A bill for an act

relating to health; adding to a definition in the electronic prescription drug program; modifying provisions in medical education and research; modifying nursing home provisions; amending Minnesota Statutes 2016, sections 62J.497, subdivision 1; 62J.498, subdivision 1; 62J.692, subdivisions 3, 4; 144A.10, subdivisions 6c, 6d, 6e, 7, 12, 14, 16; 144A.101, subdivisions 2, 5; repealing Minnesota Statutes 2016, sections 62J.692, subdivision 4a; 62Q.72, subdivision 2; 144A.04, subdivision 10; 144A.10, subdivisions 6b, 11; 144A.101, subdivision 3.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2016, section 62J.497, subdivision 1, is amended to read:

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

(a) "Backward compatible" means that the newer version of a data transmission standard would retain, at a minimum, the full functionality of the versions previously adopted, and would permit the successful completion of the applicable transactions with entities that continue to use the older versions.

(b) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(c) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

(d) "Electronic media" has the meaning given under Code of Federal Regulations, title 45, part 160.103.

(e) "E-prescribing" means the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser and two-way transmissions related to eligibility, formulary, and medication history information.

(f) "Electronic prescription drug program" means a program that provides for e-prescribing.

(g) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

(h) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

(i) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

(j) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

(k) "NCPDP Formulary and Benefits Standard" means the National Council for Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide, Version ~~1~~ 3, Release 0~~, October 2005.~~ or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance. Subsequently released versions of the NCPDP Formulary and Benefit Standard may be used, provided that the new version of the standard is backward compatible to the current version adopted by the Centers for Medicare and Medicaid Services.

(l) "NCPDP SCRIPT Standard" means the National Council for Prescription Drug Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide Version ~~8~~ 10, Release ~~1~~ 6 (Version ~~8.1~~ 10.6), ~~October 2005,~~ or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance. Subsequently released versions of the NCPDP SCRIPT Standard may be used, provided that the new version of the standard is backward compatible to the current version adopted by the Centers for Medicare and Medicaid Services.

(m) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

(n) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as defined in section 151.01, subdivision 23.

(o) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

(p) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

Sec. 2. Minnesota Statutes 2016, section 62J.498, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** The following definitions apply to sections 62J.498 to 62J.4982:

(a) "Clinical data repository" means a real time database that consolidates data from a variety of clinical sources to present a unified view of a single patient and is used by a state-certified health information exchange service provider to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph ~~(j)~~ (k). This does not include clinical data that are submitted to the commissioner for public health purposes required or permitted by law, including any rules adopted by the commissioner.

(b) "Clinical transaction" means any meaningful use transaction or other health information exchange transaction that is not covered by section 62J.536.

(c) "Commissioner" means the commissioner of health.

(d) "Health care provider" or "provider" means a health care provider or provider as defined in section 62J.03, subdivision 8.

(e) "Health data intermediary" means an entity that provides the technical capabilities or related products and services to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph ~~(j)~~ (k). This includes but is not limited to: health information service providers (HISP), electronic health record vendors, and pharmaceutical electronic data intermediaries as defined in section 62J.495.

(f) "Health information exchange" means the electronic transmission of health-related information between organizations according to nationally recognized standards.

(g) "Health information exchange service provider" means a health data intermediary or health information organization.

(h) "Health information organization" means an organization that oversees, governs, and facilitates health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph ~~(j)~~ (k), to improve coordination of patient care and the efficiency of health care delivery.

(i) "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act as defined in section 62J.495.

(j) "Major participating entity" means:

(1) a participating entity that receives compensation for services that is greater than 30 percent of the health information organization's gross annual revenues from the health information exchange service provider;

(2) a participating entity providing administrative, financial, or management services to the health information organization, if the total payment for all services provided by the participating entity exceeds three percent of the gross revenue of the health information organization; and

(3) a participating entity that nominates or appoints 30 percent or more of the board of directors or equivalent governing body of the health information organization.

(k) "Master patient index" means an electronic database that holds unique identifiers of patients registered at a care facility and is used by a state-certified health information exchange service provider to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph ~~(j)~~ (k). This does not include data that are submitted to the commissioner for public health purposes required or permitted by law, including any rules adopted by the commissioner.

