform tool and instead elected to outline uniform tool elements in rule, due in part to the unrealistic cost and time investment associated with the development of the tool.[187] Moreover, the Assisted Living Rules Advisory Committee provided detailed feedback about the proposed tool. Some members persuasively argued that the proposed tool was overly burdensome in light of the fact that assisted living providers already use existing software packages to conduct assessments that cover all of the elements listed in this subpart. After further consideration, the department agreed that the proposed tool was too complex, costly, and inflexible, especially considering that many facilities have already incurred substantial cost in assessment tools that can easily achieve compliance with this rule. Facilities that do not conduct assessments that address all of the elements of this subpart will either need to adjust their current assessment tools, invest in new assessment software, or devise alternative ways to develop a tool and achieve compliance.

Second, the department's use of Oregon's assessment as a model is reasonable because the Oregon law utilizes a holistic approach that addresses multiple domains of the resident's

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[184] *See* O.A.R. § 411-054-0034.

[185] *See* Washington State Department of Social and Health Services, Aging and Long-Term Support Administration Comprehensive Assessment Reporting Evaluation-Care (www.dshs.wa.gov/altsa/home-and-community-services/comprehensive-assessment-reporting-evaluation-care).

[186] *See* DHS Legislative Report, MnCHOICES Benchmarks (PDF) (www.leg.mn.gov/docs/2020/mandated/200306.pdf); DHS Licensing fo Home and Community-Based Services-245D providers (https://mn.gov/dhs/partners-and-providers/licensing/hcbs-245d/).

[187] Some cost estimates associated with the MnCHOICES tool exceeded $600 million. *See* "Minnesota takes steps to modernize disability services", *Star Tribune* (www.startribune.com/minnesota-takes-steps-to-modernize-disability-services/567211422/). In addition, DHS developed the tool from 2004 to 2013, the year of its eventual rollout. *See* Dominiak, Maria, et. al., "Considerations for a National Risk-Adjustment Model for Medicaid Managed Long-Term Services and Supports Programs", *Center for Health Care Strategies, Inc.*, p. 3 (Sept. 2016) (PDF) (www.chcs.org/media/Considerations-for-a-National-Risk-Adjustment-Model-MLTSS_092816.pdf).

physical, cognitive, and emotional well-being. Academic research confirms that a resident experiences better health outcomes when an assisted living facility addresses the resident's needs in a holistic manner.[188]

Finally, like the Oregon law, this subpart also provides flexibility to facilities by not prescribing a form or format for the assessment. Flexibility is reasonable and necessary goal, as facilities range from smaller residences that may be able to conduct and keep assessments on paper, to much larger residential complexes and corporate entities that require an automated assessment system. Many facilities have invested considerable cost on assessment tools used in the provision of their current services. Allowing them to supplement those assessment tools to include any assessment elements not addressed in their existing tool is a reasonable and cost effective compromise.

Subp. 3. ***Record keeping.***

This subpart is needed to clarify, consistent with Minnesota Statutes, section 144G.43, subdivision 3(7), that a facility is required to keep copies of completed assessment tool results in resident records.

Subp. 4. ***Licensee attestation.***

This requirement allows the department to ensure that the facility is prepared to comply with the assessment and review requirements of this rule part. The assessment tool, as well as other documents facilities are required to establish, use, and maintain, must be available for review by the Commissioner at any time, including at the time of a survey, complaint investigation, or other licensing activities. *See* Minn. Stat. § 144G.30, subd. 4. This attestation, coupled with the department's survey, complaint investigation, and enforcement responsibilities, are a reasonable means of ensuring compliance with assessment obligations and alerting facilities to the importance of those obligations.

Subp. 5. ***Department access to the uniform assessment tool.***

At the time of a survey, investigation, or licensing activity, a department surveyor will verify that the licensee's uniform assessment tool complies with this rule. Facilities found to be using assessment tools that do not comply with this rule may be subject to fines or enforcement actions under Minnesota Statutes, sections 144G.20 and 144G.31. This subpart, similar to subpart 3, is a necessary and reasonable means of signaling the importance of uniform assessment obligations to a facility, and imposing a directive to department investigators and surveyors to verify assessment tool compliance.

[188] Thompson, Hilaire J., et al., "A Holistic Approch to Assess Older Adults' Wellness Using e-Health Technologies", *Telemedicine Journal and E-Health*, Vol. 17, No. 10, pp. 794-800 (Dec. 17, 2011) (www.ncbi.nlm.nih.gov/pmc/articles/PMC3228591/).

4659.0160 RELINQUISHING AN ASSISTED LIVING FACILITY WITH DEMENTIA CARE LICENSE.

Under Minnesota Statutes, section 144G.80, subdivision 3, a licensee holding an assisted living with dementia care license can voluntarily relinquish the license and downgrade to an assisted living facility license. The statute requires the licensee to provide written notice of the license relinquishment to the commissioner and the ombudsman.

This proposed rule part draws from the Centers for Medicaid and Medicare Services licensee notification requirements for the planned closures of nursing homes.[189] Similar to a planned closure, a license relinquishment will often require assisted living residents with significant physical cognitive and physical frailties to relocate to another setting. Minnesota law allows an assisted living facility to provide the same levels of complex care as a nursing home.[190] Generally, an assisted living facility with dementia care facility cares for vulnerable adults with severe cognitive deficits and can also have a secured dementia care unit.[191]

Subp. 1. ***Voluntary relinquishment; notifying commissioner and ombudsman.***

Under **Item A**, a licensee must submit to the commissioner and ombudsman a copy of its transitional plan. A licensee is already required by statute to provide a copy of its transitional plan to the commissioner along with its written notice of voluntary relinquishment.[192] This item requires the facility to also submit a copy to the ombudsman. **Item B** requires a licensee to include with the transition plan contact information of a senior staff member other than the director who can serve as a point of contact during the relinquishment process.

The ombudsman's staff are experienced in reviewing plans for closure or other transitions and can identify when there are problems with the plans. It is necessary for the transitional plan to be reviewed by the ombudsman in order to ensure that all of the elements of the transitional plan are adequately addressed and that the plan ensures that the license relinquishment process does not negatively affect the safety and wellbeing of the facility's residents.[193] Further, the ombudsman can inform residents of their rights and options and observe the transfer and discharge process. It is reasonable for the commissioner and the ombudsman to review the plan jointly in order to assess the plan's completeness and coordinate the deployment of their staff during the license relinquishment. Maintaining contact with the

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[189] *See Appendix PP—*"Guidance to Surveyors for Long Term Care Facilities", *CMS State Operations Manual*, § 483.70(m), Rev. Nov. 22, 2017 (PDF) (www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf).

[190] *See* Minn. Stat. § 144G.08, subd. 9 (12) (defining "assisted living services" to include "complex or specialty health care services…").

[191] Minn. Stat. § 144G.08, subd. 8 ("Assisted living facility with dementia care" means a licensed assisted living facility that is advertised, marketed, or otherwise promoted as providing specialized care for individuals with Alzheimer's disease or other dementias. An assisted living facility with a secured dementia care unit must be licensed as an assisted living facility with dementia care.").

[192] *See* Minn. Stat. § 144G.80, subd. 3(a).

[193] Minn. Stat. § 144G.80, subd. 3(2) (The transition plan must demonstrate "how the current residents shall be evaluated and assessed to reside in other housing settings that are not an assisted living facility with dementia care, that are physically unsecured, or that would require move-out or transfer to other settings…").

facility is necessary to facilitate this process, and the reasonableness of designating an alternative point of contact is discussed in the Rule-By-Rule analysis of the planned closures rule, above.

Subp. 2. ***Transition plan; contents.***

Subpart 2 lays out the required contents of the transitional plan in addition to those expressly required in statute. The purpose of this subpart is to obtain key information about the plans, policies, and procedures the licensee has established to ensure the license relinquishment process does not negatively affect the safety and wellbeing of the facility's residents.[194]

Under **item A**, the transition plan must provide the reason for relinquishing the license and proposed date of relinquishment. Voluntary relinquishment of a license can occur for many reasons. For example, a licensee may want to surrender a license in anticipation of further enforcement actions by the state due to chronic poor performance on surveys. A licensee may be facing chronic staffing shortages and be unable to provide the additional services, meet physical plant requirements, or to meet staffing requirements under the dementia-care license. Submitting the information to the commissioner in advance of the relinquishment allows the commissioner to make an informed decision about how and if to exercise the commissioner's investigative authority to monitor a facility throughout the relinquishment process.[195]

