PUBLIC HEALTH CODE (EXCERPT)
Act 368 of 1978

PART 201
GENERAL PROVISIONS

333.20101 Meanings of words and phrases; principles of construction.

Sec. 20101. (1) The words and phrases defined in sections 20102 to 20109 apply to all parts in this article except part 222 and have the meanings ascribed to them in those sections.

(2) In addition, article 1 contains general definitions and principles of construction applicable to all articles in this code.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1988, Act 332, Eff. Oct. 1, 1988.

Compiler's note: For transfer of powers and duties of the division of health facility licensing and certification in the bureau of health systems, division of federal support services, and the division of emergency medical services, with the exception of the division of managed care and division of health facility development, from the department of public health to the director of the department of commerce, see E.R.O. No. 1996-1, compiled at MCL 330.3101 of the Michigan Compiled Laws.

For transfer of powers and duties of the bureau of health services from the department of consumer and industry services to the director of the department of community health by Type II transfer, see E.R.O. No. 2003-1, compiled at MCL 445.2011.

For transfer of powers and duties of the bureau of family services from the department of consumer and industry services to the family independence agency by Type II transfer, see E.R.O. No. 2003-1, compiled at MCL 445.2011.

Popular name: Act 368

333.20102 Definitions; A.

Sec. 20102. (1) "Advisory commission" means the health facilities and agencies advisory commission created in section 20121.

(2) "Aircraft transport operation" means that term as defined in section 20902.

(3) "Ambulance operation" means that term as defined in section 20902.

(4) "Attending physician" means the physician selected by, or assigned to, the patient and who has primary responsibility for the treatment and care of the patient.

(5) "Authorized representative" means the individual designated in writing by the board of directors of the corporation or by the owner or person with legal authority to act on behalf of the company or organization on licensing matters. The authorized representative who is not an owner or licensee shall not sign the original license application or amendments to the application.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1981, Act 79, Imd. Eff. June 30, 1981;—Am. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2010, Act 381, Imd. Eff. Dec. 22, 2010.

Popular name: Act 368

333.20104 Definitions; C to G.

Sec. 20104. (1) "Certification" means the issuance of a document by the department to a health facility or agency attesting to the fact that the health facility or agency meets both of the following:

(a) It complies with applicable statutory and regulatory requirements and standards.

(b) It is eligible to participate as a provider of care and services in a specific federal or state health program.

(2) "Consumer" means a person who is not a health care provider as defined in section 300jj of title 15 of the public health service act, 42 USC 300jj.

(3) "County medical care facility" means a nursing care facility, other than a hospital long-term care unit, that provides organized nursing care and medical treatment to 7 or more unrelated individuals who are suffering or recovering from illness, injury, or infirmity and that is owned by a county or counties.

(4) "Department" means the department of licensing and regulatory affairs.

(5) "Direct access" means access to a patient or resident or to a patient's or resident's property, financial information, medical records, treatment information, or any other identifying information.

(6) "Director" means the director of the department.

(7) "Freestanding surgical outpatient facility" means a facility, other than the office of a physician, dentist, podiatrist, or other private practice office, offering a surgical procedure and related care that in the opinion of the attending physician can be safely performed without requiring overnight inpatient hospital care. Freestanding surgical outpatient facility does not include a surgical outpatient facility owned by and operated as part of a hospital.

(8) "Good moral character" means that term as defined in section 1 of 1974 PA 381, MCL 338.41.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 2010, Act 381, Imd. Eff. Dec. 22, 2010;

—Am. 2015, Act 104, Eff. Oct. 1, 2015;—Am. 2015, Act 155, Eff. Jan. 18, 2016.

Popular name: Act 368

333.20106 Definitions; H.

Sec. 20106. (1) "Health facility or agency", except as provided in section 20115, means:

(a) An ambulance operation, aircraft transport operation, nontransport prehospital life support operation, or medical first response service.

(b) A county medical care facility.

(c) A freestanding surgical outpatient facility.

(d) A health maintenance organization.

(e) A home for the aged.

(f) A hospital.

(g) A nursing home.

(h) A hospice.

(i) A hospice residence.

(j) A facility or agency listed in subdivisions (a) to (g) located in a university, college, or other educational institution.

(2) "Health maintenance organization" means that term as defined in section 3501 of the insurance code of 1956, 1956 PA 218, MCL 500.3501.

(3) "Home for the aged" means a supervised personal care facility at a single address, other than a hotel, adult foster care facility, hospital, nursing home, or county medical care facility that provides room, board, and supervised personal care to 21 or more unrelated, nontransient, individuals 55 years of age or older. Home for the aged includes a supervised personal care facility for 20 or fewer individuals 55 years of age or older if the facility is operated in conjunction with and as a distinct part of a licensed nursing home. Home for the aged does not include an area excluded from this definition by section 17(3) of the continuing care community disclosure act, 2014 PA 448, MCL 554.917.

(4) "Hospice" means a health care program that provides a coordinated set of services rendered at home or in outpatient or institutional settings for individuals suffering from a disease or condition with a terminal prognosis.

(5) "Hospital" means a facility offering inpatient, overnight care, and services for observation, diagnosis, and active treatment of an individual with a medical, surgical, obstetric, chronic, or rehabilitative condition requiring the daily direction or supervision of a physician. Hospital does not include a mental health hospital licensed or operated by the department of health and human services or a hospital operated by the department of corrections.

(6) "Hospital long-term care unit" means a nursing care facility, owned and operated by and as part of a hospital, providing organized nursing care and medical treatment to 7 or more unrelated individuals suffering or recovering from illness, injury, or infirmity.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1980, Act 293, Eff. Mar. 31, 1981;—Am. 1981, Act 79, Imd. Eff. June 30, 1981;—Am. 1982, Act 354, Imd. Eff. Dec. 21, 1982;—Am. 1984, Act 311, Eff. Mar. 29, 1985;—Am. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 1996, Act 267, Imd. Eff. June 12, 1996;—Am. 2000, Act 253, Imd. Eff. June 29, 2000;—Am. 2014, Act 449, Imd. Eff. Jan. 2, 2015;—Am. 2015, Act 104, Eff. Oct. 1, 2015;—Am. 2017, Act 167, Eff. Feb. 11, 2018.

Popular name: Act 368

333.20108 Definitions; I to N.

Sec. 20108. (1) “Intermediate care facility” means a hospital long-term care unit, nursing home, county medical care facility, or other nursing care facility, or distinct part thereof, certified by the department to provide intermediate care or basic care that is less than skilled nursing care but more than room and board.

(2) “License” means an authorization, annual or as otherwise specified, granted by the department and evidenced by a certificate of licensure or permit granting permission to a person to establish or maintain and operate, or both, a health facility or agency. For purposes of part 209, “license” includes a license issued to an individual under that part.

(3) “Licensee” means the holder of a license or permit to establish or maintain and operate, or both, a health facility or agency. For purposes of part 209, “licensee” includes an individual licensed under that part.

(4) “Limited license” means a provisional license or temporary permit or a license otherwise limited as prescribed by the department.

(5) “Medically contraindicated” means, with reference to nursing homes only, having a substantial adverse effect on the patient's physical health, as determined by the attending physician, which effect is explicitly stated in writing with the reasons therefor in the patient's medical record.

(6) “Medical first response service” means that term as defined in section 20906.

(7) “Nontransport prehospital life support operation” means that term as defined in section 20908.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1986, Act 78, Imd. Eff. Apr. 7, 1986;—Am. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20109 Definitions; N to S.

Sec. 20109. (1) "Nursing home" means a nursing care facility, including a county medical care facility, that provides organized nursing care and medical treatment to 7 or more unrelated individuals suffering or recovering from illness, injury, or infirmity. As used in this subsection, "medical treatment" includes treatment by an employee or independent contractor of the nursing home who is an individual licensed or otherwise authorized to engage in a health profession under part 170 or 175. Nursing home does not include any of the following:

(a) A unit in a state correctional facility.

(b) A hospital.

(c) A veterans facility created under 1885 PA 152, MCL 36.1 to 36.12.

(d) A hospice residence that is licensed under this article.

(e) A hospice that is certified under 42 CFR 418.100.

(2) "Person" means that term as defined in section 1106 or a governmental entity.

(3) "Public member" means a member of the general public who is not a provider; who does not have an ownership interest in or contractual relationship with a nursing home other than a resident contract; who does not have a contractual relationship with a person who does substantial business with a nursing home; and who is not the spouse, parent, sibling, or child of an individual who has an ownership interest in or contractual relationship with a nursing home, other than a resident contract.

(4) "Skilled nursing facility" means a hospital long-term care unit, nursing home, county medical care facility, or other nursing care facility, or a distinct part thereof, certified by the department to provide skilled nursing care.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1991, Act 39, Imd. Eff. June 11, 1991;—Am. 1996, Act 224, Eff. June 12, 1996;—Am. 2015, Act 156, Eff. Jan. 18, 2016.

Popular name: Act 368

333.20115 Rules defining or differentiating health facility or agency; rules differentiating freestanding surgical outpatient facility from private office; republication of certain rules; waiver or modification; information to be provided to department of licensing and regulatory affairs; definitions.

Sec. 20115. (1) The department may promulgate rules to further define the term "health facility or agency" and the definition of a health facility or agency listed in section 20106 as required to implement this article. The department may define a specific organization as a health facility or agency for the sole purpose of certification authorized under this article. For purpose of certification only, an organization defined in section 20106(5), 20108(1), or 20109(4) is considered a health facility or agency. The term "health facility or agency" does not mean a visiting nurse service or home aide service conducted by and for the adherents of a church or religious denomination for the purpose of providing service for those who depend upon spiritual means through prayer alone for healing.

(2) The department shall promulgate rules to differentiate a freestanding surgical outpatient facility from a private office of a physician, dentist, podiatrist, or other health professional. The department shall specify in the rules that a facility including, but not limited to, a private practice office described in this subsection must be licensed under this article as a freestanding surgical outpatient facility if that facility performs 120 or more surgical abortions per year and publicly advertises outpatient abortion services.

(3) The department shall promulgate rules that in effect republish R 325.3826, R 325.3832, R 325.3835, R 325.3857, R 325.3866, R 325.3867, and R 325.3868 of the Michigan administrative code, but shall include in the rules standards for a freestanding surgical outpatient facility or private practice office that performs 120 or more surgical abortions per year and that publicly advertises outpatient abortion services. The department shall assure that the standards are consistent with the most recent United States supreme court decisions regarding state regulation of abortions.

(4) Subject to section 20145 and part 222, the department may modify or waive 1 or more of the rules contained in R 325.3801 to R 325.3877 of the Michigan administrative code regarding construction or equipment standards, or both, for a freestanding surgical outpatient facility that performs 120 or more surgical abortions per year and that publicly advertises outpatient abortion services, if both of the following conditions

are met:

(a) The freestanding surgical outpatient facility was in existence and operating on December 31, 2012.

(b) The department makes a determination that the existing construction or equipment conditions, or both, within the freestanding surgical outpatient facility are adequate to preserve the health and safety of the patients and employees of the freestanding surgical outpatient facility or that the construction or equipment conditions, or both, can be modified to adequately preserve the health and safety of the patients and employees of the freestanding surgical outpatient facility without meeting the specific requirements of the rules.

(5) By January 15 each year, the department of community health shall provide the following information to the department of licensing and regulatory affairs:

(a) From data received by the department of community health through the abortion reporting requirements of section 2835, all of the following:

(*i*) The name and location of each facility at which abortions were performed during the immediately preceding calendar year.

(*ii*) The total number of abortions performed at that facility location during the immediately preceding calendar year.

(*iii*) The total number of surgical abortions performed at that facility location during the immediately preceding calendar year.

(b) Whether a facility at which surgical abortions were performed in the immediately preceding calendar year publicly advertises abortion services.

(6) As used in this section:

(a) "Abortion" means that term as defined in section 17015.

(b) "Publicly advertises" means to advertise using directory or internet advertising including yellow pages, white pages, banner advertising, or electronic publishing.

(c) "Surgical abortion" means an abortion that is not a medical abortion as that term is defined in section 17017.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1999, Act 206, Eff. Mar. 10, 2000;—Am. 2012, Act 499, Eff. Mar. 31, 2013.

Popular name: Act 368

Administrative rules: R 325.3801 et seq. and R 325.23101 et seq. of the Michigan Administrative Code.

333.20121 Health facilities and agencies advisory commission; creation; appointment and qualification of members; director as ex officio member without vote.

