(135th General Assembly)
(Substitute Senate Bill Number 144)

AN ACT

To amend sections 3702.593, 3721.01, 3721.026, 3721.072, 3721.121, 3721.28, 3721.30, 3721.31, 3721.32, 4723.32, 4723.61, 4723.64, 4723.65, 4723.651, 4723.653, 4723.66, 4723.67, 4723.68, 4723.69, 4729.41, 5124.15, 5124.151, 5165.01, 5165.06, 5165.26, 5165.51, and 5165.511; to enact section 5165.518; and to repeal section 3701.89 of the Revised Code and to amend Section 280.12 of H.B. 45 of the 134th General Assembly as subsequently amended regarding immunizations administered by pharmacists, pharmacy interns, and pharmacy technicians; regarding certificates of need and change of operator procedures for nursing homes; regarding the per Medicaid day payment rate for specified ICFs/IID; regarding medication aides and certified nurse aides, including competency evaluation programs and training and competency evaluation programs; regarding nursing home quality improvement projects; regarding conditional employment in homes and adult day care programs; regarding grants provided to adult day care providers, and regarding the Ohio Medical Quality Foundation.

Be it enacted by the General Assembly of the State of Ohio:

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

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

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

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

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

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

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

(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:

(a) Nursing home beds licensed under Chapter 3721. of the Revised Code;

(b) Beds certified as skilled nursing facility beds under the medicare program or nursing facility beds under the medicaid program;

(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;

(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;

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

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

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

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

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

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

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

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

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

be licensed as nursing home beds under Chapter 3721. of the Revised Code.

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

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

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

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

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

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

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

(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 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 area from which the beds are being relocated would be less than the state bed need rate determined by the director.~~

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

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

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

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

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

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

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

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

(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 relocated.~~

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

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

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

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

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

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

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

(ii) A residential facility as defined in section 5119.34 of the Revised Code;

(iii) A residential facility as defined in section 5123.19 of the Revised Code;

(iv) A community addiction services provider as defined in section 5119.01 of the Revised Code;

(v) A facility licensed under section 5119.37 of the Revised Code to operate an opioid treatment program;

(vi) A facility providing services under contract with the department of developmental disabilities under section 5123.18 of the Revised Code;

(vii) A facility operated by a hospice care program licensed under section 3712.04 of the Revised Code that is used exclusively for care of hospice patients;

(viii) A facility operated by a pediatric respite care program licensed under section 3712.041 of the Revised Code that is used exclusively for the care of pediatric respite care patients or a location operated by a pediatric transition care program registered under section 3712.042 of the Revised Code that is used exclusively for the care of pediatric transition care patients;

(ix) A facility, infirmary, or other entity that is operated by a religious order, provides care

exclusively to members of religious orders who take vows of celibacy and live by virtue of their vows within the orders as if related, and does not participate in the medicare program or the medicaid program if on January 1, 1994, the facility, infirmary, or entity was providing care exclusively to members of the religious order;

(x) A county home or district home that has never been licensed as a residential care facility.

(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.

(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.

(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:

(a) Irrigations, catheterizations, application of dressings, and supervision of special diets;

(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;

(c) Special procedures contributing to rehabilitation;

(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;

(e) Carrying out other treatments prescribed by the physician that involve a similar level of complexity and skill in administration.

(5)(a) "Personal care services" means services including, but not limited to, the following:

(i) Assisting residents with activities of daily living;

(ii) Assisting residents with self-administration of medication, in accordance with rules adopted under section 3721.04 of the Revised Code;

(iii) Preparing special diets, other than complex therapeutic diets, for residents pursuant to the instructions of a physician or a licensed dietitian, in accordance with rules adopted under section 3721.04 of the Revised Code.

(b) "Personal care services" does not include "skilled nursing care" as defined in division (A)(4) of this section. A facility need not provide more than one of the services listed in division (A)(5)(a) of this section to be considered to be providing personal care services.

(6) "Nursing home" means a home used for the reception and care of individuals who by reason of illness or physical or mental impairment require skilled nursing care and of individuals who require personal care services but not skilled nursing care. A nursing home is licensed to provide personal care services and skilled nursing care.

(7) "Residential care facility" means a home that provides either of the following:

(a) Accommodations for seventeen or more unrelated individuals and supervision and personal care services for three or more of those individuals who are dependent on the services of others by reason of age or physical or mental impairment;

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

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

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

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

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

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

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

(ii) A change in operational control of the nursing home, regardless of whether ownership of any or all of the real property or personal property associated with the nursing home is also transferred;

(iii) A lease of the nursing home to the entering operator or termination of the exiting operator's lease;

(iv) If the exiting operator is a partnership, dissolution of the partnership, a merger of the partnership into another person that is the survivor of the merger, or a consolidation of the partnership and at least one other person to form a new person;

(v) If the exiting operator is a limited liability company, dissolution of the limited liability company, a merger of the limited liability company into another person that is the survivor of the merger, or a consolidation of the limited liability company and at least one other person to form a new person;

(vi) If the exiting operator is a corporation, dissolution of the corporation, a merger of the corporation into another person that is the survivor of the merger, or a consolidation of the corporation and at least one other person to form a new person;

(vii) A contract for a person to assume operational control of a nursing home;

(viii) A change of fifty per cent or more in the ownership of the licensed operator that results in a change of operational control;

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

(b) The following do not constitute a change of operator:

(i) Actions necessary to create an employee stock ownership plan under section 401(a) of the "Internal Revenue Code," 26 U.S.C. 401(a);

(ii) A change of ownership of real property or personal property associated with a nursing home;

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

(iv) An initial public offering for which the securities and exchange commission has declared the registration statement effective, and the newly created public company remains the operator.