Item B, requires the transitional plan to include a proposed timetable for resident transitions and a description of how the facility will facilitate them and with what resources. The transitional plan must demonstrate "how the current residents shall be evaluated and assessed to reside in other housing settings that are not an assisted living facility with dementia care, that are physically unsecured, or that would require move-out or transfer to other settings."[196] For each resident that needs to relocate as a result of the relinquishment, the facility must ensure a coordinated move "to a safe location that is appropriate for the resident and . . . an appropriate service provider . . . ."[197] For residents who transfer instead of moving out, the facility "must provide for the safe, orderly, coordinated, and appropriate transfer of residents within the facility" subject to statutory safeguards similar to those that apply to coordinated moves.[198] Item B requires facilities to use the information gained from the evaluation the statute already requires to begin planning for the coordinated moves and transfers that chapter 144G also requires. It is necessary and reasonable to require facilities to plan for how they will satisfy these statutory obligations with regard to residents who are among the most vulnerable individuals the facilities can serve. Submitting the information to the commissioner in advance of the moves allows the commissioner to monitor and ensure compliance throughout the

[194] Minn. Stat. § 144G.80, subd. 3(a)(2).
[195] *See* Minn. Stat. § 144G.30.
[196] *See* Minn. Stat. § 144G.80, subd. 3(a)(2).
[197] *See* Minn. Stat. § 144G.55, subd. 1(a)–(b).
[198] *See* Minn. Stat. § 144G.56.

relinquishment without burdening the facility and the department with the need to demand this information under the commissioner's investigative authority.[199]

Item C, requires the transitional plan to include a list of residents who may require a change in service plan because of the relinquishment and a description of the residents' respective levels of care, special needs, or conditions. Facilities are already required to "change service or care plans as appropriate to address any needs the residents may have with the transition."[200] Accordingly, it is reasonable to require facilities to compile the information necessary to make such changes in preparation for the relinquishment. By receiving the list of residents required by item C, the ombudsman and department can ensure these necessary assessments have been conducted and help ensure residents received proper care.

Item D requires transitional plans to identify each resident to whom the facility expects to issue a notice of termination of housing or assisted living services because of relinquishment. Facilities are already required to provide written notice of termination to these residents around the same time as they are required to submit their transitional plans to the department and ombudsman.[201] It is thus reasonable to ask that facilities include a list in their plans. Further, it is necessary to provide this information to MDH and the ombudsman so that both offices can understand the scope of the relinquishment's impact on the facility's residents to determine the extent to which they need to monitor or intervene in the relinquishment and relocation process to protect these mostly vulnerable residents that must now relocate.

Subp. 3. ***Notice to Residents.***

Item A, subitem 1, adds to the statutory notice requirement in Minnesota Statute, section 144G.80, subdivision 3 (which requires notice to residents and their representatives) by requiring facilities to provide notice to residents' case managers and explain the reasons for the relinquishment. This proposed rule part is necessary to ensure the case manager can assist the resident by beginning the process of identifying payment sources for the resident's care.

It is necessary that the licensee disclose the reason for the license downgrade in order to allow residents and their families, as well as their formal and informal supports, to make informed choices about the resident's continued residency at the facility.[202] Chapter 144G already requires the licensee to provide a "detailed explanation of the reasons for the reduction [of services] and date of reduction" to residents whose services are being reduced at least 60 days before the reduction.[203] A relinquishment necessarily requires licensees to end dementia care services for residents, to the extent the facility is providing them.[204] Accordingly, it is reasonable to require this information be included in the notice.

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[199] *See* Minn. Stat. § 144G.30.
[200] Minn. Stat. § 144G.80, subd. 3(a)(3).
[201] *See* Minn. Stat. §§ 144G.55, subd. 1(d), and 144G.80, subd. 3(a); proposed Minn. R. 4659.0130, subp. 1.A.
[202] *See* Minn. Stat. § 144G.09, subd. 1(1) (requiring regulations respecting resident choice).
[203] *See* Minn. Stat. §§ 144G.55, subd. 1(d)(1), and 144G.80, subd. 3(a)(1)(i).
[204] *See* Minn. Stat. § 144G.10, subd. 2(a)(2).

Subitem 2 requires the facility to provide a primary contact that the resident and the resident's representative and case manager, if any, can contact to discuss transitioning the resident out of the facility. It is rare for a licensee, especially of larger assisted living facilities, to be an owner/operator who resides on the facility premises. Smaller facilities are likely to share the services of a licensed assisted living director as a cost-saving measure, as is typically the case in nursing homes. Given the fact that neither the licensee nor the assisted living director may be present at the facility on a full-time basis, it is necessary for the licensee to identify an alternative contact person with supervisory responsibilities that the residents or their representatives, can call with questions about the impending license downgrade and how to transition a resident out of the facility if needed.

Under **Item B**, once it has notified residents, the facility must revise its marketing materials to remove indications that the facility offers dementia care services and communicate to potential and new residents entering the facility that it will be relinquishing its license. Chapter 144G already requires the revision of the marketing materials. This item merely sets the date by which the facility must do so and adds the disclosure requirement to new and prospective residents. It is necessary for the licensee to be transparent to consumers about the impending license downgrade so that it does not accept any new residents into the facility who will need dementia care services either now or in the future based on a misapprehension that the facility will be able to provide those services.

Subp. 4. ***Resident-relocation evaluation.***

Subpart 4**, Item A**, requires the facility to prepare a resident relocation evaluation and comply with part 4659.0120, subpart 6, for each resident whose contract the facility terminates. See the Rule-By-Rule analysis of subpart for an explanation of its need and reasonableness.

Item B provides that the relocation evaluation may include recommendations for continuing to receive housing and assisted living services from the assisted living facility that is relinquishing its assisted living facility with dementia care license. This item acknowledges that it is possible for the resident to remain at the facility and arrange for provision of required assisted living services by an outside licensed home care provider.[205] The assisted living contract states that the resident has a right to obtain services from an unaffiliated service provider.[206] As this item does not impose an obligation on residents or facilities and merely provides choices, it is reasonable.

Subp. 5. ***Resident-relocation plan.***

Subpart 5 requires the facility to hold a planning conference to develop a relocation plan and comply with part 4659.0120, subpart 7, for each resident whose contract the facility terminates. See the Rule-By-Rule analysis of subpart for an explanation of its need and reasonableness

Subp. 6. ***Verifying resident relocation.***

[205] *See* Minn. Stat. § 144G.91, subd. 24.
[206] Minn. Stat. § 144G.50, subd. 2(e)(3).

Under Subpart 6, once all residents whose contracts the facility has terminated have left the facility, the licensee must notify the commissioner and verify that the residents have been safely relocated and that the licensee complied with the coordinated move requirements under Minnesota Statutes, section 144G.55. The purpose of this subpart is to assist the commissioner with her oversight of the facility's compliance with the relevant rules and statutes regarding relinquishment and coordinated moves, and to ensure that none of these residents are neglected or placed in an unsafe location as a result of the relinquishment.[207] Facilities are already required to ensure a coordinated move to a safe location and an appropriate service provider for residents that must relocate as a result of the relinquishment.[208] Asking facilities to verify their compliance with this statutory requirement should pose, at most, a minimal burden on facilities. Informing the commissioner of the completed move also helps the department ensure that it has taken the steps necessary to end any payments it is making to relocated residents of the facility to cover the services it provides.

Subp. 7. ***Information regarding resident relocation to receiving provider.***

This subpart requires facilities to comply with subpart 8 of proposed rule part 4659.0120. For an explanation of the need for and reasonableness of this subpart, see the Rule-By-Rule Analysis for its counterpart.

Subp. 8. ***Disbursement of resident funds.***

This subpart requires a facility to comply with the disbursement of resident funds statute that is currently applicable to residents undergoing a facility-initiated or resident-initiated termination.[209] As with a resident who is relocating due to a termination, a resident relocation due to an assisted living with dementia care license relinquishment necessitates the facility providing the resident with a final accounting of the resident's personal funds that were placed in the facility's care during the resident's residency at the facility. When a resident has deposited funds with the facility, it is necessary and reasonable to also require the facility to return the funds back to the resident

Subp. 9. ***Resident discharge summary.***

This subpart requires compliance with proposed rule part 4657.0120, subpart 9. For an explanation of the need for and reasonableness of this subpart, see the Rule-By-Rule Analysis for that subpart.

Subp. 10. ***Assisted living facility with dementia care license forfeiture.***

Under **Item A**, the forfeiture date of the assisted living license is the proposed date of license relinquishment, unless the commissioner has approved of an extension to that date in writing. This item exists to provide necessary clarity for facilities, residents, and the department. Utilizing the proposed relinquishment date as the default forfeiture date is reasonable because

[207] *See* Minn. Stat. §§ 144G.55 (coordinated move requirements) and subdivision 2 (defining safe location), 144G.80, subd. 3 (relinquishment statute).
[208] *See* Minn. Stat. § 144G.55, subd. 1(a).
[209] *See* Minn. Stat. § 144G.42, subd. 5.

that is the date the facility will have chosen to provide to residents and the department under its notice[210] and transitional plan.[211] The requirement that the commissioner must approve an extension in writing is necessary and reasonable to avoid confusion by ensuring that there is a clear written record with the facility and the department of the date change.