Sec. 20121. The health facilities and agencies advisory commission is created in the department. The governor shall appoint the members with the advice and consent of the senate. Half the members shall be consumers and half the members shall be representative of different types of licensees, with at least 1 representative of each type. Membership shall include at least 1 practicing physician, 1 registered nurse, and 1 enrollee of a health maintenance organization who is a consumer of health care. The director shall serve as an ex officio member of the advisory commission without vote.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the health facilities and agencies advisory commission to the director of the Michigan state department of public health, see E.R.O. No. 1994-1, compiled at MCL 333.26322 of the Michigan Compiled Laws.

Popular name: Act 368

333.20122 Advisory commission; terms of members; vacancy; removal.

Sec. 20122. (1) A member of the advisory commission shall serve for a term of 4 years or until a successor is appointed, except that the terms of members first appointed shall be as provided by section 1214. A member shall not serve more than 2 full terms and 1 partial term, consecutive or otherwise.

(2) A vacancy shall be filled in the same manner as an original appointment for the balance of the unexpired term.

(3) The director may recommend to the governor the removal of a member from the advisory commission at any time for poor attendance at meetings or other good cause.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20123 Advisory commission; meetings; chairperson and vice-chairperson; vacancy; quorum; expenses.

Sec. 20123. (1) The advisory commission shall meet at the call of its chairperson or the director at least

twice each year.

(2) The advisory commission shall elect a chairperson and vice-chairperson for terms of 2 years. The chairperson shall be a consumer and the vice-chairperson a licensee representative. A vacancy in either office shall be filled by election for the balance of the unexpired term.

(3) The advisory commission shall determine the number of voting members that constitute a quorum for the transaction of business.

(4) Advisory commission members and task force members shall be reimbursed for expenses incurred in the performance of official duties as provided in section 1216.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.20124 Advisory commission; duties generally.

Sec. 20124. The advisory commission shall:

(a) Approve rules relating to the licensure and certification of health facilities and agencies other than health maintenance organizations and the administration of this article before their promulgation.

(b) Receive reports of licenses denied, limited, suspended, or revoked pursuant to this article.

(c) Advise the department as to administration of health facility and agency licensure and certification functions, including recommendations with respect to licensing actions.

(d) Biennially conduct a review and prepare a written evaluation of health facility and agency licensure and certification functions performed by the department, including appropriate recommendations. The recommendations shall give particular attention to policies as to public disclosure and nondiscrimination and the standardization and integration of rules common to more than 1 category of health facility or agency.

(e) Review complaints made under section 20176.

(f) Provide other assistance the department reasonably requests.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 2000, Act 253, Imd. Eff. June 29, 2000.

Popular name: Act 368

333.20126 Task forces; appointment; purpose; duties; membership; staff support.

Sec. 20126. (1) The advisory commission chairperson shall appoint 4 task forces to advise the commission in carrying out its duties as follows:

(a) Task force 1 shall assist in matters pertaining to the licensure and certification of health facilities and agencies under this part, except ambulance operations, aircraft transport operations, nontransport prehospital life support operations, medical first response services, health maintenance organizations, and nursing homes.

(b) Task force 2 shall assist in matters pertaining to the licensure of ambulance operations, aircraft transport operations, nontransport prehospital life support operations, and medical first response services under part 209.

(c) Task force 3 shall assist in matters pertaining to the licensure and certification of health maintenance organizations.

(d) Task force 4 shall assist in matters pertaining to the licensure of nursing homes as provided in section 20127.

(2) Except as provided by subsections (4), (5), and (6), each task force shall be composed of a number of advisory commission members to be determined by the chairperson. The chairperson with the approval of the director may appoint noncommission members to each task force as associate task force members if necessary to provide adequate expert professional and technical support.

(3) The department shall provide staff support to the advisory commission and its task forces.

(4) The state emergency medical services coordination committee created in section 20915 shall be appointed as task force 2 and shall perform the duties set forth in this section.

(5) Initial appointments to task force 3 shall include the members of the commission created by section 7 of former Act No. 264 of the Public Acts of 1974.

(6) Task force 4 shall be established as provided in section 20127.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1981, Act 79, Imd. Eff. June 30, 1981;—Am. 1990, Act 179, Imd. Eff. July 2, 1990.

Compiler's note: Act 264 of 1974, referred to in this section, was repealed by Act 368 of 1978 .

Popular name: Act 368

333.20127 Task force 4; purpose; appointment and qualifications of members; chairperson and vice-chairperson; quorum; procedures; duties.

Sec. 20127. (1) Task force 4 shall be composed of 15 state residents to review the operation of part 217 and rules promulgated under part 217, to hear and evaluate complaints in implementation of part 217, and to recommend to the legislature and the department changes in part 217 and the rules.

(2) The director shall appoint the task force members, 1 of whom shall be a nurse having a background in gerontology, 1 a social worker having a background in gerontology, 5 representatives of nursing homes, 3 representatives of public interest health consumer groups, and 5 public members, 3 of whom have or have had relatives in a nursing home. In addition, there shall be 2 ex officio members without vote, 1 representing the department of public health, and 1 representing the department of social services.

(3) A majority of the voting members of the task force shall be consumers.

(4) The task force annually shall elect a chairperson and a vice-chairperson.

(5) The task force shall determine what constitutes a quorum and may establish procedures for the conduct of its business.

(6) The task force shall be charged with the following tasks:

(a) Meeting at least 6 times a year, at the call of the chairperson, the director, or any 3 members of the committee.

(b) Receiving and commenting on drafts of proposed rules.

(c) Receiving and making recommendations regarding complaint investigation reports, decisions, and procedures.

(d) Making reports and recommendations on needed changes in statutes and rules.

(e) Reviewing decisions as provided in section 21764.

(f) Reviewing complaints received under section 21763.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.20131 Comprehensive system of licensure and certification; establishment; purpose; certification of health facility or agency; coordination, cooperation, and agreements; public disclosure.

Sec. 20131. (1) The department shall establish a comprehensive system of licensure and certification for health facilities or agencies in accordance with this article to:

(a) Protect the health, safety, and welfare of individuals receiving care and services in or from a health facility or agency.

(b) Assure the medical accountability for reimbursed care provided by a certified health facility or agency participating in a federal or state health program.

(2) The department may certify a health facility or agency, or part thereof, defined in section 20106 or under section 20115 when certification is required by state or federal law, rule, or regulation.

(3) The department shall coordinate all functions in state government affecting health facilities and agencies licensed under this article and cooperate with other state agencies which establish standards or requirements for health facilities and agencies to assure necessary, equitable, and consistent state supervision of licensees without unnecessary duplication of survey, evaluation, and consultation services or complaint investigations. The department may enter into agreements with other state agencies necessary to accomplish this purpose.

(4) The department shall utilize public disclosure to improve the effectiveness of licensure.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20132 Regulation of medical or surgical treatment prohibited; control of communicable diseases; protection of individuals receiving care and services; standards for inpatient food service establishment; compliance.

Sec. 20132. (1) The department shall not regulate the medical or surgical treatment provided to an individual by his or her attending physician in a health facility or agency.

(2) This article does not affect the authority of the department to control communicable diseases or to take immediate action necessary to protect the public health, safety, and welfare of individuals receiving care and services in or from a health facility or agency.

(3) A license for a health facility or agency shall include the operation of an inpatient food service establishment within the facility or agency. Standards for an inpatient food service establishment shall be the same as those established under part 129. A health facility or agency issued a license under this article is considered in compliance with that part.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20141 Health facility or agency; license required; eligibility to participate in federal or state health program; personnel; services; and equipment; evidence of compliance; providing data and statistics.

Sec. 20141. (1) A person shall not establish or maintain and operate a health facility or agency without holding a license from the department.

(2) A health facility or agency is not eligible to participate in a federal or state health program requiring certification without current certification from the department.

(3) A health facility or agency shall have the physician, professional nursing, health professional, technical and supportive personnel, and the technical, diagnostic, and treatment services and equipment necessary to assure the safe performance of the health care undertaken by or in the facility or agency.

(4) Licensure and certification of a health facility or agency shall be evidence of the fact that the facility or agency complies with applicable statutory and regulatory requirements and standards at the time of issuance.

(5) A health facility or agency shall provide the department with the data and statistics required to enable the department to carry out functions required by federal and state law, including rules and regulations.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20142 Application for licensure and certification; form; certifying accuracy of information; disclosures, reports; and notices; violation; penalty; false statement as felony.

Sec. 20142. (1) A health facility or agency shall apply for licensure or certification on a form authorized and provided by the department. The application shall include attachments, additional data, and information required by the department.

(2) An applicant shall certify the accuracy of information supplied in the application and supplemental statements.

(3) An applicant or a licensee under part 213 or 217 shall disclose the names, addresses, principal occupations, and official positions of all persons who have an ownership interest in the health facility or agency. If the health facility or agency is located on or in leased real estate, the applicant or licensee shall disclose the name of the lessor and any direct or indirect interest the applicant or licensee has in the lease other than as lessee. A change in ownership shall be reported to the director not less than 15 days before the change occurs, except that a person purchasing stock of a company registered pursuant to the securities exchange act of 1934, 15 U.S.C. 78a to 78kk, is exempt from disclosing ownership in the facility. A person required to file a beneficial ownership report pursuant to section 16(a) of the securities exchange act of 1934, 15 U.S.C. 78p shall file with the department information relating to securities ownership required by the department rule or order. An applicant or licensee proposing a sale of a nursing home to another person shall provide the department with written, advance notice of the proposed sale. The applicant or licensee and the other parties to the sale shall arrange to meet with specified department representatives and shall obtain before the sale a determination of the items of noncompliance with applicable law and rules which shall be corrected. The department shall notify the respective parties of the items of noncompliance prior to the change of ownership and shall indicate that the items of noncompliance must be corrected as a condition of issuance of a license to the new owner. The department may accept reports filed with the securities and exchange commission relating to the filings. A person who violates this subsection is guilty of a misdemeanor, punishable by a fine of not more than $1,000.00 for each violation.

(4) An applicant or licensee under part 217 shall disclose the names and business addresses of suppliers who furnish goods or services to an individual nursing home or a group of nursing homes under common ownership, the aggregate charges for which exceed $5,000.00 in a 12-month period which includes a month in a nursing home's current fiscal year. An applicant or licensee shall disclose the names, addresses, principal occupations, and official positions of all persons who have an ownership interest in a business which furnishes goods or services to an individual nursing home or to a group of nursing homes under common ownership, if both of the following apply:

(a) The person, or the person's spouse, parent, sibling, or child has an ownership interest in the nursing home purchasing the goods or services.

(b) The aggregate charges for the goods or services purchased exceeds $5,000.00 in a 12-month period which includes a month in the nursing home's current fiscal year.

(5) An applicant or licensee who makes a false statement in an application or statement required by the

department pursuant to this article is guilty of a felony, punishable by imprisonment for not more than 4 years, or a fine of not more than $30,000.00, or both.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.20143 Compliance as condition to issuance of license, certificate, or certificate of need.

Sec. 20143. (1) A license or certificate under this part shall not be issued unless the applicant is in compliance with part 222.

(2) A licensee who is issued a certificate of need under part 222 shall comply with part 222 and all of the terms, conditions, and stipulations of the certificate of need.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1988, Act 332, Eff. Oct. 1, 1988.

Popular name: Act 368

333.20144 Licensing on basis of approved building program.

Sec. 20144. A health facility or agency not meeting statutory and regulatory requirements for its physical plant and equipment may be licensed by the department on the basis of a building program approved by the department which:

(a) Sets forth a plan and timetable for correction of physical plant or equipment deficiencies and items of noncompliance.

(b) Includes documented evidence of the availability and commitment of money for carrying out the approved building program.

(c) Includes other documentation the department reasonably requires to assure compliance with the plan and timetable.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20145 Construction permit; certificate of need as condition of issuance; rules; information required for project not requiring certificate of need; public information; review and approval of architectural plans and narrative; rules; waiver; fee; "capital expenditure" defined.

Sec. 20145. (1) Before contracting for and initiating a construction project involving new construction, additions, modernizations, or conversions of a health facility or agency with a capital expenditure of $1,000,000.00 or more, a person shall obtain a construction permit from the department. The department shall not issue the permit under this subsection unless the applicant holds a valid certificate of need if a certificate of need is required for the project under part 222.

(2) To protect the public health, safety, and welfare, the department may promulgate rules to require construction permits for projects other than those described in subsection (1) and the submission of plans for other construction projects to expand or change service areas and services provided.

