

As Passed by the House

135th General Assembly

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Sub. S. B. No. 144

Senator Romanchuk

**Cosponsors: Senators Antonio, Blessing, Cirino, DeMora, Gavarone, Hackett,
Huffman, S., Kunze, Lang, Manning, Reineke, Smith**

**Representatives Brennan, Brent, Brown, Dobos, Forhan, Miller, A., Somani, Troy,
Young, T.**

A BILL

To amend sections 3702.593, 3721.01, 3721.026, 1
3721.072, 3721.121, 3721.28, 3721.30, 3721.31, 2
3721.32, 4723.32, 4723.61, 4723.64, 4723.65, 3
4723.651, 4723.653, 4723.66, 4723.67, 4723.68, 4
4723.69, 4729.41, 5124.15, 5124.151, 5165.01, 5
5165.06, 5165.26, 5165.51, and 5165.511; to 6
enact section 5165.518; and to repeal section 7
3701.89 of the Revised Code and to amend Section 8
280.12 of H.B. 45 of the 134th General Assembly 9
as subsequently amended regarding immunizations 10
administered by pharmacists, pharmacy interns, 11
and pharmacy technicians; regarding certificates 12
of need and change of operator procedures for 13
nursing homes; regarding the per Medicaid day 14
payment rate for specified ICFs/IID; regarding 15
medication aides and certified nurse aides, 16
including competency evaluation programs and 17
training and competency evaluation programs; 18
regarding nursing home quality improvement 19
projects; regarding conditional employment in 20
homes and adult day care programs; regarding 21

grants provided to adult day care providers, and 22
regarding the Ohio Medical Quality Foundation. 23

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 3702.593, 3721.01, 3721.026, 24
3721.072, 3721.121, 3721.28, 3721.30, 3721.31, 3721.32, 4723.32, 25
4723.61, 4723.64, 4723.65, 4723.651, 4723.653, 4723.66, 4723.67, 26
4723.68, 4723.69, 4729.41, 5124.15, 5124.151, 5165.01, 5165.06, 27
5165.26, 5165.51, and 5165.511 be amended and section 5165.518 28
of the Revised Code be enacted to read as follows: 29

Sec. 3702.593. (A) At the times specified in this section, 30
the director of health shall accept, for review under section 31
3702.52 of the Revised Code, certificate of need applications 32
for any of the following purposes if the proposed increase in 33
beds is attributable solely to relocation of existing beds from 34
an existing long-term care facility in a county with excess beds 35
to a long-term care facility in a county in which there are 36
fewer long-term care beds than the county's bed need: 37

(1) Approval of beds in a new long-term care facility or 38
an increase of beds in an existing long-term care facility if 39
the beds are proposed to be licensed as nursing home beds under 40
Chapter 3721. of the Revised Code; 41

(2) Approval of beds in a new county home or new county 42
nursing home, or an increase of beds in an existing county home 43
or existing county nursing home if the beds are proposed to be 44
certified as skilled nursing facility beds under the medicare 45
program, Title XVIII of the "Social Security Act," 49 Stat. 286 46
(1965), 42 U.S.C. 1395, as amended, or nursing facility beds 47

under the medicaid program, Title XIX of the "Social Security Act," 49 Stat. 286 (1965), 42 U.S.C. 1396, as amended; 48
49

(3) An increase of hospital beds reported in an application submitted under section 3722.03 of the Revised Code as long-term care beds. 50
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52

(B) For the purpose of implementing this section, the director shall do all of the following: 53
54

(1) Not later than October 1, 2023, and every ~~four~~two years thereafter, determine the long-term care bed supply for each county, which shall consist of all of the following: 55
56
57

(a) Nursing home beds licensed under Chapter 3721. of the Revised Code; 58
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(b) Beds certified as skilled nursing facility beds under the medicare program or nursing facility beds under the medicaid program; 60
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62

(c) Beds in any portion of a hospital that are properly reported in an application submitted under section 3722.03 of the Revised Code as skilled nursing beds, long-term care beds, or special skilled nursing beds; 63
64
65
66

(d) Beds in a county home or county nursing home that are certified under section 5155.38 of the Revised Code as having been in operation on July 1, 1993, and are eligible for licensure as nursing home beds; 67
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70

(e) Beds described in division (O) (5) of section 3702.51 of the Revised Code. 71
72

(2) Determine the long-term care bed occupancy rate for the state at the time the determination is made; 73
74

(3) For each county, determine the county's bed need by 75
identifying the number of long-term care beds that would be 76
needed in the county in order for the statewide occupancy rate 77
for a projected population aged sixty-five and older to be 78
ninety per cent. 79

In determining each county's bed need, the director shall 80
use the formula developed in rules adopted under section 3702.57 81
of the Revised Code. A determination shall be made not later 82
than October 1, 2023, and every ~~four~~two years thereafter. After 83
each determination is made, the director shall publish the 84
county's bed need on the web site maintained by the department 85
of health. 86

(C) The director's consideration of an application for a 87
certificate of need that would increase the number of beds in a 88
county shall be consistent with the county's bed need determined 89
under division (B) of this section, except as follows: 90

~~(1) If (1)(a) Except as provided in division (C)(1)(b) of~~ 91
~~this section, if a county's occupancy rate is less than eighty-~~ 92
~~five per cent, the county shall be considered to have no need~~ 93
~~for additional beds.~~ 94

(b) Division (C)(1)(a) of this section does not apply, 95
such that a county shall be considered to have a need for 96
additional beds regardless of its occupancy rate, if all of the 97
following conditions are satisfied: 98

(i) The county has at least sixty fewer long-term care 99
beds than the county's bed need. 100

(ii) The application for a certificate of need is for the 101
approval of beds in a new long-term care facility or an increase 102
of beds in an existing long-term care facility, and the beds are 103

proposed to be licensed as nursing home beds under Chapter 3721. 104
of the Revised Code. 105

(iii) The additional beds will be located in category one 106
private rooms, as that term is defined in section 5165.158 of 107
the Revised Code. 108

(2) Even if a county is determined not to need any 109
additional long-term care beds, the director may approve an 110
increase in beds equal to up to ten per cent of the county's bed 111
supply if the county's occupancy rate is greater than ninety per 112
cent. 113

(D) (1) For the review process used in considering 114
certificate of need applications, the director shall establish a 115
review period that begins January 1, 2020, and ends December 31, 116
2023. Thereafter, the review period for each review process 117
shall begin on the first day of January following the end of the 118
previous review period and shall be ~~four~~two years. 119

(2) Certificate of need applications shall be accepted 120
during the first month of the review period and reviewed through 121
the thirtieth day of September of the year in which the review 122
period begins. 123

(E) The director shall consider certificate of need 124
applications in accordance with all of the following: 125

(1) The number of beds approved for a county shall include 126
only beds available for relocation from another county and shall 127
not exceed the bed need of the receiving county~~+~~. 128

(2) The director shall consider the existence of community 129
resources serving persons who are age sixty-five or older or 130
disabled that are demonstrably effective in providing 131
alternatives to long-term care facility placement. 132

(3) The director shall approve relocation of beds from a county only if, after the relocation, the number of beds remaining in the county will exceed the county's bed need by at least ~~one hundred fifty~~ fifty beds;—

~~(4) The director shall approve relocation of beds from a long term care facility only if, after the relocation, the number of beds in the facility's service area is at least equal to the state bed need rate. For purposes of this division, a facility's service area shall be either of the following:—~~

~~(a) The census tract in which the facility is located, if the facility is located in an area designated by the United States secretary of health and human services as a health professional shortage area under the "Public Health Service Act," 88 Stat. 682 (1944), 42 U.S.C. 254(e), as amended;—~~

~~(b) The area that is within a fifteen mile radius of the facility's location, if the facility is not located in a health professional shortage area.~~

(F) Applications made under this section are subject to comparative review if two or more applications are submitted during the same review period and any of the following applies:

(1) The applications propose to relocate beds from the same county and the number of beds for which certificates of need are being requested totals more than the number of beds available in the county from which the beds are to be relocated.

(2) The applications propose to relocate beds to the same county and the number of beds for which certificates of need are being requested totals more than the number of beds needed in the county to which the beds are to be relocated.

~~(3) The applications propose to relocate beds from the~~

~~same service area and the number of beds left in the service-~~ 162
~~area from which the beds are being relocated would be less than-~~ 163
~~the state bed need rate determined by the director.~~ 164

(G) In determining which applicants should receive 165
preference in the comparative review process, the director shall 166
consider all of the following as weighted priorities: 167

(1) Whether the beds will be part of a continuing care 168
retirement community; 169

(2) Whether the beds will serve an underserved population, 170
such as low-income individuals, individuals with disabilities, 171
or individuals who are members of racial or ethnic minority 172
groups; 173

(3) Whether the project in which the beds will be included 174
will provide alternatives to institutional care, such as adult 175
day-care, home health care, respite or hospice care, mobile 176
meals, residential care, independent living, or congregate 177
living services; 178

(4) Whether the long-term care facility's owner or 179
operator will participate in medicaid waiver programs for 180
alternatives to institutional care; 181

(5) Whether the project in which the beds will be included 182
will reduce alternatives to institutional care by converting 183
residential care beds or other alternative care beds to long- 184
term care beds; 185

(6) Whether the facility in which the beds will be placed 186
has positive resident and family satisfaction surveys; 187

(7) Whether the facility in which the beds will be placed 188
has fewer than fifty long-term care beds; 189

(8) Whether the long-term care facility in which the beds will be placed is located within the ~~service area of~~ served by a hospital and is designed to accept patients for rehabilitation after an in-patient hospital stay;

(9) Whether the long-term care facility in which the beds will be placed is or proposes to become a nurse aide training and testing site;

(10) The rating, under the centers for medicare and medicaid services' five star nursing home quality rating system, of the long-term care facility in which the beds will be placed.

(H) A person who has submitted an application under this section that is not subject to comparative review may revise the site of the proposed project pursuant to section 3702.522 of the Revised Code.

~~(I) When a certificate of need application is approved, in addition to the actions required by division (D) of section 3702.52 of the Revised Code, the long term care facility from which the beds were relocated shall reduce the number of beds operated in the facility by a number of beds equal to at least ten per cent of the number of beds relocated. If these beds are in a home licensed under Chapter 3721. of the Revised Code, the long term care facility shall have the beds removed from the license. If the beds are in a facility that is certified as a skilled nursing facility or nursing facility under Title XVIII or XIX of the "Social Security Act," the facility shall surrender the certification of these beds. If the beds are reported in an application submitted under section 3722.03 of the Revised Code as skilled nursing beds or long term care beds, the long term care facility shall surrender the registration for these beds. This reduction shall be made not later than the~~

~~completion date of the project for which the beds were~~ 220
~~relocated.~~ 221

Sec. 3721.01. (A) As used in sections 3721.01 to 3721.09 222
and 3721.99 of the Revised Code: 223

(1) (a) "Home" means an institution, residence, or facility 224
that provides, for a period of more than twenty-four hours, 225
whether for a consideration or not, accommodations to three or 226
more unrelated individuals who are dependent upon the services 227
of others, including a nursing home, residential care facility, 228
home for the aging, and a veterans' home operated under Chapter 229
5907. of the Revised Code. 230

(b) "Home" also means both of the following: 231

(i) Any facility that a person, as defined in section 232
3702.51 of the Revised Code, proposes for certification as a 233
skilled nursing facility or nursing facility under Title XVIII 234
or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 235
U.S.C.A. 301, as amended, and for which a certificate of need, 236
other than a certificate to recategorize hospital beds as 237
described in section 3702.521 of the Revised Code or division 238
(R) (7) (d) of the version of section 3702.51 of the Revised Code 239
in effect immediately prior to April 20, 1995, has been granted 240
to the person under sections 3702.51 to 3702.62 of the Revised 241
Code after August 5, 1989; 242

(ii) A county home or district home that is or has been 243
licensed as a residential care facility. 244

(c) "Home" does not mean any of the following: 245

(i) Except as provided in division (A) (1) (b) of this 246
section, a public hospital or hospital as defined in section 247
3701.01 or 5122.01 of the Revised Code; 248

(ii) A residential facility as defined in section 5119.34	249
of the Revised Code;	250
(iii) A residential facility as defined in section 5123.19	251
of the Revised Code;	252
(iv) A community addiction services provider as defined in	253
section 5119.01 of the Revised Code;	254
(v) A facility licensed under section 5119.37 of the	255
Revised Code to operate an opioid treatment program;	256
(vi) A facility providing services under contract with the	257
department of developmental disabilities under section 5123.18	258
of the Revised Code;	259
(vii) A facility operated by a hospice care program	260
licensed under section 3712.04 of the Revised Code that is used	261
exclusively for care of hospice patients;	262
(viii) A facility operated by a pediatric respite care	263
program licensed under section 3712.041 of the Revised Code that	264
is used exclusively for the care of pediatric respite care	265
patients or a location operated by a pediatric transition care	266
program registered under section 3712.042 of the Revised Code	267
that is used exclusively for the care of pediatric transition	268
care patients;	269
(ix) A facility, infirmary, or other entity that is	270
operated by a religious order, provides care exclusively to	271
members of religious orders who take vows of celibacy and live	272
by virtue of their vows within the orders as if related, and	273
does not participate in the medicare program or the medicaid	274
program if on January 1, 1994, the facility, infirmary, or	275
entity was providing care exclusively to members of the	276
religious order;	277

(x) A county home or district home that has never been licensed as a residential care facility.	278 279
(2) "Unrelated individual" means one who is not related to the owner or operator of a home or to the spouse of the owner or operator as a parent, grandparent, child, grandchild, brother, sister, niece, nephew, aunt, uncle, or as the child of an aunt or uncle.	280 281 282 283 284
(3) "Mental impairment" does not mean mental illness, as defined in section 5122.01 of the Revised Code, or developmental disability, as defined in section 5123.01 of the Revised Code.	285 286 287
(4) "Skilled nursing care" means procedures that require technical skills and knowledge beyond those the untrained person possesses and that are commonly employed in providing for the physical, mental, and emotional needs of the ill or otherwise incapacitated. "Skilled nursing care" includes, but is not limited to, the following:	288 289 290 291 292 293
(a) Irrigations, catheterizations, application of dressings, and supervision of special diets;	294 295
(b) Objective observation of changes in the patient's condition as a means of analyzing and determining the nursing care required and the need for further medical diagnosis and treatment;	296 297 298 299
(c) Special procedures contributing to rehabilitation;	300
(d) Administration of medication by any method ordered by a physician, such as hypodermically, rectally, or orally, including observation of the patient after receipt of the medication;	301 302 303 304
(e) Carrying out other treatments prescribed by the	305

physician that involve a similar level of complexity and skill	306
in administration.	307
(5) (a) "Personal care services" means services including,	308
but not limited to, the following:	309
(i) Assisting residents with activities of daily living;	310
(ii) Assisting residents with self-administration of	311
medication, in accordance with rules adopted under section	312
3721.04 of the Revised Code;	313
(iii) Preparing special diets, other than complex	314
therapeutic diets, for residents pursuant to the instructions of	315
a physician or a licensed dietitian, in accordance with rules	316
adopted under section 3721.04 of the Revised Code.	317
(b) "Personal care services" does not include "skilled	318
nursing care" as defined in division (A) (4) of this section. A	319
facility need not provide more than one of the services listed	320
in division (A) (5) (a) of this section to be considered to be	321
providing personal care services.	322
(6) "Nursing home" means a home used for the reception and	323
care of individuals who by reason of illness or physical or	324
mental impairment require skilled nursing care and of	325
individuals who require personal care services but not skilled	326
nursing care. A nursing home is licensed to provide personal	327
care services and skilled nursing care.	328
(7) "Residential care facility" means a home that provides	329
either of the following:	330
(a) Accommodations for seventeen or more unrelated	331
individuals and supervision and personal care services for three	332
or more of those individuals who are dependent on the services	333

of others by reason of age or physical or mental impairment; 334

(b) Accommodations for three or more unrelated 335
individuals, supervision and personal care services for at least 336
three of those individuals who are dependent on the services of 337
others by reason of age or physical or mental impairment, and, 338
to at least one of those individuals, any of the skilled nursing 339
care authorized by section 3721.011 of the Revised Code. 340

(8) "Home for the aging" means a home that provides 341
services as a residential care facility and a nursing home, 342
except that the home provides its services only to individuals 343
who are dependent on the services of others by reason of both 344
age and physical or mental impairment. 345

The part or unit of a home for the aging that provides 346
services only as a residential care facility is licensed as a 347
residential care facility. The part or unit that may provide 348
skilled nursing care beyond the extent authorized by section 349
3721.011 of the Revised Code is licensed as a nursing home. 350

(9) "County home" and "district home" mean a county home 351
or district home operated under Chapter 5155. of the Revised 352
Code. 353

(10) "Change of operator" ~~has the same meaning as in~~ 354
~~section 5165.01 of the Revised Code~~includes circumstances in 355
which an entering operator becomes the operator of a nursing 356
home in the place of the exiting operator. 357

(a) Actions that constitute a change of operator include 358
the following: 359

(i) A change in an exiting operator's form of legal 360
organization, including the formation of a partnership or 361
corporation from a sole proprietorship; 362

- (ii) A change in operational control of the nursing home, 363
regardless of whether ownership of any or all of the real 364
property or personal property associated with the nursing home 365
is also transferred; 366
- (iii) A lease of the nursing home to the entering operator 367
or termination of the exiting operator's lease; 368
- (iv) If the exiting operator is a partnership, dissolution 369
of the partnership, a merger of the partnership into another 370
person that is the survivor of the merger, or a consolidation of 371
the partnership and at least one other person to form a new 372
person; 373
- (v) If the exiting operator is a limited liability 374
company, dissolution of the limited liability company, a merger 375
of the limited liability company into another person that is the 376
survivor of the merger, or a consolidation of the limited 377
liability company and at least one other person to form a new 378
person; 379
- (vi) If the exiting operator is a corporation, dissolution 380
of the corporation, a merger of the corporation into another 381
person that is the survivor of the merger, or a consolidation of 382
the corporation and at least one other person to form a new 383
person; 384
- (vii) A contract for a person to assume operational 385
control of a nursing home; 386
- (viii) A change of fifty per cent or more in the ownership 387
of the licensed operator that results in a change of operational 388
control; 389
- (ix) Any pledge, assignment, or hypothecation of or lien 390
or other encumbrance on any of the legal or beneficial equity 391

<u>interests in the operator or a person with operational control.</u>	392
<u>(b) The following do not constitute a change of operator:</u>	393
<u>(i) Actions necessary to create an employee stock</u>	394
<u>ownership plan under section 401(a) of the "Internal Revenue</u>	395
<u>Code," 26 U.S.C. 401(a);</u>	396
<u>(ii) A change of ownership of real property or personal</u>	397
<u>property associated with a nursing home;</u>	398
<u>(iii) If the operator is a corporation that has securities</u>	399
<u>publicly traded in a marketplace, a change of one or more</u>	400
<u>members of the corporation's governing body or transfer of</u>	401
<u>ownership of one or more shares of the corporation's stock, if</u>	402
<u>the same corporation continues to be the operator;</u>	403
<u>(iv) An initial public offering for which the securities</u>	404
<u>and exchange commission has declared the registration statement</u>	405
<u>effective, and the newly created public company remains the</u>	406
<u>operator.</u>	407
<u>(11) "Related party" has the same meaning as in section</u>	408
<u>5165.01 of the Revised Code means an individual or organization</u>	409
<u>that, to a significant extent, has common ownership with, is</u>	410
<u>associated or affiliated with, has control of, or is controlled</u>	411
<u>by, the entering operator.</u>	412
<u>(a) An individual who is a relative of an entering</u>	413
<u>operator is a related party.</u>	414
<u>(b) Common ownership exists when an individual or</u>	415
<u>individuals possess significant ownership or equity in both the</u>	416
<u>provider and the other organization. Significant ownership or</u>	417
<u>equity exists when an individual or individuals possess five per</u>	418
<u>cent ownership or equity in both the entering operator and a</u>	419

supplier. Significant ownership or equity is presumed to exist 420
when an individual or individuals possess ten per cent ownership 421
or equity in both the entering operator and another organization 422
from which the entering operator purchases or leases real 423
property. 424