(11) "Related party" ~~has the same meaning as in section 5165.01 of the Revised Code~~means an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by, the entering operator.

(a) An individual who is a relative of an entering operator is a related party.

(b) Common ownership exists when an individual or individuals possess significant ownership or equity in both the provider and the other organization. Significant ownership or equity exists when an individual or individuals possess five per cent ownership or equity in both the entering operator and a supplier. Significant ownership or equity is presumed to exist when an individual or individuals possess ten per cent ownership or equity in both the entering operator and another organization from which the entering operator purchases or leases real property.

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

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

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

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

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

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

the supplier.

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

(13) "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).

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

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

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

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

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

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

(a) Spouse;

(b) Natural parent, child, or sibling;

(c) Adopted parent, child, or sibling;

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

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

(f) Grandparent or grandchild;

(g) Foster caregiver, foster child, foster brother, or foster sister.

(18) "Exiting operator" means any of the following:

(a) An operator that will cease to be the operator of a nursing home on the effective date of a change of operator;

(b) An operator that will cease to be the operator of a nursing home on the effective date of a facility closure;

(c) An operator of a nursing home that is undergoing or has undergone a surrender of license;

(d) An operator of a nursing home that is undergoing or has undergone a license revocation.

(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:

(a) The person, persons, or government entity directly operating the nursing home;

(b) The person, persons, or government entity directly or indirectly owning fifty per cent or more of the operator of the nursing home;

(c) An agreement or other arrangement granting the person, persons, or government entity operational control of the nursing home.

(20) "Property owner" means any person or government entity that has at least five per cent ownership or interest, either directly, indirectly, or in any combination, in any of the following regarding a nursing home:

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

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

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

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

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

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

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

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

(D) Nothing in division (A)(4) of this section shall be construed to permit skilled nursing care to be imposed on an individual who does not require skilled nursing care.

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

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

(F) Nothing in this chapter, or rules adopted pursuant to it, shall be construed as authorizing the supervision, regulation, or control of the spiritual care or treatment of residents or patients in any home who rely upon treatment by prayer or spiritual means in accordance with the creed or tenets of

any recognized church or religious denomination.

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

(1) The ~~person~~ entering operator completes a change of operator license application on a form prescribed by the director and pays the applicable fee as determined by the director.

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

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

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

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

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

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

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

(iv) ~~The management firm or business employed to manage the nursing home, if the management firm or business employed to manage the nursing home is a different person from the applicant;~~

~~(v)~~ Each related party that provides or will provide services to the nursing home, through contracts with any party identified in division (A)(1)(a) of this section.

(b) Disclosure of ~~the direct or indirect ownership interest of each individual~~ whether a person or government entity identified in division (A)(1)(a) of this section has or had a direct or indirect ownership or operational interest in a current or previously licensed nursing home in this state or another state, including disclosure of whether any of the following occurred with respect to an identified nursing home within the five years immediately ~~proceeding~~ preceding the date of application:

(i) Voluntary or involuntary closure of the nursing home;

(ii) Voluntary or involuntary bankruptcy proceedings;

(iii) Voluntary or involuntary receivership proceedings;

(iv) License suspension, denial, or revocation;

(v) Injunction proceedings initiated by a regulatory agency;

(vi) The nursing home is listed in table A, table B, or table D on the SFF list under the special focus facility program;

(vii) A civil or criminal action was filed against it by a state or federal entity.

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

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

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

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

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

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

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

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

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

~~(5)~~(v) The nursing home undergoes a change of operator, unless the new applicant submits a

bond or other financial security in accordance with this section.

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

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

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

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

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

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

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

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

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

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

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

~~(1)~~ (D) The requirements established by this section are in addition to the other requirements established by this chapter and the rules adopted under it for a license to operate a nursing home.