Item B provides that the commissioner shall reclassify the license to the assisted living facility license category as of the date of relinquishment. This is necessary to include in rule to avoid confusion about whether a facility retains its license to provide assisted living services upon relinquishment of its license to also provide dementia care services and to clarify that the date of reclassification is the same as the date of relinquishment.

When a licensee relinquishes an assisted living with dementia care license, the licensee automatically receives an assisted living facility license. If this were not so, the licensee would undergo a planned closure instead.[212] Reclassification also means that the licensee does not have to go through the requirements of initial licensure as stated in Minnesota Statutes, section 144G.12. Instead, the licensee is able to continue operating with minimal disruption to its residents that do not receive dementia care services.

Under **Item C**, a licensee may not reapply for an assisted living facility with dementia care license until one year after relinquishment. This item intends to prevent licensees who are unable to meet the heightened demands of the dementia care population from attempting to do so. Residents who must leave a facility because of license relinquishment are subjected to a stressful and intense relocation process. Relinquishments and resulting relocations also require the department and ombudsman to dedicate resources to overseeing the relinquishments and responding to resident concerns.[213] It is necessary and reasonable, therefore, to seek to discourage relinquishments by requiring licensees to take time to prepare to succeed before making a subsequent attempt at obtaining an assisted living with dementia care license.

4659.0170 DISEASE PREVENTION AND INFECTION CONTROL.

The assisted living licensure law requires that facilities "establish and maintain an infection control program" and implement up-to-date infection control practices. *See* Minn. Stat. § 144G.41, subds. 2(8) and 3. But further clarification is needed to explain what assisted living facilities should do to control infection and the sources of information that should inform facility infection control programs and practices. These clarifications are consistent with the legislature's directive to establish regulations "to ensure, to the extent possible, the health, safety, well-being, and appropriate treatment of residents" and to protect public health and safety. *See* Minn. Stat. § 144.09, subds. 1(1) and 3(a). Further, this rule is consistent with the

[210] *See* Minn. Stat. § 144G.80, subd. 3(a)(1)(i).
[211] Proposed Minn. R. 4659.0160, subp. 2.A.
[212] *See* Minn. Stat. § 144G.57 (planned closure); 144G.80, subd. 3(b) ("Nothing in this section alters obligations under section 144G.57.").
[213] *See, e.g.*, Minn. Stat. § 144G.80, subd. 3(a) ("The licensee must notify the commissioner and the Office of Ombudsman for Long-Term Care in writing at least 60 calendar days prior to the voluntary relinquishment of an assisted living facility with dementia care license.").

requirements under Minnesota Statutes, section 144A.4798, subdivisions 2 and 3 that already apply to licensed home care providers that provide assisted living services in registered housing with services establishments.

Subpart 1. Communicable diseases. Communicable disease reporting requirements are the standard method for performing public health surveillance in every state, including Minnesota. The reporting requirements in this rule part are necessary in a facility providing health care services in a long term care setting to vulnerable adults who may have health conditions that make them especially susceptible to communicable diseases.

The COVID-19 pandemic has highlighted the vulnerability of residents in these settings and the need for clear guidance on reporting such diseases.[214] Further, this pandemic has highlighted that the role of public health follow up, testing, and contact tracing as a means of controlling the spread of disease and infection, including in long-term care settings.[215] Accordingly, it is reasonable to clarify for all assisted living facilities that they must comply with state disease reporting and provide specific citation to applicable requirements.

Subp. 2. Infection control program. Health care-associated infections (HAIs) are infections people get while they're receiving health care for another condition. They can happen at any health care facility, including assisted living facilities. HAIs are a significant cause of illness and death, and they can have serious emotional, financial, and medical consequences. These infections lead to tens of thousands of deaths and cost the U.S. health care system billions of dollars each year.[216] The Center for Disease Control and Prevention (CDC), estimates that 1 to 3 million serious infections occur every year in long-term care facilities, which include assisted living facilities.[217] These numbers emphasize the need for effective infection prevention planning in assisted living facilities.

With the current emphasis on appropriate infection control practices in the health care industry as a result of the COVID-19 pandemic, this rule part is critically important to protecting resident health and safety. This subpart reasonably requires that facility infection-control programs under Minnesota Statutes, section 144G.41, subdivision 3 incorporate current guidelines for infection prevention and control for long term care facilities from the CDC and—consistent with Minnesota Statute, section 144A.4798—accepted health care, medical and nursing standards. The CDC offers free guidance and tools specifically for long term care setting that facilities can use to establish their infection control programs.[218] Further, because the science and

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[214] *See, e.g*, Howatt, Glenn & Serres, Chris, "Minnesota COVID-19 cases surge again among long-term care residents and workers", *StarTribune* (Aug. 8, 2020) (www.startribune.com/state-s-covid-cases-increasing-among-long-term-care-residents/572041592/).

[215] MDH Long-term Care Testing: COVID-19 (www.health.state.mn.us/diseases/coronavirus/hcp/ltctesting.html); MDH Tracing COVID-19 (www.health.state.mn.us/diseases/coronavirus/tracing.html).

[216] U.S. Department of health and Human Services, Health Care Associated Infections (https://health.gov/our-work/health-care-quality/health-care-associated-infections).

[217] Centers for Disease Control and Prevention, Nursing Homes and Assisted Living (Long-term Care Facilities [LTCFs]) (www.cdc.gov/longtermcare/index.html).

[218] Centers for Disease Control and Prevention,Infection Prevention and Control Assessment Tool for Long-term Care Facilities (PDF) (www.cdc.gov/infectioncontrol/pdf/icar/ltcf.pdf).

understanding of infections and diseases—particularly those that are newly emerging—continues to evolve over time, this rule part reasonably requires facilities to follow the most up-to-date guidelines.

4659.0180 STAFFING.

The commissioner is authorized to implement rules to address "staffing appropriate for each licensure category to best protect the health and safety of residents no matter their vulnerability." Minn. Stat. § 144G.09, subd. 3(c). In addition, Minnesota Statute, section 144G.41, subdivision 1(11) requires facilities to have a staffing plan that meets certain criteria. This part establishes several reasonable requirements to guarantee that facility staffing and staffing plans are adequate to meet the needs of facility residents. These requirements are also consistent with person-centered planning and service delivery and provide needed flexibility to facilities (which vary in size and resident population) by making clear that adequate staffing levels depend on an individualized professional assessment of each resident's needs and the care environment. Minn. Stat. § 144G.41, subd. 1(3) (requiring all assisted living facilities to "utilize a person-centered planning and service delivery process").

Subp. 1. Definition.

This proposed subpart defines the group of individuals who provide assisted living services directly to the assisted living residents. Direct-care staff includes licensed practical nurses, advanced practice nurses, registered nurses, and unlicensed personnel. This definition is needed and reasonable because this part establishes staffing and planning requirements for only those staff that are directly responsible for meeting the care needs of residents.

Subp. 2. Clinical nurse supervisor.

Minnesota Statutes, section 144G.41, subdivision 4 requires that every facility have a clinical nurse supervisor on staff who is a registered nurse licensed in Minnesota. The rule also establishes a number of responsibilities for registered nurses. See, e.g., Minn. Stat. §§ 144G.41, subd. 2; 144G.62, subd. 1. This proposed rule clarifies that a facility's clinical nurse supervisor may meet all of the facility's registered nurse responsibilities and the facility does not have to hire a second registered nurse. The department anticipates that it would be cost prohibitive for certain facilities to hire two nurses, especially smaller facilities that may otherwise only employ one nurse on a part-time basis.

Subp. 3. Direct-care staffing; plan required.

This proposed rule part provides guidelines for developing a direct-care staffing plan. Minnesota Statutes, section 144G.41, subdivision 1(11) requires a facility to develop a staffing plan that, in part, will "ensure[] sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis." While there are numerous references in chapter 144G emphasizing the need for a facility to have a fully staffed and trained workforce to care for residents, the department believes it is necessary to provide additional guidance for developing a direct-care staffing plan because the statute does not explain who develops the plan and provides minimal guidance on what the person developing

the plan must consider. It is also critically important that staffing plan requirements are clearly explained in rule for several reasons.

First, long-term care facilities, including assisted living facilities, are experiencing chronic staffing shortages, especially for direct-care workers like registered nurses, licensed practical nurses, and nursing aides.[219] The COVID-19 pandemic has only exacerbated the staffing shortage crisis.[220] One of the underlying reasons for the shortage include a decreasing supply of available workers and persistently low wages.[221] Given the staffing shortage, the department believes it is incumbent upon the facility to ensure that it is able to meet the needs of its residents with its staff, identify any gaps in its staffing, and make timely arrangements for an outside service provider or temporary staffing personnel to care for residents.