(c) Control exists when an individual or organization has 425
the power, directly or indirectly, to significantly influence or 426
direct the actions or policies of an organization. 427

(d) An individual or organization that supplies goods or 428
services to an entering operator shall not be considered a 429
related party if all of the following conditions are met: 430

(i) The supplier is a separate bona fide organization. 431

(ii) A substantial part of the supplier's business 432
activity of the type carried on with the entering operator is 433
transacted with others than the entering operator and there is 434
an open, competitive market for the types of goods or services 435
the supplier furnishes. 436

(iii) The types of goods or services are commonly obtained 437
by other nursing homes from outside organizations and are not a 438
basic element of patient care ordinarily furnished directly to 439
patients by nursing homes. 440

(iv) The charge to the entering operator is in line with 441
the charge for the goods or services in the open market and not 442
more than the charge made under comparable circumstances to 443
others by the supplier. 444

(12) "SFF list" means the list of nursing facilities 445
created by the United States department of health and human 446
services under the special focus facility program. 447

(13) "Special focus facility program" means the program 448
conducted by the United States secretary of health and human 449
services pursuant to section 1919(f)(10) of the "Social Security 450
Act," 42 U.S.C. 1396r(f)(10). 451

(14) "Real and present danger" means immediate danger of 452
serious physical or life-threatening harm to one or more 453
occupants of a home. 454

(15) "Operator" means a person or government entity 455
responsible for the operational control of a nursing home and 456
that holds both of the following: 457

(a) A license to operate the nursing home issued under 458
section 3721.02 of the Revised Code, if such a license is 459
required by section 3721.05 of the Revised Code; 460

(b) A medicaid provider agreement issued under section 461
5165.07 of the Revised Code, if applicable. 462

(16) "Entering operator" means the person or government 463
entity that will become the operator of a nursing home when a 464
change of operator occurs or following a license revocation. 465

(17) "Relative of entering operator" means an individual 466
who is related to an entering operator of a nursing home by one 467
of the following relationships: 468

(a) Spouse; 469

(b) Natural parent, child, or sibling; 470

(c) Adopted parent, child, or sibling; 471

(d) Stepparent, stepchild, stepbrother, or stepsister; 472

(e) Father-in-law, mother-in-law, son-in-law, daughter-in- 473
law, brother-in-law, or sister-in-law; 474

<u>(f) Grandparent or grandchild;</u>	475
<u>(g) Foster caregiver, foster child, foster brother, or foster sister.</u>	476 477
<u>(18) "Exiting operator" means any of the following:</u>	478
<u>(a) An operator that will cease to be the operator of a nursing home on the effective date of a change of operator;</u>	479 480
<u>(b) An operator that will cease to be the operator of a nursing home on the effective date of a facility closure;</u>	481 482
<u>(c) An operator of a nursing home that is undergoing or has undergone a surrender of license;</u>	483 484
<u>(d) An operator of a nursing home that is undergoing or has undergone a license revocation.</u>	485 486
<u>(19) "Operational control" means having the ability to direct the overall operations and cash flow of a nursing home. "Operational control" may be exercised by one person or by multiple persons acting together or by a government entity, and may exist by means of any of the following:</u>	487 488 489 490 491
<u>(a) The person, persons, or government entity directly operating the nursing home;</u>	492 493
<u>(b) The person, persons, or government entity directly or indirectly owning fifty per cent or more of the operator of the nursing home;</u>	494 495 496
<u>(c) An agreement or other arrangement granting the person, persons, or government entity operational control of the nursing home.</u>	497 498 499
<u>(20) "Property owner" means any person or government entity that has at least five per cent ownership or interest,</u>	500 501

either directly, indirectly, or in any combination, in any of 502
the following regarding a nursing home: 503

(a) The land on which the nursing home is located; 504

(b) The structure in which the nursing home is located; 505

(c) Any mortgage, contract for deed, or other obligation 506
secured in whole or in part by the land or structure on or in 507
which the nursing home is located; 508

(d) Any lease or sublease of the land or structure on or 509
in which the nursing home is located. 510

"Property owner" does not include a holder of a debenture 511
or bond related to the nursing home and purchased at public 512
issue or a regulated lender that has made a loan related to the 513
nursing home, unless the holder or lender operates the nursing 514
home directly or through a subsidiary. 515

(21) "Person" has the same meaning as in section 1.59 of 516
the Revised Code. 517

(B) The director of health may further classify homes. For 518
the purposes of this chapter, any residence, institution, hotel, 519
congregate housing project, or similar facility that meets the 520
definition of a home under this section is such a home 521
regardless of how the facility holds itself out to the public. 522

(C) For purposes of this chapter, personal care services 523
or skilled nursing care shall be considered to be provided by a 524
facility if they are provided by a person employed by or 525
associated with the facility or by another person pursuant to an 526
agreement to which neither the resident who receives the 527
services nor the resident's sponsor is a party. 528

(D) Nothing in division (A) (4) of this section shall be 529

construed to permit skilled nursing care to be imposed on an 530
individual who does not require skilled nursing care. 531

Nothing in division (A) (5) of this section shall be 532
construed to permit personal care services to be imposed on an 533
individual who is capable of performing the activity in question 534
without assistance. 535

(E) Division (A) (1) (c) (ix) of this section does not 536
prohibit a facility, infirmary, or other entity described in 537
that division from seeking licensure under sections 3721.01 to 538
3721.09 of the Revised Code or certification under Title XVIII 539
or XIX of the "Social Security Act." However, such a facility, 540
infirmary, or entity that applies for licensure or certification 541
must meet the requirements of those sections or titles and the 542
rules adopted under them and obtain a certificate of need from 543
the director of health under section 3702.52 of the Revised 544
Code. 545

(F) Nothing in this chapter, or rules adopted pursuant to 546
it, shall be construed as authorizing the supervision, 547
regulation, or control of the spiritual care or treatment of 548
residents or patients in any home who rely upon treatment by 549
prayer or spiritual means in accordance with the creed or tenets 550
of any recognized church or religious denomination. 551

Sec. 3721.026. (A) ~~If~~ Before the director of health can 552
issue a license to operate a nursing home ~~undergoes a change of~~ 553
to an entering operator, all of the following requirements must 554
be satisfied ~~before the director of health may issue a license~~ 555
~~authorizing the person to operate the nursing home:~~ 556

(1) The ~~person~~ entering operator completes a change of 557
operator license application on a form prescribed by the 558

director and pays the applicable fee as determined by the 559
director. 560

Any fee required by the director under division (A) (1) of 561
this section shall be credited to the general operations fund 562
established under section 3701.83 of the Revised Code. 563

A completed application shall be submitted not later than 564
forty-five days before the proposed effective date of the change 565
of operator if the change of operator does not entail the 566
relocation of residents. A completed application shall be 567
submitted not later than ninety days before the proposed 568
effective date of the change of operator if the change of 569
operator entails the relocation of residents. The director may 570
waive the time requirements specified in division (A) (1) of this 571
section in an emergency, such as the death of the operator. 572

The change of operator license application established 573
under this section shall include all of the following: 574

(a) Disclosure of all direct and indirect owners owning at 575
least five per cent of each of the following: 576

(i) ~~The applicant~~entering operator, if the ~~applicant~~entering operator is an entity; 577
578

(ii) The owner of the building or buildings in which the 579
nursing home is housed, if the owner of the building or 580
buildings is a different person or government entity from the 581
~~applicant~~entering operator; 582

(iii) The owner of the legal rights associated with the 583
ownership and operation of the nursing home beds, if the owner 584
of the legal rights is a different person or government entity 585
from the ~~applicant~~entering operator; 586

(iv) The management firm or business employed to manage	587
the nursing home, if the management firm or business employed to	588
manage the nursing home is a different person from the	589
applicant;	590
(v) Each related party that provides or will provide	591
services to the nursing home, through contracts with any party	592
identified in division (A) (1) (a) of this section.	593
(b) Disclosure of the direct or indirect ownership	594
interest of each individual whether a person or government	595
<u>entity identified in division (A) (1) (a) of this section has or</u>	596
<u>had a direct or indirect ownership or operational interest in a</u>	597
current or previously licensed nursing home in this state or	598
another state, including disclosure of whether any of the	599
following occurred with respect to an identified nursing home	600
within the five years immediately proceeding <u>preceding</u> the date	601
of application:	602
(i) Voluntary or involuntary closure of the nursing home;	603
(ii) Voluntary or involuntary bankruptcy proceedings;	604
(iii) Voluntary or involuntary receivership proceedings;	605
(iv) License suspension, denial, or revocation;	606
(v) Injunction proceedings initiated by a regulatory	607
agency;	608
(vi) The nursing home is listed in table A, table B, or	609
table D on the SFF list under the special focus facility	610
program;	611
(vii) A civil or criminal action was filed against it by a	612
state or federal entity.	613

(c) Any additional information that the director considers 614
necessary to determine the ownership, operation, management, and 615
control of the nursing home. 616

~~(2) The application fee required under division (A) (1) of 617
this section is credited to the general operations fund 618
established under section 3701.83 of the Revised Code. 619~~

~~(3) Except for applications that demonstrate that the 620
applicant entering operator, or a person or government entity 621
that directly or indirectly owns at least fifty per cent of the 622
entering operator, directly or indirectly owns at least fifty 623
per cent of the nursing home and its assets or at least fifty 624
per cent of the entity that owns the nursing home and its assets 625
, the applicant entering operator submits evidence of a bond or 626
other financial security reasonably acceptable to the director 627
for an amount not less than the product of the number of 628
licensed beds in the nursing home, as reflected in the 629
application, multiplied by ten thousand dollars. The bond may be 630
supplied by either the entering operator or the property owner 631
of the nursing home. 632~~

(a) The bond or other financial security shall be renewed, 633
replaced, or maintained for five years after the effective date 634
of the change of operator. The aggregate liability of a surety 635
shall not exceed the sum of the bond, which is not cumulative 636
from period to period. If the bond or other financial security 637
is not renewed, replaced, or maintained in accordance with this 638
division, the director shall revoke the nursing home operator's 639
license after providing thirty days' notice to the operator. The 640
bond or other financial security shall be released five years 641
after the effective date of the change of operator if none of 642
the events described in division ~~(A) (3) (b)~~ (A) (2) (b) of this 643

section have occurred. 644

(b) The director may utilize the bond or other financial 645
security required under division ~~(A) (3)~~ (A) (2) of this section 646
to pay expenses incurred by the director or another state 647
official or agency if any of the following occur during the 648
five-year period for which the bond or other financial security 649
is required: 650

~~(1)~~ (i) The nursing home is voluntarily or involuntarily 651
closed. 652

~~(2)~~ (ii) The nursing home or its owner or operator is the 653
subject of voluntary or involuntary bankruptcy proceedings. 654

~~(3)~~ (iii) The nursing home or its owner or operator is the 655
subject of voluntary or involuntary receivership proceedings. 656

~~(4)~~ (iv) The license to operate the nursing home is 657
suspended, denied, or revoked. 658

~~(5)~~ (v) The nursing home undergoes a change of operator, 659
unless the new applicant submits a bond or other financial 660
security in accordance with this section. 661

~~(6)~~ (vi) The nursing home appears in table A, table B, or 662
table D on the SFF list under the special focus facility 663
program. 664

~~(4) A (3)~~ The entering operator or a person or government 665
entity who is a direct or indirect owner of fifty per cent or 666
more of the applicant is an individual who will have operational 667
control of the nursing home has at least five years of 668
experience as either of the following: 669

(a) An administrator of a nursing home located in this 670
state or another state; 671

~~(b) A direct or indirect owner of at least fifty per cent-~~ 672
~~in either of the following:~~ 673

~~(i) An operator~~ A person or government entity with 674
operational control of a nursing home located in this state or 675
another state; ~~—~~ 676

~~(ii) A manager of a nursing home located in this state or-~~ 677
~~another state.~~ 678

~~(5)~~ (4) The applicant entering operator attests that the 679
applicant entering operator has plans for quality assurance and 680
risk management for the operation of the nursing home. 681

~~(6)~~ (5) The applicant entering operator attests that the 682
applicant entering operator has general and professional 683
liability insurance coverage that provides coverage of at least 684
one million dollars per occurrence and three million dollars 685
aggregate. 686

~~(7)~~ (6) The applicant entering operator attests that the 687
applicant entering operator has sufficient numbers of qualified 688
staff, by training or experience, who will be employed to 689
properly care for the type and number of nursing home residents. 690

(B) The director shall issue to the entering operator a 691
notice of intent to grant a change of operator license upon a 692
determination that all requirements of this section have been 693
met, except for submission of the final document evidencing 694
completion of the transaction. 695

(C) The director shall ~~shall~~ may conduct a survey of the nursing 696
home not ~~more~~ less than sixty days after the effective date of 697
the change of operator. 698

~~(1)~~ (D) The requirements established by this section are 699

in addition to the other requirements established by this 700
chapter and the rules adopted under it for a license to operate 701
a nursing home. 702

(E) The director shall deny a change of operator license 703
application if any of the following circumstances exist: 704

(1) The requirements established by this section are not 705
satisfied license application or if the applicant. 706

(2) The entering operator or a person or government entity 707
identified in division (A) (1) (a) of this section who directly or 708
indirectly has twenty-five per cent or more ownership of the 709
entering operator meets both of the following criteria: 710

(a) The entering operator or the person or government 711
entity has or had fifty either of the following relationships to 712
a currently or previously licensed nursing home in this state or 713
another state: 714

(i) Fifty per cent or more direct or indirect ownership in 715
the operator or manager of a current or previously licensed 716
nursing home in this state or another state with respect to 717
which any; 718

(ii) Alone or together with one or more other persons, 719
operational control of the nursing home. 720

(b) Any of the following occurred with respect to the 721
current or previously licensed nursing home described in 722
division (E) (2) (a) of this section within the five years 723
immediately preceding the date of application: 724

~~(a)~~ (i) Involuntary closure of the nursing home by a 725
regulatory agency or voluntary closure in response to licensure 726
or certification action; 727

(b) <u>(ii) Voluntary or involuntary bankruptcy proceedings</u>	728
that are not dismissed within sixty days;	729
(e) <u>(iii) Voluntary or involuntary receivership</u>	730
proceedings that are not dismissed within sixty days;	731
(d) <u>(iv) License suspension, denial, or revocation for</u>	732
failure to comply with operating standards.	733
<u>(3) If a change of twenty-five per cent or more of the</u>	734
<u>property ownership interest in a nursing home occurs in</u>	735
<u>connection with the change of operator, the person or government</u>	736
<u>entity who acquired the property ownership interest meets both</u>	737
<u>of the following criteria:</u>	738
<u>(a) The person or government entity has or had either of</u>	739
<u>the following relationships to a currently or previously</u>	740
<u>licensed nursing home in this state or another state:</u>	741
<u>(i) Fifty per cent or more direct or indirect property</u>	742
<u>ownership in the nursing home;</u>	743
<u>(ii) Alone or together with one or more other persons,</u>	744
<u>operational control of the nursing home.</u>	745
<u>(b) Any of the following occurred with respect to the</u>	746
<u>current or previously licensed nursing home described in</u>	747
<u>division (E) (3) (a) of this section within the five years</u>	748
<u>immediately preceding the date of application:</u>	749
<u>(i) Involuntary closure of the nursing home by a</u>	750
<u>regulatory agency or voluntary closure in response to licensure</u>	751
<u>or certification action;</u>	752
<u>(ii) Voluntary or involuntary bankruptcy proceedings that</u>	753
<u>are not dismissed within sixty days;</u>	754

(iii) Voluntary or involuntary receivership proceedings 755
that are not dismissed within sixty days; 756

(iv) License suspension, denial, or revocation for failure 757
to comply with operating standards. 758

~~(2)-(F) An applicant-entering operator~~ may appeal the 759
denial of a change of operator license application in accordance 760
with Chapter 119. of the Revised Code. 761

~~(C)-(G) An applicant-entering operator shall notify do all~~ 762
of the following: 763

(1) Notify the director immediately upon discovery of any 764
error, omission, or change of information in a change of 765
operator license application. 766

(2) Notify the director within ten days of any change in 767
the information or documentation required by this section, 768
~~whether the change that occurs before or after the effective~~ 769
date of the change of operator. 770

(3) Truthfully supply any additional information or 771
documentation requested by the director. 772

If an ~~applicant-entering operator~~ fails to notify the 773
director or supply additional information or documentation in 774
accordance with this division, the director shall impose a civil 775
penalty of two thousand dollars for each day of noncompliance. 776

(4) Not complete the change of operator until the director 777
issues to the entering operator notice of intent to grant a 778
change of operator license in accordance with division (B) of 779
this section. The entering operator shall submit the final 780
document evidencing completion of the transaction not later than 781
five days after completion. 782

~~(D)~~ ~~(1)~~ (H) (1) The director shall investigate an allegation 783
that a change of operator has occurred and the entering operator 784
failed to submit an application in accordance with this section 785
or an application was filed but the information was fraudulent. 786
The director may request the attorney general's assistance with 787
an investigation under this section. 788

(2) If the director becomes aware, by means of an 789
investigation or otherwise, that a change of operator has 790
occurred and the entering operator failed to submit an 791
application in accordance with this section, or an application 792
was filed but the information provided was fraudulent, the 793
director shall impose a civil penalty of two thousand dollars 794
for each day of noncompliance after the date the director 795
becomes aware that the change of operator has occurred. If the 796
entering operator fails to submit an application or new 797
application in accordance with this section within sixty days of 798
the director becoming aware of the change of operator, the 799
director shall begin the process of revoking a nursing home 800
license as specified in section 3721.03 of the Revised Code. 801

~~(E)~~ (I) It is the intent of the general assembly in 802
amending this section to require full and complete disclosure 803
and transparency with respect to the ownership, operation, and 804
management of each licensed nursing home located in this state. 805
The director may adopt rules as necessary to implement this 806
section. Any rules shall be adopted in accordance with Chapter 807
119. of the Revised Code. 808

Sec. 3721.072. (A) As used in this section: 809

(1) "Advance care planning" means providing an opportunity 810
to discuss the goals that may be met through the care provided 811
by a nursing home. 812

(2) "Overhead paging" means sending audible announcements 813
through an electronic sound amplification and distribution 814
system throughout part or all of a nursing home to staff, 815
residents, residents' families, or others. 816

(B) ~~Beginning July 1, 2013, each~~ Each nursing home shall 817
participate every two years in at least one ~~of the~~ quality 818
improvement ~~projects~~ project, and in doing so, shall prioritize 819
projects to assist with workforce, such as employee satisfaction 820
surveys, enhanced recruitment methods, or workplace culture 821
improvements. A nursing home may consider projects included on 822
the list made available by the department of aging under the 823
nursing home quality initiative established under section 173.60 824
of the Revised Code. 825

(C) Beginning July 1, 2015, each nursing home shall 826
participate in advance care planning with each resident or the 827
resident's sponsor if the resident is unable to participate. For 828
each resident, the advance care planning shall be provided on 829
admission to the nursing home or, in the case of an individual 830
residing in a nursing home on July 1, 2015, as soon as 831
practicable. Thereafter, for each resident, the advance care 832
planning shall be provided quarterly each year. 833

(D) Beginning July 1, 2015, each nursing home shall 834
prohibit the use of overhead paging within the nursing home, 835
except that the nursing home may permit the use of overhead 836
paging for matters of urgent public safety or urgent clinical 837
operations. The nursing home shall develop a written policy 838
regarding its use of overhead paging and make the policy 839
available to staff, residents, and residents' families. 840

Sec. 3721.121. (A) As used in this section: 841

(1) "Adult day-care program" means a program operated 842
pursuant to rules adopted by the director of health under 843
section 3721.04 of the Revised Code and provided by and on the 844
same site as homes licensed under this chapter. 845