(3) If a construction project requires a construction permit under subsection (1) or (2), but does not require a certificate of need under part 222, the department shall require the applicant to submit information considered necessary by the department to assure that the capital expenditure for the project is not a covered capital expenditure as defined in section 22203(9).

(4) If a construction project requires a construction permit under subsection (1), but does not require a certificate of need under part 222, the department shall require the applicant to submit information on a 1-page sheet, along with the application for a construction permit, consisting of all of the following:

(a) A short description of the reason for the project and the funding source.

(b) A contact person for further information, including address and phone number.

(c) The estimated resulting increase or decrease in annual operating costs.

(d) The current governing board membership of the applicant.

(e) The entity, if any, that owns the applicant.

(5) The information filed under subsection (4) shall be made publicly available by the department by the same methods used to make information about certificate of need applications publicly available.

(6) The review and approval of architectural plans and narrative shall require that the proposed construction project is designed and constructed in accord with applicable statutory and other regulatory requirements. In performing a construction permit review for a health facility or agency under this section, the department shall, at a minimum, apply the standards contained in the document entitled "Minimum Design Standards for Health Care Facilities in Michigan" published by the department and dated July 2007. The

standards are incorporated by reference for purposes of this subsection. The department may promulgate rules that are more stringent than the standards if necessary to protect the public health, safety, and welfare.

(7) The department shall promulgate rules to further prescribe the scope of construction projects and other alterations subject to review under this section.

(8) The department may waive the applicability of this section to a construction project or alteration if the waiver will not affect the public health, safety, and welfare.

(9) Upon request by the person initiating a construction project, the department may review and issue a construction permit to a construction project that is not subject to subsection (1) or (2) if the department determines that the review will promote the public health, safety, and welfare.

(10) The department shall assess a fee for each review conducted under this section. The fee is .5% of the first $1,000,000.00 of capital expenditure and .85% of any amount over $1,000,000.00 of capital expenditure, up to a maximum of $60,000.00.

(11) As used in this section, "capital expenditure" means that term as defined in section 22203(2), except that capital expenditure does not include the cost of equipment that is not fixed equipment.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1990, Act 331, Imd. Eff. Dec. 21, 1990;—Am. 1991, Act 13, Imd. Eff. Apr. 25, 1991;—Am. 1993, Act 88, Imd. Eff. July 9, 1993;—Am. 2002, Act 683, Imd. Eff. Dec. 30, 2002;—Am. 2004, Act 469, Imd. Eff. Dec. 28, 2004;—Am. 2015, Act 104, Eff. Oct. 1, 2015.

Popular name: Act 368

Administrative rules: R 325.3801 et seq. and R 325.20101 et seq. of the Michigan Administrative Code.

333.20151 Cooperation; professional advice and consultation.

Sec. 20151. A licensee or certificate holder shall cooperate with the department in carrying out its responsibility under this article. The department shall, to the extent allowed by law, provide professional advice and consultation as to the quality of facility or agency aspects of health care and services provided by the applicant or licensee.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 2000, Act 171, Imd. Eff. June 20, 2000.

Popular name: Act 368

333.20152 Certification by licensee; developing facilities and programs of care; rating individuals for purposes of reimbursement.

Sec. 20152. (1) A licensee shall certify to the department as part of its application for licensing and certification, that:

(a) All phases of its operation, including its training programs, comply with state and federal laws prohibiting discrimination. The applicant shall direct the administrator of the health facility or agency to take the necessary action to assure that the facility or agency is, in fact, so operated.

(b) Selection and appointment of physicians to its medical staff is without discrimination on the basis of licensure or registration as doctors of medicine or doctors of osteopathic medicine and surgery.

(2) This section does not prohibit a health facility or agency from developing facilities and programs of care that are for specific ages or sexes or rating individuals for purposes of determining appropriate reimbursement for care and services.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1981, Act 111, Imd. Eff. July 17, 1981.

Popular name: Act 368

333.20153 Definitions; single-use device; reusing, recycling, or refurbishing prohibited; exceptions; violation as felony; penalty.

Sec. 20153. (1) As used in this section:

(a) "Health care provider" means a health facility or agency or a health professional that utilizes single-use devices in furnishing medical or surgical treatment or care to human patients.

(b) "Health professional" means an individual licensed, certified, or authorized to engage in a health profession under article 15, but not including dentists, dental hygienists, or dental assistants under part 166 or veterinarians or veterinary technicians under part 188.

(c) "Original device" means a new, unused single-use device.

(d) "Reprocessed" means with respect to a single-use device, an original device that has previously been used on a human patient and has been subjected to additional processing and manufacturing for the purpose of additional use on a different human patient. Reprocessed includes the subsequent processing and manufacture of a reprocessed single-use device and any single-use device that meets the definition in this subdivision without regard to any description of the device used by the manufacturer of the device or other persons,

including a description that uses the term "recycled", "refurbished", or "reused" rather than the term "reprocessed". Reprocessed does not include a disposable or single-use device that has been opened but not used on a person.

(e) "Single-use device" means a medical device that is intended for 1 use or procedure on a human patient, including any device marked "single-use device".

(2) Except as otherwise provided in this section, a health care provider shall not knowingly reuse, recycle, refurbish for reuse, or provide for reuse a single-use device.

(3) This section does not apply to a health care provider that does any of the following:

(a) Utilizes, recycles or reprocesses for utilization, or provides for utilization a single-use device that has been reprocessed by an entity that is registered as a reprocessor and is regulated by the United States food and drug administration.

(b) Utilizes an opened, but unused single-use device for which the sterility has been breached or compromised and that meets all of the following requirements:

(*i*) The single-use device has not been used on a human patient and has not been in contact with blood or bodily fluids.

(*ii*) The single-use device has been resterilized.

(c) Utilizes a used single-use device on the same human patient in an emergency situation.

(4) A health care provider that violates this section is guilty of a felony punishable by imprisonment for not more than 10 years or a fine of not more than $50,000.00, or both. A violation of this section by a health professional is considered a violation of article 15 and that health professional is subject to administrative action under sections 16221(h) and 16226.

History: Add. 2010, Act 25, Imd. Eff. Mar. 26, 2010.

Popular name: Act 368

333.20155 Visit to health facility or agency; survey and evaluation for purpose of licensure; nursing home surveyor; criminal history check; survey team; composition and membership; waiver; confidentiality of accreditation information; limitation and effect; consultation engineering survey; summary of substantial noncompliance or deficiencies and response; investigations or inspections; prior notice as misdemeanor; record; periodic reports; access to documents; disclosure; delegation of functions; voluntary inspections; forwarding evidence of violation to licensing agency; reports; clarification of terms; quarterly meeting; resident care policies and compliance protocols; nursing home's survey report; posting; other state and federal law; definitions.

Sec. 20155. (1) Except as otherwise provided in this section and section 20155a, the department shall make at least 1 visit to each licensed health facility or agency every 3 years for survey and evaluation for the purpose of licensure. A visit made according to a complaint shall be unannounced. Except for a county medical care facility, a home for the aged, a nursing home, or a hospice residence, the department shall determine whether the visits that are not made according to a complaint are announced or unannounced. The department shall ensure that each newly hired nursing home surveyor, as part of his or her basic training, is assigned full-time to a licensed nursing home for at least 10 days within a 14-day period to observe actual operations outside of the survey process before the trainee begins oversight responsibilities.

(2) The department shall establish a process that ensures both of the following:

(a) A newly hired nursing home surveyor does not make independent compliance decisions during his or her training period.

(b) A nursing home surveyor is not assigned as a member of a survey team for a nursing home in which he or she received training for 1 standard survey following the training received in that nursing home.

(3) The department shall perform a criminal history check on all nursing home surveyors in the manner provided for in section 20173a.

(4) A member of a survey team must not be employed by a licensed nursing home or a nursing home management company doing business in this state at the time of conducting a survey under this section. The department shall not assign an individual to be a member of a survey team for purposes of a survey, evaluation, or consultation visit at a nursing home in which he or she was an employee within the preceding 3 years.

(5) The department shall invite representatives from all nursing home provider organizations and the state long-term care ombudsman or his or her designee to participate in the planning process for the joint provider and surveyor training sessions. The department shall include at least 1 representative from nursing home provider organizations that do not own or operate a nursing home representing 30 or more nursing homes

statewide in internal surveyor group quality assurance training provided for the purpose of general clarification and interpretation of existing or new regulatory requirements and expectations.

(6) The department shall make available online the general civil service position description related to the required qualifications for individual surveyors. The department shall use the required qualifications to hire, educate, develop, and evaluate surveyors.

(7) The department shall ensure that each annual survey team is composed of an interdisciplinary group of professionals, 1 of whom must be a registered nurse. Other members may include social workers, therapists, dietitians, pharmacists, administrators, physicians, sanitarians, and others who may have the expertise necessary to evaluate specific aspects of nursing home operation.

(8) The department shall semiannually provide for joint training with nursing home surveyors and providers on at least 1 of the 10 most frequently issued federal citations in this state during the past calendar year. The department shall develop a protocol for the review of citation patterns compared to regional outcomes and standards and complaints regarding the nursing home survey process. The department shall include the review under this subsection in the report required under subsection (20). Except as otherwise provided in this subsection, each member of a department nursing home survey team who is a health professional licensee under article 15 shall earn not less than 50% of his or her required continuing education credits, if any, in geriatric care. If a member of a nursing home survey team is a pharmacist licensed under article 15, he or she shall earn not less than 30% of his or her required continuing education credits in geriatric care.

(9) Subject to subsection (12), the department may waive the visit required by subsection (1) if a health facility or agency, requests a waiver and submits the following as applicable and if all of the requirements of subsection (11) are met:

(a) Evidence that it is currently fully accredited by a body with expertise in the health facility or agency type and the accrediting organization is accepted by the United States Department of Health and Human Services for purposes of section 1865 of the social security act, 42 USC 1395bb.

(b) A copy of the most recent accreditation report, or executive summary, issued by a body described in subdivision (a), and the health facility's or agency's responses to the accreditation report is submitted to the department at least 30 days from license renewal. Submission of an executive summary does not prevent or prohibit the department from requesting the entire accreditation report if the department considers it necessary.

(c) For a nursing home, a standard federal certification survey conducted within the immediately preceding 9 to 15 months that shows substantial compliance or has an accepted plan of correction, if applicable.

(10) Except as otherwise provided in subsection (14), accreditation information provided to the department under subsection (9) is confidential, is not a public record, and is not subject to court subpoena. The department shall use the accreditation information only as provided in this section and properly destroy the documentation after a decision on the waiver request is made.

(11) The department shall grant a waiver under subsection (9) if the accreditation report submitted under subsection (9)(b) is less than 3 years old or the standard federal survey submitted under subsection (9)(c) is less than 15 months old and there is no indication of substantial noncompliance with licensure standards or of deficiencies that represent a threat to public safety or patient care. If the accreditation report or standard federal survey is too old, the department may deny the waiver request and conduct the visits required under subsection (9). Denial of a waiver request by the department is not subject to appeal.

(12) This section does not prohibit the department from citing a violation of this part during a survey, conducting investigations or inspections according to section 20156, or conducting surveys of health facilities or agencies for the purpose of complaint investigations or federal certification. This section does not prohibit the bureau of fire services created in section 1b of the fire prevention code, 1941 PA 207, MCL 29.1b, from conducting annual surveys of hospitals, nursing homes, and county medical care facilities.

(13) At the request of a health facility or agency, the department may conduct a consultation engineering survey of a health facility and provide professional advice and consultation regarding health facility construction and design. A health facility or agency may request a voluntary consultation survey under this subsection at any time between licensure surveys. The fees for a consultation engineering survey are the same as the fees established for waivers under section 20161(8).

(14) If the department determines that substantial noncompliance with licensure standards exists or that deficiencies that represent a threat to public safety or patient care exist based on a review of an accreditation report submitted under subsection (9)(b), the department shall prepare a written summary of the substantial noncompliance or deficiencies and the health facility's or agency's response to the department's determination. The department's written summary and the health facility's or agency's response are public documents.

(15) The department or a local health department shall conduct investigations or inspections, other than

inspections of financial records, of a county medical care facility, home for the aged, nursing home, or hospice residence without prior notice to the health facility or agency. An employee of a state agency charged with investigating or inspecting the health facility or agency or an employee of a local health department who directly or indirectly gives prior notice regarding an investigation or an inspection, other than an inspection of the financial records, to the health facility or agency or to an employee of the health facility or agency, is guilty of a misdemeanor. Consultation visits that are not for the purpose of annual or follow-up inspection or survey may be announced.