Second, federal and state regulations governing nursing homes and home care licensure laws historically have required a sufficient number of adequately trained staff as a condition of licensure.[222] Despite these regulations, the department continues to substantiate maltreatment findings from these facilities.[223] For example, the Office of Health Facility Complaints reported a 50-percent increase in 2017 in the number of reports of alleged maltreatment or licensing violations from 2012.[224] In fiscal year 2017, the Office of Health Facility complaints received 24,100 alleged maltreatment and licensing complaints.[225] Low staffing can contribute to maltreatment by neglect and facility responsibility for these incidents,[226] and these statistics underscore the critical importance direct-care staff play in a resident's health and safety and the need to provide additional guidance to facilities to develop a robust direct-care staffing plan.

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[219] Stone, Robyn and Harahan, Mary, "Improving the Long-Term Care Workforce Serving Older Adults", *Health Affairs* (2010) (www.healthaffairs.org/doi/full/10.1377/hlthaff.2009.0554); "Direct Care/Support Workforce Summit: Summary Report and Next Steps", Minnesota Department of Human Services, p. 1, (Nov. 18, 2016) (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7271A-ENG).

[220] *The Associated Press*, "Pandemic aggravates Minnesota care center staffing shortages", *Minnesota Public Radio* (May 1, 2020) (www.mprnews.org/story/2020/05/01/pandemic-aggravates-minnesota-care-center-staffing-shortages).

[221] Stone, Robyn and Harahan, Mary, "Improving the Long-Term Care Workforce Serving Older Adults", *Health Affairs* (2010) (www.healthaffairs.org/doi/full/10.1377/hlthaff.2009.0554).

[222] *See* 42 C.F.R. § 483.35 ("[t]he facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident…"); Minn. Stat., § 144A.04, subd. 7 (requiring minimum staffing standards for nursing personnel in nursing homes); Minn. Stat. § 144A.4791, subdivision 4 ("No home care provider may accept a person as a client unless the home care provider has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the service plan and that are within the provider's scope of practice").

[223] Maltreatment is defined as abuse, neglect or financial exploitation of a vulnerable adult. Minn. Stat. § 626.5572, subd. 15.

[224] Office of Health Facility Complaints: 2018 Evaluation Report, Office of the Legislative Auditor, p. S-2 (2018) (PDF) (www.auditor.leg.state.mn.us/ped/pedrep/ohfc.pdf).

[225] *Id*.

[226] *See* Minn. Stat. § 656.5572 (noting "neglect" includes the failure to provide necessary care or supervision); Minn. Stat. § 656.557, subd. 9c (c) (stating facility responsibility depends on adequacy of facility staffing levels and policies, among other factors).

Third, Minnesotans recognize the importance of competent and trained staff caring for their loved ones in assisted living facilities. DHS recently contracted with the University of Minnesota to develop an Assisted Living Report Card that will measure and report on the quality of assisted living settings.[227] In developing the report card, university researchers crafted a survey asking 822 respondents to rate the level of importance of nine factors affecting the quality of assisted living communities.[228] Respondents ranked staff quality as the second most important factor.[229] This result held controlling for the respondent's gender, location, age, and race/ethnicity.[230]

This subpart designates the clinical nurse supervisor as the person responsible for developing the staffing plan, and this is reasonable because the clinical nurse supervisor must have a substantive and active role in staffing decisions and evaluating the needs of each individual resident. The clinical nurse supervisor, with input from the residents' health professionals, should define the competencies required for all direct-care staff to deliver, individualize, and provide care for the facility's residents based on the residents' assessed needs. Under the Nurse Practice Act, Minnesota Statutes, section 148.171, subdivision 15, the registered nurse is responsible for collaborating with other health care providers and caregivers to develop and coordinate an integrated plan of care for each resident. The registered nurse is also accountable for the quality of care delivered. *Id*.

Under **Item A**, the clinical nurse supervisor must ensure that the direct-care staffing levels meet the resident's needs under the service plan and that the resident receives any other negotiated services listed in the assisted living contract. Based on the resident's nursing assessment (*see* Minn. Stat. § 144G.70), the clinical nurse supervisor must determine how the direct-care staff will provide the resident's service plan. The assisted living contract is the written agreement between the facility and the resident concerning the provision of housing, assisted living services, and the resident's service plan.[231] The contract also discloses the nature of any other services to be provided to the resident for an additional fee.[232] It is reasonable for a staffing plan to ensure that each resident receives the appropriate level of direct staff care as dictated by these contracts and service plans. This subpart is needed because chapter 144G does not discuss resident contracts and service plans in the context of the facility's staffing plan.

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[227] Shippee, Tetyana, et al., "Stakeholder Feedback on Identifying Quality Measures for a Minnesota Assisted Living Report Card", University of Minnesota School of Public Health (Jan 2020) (PDF) (https://mn.gov/dhs/assets/UMN-Assisted-living-report-card-stakeholder-report_tcm1053-417276.pdf).

[228] *See id. at* 8-10. The nine factors measured are: resident quality of life, resident and family satisfaction, safety, resident health outcomes, staff, physical and social environment, service availability, core values and philosophy, and care services and integration.

[229] *Id.* at 3.

[230] *Id.* at 42.

[231] Minnesota Statute, section 144G.50, subdivision 1.

[232] Minnesota Statute, section 144G.50, subdivision 2(b).

Item B is needed because acuity levels in assisted living populations continue to rise as individuals shift away from nursing homes and instead opt to live in assisted living facilities.[233] Acuity level means the intensity of nursing care for a resident that is "difficult, time-consuming, or complex."[234] Acuity of care is greater for residents who require complicated health procedures, have psychosocial or therapeutic interventions, take oral medications, and use complicated intravenous drugs and other medications.[235]

When developing the staffing schedule, assisted living residents with higher acuity levels will require more staff time in order to meet the residents' needs.[236] In fact, one of the most important factors in determining staffing levels is the level of acuity of the residents.[237] It is reasonable for the clinical nurse supervisor to ensure that there is sufficient qualified nursing staff available at all times to provide nursing and related services commensurate with the residents' acuity levels and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being. It is also reasonable to base this on the individualized, resident-centered assessments that are already required under 144G.

Under **Item C**, it is necessary to clarify that the staffing plan must take into account how each setting affects the ability of the direct-care staff to carry out their duties in a timely fashion.[238] Assisted living facilities can range from a single family home providing services to a few residents, to a continuing care retirement campus housing hundreds of residents in different buildings.[239] Direct-care staff may have to travel farther distances to reach residents who need care if the resident population is spread out in different wings, floors, or buildings. It is therefore reasonable to state that the direct-care staffing plan should take into account how long it takes for direct-care staff to travel around the facility's premises during their shift in order to meet the scheduled and reasonably foreseeable unscheduled needs of the residents.

Item D is needed because assisted living residents with Alzheimer's disease or related dementias and who reside in a secured dementia care unit often have "dementia-related behavior", which may include agitation, mood and sleep disturbances, and aggression.[240]

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[233] "Literature Review and Environmental Scan: Identifying Quality Measures in Assisted Living", University of Minnesota School of Public Health, p. 6 (June 30, 2019) (PDF) (https://mn.gov/dhs/assets/UMN-assisted-living-quality-report_tcm1053-393870.pdf).

[234] *See* Kidd, Michelle et al., "A New Patient Acuity Tool Promotes Equitable Nurse-Patients Assignments" Workforce Management, *American Nurse Today,* Vol. 9, No. 3 (March 2014) (PDF) (www.myamericannurse.com/wp-content/uploads/2014/03/ant3-Workforce-Management-Acuity-304.pdf).

[235] *Id.*

[236] *See id.*

[237] *See* Institute of Medicine (U.S.) Committee on Improving Quality in Long-Term Care, Improving the Quality of Long-Term Care, Ch. 6: "Strengthening the Caregiving Work Force" (2001) (www.ncbi.nlm.nih.gov/books/NBK224489/).

[238] *See* "American Nurse Association's Principles for Nurse Staffing", *American Nurses Association*, p. 6 (2nd Ed. 2012) (PDF) (www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/principles-of-nurse--staffing--2nd-edition.pdf).

[239] *See* Connolly, John, "Continuing Care Retirement Communities Explained", AgingCare (www.agingcare.com/articles/defining-continuing-care-retirement-communities-104569.htm).

[240] Gaugler, Joseph, et al., "Direct Care Worker Training to Respond to the Behavior of Individuals with Dementia, *Gerontology and Geriatric Medicine* (Feb. 11, 2016) (www.ncbi.nlm.nih.gov/pmc/articles/PMC3228591/)

Dementia-related behaviors occur in more than 80% to 90% of those individuals with Alzheimer's disease and related dementias. [241] These behaviors may cause additional stress for direct-care workers in these units, and negatively impact their ability to complete their job duties.[242] One study found that nurses' aides in nursing homes who work with cognitively impaired residents with aggressive behaviors reported increased exhaustion, increased burden, and declines in physical health and work attendance.[243] This item reasonably requires a facility to consider the increased demands of dementia care units to ensure that resident needs can be met without undue staff burden. This item is consistent with the directive in Minnesota Statutes, section 144G.09, subdivision 3(c)(1) to consider different licensure categories in staffing-related regulations.