(2) "Applicant" means a person who is under final 846
consideration for employment with a home or adult day-care 847
program in a full-time, part-time, or temporary position that 848
involves providing direct care to an older adult. "Applicant" 849
does not include a person who provides direct care as a 850
volunteer without receiving or expecting to receive any form of 851
remuneration other than reimbursement for actual expenses. 852

(3) "Community-based long-term care services provider" 853
means a provider as defined in section 173.39 of the Revised 854
Code. 855

(4) "Criminal records check" has the same meaning as in 856
section 109.572 of the Revised Code. 857

(5) "Home" means a home as defined in section 3721.10 of 858
the Revised Code. 859

(6) "Older adult" means a person age sixty or older. 860

(B) (1) Except as provided in division (I) of this section, 861
the chief administrator of a home or adult day-care program 862
shall request that the superintendent of the bureau of criminal 863
identification and investigation conduct a criminal records 864
check of each applicant. If an applicant for whom a criminal 865
records check request is required under this division does not 866
present proof of having been a resident of this state for the 867
five-year period immediately prior to the date the criminal 868
records check is requested or provide evidence that within that 869
five-year period the superintendent has requested information 870

about the applicant from the federal bureau of investigation in 871
a criminal records check, the chief administrator shall request 872
that the superintendent obtain information from the federal 873
bureau of investigation as part of the criminal records check of 874
the applicant. Even if an applicant for whom a criminal records 875
check request is required under this division presents proof of 876
having been a resident of this state for the five-year period, 877
the chief administrator may request that the superintendent 878
include information from the federal bureau of investigation in 879
the criminal records check. 880

(2) A person required by division (B)(1) of this section 881
to request a criminal records check shall do both of the 882
following: 883

(a) Provide to each applicant for whom a criminal records 884
check request is required under that division a copy of the form 885
prescribed pursuant to division (C)(1) of section 109.572 of the 886
Revised Code and a standard fingerprint impression sheet 887
prescribed pursuant to division (C)(2) of that section, and 888
obtain the completed form and impression sheet from the 889
applicant; 890

(b) Forward the completed form and impression sheet to the 891
superintendent of the bureau of criminal identification and 892
investigation. 893

(3) An applicant provided the form and fingerprint 894
impression sheet under division (B)(2)(a) of this section who 895
fails to complete the form or provide fingerprint impressions 896
shall not be employed in any position for which a criminal 897
records check is required by this section. 898

(C)(1) Except as provided in rules adopted by the director 899

of health in accordance with division (F) of this section and 900
subject to division (C) (2) of this section, no home or adult 901
day-care program shall employ a person in a position that 902
involves providing direct care to an older adult if the person 903
has been convicted of or pleaded guilty to any of the following: 904

(a) A violation of section 2903.01, 2903.02, 2903.03, 905
2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 906
2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 907
2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 908
2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 909
2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 910
2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 911
2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 912
2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code. 913

(b) A violation of an existing or former law of this 914
state, any other state, or the United States that is 915
substantially equivalent to any of the offenses listed in 916
division (C) (1) (a) of this section. 917

(2) (a) A home or an adult day-care program may employ 918
conditionally an applicant for whom a criminal records check 919
request is required under division (B) of this section prior to 920
obtaining the results of a criminal records check regarding the 921
individual, provided that the home or program shall request a 922
criminal records check regarding the individual in accordance 923
with division (B) (1) of this section not later than five 924
business days after the individual begins conditional 925
employment. In the circumstances described in division (I) (2) of 926
this section, a home or adult day-care program may employ 927
conditionally an applicant who has been referred to the home or 928
adult day-care program by an employment service that supplies 929

full-time, part-time, or temporary staff for positions involving 930
the direct care of older adults and for whom, pursuant to that 931
division, a criminal records check is not required under 932
division (B) of this section. 933

(b) A home or adult day-care program that employs an 934
individual conditionally under authority of division (C) (2) (a) 935
of this section shall terminate the individual's employment if 936
the results of the criminal records check requested under 937
division (B) of this section or described in division (I) (2) of 938
this section, other than the results of any request for 939
information from the federal bureau of investigation, are not 940
obtained within the period ending ~~thirty~~sixty days after the 941
date the request is made. Regardless of when the results of the 942
criminal records check are obtained, if the results indicate 943
that the individual has been convicted of or pleaded guilty to 944
any of the offenses listed or described in division (C) (1) of 945
this section, the home or program shall terminate the 946
individual's employment unless the home or program chooses to 947
employ the individual pursuant to division (F) of this section. 948
Termination of employment under this division shall be 949
considered just cause for discharge for purposes of division (D) 950
(2) of section 4141.29 of the Revised Code if the individual 951
makes any attempt to deceive the home or program about the 952
individual's criminal record. 953

(D) (1) Each home or adult day-care program shall pay to 954
the bureau of criminal identification and investigation the fee 955
prescribed pursuant to division (C) (3) of section 109.572 of the 956
Revised Code for each criminal records check conducted pursuant 957
to a request made under division (B) of this section. 958

(2) A home or adult day-care program may charge an 959

applicant a fee not exceeding the amount the home or program 960
pays under division (D) (1) of this section. A home or program 961
may collect a fee only if both of the following apply: 962

(a) The home or program notifies the person at the time of 963
initial application for employment of the amount of the fee and 964
that, unless the fee is paid, the person will not be considered 965
for employment; 966

(b) The medicaid program does not reimburse the home or 967
program the fee it pays under division (D) (1) of this section. 968

(E) The report of any criminal records check conducted 969
pursuant to a request made under this section is not a public 970
record for the purposes of section 149.43 of the Revised Code 971
and shall not be made available to any person other than the 972
following: 973

(1) The individual who is the subject of the criminal 974
records check or the individual's representative; 975

(2) The chief administrator of the home or program 976
requesting the criminal records check or the administrator's 977
representative; 978

(3) The administrator of any other facility, agency, or 979
program that provides direct care to older adults that is owned 980
or operated by the same entity that owns or operates the home or 981
program; 982

(4) A court, hearing officer, or other necessary 983
individual involved in a case dealing with a denial of 984
employment of the applicant or dealing with employment or 985
unemployment benefits of the applicant; 986

(5) Any person to whom the report is provided pursuant to, 987

and in accordance with, division (I) (1) or (2) of this section; 988

(6) The board of nursing for purposes of accepting and 989
processing an application for a medication aide certificate 990
issued under Chapter 4723. of the Revised Code; 991

(7) The director of aging or the director's designee if 992
the criminal records check is requested by the chief 993
administrator of a home that is also a community-based long-term 994
care services provider. 995

(F) In accordance with section 3721.11 of the Revised 996
Code, the director of health shall adopt rules to implement this 997
section. The rules shall specify circumstances under which a 998
home or adult day-care program may employ a person who has been 999
convicted of or pleaded guilty to an offense listed or described 1000
in division (C) (1) of this section but meets personal character 1001
standards set by the director. 1002

(G) The chief administrator of a home or adult day-care 1003
program shall inform each individual, at the time of initial 1004
application for a position that involves providing direct care 1005
to an older adult, that the individual is required to provide a 1006
set of fingerprint impressions and that a criminal records check 1007
is required to be conducted if the individual comes under final 1008
consideration for employment. 1009

(H) In a tort or other civil action for damages that is 1010
brought as the result of an injury, death, or loss to person or 1011
property caused by an individual who a home or adult day-care 1012
program employs in a position that involves providing direct 1013
care to older adults, all of the following shall apply: 1014

(1) If the home or program employed the individual in good 1015
faith and reasonable reliance on the report of a criminal 1016

records check requested under this section, the home or program 1017
shall not be found negligent solely because of its reliance on 1018
the report, even if the information in the report is determined 1019
later to have been incomplete or inaccurate; 1020

(2) If the home or program employed the individual in good 1021
faith on a conditional basis pursuant to division (C) (2) of this 1022
section, the home or program shall not be found negligent solely 1023
because it employed the individual prior to receiving the report 1024
of a criminal records check requested under this section; 1025

(3) If the home or program in good faith employed the 1026
individual according to the personal character standards 1027
established in rules adopted under division (F) of this section, 1028
the home or program shall not be found negligent solely because 1029
the individual prior to being employed had been convicted of or 1030
pleaded guilty to an offense listed or described in division (C) 1031
(1) of this section. 1032

(I) (1) The chief administrator of a home or adult day-care 1033
program is not required to request that the superintendent of 1034
the bureau of criminal identification and investigation conduct 1035
a criminal records check of an applicant if the applicant has 1036
been referred to the home or program by an employment service 1037
that supplies full-time, part-time, or temporary staff for 1038
positions involving the direct care of older adults and both of 1039
the following apply: 1040

(a) The chief administrator receives from the employment 1041
service or the applicant a report of the results of a criminal 1042
records check regarding the applicant that has been conducted by 1043
the superintendent within the one-year period immediately 1044
preceding the applicant's referral; 1045

(b) The report of the criminal records check demonstrates 1046
that the person has not been convicted of or pleaded guilty to 1047
an offense listed or described in division (C)(1) of this 1048
section, or the report demonstrates that the person has been 1049
convicted of or pleaded guilty to one or more of those offenses, 1050
but the home or adult day-care program chooses to employ the 1051
individual pursuant to division (F) of this section. 1052

(2) The chief administrator of a home or adult day-care 1053
program is not required to request that the superintendent of 1054
the bureau of criminal identification and investigation conduct 1055
a criminal records check of an applicant and may employ the 1056
applicant conditionally as described in this division, if the 1057
applicant has been referred to the home or program by an 1058
employment service that supplies full-time, part-time, or 1059
temporary staff for positions involving the direct care of older 1060
adults and if the chief administrator receives from the 1061
employment service or the applicant a letter from the employment 1062
service that is on the letterhead of the employment service, 1063
dated, and signed by a supervisor or another designated official 1064
of the employment service and that states that the employment 1065
service has requested the superintendent to conduct a criminal 1066
records check regarding the applicant, that the requested 1067
criminal records check will include a determination of whether 1068
the applicant has been convicted of or pleaded guilty to any 1069
offense listed or described in division (C)(1) of this section, 1070
that, as of the date set forth on the letter, the employment 1071
service had not received the results of the criminal records 1072
check, and that, when the employment service receives the 1073
results of the criminal records check, it promptly will send a 1074
copy of the results to the home or adult day-care program. If a 1075
home or adult day-care program employs an applicant 1076

conditionally in accordance with this division, the employment 1077
service, upon its receipt of the results of the criminal records 1078
check, promptly shall send a copy of the results to the home or 1079
adult day-care program, and division (C) (2) (b) of this section 1080
applies regarding the conditional employment. 1081

Sec. 3721.28. (A) (1) Each nurse aide used by a long-term 1082
care facility on a full-time, temporary, per diem, or other 1083
basis on July 1, 1989, shall be provided by the facility a 1084
competency evaluation program approved by the director of health 1085
under division (A) of section 3721.31 of the Revised Code or 1086
conducted by the director under division (C) of that section. 1087
Each long-term care facility using a nurse aide on July 1, 1989, 1088
shall provide the nurse aide the preparation necessary to 1089
complete the competency evaluation program by January 1, 1990. 1090

(2) Each nurse aide used by a long-term care facility on a 1091
full-time, temporary, per diem, or other basis on January 1, 1092
1990, who either was not used by the facility on July 1, 1989, 1093
or was used by the facility on July 1, 1989, but had not 1094
successfully completed a competency evaluation program by 1095
January 1, 1990, shall be provided by the facility a competency 1096
evaluation program approved by the director under division (A) 1097
of section 3721.31 of the Revised Code or conducted by the 1098
director under division (C) of that section. Each long-term care 1099
facility using a nurse aide described in division (A) (2) of this 1100
section shall provide the nurse aide the preparation necessary 1101
to complete the competency evaluation program by October 1, 1102
1990, and shall assist the nurse aide in registering for the 1103
program. 1104

(B) Effective June 1, 1990, no long-term care facility 1105
shall use an individual as a nurse aide for more than four 1106

months unless the individual is competent to provide the 1107
services the individual is to provide, the facility has received 1108
from the nurse aide registry established under section 3721.32 1109
of the Revised Code the information concerning the individual 1110
provided through the registry, and one of the following is the 1111
case: 1112

(1) The individual was used by a facility as a nurse aide 1113
on a full-time, temporary, per diem, or other basis at any time 1114
during the period commencing July 1, 1989, and ending January 1, 1115
1990, and successfully completed, not later than October 1, 1116
1990, a competency evaluation program approved by the director 1117
under division (A) of section 3721.31 of the Revised Code or 1118
conducted by the director under division (C) of that section. 1119

(2) The individual has successfully completed a training 1120
and competency evaluation program approved by the director under 1121
division (A) of section 3721.31 of the Revised Code or conducted 1122
by the director under division (C) of that section or has met 1123
the conditions specified in division (F)(1) or (2) of this 1124
section and, in addition, if the training and competency 1125
evaluation program or the training, instruction, or education 1126
the individual completed in meeting the conditions specified in 1127
division (F)(1) or (2) of this section was conducted by or in a 1128
long-term care facility, ~~or if the director pursuant to division~~ 1129
~~(E) of section 3721.31 of the Revised Code so requires,~~ the 1130
individual has successfully completed a competency evaluation 1131
program conducted by the director. 1132

(3) Prior to July 1, 1989, if the long-term care facility 1133
is certified as a skilled nursing facility or a nursing facility 1134
under Title XVIII or XIX of the "Social Security Act," 49 Stat. 1135
620 (1935), 42 U.S.C.A. 301, as amended, or prior to January 1, 1136

1990, if the facility is not so certified, the individual 1137
completed a program that the director determines included a 1138
competency evaluation component no less stringent than the 1139
competency evaluation programs approved by the director under 1140
division (A) of section 3721.31 of the Revised Code or conducted 1141
by the director under division (C) of that section, and was 1142
otherwise comparable to the training and competency evaluation 1143
programs being approved by the director under division (A) of 1144
that section. 1145

(4) The individual is listed in a nurse aide registry 1146
maintained by another state and that state certifies that its 1147
program for training and evaluation of competency of nurse aides 1148
complies with Titles XVIII and XIX of the "Social Security Act" 1149
and regulations adopted thereunder. 1150

(5) Prior to July 1, 1989, the individual was found 1151
competent to serve as a nurse aide after the completion of a 1152
course of nurse aide training of at least one hundred hours' 1153
duration. 1154

(6) The individual is enrolled in a prelicensure program 1155
of nursing education approved by the board of nursing or by an 1156
agency of another state that regulates nursing education, has 1157
provided the long-term care facility with a certificate from the 1158
program indicating that the individual has successfully 1159
completed the courses that teach basic nursing skills including 1160
infection control, safety and emergency procedures, and personal 1161
care, and has successfully completed a competency evaluation 1162
program conducted by the director under division (C) of section 1163
3721.31 of the Revised Code. 1164

(7) The individual has the equivalent of twelve months or 1165
more of full-time employment in the preceding five years as a 1166

hospital aide or orderly and has successfully completed a 1167
competency evaluation program conducted by the director under 1168
division (C) of section 3721.31 of the Revised Code. 1169

(8) The individual has successfully completed a 1170
prelicensure program of nursing education approved by the board 1171
of nursing under section 4723.06 of the Revised Code or by an 1172
agency of another state that regulates nursing education and has 1173
passed the examination accepted by the board of nursing under 1174
section 4723.10 of the Revised Code, which shall be deemed as 1175
the successful completion of a competency evaluation program 1176
conducted by the director under division (C) of section 3721.31 1177
of the Revised Code. 1178

(C) Effective June 1, 1990, no long-term care facility 1179
shall continue for longer than four months to use as a nurse 1180
aide an individual who previously met the requirements of 1181
division (B) of this section but since most recently doing so 1182
has not performed nursing and nursing-related services for 1183
monetary compensation for twenty-four consecutive months, unless 1184
the individual successfully completes additional training and 1185
competency evaluation by complying with divisions (C) (1) and (2) 1186
of this section: 1187

(1) Doing one of the following: 1188

(a) Successfully completing a training and competency 1189
evaluation program approved by the director under division (A) 1190
of section 3721.31 of the Revised Code or conducted by the 1191
director under division (C) of that section; 1192

(b) Successfully completing a training and competency 1193
evaluation program described in division (B) (4) of this section; 1194

(c) Meeting the requirements specified in division (B) (6) 1195

or (7) of this section. 1196

(2) If the training and competency evaluation program 1197
completed under division (C) (1) (a) of this section was conducted 1198
by or in a long-term care facility, ~~or if the director pursuant to~~ 1199
~~division (E) of section 3721.31 of the Revised Code so~~ 1200
~~requires,~~ successfully completing a competency evaluation 1201
program conducted by the director. 1202

(D) (1) The four-month periods provided for in divisions 1203
(B) and (C) of this section include any time, on or after June 1204
1, 1990, that an individual is used as a nurse aide on a full- 1205
time, temporary, per diem, or any other basis by the facility or 1206
any other long-term care facility. 1207

(2) During the four-month period provided for in division 1208
(B) of this section, during which a long-term care facility may, 1209
subject to division (E) of this section, use as a nurse aide an 1210
individual who does not have the qualifications specified in 1211
divisions (B) (1) to (7) of this section, a facility shall 1212
require the individual to comply with divisions (D) (2) (a) and 1213
(b) of this section: 1214

(a) Participate in one of the following: 1215

(i) If the individual has successfully completed a 1216
training and competency evaluation program approved by the 1217
director under division (A) of section 3721.31 of the Revised 1218
Code, and the program was conducted by or in a long-term care 1219
facility, ~~or the director pursuant to division (E) of section~~ 1220
~~3721.31 of the Revised Code so requires,~~ a competency evaluation 1221
program conducted by the director; 1222

(ii) If the individual is enrolled in a prelicensure 1223
program of nursing education described in division (B) (6) of 1224

this section and has completed or is working toward completion 1225
of the courses described in that division, or the individual has 1226
the experience described in division (B) (7) of this section, a 1227
competency evaluation program conducted by the director; 1228

(iii) A training and competency evaluation program 1229
approved by the director under division (A) of section 3721.31 1230
of the Revised Code or conducted by the director under division 1231
(C) of that section. 1232

(b) If the individual participates in or has successfully 1233
completed a training and competency evaluation program under 1234
division (D) (2) (a) (iii) of this section that is conducted by or 1235
in a long-term care facility, ~~or the director pursuant to~~ 1236
~~division (E) of section 3721.31 of the Revised Code so requires,~~ 1237
participate in a competency evaluation program conducted by the 1238
director. 1239

(3) During the four-month period provided for in division 1240
(C) of this section, during which a long-term care facility may, 1241
subject to division (E) of this section, use as a nurse aide an 1242
individual who does not have the qualifications specified in 1243
divisions (C) (1) and (2) of this section, a facility shall 1244
require the individual to comply with divisions (D) (3) (a) and 1245
(b) of this section: 1246

(a) Participate in one of the following: 1247

(i) If the individual has successfully completed a 1248
training and competency evaluation program approved by the 1249
director, and the program was conducted by or in a long-term 1250
care facility, ~~or the director pursuant to division (E) of~~ 1251
~~section 3721.31 of the Revised Code so requires,~~ a competency 1252
evaluation program conducted by the director; 1253

(ii) If the individual is enrolled in a prelicensure program of nursing education described in division (B) (6) of this section and has completed or is working toward completion of the courses described in that division, or the individual has the experience described in division (B) (7) of this section, a competency evaluation program conducted by the director;

(iii) A training and competency evaluation program approved or conducted by the director.

(b) If the individual participates in or has successfully completed a training and competency evaluation program under division (D) (3) (a) (iii) of this section that is conducted by or in a long-term care facility, ~~or the director pursuant to division (E) of section 3721.31 of the Revised Code so requires,~~ participate in a competency evaluation program conducted by the director.

(E) A long-term care facility shall not permit an individual used by the facility as a nurse aide while participating in a training and competency evaluation program to provide nursing and nursing-related services unless both of the following are the case:

(1) The individual has completed the number of hours of training that must be completed prior to providing services to residents as prescribed by rules that shall be adopted by the director in accordance with Chapter 119. of the Revised Code;

(2) The individual is under the personal supervision of a registered or licensed practical nurse licensed under Chapter 4723. of the Revised Code.