(l) "Meaningful use" means use of certified electronic health record technology to improve quality, safety, and efficiency and reduce health disparities; engage patients and families; improve care coordination and population and public health; and maintain privacy and security of patient health information as established by the Centers for Medicare and Medicaid Services and the Minnesota Department of Human Services pursuant to sections 4101, 4102, and 4201 of the HITECH Act.

(m) "Meaningful use transaction" means an electronic transaction that a health care provider must exchange to receive Medicare or Medicaid incentives or avoid Medicare penalties pursuant to sections 4101, 4102, and 4201 of the HITECH Act.

(n) "Participating entity" means any of the following persons, health care providers, companies, or other organizations with which a health information organization or health

data intermediary has contracts or other agreements for the provision of health information exchange services:

(1) a health care facility licensed under sections 144.50 to 144.56, a nursing home licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise licensed under the laws of this state or registered with the commissioner;

(2) a health care provider, and any other health care professional otherwise licensed under the laws of this state or registered with the commissioner;

(3) a group, professional corporation, or other organization that provides the services of individuals or entities identified in clause (2), including but not limited to a medical clinic, a medical group, a home health care agency, an urgent care center, and an emergent care center;

(4) a health plan as defined in section 62A.011, subdivision 3; and

(5) a state agency as defined in section 13.02, subdivision 17.

(o) "Reciprocal agreement" means an arrangement in which two or more health information exchange service providers agree to share in-kind services and resources to allow for the pass-through of clinical transactions.

(p) "State-certified health data intermediary" means a health data intermediary that has been issued a certificate of authority to operate in Minnesota.

(q) "State-certified health information organization" means a health information organization that has been issued a certificate of authority to operate in Minnesota.

Sec. 3. Minnesota Statutes 2016, section 62J.692, subdivision 3, is amended to read:

Subd. 3. **Application process.** (a) A clinical medical education program conducted in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners, dentists, chiropractors, physician assistants, dental therapists and advanced dental therapists, psychologists, clinical social workers, community paramedics, or community health workers is eligible for funds under subdivision 4 if the program:

(1) is funded, in part, by patient care revenues;

(2) occurs in patient care settings that face increased financial pressure as a result of competition with nonteaching patient care entities; and

(3) emphasizes primary care or specialties that are in undersupply in Minnesota.

(b) A clinical medical education program for advanced practice nursing is eligible for funds under subdivision 4 if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College Council.

(c) Applications must be submitted to the commissioner by a sponsoring institution on behalf of an eligible clinical medical education program and must be received by October 31 of each year for distribution in the following year. An application for funds must contain the following information:

(1) the official name and address of the sponsoring institution and the official name and site address of the clinical medical education programs on whose behalf the sponsoring institution is applying;

(2) the name, title, and business address of those persons responsible for administering the funds;

(3) for each clinical medical education program for which funds are being sought; the type and specialty orientation of trainees in the program; the name, site address, and medical assistance provider number and national provider identification number of each training site used in the program; the federal tax identification number of each training site used in the program, where available; the total number of trainees at each training site; and the total number of eligible trainee FTEs at each site; and

(4) other supporting information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable distribution of funds.

~~(d) An application must include the information specified in clauses (1) to (3) for each clinical medical education program on an annual basis for three consecutive years. After that time, an application must include the information specified in clauses (1) to (3) when requested, at the discretion of the commissioner:~~

~~(1) audited clinical training costs per trainee for each clinical medical education program when available or estimates of clinical training costs based on audited financial data;~~

~~(2) a description of current sources of funding for clinical medical education costs, including a description and dollar amount of all state and federal financial support, including Medicare direct and indirect payments; and~~

~~(3) other revenue received for the purposes of clinical training.~~

~~(c)~~ (d) An applicant that does not provide information requested by the commissioner shall not be eligible for funds for the current funding cycle.

Sec. 4. Minnesota Statutes 2016, section 62J.692, subdivision 4, is amended to read:

Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute the available medical education funds to all qualifying applicants based on a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool.