Item E is needed to emphasize that the clinical nurse supervisor must ensure that the staff's expertise and experience match the needs of the assisted living residents. The specific needs of the resident population served should determine the appropriate clinical competencies required of the registered nurse and direct-care staff practicing in that facility, so it is reasonable to require the clinical nurse supervisor to consider these factors in developing the direct care staffing plan.

Subp. 4. Daily staffing schedule.

Under **Item A, Subitem 1**, direct-care staff need a 24-hour daily staffing schedule so that they understand their immediate work responsibilities for each shift, and residents know where the staff are located on the facility premises. It is also important for facilities to have this schedule information documented so department staff may review it as part of its survey or complaint investigation. It is reasonable that the clinical nurse supervisor be responsible for this task because this individual is responsible for developing and implementing the staffing plan discussed in subpart 3. This requirement ensures that the clinical nurse supervisor can verify that actual staffing practices are consistent with that plan.

Subitem 2 ensures that the daily staffing schedule explains staff work responsibilities and the location that the staff member can be found during a work shift. This rule is reasonable because it clarifies for the entire staff which particular staff member is assigned to work with a resident, or where a staff member can generally be located in case additional assistance is needed elsewhere or in case of an emergency.

Item B requires posting the daily staffing schedule in a central location on each floor of the facility, and this requirement is needed to allow staff, residents, and residents' family members, among other individuals, to understand who is caring for a resident, where to locate a particular staff member, and how many staff are allocated throughout the facility's premises on a given shift. It also indicates whether a licensed health professional, such as a physical

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[241] *Id.*

[242] *Id.*

[243] McKenzie, et al., "Reactions of Assisted Living Staff to Behavioral and Psychological Symptoms to Dementia", Geriatric Nursing, Vol. 33, pp. 96-104 (Feb. 2012) (www.researchgate.net/publication/221820388_Reactions_of_Assisted_Living_Staff_to_Behavioral_and_Psychological_Symptoms_of_Dementia).

therapist, social worker, or a registered nurse, is available on the premises on that particular shift. This requirement is reasonable because residents and their representatives may want to talk to the staff member or licensed health professional during their shift about issues or concerns relating to the resident's health. This requirement also ensures that staff have quick access to staff information if additional assistance is needed for resident care or in emergency situations.

Subp. 5. Direct-care staff availability.

This requirement is needed to ensure adequate staffing during nights and weekends at assisted living facilities, specifically for residents' scheduled and foreseeable unscheduled needs, such as toileting for residents' who require use of a two person lift. Studies confirm that staffing levels in long-term care settings tend to be lower on nights and weekends.[244] This proposed rule part comes from Oregon Administrative Code for assisted living facilities.[245] It is reasonable because it does not require the facility to hire any extra staff, as the resident's care plan should already specify when a resident needs assistance from two direct-care staff and the facility should have adequate staff available to meet the residents' needs. It also ensures that direct-care staff will have assistance in performing certain activities, like resident lifts, where workplace injury is common.[246]

Subp. 6. Direct-care staff availability: night supervision.

Minnesota Statutes, section 144G.41, subdivision 1(12)(ii), states that a facility must ensure that one or more persons are available 24 hours per day, seven days a week, who can respond to residents' request for assistance with their health and safety needs in "a reasonable amount of time." This proposed rule offers more guidance on a facility's required response time to a resident's request for assistance. This rule is needed to clarify that during overnight hours where staffing is typically lower, the facility still must have sufficient staff to respond as soon as possible to residents' requests for assistance with their health or safety needs, but no later than ten minutes.

The department selected a maximum response time of ten minutes because research confirms that faster call response times prevent harm to residents, and residents reasonably expect to receive help from direct-care staff in a timely manner.[247] Moreover, timely responses to call

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[244] *See* Harrington, Charlene, et al., "Appropriate Nurse Staffing Levels for U.S. Nursing Homes", Health Service Insights (June 29, 2020) (www.ncbi.nlm.nih.gov/pmc/articles/PMC7328494/); Marselas, Kimberly, "Keeping Watch by Night", *McKnight's Long Term Care News* (July 4, 2016) (www.mcknights.com/news/keeping-watch-by-night/).

[245] O.A.R. 411-054-0070 (1)(g), (https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=247875).

[246] *See generally* "Guidelines for Nursing Homes: Ergonomics for the Prevention of Musculoskeletal Disorders", U.S. Department of Labor: Occupational Safety and Health Administration, OSHA 3182 (2009), (PDF) (www.osha.gov/ergonomics/guidelines/nursinghome/final_nh_guidelines.pdf).

[247] *See* Tzeng, Heury-Ming, et al. "The Contribution of Staff Call Light Response Time to Fall and Injurious Fall Rates: An Exploratory Study in Four U.S. Hospitals Using Archived Hospital Data", *BMC Health Services Research* (Mar. 31, 2012), (www.ncbi.nlm.nih.gov/pmc/articles/PMC3364911/).

light requests for assistance are associated with greater resident satisfaction[248] and lower total fall and injurious fall rates.[249] California also requires a ten-minute response time for resident's request for emergency assistance in residential care facilities for the elderly.[250]

4659.0190 TRAINING REQUIREMENTS.

This rule part establishes standards to ensure that all staff persons providing assisted living services are trained and competent in the provision of services consistent with current practice standards appropriate to resident needs and the assisted living bill of rights. *See* Minn. Stat. § 144G.91 ("Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties . . ."). Minnesota Statutes, chapter 144G provides a largely comprehensive list of training topics and provisions to ensure staff are competent and trained. This rule incorporates and supplements those requirements where necessary and where the statute is unclear, under the Legislature's directive to implement regulation and rules establishing "standards of training of facility personnel" and "training prerequisites and ongoing training, including dementia care training and standards for demonstrating competency." Minn. Stat. § 144G.09, subds. 1(3), 3(c)(2). This rule part also establishes standards for portability of staff training from one facility to another, and for maintaining staff training records as required under Minnesota Statutes, section 144G.42, subdivision 8.

The requirements of this rule part and chapter 144G are consistent with many of the key best practices and recommendations for staff training identified in the Long Term Care Community Coalition's 2018 report, *Assisted Living: Promising Policies and Practices for Improving Resident Health, Quality of Life, and Safety*.[251] The report notes that "[s]taff training, knowledge, and skills are essential to assisted living resident care. If staff members are not properly trained to meet residents' needs, residents will likely have a greater risk of experiencing poor outcomes and harm (such as that resulting from abuse or neglect), and even death."

Subp. 1. Training policy. This subpart is needed to clarify the elements that must be included in a facility's training, orientation, and competency evaluation policy under Minnesota Statutes, section 144G.41, subdivision 2, and encompasses the orientation, training and competency requirements included in eight separate sections of 144G, broken down by category of

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[248] Deitrick, Lynn, et. al,. "Dance of the call bells: using ethnography to evaluate patient satisfaction with quality of care", *Journal of Nursing Care Quality*, Vol. 21, No. 4, p. 316 (2006), (PDF) (http://citeseerx.ist.psu.edu/viewdoc/download;jsessionid=635437049235B9CE49F849ED09E9A9A8?doi=10.1.1.519.9215&rep=rep1&type=pdf).

[249] Tzeng, et al., "The Contribution of Staff Call Light Response Time to Fall and Injurious Fall Rates: An Exploratory Study in Four U.S. Hospitals Using Archived Hospital Data", BMC Health Services Research (Mar. 31, 2012), (www.ncbi.nlm.nih.gov/pmc/articles/PMC3364911/).

[250] 22 CCR § 87581, (https://govt.westlaw.com/calregs/Document/I936C0BE0D4BE11DE8879F88E8B0DAAAE?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)).

[251] See "Assisted Living: Promising Policies and Practices for Improving Resident Health, Quality of Life, and Safety", *Long Term Care Community Coalition* (2018) (PDF) (https://nursinghome411.org/wp-content/uploads/2018/10/LTCCC-Report-on-Assisted-Living.pdf).

licensure. This subpart is reasonable because it provides a single reference for providers to easily find various requirements in statute and makes clear that facility policies need to address these requirements.

Subp. 2. Additional orientation.

Minnesota Statute, section 144.63 establishes detailed orientation requirements for staff, but this subpart is needed to fill several important gaps in that required orientation. Under **Item A**, it is necessary to require staff to receive orientation on their job duties upon hire and anytime there are changes to the job or how it is performed to ensure staff can know and perform assigned duties. The reasonableness of this requirement is self-explanatory.

Under **Item B**, it is necessary for staff to receive orientation on the facility's organizational structure and the services offered by the facility so that they understand the scope of services provided by the facility and how the services are provided and by whom. A comprehensive understanding of these functions provides context to staff about their role in the facility. In addition, this orientation is reasonable to ensure that staff know where to bring concerns or complaints (whether about their own employment or resident care), or seek needed services for residents that the staff person cannot provide.