(F) An individual shall be considered to have satisfied the requirement, under division (B) (2) of this section, of

having successfully completed a training and competency 1283
evaluation program conducted or approved by the director, if 1284
either of the following apply: 1285

(1) The individual, as of July 1, 1989, met both of the 1286
following conditions: 1287

(a) Completed at least sixty hours divided between skills 1288
training and classroom instruction in the topic areas described 1289
in divisions (B) (1) to (8) of section 3721.30 of the Revised 1290
Code; 1291

(b) Received at least the difference between seventy-five 1292
hours and the number of hours actually spent in training and 1293
competency evaluation in supervised practical nurse aide 1294
training or regular in-service nurse aide education. 1295

(2) The individual meets both of the following conditions: 1296

(a) Has completed during the COVID-19 public health 1297
emergency declared by the United States secretary of health and 1298
human services a minimum of seventy-five hours of training that 1299
occurs in a long-term care facility setting, includes on-site 1300
observation and work as a nurse aide under a COVID-19 pandemic 1301
waiver issued by the federal centers for medicare and medicaid 1302
services, and addresses all of the required areas specified in 1303
42 C.F.R. 483.152(b), except that if gaps in on-site training 1304
are identified, the individual also must complete supplemental 1305
training; 1306

(b) Has successfully completed the competency evaluation 1307
conducted by the director of health under section 3721.31 of the 1308
Revised Code. 1309

(G) The director shall adopt rules in accordance with 1310
Chapter 119. of the Revised Code specifying persons, in addition 1311

to the director, who may establish competence of nurse aides 1312
under division (B) (5) of this section, and establishing criteria 1313
for determining whether an individual meets the conditions 1314
specified in division (F) (1) of this section. 1315

(H) The rules adopted pursuant to divisions (E) (1) and (G) 1316
of this section shall be no less stringent than the 1317
requirements, guidelines, and procedures established by the 1318
United States secretary of health and human services under 1319
sections 1819 and 1919 of the "Social Security Act." 1320

Sec. 3721.30. (A) (1) A training and competency evaluation 1321
program approved by the director of health under division (A) of 1322
section 3721.31 of the Revised Code or a competency evaluation 1323
program conducted by the director under division (C) of that 1324
section shall evaluate the competency of a nurse aide in the 1325
following areas: 1326

- (a) Basic nursing skills; 1327
- (b) Personal care skills; 1328
- (c) Recognition of mental health and social service needs; 1329
- (d) Care of residents with cognitive impairments; 1330
- (e) Basic restorative services; 1331
- (f) Residents' rights; 1332
- (g) Any other area specified by rule of the director. 1333

(2) Any training and competency evaluation program 1334
approved or competency evaluation program conducted by the 1335
director may include a written examination, but shall permit a 1336
nurse aide, at the nurse aide's option, to establish competency 1337
in another manner approved by the director. A nurse aide shall 1338

be permitted to have the competency evaluation conducted at the 1339
long-term care facility at which the nurse aide is or will be 1340
employed, unless the facility has been determined by the 1341
director or the United States secretary of health and human 1342
services to have been out of compliance with the requirements of 1343
subsection (b), (c), or (d) of section 1819 or 1919 of the 1344
"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as 1345
amended, within the previous two years. 1346

(B) A training and competency evaluation program approved 1347
or conducted by the director under section 3721.31 of the 1348
Revised Code shall consist of training and competency evaluation 1349
specified by the director in rules adopted under division (C) of 1350
this section, including a minimum of seventy-five hours divided 1351
between skills training and classroom instruction in the 1352
following topic areas: 1353

(1) Basic nursing skills; 1354

(2) Personal care skills; 1355

(3) Recognition of mental health and social service needs; 1356

(4) Care of residents with cognitive impairments; 1357

(5) Basic restorative services; 1358

(6) Residents' rights; 1359

(7) Needs of various groups of long-term care facility 1360
residents and patients; 1361

(8) Other topic areas specified by rule of the director. 1362

(C) In accordance with Chapter 119. of the Revised Code, 1363
the director shall adopt rules establishing procedures and 1364
criteria for approval of ~~competency evaluation programs and~~ 1365

training and competency evaluation programs. The requirements 1366
established by rules shall be no less stringent than the 1367
requirements, guidelines, and procedures established by the 1368
United States secretary of health and human services under 1369
sections 1819 and 1919 of the "Social Security Act." The 1370
director also shall adopt rules governing all of the following: 1371

(1) Procedures for determination of an individual's 1372
competency to perform services as a nurse aide; 1373

(2) The curriculum of training and competency evaluation 1374
programs; 1375

(3) The clinical supervision and physical facilities used 1376
for ~~competency evaluation programs and training and competency~~ 1377
evaluation programs; 1378

(4) The number of hours of training required in training 1379
and competency evaluation programs; 1380

(5) The qualifications for instructors, coordinators, and 1381
evaluators of ~~competency evaluation programs and training and~~ 1382
competency evaluation programs, except that the rules shall not 1383
require an instructor for a training and competency evaluation 1384
program to have nursing home experience if the program is under 1385
the general supervision of a coordinator who is a registered 1386
nurse who possesses a minimum of two years of nursing 1387
experience, at least one of which is in the provision of 1388
services in a nursing home or intermediate care facility for 1389
individuals with intellectual disabilities; 1390

(6) Requirements that ~~approved competency evaluation~~ 1391
~~programs and training and competency evaluation programs~~ must 1392
meet to retain approval; 1393

(7) Standards for successful completion of a ~~competency~~ 1394

evaluation program or training and competency evaluation	1395
program;	1396
(8) Procedures and criteria for review and reapproval of	1397
competency evaluation programs and training and competency	1398
evaluation programs;	1399
(9) Fees for application for approval or reapproval of	1400
competency evaluation programs, training and competency	1401
evaluation programs, and programs to train instructors and,	1402
coordinators, and evaluators for training and competency	1403
evaluation programs and evaluators for competency evaluation	1404
programs;	1405
(10) Fees for participation in any competency evaluation	1406
program, training and competency evaluation program, or other	1407
program conducted by the director under section 3721.31 of the	1408
Revised Code;	1409
(11) Procedures for reporting to the nurse aide registry	1410
established under section 3721.32 of the Revised Code whether or	1411
not individuals participating in competency evaluation programs	1412
and training and competency evaluation programs have	1413
successfully completed the programs.	1414
(D) In accordance with Chapter 119. of the Revised Code,	1415
the director may adopt rules prescribing criteria and procedures	1416
for approval of training programs for instructors and,	1417
coordinators, and evaluators for competency evaluation programs	1418
and training and competency evaluation programs, and for	1419
evaluators for competency evaluation programs. The director may	1420
adopt other rules that the director considers necessary for the	1421
administration and enforcement of sections 3721.28 to 3721.34 of	1422
the Revised Code or for compliance with requirements,	1423

guidelines, or procedures issued by the United States secretary 1424
of health and human services for implementation of section 1819 1425
or 1919 of the "Social Security Act." 1426

(E) No person or government entity shall impose on a nurse 1427
aide any charge for participation in any competency evaluation 1428
program or training and competency evaluation program approved 1429
or conducted by the director under section 3721.31 of the 1430
Revised Code, including any charge for textbooks, other required 1431
course materials, or a competency evaluation. 1432

(F) No person or government entity shall require that an 1433
individual used by the person or government entity as a nurse 1434
aide or seeking employment as a nurse aide pay or repay, either 1435
before or while the individual is employed by the person or 1436
government entity or when the individual leaves the person or 1437
government entity's employ, any costs associated with the 1438
individual's participation in a competency evaluation program or 1439
training and competency evaluation program approved or conducted 1440
by the director. 1441

Sec. 3721.31. (A) (1) ~~Except as provided in division (E) of~~ 1442
~~this section, the~~ The director of health shall approve 1443
~~competency evaluation programs and~~ training and competency 1444
evaluation programs in accordance with rules adopted under 1445
section 3721.30 of the Revised Code and shall periodically 1446
review and reapprove programs approved under this section. 1447

(2) Except as otherwise provided in division (A) (3) of 1448
this section, the director may approve and reapprove programs 1449
conducted by or in long-term care facilities, or by any 1450
government agency or person, including an employee organization. 1451

(3) The director shall not approve or reapprove a 1452

~~competency evaluation program or training and competency~~ 1453
evaluation program conducted by or in a long-term care facility 1454
that was determined by the director or the United States 1455
secretary of health and human services to have been out of 1456
compliance with the requirements of subsection (b), (c), or (d) 1457
of section 1819 or 1919 of the "Social Security Act," 49 Stat. 1458
620 (1935), 42 U.S.C.A. 301, as amended, within a two-year 1459
period prior to making application for approval or reapproval 1460
and shall revoke the approval or reapproval of a program 1461
conducted by or in a facility for which such a determination is 1462
made. This division does not apply to a program conducted by or 1463
in a long-term care facility to which the United States centers 1464
for medicare and medicaid services granted a waiver of the 1465
prohibition on training and competency programs. 1466

(4) A long-term care facility, employee organization, 1467
person, or government entity seeking approval or reapproval of a 1468
~~competency evaluation program or training and competency~~ 1469
evaluation program shall make an application to the director for 1470
approval or reapproval of the program and shall provide any 1471
documentation requested by the director. 1472

(5) The director may conduct inspections and examinations 1473
of approved ~~competency evaluation programs and training and~~ 1474
competency evaluation programs, ~~competency evaluation programs~~ 1475
~~and training and competency evaluation programs~~ for which an 1476
application for approval has been submitted under division (A) 1477
(4) of this section, and the sites at which they are or will be 1478
conducted. The director may conduct inspections of long-term 1479
care facilities in which individuals who have participated in 1480
approved ~~competency evaluation programs and training and~~ 1481
competency evaluation programs are being used as nurse aides. 1482

(B) In accordance with Chapter 119. of the Revised Code, 1483
the director may do the following: 1484

(1) Deny, suspend, or revoke approval or reapproval of any 1485
of the following that is not in compliance with this section and 1486
section 3721.30 of the Revised Code and rules adopted 1487
thereunder: 1488

(a) ~~A competency evaluation program;~~ 1489

~~(b) A training and competency evaluation program;~~ 1490

~~(c) (b) A training program for instructors or, 1491
coordinators, or evaluators for training and competency 1492
evaluation programs;~~ 1493

~~(d) A training program for evaluators for competency 1494
evaluation programs.~~ 1495

(2) Deny a request that the director determine any of the 1496
following for the purposes of division (B) of section 3721.28 of 1497
the Revised Code: 1498

(a) That a program completed prior to the dates specified 1499
in division (B) (3) of section 3721.28 of the Revised Code 1500
included a competency evaluation component no less stringent 1501
than the competency evaluation programs approved or conducted by 1502
the director under this section, and was otherwise comparable to 1503
the training and competency evaluation programs being approved 1504
under this section; 1505

(b) That an individual satisfies division (B) (5) of 1506
section 3721.28 of the Revised Code; 1507

(c) That an individual meets the conditions specified in 1508
division (F) (1) or (2) of section 3721.28 of the Revised Code. 1509

(C) The director may develop and conduct a competency 1510
evaluation program for individuals used by long-term care 1511
facilities as nurse aides at any time during the period 1512
commencing July 1, 1989, and ending January 1, 1990, and 1513
individuals who participate in training and competency 1514
evaluation programs conducted in or by long-term care 1515
facilities. The director also may conduct other competency 1516
evaluation programs and training and competency evaluation 1517
programs. When conducting competency evaluation programs and 1518
training and competency evaluation programs, the both of the 1519
following apply: 1520

(1) The director may use a nurse aide competency 1521
evaluation prepared by a testing service, and may contract with 1522
the service to administer the evaluation pursuant to section 1523
3701.044 of the Revised Code. 1524

(2) The director shall permit a training and competency 1525
evaluation program approved under division (A) of this section 1526
that is operated by a career center, community college, or 1527
similar educational institution to perform competency 1528
evaluations if the director determines that the program complies 1529
with federal laws and regulations relating to competency 1530
evaluations and the competency evaluation is substantially 1531
similar to the competency evaluation conducted by the director. 1532
A nursing home may proctor a competency evaluation under the 1533
circumstances specified in federal laws and regulations. 1534

(D) The director may approve or conduct programs to train 1535
instructors ~~and~~, coordinators, and evaluators for training and 1536
competency evaluation programs ~~and evaluators for competency~~ 1537
~~evaluation programs~~. The director may conduct inspections and 1538
examinations of those programs that have been approved by the 1539

director or for which an application for approval has been 1540
submitted, and the sites at which the programs are or will be 1541
conducted. The director shall not restrict participation in a 1542
training program for instructors to individuals who have 1543
experience working in a nursing home. 1544

~~(E) Notwithstanding division (A) of this section and~~ 1545
~~division (C) of section 3721.30 of the Revised Code, the~~ 1546
~~director, in the director's discretion, may decline to approve~~ 1547
~~any competency evaluation programs. The director may require all~~ 1548
~~individuals used by long-term care facilities as nurse aides~~ 1549
~~after June 1, 1990, who have completed a training and competency~~ 1550
~~evaluation program approved by the director under division (A)~~ 1551
~~of this section or who have met the conditions specified in~~ 1552
~~division (F) (1) or (2) of section 3721.28 of the Revised Code to~~ 1553
~~complete a competency evaluation program conducted by the~~ 1554
~~director under division (C) of this section. The director also~~ 1555
~~may require all individuals used as nurse aides by long-term~~ 1556
~~care facilities after June 1, 1990, who were used by a facility~~ 1557
~~at any time during the period commencing July 1, 1989, and~~ 1558
~~ending January 1, 1990, to complete a competency evaluation~~ 1559
~~program conducted by the director under division (C) of this~~ 1560
~~section rather than a competency evaluation program approved by~~ 1561
~~the director under division (A) of this section.~~ 1562

~~(F)~~The test materials, examinations, or evaluation tools 1563
used in any competency evaluation program or training and 1564
competency evaluation program that the director conducts or 1565
approves under this section are subject to the confidentiality 1566
provisions of section 3701.044 of the Revised Code. 1567

~~(G)~~(F)The director shall impose fees prescribed by rules 1568
adopted under section 3721.30 of the Revised Code for both of 1569

the following: 1570

(1) Making application for approval or reapproval of 1571
either of the following: 1572

(a) A ~~competency evaluation program or a training and~~ 1573
competency evaluation program; 1574

(b) A training program for instructors ~~or~~ coordinators, 1575
or evaluators for training and competency evaluation programs, ~~or~~ 1576
~~or evaluators for competency evaluation programs;~~ 1577

(2) Participation in any competency evaluation program, 1578
training and competency evaluation program, or other program 1579
conducted by the director under this section. 1580

(G) Each participant shall provide evidence of the 1581
participant's identity by showing identification issued by this 1582
or another state or the United States citizenship and 1583
immigration services. 1584

Sec. 3721.32. (A) The director of health shall establish a 1585
state nurse aide registry listing all individuals who have done 1586
any of the following: 1587

(1) Were used by a long-term care facility as nurse aides 1588
on a full-time, temporary, per diem, or other basis at any time 1589
during the period commencing July 1, 1989, and ending January 1, 1590
1990, and successfully completed, not later than October 1, 1591
1990, a competency evaluation program approved by the director 1592
under division (A) of section 3721.31 of the Revised Code or 1593
conducted by the director under division (C) of that section; 1594

(2) Successfully completed a training and competency 1595
evaluation program approved by the director under division (A) 1596
of section 3721.31 of the Revised Code or met the conditions 1597

specified in division (F) (1) or (2) of section 3721.28 of the Revised Code, and, if the training and competency evaluation program or the training, instruction, or education the individual completed in meeting the conditions specified in division (F) (1) of section 3721.28 of the Revised Code was conducted in or by a long-term care facility, ~~or if the director so required pursuant to division (E) of section 3721.31 of the Revised Code,~~ has successfully completed a competency evaluation program conducted by the director;

(3) Successfully completed a training and competency evaluation program conducted by the director under division (C) of section 3721.31 of the Revised Code;

(4) Successfully completed, prior to July 1, 1989, a program that the director has determined under division (B) (3) of section 3721.28 of the Revised Code included a competency evaluation component no less stringent than the competency evaluation programs approved or conducted by the director under section 3721.31 of the Revised Code, and was otherwise comparable to the training and competency evaluation program being approved by the director under section 3721.31 of the Revised Code;

(5) Are listed in a nurse aide registry maintained by another state that certifies that its program for training and evaluation of competency of nurse aides complies with Titles XVIII and XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or regulations adopted thereunder;

(6) Were found competent, as provided in division (B) (5) of section 3721.28 of the Revised Code, prior to July 1, 1989, after the completion of a course of nurse aide training of at least one hundred hours' duration;

(7) Are enrolled in a prelicensure program of nursing 1628
education approved by the board of nursing or by an agency of 1629
another state that regulates nursing education, have provided 1630
the long-term care facility with a certificate from the program 1631
indicating that the individual has successfully completed the 1632
courses that teach basic nursing skills including infection 1633
control, safety and emergency procedures, and personal care, and 1634
have successfully completed a competency evaluation program 1635
conducted by the director under division (A) of section 3721.31 1636
of the Revised Code; 1637

(8) Have the equivalent of twelve months or more of full- 1638
time employment in the five years preceding listing in the 1639
registry as a hospital aide or orderly and have successfully 1640
completed a competency evaluation program conducted by the 1641
director under division (C) of section 3721.31 of the Revised 1642
Code; 1643

(9) Successfully completed a prelicensure program of 1644
nursing education approved by the board of nursing under section 1645
4723.06 of the Revised Code or by an agency of another state 1646
that regulates nursing education and passed the examination 1647
accepted by the board of nursing under section 4723.10 of the 1648
Revised Code, which shall be deemed as successfully completing a 1649
competency evaluation program conducted by the director under 1650
division (C) of section 3721.31 of the Revised Code. 1651

(B) In addition to the list of individuals required by 1652
division (A) of this section, the registry shall include both of 1653
the following: 1654

(1) The statement required by section 3721.23 of the 1655
Revised Code detailing findings by the director under that 1656
section regarding alleged abuse, neglect, or exploitation of a 1657

resident or misappropriation of resident property; 1658

(2) Any statement provided by an individual under section 1659
3721.23 of the Revised Code disputing the director's findings. 1660

Whenever an inquiry is received as to the information 1661
contained in the registry concerning an individual about whom a 1662
statement required by section 3721.23 of the Revised Code is 1663
included in the registry, the director shall disclose the 1664
statement or a summary of the statement together with any 1665
statement provided by the individual under section 3721.23 or a 1666
clear and accurate summary of that statement. 1667

(C) The director may by rule specify additional 1668
information that must be provided to the registry by long-term 1669
care facilities and persons or government agencies conducting 1670
approved ~~competency evaluation programs and training and~~ 1671
competency evaluation programs. 1672

(D) Information contained in the registry is a public 1673
record for the purposes of section 149.43 of the Revised Code, 1674
and is subject to inspection and copying under section 1347.08 1675
of the Revised Code. 1676

(E) An individual who is listed on the registry in good 1677
standing shall be referred to as a certified nurse aide. Only 1678
individuals listed on the registry shall use the designation 1679
"certified nurse aide" or "CNA." 1680

Sec. 4723.32. This chapter does not prohibit any of the 1681
following: 1682

(A) The practice of nursing by a student currently 1683
enrolled in and actively pursuing completion of a prelicensure 1684
nursing education program, if all of the following are the case: 1685

(1) The student is participating in a program located in 1686
this state and approved by the board of nursing or participating 1687
in this state in a component of a program located in another 1688
jurisdiction and approved by a board that is a member of the 1689
national council of state boards of nursing; 1690

(2) The student's practice is under the auspices of the 1691
program; 1692

(3) The student acts under the supervision of a registered 1693
nurse serving for the program as a faculty member or teaching 1694
assistant. 1695