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

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

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

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

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

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

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

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

~~(b)~~ (ii) Voluntary or involuntary bankruptcy proceedings that are not dismissed within sixty days;

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

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

(3) If a change of twenty-five per cent or more of the property ownership interest in a nursing home occurs in connection with the change of operator, the person or government entity who acquired the property ownership interest meets both of the following criteria:

(a) The person or government entity has or had either of the following relationships to a currently or previously licensed nursing home in this state or another state:

(i) Fifty per cent or more direct or indirect property ownership in the nursing home;

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

(b) Any of the following occurred with respect to the current or previously licensed nursing home described in division (E)(3)(a) of this section within the five years immediately preceding the date of application:

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

(ii) Voluntary or involuntary bankruptcy proceedings that are not dismissed within sixty days;

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

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

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

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

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

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

change of operator.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B)(1) Except as provided in division (I) of this section, the chief administrator of a home or adult day-care program shall request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of each applicant. If an applicant for whom a criminal records check request is required under this division does not present proof of having been a resident of this state for the five-year period immediately prior to the date the criminal records check is requested or provide evidence that within that five-year period the superintendent has requested information about the applicant from the federal bureau of investigation in a criminal records check, the chief administrator shall request that the superintendent obtain information from the federal bureau of investigation as part of the criminal records check of the applicant. Even if an applicant for whom a criminal records check request is required under this division presents proof of having been a resident of this state for the five-year period, the chief administrator may request that the superintendent include information from the federal bureau of investigation in the criminal records check.

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

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

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

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

(C)(1) Except as provided in rules adopted by the director of health in accordance with division (F) of this section and subject to division (C)(2) of this section, no home or adult day-care program shall employ a person in a position that involves providing direct care to an older adult if the person has been convicted of or pleaded guilty to any of the following:

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

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

(2)(a) A home or an adult day-care program may employ conditionally an applicant for whom a criminal records check request is required under division (B) of this section prior to obtaining the results of a criminal records check regarding the individual, provided that the home or program shall request a criminal records check regarding the individual in accordance with division (B)(1) of this section not later than five business days after the individual begins conditional employment. In the circumstances described in division (I)(2) of this section, a home or adult day-care program may employ conditionally an applicant who has been referred to the home or adult day-care program by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and for whom, pursuant to that division, a criminal records check is not required under division (B) of this section.

(b) A home or adult day-care program that employs an individual conditionally under authority of division (C)(2)(a) of this section shall terminate the individual's employment if the results of the criminal records check requested under division (B) of this section or described in division (I)(2) of this section, other than the results of any request for information from the federal bureau of investigation, are not obtained within the period ending ~~thirty~~ sixty days after the date the

request is made. Regardless of when the results of the criminal records check are obtained, if the results indicate that the individual has been convicted of or pleaded guilty to any of the offenses listed or described in division (C)(1) of this section, the home or program shall terminate the individual's employment unless the home or program chooses to employ the individual pursuant to division (F) of this section. Termination of employment under this division shall be considered just cause for discharge for purposes of division (D)(2) of section 4141.29 of the Revised Code if the individual makes any attempt to deceive the home or program about the individual's criminal record.

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

(2) A home or adult day-care program may charge an applicant a fee not exceeding the amount the home or program pays under division (D)(1) of this section. A home or program may collect a fee only if both of the following apply:

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

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

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

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

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

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

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

(5) Any person to whom the report is provided pursuant to, and in accordance with, division (I)(1) or (2) of this section;

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

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

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

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

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

(1) If the home or program employed the individual in good faith and reasonable reliance on the report of a criminal records check requested under this section, the home or program shall not be found negligent solely because of its reliance on the report, even if the information in the report is determined later to have been incomplete or inaccurate;

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

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

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

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

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

division (F) of this section.

(2) The chief administrator of a home or adult day-care program is not required to request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check of an applicant and may employ the applicant conditionally as described in this division, if the applicant has been referred to the home or program by an employment service that supplies full-time, part-time, or temporary staff for positions involving the direct care of older adults and if the chief administrator receives from the employment service or the applicant a letter from the employment service that is on the letterhead of the employment service, dated, and signed by a supervisor or another designated official of the employment service and that states that the employment service has requested the superintendent to conduct a criminal records check regarding the applicant, that the requested criminal records check will include a determination of whether the applicant has been convicted of or pleaded guilty to any offense listed or described in division (C)(1) of this section, that, as of the date set forth on the letter, the employment service had not received the results of the criminal records check, and that, when the employment service receives the results of the criminal records check, it promptly will send a copy of the results to the home or adult day-care program. If a home or adult day-care program employs an applicant conditionally in accordance with this division, the employment service, upon its receipt of the results of the criminal records check, promptly shall send a copy of the results to the home or adult day-care program, and division (C)(2)(b) of this section applies regarding the conditional employment.

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

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

(B) Effective June 1, 1990, no long-term care facility shall use an individual as a nurse aide for more than four months unless the individual is competent to provide the services the individual is to provide, the facility has received from the nurse aide registry established under section 3721.32 of the Revised Code the information concerning the individual provided through the registry, and one

of the following is the case:

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

(2) The individual has successfully completed a training and competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code or conducted by the director under division (C) of that section or has met the conditions specified in division (F)(1) or (2) of this section and, in addition, 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) or (2) of this section was conducted by or in a long-term care facility, ~~or if the director pursuant to division (E) of section 3721.31 of the Revised Code so requires,~~ the individual has successfully completed a competency evaluation program conducted by the director.

