# CHAPTER 144A

# NURSING HOMES AND HOME CARE



## 144A.073 EXCEPTIONS TO THE MORATORIUM; REVIEW.

*[For text of subds 1 to 3d, see M.S.2006]*

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

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

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

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

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

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

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

(iv) adjust the existing bed supply so that the distribution of beds as projected for the year 2020 would be consistent with projected need, based on the methodology outlined in the Interagency Long-Term Care Committee's nursing home bed distribution study;

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

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

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

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

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

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

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

*[For text of subds 5 to 11, see M.S.2006]*

**History:** *2007 c 147 art 7 s 1*

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

*[For text of subds 1 and 2, see M.S.2006]*

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

*[For text of subds 3 to 4, see M.S.2006]*

**History:** *2007 c 147 art 7 s 75*

## 144A.135 TRANSFER AND DISCHARGE APPEALS.

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

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

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

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

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

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

(g) A person required to inform a health care facility of the person's status as a registered predatory offender under section 243.166, subdivision 4b, who knowingly fails to do so shall be deemed to have endangered the safety of individuals in the facility under Code of Federal Regulations, chapter 42, section 483.12. Notwithstanding paragraph (d), any appeal of the notice and discharge shall not constitute a stay of the discharge.

**History:** *2007 c 147 art 7 s 75*

## 144A.161 NURSING HOME AND BOARDING CARE HOME RESIDENT RELOCATION.

*[For text of subds 1 and 1a, see M.S.2006]*

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

(1) the commissioner of health;

(2) the commissioner of human services;

(3) the county social services agency;

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

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

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

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

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

(b) Within ten working days of receipt of the notice under paragraph (a), the county social services agency and licensee shall meet to develop the relocation plan. The county social services agency shall inform the Departments of Health and Human Services, the Office of

Ombudsman for Long–Term Care, and the Office of the Ombudsman for Mental Health and Developmental Disabilities of the date, time, and location of the meeting so that their representatives may attend. The relocation plan must be completed within 45 days of receipt of the initial notice. However, the plan may be finalized on an earlier schedule agreed to by all parties. To the extent practicable, consistent with requirements to protect the safety and health of residents, the commissioner may authorize the planning process under this subdivision to occur concurrent with the 60–day notice required under subdivision 5a. The plan shall:

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

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

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

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

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

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

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

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

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

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

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

Subd. 4. **Responsibilities of licensee for resident relocations.** The licensee shall provide for the safe, orderly, and appropriate relocation of residents. The licensee and facility staff shall cooperate with representatives from the county social services agency, the Department of Health, the Department of Human Services, the Office of Ombudsman for Long–Term Care, and Ombudsman for Mental Health and Developmental Disabilities in planning for and implementing the relocation of residents.

Subd. 5. **Licensee responsibilities prior to relocation.** (a) The licensee shall establish an interdisciplinary team responsible for coordinating and implementing the plan. The interdisciplinary team shall include representatives from the county social services agency, the Office of Ombudsman for Long–Term Care, facility staff that provide direct care services to the residents, and facility administration.

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

(1) name;

(2) date of birth;

(3) Social Security number;

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

(5) county of financial responsibility;

(6) date of admission to the facility;

(7) all diagnoses;

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

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

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

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

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

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

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

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

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

(4) the name, address, and telephone number of the county social services agency contact person; and

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

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

*[For text of subd 5b, see M.S.2006]*

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

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

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

(2) the certification level of the available beds;

(3) the types of services available; and

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

The list shall be made available to residents and their families or designated representatives, and upon request to the Office of Ombudsman for Long–Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the county social services agency.

(c) The Senior LinkAge line may make available via a Web site the name, address, and telephone and facsimile numbers of each facility with available beds, the certification level of the available beds, the types of services available, and the number of beds that are available as updated daily by the listed facilities. The licensee must provide residents, their families or designated representatives, the Office of Ombudsman for Long–Term Care, the Office of the Ombudsman for Mental Health and Developmental Disabilities, and the county social services agency with the toll–free number and Web site address for the Senior LinkAge line.

Subd. 5d. **Licensee responsibility to meet with residents and families.** Following the establishment of the plan, the licensee shall conduct meetings with residents, families and designated representatives, and resident and family councils to notify them of the process for resident relocation. Representatives from the local county social services agency, the Office

of Ombudsman for Long–Term Care, the Ombudsman for Mental Health and Developmental Disabilities, the commissioner of health, and the commissioner of human services shall receive advance notice of the meetings.

*[For text of subds 5e to 7, see M.S.2006]*

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

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

(c) The county social services agency shall serve as a resource in the relocation process.

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

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

(2) a county social services agency contact name, address, and telephone number; and

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

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

(f) The county social services agency shall monitor compliance with all components of the plan. If the licensee is not in compliance, the county social services agency shall notify the commissioners of the Departments of Health and Human Services.

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

(h) A member of the county social services agency staff shall visit residents relocated within 100 miles of the county within 30 days after the relocation. This requirement does not apply to changes in operation where the facility moved to a new location and residents chose to move to that new location. The requirement also does not apply to residents admitted after the notice of closure and discharged prior to the actual closure. County social services agency staff shall interview the resident and family or designated representative, observe the resident on site, and review and discuss pertinent medical or social records with appropriate facility staff to:

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

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

(3) identify residents at risk.