(B) The rendering of medical assistance to a licensed 1696
physician, licensed dentist, or licensed podiatrist by a person 1697
under the direction, supervision, and control of such licensed 1698
physician, dentist, or podiatrist; 1699

(C) The activities of persons employed as nursing aides, 1700
attendants, orderlies, or other auxiliary workers in patient 1701
homes, nurseries, nursing homes, hospitals, home health 1702
agencies, or other similar institutions; 1703

(D) The provision of nursing services to family members or 1704
in emergency situations; 1705

(E) The care of the sick when done in connection with the 1706
practice of religious tenets of any church and by or for its 1707
members; 1708

(F) The practice of nursing as an advanced practice 1709
registered nurse by a student currently enrolled in and actively 1710
pursuing completion of a program of study leading to initial 1711
authorization by the board of nursing to practice nursing as an 1712
advanced practice registered nurse in a designated specialty, if 1713
all of the following are the case: 1714

(1) The program qualifies the student to sit for the 1715
examination of a national certifying organization approved by 1716
the board under section 4723.46 of the Revised Code or the 1717
program prepares the student to receive a master's or doctoral 1718
degree in accordance with division (A) (2) of section 4723.41 of 1719
the Revised Code; 1720

(2) The student's practice is under the auspices of the 1721
program; 1722

(3) The student acts under the supervision of an advanced 1723
practice registered nurse serving for the program as a faculty 1724
member, teaching assistant, or preceptor. 1725

(G) The activities of an individual who is a resident of a 1726
state other than this state and who currently holds a license to 1727
practice nursing or equivalent authorization from another 1728
jurisdiction, but only if the individual's activities are 1729
limited to those activities that the same type of nurse may 1730
engage in pursuant to a license issued under this chapter, the 1731
individual's authority to practice has not been revoked, the 1732
individual is not currently under suspension or on probation, 1733
the individual does not represent the individual as being 1734
licensed under this chapter, and one of the following is the 1735
case: 1736

(1) The individual is engaging in the practice of nursing 1737
by discharging official duties while employed by or under 1738
contract with the United States government or any agency 1739
thereof; 1740

(2) The individual is engaging in the practice of nursing 1741
as an employee of an individual, agency, or corporation located 1742
in the other jurisdiction in a position with employment 1743

responsibilities that include transporting patients into, out 1744
of, or through this state, as long as each trip in this state 1745
does not exceed seventy-two hours; 1746

(3) The individual is consulting with an individual 1747
licensed in this state to practice any health-related 1748
profession; 1749

(4) The individual is engaging in activities associated 1750
with teaching in this state as a guest lecturer at or for a 1751
nursing education program, continuing nursing education program, 1752
or in-service presentation; 1753

(5) The individual is conducting evaluations of nursing 1754
care that are undertaken on behalf of an accrediting 1755
organization, including the national league for nursing 1756
accrediting committee, the joint commission (formerly known as 1757
the joint commission on accreditation of healthcare 1758
organizations), or any other nationally recognized accrediting 1759
organization; 1760

(6) The individual is providing nursing care to an 1761
individual who is in this state on a temporary basis, not to 1762
exceed six months in any one calendar year, if the nurse is 1763
directly employed by or under contract with the individual or a 1764
guardian or other person acting on the individual's behalf; 1765

(7) The individual is providing nursing care during any 1766
disaster, natural or otherwise, that has been officially 1767
declared to be a disaster by a public announcement issued by an 1768
appropriate federal, state, county, or municipal official; 1769

(8) The individual is providing nursing care at a free-of- 1770
charge camp accredited by the SeriousFun children's network that 1771
specializes in providing therapeutic recreation, as defined in 1772

section 2305.231 of the Revised Code, for individuals with 1773
chronic diseases, if all of the following are the case: 1774

(a) The individual provides documentation to the medical 1775
director of the camp that the individual holds a current, valid 1776
license to practice nursing or equivalent authorization from 1777
another jurisdiction. 1778

(b) The individual provides nursing care only at the camp 1779
or in connection with camp events or activities that occur off 1780
the grounds of the camp. 1781

(c) The individual is not compensated for the individual's 1782
services. 1783

(d) The individual provides nursing care within this state 1784
for not more than thirty days per calendar year. 1785

(e) The camp has a medical director who holds an 1786
unrestricted license to practice medicine issued in accordance 1787
with Chapter 4731. of the Revised Code. 1788

(9) The individual is providing nursing care as a 1789
volunteer without remuneration during a charitable event that 1790
lasts not more than seven days if both of the following are the 1791
case: 1792

(a) The individual, or the charitable event's organizer, 1793
notifies the board of nursing not less than seven calendar days 1794
before the first day of the charitable event of the individual's 1795
intent to engage in the practice of nursing as a registered 1796
nurse, advanced practice registered nurse, or licensed practical 1797
nurse at the event; 1798

(b) If the individual's scope of practice in the other 1799
jurisdiction is more restrictive than in this state, the 1800

individual is limited to performing only those procedures that a 1801
registered nurse, advanced practice registered nurse, or 1802
licensed practical nurse in the other jurisdiction may perform. 1803

(H) The administration of medication by an individual who 1804
holds a valid medication aide certificate issued under this 1805
chapter, if the medication is administered to a resident of a 1806
nursing home, ~~or residential care facility, or ICF/IID~~ 1807
~~authorized by section 4723.64 of the Revised Code to use a~~ 1808
~~certified medication aide~~ and the medication is administered in 1809
accordance with section 4723.67 of the Revised Code. 1810

(I) An individual who is a resident of a state other than 1811
this state and who holds a license to practice nursing or 1812
equivalent authorization from another jurisdiction is not 1813
required to obtain a license in accordance with Chapter 4796. of 1814
the Revised Code to perform the activities described under 1815
division (G) of this section. 1816

Sec. 4723.61. As used in this section and in sections 1817
4723.64 to 4723.69 of the Revised Code: 1818

(A) ~~"Intermediate care facility for individuals with~~ 1819
~~intellectual disabilities" and "ICF/IID" have the same meanings~~ 1820
~~as in section 5124.01 of the Revised Code.~~ "Contact hour" means 1821
sixty minutes of continuing education, which may be determined 1822
by rounding to the nearest quarter hour. 1823

(B) "Medication" means a drug, as defined in section 1824
4729.01 of the Revised Code. 1825

(C) ~~"Medication error" means a failure to follow the~~ 1826
~~prescriber's instructions when administering a prescription~~ 1827
~~medication.~~ 1828

~~(D)~~ "Nursing home" and "residential care facility" have 1829

the same meanings as in section 3721.01 of the Revised Code. 1830

~~(E)~~ (D) "Prescription medication" means a medication that 1831
may be dispensed only pursuant to a prescription. 1832

~~(F)~~ (E) "Prescriber" and "prescription" have the same 1833
meanings as in section 4729.01 of the Revised Code. 1834

Sec. 4723.64. A nursing home ~~or~~ or residential care 1835
facility, ~~or ICF/IID~~ may use one or more medication aides to 1836
administer prescription medications to its residents, subject to 1837
both of the following conditions: 1838

(A) Each individual used as a medication aide must hold a 1839
current, valid medication aide certificate issued by the board 1840
of nursing under this chapter. 1841

(B) The nursing home ~~or~~ or residential care facility, ~~or~~ 1842
~~ICF/IID~~ shall ensure that the requirements of section 4723.67 of 1843
the Revised Code are met. 1844

Sec. 4723.65. An individual seeking certification as a 1845
medication aide shall apply to the board of nursing on a form 1846
prescribed and provided by the board. The application shall be 1847
accompanied by ~~the a~~ certification fee ~~established in rules~~ 1848
~~adopted under section 4723.69 of the Revised Code of fifty~~ 1849
dollars. 1850

Sec. 4723.651. (A) To be eligible to receive a medication 1851
aide certificate, an applicant shall meet all of the following 1852
conditions: 1853

(1) Be at least eighteen years of age; 1854

(2) Have a high school diploma or a certificate of high 1855
school equivalence as defined in section 5107.40 of the Revised 1856
Code; 1857

~~(3) If the applicant is to practice as a medication aide in a nursing home, be a nurse aide who satisfies the requirements of division (A) (1), (2), (3), (4), (5), (6), or (8) of section 3721.32 of the Revised Code;~~ 1858
1859
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~~(4) If the applicant is to practice as a medication aide in a residential care facility, be a nurse aide who satisfies the requirements of division (A) (1), (2), (3), (4), (5), (6), or (8) of section 3721.32 of the Revised Code or an individual who has at least one year of direct care experience in a residential care facility;~~ 1862
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~~(5) If the applicant is to practice as a medication aide in an ICF/IID, be a nurse aide who satisfies the requirements of division (A) (1), (2), (3), (4), (5), (6), or (8) of section 3721.32 of the Revised Code or an individual who has at least one year of direct care experience in an ICF/IID;~~ 1868
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~~(6) Successfully complete the course of instruction provided by a training program approved under section 4723.66 of the Revised Code;~~ 1873
1874
1875

~~(7) Not be ineligible for licensure or certification in accordance with section 4723.092 of the Revised Code;~~ 1876
1877

~~(8) Have not committed any act that is grounds for disciplinary action under section 3123.47 or 4723.28 of the Revised Code or be determined by the board to have made restitution, been rehabilitated, or both;~~ 1878
1879
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1881

~~(9) (4) Meet all other the requirements for a medication aide certificate established in rules adopted providing direct care under section 4723.69 of the Revised Code.~~ 1882
1883
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(B) Except as provided in division (C) of this section, if an applicant meets the requirements specified in division (A) of 1885
1886

this section, the board of nursing shall issue a medication aide certificate to the applicant. ~~If a medication aide certificate is issued to an individual on the basis of having at least one year of direct care experience working in a residential care facility, as provided in division (A) (4) of this section, the certificate is valid for use only in a residential care facility. If a medication aide certificate is issued to an individual on the basis of having at least one year of direct care experience working in an ICF/IID, as provided in division (A) (5) of this section, the certificate is valid for use only in an ICF/IID. The board shall state the limitation on the certificate issued to the individual.~~

(C) The board shall issue a medication aide certificate in accordance with Chapter 4796. of the Revised Code to an applicant if either of the following applies:

(1) The applicant holds a certificate or license in another state.

(2) The applicant has satisfactory work experience, a government certification, or a private certification as described in that chapter as a medication aide in a state that does not issue that certificate or license.

(D) A medication aide certificate is valid for two years, ~~unless earlier suspended or revoked. The certificate may be renewed in accordance with procedures specified by the board in rules adopted under section 4723.69 of the Revised Code. To be eligible for renewal, an applicant shall pay the renewal fee established in the rules and meet all renewal qualifications specified in the rules. All of the following apply to renewal:~~

(1) The board shall provide each holder of a medication

aide certificate the option to renew through the mail or by 1916
accessing, completing, and submitting a renewal application 1917
online. The board is not required to provide an individual such 1918
options if it is aware that the holder is ineligible for 1919
renewal. 1920

(2) To be eligible for renewal, an applicant shall do all 1921
of the following: 1922

(a) Submit on or before the thirtieth day of April of an 1923
even-numbered year a completed renewal application; 1924

(b) Pay the renewal fee in an amount as follows: 1925

(i) For an application submitted on or before the first 1926
day of March of an even-numbered year, fifty dollars; 1927

(ii) For an application submitted after the first day of 1928
March, but before the first day of May, of an even-numbered 1929
year, one hundred dollars. 1930

(c) Demonstrate to the board that the applicant 1931
successfully completed eight contact hours that included at 1932
least the following: 1933

(i) One hour directly related to this chapter and any 1934
rules adopted under it; 1935

(ii) One hour directly related to establishing and 1936
maintaining professional boundaries; 1937

(iii) Six hours related to medications or the 1938
administration of prescription medications. 1939

Sec. 4723.653. (A) A person who holds a current, valid 1940
certificate as a medication aide shall be known as a "certified 1941
medication aide" or "CMA." The board of nursing shall establish 1942

and maintain a registry of certified medication aides and make 1943
the registry available on its internet web site. 1944

(B) No person shall engage in the administration of 1945
medication as a medication aide, represent the person as being a 1946
certified medication aide, or use the title, "medication aide," 1947
or any other title implying that the person is a certified 1948
medication aide, for a fee, salary, or other compensation, or as 1949
a volunteer, without holding a current, valid certificate as a 1950
medication aide under this chapter. 1951

~~(B)~~ (C) No person shall employ a person not certified as a 1952
medication aide under this chapter to engage in the 1953
administration of medication as a medication aide. 1954

Sec. 4723.66. (A) A person or government entity seeking 1955
approval to provide a medication aide training program shall 1956
apply to the board of nursing on a form prescribed and provided 1957
by the board. The application shall be accompanied by ~~the~~ a fee 1958
~~established in rules adopted under section 4723.69 of the~~ 1959
~~Revised Code~~ fifty dollars. 1960

(B) Except as provided in division (C) of this section, 1961
the board shall approve the applicant to provide a medication 1962
aide training program if the content of the course of 1963
instruction to be provided by the program ~~meets the standards~~ 1964
~~specified by the board in rules adopted under section 4723.69 of~~ 1965
~~the Revised Code and includes all of the following:~~ 1966

(1) ~~At least seventy~~ Thirty clock-hours of instruction in 1967
medication administration, including both classroom instruction 1968
~~on medication administration and at least~~ twenty sixteen clock- 1969
hours of supervised clinical practice ~~in medication~~ 1970
administration; 1971

(2) A mechanism for evaluating whether an individual's reading, writing, and mathematical skills are sufficient for the individual to be able to administer prescription medications safely;

(3) An examination that tests the ability to administer prescription medications safely ~~and that meets the requirements established by the board in rules adopted under section 4723.69 of the Revised Code.~~ The examination may be administered by the program that provides the instruction required by division (B) (1) of this section.

(C) The board shall deny the application for approval if an applicant submits or causes to be submitted to the board false, misleading, or deceptive statements, information, or documentation in the process of applying for approval of the program.

~~(D) (1) (D)~~ The board may deny, suspend, or revoke the approval granted to a medication aide training program for ~~reasons specified in rules adopted under section 4723.69 of the Revised Code~~ failure to meet any of the standards specified in division (B) of this section.

~~(2) The board may deny the application for approval if the program is controlled by a person who controls or has controlled a program that had its approval withdrawn, revoked, suspended, or restricted by the board or a board of another jurisdiction that is a member of the national council of state boards of nursing. As used in division (D) (2) of this section, "control" means any of the following:~~

~~(a) Holding fifty per cent or more of the program's outstanding voting securities or membership interest;~~

~~(b) In the case of a program that is not incorporated, having the right to fifty per cent or more of the program's profits or in the event of a dissolution, fifty per cent or more of the program's assets;~~ 2001
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~~(c) In the case of a program that is a for-profit or not-for-profit corporation, having the contractual authority presently to designate fifty per cent or more of the program's directors;~~ 2005
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~~(d) In the case of a program that is a trust, having the contractual authority presently to designate fifty per cent or more of the program's trustees;~~ 2009
2010
2011

~~(e) Having the authority to direct the program's management, policies, or investments.~~ 2012
2013

~~(E) Except as otherwise provided in this division, all~~ All 2014
actions taken by the board to deny, suspend, or revoke the 2015
approval of a training program shall be taken in accordance with 2016
Chapter 119. of the Revised Code. 2017

~~When an action taken by the board is required to be taken pursuant to an adjudication conducted under Chapter 119. of the Revised Code, the board may, in lieu of an adjudication hearing, enter into a consent agreement to resolve the matter. A consent agreement, when ratified by a vote of a quorum of the board, constitutes the findings and order of the board with respect to the matter addressed in the agreement. If the board refuses to ratify a consent agreement, the admissions and findings contained in the agreement are of no effect.~~ 2018
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~~In any instance in which the board is required under Chapter 119. of the Revised Code to give notice to a program of an opportunity for a hearing and the program does not make a~~ 2027
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~~timely request for a hearing in accordance with section 119.07- 2030
of the Revised Code, the board is not required to hold a 2031
hearing, but may adopt, by a vote of a quorum, a final order 2032
that contains the board's findings. 2033~~

~~(F) When the board denies, suspends, or revokes approval 2034
of a program, the board may specify that its action is 2035
permanent. A program subject to a permanent action taken by the 2036
board is forever ineligible for approval and the board shall not 2037
accept an application for the program's reinstatement or 2038
approval. 2039~~

~~**Sec. 4723.67.** (A) Except for the prescription medications- 2040
specified in division (C) of this section and the methods of 2041
medication administration specified in division (D) of In 2042
accordance with this section, a medication aide who holds a 2043
current, valid medication aide certificate issued under this 2044
chapter may administer prescription medications to the residents 2045
of nursing homes, and residential care facilities, and ICFs/IID- 2046
that use medication aides pursuant to section 4723.64 of the 2047
Revised Code. A medication aide shall administer prescription- 2048
medications but only pursuant to the delegation supervision of a 2049
registered nurse or a licensed practical nurse acting at the 2050
direction of a registered nurse. 2051~~

~~Delegation of medication administration to a medication- 2052
aide shall be carried out in accordance with the rules for 2053
nursing delegation adopted under this chapter by the board of 2054
nursing. A nurse who has delegated to a medication aide- 2055
responsibility for the administration of prescription- 2056
medications to the residents of a nursing home, residential care- 2057
facility, or ICF/IID shall not withdraw the delegation on an 2058
arbitrary basis or for any purpose other than patient safety. 2059~~

(B) In exercising the authority to administer prescription medications pursuant to nursing ~~delegation~~supervision, a medication aide may administer prescription medications in any of the following categories:

(1) Oral medications;

(2) Topical medications;

(3) Medications administered as drops to the eye, ear, or nose;

(4) Rectal and vaginal medications;

(5) Medications prescribed with a designation authorizing or requiring administration on an as-needed basis, ~~but only if a nursing assessment of the patient is completed before the medication is administered~~regardless of whether the supervising nurse is present at the facility.

(C) A medication aide shall not administer prescription medications ~~in either of the following categories:~~

~~(1) Medications containing a schedule II controlled substance, as defined in section 3719.01 of the Revised Code;~~

~~(2) Medications requiring dosage calculations.~~

(D) A medication aide shall not administer prescription medications by any of the following methods:

(1) Injection, except for insulin as provided in division (E) of this section;

(2) Intravenous therapy procedures;

(3) Splitting pills for purposes of changing the dose being given.

(E) ~~A nursing home, residential care facility, or ICF/IID that uses medication aides shall ensure that medication aides do not have access to any schedule II controlled substances within the home, facility, or ICF/IID for use by its residents.~~ medication aide may administer insulin to a resident by injection, but only if both of the following are satisfied:

(1) The medication aide satisfies training and competency requirements established by the aide's employer.

(2) The insulin is injected using an insulin pen device that contains a dosage indicator.

Sec. 4723.68. ~~(A) A registered nurse, or licensed practical nurse acting at the direction of a registered nurse, who delegates supervises medication administration to by a medication aide who holds a current, valid medication aide certificate issued under this chapter is not liable in damages to any person or government entity in a civil action for injury, death, or loss to person or property that allegedly arises from an action or omission of the medication aide in performing the medication administration, if the delegating supervising nurse delegates supervises the medication administration in accordance with this chapter and the rules adopted under this chapter.~~ standards applicable to a nurse's supervision of health care provided by others.

