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135th General Assembly

Regular Session

2023-2024

Sub. S. B. No. 144

A BILL

To amend sections 3702.593, 3721.01, 3721.026, 1
3721.072, 3721.121, 3721.28, 3721.30, 3721.31, 2
3721.32, 4723.32, 4723.61, 4723.64, 4723.65, 3
4723.651, 4723.653, 4723.66, 4723.67, 4723.68, 4
4723.69, 4729.41, 5124.15, 5124.151, 5165.01, 5
5165.06, 5165.26, 5165.51, and 5165.511 and to 6
enact section 5165.518 of the Revised Code and 7
to amend Section 333.270 of H.B. 33 of the 135th 8
General Assembly and Section 280.12 of H.B. 45 9
of the 134th General Assembly, as subsequently 10
amended, regarding immunizations administered by 11
pharmacists, pharmacy interns, and pharmacy 12
technicians; regarding Medicaid reimbursement 13
for dispensing drugs in lockable containers or 14
tamper-evident containers; regarding 15
certificates of need and change of operator 16
procedures for nursing homes; regarding the per 17
Medicaid day payment rate for specified 18
ICFs/IID; regarding medication aides and 19
certified nurse aides, including competency 20
evaluation programs and training and competency 21
evaluation programs; regarding nursing home 22



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quality improvement projects; regarding 23
conditional employment in homes and adult day 24
care programs; and regarding grants provided to 25
adult day care providers. 26

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

Section 1. That sections 3702.593, 3721.01, 3721.026, 27
3721.072, 3721.121, 3721.28, 3721.30, 3721.31, 3721.32, 4723.32, 28
4723.61, 4723.64, 4723.65, 4723.651, 4723.653, 4723.66, 4723.67, 29
4723.68, 4723.69, 4729.41, 5124.15, 5124.151, 5165.01, 5165.06, 30
5165.26, 5165.51, and 5165.511 be amended and section 5165.518 31
of the Revised Code be enacted to read as follows: 32

Sec. 3702.593. (A) At the times specified in this section, 33
the director of health shall accept, for review under section 34
3702.52 of the Revised Code, certificate of need applications 35
for any of the following purposes if the proposed increase in 36
beds is attributable solely to relocation of existing beds from 37
an existing long-term care facility in a county with excess beds 38
to a long-term care facility in a county in which there are 39
fewer long-term care beds than the county's bed need: 40

(1) Approval of beds in a new long-term care facility or 41
an increase of beds in an existing long-term care facility if 42
the beds are proposed to be licensed as nursing home beds under 43
Chapter 3721. of the Revised Code; 44

(2) Approval of beds in a new county home or new county 45
nursing home, or an increase of beds in an existing county home 46
or existing county nursing home if the beds are proposed to be 47
certified as skilled nursing facility beds under the medicare 48

program, Title XVIII of the "Social Security Act," 49 Stat. 286 49
(1965), 42 U.S.C. 1395, as amended, or nursing facility beds 50
under the medicaid program, Title XIX of the "Social Security 51
Act," 49 Stat. 286 (1965), 42 U.S.C. 1396, as amended; 52

(3) An increase of hospital beds reported in an 53
application submitted under section 3722.03 of the Revised Code 54
as long-term care beds. 55

(B) For the purpose of implementing this section, the 56
director shall do all of the following: 57

(1) Not later than October 1, 2023, and every ~~four~~two 58
years thereafter, determine the long-term care bed supply for 59
each county, which shall consist of all of the following: 60

(a) Nursing home beds licensed under Chapter 3721. of the 61
Revised Code; 62

(b) Beds certified as skilled nursing facility beds under 63
the medicare program or nursing facility beds under the medicaid 64
program; 65

(c) Beds in any portion of a hospital that are properly 66
reported in an application submitted under section 3722.03 of 67
the Revised Code as skilled nursing beds, long-term care beds, 68
or special skilled nursing beds; 69

(d) Beds in a county home or county nursing home that are 70
certified under section 5155.38 of the Revised Code as having 71
been in operation on July 1, 1993, and are eligible for 72
licensure as nursing home beds; 73

(e) Beds described in division (O) (5) of section 3702.51 74
of the Revised Code. 75

(2) Determine the long-term care bed occupancy rate for 76

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 106
proposed to be licensed as nursing home beds under Chapter 3721. 107
of the Revised Code. 108

(iii) The additional beds will be located in category one 109
private rooms, as that term is defined in section 5165.158 of 110
the Revised Code. 111

(2) Even if a county is determined not to need any 112
additional long-term care beds, the director may approve an 113
increase in beds equal to up to ten per cent of the county's bed 114
supply if the county's occupancy rate is greater than ninety per 115
cent. 116

(D) (1) For the review process used in considering 117
certificate of need applications, the director shall establish a 118
review period that begins January 1, 2020, and ends December 31, 119
2023. Thereafter, the review period for each review process 120
shall begin on the first day of January following the end of the 121
previous review period and shall be ~~four~~two years. 122

(2) Certificate of need applications shall be accepted 123
during the first month of the review period and reviewed through 124
the thirtieth day of September of the year in which the review 125
period begins. 126

(E) The director shall consider certificate of need 127
applications in accordance with all of the following: 128

(1) The number of beds approved for a county shall include 129
only beds available for relocation from another county and shall 130
not exceed the bed need of the receiving county~~+~~. 131

(2) The director shall consider the existence of community 132
resources serving persons who are age sixty-five or older or 133
disabled that are demonstrably effective in providing 134

alternatives to long-term care facility placement. 135

(3) The director shall approve relocation of beds from a 136
county only if, after the relocation, the number of beds 137
remaining in the county will exceed the county's bed need by at 138
least ~~one hundred fifty~~ fifty beds;— 139

~~(4) The director shall approve relocation of beds from a 140
long-term care facility only if, after the relocation, the 141
number of beds in the facility's service area is at least equal 142
to the state bed need rate. For purposes of this division, a 143
facility's service area shall be either of the following: 144~~

~~(a) The census tract in which the facility is located, if 145
the facility is located in an area designated by the United 146
States secretary of health and human services as a health 147
professional shortage area under the "Public Health Service 148
Act," 88 Stat. 682 (1944), 42 U.S.C. 254(e), as amended; 149~~

~~(b) The area that is within a fifteen-mile radius of the 150
facility's location, if the facility is not located in a health- 151
professional shortage area. 152~~

(F) Applications made under this section are subject to 153
comparative review if two or more applications are submitted 154
during the same review period and any of the following applies: 155

(1) The applications propose to relocate beds from the 156
same county and the number of beds for which certificates of 157
need are being requested totals more than the number of beds 158
available in the county from which the beds are to be relocated. 159

(2) The applications propose to relocate beds to the same 160
county and the number of beds for which certificates of need are 161
being requested totals more than the number of beds needed in 162
the county to which the beds are to be relocated. 163

~~(3) The applications propose to relocate beds from the~~ 164
~~same service area and the number of beds left in the service~~ 165
~~area from which the beds are being relocated would be less than~~ 166
~~the state bed need rate determined by the director.~~ 167

(G) In determining which applicants should receive 168
preference in the comparative review process, the director shall 169
consider all of the following as weighted priorities: 170

(1) Whether the beds will be part of a continuing care 171
retirement community; 172

(2) Whether the beds will serve an underserved population, 173
such as low-income individuals, individuals with disabilities, 174
or individuals who are members of racial or ethnic minority 175
groups; 176

(3) Whether the project in which the beds will be included 177
will provide alternatives to institutional care, such as adult 178
day-care, home health care, respite or hospice care, mobile 179
meals, residential care, independent living, or congregate 180
living services; 181

(4) Whether the long-term care facility's owner or 182
operator will participate in medicaid waiver programs for 183
alternatives to institutional care; 184

(5) Whether the project in which the beds will be included 185
will reduce alternatives to institutional care by converting 186
residential care beds or other alternative care beds to long- 187
term care beds; 188

(6) Whether the facility in which the beds will be placed 189
has positive resident and family satisfaction surveys; 190

(7) Whether the facility in which the beds will be placed 191

has fewer than fifty long-term care beds; 192

(8) Whether the long-term care facility in which the beds 193
will be placed is located within the ~~service area of~~ served by a 194
hospital and is designed to accept patients for rehabilitation 195
after an in-patient hospital stay; 196

(9) Whether the long-term care facility in which the beds 197
will be placed is or proposes to become a nurse aide training 198
and testing site; 199

(10) The rating, under the centers for medicare and 200
medicaid services' five star nursing home quality rating system, 201
of the long-term care facility in which the beds will be placed. 202

(H) A person who has submitted an application under this 203
section that is not subject to comparative review may revise the 204
site of the proposed project pursuant to section 3702.522 of the 205
Revised Code. 206

~~(I) When a certificate of need application is approved, in 207
addition to the actions required by division (D) of section 208
3702.52 of the Revised Code, the long term care facility from 209
which the beds were relocated shall reduce the number of beds 210
operated in the facility by a number of beds equal to at least 211
ten per cent of the number of beds relocated. If these beds are 212
in a home licensed under Chapter 3721. of the Revised Code, the 213
long term care facility shall have the beds removed from the 214
license. If the beds are in a facility that is certified as a 215
skilled nursing facility or nursing facility under Title XVIII 216
or XIX of the "Social Security Act," the facility shall 217
surrender the certification of these beds. If the beds are 218
reported in an application submitted under section 3722.03 of 219
the Revised Code as skilled nursing beds or long term care beds, 220~~

~~the long term care facility shall surrender the registration for~~ 221
~~these beds. This reduction shall be made not later than the~~ 222
~~completion date of the project for which the beds were~~ 223
~~relocated.~~ 224

Sec. 3721.01. (A) As used in sections 3721.01 to 3721.09 225
and 3721.99 of the Revised Code: 226

(1) (a) "Home" means an institution, residence, or facility 227
that provides, for a period of more than twenty-four hours, 228
whether for a consideration or not, accommodations to three or 229
more unrelated individuals who are dependent upon the services 230
of others, including a nursing home, residential care facility, 231
home for the aging, and a veterans' home operated under Chapter 232
5907. of the Revised Code. 233

(b) "Home" also means both of the following: 234

(i) Any facility that a person, as defined in section 235
3702.51 of the Revised Code, proposes for certification as a 236
skilled nursing facility or nursing facility under Title XVIII 237
or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 238
U.S.C.A. 301, as amended, and for which a certificate of need, 239
other than a certificate to recategorize hospital beds as 240
described in section 3702.521 of the Revised Code or division 241
(R) (7) (d) of the version of section 3702.51 of the Revised Code 242
in effect immediately prior to April 20, 1995, has been granted 243
to the person under sections 3702.51 to 3702.62 of the Revised 244
Code after August 5, 1989; 245

(ii) A county home or district home that is or has been 246
licensed as a residential care facility. 247

(c) "Home" does not mean any of the following: 248

(i) Except as provided in division (A) (1) (b) of this 249

section, a public hospital or hospital as defined in section 250
3701.01 or 5122.01 of the Revised Code; 251

(ii) A residential facility as defined in section 5119.34 252
of the Revised Code; 253

(iii) A residential facility as defined in section 5123.19 254
of the Revised Code; 255

(iv) A community addiction services provider as defined in 256
section 5119.01 of the Revised Code; 257

(v) A facility licensed under section 5119.37 of the 258
Revised Code to operate an opioid treatment program; 259

(vi) A facility providing services under contract with the 260
department of developmental disabilities under section 5123.18 261
of the Revised Code; 262

(vii) A facility operated by a hospice care program 263
licensed under section 3712.04 of the Revised Code that is used 264
exclusively for care of hospice patients; 265

(viii) A facility operated by a pediatric respite care 266
program licensed under section 3712.041 of the Revised Code that 267
is used exclusively for the care of pediatric respite care 268
patients or a location operated by a pediatric transition care 269
program registered under section 3712.042 of the Revised Code 270
that is used exclusively for the care of pediatric transition 271
care patients; 272

(ix) A facility, infirmary, or other entity that is 273
operated by a religious order, provides care exclusively to 274
members of religious orders who take vows of celibacy and live 275
by virtue of their vows within the orders as if related, and 276
does not participate in the medicare program or the medicaid 277

program if on January 1, 1994, the facility, infirmary, or 278
entity was providing care exclusively to members of the 279
religious order; 280

(x) A county home or district home that has never been 281
licensed as a residential care facility. 282

(2) "Unrelated individual" means one who is not related to 283
the owner or operator of a home or to the spouse of the owner or 284
operator as a parent, grandparent, child, grandchild, brother, 285
sister, niece, nephew, aunt, uncle, or as the child of an aunt 286
or uncle. 287

(3) "Mental impairment" does not mean mental illness, as 288
defined in section 5122.01 of the Revised Code, or developmental 289
disability, as defined in section 5123.01 of the Revised Code. 290

(4) "Skilled nursing care" means procedures that require 291
technical skills and knowledge beyond those the untrained person 292
possesses and that are commonly employed in providing for the 293
physical, mental, and emotional needs of the ill or otherwise 294
incapacitated. "Skilled nursing care" includes, but is not 295
limited to, the following: 296

(a) Irrigations, catheterizations, application of 297
dressings, and supervision of special diets; 298

(b) Objective observation of changes in the patient's 299
condition as a means of analyzing and determining the nursing 300
care required and the need for further medical diagnosis and 301
treatment; 302

(c) Special procedures contributing to rehabilitation; 303

(d) Administration of medication by any method ordered by 304
a physician, such as hypodermically, rectally, or orally, 305

including observation of the patient after receipt of the 306
medication; 307

(e) Carrying out other treatments prescribed by the 308
physician that involve a similar level of complexity and skill 309
in administration. 310

(5) (a) "Personal care services" means services including, 311
but not limited to, the following: 312

(i) Assisting residents with activities of daily living; 313

(ii) Assisting residents with self-administration of 314
medication, in accordance with rules adopted under section 315
3721.04 of the Revised Code; 316

(iii) Preparing special diets, other than complex 317
therapeutic diets, for residents pursuant to the instructions of 318
a physician or a licensed dietitian, in accordance with rules 319
adopted under section 3721.04 of the Revised Code. 320

(b) "Personal care services" does not include "skilled 321
nursing care" as defined in division (A) (4) of this section. A 322
facility need not provide more than one of the services listed 323
in division (A) (5) (a) of this section to be considered to be 324
providing personal care services. 325

(6) "Nursing home" means a home used for the reception and 326
care of individuals who by reason of illness or physical or 327
mental impairment require skilled nursing care and of 328
individuals who require personal care services but not skilled 329
nursing care. A nursing home is licensed to provide personal 330
care services and skilled nursing care. 331

(7) "Residential care facility" means a home that provides 332
either of the following: 333

(a) Accommodations for seventeen or more unrelated 334
individuals and supervision and personal care services for three 335
or more of those individuals who are dependent on the services 336
of others by reason of age or physical or mental impairment; 337

(b) Accommodations for three or more unrelated 338
individuals, supervision and personal care services for at least 339
three of those individuals who are dependent on the services of 340
others by reason of age or physical or mental impairment, and, 341
to at least one of those individuals, any of the skilled nursing 342
care authorized by section 3721.011 of the Revised Code. 343

(8) "Home for the aging" means a home that provides 344
services as a residential care facility and a nursing home, 345
except that the home provides its services only to individuals 346
who are dependent on the services of others by reason of both 347
age and physical or mental impairment. 348

The part or unit of a home for the aging that provides 349
services only as a residential care facility is licensed as a 350
residential care facility. The part or unit that may provide 351
skilled nursing care beyond the extent authorized by section 352
3721.011 of the Revised Code is licensed as a nursing home. 353

(9) "County home" and "district home" mean a county home 354
or district home operated under Chapter 5155. of the Revised 355
Code. 356

(10) "Change of operator" ~~has the same meaning as in~~ 357
~~section 5165.01 of the Revised Code~~ includes circumstances in 358
which an entering operator becomes the operator of a nursing 359
home in the place of the exiting operator. 360

(a) Actions that constitute a change of operator include 361
the following: 362

- (i) A change in an exiting operator's form of legal organization, including the formation of a partnership or corporation from a sole proprietorship; 363
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- (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; 366
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- (iii) A lease of the nursing home to the entering operator or termination of the exiting operator's lease; 370
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- (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; 372
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- (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; 377
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- (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; 383
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- (vii) A contract for a person to assume operational control of a nursing home; 388
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- (viii) A change of fifty per cent or more in the ownership of the licensed operator that results in a change of operational 390
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control; 392

(ix) Any pledge, assignment, or hypothecation of or lien 393
or other encumbrance on any of the legal or beneficial equity 394
interests in the operator or a person with operational control. 395

(b) The following do not constitute a change of operator: 396

(i) Actions necessary to create an employee stock 397
ownership plan under section 401(a) of the "Internal Revenue 398
Code," 26 U.S.C. 401(a); 399

(ii) A change of ownership of real property or personal 400
property associated with a nursing home; 401

(iii) If the operator is a corporation that has securities 402
publicly traded in a marketplace, a change of one or more 403
members of the corporation's governing body or transfer of 404
ownership of one or more shares of the corporation's stock, if 405
the same corporation continues to be the operator; 406

(iv) An initial public offering for which the securities 407
and exchange commission has declared the registration statement 408
effective, and the newly created public company remains the 409
operator. 410

(11) "Related party" ~~has the same meaning as in section~~ 411
5165.01 of the Revised Code means an individual or organization 412
that, to a significant extent, has common ownership with, is 413
associated or affiliated with, has control of, or is controlled 414
by, the entering operator. 415

(a) An individual who is a relative of an entering 416
operator is a related party. 417

(b) Common ownership exists when an individual or 418
individuals possess significant ownership or equity in both the 419

provider and the other organization. Significant ownership or 420
equity exists when an individual or individuals possess five per 421
cent ownership or equity in both the entering operator and a 422
supplier. Significant ownership or equity is presumed to exist 423
when an individual or individuals possess ten per cent ownership 424
or equity in both the entering operator and another organization 425
from which the entering operator purchases or leases real 426
property. 427

(c) Control exists when an individual or organization has 428
the power, directly or indirectly, to significantly influence or 429
direct the actions or policies of an organization. 430

(d) An individual or organization that supplies goods or 431
services to an entering operator shall not be considered a 432
related party if all of the following conditions are met: 433

(i) The supplier is a separate bona fide organization. 434

(ii) A substantial part of the supplier's business 435
activity of the type carried on with the entering operator is 436
transacted with others than the entering operator and there is 437
an open, competitive market for the types of goods or services 438
the supplier furnishes. 439

(iii) The types of goods or services are commonly obtained 440
by other nursing homes from outside organizations and are not a 441
basic element of patient care ordinarily furnished directly to 442
patients by nursing homes. 443

(iv) The charge to the entering operator is in line with 444
the charge for the goods or services in the open market and not 445
more than the charge made under comparable circumstances to 446
others by the supplier. 447

(12) "SFF list" means the list of nursing facilities 448

created by the United States department of health and human 449
services under the special focus facility program. 450

(13) "Special focus facility program" means the program 451
conducted by the United States secretary of health and human 452
services pursuant to section 1919(f)(10) of the "Social Security 453
Act," 42 U.S.C. 1396r(f)(10). 454

(14) "Real and present danger" means immediate danger of 455
serious physical or life-threatening harm to one or more 456
occupants of a home. 457