(3) Prior to July 1, 1989, if the long-term care facility is certified as a skilled nursing facility or a nursing facility under Title XVIII or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or prior to January 1, 1990, if the facility is not so certified, the individual completed a program that the director determines included a competency evaluation component no less stringent than the competency evaluation programs approved by the director under division (A) of section 3721.31 of the Revised Code or conducted by the director under division (C) of that section, and was otherwise comparable to the training and competency evaluation programs being approved by the director under division (A) of that section.

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

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

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

(7) The individual has the equivalent of twelve months or more of full-time employment in the preceding five years as a hospital aide or orderly and has successfully completed a competency evaluation program conducted by the director under division (C) of section 3721.31 of the Revised Code.

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

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

(1) Doing one of the following:

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

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

(c) Meeting the requirements specified in division (B)(6) or (7) of this section.

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

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

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

(a) Participate in one of the following:

(i) If the individual has successfully completed a training and competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code, and the program was 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,~~ a competency evaluation program conducted by the director;

(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 by the director under division (A) of section 3721.31 of the Revised Code or conducted by the director under division (C) of that section.

(b) If the individual participates in or has successfully completed a training and competency evaluation program under division (D)(2)(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.

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

(a) Participate in one of the following:

(i) If the individual has successfully completed a training and competency evaluation program approved by the director, and the program was 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,~~ a competency evaluation program conducted by the director;

(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 evaluation program conducted or approved by the director, if either of the following apply:

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

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

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

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

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

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

(G) The director shall adopt rules in accordance with Chapter 119. of the Revised Code specifying persons, in addition to the director, who may establish competence of nurse aides under division (B)(5) of this section, and establishing criteria for determining whether an individual meets the conditions specified in division (F)(1) of this section.

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

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

(a) Basic nursing skills;

(b) Personal care skills;

(c) Recognition of mental health and social service needs;

(d) Care of residents with cognitive impairments;

(e) Basic restorative services;

(f) Residents' rights;

(g) Any other area specified by rule of the director.

(2) Any training and competency evaluation program approved or competency evaluation program conducted by the director may include a written examination, but shall permit a nurse aide, at the nurse aide's option, to establish competency in another manner approved by the director. A nurse aide shall be permitted to have the competency evaluation conducted at the long-term care facility at which the nurse aide is or will be employed, unless the facility has been determined by the

director or the United States secretary of health and human services to have been out of compliance with the requirements of subsection (b), (c), or (d) of section 1819 or 1919 of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, within the previous two years.

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

(1) Basic nursing skills;

(2) Personal care skills;

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

(4) Care of residents with cognitive impairments;

(5) Basic restorative services;

(6) Residents' rights;

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

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

(C) In accordance with Chapter 119. of the Revised Code, the director shall adopt rules establishing procedures and criteria for approval of ~~competency evaluation programs and~~ training and competency evaluation programs. The requirements established by rules shall be no less stringent than the requirements, guidelines, and procedures established by the United States secretary of health and human services under sections 1819 and 1919 of the "Social Security Act." The director also shall adopt rules governing all of the following:

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

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

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

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

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

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

(7) Standards for successful completion of a ~~competency evaluation program or~~ training and

competency evaluation program;

(8) Procedures and criteria for review and reapproval of ~~competency evaluation programs and~~ training and competency evaluation programs;

(9) Fees for application for approval or reapproval of ~~competency evaluation programs,~~ training and competency evaluation programs~~,~~ and programs to train instructors ~~and~~ , coordinators, and evaluators for training and competency evaluation programs ~~and evaluators for competency evaluation programs~~;

(10) Fees for participation in any ~~competency evaluation program,~~ training and competency evaluation program~~,~~ or other program conducted by the director under section 3721.31 of the Revised Code;

(11) Procedures for reporting to the nurse aide registry established under section 3721.32 of the Revised Code whether or not individuals participating in ~~competency evaluation programs and~~ training and competency evaluation programs have successfully completed the programs.

(D) In accordance with Chapter 119. of the Revised Code, the director may adopt rules prescribing criteria and procedures for approval of training programs for instructors ~~and~~ , coordinators, and evaluators for competency evaluation programs and training and competency evaluation programs~~, and for evaluators for competency evaluation programs~~. The director may adopt other rules that the director considers necessary for the administration and enforcement of sections 3721.28 to 3721.34 of the Revised Code or for compliance with requirements, guidelines, or procedures issued by the United States secretary of health and human services for implementation of section 1819 or 1919 of the "Social Security Act."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) That a program completed prior to the dates specified in 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 this section, and was otherwise comparable to the training and competency evaluation programs being approved under this section;

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

(c) That an individual meets the conditions specified in division (F)(1) or (2) of section

3721.28 of the Revised Code.

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

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

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

(D) The director may approve or conduct programs to train instructors ~~and~~ , coordinators, and evaluators for training and competency evaluation programs ~~and evaluators for competency evaluation programs~~. The director may conduct inspections and examinations of those programs that have been approved by the director or for which an application for approval has been submitted, and the sites at which the programs are or will be conducted. The director shall not restrict participation in a training program for instructors to individuals who have experience working in a nursing home.

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

~~(F)~~ The test materials, examinations, or evaluation tools used in any competency evaluation program or training and competency evaluation program that the director conducts or approves

under this section are subject to the confidentiality provisions of section 3701.044 of the Revised Code.