~~(B) A person employed by a nursing home, residential care facility, or ICF/IID that uses medication aides pursuant to section 4723.64 of the Revised Code who reports in good faith a medication error at the nursing home, residential care facility, or ICF/IID is not subject to disciplinary action by the board of nursing or any other government entity regulating that person's professional practice and is not liable in damages to any person~~

~~or government entity in a civil action for injury, death, or
loss to person or property that allegedly results from reporting
the medication error.~~ 2116
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Sec. 4723.69. ~~(A)~~ The board of nursing ~~shall~~ may adopt 2119
rules to implement sections 4723.61 to 4723.68 of the Revised 2120
Code. All rules adopted under this section shall be adopted in 2121
accordance with Chapter 119. of the Revised Code. 2122

~~(B) The rules adopted under this section shall establish
or specify all of the following:~~ 2123
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~~(1) Fees, in an amount sufficient to cover the costs the
board incurs in implementing sections 4723.61 to 4723.68 of the
Revised Code, for certification as a medication aide and
approval of a medication aide training program;~~ 2125
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~~(2) Requirements to obtain a medication aide certificate
that are not otherwise specified in section 4723.651 of the
Revised Code;~~ 2129
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~~(3) Procedures for renewal of medication aide
certificates;~~ 2132
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~~(4) The extent to which the board determines that the
reasons for taking disciplinary actions under section 4723.28 of
the Revised Code are applicable reasons for taking disciplinary
actions under section 4723.652 of the Revised Code against an
applicant for or holder of a medication aide certificate;~~ 2134
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~~(5) Standards for medication aide training programs,
including the examination to be administered by the training
program to test an individual's ability to administer
prescription medications safely;~~ 2139
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~~(6) Standards for approval of continuing education~~ 2143

~~programs and courses for medication aides;~~ 2144

~~(7) Reasons for denying, revoking, or suspending approval
of a medication aide training program;~~ 2145
2146

~~(8) Other standards and procedures the board considers
necessary to implement sections 4723.61 to 4723.68 of the
Revised Code.~~ 2147
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2149

Sec. 4729.41. (A) (1) A pharmacist licensed under this 2150
chapter who meets the requirements of division (B) of this 2151
section, ~~and a pharmacy intern licensed under this chapter who~~ 2152
meets the requirements of division (B) of this section and is 2153
working under the direct supervision of a pharmacist who meets 2154
the requirements of that division, and a certified pharmacy 2155
technician or a registered pharmacy technician who meets the 2156
requirements of division (B) of this section and is working 2157
under the direct supervision of a pharmacist who meets the 2158
requirements of that division, may do any of the following: 2159

~~(a) In the case of administer to an individual who is 2160
seven-five years of age or older ~~but not more than thirteen~~ 2161
~~years of age, administer to the individual an immunization for~~ 2162
~~any of the following:~~ 2163~~

~~(i) Influenza;~~ 2164

~~(ii) COVID-19;~~ 2165

~~(iii) Any other disease, but only pursuant to a 2166
prescription.~~ 2167

~~(b) In the case of an individual who is thirteen years of 2168
age or older, administer to the individual an immunization for 2169
any disease, including an immunization for influenza or COVID- 2170
19.~~ 2171

(2) As part of engaging in the administration of 2172
immunizations or supervising a pharmacy intern's, certified 2173
pharmacy technician's, or registered pharmacy technician's 2174
administration of immunizations, a pharmacist may administer 2175
epinephrine or diphenhydramine, or both, to individuals in 2176
emergency situations resulting from adverse reactions to the 2177
immunizations administered by the pharmacist-~~or,~~ pharmacy 2178
intern, certified pharmacy technician, or registered pharmacy 2179
technician. 2180

(B) For a pharmacist-~~or,~~ pharmacy intern, certified 2181
pharmacy technician, or registered pharmacy technician to be 2182
authorized to engage in the administration of immunizations, the 2183
pharmacist-~~or,~~ pharmacy intern, certified pharmacy technician, 2184
or registered pharmacy technician shall do all of the following: 2185

(1) Successfully complete a course in the administration 2186
of immunizations that meets the requirements established in 2187
rules adopted under this section for such courses; 2188

(2) Receive and maintain certification to perform basic 2189
life-support procedures by successfully completing a basic life- 2190
support training course that is certified by the American red 2191
cross or American heart association or approved by the state 2192
board of pharmacy; 2193

(3) Practice in accordance with a protocol that meets the 2194
requirements of division (C) of this section. 2195

(C) All of the following apply with respect to the 2196
protocol required by division (B) (3) of this section: 2197

(1) The protocol shall be established by a physician 2198
authorized under Chapter 4731. of the Revised Code to practice 2199
medicine and surgery or osteopathic medicine and surgery. 2200

(2) The protocol shall specify a definitive set of 2201
treatment guidelines and the locations at which a pharmacist ~~or~~ 2202
, pharmacy intern, certified pharmacy technician, or registered 2203
pharmacy technician may engage in the administration of 2204
immunizations. 2205

(3) The protocol shall satisfy the requirements 2206
established in rules adopted under this section for protocols. 2207

(4) The protocol shall include provisions for 2208
implementation of the following requirements: 2209

(a) The pharmacist ~~or~~, pharmacy intern, certified 2210
pharmacy technician, or registered pharmacy technician who 2211
administers an immunization shall observe the individual who 2212
receives the immunization to determine whether the individual 2213
has an adverse reaction to the immunization. The length of time 2214
and location of the observation shall comply with the rules 2215
adopted under this section establishing requirements for 2216
protocols. The protocol shall specify procedures to be followed 2217
by a pharmacist when administering epinephrine~~, or~~ 2218
diphenhydramine, or both, to an individual who has an adverse 2219
reaction to an immunization administered by the pharmacist or by 2220
a pharmacy intern, certified pharmacy technician, or registered 2221
pharmacy technician. 2222

(b) For each immunization administered to an individual by 2223
a pharmacist ~~or~~, pharmacy intern, certified pharmacy 2224
technician, or registered pharmacy technician, other than an 2225
immunization for influenza administered to an individual 2226
eighteen years of age or older, the pharmacist ~~or~~, pharmacy 2227
intern, certified pharmacy technician, or registered pharmacy 2228
technician shall notify the individual's primary care provider 2229
or, if the individual has no primary care provider, the board of 2230

health of the health district in which the individual resides or 2231
the authority having the duties of a board of health for that 2232
district under section 3709.05 of the Revised Code. The notice 2233
shall be given not later than thirty days after the immunization 2234
is administered. 2235

(c) For each immunization administered by a pharmacist ~~or~~ 2236
, pharmacy intern, certified pharmacy technician, or registered 2237
pharmacy technician to an individual younger than eighteen years 2238
of age, the pharmacist ~~or~~, a pharmacy intern, certified 2239
pharmacy technician, or registered pharmacy technician shall 2240
obtain permission from the individual's parent or legal guardian 2241
in accordance with the procedures specified in rules adopted 2242
under this section. 2243

(d) For each immunization administered by a pharmacist, 2244
pharmacy intern, certified pharmacy technician, or registered 2245
pharmacy technician to an individual who is younger than 2246
eighteen years of age, the pharmacist, pharmacy intern, 2247
certified pharmacy technician, or registered pharmacy technician 2248
shall inform the individual's parent or legal guardian of the 2249
importance of well child visits with a pediatrician or other 2250
primary care provider and shall refer patients when appropriate. 2251

(D) (1) No pharmacist shall do either of the following: 2252

(a) Engage in the administration of immunizations unless 2253
the requirements of division (B) of this section have been met; 2254

(b) Delegate to any person the pharmacist's authority to 2255
engage in or supervise the administration of immunizations. 2256

(2) No pharmacy intern shall engage in the administration 2257
of immunizations unless the requirements of division (B) of this 2258
section have been met. 2259

(3) No certified pharmacy technician or registered 2260
pharmacy technician shall engage in the administration of 2261
immunizations unless the requirements of division (B) of this 2262
section have been met. 2263

(E) (1) The state board of pharmacy shall adopt rules to 2264
implement this section. The rules shall be adopted in accordance 2265
with Chapter 119. of the Revised Code and shall include the 2266
following: 2267

(a) Requirements for courses in administration of 2268
immunizations, including requirements that are consistent with 2269
any standards established for such courses by the centers for 2270
disease control and prevention; 2271

(b) Requirements for protocols to be followed by 2272
~~pharmacists and,~~ pharmacy interns, certified pharmacy 2273
technicians, and registered pharmacy technicians in engaging in 2274
the administration of immunizations; 2275

(c) Procedures to be followed by ~~pharmacists and,~~ 2276
pharmacy interns, certified pharmacy technicians, and registered 2277
pharmacy technicians in obtaining from the individual's parent 2278
or legal guardian permission to administer immunizations to an 2279
individual younger than eighteen years of age. 2280

(2) Prior to adopting rules regarding requirements for 2281
protocols to be followed by ~~pharmacists and,~~ pharmacy interns, 2282
certified pharmacy technicians, and registered pharmacy 2283
technicians in engaging in the administration of immunizations, 2284
the state board of pharmacy shall consult with the state medical 2285
board and the board of nursing. 2286

Sec. 5124.15. (A) Except as otherwise provided by section 2287
5124.101 of the Revised Code, sections 5124.151 to 5124.154 of 2288

the Revised Code, and ~~divisions~~ division (B) and (C) of this 2289
section, the total per medicaid day payment rate that the 2290
department of developmental disabilities shall pay to an ICF/IID 2291
provider for ICF/IID services the provider's ICF/IID provides 2292
during a fiscal year shall equal the sum of all of the 2293
following: 2294

(1) The per medicaid day capital component rate determined 2295
for the ICF/IID under section 5124.17 of the Revised Code; 2296

(2) The per medicaid day direct care costs component rate 2297
determined for the ICF/IID under section 5124.19 of the Revised 2298
Code; 2299

(3) The per medicaid day indirect care costs component 2300
rate determined for the ICF/IID under section 5124.21 of the 2301
Revised Code; 2302

(4) The per medicaid day other protected costs component 2303
rate determined for the ICF/IID under section 5124.23 of the 2304
Revised Code; 2305

(5) The sum of the following: 2306

(a) The per medicaid day quality incentive payment 2307
determined for the ICF/IID under section 5124.24 of the Revised 2308
Code; 2309

(b) A direct support personnel payment equal to two and 2310
four-hundredths per cent of the ICF/IID's desk-reviewed, actual, 2311
allowable, per medicaid day direct care costs from the 2312
applicable cost report year; 2313

(c) A professional workforce development payment equal to 2314
thirteen and fifty-five hundredths for state fiscal year 2024 2315
and twenty and eighty-one hundredths during fiscal year 2025 per 2316

cent of the ICF/IID's desk-reviewed, actual, allowable, per 2317
medicaid day direct care costs from the applicable cost report 2318
year. 2319

~~(B) The total per medicaid day payment rate for an ICF/IID 2320
that is in peer group 5 shall not exceed the average total per- 2321
medicaid day payment rate in effect on July 1, 2013, for 2322
developmental centers. 2323~~

~~(C) The department shall adjust the total per medicaid day 2324
payment rate otherwise determined for an ICF/IID under this 2325
section as directed by the general assembly through the 2326
enactment of law governing medicaid payments to ICF/IID 2327
providers. 2328~~

~~(D) (1) (C) (1) In addition to paying an ICF/IID provider 2329
the total per medicaid day payment rate determined for the 2330
provider's ICF/IID under divisions (A), and (B), ~~and (C)~~ of this 2331
section for a fiscal year, the department may do either or both 2332
of the following: 2333~~

(a) In accordance with section 5124.25 of the Revised 2334
Code, pay the provider a rate add-on for ventilator-dependent 2335
outlier ICF/IID services if the rate add-on is to be paid under 2336
that section and the department approves the provider's 2337
application for the rate add-on; 2338

(b) In accordance with section 5124.26 of the Revised 2339
Code, pay the provider for outlier ICF/IID services the ICF/IID 2340
provides to residents identified as needing intensive behavioral 2341
health support services if the rate add-on is to be paid under 2342
that section and the department approves the provider's 2343
application for the rate add-on. 2344

(2) The rate add-ons are not to be part of the ICF/IID's 2345

total per medicaid day payment rate. 2346

Sec. 5124.151. (A) The total per medicaid day payment rate 2347
determined under section 5124.15 of the Revised Code shall not 2348
be the initial rate for ICF/IID services provided by a new 2349
ICF/IID. Instead, the initial total per medicaid day payment 2350
rate for ICF/IID services provided by a new ICF/IID shall be 2351
determined in accordance with this section. 2352

(B) The initial total per medicaid day payment rate for 2353
ICF/IID services provided by a new ICF/IID, ~~other than an~~ 2354
~~ICF/IID in peer group 5,~~ shall be determined in the following 2355
manner: 2356

(1) The initial per medicaid day capital component rate 2357
shall be the median per medicaid day capital component rate for 2358
the ICF/IID's peer group for the fiscal year. 2359

(2) The initial per medicaid day direct care costs 2360
component rate shall be determined as follows: 2361

(a) If there are no cost or resident assessment data for 2362
the new ICF/IID as necessary to determine a rate under section 2363
5124.19 of the Revised Code, the rate shall be determined as 2364
follows: 2365

(i) Determine the median cost per case-mix unit under 2366
division (B) of section 5124.19 of the Revised Code for the new 2367
ICF/IID's peer group for the applicable cost report year; 2368

(ii) Multiply the amount determined under division (B) (2) 2369
(a) (i) of this section by the median annual average case-mix 2370
score for the new ICF/IID's peer group for that period; 2371

(iii) Adjust the product determined under division (B) (2) 2372
(a) (ii) of this section by the rate of inflation estimated under 2373

division (D) of section 5124.19 of the Revised Code. 2374

(b) If the new ICF/IID is a replacement ICF/IID and the 2375
ICF/IID or ICFs/IID that are being replaced are in operation 2376
immediately before the new ICF/IID opens, the rate shall be the 2377
same as the rate for the replaced ICF/IID or ICFs/IID, 2378
proportionate to the number of ICF/IID beds in each replaced 2379
ICF/IID. 2380

(c) If the new ICF/IID is a replacement ICF/IID and the 2381
ICF/IID or ICFs/IID that are being replaced are not in operation 2382
immediately before the new ICF/IID opens, the rate shall be 2383
determined under division (B) (2) (a) of this section. 2384

(3) The initial per medicaid day indirect care costs 2385
component rate shall be the maximum rate for the new ICF/IID's 2386
peer group as determined for the fiscal year in accordance with 2387
division (C) of section 5124.21 of the Revised Code. 2388

(4) The initial per medicaid day other protected costs 2389
component rate shall be one hundred fifteen per cent of the 2390
median rate for ICFs/IID determined for the fiscal year under 2391
section 5124.23 of the Revised Code. 2392

~~(C) The initial total medicaid day payment rate for 2393
ICF/IID services provided by a new ICF/IID in peer group 5 shall 2394
be determined in the following manner: 2395~~

~~(1) The initial per medicaid day capital component rate 2396
shall be \$29.61. 2397~~

~~(2) The initial per medicaid day direct care costs 2398
component rate shall be \$264.89. 2399~~

~~(3) The initial per medicaid day indirect care costs 2400
component rate shall be \$59.85. 2401~~

~~(4) The initial per medicaid day other protected costs component rate shall be \$25.99.~~ 2402
2403

~~(D)(1)~~ (C)(1) Except as provided in division ~~(D)(2)~~ (C)(2) 2404
of this section, the department of developmental disabilities 2405
shall adjust a new ICF/IID's initial total per medicaid day 2406
payment rate determined under this section effective the first 2407
day of July, to reflect new rate determinations for all ICFs/IID 2408
under this chapter. 2409

(2) If the department accepts, under division (A) of 2410
section 5124.101 of the Revised Code, a cost report filed by the 2411
provider of a new ICF/IID, the department shall adjust the 2412
ICF/IID's initial total per medicaid day payment rate in 2413
accordance with divisions (E) and (F) of that section rather 2414
than division ~~(D)(1)~~ (C)(1) of this section. 2415

Sec. 5165.01. As used in this chapter: 2416

(A) "Affiliated operator" means an operator affiliated 2417
with either of the following: 2418

(1) The exiting operator for whom the affiliated operator 2419
is to assume liability for the entire amount of the exiting 2420
operator's debt under the medicaid program or the portion of the 2421
debt that represents the franchise permit fee the exiting 2422
operator owes; 2423

(2) The entering operator involved in the change of 2424
operator with the exiting operator specified in division (A)(1) 2425
of this section. 2426

(B) "Allowable costs" are a nursing facility's costs that 2427
the department of medicaid determines are reasonable. Fines paid 2428
under sections 5165.60 to 5165.89 and section 5165.99 of the 2429
Revised Code are not allowable costs. 2430

(C) "Ancillary and support costs" means all reasonable 2431
costs incurred by a nursing facility other than direct care 2432
costs, tax costs, or capital costs. "Ancillary and support 2433
costs" includes, but is not limited to, costs of activities, 2434
social services, pharmacy consultants, habilitation supervisors, 2435
qualified intellectual disability professionals, program 2436
directors, medical and habilitation records, program supplies, 2437
incontinence supplies, food, enterals, dietary supplies and 2438
personnel, laundry, housekeeping, security, administration, 2439
medical equipment, utilities, liability insurance, bookkeeping, 2440
purchasing department, human resources, communications, travel, 2441
dues, license fees, subscriptions, home office costs not 2442
otherwise allocated, legal services, accounting services, minor 2443
equipment, maintenance and repairs, help-wanted advertising, 2444
informational advertising, start-up costs, organizational 2445
expenses, other interest, property insurance, employee training 2446
and staff development, employee benefits, payroll taxes, and 2447
workers' compensation premiums or costs for self-insurance 2448
claims and related costs as specified in rules adopted under 2449
section 5165.02 of the Revised Code, for personnel listed in 2450
this division. "Ancillary and support costs" also means the cost 2451
of equipment, including vehicles, acquired by operating lease 2452
executed before December 1, 1992, if the costs are reported as 2453
administrative and general costs on the nursing facility's cost 2454
report for the cost reporting period ending December 31, 1992. 2455

(D) "Applicable calendar year" means the calendar year 2456
immediately preceding the first of the state fiscal years for 2457
which a rebasing is conducted. 2458

(E) For purposes of calculating a critical access nursing 2459
facility's occupancy rate and utilization rate under this 2460
chapter, "as of the last day of the calendar year" refers to the 2461

occupancy and utilization rates during the calendar year	2462
identified in the cost report filed under section 5165.10 of the	2463
Revised Code.	2464
(F) (1) "Capital costs" means the actual expense incurred	2465
by a nursing facility for all of the following:	2466
(a) Depreciation and interest on any capital assets that	2467
cost five hundred dollars or more per item, including the	2468
following:	2469
(i) Buildings;	2470
(ii) Building improvements;	2471
(iii) Except as provided in division (D) of this section,	2472
equipment;	2473
(iv) Transportation equipment.	2474
(b) Amortization and interest on land improvements and	2475
leasehold improvements;	2476
(c) Amortization of financing costs;	2477
(d) Lease and rent of land, buildings, and equipment.	2478
(2) The costs of capital assets of less than five hundred	2479
dollars per item may be considered capital costs in accordance	2480
with a provider's practice.	2481
(G) "Capital lease" and "operating lease" shall be	2482
construed in accordance with generally accepted accounting	2483
principles.	2484
(H) "Case-mix score" means a measure determined under	2485
section 5165.192 of the Revised Code of the relative direct-care	2486
resources needed to provide care and habilitation to a nursing	2487
facility resident.	2488

(I) "Change in control" means either of the following:	2489
(1) Any pledge, assignment, or hypothecation of or lien or other encumbrance on any of the legal or beneficial equity interests in the applicable person;	2490
	2491
	2492
(2) A change of fifty per cent or more in the legal or beneficial ownership or control of the outstanding voting equity interests of the applicable person necessary at all times to elect a majority of the board of directors or similar governing body and to direct the management policies and decisions.	2493
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	2497
(J) "Change of operator" includes circumstances in which an entering operator becomes the operator of a nursing facility in the place of the exiting operator or there is a change in owner of a nursing facility.	2498
	2499
	2500
	2501
(1) Actions that constitute a change of operator include the following:	2502
	2503
(a) A change in an exiting operator's or owner's form of legal organization, including the formation of a partnership or corporation from a sole proprietorship;	2504
	2505
	2506
(b) A change of <u>in operational control in of the exiting operator or owner</u> <u>nursing facility</u> , regardless of whether ownership of any or all of the real property or personal property associated with the nursing facility is also transferred;	2507
	2508
	2509
	2510
	2511
(c) A lease of the nursing facility to the entering operator or owner or the exiting operator's or owner's termination of the exiting operator's or owner's lease;	2512
	2513
	2514
(d) If the exiting operator or owner is a partnership, dissolution of the partnership, a merger of the partnership into	2515
	2516

another person that is the survivor of the merger, or a 2517
consolidation of the partnership and at least one other person 2518
to form a new person; 2519