(15) "Operator" means a person or government entity 458
responsible for the operational control of a nursing home and 459
that holds both of the following: 460

(a) A license to operate the nursing home issued under 461
section 3721.02 of the Revised Code, if such a license is 462
required by section 3721.05 of the Revised Code; 463

(b) A medicaid provider agreement issued under section 464
5165.07 of the Revised Code, if applicable. 465

(16) "Entering operator" means the person or government 466
entity that will become the operator of a nursing home when a 467
change of operator occurs or following a license revocation. 468

(17) "Relative of entering operator" means an individual 469
who is related to an entering operator of a nursing home by one 470
of the following relationships: 471

(a) Spouse; 472

(b) Natural parent, child, or sibling; 473

(c) Adopted parent, child, or sibling; 474

(d) Stepparent, stepchild, stepbrother, or stepsister; 475

<u>(e) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law;</u>	476 477
<u>(f) Grandparent or grandchild;</u>	478
<u>(g) Foster caregiver, foster child, foster brother, or foster sister.</u>	479 480
<u>(18) "Exiting operator" means any of the following:</u>	481
<u>(a) An operator that will cease to be the operator of a nursing home on the effective date of a change of operator;</u>	482 483
<u>(b) An operator that will cease to be the operator of a nursing home on the effective date of a facility closure;</u>	484 485
<u>(c) An operator of a nursing home that is undergoing or has undergone a surrender of license;</u>	486 487
<u>(d) An operator of a nursing home that is undergoing or has undergone a license revocation.</u>	488 489
<u>(19) "Operational control" means having the ability to direct the overall operations and cash flow of a nursing home. "Operational control" may be exercised by one person or by multiple persons acting together or by a government entity, and may exist by means of any of the following:</u>	490 491 492 493 494
<u>(a) The person, persons, or government entity directly operating the nursing home;</u>	495 496
<u>(b) The person, persons, or government entity directly or indirectly owning fifty per cent or more of the operator of the nursing home;</u>	497 498 499
<u>(c) An agreement or other arrangement granting the person, persons, or government entity operational control of the nursing home.</u>	500 501 502

(20) "Property owner" means any person or government 503
entity that has at least five per cent ownership or interest, 504
either directly, indirectly, or in any combination, in any of 505
the following regarding a nursing home: 506

(a) The land on which the nursing home is located; 507

(b) The structure in which the nursing home is located; 508

(c) Any mortgage, contract for deed, or other obligation 509
secured in whole or in part by the land or structure on or in 510
which the nursing home is located; 511

(d) Any lease or sublease of the land or structure on or 512
in which the nursing home is located. 513

"Property owner" does not include a holder of a debenture 514
or bond related to the nursing home and purchased at public 515
issue or a regulated lender that has made a loan related to the 516
nursing home, unless the holder or lender operates the nursing 517
home directly or through a subsidiary. 518

(21) "Person" has the same meaning as in section 1.59 of 519
the Revised Code. 520

(B) The director of health may further classify homes. For 521
the purposes of this chapter, any residence, institution, hotel, 522
congregate housing project, or similar facility that meets the 523
definition of a home under this section is such a home 524
regardless of how the facility holds itself out to the public. 525

(C) For purposes of this chapter, personal care services 526
or skilled nursing care shall be considered to be provided by a 527
facility if they are provided by a person employed by or 528
associated with the facility or by another person pursuant to an 529
agreement to which neither the resident who receives the 530

services nor the resident's sponsor is a party. 531

(D) Nothing in division (A) (4) of this section shall be 532
construed to permit skilled nursing care to be imposed on an 533
individual who does not require skilled nursing care. 534

Nothing in division (A) (5) of this section shall be 535
construed to permit personal care services to be imposed on an 536
individual who is capable of performing the activity in question 537
without assistance. 538

(E) Division (A) (1) (c) (ix) of this section does not 539
prohibit a facility, infirmary, or other entity described in 540
that division from seeking licensure under sections 3721.01 to 541
3721.09 of the Revised Code or certification under Title XVIII 542
or XIX of the "Social Security Act." However, such a facility, 543
infirmary, or entity that applies for licensure or certification 544
must meet the requirements of those sections or titles and the 545
rules adopted under them and obtain a certificate of need from 546
the director of health under section 3702.52 of the Revised 547
Code. 548

(F) Nothing in this chapter, or rules adopted pursuant to 549
it, shall be construed as authorizing the supervision, 550
regulation, or control of the spiritual care or treatment of 551
residents or patients in any home who rely upon treatment by 552
prayer or spiritual means in accordance with the creed or tenets 553
of any recognized church or religious denomination. 554

Sec. 3721.026. (A) ~~If Before the director of health can~~ 555
~~issue a license to operate a nursing home undergoes a change of~~ 556
~~to an entering operator,~~ all of the following requirements must 557
be satisfied ~~before the director of health may issue a license~~ 558
~~authorizing the person to operate the nursing home:~~ 559

(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 personor 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 ownerof the legal rights is a different personor government entity

from the ~~applicant~~entering operator; 589

(iv) ~~The management firm or business employed to manage~~ 590
~~the nursing home, if the management firm or business employed to~~ 591
~~manage the nursing home is a different person from the~~ 592
~~applicant;~~ 593

~~(v)~~ Each related party that provides or will provide 594
services to the nursing home, through contracts with any party 595
identified in division (A) (1) (a) of this section. 596

(b) Disclosure of ~~the direct or indirect ownership~~ 597
~~interest of each individual whether a person or government~~ 598
entity identified in division (A) (1) (a) of this section has or 599
had a direct or indirect ownership or operational interest in a 600
current or previously licensed nursing home in this state or 601
another state, including disclosure of whether any of the 602
following occurred with respect to an identified nursing home 603
within the five years immediately ~~proceeding~~ preceding the date 604
of application: 605

(i) Voluntary or involuntary closure of the nursing home; 606

(ii) Voluntary or involuntary bankruptcy proceedings; 607

(iii) Voluntary or involuntary receivership proceedings; 608

(iv) License suspension, denial, or revocation; 609

(v) Injunction proceedings initiated by a regulatory 610
agency; 611

(vi) The nursing home is listed in table A, table B, or 612
table D on the SFF list under the special focus facility 613
program; 614

(vii) A civil or criminal action was filed against it by a 615

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 646
section have occurred. 647

(b) The director may utilize the bond or other financial 648
security required under division ~~(A) (3)~~ (A) (2) of this section_ 649
to pay expenses incurred by the director or another state 650
official or agency if any of the following occur during the 651
five-year period for which the bond or other financial security 652
is required: 653

~~(1)~~ (i) The nursing home is voluntarily or involuntarily 654
closed. 655

~~(2)~~ (ii) The nursing home or its owner or operator is the 656
subject of voluntary or involuntary bankruptcy proceedings. 657

~~(3)~~ (iii) The nursing home or its owner or operator is the 658
subject of voluntary or involuntary receivership proceedings. 659

~~(4)~~ (iv) The license to operate the nursing home is 660
suspended, denied, or revoked. 661

~~(5)~~ (v) The nursing home undergoes a change of operator, 662
unless the new applicant submits a bond or other financial 663
security in accordance with this section. 664

~~(6)~~ (vi) The nursing home appears in table A, table B, or 665
table D on the SFF list under the special focus facility 666
program. 667

~~(4) A (3) The entering operator or a person or government~~ 668
~~entity who is a direct or indirect owner of fifty per cent or~~ 669
~~more of the applicant is an individual who will have operational~~ 670
~~control of the nursing home~~ has at least five years of 671
experience as either of the following: 672

(a) An administrator of a nursing home located in this 673

state or another state; 674

~~(b) A direct or indirect owner of at least fifty per cent-~~ 675
~~in either of the following:~~ 676

~~(i) An operator~~ A person or government entity with 677
operational control of a nursing home located in this state or 678
another state; ~~—~~ 679

~~(ii) A manager of a nursing home located in this state or~~ 680
~~another state.~~ 681

~~(5) (4) The applicant~~ entering operator attests that the 682
~~applicant~~ entering operator has plans for quality assurance and 683
risk management for the operation of the nursing home. 684

~~(6) (5) The applicant~~ entering operator attests that the 685
~~applicant~~ entering operator has general and professional 686
liability insurance coverage that provides coverage of at least 687
one million dollars per occurrence and three million dollars 688
aggregate. 689

~~(7) (6) The applicant~~ entering operator attests that the 690
~~applicant~~ entering operator has sufficient numbers of qualified 691
staff, by training or experience, who will be employed to 692
properly care for the type and number of nursing home residents. 693

(B) The director shall issue to the entering operator a 694
notice of intent to grant a change of operator license upon a 695
determination that all requirements of this section have been 696
met, except for submission of the final document evidencing 697
completion of the transaction. 698

(C) The director shall ~~may~~ conduct a survey of the nursing 699
home not ~~more~~ less than sixty days after the effective date of 700
the change of operator. 701

~~(1)~~ (D) The requirements established by this section are 702
in addition to the other requirements established by this 703
chapter and the rules adopted under it for a license to operate 704
a nursing home. 705

(E) The director shall deny a change of operator license 706
application if any of the following circumstances exist: 707

(1) The requirements established by this section are not 708
satisfied license application or if the applicant. 709

(2) The entering operator or a person or government entity 710
identified in division (A) (1) (a) of this section who directly or 711
indirectly has twenty-five per cent or more ownership of the 712
entering operator meets both of the following criteria: 713

(a) The entering operator or the person or government 714
entity has or had fifty either of the following relationships to 715
a currently or previously licensed nursing home in this state or 716
another state: 717

(i) Fifty per cent or more direct or indirect ownership in 718
the operator or manager of a current or previously licensed 719
nursing home in this state or another state with respect to 720
which any; 721

(ii) Alone or together with one or more other persons, 722
operational control of the nursing home. 723

(b) Any of the following occurred with respect to the 724
current or previously licensed nursing home described in 725
division (E) (2) (a) of this section within the five years 726
immediately preceding the date of application: 727

~~(a)~~ (i) Involuntary closure of the nursing home by a 728
regulatory agency or voluntary closure in response to licensure 729

or certification action; 730

~~(b)~~ (ii) Voluntary or involuntary bankruptcy proceedings 731
that are not dismissed within sixty days; 732

~~(e)~~ (iii) Voluntary or involuntary receivership 733
proceedings that are not dismissed within sixty days; 734

~~(d)~~ (iv) License suspension, denial, or revocation for 735
failure to comply with operating standards. 736

(3) If a change of twenty-five per cent or more of the 737
property ownership interest in a nursing home occurs in 738
connection with the change of operator, the person or government 739
entity who acquired the property ownership interest meets both 740
of the following criteria: 741

(a) The person or government entity has or had either of 742
the following relationships to a currently or previously 743
licensed nursing home in this state or another state: 744

(i) Fifty per cent or more direct or indirect property 745
ownership in the nursing home; 746

(ii) Alone or together with one or more other persons, 747
operational control of the nursing home. 748

(b) Any of the following occurred with respect to the 749
current or previously licensed nursing home described in 750
division (E) (3) (a) of this section within the five years 751
immediately preceding the date of application: 752

(i) Involuntary closure of the nursing home by a 753
regulatory agency or voluntary closure in response to licensure 754
or certification action; 755

(ii) Voluntary or involuntary bankruptcy proceedings that 756

are not dismissed within sixty days; 757

(iii) Voluntary or involuntary receivership proceedings 758

that are not dismissed within sixty days; 759

(iv) License suspension, denial, or revocation for failure 760

to comply with operating standards. 761

~~(2) (F) An applicant entering operator~~ may appeal the 762

denial of a change of operator license application in accordance 763

with Chapter 119. of the Revised Code. 764

~~(C) (G) An applicant entering operator~~ shall ~~notify do all~~ 765

of the following: 766

(1) Notify the director immediately upon discovery of any 767

error, omission, or change of information in a change of 768

operator license application. 769

(2) Notify the director within ten days of any change in 770

the information or documentation required by this section, ~~—~~ 771

~~whether the change that occurs before or after the effective~~ 772

date of the change of operator. 773

(3) Truthfully supply any additional information or 774

documentation requested by the director. 775

If an ~~applicant entering operator~~ fails to notify the 776

director or supply additional information or documentation in 777

accordance with this division, the director shall impose a civil 778

penalty of two thousand dollars for each day of noncompliance. 779

(4) Not complete the change of operator until the director 780

issues to the entering operator notice of intent to grant a 781

change of operator license in accordance with division (B) of 782

this section. The entering operator shall submit the final 783

document evidencing completion of the transaction not later than 784

five days after completion. 785

~~(D)~~ ~~(1)~~ (H) (1) The director shall investigate an allegation 786
that a change of operator has occurred and the entering operator 787
failed to submit an application in accordance with this section 788
or an application was filed but the information was fraudulent. 789
The director may request the attorney general's assistance with 790
an investigation under this section. 791

(2) If the director becomes aware, by means of an 792
investigation or otherwise, that a change of operator has 793
occurred and the entering operator failed to submit an 794
application in accordance with this section, or an application 795
was filed but the information provided was fraudulent, the 796
director shall impose a civil penalty of two thousand dollars 797
for each day of noncompliance after the date the director 798
becomes aware that the change of operator has occurred. If the 799
entering operator fails to submit an application or new 800
application in accordance with this section within sixty days of 801
the director becoming aware of the change of operator, the 802
director shall begin the process of revoking a nursing home 803
license as specified in section 3721.03 of the Revised Code. 804

~~(E)~~ (I) It is the intent of the general assembly in 805
amending this section to require full and complete disclosure 806
and transparency with respect to the ownership, operation, and 807
management of each licensed nursing home located in this state. 808
The director may adopt rules as necessary to implement this 809
section. Any rules shall be adopted in accordance with Chapter 810
119. of the Revised Code. 811

Sec. 3721.072. (A) As used in this section: 812

(1) "Advance care planning" means providing an opportunity 813

to discuss the goals that may be met through the care provided 814
by a nursing home. 815

(2) "Overhead paging" means sending audible announcements 816
through an electronic sound amplification and distribution 817
system throughout part or all of a nursing home to staff, 818
residents, residents' families, or others. 819

(B) ~~Beginning July 1, 2013, each~~ Each nursing home shall 820
participate every two years in at least one ~~of the~~ quality 821
improvement ~~projects~~ project, and in doing so, shall prioritize 822
projects to assist with workforce, such as employee satisfaction 823
surveys, enhanced recruitment methods, or workplace culture 824
improvements. A nursing home may consider projects included on 825
the list made available by the department of aging under the 826
nursing home quality initiative established under section 173.60 827
of the Revised Code. 828

(C) Beginning July 1, 2015, each nursing home shall 829
participate in advance care planning with each resident or the 830
resident's sponsor if the resident is unable to participate. For 831
each resident, the advance care planning shall be provided on 832
admission to the nursing home or, in the case of an individual 833
residing in a nursing home on July 1, 2015, as soon as 834
practicable. Thereafter, for each resident, the advance care 835
planning shall be provided quarterly each year. 836

(D) Beginning July 1, 2015, each nursing home shall 837
prohibit the use of overhead paging within the nursing home, 838
except that the nursing home may permit the use of overhead 839
paging for matters of urgent public safety or urgent clinical 840
operations. The nursing home shall develop a written policy 841
regarding its use of overhead paging and make the policy 842
available to staff, residents, and residents' families. 843

Sec. 3721.121. (A) As used in this section: 844

(1) "Adult day-care program" means a program operated 845
pursuant to rules adopted by the director of health under 846
section 3721.04 of the Revised Code and provided by and on the 847
same site as homes licensed under this chapter. 848

(2) "Applicant" means a person who is under final 849
consideration for employment with a home or adult day-care 850
program in a full-time, part-time, or temporary position that 851
involves providing direct care to an older adult. "Applicant" 852
does not include a person who provides direct care as a 853
volunteer without receiving or expecting to receive any form of 854
remuneration other than reimbursement for actual expenses. 855

(3) "Community-based long-term care services provider" 856
means a provider as defined in section 173.39 of the Revised 857
Code. 858

(4) "Criminal records check" has the same meaning as in 859
section 109.572 of the Revised Code. 860

(5) "Home" means a home as defined in section 3721.10 of 861
the Revised Code. 862

(6) "Older adult" means a person age sixty or older. 863

(B) (1) Except as provided in division (I) of this section, 864
the chief administrator of a home or adult day-care program 865
shall request that the superintendent of the bureau of criminal 866
identification and investigation conduct a criminal records 867
check of each applicant. If an applicant for whom a criminal 868
records check request is required under this division does not 869
present proof of having been a resident of this state for the 870
five-year period immediately prior to the date the criminal 871
records check is requested or provide evidence that within that 872

five-year period the superintendent has requested information 873
about the applicant from the federal bureau of investigation in 874
a criminal records check, the chief administrator shall request 875
that the superintendent obtain information from the federal 876
bureau of investigation as part of the criminal records check of 877
the applicant. Even if an applicant for whom a criminal records 878
check request is required under this division presents proof of 879
having been a resident of this state for the five-year period, 880
the chief administrator may request that the superintendent 881
include information from the federal bureau of investigation in 882
the criminal records check. 883

(2) A person required by division (B)(1) of this section 884
to request a criminal records check shall do both of the 885
following: 886

(a) Provide to each applicant for whom a criminal records 887
check request is required under that division a copy of the form 888
prescribed pursuant to division (C)(1) of section 109.572 of the 889
Revised Code and a standard fingerprint impression sheet 890
prescribed pursuant to division (C)(2) of that section, and 891
obtain the completed form and impression sheet from the 892
applicant; 893

(b) Forward the completed form and impression sheet to the 894
superintendent of the bureau of criminal identification and 895
investigation. 896

(3) An applicant provided the form and fingerprint 897
impression sheet under division (B)(2)(a) of this section who 898
fails to complete the form or provide fingerprint impressions 899
shall not be employed in any position for which a criminal 900
records check is required by this section. 901

(C) (1) Except as provided in rules adopted by the director 902
of health in accordance with division (F) of this section and 903
subject to division (C) (2) of this section, no home or adult 904
day-care program shall employ a person in a position that 905
involves providing direct care to an older adult if the person 906
has been convicted of or pleaded guilty to any of the following: 907

(a) A violation of section 2903.01, 2903.02, 2903.03, 908
2903.04, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 909
2905.01, 2905.02, 2905.11, 2905.12, 2907.02, 2907.03, 2907.05, 910
2907.06, 2907.07, 2907.08, 2907.09, 2907.12, 2907.25, 2907.31, 911
2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 912
2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 913
2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.25, 914
2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.11, 915
2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code. 916

(b) A violation of an existing or former law of this 917
state, any other state, or the United States that is 918
substantially equivalent to any of the offenses listed in 919
division (C) (1) (a) of this section. 920

(2) (a) A home or an adult day-care program may employ 921
conditionally an applicant for whom a criminal records check 922
request is required under division (B) of this section prior to 923
obtaining the results of a criminal records check regarding the 924
individual, provided that the home or program shall request a 925
criminal records check regarding the individual in accordance 926
with division (B) (1) of this section not later than five 927
business days after the individual begins conditional 928
employment. In the circumstances described in division (I) (2) of 929
this section, a home or adult day-care program may employ 930
conditionally an applicant who has been referred to the home or 931

adult day-care program by an employment service that supplies 932
full-time, part-time, or temporary staff for positions involving 933
the direct care of older adults and for whom, pursuant to that 934
division, a criminal records check is not required under 935
division (B) of this section. 936