Public program revenue for the distribution formula includes revenue from medical assistance and prepaid medical assistance. Training sites that receive no public program revenue are ineligible for funds available under this subdivision. ~~For purposes of determining training-site level grants to be distributed under this paragraph, total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee in primary care clinical medical education programs for medical residents. Total statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students.~~ Training sites whose training site level grant is less than $5,000, based on the formula described in this paragraph, or that train fewer than 0.1 FTE eligible trainees, are ineligible for funds available under this subdivision. No training sites shall receive a grant per FTE trainee that is in excess of the 95th percentile grant per FTE across all eligible training sites; grants in excess of this amount will be redistributed to other eligible sites based on the formula described in this paragraph.

~~(b) For funds distributed in fiscal years 2014 and 2015, the distribution formula shall include a supplemental public program volume factor, which is determined by providing a supplemental payment to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. The supplemental public program volume factor shall be equal to ten percent of each training site's grant for funds distributed in fiscal year 2014 and for funds distributed in fiscal year 2015. Grants to training sites whose public program revenue accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental payment. For fiscal year 2016 and beyond, the distribution of funds shall be based solely on the public program volume factor as described in paragraph (a).~~

~~(c)~~ (b) Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

~~(d)~~ (c) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter. Each clinical medical education program must distribute funds allocated under ~~paragraphs~~ paragraph (a) ~~and (b)~~ to the training sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited through an organization recognized by the Department of Education or the Centers for Medicare and Medicaid Services, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

(1) develop contracts specifying the terms, expectations, and outcomes of the clinical training conducted at sites; and

(2) take necessary action if the contract requirements are not met. Action may include the withholding of payments under this section or the removal of students from the site.

~~(e)~~ (d) Use of funds is limited to expenses related to clinical training program costs for eligible programs.

~~(f)~~ (e) Any funds not distributed in accordance with the commissioner's approval letter must be returned to the medical education and research fund within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

~~(g)~~ (f) A maximum of $150,000 of the funds dedicated to the commissioner under section 297F.10, subdivision 1, clause (2), may be used by the commissioner for administrative expenses associated with implementing this section.

Sec. 5. Minnesota Statutes 2016, section 144A.10, subdivision 6c, is amended to read:

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

Sec. 6. Minnesota Statutes 2016, section 144A.10, subdivision 6d, is amended to read:

Subd. 6d. **Schedule of fines.** (a) The schedule of fines for noncompliance with correction orders issued to nursing homes that was adopted under the provisions of section 144A.10,

subdivision 6, and in effect on May 1, 1989, is effective until repealed, modified, or superseded by rule.

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

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

Sec. 7. Minnesota Statutes 2016, section 144A.10, subdivision 6e, is amended to read:

Subd. 6e. **Use of fines.** When the commissioner of health determines the use of, or provides recommendations on the use of ~~fines collected under subdivision 6 or 6b~~ federal civil monetary penalties, two representatives of the nursing home industry, appointed by nursing home trade associations, and two consumer representatives as appointed by the commissioner must be included in the process of developing or preparing any information, reviews, or recommendations on the use of the fines. This includes, but is not limited to, including two representatives of the nursing home industry in any committee designed to provide information and recommendations for the use of the fines.

Sec. 8. Minnesota Statutes 2016, section 144A.10, subdivision 7, is amended to read:

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

The cost of a reinspection conducted pursuant to this subdivision shall be added to the total assessment due from the nursing home.

Sec. 9. Minnesota Statutes 2016, section 144A.10, subdivision 12, is amended to read:

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

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

Sec. 10. Minnesota Statutes 2016, section 144A.10, subdivision 14, is amended to read:

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

Sec. 11. Minnesota Statutes 2016, section 144A.10, subdivision 16, is amended to read:

Subd. 16. **Independent informal dispute resolution.** (a) Notwithstanding subdivision 15, a facility certified under the federal Medicare or Medicaid programs may request from the commissioner, in writing, an independent informal dispute resolution process regarding any deficiency citation issued to the facility. The facility must specify in its written request each deficiency citation that it disputes. The commissioner shall provide ~~a hearing under sections 14.57 to 14.62~~ an informal dispute resolution procedure consistent with federal

requirements. Upon the written request of the facility, ~~the parties must submit the issues raised to arbitration by an administrative law judge.~~ an informal dispute resolution proceeding shall be scheduled by the reviewer. The informal dispute proceeding shall take place within 90 days of the request. The commissioner may contract with the Office of Administrative Hearings or another federally approved reviewer to conduct the informal dispute process.