(16) The department shall maintain a record indicating whether a visit and inspection is announced or unannounced. Survey findings gathered at each health facility or agency during each visit and inspection, whether announced or unannounced, shall be taken into account in licensure decisions.

(17) The department shall require periodic reports and a health facility or agency shall give the department access to books, records, and other documents maintained by a health facility or agency to the extent necessary to carry out the purpose of this article and the rules promulgated under this article. The department shall not divulge or disclose the contents of the patient's clinical records in a manner that identifies an individual except under court order. The department may copy health facility or agency records as required to document findings. Surveyors shall use electronic resident information, whenever available, as a source of survey-related data and shall request facility assistance to access the system to maximize data export.

(18) The department may delegate survey, evaluation, or consultation functions to another state agency or to a local health department qualified to perform those functions. The department shall not delegate survey, evaluation, or consultation functions to a local health department that owns or operates a hospice or hospice residence licensed under this article. The department shall delegate under this subsection by cost reimbursement contract between the department and the state agency or local health department. The department shall not delegate survey, evaluation, or consultation functions to nongovernmental agencies, except as provided in this section. The voluntary inspection described in this subsection must be agreed upon by both the licensee and the department.

(19) If, upon investigation, the department or a state agency determines that an individual licensed to practice a profession in this state has violated the applicable licensure statute or the rules promulgated under that statute, the department, state agency, or local health department shall forward the evidence it has to the appropriate licensing agency.

(20) The department may consolidate all information provided for any report required under this section and section 20155a into a single report. The department shall report to the appropriations subcommittees, the senate and house of representatives standing committees having jurisdiction over issues involving senior citizens, and the fiscal agencies on March 1 of each year on the initial and follow-up surveys conducted on all nursing homes in this state. The department shall include all of the following information in the report:

(a) The number of surveys conducted.

(b) The number requiring follow-up surveys.

(c) The average number of citations per nursing home for the most recent calendar year.

(d) The number of night and weekend complaints filed.

(e) The number of night and weekend responses to complaints conducted by the department.

(f) The average length of time for the department to respond to a complaint filed against a nursing home.

(g) The number and percentage of citations disputed through informal dispute resolution and independent informal dispute resolution.

(h) The number and percentage of citations overturned or modified, or both.

(i) The review of citation patterns developed under subsection (8).

(j) Information regarding the progress made on implementing the administrative and electronic support structure to efficiently coordinate all nursing home licensing and certification functions.

(k) The number of annual standard surveys of nursing homes that were conducted during a period of open survey or enforcement cycle.

(*l*) The number of abbreviated complaint surveys that were not conducted on consecutive surveyor workdays.

(m) The percent of all form CMS-2567 reports of findings that were released to the nursing home within the 10-working-day requirement.

(n) The percent of provider notifications of acceptance or rejection of a plan of correction that were released to the nursing home within the 10-working-day requirement.

(o) The percent of first revisits that were completed within 60 days from the date of survey completion.

(p) The percent of second revisits that were completed within 85 days from the date of survey completion.

(q) The percent of letters of compliance notification to the nursing home that were released within 10 working days of the date of the completion of the revisit.

(r) A summary of the discussions from the meetings required in subsection (24).

(s) The number of nursing homes that participated in a recognized quality improvement program as described under section 20155a(3).

(21) The department shall report March 1 of each year to the standing committees on appropriations and the standing committees having jurisdiction over issues involving senior citizens in the senate and the house of representatives on all of the following:

(a) The percentage of nursing home citations that are appealed through the informal dispute resolution process.

(b) The number and percentage of nursing home citations that are appealed and supported, amended, or deleted through the informal dispute resolution process.

(c) A summary of the quality assurance review of the amended citations and related survey retraining efforts to improve consistency among surveyors and across the survey administrative unit that occurred in the year being reported.

(22) Subject to subsection (23), a clarification work group comprised of the department in consultation with a nursing home resident or a member of a nursing home resident's family, nursing home provider groups, the American Medical Directors Association, the state long-term care ombudsman, and the federal Centers for Medicare and Medicaid Services shall clarify the following terms as those terms are used in title XVIII and title XIX and applied by the department to provide more consistent regulation of nursing homes in this state:

(a) Immediate jeopardy.

(b) Harm.

(c) Potential harm.

(d) Avoidable.

(e) Unavoidable.

(23) All of the following clarifications developed under subsection (22) apply for purposes of subsection (22):

(a) Specifically, the term "immediate jeopardy" means a situation in which immediate corrective action is necessary because the nursing home's noncompliance with 1 or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident receiving care in a nursing home.

(b) The likelihood of immediate jeopardy is reasonably higher if there is evidence of a flagrant failure by the nursing home to comply with a peer-reviewed, evidence-based, nationally recognized clinical process guideline than if the nursing home has substantially and continuously complied with peer-reviewed, evidence-based, nationally recognized guidelines. If federal regulations and guidelines are not clear, and if the clinical process guidelines have been recognized, a process failure giving rise to an immediate jeopardy may involve an egregious widespread or repeated process failure and the absence of reasonable efforts to detect and prevent the process failure.

(c) In determining whether or not there is immediate jeopardy, the survey agency should consider at least all of the following:

(*i*) Whether the nursing home could reasonably have been expected to know about the deficient practice and to stop it, but did not stop the deficient practice.

(*ii*) Whether the nursing home could reasonably have been expected to identify the deficient practice and to correct it, but did not correct the deficient practice.

(*iii*) Whether the nursing home could reasonably have been expected to anticipate that serious injury, serious harm, impairment, or death might result from continuing the deficient practice, but did not so anticipate.

(*iv*) Whether the nursing home could reasonably have been expected to know that a widely accepted high-risk practice is or could be problematic, but did not know.

(*v*) Whether the nursing home could reasonably have been expected to detect the process problem in a more timely fashion, but did not so detect.

(d) The existence of 1 or more of the factors described in subdivision (c), and especially the existence of 3 or more of those factors simultaneously, may lead to a conclusion that the situation is one in which the nursing home's practice makes adverse events likely to occur if immediate intervention is not undertaken, and therefore constitutes immediate jeopardy. If none of the factors described in subdivision (c) is present, the situation may involve harm or potential harm that is not immediate jeopardy.

(e) Specifically, "actual harm" means a negative outcome to a resident that has compromised the resident's ability to maintain or reach, or both, his or her highest practicable physical, mental, and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. Harm does not include a deficient practice that only may cause or has caused limited consequences to the resident.

(f) For purposes of subdivision (e), in determining whether a negative outcome is of limited consequence, if the "state operations manual" or "the guidance to surveyors" published by the federal Centers for Medicare and Medicaid Services does not provide specific guidance, the department may consider whether most people in similar circumstances would feel that the damage was of such short duration or impact as to be inconsequential or trivial. In such a case, the consequence of a negative outcome may be considered more limited if it occurs in the context of overall procedural consistency with a peer-reviewed, evidence-based, nationally recognized clinical process guideline, as compared to a substantial inconsistency with or variance from the guideline.

(g) For purposes of subdivision (e), if the publications described in subdivision (f) do not provide specific guidance, the department may consider the degree of a nursing home's adherence to a peer-reviewed, evidence-based, nationally recognized clinical process guideline in considering whether the degree of compromise and future risk to the resident constitutes actual harm. The risk of significant compromise to the resident may be considered greater in the context of substantial deviation from the guidelines than in the case of overall adherence.

(h) To improve consistency and to avoid disputes over avoidable and unavoidable negative outcomes, nursing homes and survey agencies must have a common understanding of accepted process guidelines and of the circumstances under which it can reasonably be said that certain actions or inactions will lead to avoidable negative outcomes. If the "state operations manual" or "the guidance to surveyors" published by the federal Centers for Medicare and Medicaid Services is not specific, a nursing home's overall documentation of adherence to a peer-reviewed, evidence-based, nationally recognized clinical process guideline with a process indicator is relevant information in considering whether a negative outcome was avoidable or unavoidable and may be considered in the application of that term.

(24) The department shall conduct a quarterly meeting and invite appropriate stakeholders. The department shall invite as appropriate stakeholders under this subsection at least 1 representative from each nursing home provider organization that does not own or operate a nursing home representing 30 or more nursing homes statewide, the state long-term care ombudsman or his or her designee, and any other clinical experts. Individuals who participate in these quarterly meetings, jointly with the department, may designate advisory workgroups to develop recommendations on the discussion topics that should include, at a minimum, all of the following:

(a) Opportunities for enhanced promotion of nursing home performance, including, but not limited to, programs that encourage and reward providers that strive for excellence.

(b) Seeking quality improvement to the survey and enforcement process, including clarifications to process-related policies and protocols that include, but are not limited to, all of the following:

(*i*) Improving the surveyors' quality and preparedness.

(*ii*) Enhanced communication between regulators, surveyors, providers, and consumers.

(*iii*) Ensuring fair enforcement and dispute resolution by identifying methods or strategies that may resolve identified problems or concerns.

(c) Promoting transparency across provider and surveyor communities, including, but not limited to, all of the following:

(*i*) Applying regulations in a consistent manner and evaluating changes that have been implemented to resolve identified problems and concerns.

(*ii*) Providing consumers with information regarding changes in policy and interpretation.

(*iii*) Identifying positive and negative trends and factors contributing to those trends in the areas of resident care, deficient practices, and enforcement.

(d) Clinical process guidelines.

(25) A nursing home shall use peer-reviewed, evidence-based, nationally recognized clinical process guidelines or peer-reviewed, evidence-based, best-practice resources to develop and implement resident care policies and compliance protocols with measurable outcomes specifically in the following clinical practice areas:

(a) Use of bed rails.

(b) Adverse drug effects.

(c) Prevention of falls.

(d) Prevention of pressure ulcers.

(e) Nutrition and hydration.

(f) Pain management.

(g) Depression and depression pharmacotherapy.

(h) Heart failure.

(i) Urinary incontinence.

(j) Dementia care.

(k) Osteoporosis.

(*l*) Altered mental states.

(m) Physical and chemical restraints.

(n) Person-centered care principles.

(26) In an area of clinical practice that is not listed in subsection (25), a nursing home may use peer-reviewed, evidence-based, nationally recognized clinical process guidelines or peer-reviewed, evidence-based, best-practice resources to develop and implement resident care policies and compliance protocols with measurable outcomes to promote performance excellence.

(27) The department shall consider recommendations from an advisory workgroup created under subsection (24). The department may include training on new and revised peer-reviewed, evidence-based, nationally recognized clinical process guidelines or peer-reviewed, evidence-based, best-practice resources, which contain measurable outcomes, in the joint provider and surveyor training sessions to assist provider efforts toward improved regulatory compliance and performance excellence and to foster a common understanding of accepted peer-reviewed, evidence-based, best-practice resources between providers and the survey agency. The department shall post on its website all peer-reviewed, evidence-based, nationally recognized clinical process guidelines and peer-reviewed, evidence-based, best-practice resources used in a training session under this subsection for provider, surveyor, and public reference.

(28) Representatives from each nursing home provider organization that does not own or operate a nursing home representing 30 or more nursing homes statewide and the state long-term care ombudsman or his or her designee are permanent members of a clinical advisory workgroup created under subsection (24). The department shall issue survey certification memorandums to providers to announce or clarify changes in the interpretation of regulations.

(29) The department shall maintain the process by which the director of the long-term care division or his or her designee reviews and authorizes the issuance of a citation for immediate jeopardy or substandard quality of care before the statement of deficiencies is made final. The review must assure the consistent and accurate application of federal and state survey protocols and defined regulatory standards. As used in this subsection, "immediate jeopardy" and "substandard quality of care" mean those terms as defined by the federal Centers for Medicare and Medicaid Services.

(30) Upon availability of funds, the department shall give grants, awards, or other recognition to nursing homes to encourage the rapid development and implementation of resident care policies and compliance protocols that are created from peer-reviewed, evidence-based, nationally recognized clinical process guidelines or peer-reviewed, evidence-based, best-practice resources with measurable outcomes to promote performance excellence.

(31) A nursing home shall post the nursing home's survey report in a conspicuous place within the nursing home for public review.

(32) Nothing in this section limits the requirements of related state and federal law.

(33) As used in this section:

(a) "Consecutive days" means calendar days, but does not include Saturday, Sunday, or state- or federally-recognized holidays.

(b) "Form CMS-2567" means the federal Centers for Medicare and Medicaid Services' form for the statement of deficiencies and plan of correction or a successor form serving the same purpose.