Finally, under **Item C**, it is necessary to require that staff receive a comprehensive orientation on their obligations under Vulnerable Adults Act in Minnesota Statutes, sections 626.557 to 6262.5572. Currently, the statute requires orientation on staff reporting obligations, but does not clearly and directly explain that staff must receive instruction on what constitutes maltreatment and that maltreatment is prohibited. This clarification is reasonable to support safe, effective delivery of assisted living services, and protects residents' health and safety. Further, when staff understand what constitutes maltreatment, they are better prepared to fulfill their obligation as a mandated reporters.

Subp. 3. Additional training requirements for assisted living facilities with dementia care licenses.

"About 70 percent of assisted living residents live with Alzheimer's Disease or some form of dementia," and specific training in caring for residents with these conditions is an essential purpose of chapter 144G.[252] Indeed, chapter 144G requires all staff to complete dementia related training across a number of topics, whether or not a facility has a dementia care license.[253] But facilities that are licensed to provide specialized care for Alzheimer's disease or other dementias and specifically market or promote themselves as providing such specialized

[252] Mollot, Richard, et. al., "Assisted Living: Promising Policies and Practices for Improving Resident Health, Quality of Life, and Safety", *Long Term Care Community Coalition* (2018) (PDF) (https://nursinghome411.org/wp-content/uploads/2018/10/LTCCC-Report-on-Assisted-Living.pdf)

[253] This mandatory training includes: effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders (Minn. Stat. §§ 144G.63, subd. 5 and 144G.64(b)(3)-(4)); an explanation of Alzheimer's disease and other dementias (Minn. Stat. § 144G.64(b)(1); assistance with activities of daily living (Minn. Stat. § 144G.64(b)(2)); and person-centered planning and service delivery (Minn. Stat. §§ 144G.63, subd. 2(a)(6) and 144G.64(b)(5).

care must also comply with additional statutory requirements. For example, these facilities are required to have policies that address "staff training specific to dementia care." Minn. Stat. § 144G.82, subd. 3(5). Further, staff in dementia care licensed facilities "must be trained on the [dementia-related] topics identified" in the department's rules. Minn. Stat. § 144G.83, subd. 2(a). **Item A** is needed to outline necessary dementia care training topics for these specialized dementia-care facilities, and this rule reasonably limits these additional training requirements to staff persons directly providing services to residents.

Under **Subitem 1**, it is necessary that staff training in these facilities go beyond "an explanation of" various dementias (*see* Minn. Stat. § 144G.64(b)(1), and provide at least a baseline understanding of cognitive impairment and behavioral and psychological symptoms of dementia (BPSD). BPSD are commonplace and associated with high levels of distress both in dementia sufferers and their caregivers, as well as with adverse outcomes and increased use of health care resources.[254] Effective caregiver training (which "typically focuses on understanding behavioral disturbances as responses to discomfort, unmet needs, or attempts to communicate; creating soothing environments with optimal levels of stimulation; and responding to patients in ways that de-escalate problematic behaviors") is "effective in both reducing a range of BPSD as well as improving caregiver well-being."[255]

Regarding **Subitem 2**, research indicates that a "care plan focused on non-pharmacological interventions is considered best practice as the first-line management of most [neuropsychiatric symptoms] of dementia," and emphasizes the importance of training caregivers on such approaches as a means to significantly improve both caregiver and resident quality of life.[256] The statute also requires facilities to address non-pharmacological approaches that are "person-centered and evidence-informed" and other various methods of care and intervention. Minn. Stat. § 144G.82, subd. 3(a). Thus, it is reasonable for this subitem to require training on standards of dementia care, including non-pharmacological approaches.

Under **Item B**, it is necessary to require that a facility verify that individuals responsible for overseeing and providing dementia training meet the qualifications in Minnesota Statute, section 144G.83, subdivision 3 before the individual provides or oversees training. This reasonable requirement ensures that only properly qualified staff provide this critical health and safety instruction, and it is reasonable to require that facilities maintain documentation of qualifications so the commissioner can verify compliance with this requirement.

In addition, this item is needed to clarify the "skills competency or knowledge test" that a trainer or training supervisor must pass under Minnesota Statute, section 144G.83, subdivison 3(3) (stating training providers and supervisors must pass a test "required by the

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[254] J. Cerejeira, et. al., "Behavioral and Psychological Symptoms of Dementia", *Frontiers in Neurology* (May 7, 2012), (www.ncbi.nlm.nih.gov/pmc/articles/PMC3345875/).

[255] Cloak, Nancy and Khalili, Yasir Al, "Behavioral and Psychological Symptoms in Dementia", *StatPearls*, (Jan. 2020), (www.ncbi.nlm.nih.gov/books/NBK551552/).

[256] D'Onofrio, et. al., *Update on Dementia*, Ch. 18 (Non-Pharmacological Approaches in the Treatment of Dementia), p. 484 (Sept. 2016), (www.researchgate.net/publication/308696361_Non-Pharmacological_Approaches_in_the_Treatment_of_Dementia).

commissioner"). This item reasonably clarifies that the commissioner will keep and update a list of acceptable tests that are based on current recognized best practice standards in the field of dementia care. For example, the Alzheimer's Association—a recognized leader in dementia care training programs—provides certification examinations that reflect current best practices and standards of care. *See* Pathways to Dementia Care Training and Certification, Options for individuals and providers (www.alz.org/professionals/professional-providers/dementia-care-training-certification). Publishing a list of acceptable tests is reasonable and flexible because this option does not require a rule amendment each time a test is added or developed, or when industry best practice changes. Further, facilities, residents, and resident advocates can provide suggested tests to the commissioner for consideration and addition.

Subp. 4. Staff competency; retraining.

Chapter 144G requires staff competency in a number of areas (*see, e.g.*, Minn. Stat. §§ 144G.60, subds. 2 to 4, 144G.61, and 144G.62, subds. 2 to 4), but a rule part is needed to address the situation where a facility determines that a staff is not demonstrating competence in performing their duties. Assisted living staff must generally be supervised for competency when providing assisted living services, including those delegated by a health professional. *See* Minn. Stat. § 144G.62. This subpart reasonably requires that facilities incorporate into their policies a plan for retraining staff who are not demonstrating competency. Further, this subpart provides facilities opportunities to develop and implement plans to actively bring staff into competency in a manner that protects resident rights (including those in the Assisted Living Bill of Rights under Minnesota Statute, section 144G.91), in effort to mitigate the workforce shortage issues in Minnesota that plague assisted living facilities that rely on direct care support workers.[257]

Subp. 5. Portability of staff training.

Unlicensed personnel are required to receive training and achieve competency in a range of areas before providing assisted living services to residents. *See generally* Minn. Stat. § 144G.60, subd. 4. But this subpart is needed to address situations where competent and trained staff are hired by a new facility or change facilities—an issue not addressed in statute. **Items A and B** reasonably state that unlicensed staff members are deemed trained and competent in their new facility as long as they received the training within the prior 18 months and are able to pass the facility's competency evaluation.[258] The 18-month period is consistent with the time

[257] "Direct Care/Support Workforce Summit: Summary Report and Next Steps", Minnesota Department of Human Services, p. 1, (Nov. 18, 2016), (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7271A-ENG).

[258] This subpart also indirectly recognizes that certain areas of training are inherently nontransferable, including: orientation requirements under Minnesota Statutes, section 144G.63, subdivisions 1 and 2, facility policies under Minnesota Statute, section 144G.41,258 subdivision 2, and facility emergency preparedness and missing person plans, which are specific to each facility and resident population; orientation to residents and their service plans under Minnesota Statutes, section 144G.63, subdivision 3, which are specific to individual residents; annual training requirements under Minnesota Statutes, section 144G.63, subdivision 5, because a new 12-month period for completing annual training begins with the staff person's employment at the new facility; and training on tasks delegated by a licensed health professional, as these tasks are specific to the delegating professional and subject to the appropriate Minnesota professional practice act under Minnesota Statute, section 144G.62, subdivision 2.

frame for transferring prior dementia care training to a new facility under Minnesota Statute, section 144G.64(b). In addition, this subpart aids facilities dealing with the pervasive staffing shortages and high rate of turnover referenced in subpart 4, above.

Subd. 6. Training records and certificate.

This subpart is needed to clarify the documentation requirements required by this rule part and Minnesota Statutes, section 144G. 42, subdivision 8, regarding employee records (the latter of which requires "records of orientation, required annual training and infection control training, and competency evaluations"). This part sets forth a number of basic, reasonable documentation requirements so the department can verify the facility involved with the training, the training topics or program (including the date and length of the training), and that the necessary parties (including the employee, the trainer, and the competency evaluator) have signed off on the employee's completion of training and competency. Further, this part reasonably requires that employees be provided copies of their training and competency certificates.