(b) A home or adult day-care program that employs an 937
individual conditionally under authority of division (C) (2) (a) 938
of this section shall terminate the individual's employment if 939
the results of the criminal records check requested under 940
division (B) of this section or described in division (I) (2) of 941
this section, other than the results of any request for 942
information from the federal bureau of investigation, are not 943
obtained within the period ending ~~thirty-sixty~~ days after the 944
date the request is made. Regardless of when the results of the 945
criminal records check are obtained, if the results indicate 946
that the individual has been convicted of or pleaded guilty to 947
any of the offenses listed or described in division (C) (1) of 948
this section, the home or program shall terminate the 949
individual's employment unless the home or program chooses to 950
employ the individual pursuant to division (F) of this section. 951
Termination of employment under this division shall be 952
considered just cause for discharge for purposes of division (D) 953
(2) of section 4141.29 of the Revised Code if the individual 954
makes any attempt to deceive the home or program about the 955
individual's criminal record. 956

(D) (1) Each home or adult day-care program shall pay to 957
the bureau of criminal identification and investigation the fee 958
prescribed pursuant to division (C) (3) of section 109.572 of the 959
Revised Code for each criminal records check conducted pursuant 960
to a request made under division (B) of this section. 961

(2) A home or adult day-care program may charge an 962
applicant a fee not exceeding the amount the home or program 963
pays under division (D) (1) of this section. A home or program 964
may collect a fee only if both of the following apply: 965

(a) The home or program notifies the person at the time of 966
initial application for employment of the amount of the fee and 967
that, unless the fee is paid, the person will not be considered 968
for employment; 969

(b) The medicaid program does not reimburse the home or 970
program the fee it pays under division (D) (1) of this section. 971

(E) The report of any criminal records check conducted 972
pursuant to a request made under this section is not a public 973
record for the purposes of section 149.43 of the Revised Code 974
and shall not be made available to any person other than the 975
following: 976

(1) The individual who is the subject of the criminal 977
records check or the individual's representative; 978

(2) The chief administrator of the home or program 979
requesting the criminal records check or the administrator's 980
representative; 981

(3) The administrator of any other facility, agency, or 982
program that provides direct care to older adults that is owned 983
or operated by the same entity that owns or operates the home or 984
program; 985

(4) A court, hearing officer, or other necessary 986
individual involved in a case dealing with a denial of 987
employment of the applicant or dealing with employment or 988
unemployment benefits of the applicant; 989

(5) Any person to whom the report is provided pursuant to, 990
and in accordance with, division (I)(1) or (2) of this section; 991

(6) The board of nursing for purposes of accepting and 992
processing an application for a medication aide certificate 993
issued under Chapter 4723. of the Revised Code; 994

(7) The director of aging or the director's designee if 995
the criminal records check is requested by the chief 996
administrator of a home that is also a community-based long-term 997
care services provider. 998

(F) In accordance with section 3721.11 of the Revised 999
Code, the director of health shall adopt rules to implement this 1000
section. The rules shall specify circumstances under which a 1001
home or adult day-care program may employ a person who has been 1002
convicted of or pleaded guilty to an offense listed or described 1003
in division (C)(1) of this section but meets personal character 1004
standards set by the director. 1005

(G) The chief administrator of a home or adult day-care 1006
program shall inform each individual, at the time of initial 1007
application for a position that involves providing direct care 1008
to an older adult, that the individual is required to provide a 1009
set of fingerprint impressions and that a criminal records check 1010
is required to be conducted if the individual comes under final 1011
consideration for employment. 1012

(H) In a tort or other civil action for damages that is 1013
brought as the result of an injury, death, or loss to person or 1014
property caused by an individual who a home or adult day-care 1015
program employs in a position that involves providing direct 1016
care to older adults, all of the following shall apply: 1017

(1) If the home or program employed the individual in good 1018

faith and reasonable reliance on the report of a criminal 1019
records check requested under this section, the home or program 1020
shall not be found negligent solely because of its reliance on 1021
the report, even if the information in the report is determined 1022
later to have been incomplete or inaccurate; 1023

(2) If the home or program employed the individual in good 1024
faith on a conditional basis pursuant to division (C) (2) of this 1025
section, the home or program shall not be found negligent solely 1026
because it employed the individual prior to receiving the report 1027
of a criminal records check requested under this section; 1028

(3) If the home or program in good faith employed the 1029
individual according to the personal character standards 1030
established in rules adopted under division (F) of this section, 1031
the home or program shall not be found negligent solely because 1032
the individual prior to being employed had been convicted of or 1033
pleaded guilty to an offense listed or described in division (C) 1034
(1) of this section. 1035

(I) (1) The chief administrator of a home or adult day-care 1036
program is not required to request that the superintendent of 1037
the bureau of criminal identification and investigation conduct 1038
a criminal records check of an applicant if the applicant has 1039
been referred to the home or program by an employment service 1040
that supplies full-time, part-time, or temporary staff for 1041
positions involving the direct care of older adults and both of 1042
the following apply: 1043

(a) The chief administrator receives from the employment 1044
service or the applicant a report of the results of a criminal 1045
records check regarding the applicant that has been conducted by 1046
the superintendent within the one-year period immediately 1047
preceding the applicant's referral; 1048

(b) The report of the criminal records check demonstrates 1049
that the person has not been convicted of or pleaded guilty to 1050
an offense listed or described in division (C)(1) of this 1051
section, or the report demonstrates that the person has been 1052
convicted of or pleaded guilty to one or more of those offenses, 1053
but the home or adult day-care program chooses to employ the 1054
individual pursuant to division (F) of this section. 1055

(2) The chief administrator of a home or adult day-care 1056
program is not required to request that the superintendent of 1057
the bureau of criminal identification and investigation conduct 1058
a criminal records check of an applicant and may employ the 1059
applicant conditionally as described in this division, if the 1060
applicant has been referred to the home or program by an 1061
employment service that supplies full-time, part-time, or 1062
temporary staff for positions involving the direct care of older 1063
adults and if the chief administrator receives from the 1064
employment service or the applicant a letter from the employment 1065
service that is on the letterhead of the employment service, 1066
dated, and signed by a supervisor or another designated official 1067
of the employment service and that states that the employment 1068
service has requested the superintendent to conduct a criminal 1069
records check regarding the applicant, that the requested 1070
criminal records check will include a determination of whether 1071
the applicant has been convicted of or pleaded guilty to any 1072
offense listed or described in division (C)(1) of this section, 1073
that, as of the date set forth on the letter, the employment 1074
service had not received the results of the criminal records 1075
check, and that, when the employment service receives the 1076
results of the criminal records check, it promptly will send a 1077
copy of the results to the home or adult day-care program. If a 1078
home or adult day-care program employs an applicant 1079

conditionally in accordance with this division, the employment 1080
service, upon its receipt of the results of the criminal records 1081
check, promptly shall send a copy of the results to the home or 1082
adult day-care program, and division (C) (2) (b) of this section 1083
applies regarding the conditional employment. 1084

Sec. 3721.28. (A) (1) Each nurse aide used by a long-term 1085
care facility on a full-time, temporary, per diem, or other 1086
basis on July 1, 1989, shall be provided by the facility a 1087
competency evaluation program approved by the director of health 1088
under division (A) of section 3721.31 of the Revised Code or 1089
conducted by the director under division (C) of that section. 1090
Each long-term care facility using a nurse aide on July 1, 1989, 1091
shall provide the nurse aide the preparation necessary to 1092
complete the competency evaluation program by January 1, 1990. 1093

(2) Each nurse aide used by a long-term care facility on a 1094
full-time, temporary, per diem, or other basis on January 1, 1095
1990, who either was not used by the facility on July 1, 1989, 1096
or was used by the facility on July 1, 1989, but had not 1097
successfully completed a competency evaluation program by 1098
January 1, 1990, shall be provided by the facility a competency 1099
evaluation program approved by the director under division (A) 1100
of section 3721.31 of the Revised Code or conducted by the 1101
director under division (C) of that section. Each long-term care 1102
facility using a nurse aide described in division (A) (2) of this 1103
section shall provide the nurse aide the preparation necessary 1104
to complete the competency evaluation program by October 1, 1105
1990, and shall assist the nurse aide in registering for the 1106
program. 1107

(B) Effective June 1, 1990, no long-term care facility 1108
shall use an individual as a nurse aide for more than four 1109

months unless the individual is competent to provide the 1110
services the individual is to provide, the facility has received 1111
from the nurse aide registry established under section 3721.32 1112
of the Revised Code the information concerning the individual 1113
provided through the registry, and one of the following is the 1114
case: 1115

(1) The individual was used by a facility as a nurse aide 1116
on a full-time, temporary, per diem, or other basis at any time 1117
during the period commencing July 1, 1989, and ending January 1, 1118
1990, and successfully completed, not later than October 1, 1119
1990, a competency evaluation program approved by the director 1120
under division (A) of section 3721.31 of the Revised Code or 1121
conducted by the director under division (C) of that section. 1122

(2) The individual has successfully completed a training 1123
and competency evaluation program approved by the director under 1124
division (A) of section 3721.31 of the Revised Code or conducted 1125
by the director under division (C) of that section or has met 1126
the conditions specified in division (F)(1) or (2) of this 1127
section and, in addition, if the training and competency 1128
evaluation program or the training, instruction, or education 1129
the individual completed in meeting the conditions specified in 1130
division (F)(1) or (2) of this section was conducted by or in a 1131
long-term care facility, ~~or if the director pursuant to division~~ 1132
~~(E) of section 3721.31 of the Revised Code so requires,~~ the 1133
individual has successfully completed a competency evaluation 1134
program conducted by the director. 1135

(3) Prior to July 1, 1989, if the long-term care facility 1136
is certified as a skilled nursing facility or a nursing facility 1137
under Title XVIII or XIX of the "Social Security Act," 49 Stat. 1138
620 (1935), 42 U.S.C.A. 301, as amended, or prior to January 1, 1139

1990, if the facility is not so certified, the individual 1140
completed a program that the director determines included a 1141
competency evaluation component no less stringent than the 1142
competency evaluation programs approved by the director under 1143
division (A) of section 3721.31 of the Revised Code or conducted 1144
by the director under division (C) of that section, and was 1145
otherwise comparable to the training and competency evaluation 1146
programs being approved by the director under division (A) of 1147
that section. 1148

(4) The individual is listed in a nurse aide registry 1149
maintained by another state and that state certifies that its 1150
program for training and evaluation of competency of nurse aides 1151
complies with Titles XVIII and XIX of the "Social Security Act" 1152
and regulations adopted thereunder. 1153

(5) Prior to July 1, 1989, the individual was found 1154
competent to serve as a nurse aide after the completion of a 1155
course of nurse aide training of at least one hundred hours' 1156
duration. 1157

(6) The individual is enrolled in a prelicensure program 1158
of nursing education approved by the board of nursing or by an 1159
agency of another state that regulates nursing education, has 1160
provided the long-term care facility with a certificate from the 1161
program indicating that the individual has successfully 1162
completed the courses that teach basic nursing skills including 1163
infection control, safety and emergency procedures, and personal 1164
care, and has successfully completed a competency evaluation 1165
program conducted by the director under division (C) of section 1166
3721.31 of the Revised Code. 1167

(7) The individual has the equivalent of twelve months or 1168
more of full-time employment in the preceding five years as a 1169

hospital aide or orderly and has successfully completed a 1170
competency evaluation program conducted by the director under 1171
division (C) of section 3721.31 of the Revised Code. 1172

(8) The individual has successfully completed a 1173
prelicensure program of nursing education approved by the board 1174
of nursing under section 4723.06 of the Revised Code or by an 1175
agency of another state that regulates nursing education and has 1176
passed the examination accepted by the board of nursing under 1177
section 4723.10 of the Revised Code, which shall be deemed as 1178
the successful completion of a competency evaluation program 1179
conducted by the director under division (C) of section 3721.31 1180
of the Revised Code. 1181

(C) Effective June 1, 1990, no long-term care facility 1182
shall continue for longer than four months to use as a nurse 1183
aide an individual who previously met the requirements of 1184
division (B) of this section but since most recently doing so 1185
has not performed nursing and nursing-related services for 1186
monetary compensation for twenty-four consecutive months, unless 1187
the individual successfully completes additional training and 1188
competency evaluation by complying with divisions (C) (1) and (2) 1189
of this section: 1190

(1) Doing one of the following: 1191

(a) Successfully completing a training and competency 1192
evaluation program approved by the director under division (A) 1193
of section 3721.31 of the Revised Code or conducted by the 1194
director under division (C) of that section; 1195

(b) Successfully completing a training and competency 1196
evaluation program described in division (B) (4) of this section; 1197

(c) Meeting the requirements specified in division (B) (6) 1198

or (7) of this section. 1199

(2) If the training and competency evaluation program 1200
completed under division (C) (1) (a) of this section was conducted 1201
by or in a long-term care facility, ~~or if the director pursuant~~ 1202
~~to division (E) of section 3721.31 of the Revised Code so~~ 1203
~~requires,~~ successfully completing a competency evaluation 1204
program conducted by the director. 1205

(D) (1) The four-month periods provided for in divisions 1206
(B) and (C) of this section include any time, on or after June 1207
1, 1990, that an individual is used as a nurse aide on a full- 1208
time, temporary, per diem, or any other basis by the facility or 1209
any other long-term care facility. 1210

(2) During the four-month period provided for in division 1211
(B) of this section, during which a long-term care facility may, 1212
subject to division (E) of this section, use as a nurse aide an 1213
individual who does not have the qualifications specified in 1214
divisions (B) (1) to (7) of this section, a facility shall 1215
require the individual to comply with divisions (D) (2) (a) and 1216
(b) of this section: 1217

(a) Participate in one of the following: 1218

(i) If the individual has successfully completed a 1219
training and competency evaluation program approved by the 1220
director under division (A) of section 3721.31 of the Revised 1221
Code, and the program was conducted by or in a long-term care 1222
facility, ~~or the director pursuant to division (E) of section~~ 1223
~~3721.31 of the Revised Code so requires,~~ a competency evaluation 1224
program conducted by the director; 1225

(ii) If the individual is enrolled in a prelicensure 1226
program of nursing education described in division (B) (6) of 1227

this section and has completed or is working toward completion 1228
of the courses described in that division, or the individual has 1229
the experience described in division (B) (7) of this section, a 1230
competency evaluation program conducted by the director; 1231

(iii) A training and competency evaluation program 1232
approved by the director under division (A) of section 3721.31 1233
of the Revised Code or conducted by the director under division 1234
(C) of that section. 1235

(b) If the individual participates in or has successfully 1236
completed a training and competency evaluation program under 1237
division (D) (2) (a) (iii) of this section that is conducted by or 1238
in a long-term care facility, ~~or the director pursuant to~~ 1239
~~division (E) of section 3721.31 of the Revised Code so requires,~~ 1240
participate in a competency evaluation program conducted by the 1241
director. 1242

(3) During the four-month period provided for in division 1243
(C) of this section, during which a long-term care facility may, 1244
subject to division (E) of this section, use as a nurse aide an 1245
individual who does not have the qualifications specified in 1246
divisions (C) (1) and (2) of this section, a facility shall 1247
require the individual to comply with divisions (D) (3) (a) and 1248
(b) of this section: 1249

(a) Participate in one of the following: 1250

(i) If the individual has successfully completed a 1251
training and competency evaluation program approved by the 1252
director, and the program was conducted by or in a long-term 1253
care facility, ~~or the director pursuant to division (E) of~~ 1254
~~section 3721.31 of the Revised Code so requires,~~ a competency 1255
evaluation program conducted by the director; 1256

(ii) If the individual is enrolled in a prelicensure 1257
program of nursing education described in division (B) (6) of 1258
this section and has completed or is working toward completion 1259
of the courses described in that division, or the individual has 1260
the experience described in division (B) (7) of this section, a 1261
competency evaluation program conducted by the director; 1262

(iii) A training and competency evaluation program 1263
approved or conducted by the director. 1264

(b) If the individual participates in or has successfully 1265
completed a training and competency evaluation program under 1266
division (D) (3) (a) (iii) of this section that is conducted by or 1267
in a long-term care facility, ~~or the director pursuant to~~ 1268
~~division (E) of section 3721.31 of the Revised Code so requires,~~ 1269
participate in a competency evaluation program conducted by the 1270
director. 1271

(E) A long-term care facility shall not permit an 1272
individual used by the facility as a nurse aide while 1273
participating in a training and competency evaluation program to 1274
provide nursing and nursing-related services unless both of the 1275
following are the case: 1276

(1) The individual has completed the number of hours of 1277
training that must be completed prior to providing services to 1278
residents as prescribed by rules that shall be adopted by the 1279
director in accordance with Chapter 119. of the Revised Code; 1280

(2) The individual is under the personal supervision of a 1281
registered or licensed practical nurse licensed under Chapter 1282
4723. of the Revised Code. 1283

(F) An individual shall be considered to have satisfied 1284
the requirement, under division (B) (2) of this section, of 1285

having successfully completed a training and competency 1286
evaluation program conducted or approved by the director, if 1287
either of the following apply: 1288

(1) The individual, as of July 1, 1989, met both of the 1289
following conditions: 1290

(a) Completed at least sixty hours divided between skills 1291
training and classroom instruction in the topic areas described 1292
in divisions (B) (1) to (8) of section 3721.30 of the Revised 1293
Code; 1294

(b) Received at least the difference between seventy-five 1295
hours and the number of hours actually spent in training and 1296
competency evaluation in supervised practical nurse aide 1297
training or regular in-service nurse aide education. 1298

(2) The individual meets both of the following conditions: 1299

(a) Has completed during the COVID-19 public health 1300
emergency declared by the United States secretary of health and 1301
human services a minimum of seventy-five hours of training that 1302
occurs in a long-term care facility setting, includes on-site 1303
observation and work as a nurse aide under a COVID-19 pandemic 1304
waiver issued by the federal centers for medicare and medicaid 1305
services, and addresses all of the required areas specified in 1306
42 C.F.R. 483.152(b), except that if gaps in on-site training 1307
are identified, the individual also must complete supplemental 1308
training; 1309

(b) Has successfully completed the competency evaluation 1310
conducted by the director of health under section 3721.31 of the 1311
Revised Code. 1312

(G) The director shall adopt rules in accordance with 1313
Chapter 119. of the Revised Code specifying persons, in addition 1314

to the director, who may establish competence of nurse aides 1315
under division (B) (5) of this section, and establishing criteria 1316
for determining whether an individual meets the conditions 1317
specified in division (F) (1) of this section. 1318

(H) The rules adopted pursuant to divisions (E) (1) and (G) 1319
of this section shall be no less stringent than the 1320
requirements, guidelines, and procedures established by the 1321
United States secretary of health and human services under 1322
sections 1819 and 1919 of the "Social Security Act." 1323

Sec. 3721.30. (A) (1) A training and competency evaluation 1324
program approved by the director of health under division (A) of 1325
section 3721.31 of the Revised Code or a competency evaluation 1326
program conducted by the director under division (C) of that 1327
section shall evaluate the competency of a nurse aide in the 1328
following areas: 1329