(c) "Title XVIII" means title XVIII of the social security act, 42 USC 1395 to 1395*lll*.

(d) "Title XIX" means title XIX of the social security act, 42 USC 1396 to 1396w-5.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1981, Act 111, Imd. Eff. July 17, 1981;—Am. 1982, Act 474, Eff. Mar. 30, 1983;—Am. 1992, Act 80, Imd. Eff. June 2, 1992;—Am. 1996, Act 267, Imd. Eff. June 12, 1996;—Am. 2000, Act 170, Imd. Eff. June 20, 2000;—Am. 2000, Act 171, Imd. Eff. June 20, 2000;—Am. 2001, Act 218, Imd. Eff. Dec. 28, 2001;—Am. 2006, Act 195, Imd. Eff. June 19, 2006;—Am. 2012, Act 322, Imd. Eff. Oct. 9, 2012;—Am. 2015, Act 104, Eff. Oct. 1, 2015;—Am. 2015, Act 155, Eff. Jan. 18, 2016.

Compiler's note: For transfer of the clinical advisory committee to the department of community health, and abolishment of the committee, see E.R.O. No. 2009-6, compiled at MCL 333.26329.

Popular name: Act 368

Administrative rules: R 325.3801 et seq. of the Michigan Administrative Code.

333.20155a Nursing home health survey tasks; electronic system; determination of open survey cycle; grants; reports of survey findings; nursing home's plan of correction; notifications of acceptance or rejection; revisit; evidence of substantial compliance; informal dispute resolution; citation levels.

Sec. 20155a. (1) Nursing home health survey tasks shall be facilitated by the licensing and regulatory affairs bureau of health systems to ensure consistent and efficient coordination of the nursing home licensing and certification functions for standard and abbreviated surveys. The department shall develop an electronic system to support the coordination of these activities. If funds are appropriated for the system, the department shall implement the system within 120 days of that appropriation.

(2) When preparing to conduct an annual standard survey, the department shall determine if there is an open survey cycle and make every reasonable effort to confirm that substantial compliance has been achieved by implementation of the nursing home's accepted plan of correction before initiating the annual standard survey while maintaining the federal requirement for standard annual survey interval and state survey average of 12 months.

(3) The department shall seek approval from the Centers for Medicare and Medicaid Services to develop a program to provide grants to nursing homes that have achieved a 5-star quality rating from the Centers for Medicare and Medicaid Services. The department shall seek approval from the Centers for Medicare and Medicaid Services for nursing homes to be eligible to receive a grant, up to $5,000.00 per nursing home from the civil monetary fund for nursing homes that meet the Centers for Medicare and Medicaid Services standards for the 5-star quality rating. Grants to nursing homes shall be used to implement evidence-based quality improvement programs within the nursing home. Each nursing home that receives a grant shall submit a report to the department that describes the final outcome from implementing the program.

(4) All abbreviated complaint surveys shall be conducted on consecutive days until complete. All form CMS-2567 reports of survey findings shall be released to the nursing home within 10 consecutive days after completion of the survey.

(5) Departmental notifications of acceptance or rejection of a nursing home's plan of correction shall be reviewed and released to the nursing home within 10 consecutive days of receipt of that plan of correction.

(6) A nursing-home-submitted plan of correction in response to any survey must have a completion date not to exceed 40 days from the exit date of survey. If a nursing home has not received additional citations before a revisit occurs, the department shall conduct the first revisit not more than 60 days from the exit date of the survey.

(7) Letters of compliance notification to nursing homes shall be released to the nursing home within 10 consecutive days of all survey revisit completion dates.

(8) The department may accept a nursing home's evidence of substantial compliance instead of requiring a post survey on-site first or second revisit as the department considers appropriate in accordance with the Centers for Medicare and Medicaid Services survey protocols. A nursing home requesting consideration of evidence of substantial compliance in lieu of an on-site revisit must include an affidavit that asserts the nursing home is in substantial compliance as shown by the submitted evidence for that specific survey event. There may be no deficiencies with a scope and severity originating higher than level F. Citations with a scope and severity of level F or below may go through a desk review by the department upon thorough review of the plan of correction. Citations with a scope and severity of level G or higher are not to be considered for a desk review. If there is no enforcement action, the nursing home's evidence of substantial compliance may be reviewed administratively and accepted as evidence of deficiency correction.

(9) Informal dispute resolution conducted by the Michigan peer review organization shall be given strong consideration upon final review by the department. In the annual report to the legislature, the department shall include the number of Michigan peer review organization-referred reviews and, of those reviews, the number of citations that were overturned by the department.

(10) Citation levels used in this section mean citation levels as defined by the Centers for Medicare and Medicaid Services' survey protocol grid defining scope and severity assessment of deficiency.

History: Add. 2012, Act 322, Imd. Eff. Oct. 9, 2012;—Am. 2015, Act 155, Eff. Jan. 18, 2016.

Popular name: Act 368

333.20156 Entering premises of applicant or licensee; enforcement of rules; review and inspection of existing facilities; amendment of rules; verification of existing facilities; certificate of approval from bureau of fire services; applicability of subsections (2), (3), (4), and (5).

Sec. 20156. (1) A representative of the department or the bureau of fire services created in section 1b of the fire prevention code, 1941 PA 207, MCL 29.1b, upon presentation of proper identification, may enter the premises of an applicant or licensee at any reasonable time to determine whether the applicant or licensee meets the requirements of this article and the rules promulgated under this article. The director; the director of the department of health and human services; the bureau of fire services; the director of the office of services

to the aging; or the director of a local health department; or an authorized representative of the director, the director of the department of health and human services, the bureau of fire services, the director of the office of services to the aging, or the director of a local health department may enter on the premises of an applicant or licensee under part 217 at any time in the course of carrying out program responsibilities.

(2) The bureau of fire services created in section 1b of the fire prevention code, 1941 PA 207, MCL 29.1b, shall enforce rules promulgated by the bureau of fire services for health facilities and agencies to ensure that physical facilities owned, maintained, or operated by a health facility or agency are planned, constructed, and maintained in a manner to protect the health, safety, and welfare of patients.

(3) Beginning on the effective date of the amendatory act that added this subsection, the bureau of fire services shall amend the rules to allow facilities in existence on or before the effective date of the amendatory act that added this subsection and continuously operating up to the time of application for a home for the aged license to be reviewed and inspected to comply with the provisions of chapter 18 or 19 or chapter 32 or 33 of the National Fire Protection Association standard number 101.

(4) An applicant under subsection (3) shall provide information requested by the department that allows the department to verify that the facility was in existence on or before the effective date of the amendatory act that added this subsection and has been continuously operating up to the time of application.

(5) The department shall not issue a license or certificate to a health facility or agency until it receives an appropriate certificate of approval from the bureau of fire services. For purposes of this section, a decision of the bureau of fire services to issue a certificate controls over that of a local fire department.

(6) Subsections (2), (3), (4), and (5) do not apply to a health facility or an agency licensed under part 205 or 209.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1982, Act 474, Eff. Mar. 30, 1983;—Am. 1986, Act 78, Imd. Eff. Apr. 7, 1986;—Am. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2006, Act 195, Imd. Eff. June 19, 2006;—Am. 2017, Act 167, Eff. Feb. 11, 2018.

Compiler's note: For transfer of powers and duties of the fire marshal division on programs relating to fire safety inspections of adult foster care, correctional, and health care facilities from the department of state police to the department of consumer and industry services, see E.R.O. No. 1997-2, compiled at MCL 29.451 of the Michigan Compiled Laws.

Popular name: Act 368

333.20161 Fees and assessments for health facility and agency licenses and certificates of need; schedule; fees; use of quality assurance assessment; tax levy; definitions.

Sec. 20161. (1) The department shall assess fees and other assessments for health facility and agency licenses and certificates of need on an annual basis as provided in this article. Until October 1, 2019, except as otherwise provided in this article, fees and assessments must be paid as provided in the following schedule:

(a) Freestanding surgical outpatient facilities	$500.00 per facility license.
(b) Hospitals	$500.00 per facility license and $10.00 per licensed bed.
(c) Nursing homes, county medical care facilities, and hospital long-term care units	$500.00 per facility license and $3.00 per licensed bed over 100 licensed beds.
(d) Homes for the aged	$6.27 per licensed bed.
(e) Hospice agencies	$500.00 per agency license.
(f) Hospice residences	$500.00 per facility license and $5.00 per licensed bed.
(g) Subject to subsection (11), quality assurance assessment for nursing homes and hospital long-term care units	an amount resulting in not more than 6% of total industry revenues.
(h) Subject to subsection	

(12), quality assurance assessment for hospitals.....	at a fixed or variable rate that generates funds not more than the maximum allowable under the federal matching requirements, after consideration for the amounts in subsection (12)(a) and (i).
(i) Initial licensure application fee for subdivisions (a), (b), (c), (e), and (f).....	$2,000.00 per initial license.

(2) If a hospital requests the department to conduct a certification survey for purposes of title XVIII or title XIX, the hospital shall pay a license fee surcharge of $23.00 per bed. As used in this subsection, "title XVIII" and "title XIX" mean those terms as defined in section 20155.

(3) All of the following apply to the assessment under this section for certificates of need:

(a) The base fee for a certificate of need is $3,000.00 for each application. For a project requiring a projected capital expenditure of more than $500,000.00 but less than $4,000,000.00, an additional fee of $5,000.00 is added to the base fee. For a project requiring a projected capital expenditure of $4,000,000.00 or more but less than $10,000,000.00, an additional fee of $8,000.00 is added to the base fee. For a project requiring a projected capital expenditure of $10,000,000.00 or more, an additional fee of $12,000.00 is added to the base fee.

(b) In addition to the fees under subdivision (a), the applicant shall pay $3,000.00 for any designated complex project including a project scheduled for comparative review or for a consolidated licensed health facility application for acquisition or replacement.

(c) If required by the department, the applicant shall pay $1,000.00 for a certificate of need application that receives expedited processing at the request of the applicant.

(d) The department shall charge a fee of $500.00 to review any letter of intent requesting or resulting in a waiver from certificate of need review and any amendment request to an approved certificate of need.

(e) A health facility or agency that offers certificate of need covered clinical services shall pay $100.00 for each certificate of need approved covered clinical service as part of the certificate of need annual survey at the time of submission of the survey data.

(f) The department shall use the fees collected under this subsection only to fund the certificate of need program. Funds remaining in the certificate of need program at the end of the fiscal year do not lapse to the general fund but remain available to fund the certificate of need program in subsequent years.

(4) A license issued under this part is effective for no longer than 1 year after the date of issuance.

(5) Fees described in this section are payable to the department at the time an application for a license, permit, or certificate is submitted. If an application for a license, permit, or certificate is denied or if a license, permit, or certificate is revoked before its expiration date, the department shall not refund fees paid to the department.

(6) The fee for a provisional license or temporary permit is the same as for a license. A license may be issued at the expiration date of a temporary permit without an additional fee for the balance of the period for which the fee was paid if the requirements for licensure are met.

(7) The cost of licensure activities must be supported by license fees.

(8) The application fee for a waiver under section 21564 is $200.00 plus $40.00 per hour for the professional services and travel expenses directly related to processing the application. The travel expenses must be calculated in accordance with the state standardized travel regulations of the department of technology, management, and budget in effect at the time of the travel.

(9) An applicant for licensure or renewal of licensure under part 209 shall pay the applicable fees set forth in part 209.

(10) Except as otherwise provided in this section, the fees and assessments collected under this section must be deposited in the state treasury, to the credit of the general fund. The department may use the unreserved fund balance in fees and assessments for the criminal history check program required under this article.

(11) The quality assurance assessment collected under subsection (1)(g) and all federal matching funds attributed to that assessment must be used only for the following purposes and under the following specific

circumstances:

(a) The quality assurance assessment and all federal matching funds attributed to that assessment must be used to finance Medicaid nursing home reimbursement payments. Only licensed nursing homes and hospital long-term care units that are assessed the quality assurance assessment and participate in the Medicaid program are eligible for increased per diem Medicaid reimbursement rates under this subdivision. A nursing home or long-term care unit that is assessed the quality assurance assessment and that does not pay the assessment required under subsection (1)(g) in accordance with subdivision (c)(*i*) or in accordance with a written payment agreement with this state shall not receive the increased per diem Medicaid reimbursement rates under this subdivision until all of its outstanding quality assurance assessments and any penalties assessed under subdivision (f) have been paid in full. This subdivision does not authorize or require the department to overspend tax revenue in violation of the management and budget act, 1984 PA 431, MCL 18.1101 to 18.1594.