(e) If the exiting operator ~~or owner~~ is a limited 2520
liability company, dissolution of the limited liability company, 2521
a merger of the limited liability company into another person 2522
that is the survivor of the merger, or a consolidation of the 2523
limited liability company and at least one other person to form 2524
a new person. 2525

(f) If the operator ~~or owner~~ is a corporation, dissolution 2526
of the corporation, a merger of the corporation into another 2527
person that is the survivor of the merger, or a consolidation of 2528
the corporation and at least one other person to form a new 2529
person; 2530

(g) A contract for a person to assume operational control 2531
~~of the operations and cash flow of a nursing facility as the~~ 2532
~~operator's or owner's agent;~~ 2533

(h) A change ~~in control of the owner of the real property~~ 2534
~~associated with the nursing facility if, within one year of the~~ 2535
~~change of control, there is a material increase in lease~~ 2536
~~payments or other financial obligations of the operator to the~~ 2537
~~owner of fifty per cent or more in the ownership of the licensed~~ 2538
operator that results in a change of operational control; 2539

(i) Any pledge, assignment, or hypothecation of or lien or 2540
other encumbrance on any of the legal or beneficial equity 2541
interests in the operator or a person with operational control. 2542

(2) The following, ~~alone,~~ do not constitute a change of 2543
operator: 2544

(a) ~~an employer~~ Actions necessary to create an employee 2545

stock ownership plan ~~created~~ under section 401(a) of the 2546
"Internal Revenue Code," 26 U.S.C. 401(a); 2547

(b) ~~Except as provided in division (J)(1) of this section,~~ 2548
~~a~~ A change of ownership of real property or personal property 2549
associated with a nursing facility; 2550

(c) If the operator ~~or owner~~ is a corporation that has 2551
securities publicly traded in a marketplace, a change of one or 2552
more members of the corporation's governing body or transfer of 2553
ownership of one or more shares of the corporation's stock, if 2554
the same corporation continues to be the operator ~~or owner~~; 2555

(d) An initial public offering for which the securities 2556
and exchange commission has declared the registration statement 2557
effective, and the newly created public company remains the 2558
operator ~~or owner~~. 2559

~~(K)~~ (J) "Cost center" means the following: 2560

(1) Ancillary and support costs; 2561

(2) Capital costs; 2562

(3) Direct care costs; 2563

(4) Tax costs. 2564

~~(L)~~ (K) "Custom wheelchair" means a wheelchair to which 2565
both of the following apply: 2566

(1) It has been measured, fitted, or adapted in 2567
consideration of either of the following: 2568

(a) The body size or disability of the individual who is 2569
to use the wheelchair; 2570

(b) The individual's period of need for, or intended use 2571
of, the wheelchair. 2572

(2) It has customized features, modifications, or 2573
components, such as adaptive seating and positioning systems, 2574
that the supplier who assembled the wheelchair, or the 2575
manufacturer from which the wheelchair was ordered, added or 2576
made in accordance with the instructions of the physician of the 2577
individual who is to use the wheelchair. 2578

~~(M) (1)~~ (L) (1) "Date of licensure" means the following: 2579

(a) In the case of a nursing facility that was required by 2580
law to be licensed as a nursing home under Chapter 3721. of the 2581
Revised Code when it originally began to be operated as a 2582
nursing home, the date the nursing facility was originally so 2583
licensed; 2584

(b) In the case of a nursing facility that was not 2585
required by law to be licensed as a nursing home when it 2586
originally began to be operated as a nursing home, the date it 2587
first began to be operated as a nursing home, regardless of the 2588
date the nursing facility was first licensed as a nursing home. 2589

(2) If, after a nursing facility's original date of 2590
licensure, more nursing home beds are added to the nursing 2591
facility, the nursing facility has a different date of licensure 2592
for the additional beds. This does not apply, however, to 2593
additional beds when both of the following apply: 2594

(a) The additional beds are located in a part of the 2595
nursing facility that was constructed at the same time as the 2596
continuing beds already located in that part of the nursing 2597
facility; 2598

(b) The part of the nursing facility in which the 2599
additional beds are located was constructed as part of the 2600
nursing facility at a time when the nursing facility was not 2601

required by law to be licensed as a nursing home. 2602

(3) The definition of "date of licensure" in this section 2603
applies in determinations of nursing facilities' medicaid 2604
payment rates but does not apply in determinations of nursing 2605
facilities' franchise permit fees. 2606

~~(N)~~(M) "Desk-reviewed" means that a nursing facility's 2607
costs as reported on a cost report submitted under section 2608
5165.10 of the Revised Code have been subjected to a desk review 2609
under section 5165.108 of the Revised Code and preliminarily 2610
determined to be allowable costs. 2611

~~(O)~~(N) "Direct care costs" means all of the following 2612
costs incurred by a nursing facility: 2613

(1) Costs for registered nurses, licensed practical 2614
nurses, and nurse aides employed by the nursing facility; 2615

(2) Costs for direct care staff, administrative nursing 2616
staff, medical directors, respiratory therapists, and except as 2617
provided in division ~~(O)~~~~(8)~~(N) (8) of this section, other 2618
persons holding degrees qualifying them to provide therapy; 2619

(3) Costs of purchased nursing services; 2620

(4) Costs of quality assurance; 2621

(5) Costs of training and staff development, employee 2622
benefits, payroll taxes, and workers' compensation premiums or 2623
costs for self-insurance claims and related costs as specified 2624
in rules adopted under section 5165.02 of the Revised Code, for 2625
personnel listed in divisions ~~(O)~~~~(1)~~(N) (1), (2), (4), and (8) of 2626
this section; 2627

(6) Costs of consulting and management fees related to 2628
direct care; 2629

(7) Allocated direct care home office costs;	2630
(8) Costs of habilitation staff (other than habilitation supervisors), medical supplies, emergency oxygen, over-the-counter pharmacy products, physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, speech therapists, audiologists, habilitation supplies, and universal precautions supplies;	2631 2632 2633 2634 2635 2636
(9) Costs of wheelchairs other than the following:	2637
(a) Custom wheelchairs;	2638
(b) Repairs to and replacements of custom wheelchairs and parts that are made in accordance with the instructions of the physician of the individual who uses the custom wheelchair.	2639 2640 2641
(10) Costs of other direct-care resources that are specified as direct care costs in rules adopted under section 5165.02 of the Revised Code.	2642 2643 2644
(P) <u>(O)</u> "Dual eligible individual" has the same meaning as in section 5160.01 of the Revised Code.	2645 2646
(Q) <u>(P)</u> "Effective date of a change of operator" means the day the entering operator becomes the operator of the nursing facility.	2647 2648 2649
(R) <u>(Q)</u> "Effective date of a facility closure" means the last day that the last of the residents of the nursing facility resides in the nursing facility.	2650 2651 2652
(S) <u>(R)</u> "Effective date of an involuntary termination" means the date the department of medicaid terminates the operator's provider agreement for the nursing facility.	2653 2654 2655
(T) <u>(S)</u> "Effective date of a voluntary withdrawal of	2656

participation" means the day the nursing facility ceases to 2657
accept new medicaid residents other than the individuals who 2658
reside in the nursing facility on the day before the effective 2659
date of the voluntary withdrawal of participation. 2660

~~(U)~~(T) "Entering operator" means the person or government 2661
entity that will become the operator of a nursing facility when 2662
a change of operator occurs or following an involuntary 2663
termination. 2664

~~(V)~~(U) "Exiting operator" means any of the following: 2665

(1) An operator that will cease to be the operator of a 2666
nursing facility on the effective date of a change of operator; 2667

(2) An operator that will cease to be the operator of a 2668
nursing facility on the effective date of a facility closure; 2669

(3) An operator of a nursing facility that is undergoing 2670
or has undergone a voluntary withdrawal of participation; 2671

(4) An operator of a nursing facility that is undergoing 2672
or has undergone an involuntary termination. 2673

~~(W) (1)~~(V) (1) Subject to divisions ~~(W) (2)~~(V) (2) and (3) 2674
of this section, "facility closure" means either of the 2675
following: 2676

(a) Discontinuance of the use of the building, or part of 2677
the building, that houses the facility as a nursing facility 2678
that results in the relocation of all of the nursing facility's 2679
residents; 2680

(b) Conversion of the building, or part of the building, 2681
that houses a nursing facility to a different use with any 2682
necessary license or other approval needed for that use being 2683
obtained and one or more of the nursing facility's residents 2684

remaining in the building, or part of the building, to receive 2685
services under the new use. 2686

(2) A facility closure occurs regardless of any of the 2687
following: 2688

(a) The operator completely or partially replacing the 2689
nursing facility by constructing a new nursing facility or 2690
transferring the nursing facility's license to another nursing 2691
facility; 2692

(b) The nursing facility's residents relocating to another 2693
of the operator's nursing facilities; 2694

(c) Any action the department of health takes regarding 2695
the nursing facility's medicaid certification that may result in 2696
the transfer of part of the nursing facility's survey findings 2697
to another of the operator's nursing facilities; 2698

(d) Any action the department of health takes regarding 2699
the nursing facility's license under Chapter 3721. of the 2700
Revised Code. 2701

(3) A facility closure does not occur if all of the 2702
nursing facility's residents are relocated due to an emergency 2703
evacuation and one or more of the residents return to a 2704
medicaid-certified bed in the nursing facility not later than 2705
thirty days after the evacuation occurs. 2706

~~(X)~~ (W) "Franchise permit fee" means the fee imposed by 2707
sections 5168.40 to 5168.56 of the Revised Code. 2708

~~(Y)~~ (X) "Inpatient days" means both of the following: 2709

(1) All days during which a resident, regardless of 2710
payment source, occupies a licensed bed in a nursing facility; 2711

(2) Fifty per cent of the days for which payment is made 2712
under section 5165.34 of the Revised Code. 2713

~~(Z)~~ (Y) "Involuntary termination" means the department of 2714
medicaid's termination of the operator's provider agreement for 2715
the nursing facility when the termination is not taken at the 2716
operator's request. 2717

~~(AA)~~ (Z) "Low case-mix resident" means a medicaid 2718
recipient residing in a nursing facility who, for purposes of 2719
calculating the nursing facility's medicaid payment rate for 2720
direct care costs, is placed in either of the two lowest case- 2721
mix groups, excluding any case-mix group that is a default group 2722
used for residents with incomplete assessment data. 2723

~~(BB)~~ (AA) "Maintenance and repair expenses" means a 2724
nursing facility's expenditures that are necessary and proper to 2725
maintain an asset in a normally efficient working condition and 2726
that do not extend the useful life of the asset two years or 2727
more. "Maintenance and repair expenses" includes but is not 2728
limited to the costs of ordinary repairs such as painting and 2729
wallpapering. 2730

~~(CC)~~ (BB) "Medicaid-certified capacity" means the number 2731
of a nursing facility's beds that are certified for 2732
participation in medicaid as nursing facility beds. 2733

~~(DD)~~ (CC) "Medicaid days" means both of the following: 2734

(1) All days during which a resident who is a medicaid 2735
recipient eligible for nursing facility services occupies a bed 2736
in a nursing facility that is included in the nursing facility's 2737
medicaid-certified capacity; 2738

(2) Fifty per cent of the days for which payment is made 2739
under section 5165.34 of the Revised Code. 2740

~~(EE)~~ ~~(1)~~ (DD) (1) "New nursing facility" means a nursing facility for which the provider obtains an initial provider agreement following medicaid certification of the nursing facility by the director of health, including such a nursing facility that replaces one or more nursing facilities for which a provider previously held a provider agreement.

(2) "New nursing facility" does not mean a nursing facility for which the entering operator seeks a provider agreement pursuant to section 5165.511 or 5165.512 or (pursuant to section 5165.515) section 5165.07 of the Revised Code.

~~(FF)~~ (EE) "Nursing facility" has the same meaning as in the "Social Security Act," section 1919(a), 42 U.S.C. 1396r(a).

~~(GG)~~ (FF) "Nursing facility services" has the same meaning as in the "Social Security Act," section 1905(f), 42 U.S.C. 1396d(f).

~~(HH)~~ (GG) "Nursing home" has the same meaning as in section 3721.01 of the Revised Code.

~~(II)~~ (HH) "Occupancy rate" means the percentage of licensed beds that, regardless of payer source, are either of the following:

(1) Reserved for use under section 5165.34 of the Revised Code;

(2) Actually being used.

(II) "Operational control" means having the ability to direct the overall operations and cash flow of a nursing facility. "Operational control" may be exercised by one person or multiple persons acting together or by a government entity, and may exist by means of any of the following:

- (1) The person, persons, or government entity directly 2769
operating the nursing facility; 2770
- (2) The person, persons, or government entity directly or 2771
indirectly owning fifty per cent or more of the operator; 2772
- (3) An agreement or other arrangement granting the person, 2773
persons, or government entity operational control. 2774
- (JJ) "Operator" means ~~the~~ a person or government entity 2775
responsible for the ~~daily operating and management decisions for~~ 2776
operational control of a nursing facility and that holds both of 2777
the following: 2778
- (1) The license to operate the nursing facility issued 2779
under section 3721.02 of the Revised Code, if a license is 2780
required by section 3721.05 of the Revised Code; 2781
- (2) The medicaid provider agreement issued under section 2782
5165.07 of the Revised Code, if applicable. 2783
- (KK) (1) "Owner" means any person or government entity that 2784
has at least five per cent ownership or interest, either 2785
directly, indirectly, or in any combination, in any of the 2786
following regarding a nursing facility: 2787
- (a) The land on which the nursing facility is located; 2788
- (b) The structure in which the nursing facility is 2789
located; 2790
- (c) Any mortgage, contract for deed, or other obligation 2791
secured in whole or in part by the land or structure on or in 2792
which the nursing facility is located; 2793
- (d) Any lease or sublease of the land or structure on or 2794
in which the nursing facility is located. 2795

(2) "Owner" does not mean a holder of a debenture or bond related to the nursing facility and purchased at public issue or a regulated lender that has made a loan related to the nursing facility unless the holder or lender operates the nursing facility directly or through a subsidiary.

(LL) "Per diem" means a nursing facility's actual, allowable costs in a given cost center in a cost reporting period, divided by the nursing facility's inpatient days for that cost reporting period.

(MM) "Person" has the same meaning as in section 1.59 of the Revised Code.

(NN) "Private room" means a nursing facility bedroom that meets all of the following criteria:

(1) It has four permanent, floor-to-ceiling walls and a full door.

(2) It contains one licensed or certified bed that is occupied by one individual.

(3) It has access to a hallway without traversing another bedroom.

(4) It has access to a toilet and sink shared by not more than one other resident without traversing another bedroom.

(5) It meets all applicable licensure or other standards pertaining to furniture, fixtures, and temperature control.

(OO) "Provider" means an operator with a provider agreement.

(PP) "Provider agreement" means a provider agreement, as defined in section 5164.01 of the Revised Code, that is between

the department of medicaid and the operator of a nursing 2823
facility for the provision of nursing facility services under 2824
the medicaid program. 2825

(QQ) "Purchased nursing services" means services that are 2826
provided in a nursing facility by registered nurses, licensed 2827
practical nurses, or nurse aides who are not employees of the 2828
nursing facility. 2829

(RR) "Reasonable" means that a cost is an actual cost that 2830
is appropriate and helpful to develop and maintain the operation 2831
of patient care facilities and activities, including normal 2832
standby costs, and that does not exceed what a prudent buyer 2833
pays for a given item or services. Reasonable costs may vary 2834
from provider to provider and from time to time for the same 2835
provider. 2836

(SS) "Rebasing" means a redetermination of each of the 2837
following using information from cost reports for an applicable 2838
calendar year that is later than the applicable calendar year 2839
used for the previous rebasing: 2840

(1) Each peer group's rate for ancillary and support costs 2841
as determined pursuant to division (C) of section 5165.16 of the 2842
Revised Code; 2843

(2) Each peer group's rate for capital costs as determined 2844
pursuant to division (C) of section 5165.17 of the Revised Code; 2845

(3) Each peer group's cost per case-mix unit as determined 2846
pursuant to division (C) of section 5165.19 of the Revised Code; 2847

(4) Each nursing facility's rate for tax costs as 2848
determined pursuant to section 5165.21 of the Revised Code. 2849

(TT) "Related party" means an individual or organization 2850

that, to a significant extent, has common ownership with, is 2851
associated or affiliated with, has control of, or is controlled 2852
by, the provider. 2853

(1) An individual who is a relative of an owner is a 2854
related party. 2855

(2) Common ownership exists when an individual or 2856
individuals possess significant ownership or equity in both the 2857
provider and the other organization. Significant ownership or 2858
equity exists when an individual or individuals possess five per 2859
cent ownership or equity in both the provider and a supplier. 2860
Significant ownership or equity is presumed to exist when an 2861
individual or individuals possess ten per cent ownership or 2862
equity in both the provider and another organization from which 2863
the provider purchases or leases real property. 2864

(3) Control exists when an individual or organization has 2865
the power, directly or indirectly, to significantly influence or 2866
direct the actions or policies of an organization. 2867

(4) An individual or organization that supplies goods or 2868
services to a provider shall not be considered a related party 2869
if all of the following conditions are met: 2870

(a) The supplier is a separate bona fide organization. 2871

(b) A substantial part of the supplier's business activity 2872
of the type carried on with the provider is transacted with 2873
others than the provider and there is an open, competitive 2874
market for the types of goods or services the supplier 2875
furnishes. 2876

(c) The types of goods or services are commonly obtained 2877
by other nursing facilities from outside organizations and are 2878
not a basic element of patient care ordinarily furnished 2879

directly to patients by nursing facilities.	2880
(d) The charge to the provider is in line with the charge	2881
for the goods or services in the open market and no more than	2882
the charge made under comparable circumstances to others by the	2883
supplier.	2884
(UU) "Relative of owner" means an individual who is	2885
related to an owner of a nursing facility by one of the	2886
following relationships:	2887
(1) Spouse;	2888
(2) Natural parent, child, or sibling;	2889
(3) Adopted parent, child, or sibling;	2890
(4) Stepparent, stepchild, stepbrother, or stepsister;	2891
(5) Father-in-law, mother-in-law, son-in-law, daughter-in-	2892
law, brother-in-law, or sister-in-law;	2893
(6) Grandparent or grandchild;	2894
(7) Foster caregiver, foster child, foster brother, or	2895
foster sister.	2896
(VV) "Residents' rights advocate" has the same meaning as	2897
in section 3721.10 of the Revised Code.	2898
(WW) "Skilled nursing facility" has the same meaning as in	2899
the "Social Security Act," section 1819(a), 42 U.S.C. 1395i-	2900
3(a).	2901
(XX) "State fiscal year" means the fiscal year of this	2902
state, as specified in section 9.34 of the Revised Code.	2903
(YY) "Sponsor" has the same meaning as in section 3721.10	2904
of the Revised Code.	2905

(ZZ) "Surrender" has the same meaning as in section 5168.40 of the Revised Code.	2906 2907
(AAA) "Tax costs" means the costs of taxes imposed under Chapter 5751. of the Revised Code, real estate taxes, personal property taxes, and corporate franchise taxes.	2908 2909 2910
(BBB) "Title XIX" means Title XIX of the "Social Security Act," 42 U.S.C. 1396 et seq.	2911 2912
(CCC) "Title XVIII" means Title XVIII of the "Social Security Act," 42 U.S.C. 1395 et seq.	2913 2914
(DDD) "Voluntary withdrawal of participation" means an operator's voluntary election to terminate the participation of a nursing facility in the medicaid program but to continue to provide service of the type provided by a nursing facility.	2915 2916 2917 2918
Sec. 5165.06. Subject to section 5165.072 of the Revised Code, an operator is eligible to enter into <u>and retain</u> a provider agreement for a nursing facility if all of the following apply:	2919 2920 2921 2922
(A) The nursing facility is certified by the director of health for participation in medicaid;	2923 2924
(B) The nursing facility is licensed by the director of health as a nursing home if so required by law <u>and the operator is the licensed operator of the nursing home;</u>	2925 2926 2927
(C) The operator and nursing facility comply with all applicable state and federal laws and rules.	2928 2929
Sec. 5165.26. (A) As used in this section:	2930
(1) "Base rate" means the portion of a nursing facility's total per medicaid day payment rate determined under divisions	2931 2932