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

(j) Within 60 days of the completion of the follow–up visits, the county social services agency shall submit a written summary of the follow–up work to the Departments of Health and Human Services in a manner approved by the commissioners.

(k) The county social services agency shall submit to the Departments of Health and Human Services a report of any issues that may require further review or monitoring.

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

*[For text of subds 9 to 11, see M.S.2006]*

**History:** *2007 c 147 art 7 s 75*

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

The licensee shall provide for the safe, orderly, and appropriate transfer of residents within the facility. In situations where there is a curtailment, reduction, capital improvement, or change in operations within a facility, the licensee shall minimize the number of intrafacility transfers needed to complete the project or change in operations, consider individual resident needs and preferences, and provide reasonable accommodation for individual resident requests regarding their room transfer. The licensee shall provide notice to the Office of Ombudsman for Long–Term Care and, when appropriate, the Office of Ombudsman for Mental Health and Developmental Disabilities, in advance of any notice to residents and family, when all of the following circumstances apply:

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

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

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

**History:** *2007 c 147 art 7 s 75*

## 144A.351 BALANCING LONG–TERM CARE: REPORT REQUIRED.

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

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

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

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

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

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

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

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

**History:** *2007 c 147 art 6 s 1*

## 144A.44 HOME CARE BILL OF RIGHTS.

Subdivision 1. **Statement of rights.** A person who receives home care services has these rights:

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

(2) the right to receive care and services according to a suitable and up–to–date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services;

(3) the right to be told in advance of receiving care about the services that will be provided, the disciplines that will furnish care, the frequency of visits proposed to be furnished, other choices that are available, and the consequences of these choices including the consequences of refusing these services;

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

(5) the right to refuse services or treatment;

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

(7) the right to know in advance of receiving care whether the services are covered by health insurance, medical assistance, or other health programs, the charges for services that will not be covered by Medicare, and the charges that the individual may have to pay;

(8) the right to know what the charges are for services, no matter who will be paying the bill;

(9) the right to know that there may be other services available in the community, including other home care services and providers, and to know where to go for information about these services;

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

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

(12) the right to be allowed access to records and written information from records in accordance with sections 144.291 to 144.298;

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

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

(15) the right to be free from physical and verbal abuse;

(16) the right to reasonable, advance notice of changes in services or charges, including at least ten days' advance notice of the termination of a service by a provider, except in cases where:

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

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

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

(18) the right to voice grievances regarding treatment or care that is, or fails to be, furnished, or regarding the lack of courtesy or respect to the patient or the patient's property;

(19) the right to know how to contact an individual associated with the provider who is responsible for handling problems and to have the provider investigate and attempt to resolve the grievance or complaint;

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

(21) the right to assert these rights personally, or have them asserted by the patient's family or guardian when the patient has been judged incompetent, without retaliation.

Subd. 2. **Interpretation and enforcement of rights.** These rights are established for the benefit of persons who receive home care services. "Home care services" means home care services as defined in section 144A.43, subdivision 3. A home care provider may not require a person to surrender these rights as a condition of receiving services. A guardian or conservator or, when there is no guardian or conservator, a designated person, may seek to enforce these rights. This statement of rights does not replace or diminish other rights and liberties that may exist relative to persons receiving home care services, persons providing

home care services, or providers licensed under Laws 1987, chapter 378. A copy of these rights must be provided to an individual at the time home care services are initiated. The copy shall also contain the address and phone number of the Office of Health Facility Complaints and the Office of Ombudsman for Long–Term Care and a brief statement describing how to file a complaint with these offices. Information about how to contact the Office of Ombudsman for Long–Term Care shall be included in notices of change in client fees and in notices where home care providers initiate transfer or discontinuation of services.

**History:** *2007 c 147 art 7 s 75; art 10 s 15*

## 144A.4605 CLASS F PROVIDER.

*[For text of subds 1 and 2, see M.S.2006]*

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

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

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

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

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

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

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

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

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

(4) home care bill of rights;

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

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

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

(8) basic infection control;

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

(10) communication skills;

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

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

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

*[For text of subds 4 to 6, see M.S.2006]*

**History:** *2007 c 147 art 7 s 75*

## 144A.751 HOSPICE BILL OF RIGHTS.

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

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

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

(3) be told in advance of receiving care about the services that will be provided, the disciplines that will furnish care, the frequency of visits proposed to be furnished, other choices that are available, and the consequence of these choices, including the consequences of refusing these services;

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

(5) refuse services or treatment;

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

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

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

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

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

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

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

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

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

(15) voice grievances regarding treatment or care that is, or fails to be, furnished or regarding the lack of courtesy or respect to the patient or the patient's property;

(16) be free from physical and verbal abuse;

(17) reasonable, advance notice of changes in services or charges, including at least ten days' advance notice of the termination of a service by a provider, except in cases where:

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

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

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

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

(19) know how to contact an individual associated with the provider who is responsible for handling problems and to have the provider investigate and attempt to resolve the grievance or complaint;

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

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

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

*[For text of subd 2, see M.S.2006]*

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

**History:** *2007 c 147 art 7 s 75; art 10 s 15*