(b) Except as otherwise provided under subdivision (c), beginning October 1, 2005, the quality assurance assessment is based on the total number of patient days of care each nursing home and hospital long-term care unit provided to non-Medicare patients within the immediately preceding year, must be assessed at a uniform rate on October 1, 2005 and subsequently on October 1 of each following year, and is payable on a quarterly basis, with the first payment due 90 days after the date the assessment is assessed.

(c) Within 30 days after September 30, 2005, the department shall submit an application to the federal Centers for Medicare and Medicaid Services to request a waiver according to 42 CFR 433.68(e) to implement this subdivision as follows:

(*i*) If the waiver is approved, the quality assurance assessment rate for a nursing home or hospital long-term care unit with less than 40 licensed beds or with the maximum number, or more than the maximum number, of licensed beds necessary to secure federal approval of the application is $2.00 per non-Medicare patient day of care provided within the immediately preceding year or a rate as otherwise altered on the application for the waiver to obtain federal approval. If the waiver is approved, for all other nursing homes and long-term care units the quality assurance assessment rate is to be calculated by dividing the total statewide maximum allowable assessment permitted under subsection (1)(g) less the total amount to be paid by the nursing homes and long-term care units with less than 40 licensed beds or with the maximum number, or more than the maximum number, of licensed beds necessary to secure federal approval of the application by the total number of non-Medicare patient days of care provided within the immediately preceding year by those nursing homes and long-term care units with more than 39 licensed beds, but less than the maximum number of licensed beds necessary to secure federal approval. The quality assurance assessment, as provided under this subparagraph, must be assessed in the first quarter after federal approval of the waiver and must be subsequently assessed on October 1 of each following year, and is payable on a quarterly basis, with the first payment due 90 days after the date the assessment is assessed.

(*ii*) If the waiver is approved, continuing care retirement centers are exempt from the quality assurance assessment if the continuing care retirement center requires each center resident to provide an initial life interest payment of $150,000.00, on average, per resident to ensure payment for that resident's residency and services and the continuing care retirement center utilizes all of the initial life interest payment before the resident becomes eligible for medical assistance under the state's Medicaid plan. As used in this subparagraph, "continuing care retirement center" means a nursing care facility that provides independent living services, assisted living services, and nursing care and medical treatment services, in a campus-like setting that has shared facilities or common areas, or both.

(d) Beginning May 10, 2002, the department shall increase the per diem nursing home Medicaid reimbursement rates for the balance of that year. For each subsequent year in which the quality assurance assessment is assessed and collected, the department shall maintain the Medicaid nursing home reimbursement payment increase financed by the quality assurance assessment.

(e) The department shall implement this section in a manner that complies with federal requirements necessary to ensure that the quality assurance assessment qualifies for federal matching funds.

(f) If a nursing home or a hospital long-term care unit fails to pay the assessment required by subsection (1)(g), the department may assess the nursing home or hospital long-term care unit a penalty of 5% of the assessment for each month that the assessment and penalty are not paid up to a maximum of 50% of the assessment. The department may also refer for collection to the department of treasury past due amounts consistent with section 13 of 1941 PA 122, MCL 205.13.

(g) The Medicaid nursing home quality assurance assessment fund is established in the state treasury. The department shall deposit the revenue raised through the quality assurance assessment with the state treasurer for deposit in the Medicaid nursing home quality assurance assessment fund.

(h) The department shall not implement this subsection in a manner that conflicts with 42 USC 1396b(w).

(i) The quality assurance assessment collected under subsection (1)(g) must be prorated on a quarterly basis for any licensed beds added to or subtracted from a nursing home or hospital long-term care unit since the immediately preceding July 1. Any adjustments in payments are due on the next quarterly installment due date.

(j) In each fiscal year governed by this subsection, Medicaid reimbursement rates must not be reduced below the Medicaid reimbursement rates in effect on April 1, 2002 as a direct result of the quality assurance assessment collected under subsection (1)(g).

(k) The state retention amount of the quality assurance assessment collected under subsection (1)(g) must be equal to 13.2% of the federal funds generated by the nursing homes and hospital long-term care units quality assurance assessment, including the state retention amount. The state retention amount must be appropriated each fiscal year to the department to support Medicaid expenditures for long-term care services. These funds must offset an identical amount of general fund/general purpose revenue originally appropriated for that purpose.

(*l*) Beginning October 1, 2019, the department shall not assess or collect the quality assurance assessment or apply for federal matching funds. The quality assurance assessment collected under subsection (1)(g) must not be assessed or collected after September 30, 2011 if the quality assurance assessment is not eligible for federal matching funds. Any portion of the quality assurance assessment collected from a nursing home or hospital long-term care unit that is not eligible for federal matching funds must be returned to the nursing home or hospital long-term care unit.

(12) The quality assurance dedication is an earmarked assessment collected under subsection (1)(h). That assessment and all federal matching funds attributed to that assessment must be used only for the following purpose and under the following specific circumstances:

(a) To maintain the increased Medicaid reimbursement rate increases as provided for in subdivision (c).

(b) The quality assurance assessment must be assessed on all net patient revenue, before deduction of expenses, less Medicare net revenue, as reported in the most recently available Medicare cost report and is payable on a quarterly basis, with the first payment due 90 days after the date the assessment is assessed. As used in this subdivision, "Medicare net revenue" includes Medicare payments and amounts collected for coinsurance and deductibles.

(c) Beginning October 1, 2002, the department shall increase the hospital Medicaid reimbursement rates for the balance of that year. For each subsequent year in which the quality assurance assessment is assessed and collected, the department shall maintain the hospital Medicaid reimbursement rate increase financed by the quality assurance assessments.

(d) The department shall implement this section in a manner that complies with federal requirements necessary to ensure that the quality assurance assessment qualifies for federal matching funds.

(e) If a hospital fails to pay the assessment required by subsection (1)(h), the department may assess the hospital a penalty of 5% of the assessment for each month that the assessment and penalty are not paid up to a maximum of 50% of the assessment. The department may also refer for collection to the department of treasury past due amounts consistent with section 13 of 1941 PA 122, MCL 205.13.

(f) The hospital quality assurance assessment fund is established in the state treasury. The department shall deposit the revenue raised through the quality assurance assessment with the state treasurer for deposit in the hospital quality assurance assessment fund.

(g) In each fiscal year governed by this subsection, the quality assurance assessment must only be collected and expended if Medicaid hospital inpatient DRG and outpatient reimbursement rates and disproportionate share hospital and graduate medical education payments are not below the level of rates and payments in effect on April 1, 2002 as a direct result of the quality assurance assessment collected under subsection (1)(h), except as provided in subdivision (h).

(h) The quality assurance assessment collected under subsection (1)(h) must not be assessed or collected after September 30, 2011 if the quality assurance assessment is not eligible for federal matching funds. Any portion of the quality assurance assessment collected from a hospital that is not eligible for federal matching funds must be returned to the hospital.

(i) The state retention amount of the quality assurance assessment collected under subsection (1)(h) must be equal to 13.2% of the federal funds generated by the hospital quality assurance assessment, including the state retention amount. The 13.2% state retention amount described in this subdivision does not apply to the Healthy Michigan plan. In the fiscal year ending September 30, 2016, there is a 1-time additional retention amount of up to $92,856,100.00. In the fiscal year ending September 30, 2017, there is a retention amount of $105,000,000.00 for the Healthy Michigan plan. Beginning in the fiscal year ending September 30, 2018, and for each fiscal year thereafter, there is a retention amount of $118,420,600.00 for each fiscal year for the Healthy Michigan Plan. The state retention percentage must be applied proportionately to each hospital

quality assurance assessment program to determine the retention amount for each program. The state retention amount must be appropriated each fiscal year to the department to support Medicaid expenditures for hospital services and therapy. These funds must offset an identical amount of general fund/general purpose revenue originally appropriated for that purpose. By May 31, 2019, the department, the state budget office, and the Michigan Health and Hospital Association shall identify an appropriate retention amount for the fiscal year ending September 30, 2020 and each fiscal year thereafter.

(13) The department may establish a quality assurance assessment to increase ambulance reimbursement as follows:

(a) The quality assurance assessment authorized under this subsection must be used to provide reimbursement to Medicaid ambulance providers. The department may promulgate rules to provide the structure of the quality assurance assessment authorized under this subsection and the level of the assessment.

(b) The department shall implement this subsection in a manner that complies with federal requirements necessary to ensure that the quality assurance assessment qualifies for federal matching funds.

(c) The total annual collections by the department under this subsection must not exceed $20,000,000.00.

(d) The quality assurance assessment authorized under this subsection must not be collected after October 1, 2019. The quality assurance assessment authorized under this subsection must no longer be collected or assessed if the quality assurance assessment authorized under this subsection is not eligible for federal matching funds.

(14) The quality assurance assessment provided for under this section is a tax that is levied on a health facility or agency.

(15) As used in this section:

(a) "Healthy Michigan plan" means the medical assistance program described in section 105d of the social welfare act, 1939 PA 280, MCL 400.105d, that has a federal matching fund rate of not less than 90%.

(b) "Medicaid" means that term as defined in section 22207.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1981, Act 76, Eff. Oct. 1, 1981;—Am. 1984, Act 376, Eff. Mar. 29, 1985;—Am. 1987, Act 217, Imd. Eff. Dec. 22, 1987;—Am. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 1990, Act 252, Imd. Eff. Oct. 12, 1990;—Am. 1996, Act 267, Imd. Eff. June 12, 1996;—Am. 2000, Act 253, Imd. Eff. June 29, 2000;—Am. 2002, Act 303, Imd. Eff. May 10, 2002;—Am. 2002, Act 562, Imd. Eff. Oct. 1, 2002;—Am. 2003, Act 113, Imd. Eff. July 24, 2003;—Am. 2003, Act 234, Imd. Eff. Dec. 29, 2003;—Am. 2004, Act 393, Imd. Eff. Oct. 15, 2004;—Am. 2004, Act 469, Imd. Eff. Dec. 28, 2004;—Am. 2005, Act 187, Eff. Sept. 30, 2005;—Am. 2007, Act 5, Imd. Eff. Mar. 23, 2007;—Am. 2007, Act 85, Imd. Eff. Sept. 30, 2007;—Am. 2008, Act 173, Imd. Eff. July 2, 2008;—Am. 2008, Act 277, Imd. Eff. Sept. 29, 2008;—Am. 2011, Act 144, Imd. Eff. Sept. 21, 2011;—Am. 2013, Act 137, Imd. Eff. Oct. 15, 2013;—Am. 2015, Act 104, Eff. Oct. 1, 2015;—Am. 2016, Act 189, Imd. Eff. June 21, 2016;—Am. 2018, Act 245, Imd. Eff. June 28, 2018.

Compiler's note: Enacting section 2 of Act 234 of 2003 provides:

"Enacting section 2. (1) Section 20161 as amended by this amendatory act is curative and intended to express the original intent of the legislature regarding the application of 2002 PA 303 and 2002 PA 562, as amended by 2003 PA 113.

"(2) Section 20161 as amended by this amendatory act is retroactive and is effective for all quality assurance assessments made after May 9, 2002."

Enacting section 1 of Act 187 of 2005 provides:

"Enacting section 1. Section 20161 of the public health code, 1978 PA 368, MCL 333.20161, as amended by this amendatory act is retroactive and is effective for all quality assurance assessments made after September 30, 2005."

Enacting section 1 was enacted into law as follows:

"Enacting section 1. This amendatory act takes effect October 1, 2013."

Popular name: Act 368

Administrative rules: R 325.3801 et seq. of the Michigan Administrative Code.

333.20162 License; receipt of completed application; issuance of license within certain period of time; nonrenewable temporary permit; provisional license; procedure for closing facility; order to licensee upon finding of noncompliance; notice, hearing, and status requirements; report; “completed application” defined.

Sec. 20162. (1) Beginning on the effective date of the amendatory act that added section 20935, upon a determination that a health facility or agency is in compliance with this article and the rules promulgated under this article, the department shall issue an initial license within 6 months after the applicant files a completed application. Receipt of the application is considered the date the application is received by any agency or department of this state. If the application is considered incomplete by the department, the department shall notify the applicant in writing or make the notice electronically available within 30 days after receipt of the incomplete application, describing the deficiency and requesting additional information. If the department identifies a deficiency or requires the fulfillment of a corrective action plan, the 6-month period is tolled until either of the following occurs:

(a) Upon notification by the department of a deficiency, until the date the requested information is received

by the department.