- (a) Basic nursing skills; 1330
- (b) Personal care skills; 1331
- (c) Recognition of mental health and social service needs; 1332
- (d) Care of residents with cognitive impairments; 1333
- (e) Basic restorative services; 1334
- (f) Residents' rights; 1335
- (g) Any other area specified by rule of the director. 1336

(2) Any training and competency evaluation program 1337
approved or competency evaluation program conducted by the 1338
director may include a written examination, but shall permit a 1339
nurse aide, at the nurse aide's option, to establish competency 1340
in another manner approved by the director. A nurse aide shall 1341

be permitted to have the competency evaluation conducted at the 1342
long-term care facility at which the nurse aide is or will be 1343
employed, unless the facility has been determined by the 1344
director or the United States secretary of health and human 1345
services to have been out of compliance with the requirements of 1346
subsection (b), (c), or (d) of section 1819 or 1919 of the 1347
"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as 1348
amended, within the previous two years. 1349

(B) A training and competency evaluation program approved 1350
or conducted by the director under section 3721.31 of the 1351
Revised Code shall consist of training and competency evaluation 1352
specified by the director in rules adopted under division (C) of 1353
this section, including a minimum of seventy-five hours divided 1354
between skills training and classroom instruction in the 1355
following topic areas: 1356

- (1) Basic nursing skills; 1357
- (2) Personal care skills; 1358
- (3) Recognition of mental health and social service needs; 1359
- (4) Care of residents with cognitive impairments; 1360
- (5) Basic restorative services; 1361
- (6) Residents' rights; 1362
- (7) Needs of various groups of long-term care facility 1363
residents and patients; 1364
- (8) Other topic areas specified by rule of the director. 1365

(C) In accordance with Chapter 119. of the Revised Code, 1366
the director shall adopt rules establishing procedures and 1367
criteria for approval of ~~competency evaluation programs and~~ 1368

training and competency evaluation programs. The requirements 1369
established by rules shall be no less stringent than the 1370
requirements, guidelines, and procedures established by the 1371
United States secretary of health and human services under 1372
sections 1819 and 1919 of the "Social Security Act." The 1373
director also shall adopt rules governing all of the following: 1374

(1) Procedures for determination of an individual's 1375
competency to perform services as a nurse aide; 1376

(2) The curriculum of training and competency evaluation 1377
programs; 1378

(3) The clinical supervision and physical facilities used 1379
for ~~competency evaluation programs and training and competency~~ 1380
evaluation programs; 1381

(4) The number of hours of training required in training 1382
and competency evaluation programs; 1383

(5) The qualifications for instructors, coordinators, and 1384
evaluators of ~~competency evaluation programs and training and~~ 1385
competency evaluation programs, except that the rules shall not 1386
require an instructor for a training and competency evaluation 1387
program to have nursing home experience if the program is under 1388
the general supervision of a coordinator who is a registered 1389
nurse who possesses a minimum of two years of nursing 1390
experience, at least one of which is in the provision of 1391
services in a nursing home or intermediate care facility for 1392
individuals with intellectual disabilities; 1393

(6) Requirements that ~~approved competency evaluation~~ 1394
~~programs and training and competency evaluation programs~~ must 1395
meet to retain approval; 1396

(7) Standards for successful completion of a ~~competency~~ 1397

~~evaluation program or training and competency evaluation~~ 1398
~~program;~~ 1399

(8) Procedures and criteria for review and reapproval of 1400
~~competency evaluation programs and training and competency~~ 1401
evaluation programs; 1402

(9) Fees for application for approval or reapproval of 1403
~~competency evaluation programs, training and competency~~ 1404
evaluation programs, and programs to train instructors ~~and, _~~ 1405
coordinators, and evaluators for training and competency 1406
evaluation programs ~~and evaluators for competency evaluation~~ 1407
~~programs;~~ 1408

(10) Fees for participation in any ~~competency evaluation~~ 1409
~~program, training and competency evaluation program, or other~~ 1410
program conducted by the director under section 3721.31 of the 1411
Revised Code; 1412

(11) Procedures for reporting to the nurse aide registry 1413
established under section 3721.32 of the Revised Code whether or 1414
not individuals participating in ~~competency evaluation programs~~ 1415
~~and training and competency evaluation programs have~~ 1416
successfully completed the programs. 1417

(D) In accordance with Chapter 119. of the Revised Code, 1418
the director may adopt rules prescribing criteria and procedures 1419
for approval of training programs for instructors ~~and, _~~ 1420
coordinators, and evaluators for competency evaluation programs 1421
and training and competency evaluation programs, and for 1422
~~evaluators for competency evaluation programs.~~ The director may 1423
adopt other rules that the director considers necessary for the 1424
administration and enforcement of sections 3721.28 to 3721.34 of 1425
the Revised Code or for compliance with requirements, 1426

guidelines, or procedures issued by the United States secretary 1427
of health and human services for implementation of section 1819 1428
or 1919 of the "Social Security Act." 1429

(E) No person or government entity shall impose on a nurse 1430
aide any charge for participation in any competency evaluation 1431
program or training and competency evaluation program approved 1432
or conducted by the director under section 3721.31 of the 1433
Revised Code, including any charge for textbooks, other required 1434
course materials, or a competency evaluation. 1435

(F) No person or government entity shall require that an 1436
individual used by the person or government entity as a nurse 1437
aide or seeking employment as a nurse aide pay or repay, either 1438
before or while the individual is employed by the person or 1439
government entity or when the individual leaves the person or 1440
government entity's employ, any costs associated with the 1441
individual's participation in a competency evaluation program or 1442
training and competency evaluation program approved or conducted 1443
by the director. 1444

Sec. 3721.31. (A) (1) ~~Except as provided in division (E) of~~ 1445
~~this section, the~~ The director of health shall approve 1446
~~competency evaluation programs and~~ training and competency 1447
evaluation programs in accordance with rules adopted under 1448
section 3721.30 of the Revised Code and shall periodically 1449
review and reapprove programs approved under this section. 1450

(2) Except as otherwise provided in division (A) (3) of 1451
this section, the director may approve and reapprove programs 1452
conducted by or in long-term care facilities, or by any 1453
government agency or person, including an employee organization. 1454

(3) The director shall not approve or reapprove a 1455

~~competency evaluation program or training and competency~~ 1456
evaluation program conducted by or in a long-term care facility 1457
that was determined by the director or the United States 1458
secretary of health and human services to have been out of 1459
compliance with the requirements of subsection (b), (c), or (d) 1460
of section 1819 or 1919 of the "Social Security Act," 49 Stat. 1461
620 (1935), 42 U.S.C.A. 301, as amended, within a two-year 1462
period prior to making application for approval or reapproval 1463
and shall revoke the approval or reapproval of a program 1464
conducted by or in a facility for which such a determination is 1465
made. This division does not apply to a program conducted by or 1466
in a long-term care facility to which the United States centers 1467
for medicare and medicaid services granted a waiver of the 1468
prohibition on training and competency programs. 1469

(4) A long-term care facility, employee organization, 1470
person, or government entity seeking approval or reapproval of a 1471
~~competency evaluation program or training and competency~~ 1472
evaluation program shall make an application to the director for 1473
approval or reapproval of the program and shall provide any 1474
documentation requested by the director. 1475

(5) The director may conduct inspections and examinations 1476
of approved ~~competency evaluation programs and training and~~ 1477
~~competency evaluation programs, competency evaluation programs~~ 1478
~~and training and competency evaluation programs~~ for which an 1479
application for approval has been submitted under division (A) 1480
(4) of this section, and the sites at which they are or will be 1481
conducted. The director may conduct inspections of long-term 1482
care facilities in which individuals who have participated in 1483
approved ~~competency evaluation programs and training and~~ 1484
competency evaluation programs are being used as nurse aides. 1485

(B) In accordance with Chapter 119. of the Revised Code, 1486
the director may do the following: 1487

(1) Deny, suspend, or revoke approval or reapproval of any 1488
of the following that is not in compliance with this section and 1489
section 3721.30 of the Revised Code and rules adopted 1490
thereunder: 1491

(a) ~~A competency evaluation program;~~ 1492
~~(b) A training and competency evaluation program;~~ 1493
~~(c) (b) A training program for instructors or, ,~~ 1494
coordinators, or evaluators for training and competency 1495
evaluation programs; 1496
~~(d) A training program for evaluators for competency~~ 1497
~~evaluation programs.~~ 1498

(2) Deny a request that the director determine any of the 1499
following for the purposes of division (B) of section 3721.28 of 1500
the Revised Code: 1501

(a) That a program completed prior to the dates specified 1502
in division (B) (3) of section 3721.28 of the Revised Code 1503
included a competency evaluation component no less stringent 1504
than the competency evaluation programs approved or conducted by 1505
the director under this section, and was otherwise comparable to 1506
the training and competency evaluation programs being approved 1507
under this section; 1508

(b) That an individual satisfies division (B) (5) of 1509
section 3721.28 of the Revised Code; 1510

(c) That an individual meets the conditions specified in 1511
division (F) (1) or (2) of section 3721.28 of the Revised Code. 1512

(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,
other than a program operated by a nursing home, to perform
competency evaluations if the program complies with federal laws
and regulations relating to competency evaluations. 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 1543
experience working in a nursing home. 1544

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

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

~~(G)~~ (F) The director shall impose fees prescribed by rules 1568
adopted under section 3721.30 of the Revised Code for both of 1569
the following: 1570

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

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

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

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

(G) If the rules require a participant to furnish a social 1581
security number, the director shall supply a unique identifier 1582
to any participant who does not have a social security number. 1583
If a participant receives a unique identifier from the director 1584
and subsequently receives a social security number, the 1585
participant shall submit the number to the director. 1586

Sec. 3721.32. (A) The director of health shall establish a 1587
state nurse aide registry listing all individuals who have done 1588
any of the following: 1589

(1) Were used by a long-term care facility as nurse aides 1590
on a full-time, temporary, per diem, or other basis at any time 1591
during the period commencing July 1, 1989, and ending January 1, 1592
1990, and successfully completed, not later than October 1, 1593
1990, a competency evaluation program approved by the director 1594
under division (A) of section 3721.31 of the Revised Code or 1595
conducted by the director under division (C) of that section; 1596

(2) Successfully completed a training and competency 1597
evaluation program approved by the director under division (A) 1598
of section 3721.31 of the Revised Code or met the conditions 1599
specified in division (F) (1) or (2) of section 3721.28 of the 1600
Revised Code, and, if the training and competency evaluation 1601

program or the training, instruction, or education the 1602
individual completed in meeting the conditions specified in 1603
division (F) (1) of section 3721.28 of the Revised Code was 1604
conducted in or by a long-term care facility, ~~or if the director~~ 1605
~~so required pursuant to division (E) of section 3721.31 of the~~ 1606
~~Revised Code,~~ has successfully completed a competency evaluation 1607
program conducted by the director; 1608

(3) Successfully completed a training and competency 1609
evaluation program conducted by the director under division (C) 1610
of section 3721.31 of the Revised Code; 1611

(4) Successfully completed, prior to July 1, 1989, a 1612
program that the director has determined under division (B) (3) 1613
of section 3721.28 of the Revised Code included a competency 1614
evaluation component no less stringent than the competency 1615
evaluation programs approved or conducted by the director under 1616
section 3721.31 of the Revised Code, and was otherwise 1617
comparable to the training and competency evaluation program 1618
being approved by the director under section 3721.31 of the 1619
Revised Code; 1620

(5) Are listed in a nurse aide registry maintained by 1621
another state that certifies that its program for training and 1622
evaluation of competency of nurse aides complies with Titles 1623
XVIII and XIX of the "Social Security Act," 49 Stat. 620 (1935), 1624
42 U.S.C.A. 301, as amended, or regulations adopted thereunder; 1625

(6) Were found competent, as provided in division (B) (5) 1626
of section 3721.28 of the Revised Code, prior to July 1, 1989, 1627
after the completion of a course of nurse aide training of at 1628
least one hundred hours' duration; 1629

(7) Are enrolled in a prelicensure program of nursing 1630

education approved by the board of nursing or by an agency of 1631
another state that regulates nursing education, have provided 1632
the long-term care facility with a certificate from the program 1633
indicating that the individual has successfully completed the 1634
courses that teach basic nursing skills including infection 1635
control, safety and emergency procedures, and personal care, and 1636
have successfully completed a competency evaluation program 1637
conducted by the director under division (A) of section 3721.31 1638
of the Revised Code; 1639

(8) Have the equivalent of twelve months or more of full- 1640
time employment in the five years preceding listing in the 1641
registry as a hospital aide or orderly and have successfully 1642
completed a competency evaluation program conducted by the 1643
director under division (C) of section 3721.31 of the Revised 1644
Code; 1645

(9) Successfully completed a prelicensure program of 1646
nursing education approved by the board of nursing under section 1647
4723.06 of the Revised Code or by an agency of another state 1648
that regulates nursing education and passed the examination 1649
accepted by the board of nursing under section 4723.10 of the 1650
Revised Code, which shall be deemed as successfully completing a 1651
competency evaluation program conducted by the director under 1652
division (C) of section 3721.31 of the Revised Code. 1653

(B) In addition to the list of individuals required by 1654
division (A) of this section, the registry shall include both of 1655
the following: 1656

(1) The statement required by section 3721.23 of the 1657
Revised Code detailing findings by the director under that 1658
section regarding alleged abuse, neglect, or exploitation of a 1659
resident or misappropriation of resident property; 1660

(2) Any statement provided by an individual under section 1661
3721.23 of the Revised Code disputing the director's findings. 1662

Whenever an inquiry is received as to the information 1663
contained in the registry concerning an individual about whom a 1664
statement required by section 3721.23 of the Revised Code is 1665
included in the registry, the director shall disclose the 1666
statement or a summary of the statement together with any 1667
statement provided by the individual under section 3721.23 or a 1668
clear and accurate summary of that statement. 1669

(C) The director may by rule specify additional 1670
information that must be provided to the registry by long-term 1671
care facilities and persons or government agencies conducting 1672
approved ~~competency evaluation programs and training and~~ 1673
competency evaluation programs. 1674

(D) Information contained in the registry is a public 1675
record for the purposes of section 149.43 of the Revised Code, 1676
and is subject to inspection and copying under section 1347.08 1677
of the Revised Code. 1678

(E) An individual who is listed on the registry shall be 1679
referred to as a certified nurse aide. Only individuals listed 1680
on the registry shall use the designation "certified nurse aide" 1681
or "CNA." 1682

Sec. 4723.32. This chapter does not prohibit any of the 1683
following: 1684

(A) The practice of nursing by a student currently 1685
enrolled in and actively pursuing completion of a prelicensure 1686
nursing education program, if all of the following are the case: 1687

(1) The student is participating in a program located in 1688
this state and approved by the board of nursing or participating 1689

in this state in a component of a program located in another 1690
jurisdiction and approved by a board that is a member of the 1691
national council of state boards of nursing; 1692

(2) The student's practice is under the auspices of the 1693
program; 1694

(3) The student acts under the supervision of a registered 1695
nurse serving for the program as a faculty member or teaching 1696
assistant. 1697

(B) The rendering of medical assistance to a licensed 1698
physician, licensed dentist, or licensed podiatrist by a person 1699
under the direction, supervision, and control of such licensed 1700
physician, dentist, or podiatrist; 1701

(C) The activities of persons employed as nursing aides, 1702
attendants, orderlies, or other auxiliary workers in patient 1703
homes, nurseries, nursing homes, hospitals, home health 1704
agencies, or other similar institutions; 1705

(D) The provision of nursing services to family members or 1706
in emergency situations; 1707

(E) The care of the sick when done in connection with the 1708
practice of religious tenets of any church and by or for its 1709
members; 1710

(F) The practice of nursing as an advanced practice 1711
registered nurse by a student currently enrolled in and actively 1712
pursuing completion of a program of study leading to initial 1713
authorization by the board of nursing to practice nursing as an 1714
advanced practice registered nurse in a designated specialty, if 1715
all of the following are the case: 1716

(1) The program qualifies the student to sit for the 1717

examination of a national certifying organization approved by 1718
the board under section 4723.46 of the Revised Code or the 1719
program prepares the student to receive a master's or doctoral 1720
degree in accordance with division (A) (2) of section 4723.41 of 1721
the Revised Code; 1722

(2) The student's practice is under the auspices of the 1723
program; 1724

(3) The student acts under the supervision of an advanced 1725
practice registered nurse serving for the program as a faculty 1726
member, teaching assistant, or preceptor. 1727

(G) The activities of an individual who is a resident of a 1728
state other than this state and who currently holds a license to 1729
practice nursing or equivalent authorization from another 1730
jurisdiction, but only if the individual's activities are 1731
limited to those activities that the same type of nurse may 1732
engage in pursuant to a license issued under this chapter, the 1733
individual's authority to practice has not been revoked, the 1734
individual is not currently under suspension or on probation, 1735
the individual does not represent the individual as being 1736
licensed under this chapter, and one of the following is the 1737
case: 1738

(1) The individual is engaging in the practice of nursing 1739
by discharging official duties while employed by or under 1740
contract with the United States government or any agency 1741
thereof; 1742

(2) The individual is engaging in the practice of nursing 1743
as an employee of an individual, agency, or corporation located 1744
in the other jurisdiction in a position with employment 1745
responsibilities that include transporting patients into, out 1746

of, or through this state, as long as each trip in this state 1747
does not exceed seventy-two hours; 1748

(3) The individual is consulting with an individual 1749
licensed in this state to practice any health-related 1750
profession; 1751

(4) The individual is engaging in activities associated 1752
with teaching in this state as a guest lecturer at or for a 1753
nursing education program, continuing nursing education program, 1754
or in-service presentation; 1755

(5) The individual is conducting evaluations of nursing 1756
care that are undertaken on behalf of an accrediting 1757
organization, including the national league for nursing 1758
accrediting committee, the joint commission (formerly known as 1759
the joint commission on accreditation of healthcare 1760
organizations), or any other nationally recognized accrediting 1761
organization; 1762

(6) The individual is providing nursing care to an 1763
individual who is in this state on a temporary basis, not to 1764
exceed six months in any one calendar year, if the nurse is 1765
directly employed by or under contract with the individual or a 1766
guardian or other person acting on the individual's behalf; 1767

(7) The individual is providing nursing care during any 1768
disaster, natural or otherwise, that has been officially 1769
declared to be a disaster by a public announcement issued by an 1770
appropriate federal, state, county, or municipal official; 1771

(8) The individual is providing nursing care at a free-of- 1772
charge camp accredited by the SeriousFun children's network that 1773
specializes in providing therapeutic recreation, as defined in 1774
section 2305.231 of the Revised Code, for individuals with 1775

chronic diseases, if all of the following are the case: 1776

(a) The individual provides documentation to the medical 1777
director of the camp that the individual holds a current, valid 1778
license to practice nursing or equivalent authorization from 1779
another jurisdiction. 1780

(b) The individual provides nursing care only at the camp 1781
or in connection with camp events or activities that occur off 1782
the grounds of the camp. 1783

(c) The individual is not compensated for the individual's 1784
services. 1785

(d) The individual provides nursing care within this state 1786
for not more than thirty days per calendar year. 1787

(e) The camp has a medical director who holds an 1788
unrestricted license to practice medicine issued in accordance 1789
with Chapter 4731. of the Revised Code. 1790