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

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

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

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

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

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

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

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

(2) Successfully completed a training and competency evaluation program approved by the director under division (A) of section 3721.31 of the Revised Code or met the conditions 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 education approved by the board of nursing or by an agency of another state that regulates nursing education, have provided the long-term care facility with a certificate from the program indicating that the individual has successfully completed the courses that teach basic nursing skills including infection control, safety and emergency procedures, and personal care, and have successfully completed a competency evaluation program conducted by the director under division (A) of section 3721.31 of the Revised Code;

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

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

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

(1) The statement required by section 3721.23 of the Revised Code detailing findings by the director under that section regarding alleged abuse, neglect, or exploitation of a resident or misappropriation of resident property;

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

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

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

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

Revised Code.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(G) The activities of an individual who is a resident of a state other than this state and who currently holds a license to practice nursing or equivalent authorization from another jurisdiction, but only if the individual's activities are limited to those activities that the same type of nurse may engage in pursuant to a license issued under this chapter, the individual's authority to practice has not been revoked, the individual is not currently under suspension or on probation, the individual

does not represent the individual as being licensed under this chapter, and one of the following is the case:

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

(2) The individual is engaging in the practice of nursing as an employee of an individual, agency, or corporation located in the other jurisdiction in a position with employment responsibilities that include transporting patients into, out of, or through this state, as long as each trip in this state does not exceed seventy-two hours;

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

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

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

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

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

(8) The individual is providing nursing care at a free-of-charge camp accredited by the SeriousFun children's network that specializes in providing therapeutic recreation, as defined in section 2305.231 of the Revised Code, for individuals with chronic diseases, if all of the following are the case:

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

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

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

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

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

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

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

(b) If the individual's scope of practice in the other jurisdiction is more restrictive than in this state, the individual is limited to performing only those procedures that a registered nurse, advanced practice registered nurse, or licensed practical nurse in the other jurisdiction may perform.

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

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

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

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

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

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

~~(D)~~ "Nursing home" and "residential care facility" have the same meanings as in section 3721.01 of the Revised Code.

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

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

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

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

(B) The nursing home~~,~~ or residential care facility~~, or ICF/IID~~ shall ensure that the

requirements of section 4723.67 of the Revised Code are met.

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

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

(1) Be at least eighteen years of age;

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

(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;~~

~~(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;~~

~~(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;~~

~~(6)~~ Successfully complete the course of instruction provided by a training program approved under section 4723.66 of the Revised Code;

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

~~(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;~~

~~(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.

(B) Except as provided in division (C) of this section, if an applicant meets the requirements specified in division (A) of 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 accessing, completing, and submitting a renewal application online. The board is not required to provide an individual such options if it is aware that the holder is ineligible for renewal.

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

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

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

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

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

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

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

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

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

Sec. 4723.653. (A) A person who holds a current, valid certificate as a medication aide shall be known as a "certified medication aide" or "CMA." The board of nursing shall establish and maintain a registry of certified medication aides and make the registry available on its internet web site.

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

~~(B)~~ (C) No person shall employ a person not certified as a medication aide under this chapter

to engage in the administration of medication as a medication aide.

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

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

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

(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;~~

~~(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;~~

~~(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;~~

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

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

~~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.~~

~~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 timely request for a hearing in accordance with section 119.07 of the Revised Code, the board is not required to hold a hearing, but may adopt, by a vote of a quorum, a final order that contains the board's findings.~~

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

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

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

(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.~~

Sec. 4723.69. ~~(A)~~ The board of nursing ~~shall~~ may adopt rules to implement sections 4723.61 to 4723.68 of the Revised Code. All rules adopted under this section shall be adopted in accordance

with Chapter 119. of the Revised Code.

~~(B) The rules adopted under this section shall establish or specify all of the following:~~

~~(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;~~

~~(2) Requirements to obtain a medication aide certificate that are not otherwise specified in section 4723.651 of the Revised Code;~~

~~(3) Procedures for renewal of medication aide certificates;~~

~~(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;~~

~~(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;~~

~~(6) Standards for approval of continuing education programs and courses for medication aides;~~

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

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

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

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

~~(i) Influenza;~~

~~(ii) COVID-19;~~

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

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

(2) As part of engaging in the administration of immunizations or supervising a pharmacy intern's, certified pharmacy technician's, or registered pharmacy technician's administration of

immunizations, a pharmacist may administer epinephrine or diphenhydramine, or both, to individuals in emergency situations resulting from adverse reactions to the immunizations administered by the pharmacist ~~or~~, pharmacy intern, certified pharmacy technician, or registered pharmacy technician.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Prior to adopting rules regarding requirements for protocols to be followed by

pharmacists ~~and~~ , pharmacy interns, certified pharmacy technicians, and registered pharmacy technicians in engaging in the administration of immunizations, the state board of pharmacy shall consult with the state medical board and the board of nursing.