(b) Upon receipt of a written request for an ~~arbitration~~ informal dispute proceeding, the commissioner shall file with the ~~Office of Administrative Hearings~~ reviewer a ~~request for the appointment of an arbitrator and simultaneously serve the facility with~~ notice of the request. The ~~arbitrator~~ reviewer for the dispute shall be an administrative law judge appointed by the Office of Administrative Hearings or another federally approved reviewer. ~~The disclosure provisions of section 572B.12 and the notice provisions of section 572B.15, subsection (c), apply.~~ The facility ~~and the commissioner have~~ has the right to be represented by an attorney at the expense of the facility.

(c) The commissioner and the facility ~~may present written evidence, depositions, and oral statements and arguments at the arbitration proceeding~~ must abide by the federal requirements for informal dispute proceedings. Oral statements and arguments may be made by telephone.

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

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

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

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

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

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

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

~~(e) The commissioner shall reimburse the Office of Administrative Hearings for the costs incurred by that office for the arbitration proceeding. The facility shall reimburse the commissioner for the proportion of the costs that represent the sum of deficiency citations supported in full under paragraph (d), clause (1), or in substance under paragraph (d), clause (2), divided by the total number of deficiencies disputed. A deficiency citation for which the administrative law judge's sole finding is that the deficient practice was cited under the wrong requirements of participation shall not be counted in the numerator or denominator in the calculation of the proportion of costs.~~

Sec. 12. Minnesota Statutes 2016, section 144A.101, subdivision 2, is amended to read:

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

Sec. 13. Minnesota Statutes 2016, section 144A.101, subdivision 5, is amended to read:

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

Sec. 14. **REPEALER.**

Minnesota Statutes 2016, sections 62J.692, subdivision 4a; 62Q.72, subdivision 2; 144A.04, subdivision 10; 144A.10, subdivisions 6b and 11; and 144A.101, subdivision 3, are repealed.

62J.692 MEDICAL EDUCATION.

Subd. 4a. **Alternative distribution.** If federal approval is not received for the formula described in subdivision 4, paragraphs (a) and (b), 100 percent of available medical education and research funds shall be distributed based on a distribution formula that reflects a summation of two factors:

(1) a public program volume factor, that is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool; and

(2) a supplemental public program volume factor, that is determined by providing a supplemental payment of 20 percent of each training site's grant to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. Grants to training sites whose public program revenue accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental payment.

62Q.72 RECORD KEEPING; REPORTING.

Subd. 2. **Reporting.** Each health plan company shall submit to the appropriate commissioner, as part of the company's annual filing, data on the number and type of complaints that are not resolved within 30 days, or 30 business days as provided under section 72A.201, subdivision 4, clause (3), for insurance companies licensed under chapter 60A. The commissioner shall also make this information available to the public upon request.

144A.04 QUALIFICATIONS FOR LICENSE.

Subd. 10. **Assessments for short-stay residents.** Upon federal approval, a nursing home is not required to perform a resident assessment on a resident expected to remain in the facility for 30 days or less. A short-stay resident transferring from a hospital to a nursing home must have a plan of care developed at the hospital before admission to the nursing home. If a short-stay resident remains in the nursing home longer than 30 days, the nursing home must perform the resident assessment in accordance with sections 144.0721 and 144.0722 within 40 days of the resident's admission.

144A.10 INSPECTION; COMMISSIONER OF HEALTH; FINES.

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

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

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

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

(b) The commissioner:

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

(2) shall notify the Board of Nursing Home Administrators by June 1, 1999, that the commissioner has recommended to the federal government that fines not be imposed on the facilities

referred to in this subdivision or that any fines imposed on these facilities for violations of regulations governing use of physical restraints be rescinded.

144A.101 PROCEDURES FOR FEDERALLY REQUIRED SURVEY PROCESS.

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