(9) The individual is providing nursing care as a 1791
volunteer without remuneration during a charitable event that 1792
lasts not more than seven days if both of the following are the 1793
case: 1794

(a) The individual, or the charitable event's organizer, 1795
notifies the board of nursing not less than seven calendar days 1796
before the first day of the charitable event of the individual's 1797
intent to engage in the practice of nursing as a registered 1798
nurse, advanced practice registered nurse, or licensed practical 1799
nurse at the event; 1800

(b) If the individual's scope of practice in the other 1801
jurisdiction is more restrictive than in this state, the 1802
individual is limited to performing only those procedures that a 1803

registered nurse, advanced practice registered nurse, or 1804
licensed practical nurse in the other jurisdiction may perform. 1805

(H) The administration of medication by an individual who 1806
holds a valid medication aide certificate issued under this 1807
chapter, if the medication is administered to a resident of a 1808
nursing home, ~~or residential care facility, or ICF/IID~~ 1809
~~authorized by section 4723.64 of the Revised Code to use a~~ 1810
~~certified medication aide~~ and the medication is administered in 1811
accordance with section 4723.67 of the Revised Code. 1812

(I) An individual who is a resident of a state other than 1813
this state and who holds a license to practice nursing or 1814
equivalent authorization from another jurisdiction is not 1815
required to obtain a license in accordance with Chapter 4796. of 1816
the Revised Code to perform the activities described under 1817
division (G) of this section. 1818

Sec. 4723.61. As used in this section and in sections 1819
4723.64 to 4723.69 of the Revised Code: 1820

(A) ~~"Intermediate care facility for individuals with~~ 1821
~~intellectual disabilities" and "ICF/IID" have the same meanings~~ 1822
~~as in section 5124.01 of the Revised Code.~~ "Contact hour" means 1823
sixty minutes of continuing education, which may be determined 1824
by rounding to the nearest quarter hour. 1825

(B) "Medication" means a drug, as defined in section 1826
4729.01 of the Revised Code. 1827

(C) ~~"Medication error" means a failure to follow the~~ 1828
~~prescriber's instructions when administering a prescription~~ 1829
~~medication.~~ 1830

~~(D)~~ "Nursing home" and "residential care facility" have 1831
the same meanings as in section 3721.01 of the Revised Code. 1832

~~(E)~~ (D) "Prescription medication" means a medication that 1833
may be dispensed only pursuant to a prescription. 1834

~~(F)~~ (E) "Prescriber" and "prescription" have the same 1835
meanings as in section 4729.01 of the Revised Code. 1836

Sec. 4723.64. A nursing home or residential care 1837
facility, ~~or ICF/IID~~ may use one or more medication aides to 1838
administer prescription medications to its residents, subject to 1839
both of the following conditions: 1840

(A) Each individual used as a medication aide must hold a 1841
current, valid medication aide certificate issued by the board 1842
of nursing under this chapter. 1843

(B) The nursing home or residential care facility, ~~or~~ 1844
~~ICF/IID~~ shall ensure that the requirements of section 4723.67 of 1845
the Revised Code are met. 1846

Sec. 4723.65. An individual seeking certification as a 1847
medication aide shall apply to the board of nursing on a form 1848
prescribed and provided by the board. The application shall be 1849
accompanied by ~~the a~~ certification fee ~~established in rules~~ 1850
~~adopted under section 4723.69 of the Revised Code~~ of fifty 1851
dollars. 1852

Sec. 4723.651. (A) To be eligible to receive a medication 1853
aide certificate, an applicant shall meet all of the following 1854
conditions: 1855

(1) Be at least eighteen years of age; 1856

(2) Have a high school diploma or a certificate of high 1857
school equivalence as defined in section 5107.40 of the Revised 1858
Code; 1859

(3) ~~If the applicant is to practice as a medication aide~~ 1860

~~in a nursing home, be a nurse aide who satisfies the~~ 1861
~~requirements of division (A) (1), (2), (3), (4), (5), (6), or (8)~~ 1862
~~of section 3721.32 of the Revised Code;~~ 1863

~~(4) If the applicant is to practice as a medication aide~~ 1864
~~in a residential care facility, be a nurse aide who satisfies~~ 1865
~~the requirements of division (A) (1), (2), (3), (4), (5), (6), or~~ 1866
~~(8) of section 3721.32 of the Revised Code or an individual who~~ 1867
~~has at least one year of direct care experience in a residential~~ 1868
~~care facility;~~ 1869

~~(5) If the applicant is to practice as a medication aide~~ 1870
~~in an ICF/IID, be a nurse aide who satisfies the requirements of~~ 1871
~~division (A) (1), (2), (3), (4), (5), (6), or (8) of section~~ 1872
~~3721.32 of the Revised Code or an individual who has at least~~ 1873
~~one year of direct care experience in an ICF/IID;~~ 1874

~~(6) Successfully complete the course of instruction~~ 1875
~~provided by a training program approved under section 4723.66 of~~ 1876
~~the Revised Code;~~ 1877

~~(7) Not be ineligible for licensure or certification in~~ 1878
~~accordance with section 4723.092 of the Revised Code;~~ 1879

~~(8) Have not committed any act that is grounds for~~ 1880
~~disciplinary action under section 3123.47 or 4723.28 of the~~ 1881
~~Revised Code or be determined by the board to have made~~ 1882
~~restitution, been rehabilitated, or both;~~ 1883

~~(9) (4) Meet all other the requirements for a medication~~ 1884
~~aide certificate established in rules adopted providing direct~~ 1885
~~care under section 4723.69 of the Revised Code.~~ 1886

(B) Except as provided in division (C) of this section, if 1887
an applicant meets the requirements specified in division (A) of 1888
this section, the board of nursing shall issue a medication aide 1889

certificate to the applicant. ~~If a medication aide certificate~~ 1890
~~is issued to an individual on the basis of having at least one~~ 1891
~~year of direct care experience working in a residential care~~ 1892
~~facility, as provided in division (A) (4) of this section, the~~ 1893
~~certificate is valid for use only in a residential care~~ 1894
~~facility. If a medication aide certificate is issued to an~~ 1895
~~individual on the basis of having at least one year of direct~~ 1896
~~care experience working in an ICF/IID, as provided in division~~ 1897
~~(A) (5) of this section, the certificate is valid for use only in~~ 1898
~~an ICF/IID. The board shall state the limitation on the~~ 1899
~~certificate issued to the individual.~~ 1900

(C) The board shall issue a medication aide certificate in 1901
accordance with Chapter 4796. of the Revised Code to an 1902
applicant if either of the following applies: 1903

(1) The applicant holds a certificate or license in 1904
another state. 1905

(2) The applicant has satisfactory work experience, a 1906
government certification, or a private certification as 1907
described in that chapter as a medication aide in a state that 1908
does not issue that certificate or license. 1909

(D) A medication aide certificate is valid for two years, ~~—~~ 1910
~~unless earlier suspended or revoked. The certificate may be~~ 1911
~~renewed in accordance with procedures specified by the board in~~ 1912
~~rules adopted under section 4723.69 of the Revised Code. To be~~ 1913
~~eligible for renewal, an applicant shall pay the renewal fee~~ 1914
~~established in the rules and meet all renewal qualifications~~ 1915
~~specified in the rules. All of the following apply to renewal:~~ 1916

(1) The board shall provide each holder of a medication 1917
aide certificate the option to renew through the mail or by 1918

accessing, completing, and submitting a renewal application 1919
online. The board is not required to provide an individual such 1920
options if it is aware that the holder is ineligible for 1921
renewal. 1922

(2) To be eligible for renewal, an applicant shall do all 1923
of the following: 1924

(a) Submit on or before the thirtieth day of April of an 1925
even-numbered year a completed renewal application; 1926

(b) Pay the renewal fee in an amount as follows: 1927

(i) For an application submitted on or before the first 1928
day of March of an even-numbered year, fifty dollars; 1929

(ii) For an application submitted after the first day of 1930
March, but before the first day of May, of an even-numbered 1931
year, one hundred dollars. 1932

(c) Demonstrate to the board that the applicant 1933
successfully completed eight contact hours that included at 1934
least the following: 1935

(i) One hour directly related to this chapter and any 1936
rules adopted under it; 1937

(ii) One hour directly related to establishing and 1938
maintaining professional boundaries; 1939

(iii) Six hours related to medications or the 1940
administration of prescription medications. 1941

Sec. 4723.653. (A) A person who holds a current, valid 1942
certificate as a medication aide shall be known as a "certified 1943
medication aide" or "CMA." The board of nursing shall establish 1944
and maintain a registry of certified medication aides and make 1945

the registry available on its internet web site.

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(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.

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~~(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.

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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.

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(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:

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(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;~~

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(2) A mechanism for evaluating whether an individual's

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reading, writing, and mathematical skills are sufficient for the 1975
individual to be able to administer prescription medications 1976
safely; 1977

(3) An examination that tests the ability to administer 1978
prescription medications safely ~~and that meets the requirements~~ 1979
~~established by the board in rules adopted under section 4723.69~~ 1980
~~of the Revised Code. The examination may be administered by the~~ 1981
program that provides the instruction required by division (B) 1982
(1) of this section. 1983

(C) The board shall deny the application for approval if 1984
an applicant submits or causes to be submitted to the board 1985
false, misleading, or deceptive statements, information, or 1986
documentation in the process of applying for approval of the 1987
program. 1988

~~(D)(1)-(D)~~ The board may deny, suspend, or revoke the 1989
approval granted to a medication aide training program for 1990
~~reasons specified in rules adopted under section 4723.69 of the~~ 1991
Revised Code failure to meet any of the standards specified in 1992
division (B) of this section. 1993

~~(2) The board may deny the application for approval if the~~ 1994
~~program is controlled by a person who controls or has controlled~~ 1995
~~a program that had its approval withdrawn, revoked, suspended,~~ 1996
~~or restricted by the board or a board of another jurisdiction~~ 1997
~~that is a member of the national council of state boards of~~ 1998
~~nursing. As used in division (D)(2) of this section, "control"~~ 1999
~~means any of the following:~~ 2000

~~(a) Holding fifty per cent or more of the program's~~ 2001
~~outstanding voting securities or membership interest;~~ 2002

~~(b) In the case of a program that is not incorporated,~~ 2003

~~having the right to fifty per cent or more of the program's~~ 2004
~~profits or in the event of a dissolution, fifty per cent or more~~ 2005
~~of the program's assets;~~ 2006

~~(c) In the case of a program that is a for-profit or not-~~ 2007
~~for-profit corporation, having the contractual authority~~ 2008
~~presently to designate fifty per cent or more of the program's~~ 2009
~~directors;~~ 2010

~~(d) In the case of a program that is a trust, having the~~ 2011
~~contractual authority presently to designate fifty per cent or~~ 2012
~~more of the program's trustees;~~ 2013

~~(e) Having the authority to direct the program's~~ 2014
~~management, policies, or investments.~~ 2015

~~(E) Except as otherwise provided in this division, all~~ All 2016
~~actions taken by the board to deny, suspend, or revoke the~~ 2017
~~approval of a training program shall be taken in accordance with~~ 2018
~~Chapter 119. of the Revised Code.~~ 2019

~~When an action taken by the board is required to be taken~~ 2020
~~pursuant to an adjudication conducted under Chapter 119. of the~~ 2021
~~Revised Code, the board may, in lieu of an adjudication hearing,~~ 2022
~~enter into a consent agreement to resolve the matter. A consent-~~ 2023
~~agreement, when ratified by a vote of a quorum of the board,~~ 2024
~~constitutes the findings and order of the board with respect to~~ 2025
~~the matter addressed in the agreement. If the board refuses to~~ 2026
~~ratify a consent agreement, the admissions and findings~~ 2027
~~contained in the agreement are of no effect.~~ 2028

~~In any instance in which the board is required under~~ 2029
~~Chapter 119. of the Revised Code to give notice to a program of~~ 2030
~~an opportunity for a hearing and the program does not make a~~ 2031
~~timely request for a hearing in accordance with section 119.07-~~ 2032

~~of the Revised Code, the board is not required to hold a~~ 2033
~~hearing, but may adopt, by a vote of a quorum, a final order~~ 2034
~~that contains the board's findings.~~ 2035

~~(F) When the board denies, suspends, or revokes approval~~ 2036
~~of a program, the board may specify that its action is~~ 2037
~~permanent. A program subject to a permanent action taken by the~~ 2038
~~board is forever ineligible for approval and the board shall not~~ 2039
~~accept an application for the program's reinstatement or~~ 2040
~~approval.~~ 2041

Sec. 4723.67. (A) ~~Except for the prescription medications~~ 2042
~~specified in division (C) of this section and the methods of~~ 2043
~~medication administration specified in division (D) of~~ In 2044
accordance with this section, a medication aide who holds a 2045
current, valid medication aide certificate issued under this 2046
chapter may administer prescription medications to the residents 2047
of nursing homes, and residential care facilities, ~~and ICFs/IID~~ 2048
~~that use medication aides pursuant to section 4723.64 of the~~ 2049
~~Revised Code. A medication aide shall administer prescription~~ 2050
~~medications but only pursuant to the delegation supervision of a~~ 2051
registered nurse or a licensed practical nurse acting at the 2052
direction of a registered nurse. 2053

~~Delegation of medication administration to a medication~~ 2054
~~aide shall be carried out in accordance with the rules for~~ 2055
~~nursing delegation adopted under this chapter by the board of~~ 2056
~~nursing. A nurse who has delegated to a medication aide~~ 2057
~~responsibility for the administration of prescription~~ 2058
~~medications to the residents of a nursing home, residential care~~ 2059
~~facility, or ICF/IID shall not withdraw the delegation on an~~ 2060
~~arbitrary basis or for any purpose other than patient safety.~~ 2061

(B) In exercising the authority to administer prescription 2062

medications pursuant to nursing ~~delegation~~supervision, a 2063
medication aide may administer prescription medications in any 2064
of the following categories: 2065

- (1) Oral medications; 2066
- (2) Topical medications; 2067
- (3) Medications administered as drops to the eye, ear, or 2068
nose; 2069
- (4) Rectal and vaginal medications; 2070
- (5) Medications prescribed with a designation authorizing 2071
or requiring administration on an as-needed basis, ~~but only if a~~ 2072
~~nursing assessment of the patient is completed before the~~ 2073
~~medication is administered regardless of whether the supervising~~ 2074
~~nurse is present at the facility.~~ 2075

(C) A medication aide shall not administer prescription 2076
medications ~~in either of the following categories:~~ 2077

- ~~(1) Medications containing a schedule II controlled~~ 2078
~~substance, as defined in section 3719.01 of the Revised Code,~~ 2079
- ~~(2) Medications requiring dosage calculations.~~ 2080

(D) A medication aide shall not administer prescription 2081
medications by any of the following methods: 2082

- (1) Injection, except for insulin as provided in division 2083
(E) of this section; 2084

- (2) Intravenous therapy procedures; 2085
- (3) Splitting pills for purposes of changing the dose 2086
being given. 2087

(E) ~~A nursing home, residential care facility, or ICF/IID~~ 2088

~~that uses medication aides shall ensure that medication aides do~~ 2089
~~not have access to any schedule II controlled substances within~~ 2090
~~the home, facility, or ICF/IID for use by its~~ 2091
~~residents.~~ medication aide may administer insulin to a resident by 2092
injection, but only if both of the following are satisfied: 2093

(1) The medication aide satisfies training and competency 2094
requirements established by the aide's employer. 2095

(2) The insulin is injected using an insulin pen device 2096
that contains a dosage indicator. 2097

Sec. 4723.68. ~~(A)~~ A registered nurse, or licensed 2098
practical nurse acting at the direction of a registered nurse, 2099
who ~~delegates~~ supervises medication administration ~~to by a~~ 2100
medication aide who holds a current, valid medication aide 2101
certificate issued under this chapter is not liable in damages 2102
to any person or government entity in a civil action for injury, 2103
death, or loss to person or property that allegedly arises from 2104
an action or omission of the medication aide in performing the 2105
medication administration, if the ~~delegating~~ supervising nurse 2106
~~delegates~~ supervises the medication administration in accordance 2107
with ~~this chapter and the rules adopted under this~~ 2108
~~chapter~~ standards applicable to a nurse's supervision of health 2109
care provided by others. 2110

~~(B) A person employed by a nursing home, residential care~~ 2111
~~facility, or ICF/IID that uses medication aides pursuant to~~ 2112
~~section 4723.64 of the Revised Code who reports in good faith a~~ 2113
~~medication error at the nursing home, residential care facility,~~ 2114
~~or ICF/IID is not subject to disciplinary action by the board of~~ 2115
~~nursing or any other government entity regulating that person's~~ 2116
~~professional practice and is not liable in damages to any person~~ 2117
~~or government entity in a civil action for injury, death, or~~ 2118

~~loss to person or property that allegedly results from reporting~~ 2119
~~the medication error.~~ 2120

Sec. 4723.69. ~~(A)~~ The board of nursing ~~shall~~ may adopt 2121
rules to implement sections 4723.61 to 4723.68 of the Revised 2122
Code. All rules adopted under this section shall be adopted in 2123
accordance with Chapter 119. of the Revised Code. 2124

~~(B) The rules adopted under this section shall establish~~ 2125
~~or specify all of the following:~~ 2126

~~(1) Fees, in an amount sufficient to cover the costs the~~ 2127
~~board incurs in implementing sections 4723.61 to 4723.68 of the~~ 2128
~~Revised Code, for certification as a medication aide and~~ 2129
~~approval of a medication aide training program;~~ 2130

~~(2) Requirements to obtain a medication aide certificate~~ 2131
~~that are not otherwise specified in section 4723.651 of the~~ 2132
~~Revised Code;~~ 2133

~~(3) Procedures for renewal of medication aide~~ 2134
~~certificates;~~ 2135

~~(4) The extent to which the board determines that the~~ 2136
~~reasons for taking disciplinary actions under section 4723.28 of~~ 2137
~~the Revised Code are applicable reasons for taking disciplinary~~ 2138
~~actions under section 4723.652 of the Revised Code against an~~ 2139
~~applicant for or holder of a medication aide certificate;~~ 2140

~~(5) Standards for medication aide training programs,~~ 2141
~~including the examination to be administered by the training~~ 2142
~~program to test an individual's ability to administer~~ 2143
~~prescription medications safely;~~ 2144

~~(6) Standards for approval of continuing education~~ 2145
~~programs and courses for medication aides;~~ 2146

~~(7) Reasons for denying, revoking, or suspending approval~~ 2147
~~of a medication aide training program;~~ 2148

~~(8) Other standards and procedures the board considers~~ 2149
~~necessary to implement sections 4723.61 to 4723.68 of the~~ 2150
~~Revised Code.~~ 2151

Sec. 4729.41. (A) (1) A pharmacist licensed under this 2152
chapter who meets the requirements of division (B) of this 2153
section, ~~and a pharmacy intern licensed under this chapter who~~ 2154
meets the requirements of division (B) of this section and is 2155
working under the direct supervision of a pharmacist who meets 2156
the requirements of that division, and a certified pharmacy 2157
technician or a registered pharmacy technician who meets the 2158
requirements of division (B) of this section and is working 2159
under the direct supervision of a pharmacist who meets the 2160
requirements of that division, may do any of the following: 2161