Sec. 5124.15. (A) Except as otherwise provided by section 5124.101 of the Revised Code, sections 5124.151 to 5124.154 of the Revised Code, and ~~divisions~~ division (B) ~~and (C)~~ of this section, the total per medicaid day payment rate that the department of developmental disabilities shall pay to an ICF/IID provider for ICF/IID services the provider's ICF/IID provides during a fiscal year shall equal the sum of all of the following:

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

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

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

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

(5) The sum of the following:

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

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

(c) A professional workforce development payment equal to thirteen and fifty-five hundredths for state fiscal year 2024 and twenty and eighty-one hundredths during fiscal year 2025 per cent of the ICF/IID's desk-reviewed, actual, allowable, per medicaid day direct care costs from the applicable cost report year.

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

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

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

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

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

(2) The rate add-ons are not to be part of the ICF/IID's total per medicaid day payment rate.

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

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

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

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

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

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

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

(iii) Adjust the product determined under division (B)(2)(a)(ii) of this section by the rate of inflation estimated under division (D) of section 5124.19 of the Revised Code.

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

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

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

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

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

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

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

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

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

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

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

Sec. 5165.01. As used in this chapter:

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

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

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

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

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

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

(E) For purposes of calculating a critical access nursing facility's occupancy rate and utilization rate under this chapter, "as of the last day of the calendar year" refers to the occupancy and utilization rates during the calendar year identified in the cost report filed under section 5165.10 of the Revised Code.

(F)(1) "Capital costs" means the actual expense incurred by a nursing facility for all of the following:

(a) Depreciation and interest on any capital assets that cost five hundred dollars or more per item, including the following:

(i) Buildings;

(ii) Building improvements;

(iii) Except as provided in division (D) of this section, equipment;

(iv) Transportation equipment.

(b) Amortization and interest on land improvements and leasehold improvements;

(c) Amortization of financing costs;

(d) Lease and rent of land, buildings, and equipment.

(2) The costs of capital assets of less than five hundred dollars per item may be considered capital costs in accordance with a provider's practice.

(G) "Capital lease" and "operating lease" shall be construed in accordance with generally accepted accounting principles.

(H) "Case-mix score" means a measure determined under section 5165.192 of the Revised Code of the relative direct-care resources needed to provide care and habilitation to a nursing facility resident.

(I) ~~"Change in control" means either of the following:~~

~~(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;~~

~~(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.~~

~~(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~~.

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

(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;

(b) A change ~~of~~ in operational control ~~in~~ of the ~~exiting operator or owner~~nursing facility,

regardless of whether ownership of any or all of the real property or personal property associated with the nursing facility is also transferred;

(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;

(d) If the exiting operator ~~or owner~~ is a partnership, dissolution of the partnership, a merger of the partnership into another person that is the survivor of the merger, or a consolidation of the partnership and at least one other person to form a new person;

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

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

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

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

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

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

(a) ~~an employer~~ Actions necessary to create an employee stock ownership plan ~~created~~ under section 401(a) of the "Internal Revenue Code," 26 U.S.C. 401(a);

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

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

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

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

(1) Ancillary and support costs;

(2) Capital costs;

(3) Direct care costs;

(4) Tax costs.

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

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

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

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

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

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

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

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

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

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

(b) The part of the nursing facility in which the additional beds are located was constructed as part of the nursing facility at a time when the nursing facility was not required by law to be licensed as a nursing home.

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

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

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

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

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

(3) Costs of purchased nursing services;

(4) Costs of quality assurance;

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

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

(7) Allocated direct care home office costs;

(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;

(9) Costs of wheelchairs other than the following:

(a) Custom wheelchairs;

(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.

(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.

~~(P)~~ (O) "Dual eligible individual" has the same meaning as in section 5160.01 of the Revised Code.

~~(Q)~~ (P) "Effective date of a change of operator" means the day the entering operator becomes the operator of the nursing facility.

~~(R)~~ (Q) "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.

~~(S)~~ (R) "Effective date of an involuntary termination" means the date the department of medicaid terminates the operator's provider agreement for the nursing facility.

~~(T)~~ (S) "Effective date of a voluntary withdrawal of participation" means the day the nursing facility ceases to accept new medicaid residents other than the individuals who reside in the nursing facility on the day before the effective date of the voluntary withdrawal of participation.

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

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

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

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

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

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

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

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

(b) Conversion of the building, or part of the building, that houses a nursing facility to a different use with any necessary license or other approval needed for that use being obtained and one or more of the nursing facility's residents remaining in the building, or part of the building, to receive services under the new use.

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

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

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

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

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

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

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

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

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

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

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

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

~~(BB)~~ (AA) "Maintenance and repair expenses" means a nursing facility's expenditures that are necessary and proper to maintain an asset in a normally efficient working condition and that do

not extend the useful life of the asset two years or more. "Maintenance and repair expenses" includes but is not limited to the costs of ordinary repairs such as painting and wallpapering.

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

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

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

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

~~(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 operating the nursing facility;

(2) The person, persons, or government entity directly or indirectly owning fifty per cent or more of the operator;

(3) An agreement or other arrangement granting the person, persons, or government entity operational control.