4659.0200 NONRENEWAL OF HOUSING, REDUCTION IN SERVICES; REQUIRED NOTICES.

Subp. 1. ***Relocation requirements for nonrenewal of housing and reduction in services.***

Subpart 1 of this part serves a similar purpose to the planned closures and discharge planning parts, above, in that it establishes requirements for discharge and relocation planning, under the authority of Minnesota Statutes, sections 144G.09, subdivision 3(c)(3), 144G.53(c) (requiring facilities to ensure coordinated moves and relocation planning in situations of nonrenewal), and 144G.55 (requiring coordinated moves and relocation planning when a reduction in services necessitates a move). This separate section is needed for situations where a facility elects not to renew a resident's housing because a facility does not have to follow the full termination process in Minnesota Statute, section 144G.52 and rule part 4659.0120 (Discharge Planning) if it provides 60-day notice to the resident. Similarly, a reduction of services that requires a resident to move is not a complete termination under Minnesota Statute, section 144G.52, subdivision 1.

This subpart reasonably clarifies what discharge planning requirements are applicable in these situations. Because neither of these situations require compliance with the full suite of termination and pretermination procedures, but both do require relocation planning and coordinated moves to ensure resident health, safety, and welfare, this section reasonably requires compliance with only the subparts in 4659.0120 that relate to relocation planning and coordinated moves. The reasonableness of these requirements are discussed in the above analysis of part 4659.0120.

Subp. 2. ***Service reduction notice.***

Subpart 2 clarifies the process for submitting notices to the ombudsman of reductions in services required under Minnesota Statute, section 144G.55, subdivision 1(f), which requires notice when a facility, resident, or representative determines that the reduction will require the resident to move, but does not state what the notice should entail. This section reasonably requires a description of the reduction in services and why that reduction will require a move, and the name and contact information for the individuals the ombudsman may need to follow up with (i.e., the resident, case manager, and representatives).

Subp. 3. ***Change in facility operations notice.***

Similarly, Subpart 3 spells out the requirements for a notice to the ombudsman of changes to facility operations that will require a resident transfer, required under Minnesota Statute, section 144G.56, subdivision 5(a)(4). Notice to the ombudsman is required before notifying residents of a transfer so the ombudsman can follow up and ensure compliance with applicable legal requirements. Thus, this subpart reasonably requires the facility to state when transfers will occur, the facility's plan for complying with its obligations to provide proper notice (Minn. Stat. § 144G.56, subd. 3), ensure safe and orderly transfers (Minn. Stat. § 144G.56, subd. 2), and to minimize transfers, consider resident preference, and provide needed accommodations (Minn. Stat. § 144G.56, subd. 5). Further, this section reasonably requires the facility to identify affected residents and provide contact information so the ombudsman can conduct needed follow up.

4659.0210 TERMINATION APPEALS; PROCEDURES AND TIMELINES FOR APPEALS.

The department is authorized to develop and implement rules to ensure that resident appeal rights are preserved, and to develop procedures and timelines for the commissioner regarding termination appeals between facilities and the Office of Administrative Hearings. Minn. Stat. § 144G.09, subd. 3(c)(3), (9). Minnesota Statute, section 144G.54 guarantees residents a right to appeal a termination of an assisted living contract on several defined grounds.

Subp. 1. ***Resident Appeal Notice of Termination.***

Under subpart 1, the department provides two separate timelines to appeal terminations, both of which are reasonably drafted to align with the notice requirements in Minnesota Statute, section 144.52, subdivision 7. For "expedited" terminations relating to health and safety issues, a facility is required to provide at least 15-days advance notice, so this subpart allows residents to appeal within that 15-day period to effectively stay the termination until their appeal is resolved. *See* Minn. Stat. § 144G.54, subd. 6. For terminations that relate to non-payment or other violations of assisted living contracts, facilities are required to give at least 30-days advance notice, so the department similarly permits residents to appeal any time before their termination becomes effective. *Id*. The need for this clear appeal timeline is self-explanatory.

Subp. 2. ***Contact commissioner to start appeal.***

Subpart 2 requires residents to notify the commissioner in writing of their intent to appeal a termination to allow the department to track the status and timeliness of the appeal.[259] This notice also allows the department to initiate the resident's appeal with the Office of Administrative Hearings, and the reasonableness and need for this requirement is self-explanatory. Lastly, because may have potential residents waiting for admission, this subpart provides needed finality to facilities that follow proper notice requirements by establishing that residents waive their right to appeal if they do not appeal within the timelines established in this part.

Subp. 3. ***Hearing process.***

Subpart 3 establishes the procedures for a hearing to clarify the department's existing statutory mandate. Minnesota Statute, section 144G.54, subd. 3 states that hearings shall not be "formal" contested cases unless the chief administrative law judge determines a contested case is necessary. Due to the statute's expressed intent for an abbreviated and expedited hearing process, the department reasonably elected to incorporate the existing abbreviated hearing procedures in the Revenue Recapture Act rules, which establish limitations on hearing and prehearing conduct that do not exist in the contested case rules. *Compare* Minn. R. 1400.5010 to 1400.8400 *with* Minn. R. 1400.8505 to 1400.8612.

In addition, existing law mandates that administrative law judges conduct hearings in an impartial manner and permits residents to non-attorney representation in a hearing. *See, e.g.,* Minn. Stat. § 14.50; Minn. Stat. § 144G.54, subd. 3(d); Minn. R. 1400.8604, subp. 4; Minn. R. 1400.8606. Residents of assisted living facilities are often vulnerable and unable to effectively advocate for themselves, so items C and D provide that non-attorney representatives may present an appeal on a resident's behalf and emphasize that administrative law judges have authority to take necessary steps to guarantee unrepresented parties a fair hearing. An equivalent provision to item D also appears in the statute governing fair hearings before human service judges, who also frequently hear matters involving unrepresented parties. Minn. Stat. § 256.0451, subd. 20.

Subp. 4. ***Order of commissioner.***

Finally, subpart 4 gives the commissioner 14 calendar days to accept or reject the recommendation of the administrative law judge before it becomes final, and also allows parties an opportunity to submit additional argument to the commissioner. In the development of these rules, facilities expressed a strong and reasonable interest in securing a final decision on an expedited basis because terminations are based on grounds such as resident non-payment or contractual violations, some of which relate to staff or resident health and safety. The department considered its process for resolving compliance issues in nursing facilities under the Centers for Medicare and Medicaid Services State Operations Manual, which requires a final decision within 10 days. Unlike the nursing facility dispute resolution process, the department will not have a representative present at each termination appeal. As a result,

[259] Existing law is clear that service of an appeal request is effective upon mailing. Minn. R. Civ. P. 5; 1400.5550, subp. 2; Minn. R. 1400.8545, subp. 2.

the department concluded that 14 days is a reasonable amount of time to allow the commissioner to review hearing records, consider additional arguments, and issue a prompt decision.

CONCLUSION

Based on the foregoing, the proposed rules are both needed and reasonable.

_____ _____

Date

Jan Malcolm
Commissioner
Minnesota Department of Health

APPENDIX A

October 27, 2020

Ms. Lindsay Dean
Executive Budget Officer
Minnesota Management and Budget
658 Cedar St., Ste. 400
St. Paul, MN 55155

Dear Ms. Dean,

Minnesota Statutes, section 14.131, requires that an agency engaged in rulemaking consult with the Commissioner of Minnesota Management and Budget, "to help evaluate the fiscal impact and fiscal benefits of the proposed rule on units of local government."

Enclosed for your review are copies of the following documents on proposed rules relating to assisted living facility licensure:

1. The Governor's Office Proposed Rule and SONAR Form;
2. The draft of the proposed rule; and
3. A draft of the SONAR.

As you will notice, the Governor's Office Proposed Rule and SONAR Form is already signed by a Governor's Office representative. This is because MDH and the Governor's Office engaged in a two-part review process of this SONAR. The first step of this review occurred before MDH had completed certain portions of the SONAR related to cost analyses that are relevant to MMB's review.

If you or any other representative of the Commissioner of Minnesota Management and Budget has questions about the proposed rule, please call me at (651) 201-5923. Please send any correspondence about this matter to me via email at *josh.skaar@state.mn.us*.

Sincerely,

Josh Skaar
Rulemaking Attorney
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164

APPENDIX B

Uniform Disclosure of Assisted Living Services

Below is a list of services that [INSERT FACILITY NAME HERE] has elected to make available to assisted living residents, as well as services we do not provide.

The purpose of this disclosure statement is to empower consumers by describing an assisted living facility's policies and services in a uniform, person-centered manner. The categories are standardized, but facilities are not required to provide all of the listed services. Instead, facilities should use the checklist to provide facility-specific information to residents. This format provides prospective residents and their families' consistent categories of information to compare programs and services that are relevant to a resident's ability to age in place. This disclosure statement does not replace visiting facilities, talking with other residents, residents' family members, or meeting one-on-one with facility staff. The disclosure statement is not a substitute for the assisted living contract, which is a separate document. Rather, this statement serves as additional information for making an informed decision about the services provided by the facility.