~~(a) In the case of administer to an individual who is~~ 2162
~~seven five years of age or older but not more than thirteen~~ 2163
~~years of age, administer to the individual an immunization for~~ 2164
~~any of the following:~~ 2165

~~(i) Influenza;~~ 2166

~~(ii) COVID-19;~~ 2167

~~(iii) Any other disease, but only pursuant to a~~ 2168
~~prescription.~~ 2169

~~(b) In the case of an individual who is thirteen years of~~ 2170
~~age or older, administer to the individual an immunization for~~ 2171
any disease, including an immunization for influenza or COVID- 2172
19. 2173

(2) As part of engaging in the administration of 2174

immunizations or supervising a pharmacy intern's, certified 2175
pharmacy technician's, or registered pharmacy technician's 2176
administration of immunizations, a pharmacist may administer 2177
epinephrine or diphenhydramine, or both, to individuals in 2178
emergency situations resulting from adverse reactions to the 2179
immunizations administered by the pharmacist ~~or, pharmacy~~ 2180
intern, certified pharmacy technician, or registered pharmacy 2181
technician. 2182

(B) For a pharmacist ~~or, pharmacy intern, certified~~ 2183
pharmacy technician, or registered pharmacy technician to be 2184
authorized to engage in the administration of immunizations, the 2185
pharmacist ~~or, pharmacy intern, certified pharmacy technician,~~ 2186
or registered pharmacy technician shall do all of the following: 2187

(1) Successfully complete a course in the administration 2188
of immunizations that meets the requirements established in 2189
rules adopted under this section for such courses; 2190

(2) Receive and maintain certification to perform basic 2191
life-support procedures by successfully completing a basic life- 2192
support training course that is certified by the American red 2193
cross or American heart association or approved by the state 2194
board of pharmacy; 2195

(3) Practice in accordance with a protocol that meets the 2196
requirements of division (C) of this section. 2197

(C) All of the following apply with respect to the 2198
protocol required by division (B) (3) of this section: 2199

(1) The protocol shall be established by a physician 2200
authorized under Chapter 4731. of the Revised Code to practice 2201
medicine and surgery or osteopathic medicine and surgery. 2202

(2) The protocol shall specify a definitive set of 2203

treatment guidelines and the locations at which a pharmacist ~~or~~ 2204
, pharmacy intern, certified pharmacy technician, or registered 2205
pharmacy technician may engage in the administration of 2206
immunizations. 2207

(3) The protocol shall satisfy the requirements 2208
established in rules adopted under this section for protocols. 2209

(4) The protocol shall include provisions for 2210
implementation of the following requirements: 2211

(a) The pharmacist ~~or~~, pharmacy intern, certified 2212
pharmacy technician, or registered pharmacy technician who 2213
administers an immunization shall observe the individual who 2214
receives the immunization to determine whether the individual 2215
has an adverse reaction to the immunization. The length of time 2216
and location of the observation shall comply with the rules 2217
adopted under this section establishing requirements for 2218
protocols. The protocol shall specify procedures to be followed 2219
by a pharmacist when administering epinephrine~~, or~~ 2220
diphenhydramine, or both, to an individual who has an adverse 2221
reaction to an immunization administered by the pharmacist or by 2222
a pharmacy intern, certified pharmacy technician, or registered 2223
pharmacy technician. 2224

(b) For each immunization administered to an individual by 2225
a pharmacist ~~or~~, pharmacy intern, certified pharmacy 2226
technician, or registered pharmacy technician, other than an 2227
immunization for influenza administered to an individual 2228
eighteen years of age or older, the pharmacist ~~or~~, pharmacy 2229
intern, certified pharmacy technician, or registered pharmacy 2230
technician shall notify the individual's primary care provider 2231
or, if the individual has no primary care provider, the board of 2232
health of the health district in which the individual resides or 2233

the authority having the duties of a board of health for that 2234
district under section 3709.05 of the Revised Code. The notice 2235
shall be given not later than thirty days after the immunization 2236
is administered. 2237

(c) For each immunization administered by a pharmacist~~or~~ 2238
, pharmacy intern, certified pharmacy technician, or registered 2239
pharmacy technician to an individual younger than eighteen years 2240
of age, the pharmacist~~or~~, a pharmacy intern, certified 2241
pharmacy technician, or registered pharmacy technician shall 2242
obtain permission from the individual's parent or legal guardian 2243
in accordance with the procedures specified in rules adopted 2244
under this section. 2245

(d) For each immunization administered by a pharmacist, 2246
pharmacy intern, certified pharmacy technician, or registered 2247
pharmacy technician to an individual who is younger than 2248
eighteen years of age, the pharmacist, pharmacy intern, 2249
certified pharmacy technician, or registered pharmacy technician 2250
shall inform the individual's parent or legal guardian of the 2251
importance of well child visits with a pediatrician or other 2252
primary care provider and shall refer patients when appropriate. 2253

(D) (1) No pharmacist shall do either of the following: 2254

(a) Engage in the administration of immunizations unless 2255
the requirements of division (B) of this section have been met; 2256

(b) Delegate to any person the pharmacist's authority to 2257
engage in or supervise the administration of immunizations. 2258

(2) No pharmacy intern shall engage in the administration 2259
of immunizations unless the requirements of division (B) of this 2260
section have been met. 2261

(3) No certified pharmacy technician or registered 2262

pharmacy technician shall engage in the administration of 2263
immunizations unless the requirements of division (B) of this 2264
section have been met. 2265

(E) (1) The state board of pharmacy shall adopt rules to 2266
implement this section. The rules shall be adopted in accordance 2267
with Chapter 119. of the Revised Code and shall include the 2268
following: 2269

(a) Requirements for courses in administration of 2270
immunizations, including requirements that are consistent with 2271
any standards established for such courses by the centers for 2272
disease control and prevention; 2273

(b) Requirements for protocols to be followed by 2274
~~pharmacists and~~, pharmacy interns, certified pharmacy 2275
technicians, and registered pharmacy technicians in engaging in 2276
the administration of immunizations; 2277

(c) Procedures to be followed by ~~pharmacists and~~, 2278
pharmacy interns, certified pharmacy technicians, and registered 2279
pharmacy technicians in obtaining from the individual's parent 2280
or legal guardian permission to administer immunizations to an 2281
individual younger than eighteen years of age. 2282

(2) Prior to adopting rules regarding requirements for 2283
protocols to be followed by ~~pharmacists and~~, pharmacy interns, 2284
certified pharmacy technicians, and registered pharmacy 2285
technicians in engaging in the administration of immunizations, 2286
the state board of pharmacy shall consult with the state medical 2287
board and the board of nursing. 2288

Sec. 5124.15. (A) Except as otherwise provided by section 2289
5124.101 of the Revised Code, sections 5124.151 to 5124.154 of 2290
the Revised Code, and ~~divisions~~ division (B) ~~and (C)~~ of this 2291

section, the total per medicaid day payment rate that the 2292
department of developmental disabilities shall pay to an ICF/IID 2293
provider for ICF/IID services the provider's ICF/IID provides 2294
during a fiscal year shall equal the sum of all of the 2295
following: 2296

(1) The per medicaid day capital component rate determined 2297
for the ICF/IID under section 5124.17 of the Revised Code; 2298

(2) The per medicaid day direct care costs component rate 2299
determined for the ICF/IID under section 5124.19 of the Revised 2300
Code; 2301

(3) The per medicaid day indirect care costs component 2302
rate determined for the ICF/IID under section 5124.21 of the 2303
Revised Code; 2304

(4) The per medicaid day other protected costs component 2305
rate determined for the ICF/IID under section 5124.23 of the 2306
Revised Code; 2307

(5) The sum of the following: 2308

(a) The per medicaid day quality incentive payment 2309
determined for the ICF/IID under section 5124.24 of the Revised 2310
Code; 2311

(b) A direct support personnel payment equal to two and 2312
four-hundredths per cent of the ICF/IID's desk-reviewed, actual, 2313
allowable, per medicaid day direct care costs from the 2314
applicable cost report year; 2315

(c) A professional workforce development payment equal to 2316
thirteen and fifty-five hundredths for state fiscal year 2024 2317
and twenty and eighty-one hundredths during fiscal year 2025 per 2318
cent of the ICF/IID's desk-reviewed, actual, allowable, per 2319

medicaid day direct care costs from the applicable cost report 2320
year. 2321

~~(B) The total per medicaid day payment rate for an ICF/IID 2322
that is in peer group 5 shall not exceed the average total per 2323
medicaid day payment rate in effect on July 1, 2013, for 2324
developmental centers. 2325~~

~~(C)~~ The department shall adjust the total per medicaid day 2326
payment rate otherwise determined for an ICF/IID under this 2327
section as directed by the general assembly through the 2328
enactment of law governing medicaid payments to ICF/IID 2329
providers. 2330

~~(D) (1)~~ (C) (1) In addition to paying an ICF/IID provider 2331
the total per medicaid day payment rate determined for the 2332
provider's ICF/IID under divisions (A) and (B) ~~and (C)~~ of this 2333
section for a fiscal year, the department may do either or both 2334
of the following: 2335

(a) In accordance with section 5124.25 of the Revised 2336
Code, pay the provider a rate add-on for ventilator-dependent 2337
outlier ICF/IID services if the rate add-on is to be paid under 2338
that section and the department approves the provider's 2339
application for the rate add-on; 2340

(b) In accordance with section 5124.26 of the Revised 2341
Code, pay the provider for outlier ICF/IID services the ICF/IID 2342
provides to residents identified as needing intensive behavioral 2343
health support services if the rate add-on is to be paid under 2344
that section and the department approves the provider's 2345
application for the rate add-on. 2346

(2) The rate add-ons are not to be part of the ICF/IID's 2347
total per medicaid day payment rate. 2348

Sec. 5124.151. (A) The total per medicaid day payment rate 2349
determined under section 5124.15 of the Revised Code shall not 2350
be the initial rate for ICF/IID services provided by a new 2351
ICF/IID. Instead, the initial total per medicaid day payment 2352
rate for ICF/IID services provided by a new ICF/IID shall be 2353
determined in accordance with this section. 2354

(B) The initial total per medicaid day payment rate for 2355
ICF/IID services provided by a new ICF/IID, ~~other than an~~ 2356
~~ICF/IID in peer group 5,~~ shall be determined in the following 2357
manner: 2358

(1) The initial per medicaid day capital component rate 2359
shall be the median per medicaid day capital component rate for 2360
the ICF/IID's peer group for the fiscal year. 2361

(2) The initial per medicaid day direct care costs 2362
component rate shall be determined as follows: 2363

(a) If there are no cost or resident assessment data for 2364
the new ICF/IID as necessary to determine a rate under section 2365
5124.19 of the Revised Code, the rate shall be determined as 2366
follows: 2367

(i) Determine the median cost per case-mix unit under 2368
division (B) of section 5124.19 of the Revised Code for the new 2369
ICF/IID's peer group for the applicable cost report year; 2370

(ii) Multiply the amount determined under division (B) (2) 2371
(a) (i) of this section by the median annual average case-mix 2372
score for the new ICF/IID's peer group for that period; 2373

(iii) Adjust the product determined under division (B) (2) 2374
(a) (ii) of this section by the rate of inflation estimated under 2375
division (D) of section 5124.19 of the Revised Code. 2376

(b) If the new ICF/IID is a replacement ICF/IID and the 2377
ICF/IID or ICFs/IID that are being replaced are in operation 2378
immediately before the new ICF/IID opens, the rate shall be the 2379
same as the rate for the replaced ICF/IID or ICFs/IID, 2380
proportionate to the number of ICF/IID beds in each replaced 2381
ICF/IID. 2382

(c) If the new ICF/IID is a replacement ICF/IID and the 2383
ICF/IID or ICFs/IID that are being replaced are not in operation 2384
immediately before the new ICF/IID opens, the rate shall be 2385
determined under division (B) (2) (a) of this section. 2386

(3) The initial per medicaid day indirect care costs 2387
component rate shall be the maximum rate for the new ICF/IID's 2388
peer group as determined for the fiscal year in accordance with 2389
division (C) of section 5124.21 of the Revised Code. 2390

(4) The initial per medicaid day other protected costs 2391
component rate shall be one hundred fifteen per cent of the 2392
median rate for ICFs/IID determined for the fiscal year under 2393
section 5124.23 of the Revised Code. 2394

~~(C) The initial total medicaid day payment rate for 2395~~
~~ICF/IID services provided by a new ICF/IID in peer group 5 shall 2396~~
~~be determined in the following manner: 2397~~

~~(1) The initial per medicaid day capital component rate 2398~~
~~shall be \$29.61. 2399~~

~~(2) The initial per medicaid day direct care costs 2400~~
~~component rate shall be \$264.89. 2401~~

~~(3) The initial per medicaid day indirect care costs 2402~~
~~component rate shall be \$59.85. 2403~~

~~(4) The initial per medicaid day other protected costs 2404~~

~~component rate shall be \$25.99.~~ 2405

~~(D) (1)~~ (C) (1) Except as provided in division ~~(D) (2)~~ (C) (2) 2406
of this section, the department of developmental disabilities 2407
shall adjust a new ICF/IID's initial total per medicaid day 2408
payment rate determined under this section effective the first 2409
day of July, to reflect new rate determinations for all ICFs/IID 2410
under this chapter. 2411

(2) If the department accepts, under division (A) of 2412
section 5124.101 of the Revised Code, a cost report filed by the 2413
provider of a new ICF/IID, the department shall adjust the 2414
ICF/IID's initial total per medicaid day payment rate in 2415
accordance with divisions (E) and (F) of that section rather 2416
than division ~~(D) (1)~~ (C) (1) of this section. 2417

Sec. 5165.01. As used in this chapter: 2418

(A) "Affiliated operator" means an operator affiliated 2419
with either of the following: 2420

(1) The exiting operator for whom the affiliated operator 2421
is to assume liability for the entire amount of the exiting 2422
operator's debt under the medicaid program or the portion of the 2423
debt that represents the franchise permit fee the exiting 2424
operator owes; 2425

(2) The entering operator involved in the change of 2426
operator with the exiting operator specified in division (A) (1) 2427
of this section. 2428

(B) "Allowable costs" are a nursing facility's costs that 2429
the department of medicaid determines are reasonable. Fines paid 2430
under sections 5165.60 to 5165.89 and section 5165.99 of the 2431
Revised Code are not allowable costs. 2432

(C) "Ancillary and support costs" means all reasonable 2433
costs incurred by a nursing facility other than direct care 2434
costs, tax costs, or capital costs. "Ancillary and support 2435
costs" includes, but is not limited to, costs of activities, 2436
social services, pharmacy consultants, habilitation supervisors, 2437
qualified intellectual disability professionals, program 2438
directors, medical and habilitation records, program supplies, 2439
incontinence supplies, food, enterals, dietary supplies and 2440
personnel, laundry, housekeeping, security, administration, 2441
medical equipment, utilities, liability insurance, bookkeeping, 2442
purchasing department, human resources, communications, travel, 2443
dues, license fees, subscriptions, home office costs not 2444
otherwise allocated, legal services, accounting services, minor 2445
equipment, maintenance and repairs, help-wanted advertising, 2446
informational advertising, start-up costs, organizational 2447
expenses, other interest, property insurance, employee training 2448
and staff development, employee benefits, payroll taxes, and 2449
workers' compensation premiums or costs for self-insurance 2450
claims and related costs as specified in rules adopted under 2451
section 5165.02 of the Revised Code, for personnel listed in 2452
this division. "Ancillary and support costs" also means the cost 2453
of equipment, including vehicles, acquired by operating lease 2454
executed before December 1, 1992, if the costs are reported as 2455
administrative and general costs on the nursing facility's cost 2456
report for the cost reporting period ending December 31, 1992. 2457

(D) "Applicable calendar year" means the calendar year 2458
immediately preceding the first of the state fiscal years for 2459
which a rebasing is conducted. 2460

(E) For purposes of calculating a critical access nursing 2461
facility's occupancy rate and utilization rate under this 2462
chapter, "as of the last day of the calendar year" refers to the 2463

occupancy and utilization rates during the calendar year 2464
identified in the cost report filed under section 5165.10 of the 2465
Revised Code. 2466

(F) (1) "Capital costs" means the actual expense incurred 2467
by a nursing facility for all of the following: 2468

(a) Depreciation and interest on any capital assets that 2469
cost five hundred dollars or more per item, including the 2470
following: 2471

(i) Buildings; 2472

(ii) Building improvements; 2473

(iii) Except as provided in division (D) of this section, 2474
equipment; 2475

(iv) Transportation equipment. 2476

(b) Amortization and interest on land improvements and 2477
leasehold improvements; 2478

(c) Amortization of financing costs; 2479

(d) Lease and rent of land, buildings, and equipment. 2480

(2) The costs of capital assets of less than five hundred 2481
dollars per item may be considered capital costs in accordance 2482
with a provider's practice. 2483

(G) "Capital lease" and "operating lease" shall be 2484
construed in accordance with generally accepted accounting 2485
principles. 2486

(H) "Case-mix score" means a measure determined under 2487
section 5165.192 of the Revised Code of the relative direct-care 2488
resources needed to provide care and habilitation to a nursing 2489
facility resident. 2490

- (I) ~~"Change in control" means either of the following:~~ 2491
- ~~(1) Any pledge, assignment, or hypothecation of or lien or~~ 2492
~~other encumbrance on any of the legal or beneficial equity~~ 2493
~~interests in the applicable person;~~ 2494
- ~~(2) A change of fifty per cent or more in the legal or~~ 2495
~~beneficial ownership or control of the outstanding voting equity~~ 2496
~~interests of the applicable person necessary at all times to~~ 2497
~~elect a majority of the board of directors or similar governing~~ 2498
~~body and to direct the management policies and decisions.~~ 2499
- ~~(J) "Change of operator" includes circumstances in which~~ 2500
an entering operator becomes the operator of a nursing facility 2501
in the place of the exiting operator ~~or there is a change in~~ 2502
~~owner of a nursing facility.~~ 2503
- (1) Actions that constitute a change of operator include 2504
the following: 2505
- (a) A change in an exiting operator's ~~or owner's~~ form of 2506
legal organization, including the formation of a partnership or 2507
corporation from a sole proprietorship; 2508
- (b) A change ~~of in operational control in of the exiting~~ 2509
~~operator or owner~~ nursing facility, regardless of whether 2510
ownership of any or all of the real property or personal 2511
property associated with the nursing facility is also 2512
transferred; 2513
- (c) A lease of the nursing facility to the entering 2514
operator or ~~owner or the exiting operator's or owner's~~ 2515
termination of the exiting operator's ~~or owner's~~ lease; 2516
- (d) If the exiting operator ~~or owner~~ is a partnership, 2517
dissolution of the partnership, a merger of the partnership into 2518

another person that is the survivor of the merger, or a 2519
consolidation of the partnership and at least one other person 2520
to form a new person; 2521

(e) If the exiting operator ~~or owner~~ is a limited 2522
liability company, dissolution of the limited liability company, 2523
a merger of the limited liability company into another person 2524
that is the survivor of the merger, or a consolidation of the 2525
limited liability company and at least one other person to form 2526
a new person. 2527

(f) If the operator ~~or owner~~ is a corporation, dissolution 2528
of the corporation, a merger of the corporation into another 2529
person that is the survivor of the merger, or a consolidation of 2530
the corporation and at least one other person to form a new 2531
person; 2532