(JJ) "Operator" means ~~the~~ a person or government entity responsible for the ~~daily operating and management decisions for~~ operational control of a nursing facility and that holds both of the following:

(1) The license to operate the nursing facility issued under section 3721.02 of the Revised Code, if a license is required by section 3721.05 of the Revised Code;

(2) The medicaid provider agreement issued under section 5165.07 of the Revised Code, if applicable.

(KK)(1) "Owner" means any person or government entity that has at least five per cent ownership or interest, either directly, indirectly, or in any combination, in any of the following regarding a nursing facility:

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

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

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

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

(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 facility for the provision of nursing facility services under the medicaid program.

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

(RR) "Reasonable" means that a cost is an actual cost that is appropriate and helpful to develop and maintain the operation of patient care facilities and activities, including normal standby costs, and that does not exceed what a prudent buyer pays for a given item or services. Reasonable

costs may vary from provider to provider and from time to time for the same provider.

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

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

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

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

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

(TT) "Related party" means an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by, the provider.

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

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

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

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

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

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

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

(d) The charge to the provider is in line with the charge for the goods or services in the open market and no more than the charge made under comparable circumstances to others by the supplier.

(UU) "Relative of owner" means an individual who is related to an owner of a nursing facility by one of the following relationships:

(1) Spouse;

(2) Natural parent, child, or sibling;

(3) Adopted parent, child, or sibling;

(4) Stepparent, stepchild, stepbrother, or stepsister;

(5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law;

(6) Grandparent or grandchild;

(7) Foster caregiver, foster child, foster brother, or foster sister.

(VV) "Residents' rights advocate" has the same meaning as in section 3721.10 of the Revised Code.

(WW) "Skilled nursing facility" has the same meaning as in the "Social Security Act," section 1819(a), 42 U.S.C. 1395i-3(a).

(XX) "State fiscal year" means the fiscal year of this state, as specified in section 9.34 of the Revised Code.

(YY) "Sponsor" has the same meaning as in section 3721.10 of the Revised Code.

(ZZ) "Surrender" has the same meaning as in section 5168.40 of the Revised Code.

(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.

(BBB) "Title XIX" means Title XIX of the "Social Security Act," 42 U.S.C. 1396 et seq.

(CCC) "Title XVIII" means Title XVIII of the "Social Security Act," 42 U.S.C. 1395 et seq.

(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.

Sec. 5165.06. Subject to section 5165.072 of the Revised Code, an operator is eligible to enter into and retain a provider agreement for a nursing facility if all of the following apply:

(A) The nursing facility is certified by the director of health for participation in medicaid;

(B) The nursing facility is licensed by the director of health as a nursing home if so required by law and the operator is the licensed operator of the nursing home;

(C) The operator and nursing facility comply with all applicable state and federal laws and rules.

Sec. 5165.26. (A) As used in this section:

(1) "Base rate" means the portion of a nursing facility's total per medicaid day payment rate determined under divisions (A) and (B) of section 5165.15 of the Revised Code.

(2) "CMS" means the United States centers for medicare and medicaid services.

(3) "Long-stay resident" means an individual who has resided in a nursing facility for at least one hundred one days.

(4) "Nursing facilities for which a quality score was determined" includes nursing facilities that are determined to have a quality score of zero.

(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.

(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).

(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:

(1) Determine the sum of the quality scores determined under division (C) of this section for all nursing facilities.

(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.

(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 quality score was determined.

(4) Multiply the average quality score determined under division (B)(2) of this section by the sum determined under division (B)(3) of this section.

(5) Determine the value per quality point by determining the quotient of the following:

(a) The sum determined under division (E)(2) of this section.

(b) The product determined under division (B)(4) of this section.

(6) Multiply the value per quality point determined under division (B)(5) of this section by the nursing facility's quality score determined under division (C) of this section.

(C)(1) Except as provided in divisions (C)(2) and (3) of this section, a nursing facility's quality score for a state fiscal year shall be the sum of the following:

(a) The total number of points that CMS assigned to the nursing facility under CMS's nursing facility five-star quality rating system for the following quality metrics, or CMS's successor metrics as described below, based on the most recent four-quarter average data, or the average data for fewer quarters in the case of successor metrics, available in the database maintained by CMS and known as nursing home compare in the most recent month of the calendar year during which the fiscal year for which the rate is determined begins:

(i) The percentage of the nursing facility's long-stay residents at high risk for pressure ulcers who had pressure ulcers;

(ii) The percentage of the nursing facility's long-stay residents who had a urinary tract infection;

(iii) The percentage of the nursing facility's long-stay residents whose ability to move independently worsened;

(iv) The percentage of the nursing facility's long-stay residents who had a catheter inserted and left in their bladder.

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.

(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.

(c) Beginning with state fiscal year 2025, the total number of points that CMS assigned to the nursing facility under CMS's nursing facility five-star quality rating system for the following quality metrics, or successor metrics designated by CMS, based on the most recent four-quarter average data available in the database maintained by CMS and known as nursing home compare in the most recent month of the calendar year during which the fiscal year for which the rate is determined begins:

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

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

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

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

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

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

(a) Unless division (C)(2)(b) or (c) of this section applies, divide the number of the nursing facility's points for the quality metric by twenty.