(A) and (B) of section 5165.15 of the Revised Code.	2933
(2) "CMS" means the United States centers for medicare and medicaid services.	2934 2935
(3) "Long-stay resident" means an individual who has resided in a nursing facility for at least one hundred one days.	2936 2937
(4) "Nursing facilities for which a quality score was determined" includes nursing facilities that are determined to have a quality score of zero.	2938 2939 2940
(5) "SFF list" means the list of nursing facilities that the United States department of health and human services creates under the special focus facility program.	2941 2942 2943
(6) "Special focus facility program" means the program conducted by the United States secretary of health and human services pursuant to section 1919(f)(10) of the "Social Security Act," 42 U.S.C. 1396r(f)(10).	2944 2945 2946 2947
(B) Subject to divisions (D) and (E) and except as provided in division (F) of this section, the department of medicaid shall determine each nursing facility's per medicaid day quality incentive payment rate as follows:	2948 2949 2950 2951
(1) Determine the sum of the quality scores determined under division (C) of this section for all nursing facilities.	2952 2953
(2) Determine the average quality score by dividing the sum determined under division (B)(1) of this section by the number of nursing facilities for which a quality score was determined.	2954 2955 2956 2957
(3) Determine the sum of the total number of medicaid days for all of the calendar year preceding the fiscal year for which the rate is determined for all nursing facilities for which a	2958 2959 2960

quality score was determined.	2961
(4) Multiply the average quality score determined under	2962
division (B) (2) of this section by the sum determined under	2963
division (B) (3) of this section.	2964
(5) Determine the value per quality point by determining	2965
the quotient of the following:	2966
(a) The sum determined under division (E) (2) of this	2967
section.	2968
(b) The product determined under division (B) (4) of this	2969
section.	2970
(6) Multiply the value per quality point determined under	2971
division (B) (5) of this section by the nursing facility's	2972
quality score determined under division (C) of this section.	2973
(C) (1) Except as provided in divisions (C) (2) and (3) of	2974
this section, a nursing facility's quality score for a state	2975
fiscal year shall be the sum of the following:	2976
(a) The total number of points that CMS assigned to the	2977
nursing facility under CMS's nursing facility five-star quality	2978
rating system for the following quality metrics, or CMS's	2979
successor metrics as described below, based on the most recent	2980
four-quarter average data, or the average data for fewer	2981
quarters in the case of successor metrics, available in the	2982
database maintained by CMS and known as nursing home compare in	2983
the most recent month of the calendar year during which the	2984
fiscal year for which the rate is determined begins:	2985
(i) The percentage of the nursing facility's long-stay	2986
residents at high risk for pressure ulcers who had pressure	2987
ulcers;	2988

(ii) The percentage of the nursing facility's long-stay residents who had a urinary tract infection;	2989 2990
(iii) The percentage of the nursing facility's long-stay residents whose ability to move independently worsened;	2991 2992
(iv) The percentage of the nursing facility's long-stay residents who had a catheter inserted and left in their bladder.	2993 2994
If CMS ceases to publish any of the metrics specified in division (C)(1)(a) of this section, the department shall use the nursing facility quality metrics on the same topics that CMS subsequently publishes.	2995 2996 2997 2998
(b) Seven and five-tenths points for fiscal year 2024 and three points for fiscal year 2025 and subsequent fiscal years if the nursing facility's occupancy rate is greater than seventy-five per cent. For purposes of this division, the department shall utilize the facility's occupancy rate for licensed beds reported on its cost report for the calendar year preceding the fiscal year for which the rate is determined or, if the facility is not required to be licensed, the facility's occupancy rate for certified beds. If the facility surrenders licensed or certified beds before the first day of July of the calendar year in which the fiscal year begins, the department shall calculate a nursing facility's occupancy rate by dividing the inpatient days reported on the facility's cost report for the calendar year preceding the fiscal year for which the rate is determined by the product of the number of days in the calendar year and the facility's number of licensed, or if applicable, certified beds on the first day of July of the calendar year in which the fiscal year begins.	2999 3000 3001 3002 3003 3004 3005 3006 3007 3008 3009 3010 3011 3012 3013 3014 3015 3016
(c) Beginning with state fiscal year 2025, the total	3017

number of points that CMS assigned to the nursing facility under 3018
CMS's nursing facility five-star quality rating system for the 3019
following quality metrics, or successor metrics designated by 3020
CMS, based on the most recent four-quarter average data 3021
available in the database maintained by CMS and known as nursing 3022
home compare in the most recent month of the calendar year 3023
during which the fiscal year for which the rate is determined 3024
begins: 3025

(i) The percentage of the nursing facility's long-stay 3026
residents whose need for help with daily activities has 3027
increased; 3028

(ii) The percentage of the nursing facility's long-stay 3029
residents experiencing one or more falls with major injury; 3030

(iii) The percentage of the nursing facility's long-stay 3031
residents who were administered an antipsychotic medication; 3032

(iv) Adjusted total nurse staffing hours per resident per 3033
day using quintiles instead of deciles by using the points 3034
assigned to the higher of the two deciles that constitute the 3035
quintile. 3036

If CMS ceases to publish any of the metrics specified in 3037
division (C) (1) (c) of this section, the department shall use the 3038
nursing facility quality metrics on the same topics CMS 3039
subsequently publishes. 3040

(2) In determining a nursing facility's quality score for 3041
a state fiscal year, the department shall make the following 3042
adjustment to the number of points that CMS assigned to the 3043
nursing facility for each of the quality metrics specified in 3044
divisions (C) (1) (a) and (c) of this section: 3045

(a) Unless division (C) (2) (b) or (c) of this section 3046

applies, divide the number of the nursing facility's points for 3047
the quality metric by twenty. 3048

(b) If CMS assigned the nursing facility to the lowest 3049
percentile for the quality metric, reduce the number of the 3050
nursing facility's points for the quality metric to zero. 3051

(c) If the nursing facility's total number of points 3052
calculated for or during a state fiscal year for all of the 3053
quality metrics specified in divisions (C) (1) (a), and if 3054
applicable, division (C) (1) (c) of this section is less than a 3055
number of points that is equal to the twenty-fifth percentile of 3056
all nursing facilities, calculated using the points for the July 3057
1 rate setting of that fiscal year reduce the nursing facility's 3058
points to zero until the next point calculation. If a facility's 3059
recalculated points under division (C) (3) of this section are 3060
below the number of points determined to be the twenty-fifth 3061
percentile for that fiscal year, the facility shall receive zero 3062
points for the remainder of that fiscal year. 3063

(3) A nursing facility's quality score shall be 3064
recalculated for the second half of the state fiscal year based 3065
on the most recent four quarter average data, or the average 3066
data for fewer quarters in the case of successor metrics, 3067
available in the database maintained by CMS and known as the 3068
care compare, in the most recent month of the calendar year 3069
during which the fiscal year for which the rate is determined 3070
begins. The metrics specified by division (C) (1) (b) of this 3071
section shall not be recalculated. In redetermining the quality 3072
payment for each facility based on the recalculated points, the 3073
department shall use the same per point value determined for the 3074
quality payment at the start of the fiscal year. 3075

(D) A nursing facility shall not receive a quality 3076

incentive payment if the Department of Health assigned the 3077
nursing facility to the SFF list under the special focus 3078
facility program and the nursing facility is listed in table A, 3079
on the first day of May of the calendar year for which the rate 3080
is being determined. 3081

(E) The total amount to be spent on quality incentive 3082
payments under division (B) of this section for a fiscal year 3083
shall be determined as follows: 3084

(1) Determine the following amount for each nursing 3085
facility: 3086

(a) The amount that is five and two-tenths per cent of the 3087
nursing facility's base rate for nursing facility services 3088
provided on the first day of the state fiscal year plus one 3089
dollar and seventy-nine cents plus sixty per cent of the per 3090
diem amount by which the nursing facility's rate for direct care 3091
costs determined for the fiscal year under section 5165.19 of 3092
the Revised Code changed as a result of the rebasing conducted 3093
under section 5165.36 of the Revised Code. 3094

(b) Multiply the amount determined under division (E) (1) 3095
(a) of this section by the number of the nursing facility's 3096
medicaid days for the calendar year preceding the fiscal year 3097
for which the rate is determined. 3098

(2) Determine the sum of the products determined under 3099
division (E) (1) (b) of this section for all nursing facilities 3100
for which the product was determined for the state fiscal year. 3101

(3) To the sum determined under division (E) (2) of this 3102
section, add one hundred twenty-five million dollars. 3103

(F) (1) Beginning July 1, 2023, a new nursing facility 3104
shall receive a quality incentive payment for the fiscal year in 3105

which the new facility obtains an initial provider agreement and 3106
the immediately following fiscal year equal to the median 3107
quality incentive payment determined for nursing facilities for 3108
the fiscal year. For the state fiscal year after the immediately 3109
following fiscal year and subsequent fiscal years, the quality 3110
incentive payment shall be determined under division (C) of this 3111
section. 3112

(2) A nursing facility that undergoes a change of operator 3113
with an effective date of July 1, 2023, or later shall not 3114
receive a quality incentive payment until the earlier of the 3115
first day of January or the first day of July that is at least 3116
six months after the effective date of the change of operator. 3117
Thereafter quality incentive payment shall be determined under 3118
division (C) of this section. 3119

(3) A nursing facility that undergoes a change of owner 3120
with an effective date of July 1, 2023, or later shall not 3121
receive a quality incentive payment until the earlier of the 3122
first day of January or the first day of July that is at least 3123
six months after the effective date of the change of owner if, 3124
within one year after the change of owner, there is an increase 3125
in the lease payments or other financial obligations of the 3126
operator to the owner above the payments or obligations 3127
specified by the agreement between the previous owner and the 3128
operator. Thereafter, any quality incentive payments for the 3129
facility shall be determined under division (C) of this section. 3130

Sec. 5165.51. (A) An exiting operator or owner and 3131
entering operator shall provide the department of medicaid 3132
written notice of a change of operator if the nursing facility 3133
participates in the medicaid program and the entering operator 3134
seeks to continue the nursing facility's participation. The 3135

written notice shall be provided to the department in accordance 3136
with the method specified in rules authorized by section 5165.53 3137
of the Revised Code. The written notice shall be provided to the 3138
department not later than forty-five days before the effective 3139
date of the change of operator if the change of operator does 3140
not entail the relocation of residents. The written notice shall 3141
be provided to the department not later than ninety days before 3142
the effective date of the change of operator if the change of 3143
operator entails the relocation of residents. The department may 3144
waive the time requirements of division (A) of this section in 3145
an emergency, such as the death of the operator. 3146

The written notice shall include all of the following: 3147

(1) The name of the exiting operator and, if any, the 3148
exiting operator's authorized agent; 3149

(2) The name of the nursing facility that is the subject 3150
of the change of operator; 3151

(3) The exiting operator's seven-digit medicaid legacy 3152
number and ten-digit national provider identifier number for the 3153
nursing facility that is the subject of the change of operator; 3154

(4) The name of the entering operator; 3155

(5) The effective date of the change of operator; 3156

(6) The manner in which the entering operator becomes the 3157
nursing facility's operator, including through sale, lease, 3158
merger, or other action; 3159

(7) If the manner in which the entering operator becomes 3160
the nursing facility's operator involves more than one step, a 3161
description of each step; 3162

(8) Written authorization from the exiting operator or 3163

owner and entering operator for the department to process a 3164
provider agreement for the entering operator; 3165

(9) The names and addresses of the persons to whom the 3166
department should send initial correspondence regarding the 3167
change of operator; 3168

(10) If the nursing facility also participates in the 3169
medicare program, notification of whether the entering operator 3170
intends to accept assignment of the exiting operator's medicare 3171
provider agreement; 3172

(11) The signature of the exiting operator's or owner's 3173
representative. 3174

(B) An owner shall provide the department of medicaid 3175
written notice of a change of owner. The written notice shall be 3176
provided to the department in accordance with the method 3177
specified in rules adopted under section 5165.53 of the Revised 3178
Code. The written notice shall be provided to the department not 3179
later than forty-five days before the effective date of the 3180
change of owner. The department may waive the time requirements 3181
of division (B) of this section in an emergency, such as the 3182
death of the operator. 3183

The written notice shall include all of the following: 3184

(1) The name of the owner and the owner's authorized 3185
agent, if any; 3186

(2) The name of the nursing facility that is the subject 3187
of the change of owner; 3188

(3) The seven-digit medicaid legacy number and ten-digit 3189
national provider identification number for the nursing facility 3190
that is the subject of the change of owner; 3191

<u>(4) The extent of the owner's interest in the nursing facility;</u>	3192
	3193
<u>(5) The effective date of the change of owner;</u>	3194
<u>(6) The manner in which the change of owner is accomplished, including through sale, merger, or other action;</u>	3195
	3196
<u>(7) If the manner in which the change of owner is accomplished involves more than one step, a description of each step;</u>	3197
	3198
	3199
<u>(8) The names and addresses of the persons to whom the department should send correspondence regarding the change of owner;</u>	3200
	3201
	3202
<u>(9) A statement describing any material increase in lease payments or other financial obligations of the operator to the owner resulting from the change of owner, or affirming that there is no material increase;</u>	3203
	3204
	3205
	3206
<u>(10) The signature of the owner's representative.</u>	3207
<u>(C) An exiting operator or owner and, entering operator, or owner</u> immediately shall provide the department written notice of any changes to information included in a written notice of a change of operator <u>provided under division (A) or (B) of this section</u> that occur <u>within one year</u> after that notice is provided to the department. The notice of the changes shall be provided to the department in accordance with the method specified in rules authorized by section 5165.53 of the Revised Code.	3208
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Sec. 5165.511. The department of medicaid may enter into a provider agreement with an entering operator that goes into effect at 12:01 a.m. on the effective date of the change of operator if all of the following requirements are met:	3216
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(A) The department receives a properly completed written notice required by section 5165.51 of the Revised Code on or before the date required by that section.

(B) The department receives from the department of health notice of intent to grant a change of operator license issued under division (B) of section 3721.026 of the Revised Code.

(C) The department receives both of the following in accordance with the method specified in rules authorized by section 5165.53 of the Revised Code and not later than ten days after the effective date of the change of operator:

(1) From the entering operator, a completed application for a provider agreement and all other forms and documents specified in rules authorized by section 5165.53 of the Revised Code;

(2) From the exiting operator or owner, all forms and documents specified in rules authorized by section 5165.53 of the Revised Code.

~~(C)~~ (D) The entering operator is eligible for medicaid payments as provided in section 5165.06 of the Revised Code.

Sec. 5165.518. (A) Each nursing facility shall ensure that the identity of the operator that holds the license to operate the facility issued under section 3721.02 of the Revised Code and the operator that holds the medicaid provider agreement for the facility issued under section 5165.07 of the Revised Code is the same person and is consistently identified for both purposes.

(B) A nursing facility that has a difference in the identity of the operator that holds the license to operate the facility issued under section 3721.02 of the Revised Code and

the operator holding the medicaid provider agreement for the 3249
facility issued under section 5165.07 of the Revised Code shall, 3250
not later than one year after the effective date of this 3251
section, take action to ensure that the same person is the 3252
operator for both purposes and is consistently identified for 3253
both purposes. An action taken in accordance with this division 3254
shall not be considered a change of operator as defined in 3255
section 3721.01 or 5165.01 of the Revised Code. 3256

Section 2. That existing sections 3702.593, 3721.01, 3257
3721.026, 3721.072, 3721.121, 3721.28, 3721.30, 3721.31, 3258
3721.32, 4723.32, 4723.61, 4723.64, 4723.65, 4723.651, 4723.653, 3259
4723.66, 4723.67, 4723.68, 4723.69, 4729.41, 5124.15, 5124.151, 3260
5165.01, 5165.06, 5165.26, 5165.51, and 5165.511 of the Revised 3261
Code are hereby repealed. 3262

Section 3. That section 3701.89 of the Revised Code is 3263
hereby repealed. 3264

Section 4. Section 3702.593 of the Revised Code as 3265
presented in this act takes effect on the later of September 30, 3266
2024, or the effective date of this section. 3267

(September 30, 2024, is the effective date of an earlier 3268
amendment to that section by H.B. 110 of the 134th General 3269
Assembly.) 3270

Section 5. Notwithstanding division (D) (2) of section 3271
3702.593 of the Revised Code, in addition to the acceptance and 3272
review periods provided for in that division, certificate of 3273
need applications for the purposes specified in that section 3274
shall be accepted during the first month that is six months 3275
after the effective date of this section and reviewed through 3276
the last day of the ninth month after the month in which 3277

applications are accepted under this section. Thereafter, 3278
applications shall be accepted and reviewed only in accordance 3279
with division (D) (2) of section 3702.593 of the Revised Code. 3280

Section 6. (A) To assist with increased wages within the 3281
direct care workforce and other workforce supports, the per 3282
Medicaid day payment rate for an ICF/IID in peer group 5 during 3283
fiscal year 2025 shall be determined in accordance with the 3284
amendments to sections 5124.15 and 5124.151 of the Revised Code 3285
made by this act and the remaining provisions of Chapter 5124. 3286
of the Revised Code. 3287

(B) If an ICF/IID in peer group 5 receives a per Medicaid 3288
day payment from the Department of Developmental Disabilities 3289
during the period beginning July 1, 2024, and ending on the 3290
effective date of this section and the amendments to sections 3291
5124.15 and 5124.151 of the Revised Code made by this act, the 3292
Department shall make a supplemental payment to the ICF/IID that 3293
covers the difference between the amount paid during that period 3294
and the amount required to be paid in accordance with division 3295
(A) of this section. 3296

Section 7. That Section 280.12 of H.B. 45 of the 134th 3297
General Assembly (as amended by H.B. 33 of the 135th General 3298
Assembly) be amended to read as follows: 3299

Sec. 280.12. The foregoing appropriation item 042628, 3300
Adult Day Care, shall be used by the Director of Budget and 3301
Management to administer grants to eligible adult day care 3302
providers ~~during~~. An amount equal to the unexpended, 3303
unencumbered balance of the appropriation item at the end of 3304
fiscal year 2023, and the remaining \$4,000,000 shall be is 3305
hereby reappropriated and administered during fiscal year 2023- 3306
to fiscal year 2024 for the same purpose. An amount equal to the 3307

unexpended, unencumbered balance of the appropriation item at 3308
the end of fiscal year 2024, is hereby reappropriated to fiscal 3309
year 2025 for the same purpose. The Director shall administer 3310
all grants not later than December 31, 2024. 3311

Section 8. That existing Section 280.12 of H.B. 45 of the 3312
134th General Assembly (as amended by H.B. 33 of the 135th 3313
General Assembly) is hereby repealed. 3314

Section 9. By repealing section 3701.89 of the Revised 3315
Code, it is the intent of the General Assembly that the Ohio 3316
Medical Quality Foundation, a nonprofit corporation organized 3317
and formed under Chapter 1702. of the Revised Code, dissolve 3318
itself and take such actions as are required by that chapter to 3319
wind up its affairs. The General Assembly also directs the 3320
Foundation to transfer all of its remaining unencumbered funds, 3321
to the extent possible under law and contract, to the monitoring 3322
organization that the State Medical Board contracts with 3323
pursuant to section 4731.25 of the Revised Code. Following the 3324
transfer, the monitoring organization shall use the funds for 3325
purposes of the confidential monitoring program established and 3326
administered under sections 4731.25 to 4731.255 of the Revised 3327
Code. 3328