(g) A contract for a person to assume operational control 2533
~~of the operations and cash flow of a nursing facility as the~~ 2534
~~operator's or owner's agent;~~ 2535

(h) ~~A change in control of the owner of the real property~~ 2536
~~associated with the nursing facility if, within one year of the~~ 2537
~~change of control, there is a material increase in lease~~ 2538
~~payments or other financial obligations of the operator to the~~ 2539
~~owner of fifty per cent or more in the ownership of the licensed~~ 2540
operator that results in a change of operational control; 2541

(i) Any pledge, assignment, or hypothecation of or lien or 2542
other encumbrance on any of the legal or beneficial equity 2543
interests in the operator or a person with operational control. 2544

(2) The following, ~~alone,~~ do not constitute a change of 2545
operator: 2546

(a) ~~an employer~~ Actions necessary to create an employee 2547

stock ownership plan ~~created~~ under section 401(a) of the 2548
"Internal Revenue Code," 26 U.S.C. 401(a); 2549

(b) ~~Except as provided in division (J)(1) of this section,~~ 2550
~~a~~ A change of ownership of real property or personal property 2551
associated with a nursing facility; 2552

(c) If the operator ~~or owner~~ is a corporation that has 2553
securities publicly traded in a marketplace, a change of one or 2554
more members of the corporation's governing body or transfer of 2555
ownership of one or more shares of the corporation's stock, if 2556
the same corporation continues to be the operator ~~or owner~~; 2557

(d) An initial public offering for which the securities 2558
and exchange commission has declared the registration statement 2559
effective, and the newly created public company remains the 2560
operator ~~or owner~~. 2561

~~(K)~~ (J) "Cost center" means the following: 2562

- (1) Ancillary and support costs; 2563
- (2) Capital costs; 2564
- (3) Direct care costs; 2565
- (4) Tax costs. 2566

~~(L)~~ (K) "Custom wheelchair" means a wheelchair to which 2567
both of the following apply: 2568

(1) It has been measured, fitted, or adapted in 2569
consideration of either of the following: 2570

(a) The body size or disability of the individual who is 2571
to use the wheelchair; 2572

(b) The individual's period of need for, or intended use 2573
of, the wheelchair. 2574

(2) It has customized features, modifications, or 2575
components, such as adaptive seating and positioning systems, 2576
that the supplier who assembled the wheelchair, or the 2577
manufacturer from which the wheelchair was ordered, added or 2578
made in accordance with the instructions of the physician of the 2579
individual who is to use the wheelchair. 2580

~~(M) (1)~~ (L) (1) "Date of licensure" means the following: 2581

(a) In the case of a nursing facility that was required by 2582
law to be licensed as a nursing home under Chapter 3721. of the 2583
Revised Code when it originally began to be operated as a 2584
nursing home, the date the nursing facility was originally so 2585
licensed; 2586

(b) In the case of a nursing facility that was not 2587
required by law to be licensed as a nursing home when it 2588
originally began to be operated as a nursing home, the date it 2589
first began to be operated as a nursing home, regardless of the 2590
date the nursing facility was first licensed as a nursing home. 2591

(2) If, after a nursing facility's original date of 2592
licensure, more nursing home beds are added to the nursing 2593
facility, the nursing facility has a different date of licensure 2594
for the additional beds. This does not apply, however, to 2595
additional beds when both of the following apply: 2596

(a) The additional beds are located in a part of the 2597
nursing facility that was constructed at the same time as the 2598
continuing beds already located in that part of the nursing 2599
facility; 2600

(b) The part of the nursing facility in which the 2601
additional beds are located was constructed as part of the 2602
nursing facility at a time when the nursing facility was not 2603

required by law to be licensed as a nursing home. 2604

(3) The definition of "date of licensure" in this section 2605
applies in determinations of nursing facilities' medicaid 2606
payment rates but does not apply in determinations of nursing 2607
facilities' franchise permit fees. 2608

~~(N)~~ (M) "Desk-reviewed" means that a nursing facility's 2609
costs as reported on a cost report submitted under section 2610
5165.10 of the Revised Code have been subjected to a desk review 2611
under section 5165.108 of the Revised Code and preliminarily 2612
determined to be allowable costs. 2613

~~(O)~~ (N) "Direct care costs" means all of the following 2614
costs incurred by a nursing facility: 2615

(1) Costs for registered nurses, licensed practical 2616
nurses, and nurse aides employed by the nursing facility; 2617

(2) Costs for direct care staff, administrative nursing 2618
staff, medical directors, respiratory therapists, and except as 2619
provided in division ~~(O)~~ ~~(8)~~ (N) (8) of this section, other 2620
persons holding degrees qualifying them to provide therapy; 2621

(3) Costs of purchased nursing services; 2622

(4) Costs of quality assurance; 2623

(5) Costs of training and staff development, employee 2624
benefits, payroll taxes, and workers' compensation premiums or 2625
costs for self-insurance claims and related costs as specified 2626
in rules adopted under section 5165.02 of the Revised Code, for 2627
personnel listed in divisions ~~(O)~~ ~~(1)~~ (N) (1), (2), (4), and (8) of 2628
this section; 2629

(6) Costs of consulting and management fees related to 2630
direct care; 2631

(7) Allocated direct care home office costs;	2632
(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;	2633 2634 2635 2636 2637 2638
(9) Costs of wheelchairs other than the following:	2639
(a) Custom wheelchairs;	2640
(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.	2641 2642 2643
(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.	2644 2645 2646
(P) <u>(O)</u> "Dual eligible individual" has the same meaning as in section 5160.01 of the Revised Code.	2647 2648
(Q) <u>(P)</u> "Effective date of a change of operator" means the day the entering operator becomes the operator of the nursing facility.	2649 2650 2651
(R) <u>(Q)</u> "Effective date of a facility closure" means the last day that the last of the residents of the nursing facility resides in the nursing facility.	2652 2653 2654
(S) <u>(R)</u> "Effective date of an involuntary termination" means the date the department of medicaid terminates the operator's provider agreement for the nursing facility.	2655 2656 2657
(T) <u>(S)</u> "Effective date of a voluntary withdrawal of	2658

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 2687
services under the new use. 2688

(2) A facility closure occurs regardless of any of the 2689
following: 2690

(a) The operator completely or partially replacing the 2691
nursing facility by constructing a new nursing facility or 2692
transferring the nursing facility's license to another nursing 2693
facility; 2694

(b) The nursing facility's residents relocating to another 2695
of the operator's nursing facilities; 2696

(c) Any action the department of health takes regarding 2697
the nursing facility's medicaid certification that may result in 2698
the transfer of part of the nursing facility's survey findings 2699
to another of the operator's nursing facilities; 2700

(d) Any action the department of health takes regarding 2701
the nursing facility's license under Chapter 3721. of the 2702
Revised Code. 2703

(3) A facility closure does not occur if all of the 2704
nursing facility's residents are relocated due to an emergency 2705
evacuation and one or more of the residents return to a 2706
medicaid-certified bed in the nursing facility not later than 2707
thirty days after the evacuation occurs. 2708

~~(X)~~ (W) "Franchise permit fee" means the fee imposed by 2709
sections 5168.40 to 5168.56 of the Revised Code. 2710

~~(Y)~~ (X) "Inpatient days" means both of the following: 2711

(1) All days during which a resident, regardless of 2712
payment source, occupies a licensed bed in a nursing facility; 2713

(2) Fifty per cent of the days for which payment is made 2714
under section 5165.34 of the Revised Code. 2715

~~(Z)~~ (Y) "Involuntary termination" means the department of 2716
medicaid's termination of the operator's provider agreement for 2717
the nursing facility when the termination is not taken at the 2718
operator's request. 2719

~~(AA)~~ (Z) "Low case-mix resident" means a medicaid 2720
recipient residing in a nursing facility who, for purposes of 2721
calculating the nursing facility's medicaid payment rate for 2722
direct care costs, is placed in either of the two lowest case- 2723
mix groups, excluding any case-mix group that is a default group 2724
used for residents with incomplete assessment data. 2725

~~(BB)~~ (AA) "Maintenance and repair expenses" means a 2726
nursing facility's expenditures that are necessary and proper to 2727
maintain an asset in a normally efficient working condition and 2728
that do not extend the useful life of the asset two years or 2729
more. "Maintenance and repair expenses" includes but is not 2730
limited to the costs of ordinary repairs such as painting and 2731
wallpapering. 2732

~~(CC)~~ (BB) "Medicaid-certified capacity" means the number 2733
of a nursing facility's beds that are certified for 2734
participation in medicaid as nursing facility beds. 2735

~~(DD)~~ (CC) "Medicaid days" means both of the following: 2736

(1) All days during which a resident who is a medicaid 2737
recipient eligible for nursing facility services occupies a bed 2738
in a nursing facility that is included in the nursing facility's 2739
medicaid-certified capacity; 2740

(2) Fifty per cent of the days for which payment is made 2741
under section 5165.34 of the Revised Code. 2742

~~(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 2771
operating the nursing facility; 2772

(2) The person, persons, or government entity directly or 2773
indirectly owning fifty per cent or more of the operator; 2774

(3) An agreement or other arrangement granting the person, 2775
persons, or government entity operational control. 2776

(JJ) "Operator" means ~~the~~ a person or government entity 2777
responsible for the ~~daily operating and management decisions for~~ 2778
operational control of a nursing facility and that holds both of 2779
the following: 2780

(1) The license to operate the nursing facility issued 2781
under section 3721.02 of the Revised Code, if a license is 2782
required by section 3721.05 of the Revised Code; 2783

(2) The medicaid provider agreement issued under section 2784
5165.07 of the Revised Code, if applicable. 2785

(KK) (1) "Owner" means any person or government entity that 2786
has at least five per cent ownership or interest, either 2787
directly, indirectly, or in any combination, in any of the 2788
following regarding a nursing facility: 2789

(a) The land on which the nursing facility is located; 2790

(b) The structure in which the nursing facility is 2791
located; 2792

(c) Any mortgage, contract for deed, or other obligation 2793
secured in whole or in part by the land or structure on or in 2794
which the nursing facility is located; 2795

(d) Any lease or sublease of the land or structure on or 2796
in which the nursing facility is located. 2797

(2) "Owner" does not mean a holder of a debenture or bond 2798
related to the nursing facility and purchased at public issue or 2799
a regulated lender that has made a loan related to the nursing 2800
facility unless the holder or lender operates the nursing 2801
facility directly or through a subsidiary. 2802

(LL) "Per diem" means a nursing facility's actual, 2803
allowable costs in a given cost center in a cost reporting 2804
period, divided by the nursing facility's inpatient days for 2805
that cost reporting period. 2806

(MM) "Person" has the same meaning as in section 1.59 of 2807
the Revised Code. 2808

(NN) "Private room" means a nursing facility bedroom that 2809
meets all of the following criteria: 2810

(1) It has four permanent, floor-to-ceiling walls and a 2811
full door. 2812

(2) It contains one licensed or certified bed that is 2813
occupied by one individual. 2814

(3) It has access to a hallway without traversing another 2815
bedroom. 2816

(4) It has access to a toilet and sink shared by not more 2817
than one other resident without traversing another bedroom. 2818

(5) It meets all applicable licensure or other standards 2819
pertaining to furniture, fixtures, and temperature control. 2820

(OO) "Provider" means an operator with a provider 2821
agreement. 2822

(PP) "Provider agreement" means a provider agreement, as 2823
defined in section 5164.01 of the Revised Code, that is between 2824

the department of medicaid and the operator of a nursing 2825
facility for the provision of nursing facility services under 2826
the medicaid program. 2827

(QQ) "Purchased nursing services" means services that are 2828
provided in a nursing facility by registered nurses, licensed 2829
practical nurses, or nurse aides who are not employees of the 2830
nursing facility. 2831

(RR) "Reasonable" means that a cost is an actual cost that 2832
is appropriate and helpful to develop and maintain the operation 2833
of patient care facilities and activities, including normal 2834
standby costs, and that does not exceed what a prudent buyer 2835
pays for a given item or services. Reasonable costs may vary 2836
from provider to provider and from time to time for the same 2837
provider. 2838

(SS) "Rebasing" means a redetermination of each of the 2839
following using information from cost reports for an applicable 2840
calendar year that is later than the applicable calendar year 2841
used for the previous rebasing: 2842

(1) Each peer group's rate for ancillary and support costs 2843
as determined pursuant to division (C) of section 5165.16 of the 2844
Revised Code; 2845

(2) Each peer group's rate for capital costs as determined 2846
pursuant to division (C) of section 5165.17 of the Revised Code; 2847

(3) Each peer group's cost per case-mix unit as determined 2848
pursuant to division (C) of section 5165.19 of the Revised Code; 2849

(4) Each nursing facility's rate for tax costs as 2850
determined pursuant to section 5165.21 of the Revised Code. 2851

(TT) "Related party" means an individual or organization 2852

that, to a significant extent, has common ownership with, is 2853
associated or affiliated with, has control of, or is controlled 2854
by, the provider. 2855

(1) An individual who is a relative of an owner is a 2856
related party. 2857

(2) Common ownership exists when an individual or 2858
individuals possess significant ownership or equity in both the 2859
provider and the other organization. Significant ownership or 2860
equity exists when an individual or individuals possess five per 2861
cent ownership or equity in both the provider and a supplier. 2862
Significant ownership or equity is presumed to exist when an 2863
individual or individuals possess ten per cent ownership or 2864
equity in both the provider and another organization from which 2865
the provider purchases or leases real property. 2866

(3) Control exists when an individual or organization has 2867
the power, directly or indirectly, to significantly influence or 2868
direct the actions or policies of an organization. 2869

(4) An individual or organization that supplies goods or 2870
services to a provider shall not be considered a related party 2871
if all of the following conditions are met: 2872

(a) The supplier is a separate bona fide organization. 2873

(b) A substantial part of the supplier's business activity 2874
of the type carried on with the provider is transacted with 2875
others than the provider and there is an open, competitive 2876
market for the types of goods or services the supplier 2877
furnishes. 2878

(c) The types of goods or services are commonly obtained 2879
by other nursing facilities from outside organizations and are 2880
not a basic element of patient care ordinarily furnished 2881

directly to patients by nursing facilities. 2882

(d) The charge to the provider is in line with the charge 2883
for the goods or services in the open market and no more than 2884
the charge made under comparable circumstances to others by the 2885
supplier. 2886

(UU) "Relative of owner" means an individual who is 2887
related to an owner of a nursing facility by one of the 2888
following relationships: 2889

- (1) Spouse; 2890
- (2) Natural parent, child, or sibling; 2891
- (3) Adopted parent, child, or sibling; 2892
- (4) Stepparent, stepchild, stepbrother, or stepsister; 2893
- (5) Father-in-law, mother-in-law, son-in-law, daughter-in- 2894
law, brother-in-law, or sister-in-law; 2895
- (6) Grandparent or grandchild; 2896
- (7) Foster caregiver, foster child, foster brother, or 2897
foster sister. 2898

(VV) "Residents' rights advocate" has the same meaning as 2899
in section 3721.10 of the Revised Code. 2900

(WW) "Skilled nursing facility" has the same meaning as in 2901
the "Social Security Act," section 1819(a), 42 U.S.C. 1395i- 2902
3(a). 2903

(XX) "State fiscal year" means the fiscal year of this 2904
state, as specified in section 9.34 of the Revised Code. 2905

(YY) "Sponsor" has the same meaning as in section 3721.10 2906
of the Revised Code. 2907

(ZZ) "Surrender" has the same meaning as in section 2908
5168.40 of the Revised Code. 2909

(AAA) "Tax costs" means the costs of taxes imposed under 2910
Chapter 5751. of the Revised Code, real estate taxes, personal 2911
property taxes, and corporate franchise taxes. 2912

(BBB) "Title XIX" means Title XIX of the "Social Security 2913
Act," 42 U.S.C. 1396 et seq. 2914

(CCC) "Title XVIII" means Title XVIII of the "Social 2915
Security Act," 42 U.S.C. 1395 et seq. 2916

(DDD) "Voluntary withdrawal of participation" means an 2917
operator's voluntary election to terminate the participation of 2918
a nursing facility in the medicaid program but to continue to 2919
provide service of the type provided by a nursing facility. 2920

Sec. 5165.06. Subject to section 5165.072 of the Revised 2921
Code, an operator is eligible to enter into and retain a 2922
provider agreement for a nursing facility if all of the 2923
following apply: 2924

(A) The nursing facility is certified by the director of 2925
health for participation in medicaid; 2926

(B) The nursing facility is licensed by the director of 2927
health as a nursing home if so required by law and the operator 2928
is the licensed operator of the nursing home; 2929

(C) The operator and nursing facility comply with all 2930
applicable state and federal laws and rules. 2931

Sec. 5165.26. (A) As used in this section: 2932

(1) "Base rate" means the portion of a nursing facility's 2933
total per medicaid day payment rate determined under divisions 2934

(A) and (B) of section 5165.15 of the Revised Code. 2935

(2) "CMS" means the United States centers for medicare and 2936
medicaid services. 2937

(3) "Long-stay resident" means an individual who has 2938
resided in a nursing facility for at least one hundred one days. 2939

(4) "Nursing facilities for which a quality score was 2940
determined" includes nursing facilities that are determined to 2941
have a quality score of zero. 2942

(5) "SFF list" means the list of nursing facilities that 2943
the United States department of health and human services 2944
creates under the special focus facility program. 2945

(6) "Special focus facility program" means the program 2946
conducted by the United States secretary of health and human 2947
services pursuant to section 1919(f)(10) of the "Social Security 2948
Act," 42 U.S.C. 1396r(f)(10). 2949

(B) Subject to divisions (D) and (E) and except as 2950
provided in division (F) of this section, the department of 2951
medicaid shall determine each nursing facility's per medicaid 2952
day quality incentive payment rate as follows: 2953

(1) Determine the sum of the quality scores determined 2954
under division (C) of this section for all nursing facilities. 2955

(2) Determine the average quality score by dividing the 2956
sum determined under division (B)(1) of this section by the 2957
number of nursing facilities for which a quality score was 2958
determined. 2959

(3) Determine the sum of the total number of medicaid days 2960
for all of the calendar year preceding the fiscal year for which 2961
the rate is determined for all nursing facilities for which a 2962

quality score was determined. 2963

(4) Multiply the average quality score determined under 2964
division (B) (2) of this section by the sum determined under 2965
division (B) (3) of this section. 2966

(5) Determine the value per quality point by determining 2967
the quotient of the following: 2968

(a) The sum determined under division (E) (2) of this 2969
section. 2970

(b) The product determined under division (B) (4) of this 2971
section. 2972

(6) Multiply the value per quality point determined under 2973
division (B) (5) of this section by the nursing facility's 2974
quality score determined under division (C) of this section. 2975

(C) (1) Except as provided in divisions (C) (2) and (3) of 2976
this section, a nursing facility's quality score for a state 2977
fiscal year shall be the sum of the following: 2978

(a) The total number of points that CMS assigned to the 2979
nursing facility under CMS's nursing facility five-star quality 2980
rating system for the following quality metrics, or CMS's 2981
successor metrics as described below, based on the most recent 2982
four-quarter average data, or the average data for fewer 2983
quarters in the case of successor metrics, available in the 2984
database maintained by CMS and known as nursing home compare in 2985
the most recent month of the calendar year during which the 2986
fiscal year for which the rate is determined begins: 2987