(b) Upon notification by the department that a corrective action plan is required, until the date the department determines the requirements of the corrective action plan have been met.

(2) The determination of the completeness of an application does not operate as an approval of the application for the license and does not confer eligibility of an applicant determined otherwise ineligible for issuance of a license.

(3) Except as otherwise provided in this subsection, if the department fails to issue or deny a license within the time period required by this section, the department shall return the license fee and shall reduce the license fee for the applicant's next licensure application, if any, by 15%. Failure to issue or deny a license within the time period required under this section does not allow the department to otherwise delay processing an application. The completed application shall be placed in sequence with other completed applications received at that same time. The department shall not discriminate against an applicant in the processing of the application based upon the fact that the application fee was refunded or discounted under this subsection. The department may issue a nonrenewable temporary permit for not more than 6 months if additional time is needed to make a proper investigation or to permit the applicant to undertake remedial action related to operational or procedural deficiencies or items of noncompliance. A temporary permit shall not be issued to cover deficiencies in physical plant requirements.

(4) Except as provided in part 217, the department may issue a provisional license for not more than 3 consecutive years to an applicant who temporarily is unable to comply with the rules as to the physical plant owned, maintained, or operated by a health facility or agency except as otherwise provided in this article. A provisional license shall not be issued to a new health facility or agency or a facility or agency whose ownership is transferred after September 30, 1978, unless the facility or agency was licensed and operating under this article or a prior law for not less than 5 years. Provisional licensure under acts repealed by this code shall be counted against the 3-year maximum for licensure.

(5) The department, in order to protect the people of this state, shall provide a procedure for the orderly closing of a facility if it is unable to maintain its license under this section.

(6) Except as provided in part 217, the department, upon finding that a health facility or agency is not operating in accord with the requirements of its license, may:

(a) Issue an order directing the licensee to:

(*i*) Discontinue admissions.

(*ii*) Transfer selected patients out of the facility.

(*iii*) Reduce its licensed capacity.

(*iv*) Comply with specific requirements for licensure or certification as appropriate.

(b) Through the office of the attorney general, initiate misdemeanor proceedings against the licensee as provided in section 20199(1).

(7) An order issued under subsection (6) shall be governed by the notice and hearing requirements of section 20168(1) and the status requirements of section 20168(2).

(8) Beginning October 1, 2005, the director of the department shall submit a report by December 1 of each year to the standing committees and appropriations subcommittees of the senate and house of representatives concerned with public health issues. The director shall include all of the following information in the report concerning the preceding fiscal year:

(a) The number of initial applications the department received and completed within the 6-month time period required under subsection (1).

(b) The number of applications requiring a request for additional information.

(c) The number of applications denied.

(d) The average processing time for initial licenses granted after the 6-month period.

(e) The number of temporary permits issued under subsection (3).

(f) The number of initial license applications not issued within the 6-month period and the amount of money returned to applicants under subsection (3).

(9) As used in this section, “completed application” means an application complete on its face and submitted with any applicable licensing fees as well as any other information, records, approval, security, or similar item required by law or rule from a local unit of government, a federal agency, or a private entity but not from another department or agency of this state.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 2004, Act 284, Imd. Eff. July 23, 2004.

Popular name: Act 368

333.20164 Duration of license or certification; license, certification, or certificate of need nontransferable; transfer of ownership or ownership interest; notice; application for

license and certification.

Sec. 20164. (1) A license, certification, provisional license, or limited license is valid for not more than 1 year after the date of issuance, except as provided in section 20511 or part 209 or 210. A license for a facility licensed under part 215 shall be valid for 2 years, except that provisional and limited licenses may be valid for 1 year.

(2) A license, certification, or certificate of need is not transferable and shall state the persons, buildings, and properties to which it applies. Applications for licensure or certification because of transfer of ownership or essential ownership interest shall not be acted upon until satisfactory evidence is provided of compliance with part 222.

(3) If ownership is not voluntarily transferred, the department shall be notified immediately and the new owner shall apply for a license and certification not later than 30 days after the transfer.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1981, Act 111, Imd. Eff. July 17, 1981;—Am. 1982, Act 474, Eff. Mar. 30, 1983;—Am. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20165 Denying, limiting, suspending, or revoking license or certification; notice of intent; imposition of administrative fine.

Sec. 20165. (1) Except as otherwise provided in this section, after notice of intent to an applicant or licensee to deny, limit, suspend, or revoke the applicant's or licensee's license or certification and an opportunity for a hearing, the department may deny, limit, suspend, or revoke the license or certification or impose an administrative fine on a licensee if 1 or more of the following exist:

(a) Fraud or deceit in obtaining or attempting to obtain a license or certification or in the operation of the licensed health facility or agency.

(b) A violation of this article or a rule promulgated under this article.

(c) False or misleading advertising.

(d) Negligence or failure to exercise due care, including negligent supervision of employees and subordinates.

(e) Permitting a license or certificate to be used by an unauthorized health facility or agency.

(f) Evidence of abuse regarding a patient's health, welfare, or safety or the denial of a patient's rights.

(g) Failure to comply with section 10115.

(h) Failure to comply with part 222 or a term, condition, or stipulation of a certificate of need issued under part 222, or both.

(i) A violation of section 20197(1).

(2) The department may deny an application for a license or certification based on a finding of a condition or practice that would constitute a violation of this article if the applicant were a licensee.

(3) Denial, suspension, or revocation of an individual emergency medical services personnel license under part 209 is governed by section 20958.

(4) If the department determines under subsection (1) that a health facility or agency has violated section 20197(1), the department shall impose an administrative fine of $5,000,000.00 on the health facility or agency.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1986, Act 186, Eff. Oct. 7, 1986;—Am. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 1998, Act 108, Eff. Mar. 23, 1999;—Am. 2008, Act 39, Eff. May 1, 2008.

Popular name: Act 368

333.20165a Action against health facility's treatment as authorized under right to try act; definitions.

Sec. 20165a. (1) Except in the case of gross negligence or willful misconduct as determined by the department, a health facility's cooperation in a treatment recommended by a health professional as authorized under the right to try act, alone, is not grounds for the department to take any action against a licensee under section 20165.

(2) As used in this section:

(a) "Gross negligence" means conduct so reckless as to demonstrate a substantial lack of concern for whether serious injury to a person would result.

(b) "Willful misconduct" means conduct committed with an intentional or reckless disregard for the safety of others, as by failing to exercise reasonable care to prevent a known danger.

History: Add. 2014, Act 346, Imd. Eff. Oct. 17, 2014.

333.20166 Notice of intent to deny, limit, suspend, or revoke license or certification; service;

contents; hearing; record; transcript; determination; powers of department; judicial order to appear and give testimony; contempt; failure to show need for health facility or agency.

Sec. 20166. (1) Notice of intent to deny, limit, suspend, or revoke a license or certification shall be given by certified mail or personal service, shall set forth the particular reasons for the proposed action, and shall fix a date, not less that 30 days after the date of service, on which the applicant or licensee shall be given the opportunity for a hearing before the director or the director's authorized representative. The hearing shall be conducted in accordance with the administrative procedures act of 1969 and rules promulgated by the department. A full and complete record shall be kept of the proceeding and shall be transcribed when requested by an interested party, who shall pay the cost of preparing the transcript.

(2) On the basis of a hearing or on the default of the applicant or licensee, the department may issue, deny, limit, suspend, or revoke a license or certification. A copy of the determination shall be sent by certified mail or served personally upon the applicant or licensee. The determination becomes final 30 days after it is mailed or served, unless the applicant or licensee within the 30 days appeals the decision to the circuit court in the county of jurisdiction or to the Ingham county circuit court.

(3) The department may establish procedures, hold hearings, administer oaths, issue subpoenas, or order testimony to be taken at a hearing or by deposition in a proceeding pending at any stage of the proceeding. A person may be compelled to appear and testify and to produce books, papers, or documents in a proceeding.

(4) In case of disobedience of a subpoena, a party to a hearing may invoke the aid of the circuit court of the jurisdiction in which the hearing is held to require the attendance and testimony of witnesses. The circuit court may issue an order requiring an individual to appear and give testimony. Failure to obey the order of the circuit court may be punished by the court as a contempt.

(5) The department shall not deny, limit, suspend, or revoke a license on the basis of an applicant's or licensee's failure to show a need for a health facility or agency unless the health facility or agency has not obtained a certificate of need required by part 222.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1988, Act 332, Eff. Oct. 1, 1988.

Compiler's note: In paragraph (1), the words “not less that 30 days” evidently should read “not less than 30 days.”

Popular name: Act 368

333.20168 Emergency order limiting, suspending, or revoking license; limiting reimbursements or payments; hearing; contents of order; order not suspended by hearing.

Sec. 20168. (1) Upon a finding that a deficiency or violation of this article or the rules promulgated under this article seriously affects the health, safety, and welfare of individuals receiving care or services in or from a licensed health facility or agency, the department may issue an emergency order limiting, suspending, or revoking the license of the health facility or agency. If the department of public health issues an emergency order affecting the license of a nursing home, the department of public health may request the department of social services to limit reimbursements or payments authorized under section 21718. The department shall provide an opportunity for a hearing within 5 working days after issuance of the order.

(2) An order shall incorporate the department's findings. The conduct of a hearing under this section shall not suspend the department's order.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.20169 HIV infected test subject; compliance with reporting requirements; definitions.

Sec. 20169. (1) A health facility or agency licensed under this article that obtains from a test subject a test result that indicates that the test subject is HIV infected shall comply with the reporting requirements of section 5114.

(2) As used in this section:

(a) “HIV” means human immunodeficiency virus.

(b) “HIV infected” means that term as defined in section 5101.

History: Add. 1988, Act 489, Eff. Mar. 30, 1989.

Popular name: Act 368

333.20170 Medical records access; compliance.

Sec. 20170. A health facility or agency shall comply with the medical records access act.

History: Add. 2004, Act 48, Imd. Eff. Apr. 1, 2004.

Popular name: Act 368

333.20171 Rules implementing article; rules promulgated under MCL 333.21563; rules subject to MCL 554.917.

Sec. 20171. (1) The department, after obtaining approval of the advisory commission, shall promulgate and enforce rules to implement this article, including rules necessary to enable a health facility or agency to qualify for and receive federal funds available for patient care or for projects involving new construction, additions, modernizations, or conversions.

(2) The rules applicable to health facilities or agencies shall be uniform insofar as is reasonable.

(3) The rules shall establish standards relating to:

(a) Ownership.

(b) Reasonable disclosure of ownership interests in proprietary corporations and of financial interests of trustees of voluntary, nonprofit corporations and owners of proprietary corporations and partnerships.

(c) Organization and function of the health facility or agency, owner, operator, and governing body.

(d) Administration.

(e) Professional and nonprofessional staff, services, and equipment appropriate to implement section 20141(3).

(f) Policies and procedures.

(g) Fiscal and medical audit.

(h) Utilization and quality control review.

(i) Physical plant including planning, construction, functional design, sanitation, maintenance, housekeeping, and fire safety.

(j) Arrangements for the continuing evaluation of the quality of health care provided.

(k) Other pertinent organizational, operational, and procedural requirements for each type of health facility or agency.

(4) The rules promulgated under section 21563 for the designation of rural community hospitals may also specify all of the following:

(a) Maximum bed size.

(b) The level of services to be provided in each category as described in section 21562(2).

(c) Requirements for transfer agreements with other hospitals to ensure efficient and appropriate patient care.

(5) Rules promulgated under this article are subject to section 17 of the continuing care community disclosure act, MCL 554.917.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1990, Act 252, Imd. Eff. Oct. 12, 1990;—Am. 2014, Act 449, Imd. Eff. Jan. 2, 2015.

Popular name: Act 368

Administrative rules: R 325.1001 et seq.; R 325.1801 et seq.; R 325.2301 et seq.; R 325.3801 et seq.; R 325.6001 et seq.; R 325.20101 et seq.; and R 325.23101 et seq. of the Michigan Administrative Code.

333.20172 Policies and procedures; publication and distribution.

Sec. 20172. The department may publish and distribute written policies and procedures in the form of departmental letters necessary to the effective administration of this article.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20173 Repealed. 2006, Act 28, Eff. Apr. 1, 2006.

Compiler's note: The repealed section pertained to criminal history check for employment applicants to nursing home, county medical care facility, or home for the aged.