Today's Date: _____

Availability of Services (check one):

☐Services are available to any resident of the building

☐Services are available only in a portion of the building (specify): _____

_____

Availability of Unlicensed Staff (ULP) (check one):

☐Unlicensed staff are in the building and available to respond or provide services 24/7

☐Unlicensed staff are either in the building, an attached building, or within the campus and available to respond to calls

Availability of Licensed Staff (RN/LPN) (check one):

☐Licensed staff are on site 24/7

☐Licensed staff are either in the building, an attached building, or within the campus and available to respond to calls 24/7

☐Licensed staff are available to the ULP as needed but may be off site for portions of the day, weekends or holidays

[INSERT FACILITY NAME HERE] has the following license and, if applicable, secured unit (check one):

☐Assisted Living Facility License

☐Assisted Living with Dementia Care Facility License

☐We hold an Assisted Living with Dementia Care License AND have a secured dementia care unit

MEDICATION MANAGEMENT	Provided	Not Provided	Comments
Verbal or visual reminders to take regularly scheduled medications (specify any limit to frequency)			
Medication Management – includes communication with physician, pharmacy, ordering, set-up			
Medication Administration			
Delivery of previously set up medication			
Delivery of medication in original containers			
Delivery of liquid or food with medication			
Delegated medication management services			
Central storage of medication			
Diabetic care: ▪ Blood glucose monitoring ▪ Insulin pen dosing ▪ Insulin syringe dosing ▪ Sliding scale insulin management ▪ Insulin pump management			
Clinical Lab monitoring pertaining to medications			
Clinical Lab monitoring pertaining to other medications			
Anticoagulant medication management			
B-12 injections			
Nutritional supplement administration			
IV's			
PIC lines			

MEDICATION MANAGEMENT	Provided	Not Provided	Comments
Injections (specify types or limits)			
Nebulizers			
Inhalers			
Eardrops			
Eye drops			
Topicals			
Medications delivery via G-tube			
Insulin or pain pump management			
Medical cannabis storage for certified patients			
Medical cannabis administration for certified patients			
Cannabidiol oil administration			

STAFFING & SERVICES	Provided	Not Provided	Comments
One-to-One staffing			
Every 15 minutes safety checks			
Every 30 minute safety checks			
Hourly safety checks			
Overnight companion			
Services for residents who cannot leave their beds			
One-staff-to-one-resident staffing for special circumstances			
Assisted Living Director – Full Time			

STAFFING & SERVICES	Provided	Not Provided	Comments
Assisted Living Director – Part Time (# of facilities)			
Advanced Practice Registered Nurse – Full/Part Time			
Activities Director – Full/Part Time			
Dietician/Nutritionist – Full/Part Time			
Licensed Practical Nurse – Full/Part Time			
Physical Therapist – Full/Part Time			
Registered Nurse – Full/Part Time			
Respiratory Therapist – Full/Part Time			
Occupational Therapist – Full/Part Time			
Speech Language Pathologist – Full/Part Time			
Social Worker – Full/Part Time			
Other Licensed Professional – Full/Part Time			
Delegation of Services by RN or licensed health Professional to unlicensed staff: ▪ selected nursing/treatment tasks ▪ Selected therapy tasks			

TREATMENTS & THERAPIES	Provided	Not Provided	Comments
Verbal/visual reminders to perform regularly scheduled treatments or exercises			
Wound Management			
Complex wound care			

TREATMENTS & THERAPIES	Provided	Not Provided	Comments
C-PAP			
Bi-PAP			
Oxygen Management			
Ventilators			
Suctioning			
Tracheostomy Care ▪ Tracheotomy tube assistance ▪ Cleaning of tracheotomy site and tube ▪ Suctioning assistance ▪ Showering assistance			
Pacemaker Checks			
Automatic electronic defibrillators			
On-Site Dialysis			
Off-Site Dialysis			
Peritoneal Dialysis			
Management of bowel control, devices, and training programs			
Compression stockings			
Foot care			
Fall prevention ▪ Strength training ▪ Balance assessments ▪ Exercise programs			
Integrative health services			

TREATMENTS & THERAPIES	Provided	Not Provided	Comments
▪ Acupuncture ▪ Aromatherapy ▪ Massage ▪ Healing touch			
Blood pressure checks			
Lymphedema wraps			
Catheter care			
Ostomy care			
Dementia care services ▪ Secured unit or building for wandering or exit-seeking behavior ▪ Secured outdoor grounds on facility premises ▪ Individualized electronic monitoring for wandering or exit-seeking behavior ▪ Managing unsafe or dangerous behaviors			
Arrangements for hospice care			
End-of-life care			
Other			

ASSISTANCE WITH ACTIVITIES OF DAILY LIVING	Provided	Not Provided	Comments
Dressing			
Bathing – shower, bath			
Oral hygiene			
Eating and drinking (specify)			

ASSISTANCE WITH ACTIVITIES OF DAILY LIVING	Provided	Not Provided	Comments
Cuing			
Use of special utensils			
Eating for residents with complicated eating problems (e.g. difficulty swallowing, recurrent lung aspirations, etc.)			
Set-up and cut food at meals			
Manual Feeding – specify if limits			
Tube Feeding –specify type/limits			
Grooming – hair care, make-up, shaving, application of lotion, etc.			
Nail care – toe nails, finger nails			
Toileting			
Incontinence Products			
Assistance with bowel and bladder control, devices, and training programs			

MOBILITY	Provided	Not Provided	Comments
Standby Assistance			
Transfers with assist of 1			
Transfers with assist of 2			
Transfers utilizing sit-to-stand lifts			
Transfers utilizing sliding boards			
Transfers utilizing bariatric equipment			

MOBILITY	Provided	Not Provided	Comments
Ceiling lift transfers			
Non-mechanical standing frame transfers			
Mechanical lift assisted transfers			
Ambulation with assist of 1			
Bed mobility			
W/chair mobility			

SECURITY AND MONITORING	Provided	Not Provided	Comments
Wanderguard or other monitoring devices on resident			
Wanderguard system at facility exits			
Staff monitoring at facility exits			
Check-in and check-out at facility exits			
Bed alarms or sensors			
Door sensors			
Security Guard			
Key care access			
Other lock system			
Individualized electronic monitoring			
Secured unit			
I'm okay check services			
Handrails			

SECURITY AND MONITORING	Provided	Not Provided	Comments
Automatic electronic defibrillators			
Alternative energy service (e.g. generator)			

DINING SERVICES	Provided	Not Provided	Comments
3 Meals plus snacks			
Breakfast available in community space			
Breakfast available delivered to apartment			
Lunch available in community space			
Lunch available delivered to apartment			
Dinner available in community space			
Dinner available delivered to apartment			
Resident meal preparation in apartment			
Feeding in common area with 1 staff member per resident			
Feeding in resident's apartment with one staff member per resident			
Apartment tray meal delivery and pick-up			
Meal preparation in apartment			
Thickened Liquids – specify types/limits			
Modified Texture Diets – specify types provided			
Therapeutic Diets: ▪ No added salt			

DINING SERVICES	Provided	Not Provided	Comments
▪ Low sodium ▪ Low fat/low cholesterol ▪ High fiber ▪ Renal diet ▪ Diabetic or calorie controlled ▪ Cardiac diet ▪ Gluten-free			
Other special diets: ▪ Vegetarian/vegan ▪ Kosher ▪ Other			
Dietitian or Nutritionist Services			
Carbohydrate intake/tracking			

SUPPORTIVE SERVICES	Provided	Not Provided	Comments
Social and Recreational Services			
Spiritual Care/ Religious Services			
Housekeeping ▪ Weekly apartment general cleaning – vacuum, clean floors, clean sinks, shower/tub, and toilet ▪ Dusting ▪ Defrost and clean refrigerator ▪ Organize closet and drawers ▪ Trash removal – frequency ▪ Bed making ▪ other			

SUPPORTIVE SERVICES	Provided	Not Provided	Comments
Laundry – loads per week ▪ Wash, dry and fold clothing ▪ Linen – change bed and launder sheets, towels ▪ other			
Physical Therapy			
Occupational Therapy			
Speech Language Therapy			
Respiratory Therapist			
Integrative Health (aroma therapy, massage, healing touch, etc.)			
Medically related Social Services			
Arrangements for and coordination with Hospice Care			
Schedule offsite social and recreational activities			
Schedule medical and social service appointments			
Arranging transportation for social and recreational activities			
Arranging transportation to medical and social services appointments			
Provide transportation to social and recreational activities			
Provide transportation to medical and social service appointments			
Assistance accessing community resources and social services			
Assistance with bill paying			

SUPPORTIVE SERVICES	Provided	Not Provided	Comments
Shopping			
Communication boards or other supplemental communication devices			
Summoning Device – specify			
Daily “okay” check service – specify procedure			
Safety checks – specify frequency			
1:1 staffing for special circumstances			
Overnight companion			
Supervision of smoking			
Pet Care - specify			
Internet services			
Cable television services			
Elevator services			
Other			