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

(c) If the nursing facility's total number of points calculated for or during a state fiscal year

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

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

(D) A nursing facility shall not receive a quality incentive payment if the Department of Health assigned the nursing facility to the SFF list under the special focus facility program and the nursing facility is listed in table A, on the first day of May of the calendar year for which the rate is being determined.

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

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

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

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

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

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

(F)(1) Beginning July 1, 2023, a new nursing facility shall receive a quality incentive payment for the fiscal year in which the new facility obtains an initial provider agreement and the immediately following fiscal year equal to the median quality incentive payment determined for nursing facilities for the fiscal year. For the state fiscal year after the immediately following fiscal

year and subsequent fiscal years, the quality incentive payment shall be determined under division (C) of this section.

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

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

Sec. 5165.51. (A) An exiting operator or owner and entering operator shall provide the department of medicaid written notice of a change of operator if the nursing facility participates in the medicaid program and the entering operator seeks to continue the nursing facility's participation. The written notice shall be provided to the department in accordance with the method specified in rules authorized by section 5165.53 of the Revised Code. The written notice shall be provided to the department not later than forty-five days before the effective date of the change of operator if the change of operator does not entail the relocation of residents. The written notice shall be provided to the department not later than ninety days before the effective date of the change of operator if the change of operator entails the relocation of residents. The department may waive the time requirements of division (A) of this section in an emergency, such as the death of the operator.

The written notice shall include all of the following:

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

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

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

(4) The name of the entering operator;

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

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

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

(8) Written authorization from the exiting operator or owner and entering operator for the department to process a provider agreement for the entering operator;

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

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

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

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

The written notice shall include all of the following:

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

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

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

(4) The extent of the owner's interest in the nursing facility;

(5) The effective date of the change of owner;

(6) The manner in which the change of owner is accomplished, including through sale, merger, or other action;

(7) If the manner in which the change of owner is accomplished involves more than one step, a description of each step;

(8) The names and addresses of the persons to whom the department should send correspondence regarding the change of owner;

(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;

(10) The signature of the owner's representative.

(C) An exiting operator ~~or owner and~~, entering operator, or owner immediately shall provide the department written notice of any changes to information included in a written notice ~~of a change of operator~~ provided under division (A) or (B) of this section that occur within one year 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.

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:

(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 facility issued under section 5165.07 of the Revised Code shall, not later than one year after the effective date of this section, take action to ensure that the same person is the operator for both purposes and is consistently identified for both purposes. An action taken in accordance with this division shall not be considered a change of operator as defined in section 3721.01 or 5165.01 of the Revised Code.

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

SECTION 3. That section 3701.89 of the Revised Code is hereby repealed.

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

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

SECTION 5. Notwithstanding division (D)(2) of section 3702.593 of the Revised Code, in addition to the acceptance and review periods provided for in that division, certificate of need applications for the purposes specified in that section shall be accepted during the first month that is

six months after the effective date of this section and reviewed through the last day of the ninth month after the month in which applications are accepted under this section. Thereafter, applications shall be accepted and reviewed only in accordance with division (D)(2) of section 3702.593 of the Revised Code.

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

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

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

Sec. 280.12. The foregoing appropriation item 042628, Adult Day Care, shall be used by the Director of Budget and Management to administer grants to eligible adult day care providers ~~during~~ . An amount equal to the unexpended, unencumbered balance of the appropriation item at the end of fiscal year 2023, ~~and the remaining $4,000,000 shall be~~ is hereby reappropriated ~~and administered during fiscal year 2023~~ to fiscal year 2024 for the same purpose. An amount equal to the unexpended, unencumbered balance of the appropriation item at the end of fiscal year 2024, is hereby reappropriated to fiscal year 2025 for the same purpose. The Director shall administer all grants not later than December 31, 2024.

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

SECTION 9. By repealing section 3701.89 of the Revised Code, it is the intent of the General Assembly that the Ohio Medical Quality Foundation, a nonprofit corporation organized and formed under Chapter 1702. of the Revised Code, dissolve itself and take such actions as are required by that chapter to wind up its affairs. The General Assembly also directs the Foundation to transfer all of its remaining unencumbered funds, to the extent possible under law and contract, to the monitoring organization that the State Medical Board contracts with pursuant to section 4731.25 of

the Revised Code. Following the transfer, the monitoring organization shall use the funds for purposes of the confidential monitoring program established and administered under sections 4731.25 to 4731.255 of the Revised Code.

_____

Speaker _____ of the House of Representatives.

_____

President _____ of the Senate.

Passed _____, 20____

Approved _____, 20____

_____

Governor.

The section numbering of law of a general and permanent nature is complete and in conformity with the Revised Code.

_____

Director, Legislative Service Commission.

Filed in the office of the Secretary of State at Columbus, Ohio, on the ____ day of _____, A. D. 20____.

_____

Secretary of State.

File No. _____ Effective Date _____