(i) The percentage of the nursing facility's long-stay 2988
residents at high risk for pressure ulcers who had pressure 2989
ulcers; 2990

(ii) The percentage of the nursing facility's long-stay residents who had a urinary tract infection; 2991
2992

(iii) The percentage of the nursing facility's long-stay residents whose ability to move independently worsened; 2993
2994

(iv) The percentage of the nursing facility's long-stay residents who had a catheter inserted and left in their bladder. 2995
2996

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. 2997
2998
2999
3000

(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. 3001
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(c) Beginning with state fiscal year 2025, the total 3019

number of points that CMS assigned to the nursing facility under 3020
CMS's nursing facility five-star quality rating system for the 3021
following quality metrics, or successor metrics designated by 3022
CMS, based on the most recent four-quarter average data 3023
available in the database maintained by CMS and known as nursing 3024
home compare in the most recent month of the calendar year 3025
during which the fiscal year for which the rate is determined 3026
begins: 3027

(i) The percentage of the nursing facility's long-stay 3028
residents whose need for help with daily activities has 3029
increased; 3030

(ii) The percentage of the nursing facility's long-stay 3031
residents experiencing one or more falls with major injury; 3032

(iii) The percentage of the nursing facility's long-stay 3033
residents who were administered an antipsychotic medication; 3034

(iv) Adjusted total nurse staffing hours per resident per 3035
day using quintiles instead of deciles by using the points 3036
assigned to the higher of the two deciles that constitute the 3037
quintile. 3038

If CMS ceases to publish any of the metrics specified in 3039
division (C)(1)(c) of this section, the department shall use the 3040
nursing facility quality metrics on the same topics CMS 3041
subsequently publishes. 3042

(2) In determining a nursing facility's quality score for 3043
a state fiscal year, the department shall make the following 3044
adjustment to the number of points that CMS assigned to the 3045
nursing facility for each of the quality metrics specified in 3046
divisions (C)(1)(a) and (c) of this section: 3047

(a) Unless division (C)(2)(b) or (c) of this section 3048

applies, divide the number of the nursing facility's points for 3049
the quality metric by twenty. 3050

(b) If CMS assigned the nursing facility to the lowest 3051
percentile for the quality metric, reduce the number of the 3052
nursing facility's points for the quality metric to zero. 3053

(c) If the nursing facility's total number of points 3054
calculated for or during a state fiscal year for all of the 3055
quality metrics specified in divisions (C)(1)(a), and if 3056
applicable, division (C)(1)(c) of this section is less than a 3057
number of points that is equal to the twenty-fifth percentile of 3058
all nursing facilities, calculated using the points for the July 3059
1 rate setting of that fiscal year reduce the nursing facility's 3060
points to zero until the next point calculation. If a facility's 3061
recalculated points under division (C)(3) of this section are 3062
below the number of points determined to be the twenty-fifth 3063
percentile for that fiscal year, the facility shall receive zero 3064
points for the remainder of that fiscal year. 3065

(3) A nursing facility's quality score shall be 3066
recalculated for the second half of the state fiscal year based 3067
on the most recent four quarter average data, or the average 3068
data for fewer quarters in the case of successor metrics, 3069
available in the database maintained by CMS and known as the 3070
care compare, in the most recent month of the calendar year 3071
during which the fiscal year for which the rate is determined 3072
begins. The metrics specified by division (C)(1)(b) of this 3073
section shall not be recalculated. In redetermining the quality 3074
payment for each facility based on the recalculated points, the 3075
department shall use the same per point value determined for the 3076
quality payment at the start of the fiscal year. 3077

(D) A nursing facility shall not receive a quality 3078

incentive payment if the Department of Health assigned the 3079
nursing facility to the SFF list under the special focus 3080
facility program and the nursing facility is listed in table A, 3081
on the first day of May of the calendar year for which the rate 3082
is being determined. 3083

(E) The total amount to be spent on quality incentive 3084
payments under division (B) of this section for a fiscal year 3085
shall be determined as follows: 3086

(1) Determine the following amount for each nursing 3087
facility: 3088

(a) The amount that is five and two-tenths per cent of the 3089
nursing facility's base rate for nursing facility services 3090
provided on the first day of the state fiscal year plus one 3091
dollar and seventy-nine cents plus sixty per cent of the per 3092
diem amount by which the nursing facility's rate for direct care 3093
costs determined for the fiscal year under section 5165.19 of 3094
the Revised Code changed as a result of the rebasing conducted 3095
under section 5165.36 of the Revised Code. 3096

(b) Multiply the amount determined under division (E) (1) 3097
(a) of this section by the number of the nursing facility's 3098
medicaid days for the calendar year preceding the fiscal year 3099
for which the rate is determined. 3100

(2) Determine the sum of the products determined under 3101
division (E) (1) (b) of this section for all nursing facilities 3102
for which the product was determined for the state fiscal year. 3103

(3) To the sum determined under division (E) (2) of this 3104
section, add one hundred twenty-five million dollars. 3105

(F) (1) Beginning July 1, 2023, a new nursing facility 3106
shall receive a quality incentive payment for the fiscal year in 3107

which the new facility obtains an initial provider agreement and 3108
the immediately following fiscal year equal to the median 3109
quality incentive payment determined for nursing facilities for 3110
the fiscal year. For the state fiscal year after the immediately 3111
following fiscal year and subsequent fiscal years, the quality 3112
incentive payment shall be determined under division (C) of this 3113
section. 3114

(2) A nursing facility that undergoes a change of operator 3115
with an effective date of July 1, 2023, or later shall not 3116
receive a quality incentive payment until the earlier of the 3117
first day of January or the first day of July that is at least 3118
six months after the effective date of the change of operator. 3119
Thereafter quality incentive payment shall be determined under 3120
division (C) of this section. 3121

(3) A nursing facility that undergoes a change of owner 3122
with an effective date of July 1, 2023, or later shall not 3123
receive a quality incentive payment until the earlier of the 3124
first day of January or the first day of July that is at least 3125
six months after the effective date of the change of owner if, 3126
within one year after the change of owner, there is a material 3127
increase in the lease payments or other financial obligations of 3128
the operator to the owner. Thereafter, any quality incentive 3129
payments for the facility shall be determined under division (C) 3130
of this section. 3131

Sec. 5165.51. (A) An exiting operator or owner and 3132
entering operator shall provide the department of medicaid 3133
written notice of a change of operator if the nursing facility 3134
participates in the medicaid program and the entering operator 3135
seeks to continue the nursing facility's participation. The 3136
written notice shall be provided to the department in accordance 3137

with the method specified in rules authorized by section 5165.53 3138
of the Revised Code. The written notice shall be provided to the 3139
department not later than forty-five days before the effective 3140
date of the change of operator if the change of operator does 3141
not entail the relocation of residents. The written notice shall 3142
be provided to the department not later than ninety days before 3143
the effective date of the change of operator if the change of 3144
operator entails the relocation of residents. The department may 3145
waive the time requirements of division (A) of this section in 3146
an emergency, such as the death of the operator. 3147

The written notice shall include all of the following: 3148

(1) The name of the exiting operator and, if any, the 3149
exiting operator's authorized agent; 3150

(2) The name of the nursing facility that is the subject 3151
of the change of operator; 3152

(3) The exiting operator's seven-digit medicaid legacy 3153
number and ten-digit national provider identifier number for the 3154
nursing facility that is the subject of the change of operator; 3155

(4) The name of the entering operator; 3156

(5) The effective date of the change of operator; 3157

(6) The manner in which the entering operator becomes the 3158
nursing facility's operator, including through sale, lease, 3159
merger, or other action; 3160

(7) If the manner in which the entering operator becomes 3161
the nursing facility's operator involves more than one step, a 3162
description of each step; 3163

(8) Written authorization from the exiting operator or 3164
owner and entering operator for the department to process a 3165

provider agreement for the entering operator; 3166

(9) The names and addresses of the persons to whom the 3167
department should send initial correspondence regarding the 3168
change of operator; 3169

(10) If the nursing facility also participates in the 3170
medicare program, notification of whether the entering operator 3171
intends to accept assignment of the exiting operator's medicare 3172
provider agreement; 3173

(11) The signature of the exiting operator's or owner's 3174
representative. 3175

(B) An owner shall provide the department of medicaid 3176
written notice of a change of owner. The written notice shall be 3177
provided to the department in accordance with the method 3178
specified in rules adopted under section 5165.53 of the Revised 3179
Code. The written notice shall be provided to the department not 3180
later than forty-five days before the effective date of the 3181
change of owner. The department may waive the time requirements 3182
of division (B) of this section in an emergency, such as the 3183
death of the operator. 3184

The written notice shall include all of the following: 3185

(1) The name of the owner and the owner's authorized 3186
agent, if any; 3187

(2) The name of the nursing facility that is the subject 3188
of the change of owner; 3189

(3) The seven-digit medicaid legacy number and ten-digit 3190
national provider identification number for the nursing facility 3191
that is the subject of the change of owner; 3192

(4) The extent of the owner's interest in the nursing 3193

facility; 3194

(5) The effective date of the change of owner; 3195

(6) The manner in which the change of owner is 3196
accomplished, including through sale, merger, or other action; 3197

(7) If the manner in which the change of owner is 3198
accomplished involves more than one step, a description of each 3199
step; 3200

(8) The names and addresses of the persons to whom the 3201
department should send correspondence regarding the change of 3202
owner; 3203

(9) A statement describing any material increase in lease 3204
payments or other financial obligations of the operator to the 3205
owner resulting from the change of owner, or affirming that 3206
there is no material increase; 3207

(10) The signature of the owner's representative. 3208

(C) An exiting operator or owner and, entering operator, 3209
or owner immediately shall provide the department written notice 3210
of any changes to information included in a written notice ~~of a~~ 3211
~~change of operator~~ provided under division (A) or (B) of this 3212
section that occur within one year after that notice is provided 3213
to the department. The notice of the changes shall be provided 3214
to the department in accordance with the method specified in 3215
rules authorized by section 5165.53 of the Revised Code. 3216

Sec. 5165.511. The department of medicaid may enter into a 3217
provider agreement with an entering operator that goes into 3218
effect at 12:01 a.m. on the effective date of the change of 3219
operator if all of the following requirements are met: 3220

(A) The department receives a properly completed written 3221

notice required by section 5165.51 of the Revised Code on or 3222
before the date required by that section. 3223

(B) The department receives from the department of health 3224
notice of intent to grant a change of operator license issued 3225
under division (B) of section 3721.026 of the Revised Code. 3226

(C) The department receives both of the following in 3227
accordance with the method specified in rules authorized by 3228
section 5165.53 of the Revised Code and not later than ten days 3229
after the effective date of the change of operator: 3230

(1) From the entering operator, a completed application 3231
for a provider agreement and all other forms and documents 3232
specified in rules authorized by section 5165.53 of the Revised 3233
Code; 3234

(2) From the exiting operator or owner, all forms and 3235
documents specified in rules authorized by section 5165.53 of 3236
the Revised Code. 3237

~~(C)~~ (D) The entering operator is eligible for medicaid 3238
payments as provided in section 5165.06 of the Revised Code. 3239

Sec. 5165.518. (A) Each nursing facility shall ensure that 3240
the identity of the operator that holds the license to operate 3241
the facility issued under section 3721.02 of the Revised Code 3242
and the operator that holds the medicaid provider agreement for 3243
the facility issued under section 5165.07 of the Revised Code is 3244
the same person and is consistently identified for both 3245
purposes. 3246

(B) A nursing facility that has a difference in the 3247
identity of the operator that holds the license to operate the 3248
facility issued under section 3721.02 of the Revised Code and 3249
the operator holding the medicaid provider agreement for the 3250

facility issued under section 5165.07 of the Revised Code shall, 3251
not later than one year after the effective date of this 3252
section, take action to ensure that the same person is the 3253
operator for both purposes and is consistently identified for 3254
both purposes. An action taken in accordance with this division 3255
shall not be considered a change of operator as defined in 3256
section 3721.01 or 5165.01 of the Revised Code. 3257

Section 2. That existing sections 3702.593, 3721.01, 3258
3721.026, 3721.072, 3721.121, 3721.28, 3721.30, 3721.31, 3259
3721.32, 4723.32, 4723.61, 4723.64, 4723.65, 4723.651, 4723.653, 3260
4723.66, 4723.67, 4723.68, 4723.69, 4729.41, 5124.15, 5124.151, 3261
5165.01, 5165.06, 5165.26, 5165.51, and 5165.511 of the Revised 3262
Code are hereby repealed. 3263

Section 3. Section 3702.593 of the Revised Code as 3264
presented in this act takes effect on the later of September 30, 3265
2024, or the effective date of this section. 3266

(September 30, 2024, is the effective date of an earlier 3267
amendment to that section by H.B. 110 of the 134th General 3268
Assembly.) 3269

Section 4. Notwithstanding division (D) (2) of section 3270
3702.593 of the Revised Code, in addition to the acceptance and 3271
review periods provided for in that division, certificate of 3272
need applications for the purposes specified in that section 3273
shall be accepted during the first month that is six months 3274
after the effective date of this section and reviewed through 3275
the last day of the ninth month after the month in which 3276
applications are accepted under this section. Thereafter, 3277
applications shall be accepted and reviewed only in accordance 3278
with division (D) (2) of section 3702.593 of the Revised Code. 3279

Section 5. In accordance with the amendments to section 3280
5124.15 of the Revised Code made by this act, the Department of 3281
Developmental Disabilities shall redetermine the per Medicaid 3282
day payment rate for an ICF/IID in peer group 5 that on July 1, 3283
2023, exceeded the average total per Medicaid day payment rate 3284
in effect on July 1, 2013, for developmental centers. 3285

Section 6. That Section 333.270 of H.B. 33 of the 135th 3286
General Assembly be amended to read as follows: 3287

Sec. 333.270. LOCKABLE AND TAMPER-EVIDENT CONTAINERS 3288

(A) As used in this section, "lockable container" and 3289
"tamper-evident container" have the same meanings as in Section 3290
337.205 of H.B. 110 of the 134th General Assembly. 3291

(B) The Department of Medicaid shall reimburse pharmacists 3292
for costs related to dispensing drugs in lockable containers or 3293
tamper-evident containers. 3294

(C) Not later than thirty days after the effective date of 3295
this amendment, the Department shall do all of the following: 3296

(1) Add lockable containers and tamper-evident containers 3297
that are available on the market to the covered over-the-counter 3298
(OTC) products list, and thereafter, add products to the list 3299
from time to time on the request of any manufacturer; 3300

(2) Establish the additional fee to be paid to pharmacists 3301
who seek reimbursement pursuant to this section for costs 3302
related to dispensing drugs in lockable containers or tamper- 3303
evident containers, submitted by the pharmacy with the product's 3304
corresponding National Drug Code (NDC) in the claim. The 3305
additional fee shall equal the sum of both of the following: 3306

(a) The wholesale acquisition cost (WAC) of the lockable 3307

or tamper-evident container plus or minus a percentage of WAC, 3308
the latter of which shall be consistent with the Department's 3309
listed percentage of WAC for products with comparably structured 3310
rates on the covered OTC products list; 3311

(b) Forty-seven per cent of the current then in-effect 3312
dispensing fee based on the biennial cost of dispensing survey. 3313

(3) Instruct the single pharmacy benefit manager to do 3314
both of the following: 3315

(a) Incorporate electronic alerts to pharmacies on claims 3316
submitted for medications identified in division (G) of this 3317
section, alerting pharmacies that those medications dispensed 3318
qualify for the additional fee described in this section; 3319

(b) Make any and all contractual amendments, or provide 3320
any and all contractual waivers, necessary to affect the 3321
benefit, to or with any contracted third-party pharmacy 3322
providers, including without limitation the single pharmacy 3323
benefit manager and the pharmacy pricing and audit consultant. 3324

(D) Not later than ninety days after the effective date of 3325
this amendment, the Department shall: 3326

(1) Begin reimbursing pharmacists pursuant to this 3327
section; 3328

(2) To the extent any federal regulations require a waiver 3329
to preserve the Department's eligibility for drawdown of federal 3330
matching funds to fund the benefit, apply for such waiver; 3331

(3) Notify members, prescribers, and pharmacies of the 3332
additional benefit; 3333

(4) Take any other actions in accordance with its standard 3334
practices for adding a pharmacy benefit. 3335

(E) Beginning June 30, 2025, within a reasonable time at 3336
the end of each fiscal year, the Department shall publish an 3337
annual report to members of the General Assembly, the State 3338
Board of Pharmacy, the Department of Mental Health and Addiction 3339
Services, and the Joint Medicaid Oversight Committee containing 3340
measures of adoption by licensed pharmacies, by percentage of 3341
qualifying prescriptions dispensed statewide, by percentage of 3342
patients for which the prescription was dispensed, the mix of 3343
provider specialties for provider-prescribed medications, and 3344
any other measures of adoption requested by such recipients. 3345

(F) A prescription for a drug dispensed by a pharmacy 3346
shall be considered in tandem a qualifying prescription for the 3347
lockable container or tamper-evident container dispensed with 3348
the prescription, and the separate reimbursement shall not be 3349
subject to any separate prescriber indication for using such 3350
container in filling the prescription, and allow the pharmacy or 3351
pharmacist to be listed as the prescriber where necessary. 3352

(G) The fee described in division (C) of this section 3353
applies as follows: 3354

(1) Beginning on the effective date of this amendment, to 3355
medications used in addiction treatment, opioids in Schedule II 3356
of the Controlled Substances Act, and to any other medications 3357
designated by the State Board of Pharmacy; 3358

(2) Beginning July 1, 2025, to medications identified in 3359
division (G)(1) of this section, medications listed in Schedules 3360
II and III and benzodiazepines listed in Schedule IV of the 3361
Controlled Substances Act, and to any medication for which a 3362
prescriber prescribes a lockable container or tamper-evident 3363
container. 3364

(H) The Department of Medicaid may adopt rules to 3365
establish the requirements and reimbursement for mail-order 3366
pharmacies to participate in the program. 3367

Section 7. That existing Section 333.270 of H.B. 33 of the 3368
135th General Assembly is hereby repealed. 3369

Section 8. That Section 280.12 of H.B. 45 of the 134th 3370
General Assembly (as amended by H.B. 33 of the 135th General 3371
Assembly) be amended to read as follows: 3372

Sec. 280.12. The foregoing appropriation item 042628, 3373
Adult Day Care, shall be used by the Director of Budget and 3374
Management to administer grants to eligible adult day care 3375
providers ~~during~~. An amount equal to the unexpended, 3376
unencumbered balance of the appropriation item at the end of 3377
fiscal year 2023, and the remaining \$4,000,000 shall be is 3378
hereby reappropriated and administered during fiscal year 2023 3379
to fiscal year 2024 for the same purpose. An amount equal to the 3380
unexpended, unencumbered balance of the appropriation item at 3381
the end of fiscal year 2024, is hereby reappropriated to fiscal 3382
year 2025 for the same purpose. The Director shall administer 3383
all grants not later than December 31, 2024. 3384

Section 9. That existing Section 280.12 of H.B. 45 of the 3385
134th General Assembly (as amended by H.B. 33 of the 135th 3386
General Assembly) is hereby repealed. 3387