333.20173a Covered facility; employees or applicants for employment; prohibitions; criminal history check; procedure; conditional employment or clinical privileges; knowingly providing false information as misdemeanor; prohibited use or dissemination of criminal history information as misdemeanor; review by licensing or regulatory department; conditions of continued employment; failure to conduct criminal history checks as misdemeanor; storage and retention of fingerprints; notification; electronic web-based system; definitions.

Sec. 20173a. (1) Except as otherwise provided in subsection (2), a covered facility shall not employ, independently contract with, or grant clinical privileges to an individual who regularly has direct access to or provides direct services to patients or residents in the covered facility if the individual satisfies 1 or more of

the following:

(a) Has been convicted of a relevant crime described under 42 USC 1320a-7(a).

(b) Has been convicted of any of the following felonies, an attempt or conspiracy to commit any of those felonies, or any other state or federal crime that is similar to the felonies described in this subdivision, other than a felony for a relevant crime described under 42 USC 1320a-7(a), unless 15 years have lapsed since the individual completed all of the terms and conditions of his or her sentencing, parole, and probation for that conviction before the date of application for employment or clinical privileges or the date of the execution of the independent contract:

(*i*) A felony that involves the intent to cause death or serious impairment of a body function, that results in death or serious impairment of a body function, that involves the use of force or violence, or that involves the threat of the use of force or violence.

(*ii*) A felony involving cruelty or torture.

(*iii*) A felony under chapter XXA of the Michigan penal code, 1931 PA 328, MCL 750.145m to 750.145r.

(*iv*) A felony involving criminal sexual conduct.

(*v*) A felony involving abuse or neglect.

(*vi*) A felony involving the use of a firearm or dangerous weapon.

(*vii*) A felony involving the diversion or adulteration of a prescription drug or other medications.

(c) Has been convicted of a felony or an attempt or conspiracy to commit a felony, other than a felony for a relevant crime described under 42 USC 1320a-7(a) or a felony described under subdivision (b), unless 10 years have lapsed since the individual completed all of the terms and conditions of his or her sentencing, parole, and probation for that conviction prior to the date of application for employment or clinical privileges or the date of the execution of the independent contract.

(d) Has been convicted of any of the following misdemeanors, other than a misdemeanor for a relevant crime described under 42 USC 1320a-7(a), or a state or federal crime that is substantially similar to the misdemeanors described in this subdivision, within the 10 years immediately preceding the date of application for employment or clinical privileges or the date of the execution of the independent contract:

(*i*) A misdemeanor involving the use of a firearm or dangerous weapon with the intent to injure, the use of a firearm or dangerous weapon that results in a personal injury, or a misdemeanor involving the use of force or violence or the threat of the use of force or violence.

(*ii*) A misdemeanor under chapter XXA of the Michigan penal code, 1931 PA 328, MCL 750.145m to 750.145r.

(*iii*) A misdemeanor involving criminal sexual conduct.

(*iv*) A misdemeanor involving cruelty or torture unless otherwise provided under subdivision (e).

(*v*) A misdemeanor involving abuse or neglect.

(e) Has been convicted of any of the following misdemeanors, other than a misdemeanor for a relevant crime described under 42 USC 1320a-7(a), or a state or federal crime that is substantially similar to the misdemeanors described in this subdivision, within the 5 years immediately preceding the date of application for employment or clinical privileges or the date of the execution of the independent contract:

(*i*) A misdemeanor involving cruelty if committed by an individual who is less than 16 years of age.

(*ii*) A misdemeanor involving home invasion.

(*iii*) A misdemeanor involving embezzlement.

(*iv*) A misdemeanor involving negligent homicide or a violation of section 601d(1) of the Michigan vehicle code, 1949 PA 300, MCL 257.601d.

(*v*) A misdemeanor involving larceny unless otherwise provided under subdivision (g).

(*vi*) A misdemeanor of retail fraud in the second degree unless otherwise provided under subdivision (g).

(*vii*) Any other misdemeanor involving assault, fraud, theft, or the possession or delivery of a controlled substance unless otherwise provided under subdivision (d), (f), or (g).

(f) Has been convicted of any of the following misdemeanors, other than a misdemeanor for a relevant crime described under 42 USC 1320a-7(a), or a state or federal crime that is substantially similar to the misdemeanors described in this subdivision, within the 3 years immediately preceding the date of application for employment or clinical privileges or the date of the execution of the independent contract:

(*i*) A misdemeanor for assault if there was no use of a firearm or dangerous weapon and no intent to commit murder or inflict great bodily injury.

(*ii*) A misdemeanor of retail fraud in the third degree unless otherwise provided under subdivision (g).

(*iii*) A misdemeanor under part 74 unless otherwise provided under subdivision (g).

(g) Has been convicted of any of the following misdemeanors, other than a misdemeanor for a relevant crime described under 42 USC 1320a-7(a), or a state or federal crime that is substantially similar to the misdemeanors described in this subdivision, within the year immediately preceding the date of application for

employment or clinical privileges or the date of the execution of the independent contract:

(*i*) A misdemeanor under part 74 if the individual, at the time of conviction, is under the age of 18.

(*ii*) A misdemeanor for larceny or retail fraud in the second or third degree if the individual, at the time of conviction, is under the age of 16.

(h) Is the subject of an order or disposition under section 16b of chapter IX of the code of criminal procedure, 1927 PA 175, MCL 769.16b.

(i) Engages in conduct that becomes the subject of a substantiated finding of neglect, abuse, or misappropriation of property by a state or federal agency under an investigation conducted in accordance with 42 USC 1395i-3 or 1396r.

(2) Except as otherwise provided in this subsection or subsection (5), a covered facility shall not employ, independently contract with, or grant privileges to an individual who regularly has direct access to or provides direct services to patients or residents in the covered facility until the covered facility or staffing agency has a criminal history check conducted in compliance with this section or has received criminal history record information in compliance with subsections (3) and (10). This subsection and subsection (1) do not apply to any of the following:

(a) An individual who is employed by, under independent contract to, or granted clinical privileges in a covered facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subdivision and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police with a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (13). An individual who is exempt under this subdivision is not limited to working within the covered facility with which he or she is employed by, under independent contract to, or granted clinical privileges on April 1, 2006 but may transfer to another covered facility, adult foster care facility, or mental health facility. If an individual who is exempt under this subdivision is subsequently convicted of a crime described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), then he or she is no longer exempt and shall be terminated from employment or denied employment or clinical privileges.

(b) An individual who is under an independent contract with a covered facility if he or she is not under the facility's control and the services for which he or she is contracted are not directly related to the provision of services to a patient or resident or if the services for which he or she is contracted allow for direct access to the patients or residents but are not performed on an ongoing basis. This exception includes, but is not limited to, an individual who is under an independent contract with the covered facility to provide utility, maintenance, construction, or communications services.

(3) An individual who applies for employment either as an employee or as an independent contractor or for clinical privileges with a staffing agency or covered facility and who has not been the subject of a criminal history check conducted in compliance with this section shall give written consent at the time of application for the department of state police to conduct a criminal history check under this section, along with identification acceptable to the department of state police. If the applicant has been the subject of a criminal history check conducted in compliance with this section, the applicant shall give written consent at the time of application for the covered facility or staffing agency to obtain the criminal history record information as prescribed in subsection (4) from the relevant licensing or regulatory department and for the department of state police to conduct a criminal history check under this section if the requirements of subsection (10) are not met and a request to the Federal Bureau of Investigation to make a determination of the existence of any national criminal history pertaining to the applicant is necessary, along with identification acceptable to the department of state police. Upon receipt of the written consent to obtain the criminal history record information and identification required under this subsection, the staffing agency or covered facility that has made a good faith offer of employment or an independent contract or clinical privileges to the applicant shall request the criminal history record information from the relevant licensing or regulatory department and shall make a request regarding that applicant to the relevant licensing or regulatory department to conduct a check of all relevant registries in the manner required in subsection (4). If the requirements of subsection (10) are not met and a request to the Federal Bureau of Investigation to make a subsequent determination of the existence of any national criminal history pertaining to the applicant is necessary, the covered facility or staffing agency shall proceed in the manner required in subsection (4). A staffing agency that employs an individual who regularly has direct access to or provides direct services to patients or residents under an independent contract with a covered facility shall submit information regarding the criminal history check conducted by the staffing agency to the covered facility that has made a good faith offer of independent contract to that applicant.

(4) Upon receipt of the written consent to conduct a criminal history check and identification required under subsection (3), a staffing agency or covered facility that has made a good faith offer of employment or an independent contract or clinical privileges to the applicant shall make a request to the department of state police to conduct a criminal history check on the applicant, to input the applicant's fingerprints into the automated fingerprint identification system database, and to forward the applicant's fingerprints to the Federal Bureau of Investigation. The department of state police shall request the Federal Bureau of Investigation to make a determination of the existence of any national criminal history pertaining to the applicant. The applicant shall provide the department of state police with a set of fingerprints. The request shall be made in a manner prescribed by the department of state police. The staffing agency or covered facility shall make the written consent and identification available to the department of state police. The staffing agency or covered facility shall make a request regarding that applicant to the relevant licensing or regulatory department to conduct a check of all relevant registries established according to federal and state law and regulations for any substantiated findings of abuse, neglect, or misappropriation of property. If the department of state police or the Federal Bureau of Investigation charges a fee for conducting the criminal history check, the staffing agency or covered facility shall pay the cost of the charge. Except as otherwise provided in this subsection, if the department of state police or the Federal Bureau of Investigation charges a fee for conducting the criminal history check, the department shall pay the cost of or reimburse the charge for a covered facility that is a home for the aged. After October 1, 2018, if the department of state police or the Federal Bureau of Investigation charges a fee for conducting the criminal history check, the department shall pay the cost of the charge up to 40 criminal history checks per year for a covered facility that is a home for the aged with fewer than 100 beds and 50 criminal history checks per year for a home for the aged with 100 beds or more. The staffing agency or covered facility shall not seek reimbursement for a charge imposed by the department of state police or the Federal Bureau of Investigation from the individual who is the subject of the criminal history check. A prospective employee or a prospective independent contractor covered under this section may not be charged for the cost of a criminal history check required under this section. The department of state police shall conduct a criminal history check on the applicant named in the request. The department of state police shall provide the department with a written report of the criminal history check conducted under this subsection. The report shall contain any criminal history record information on the applicant maintained by the department of state police. The department of state police shall provide the results of the Federal Bureau of Investigation determination to the department within 30 days after the request is made. If the requesting staffing agency or covered facility is not a state department or agency and if criminal history record information is disclosed on the written report of the criminal history check or the Federal Bureau of Investigation determination that resulted in a conviction, the department shall notify the staffing agency or covered facility and the applicant in writing of the type of crime disclosed on the written report of the criminal history check or the Federal Bureau of Investigation determination without disclosing the details of the crime. Any charges imposed by the department of state police or the Federal Bureau of Investigation for conducting a criminal history check or making a determination under this subsection shall be paid in the manner required under this subsection. The notice shall include a statement that the applicant has a right to appeal the information relied upon by the staffing agency or covered facility in making its decision regarding his or her employment eligibility based on the criminal history check. The notice shall also include information regarding where to file and describing the appellate procedures established under section 20173b.

(5) If a covered facility determines it necessary to employ or grant clinical privileges to an applicant before receiving the results of the applicant's criminal history check or criminal history record information under this section, the covered facility may conditionally employ or grant conditional clinical privileges to the individual if all of the following apply:

(a) The covered facility requests the criminal history check or criminal history record information under this section upon conditionally employing or conditionally granting clinical privileges to the individual.

(b) The individual signs a statement in writing that indicates all of the following:

(*i*) That he or she has not been convicted of 1 or more of the crimes that are described in subsection (1)(a) to (g) within the applicable time period prescribed by each subdivision respectively.

(*ii*) That he or she is not the subject of an order or disposition described in subsection (1)(h).

(*iii*) That he or she has not been the subject of a substantiated finding as described in subsection (1)(i).

(*iv*) That he or she agrees that, if the information in the criminal history check conducted under this section does not confirm the individual's statements under subparagraphs (*i*) to (*iii*), his or her employment or clinical privileges will be terminated by the covered facility as required under subsection (1) unless and until the individual appeals and can prove that the information is incorrect.

(*v*) That he or she understands that the conditions described in subparagraphs (*i*) to (*iv*) may result in the termination of his or her employment or clinical privileges and that those conditions are good cause for

termination.

(c) Except as otherwise provided in this subdivision, the covered facility does not permit the individual to have regular direct access to or provide direct services to patients or residents in the covered facility without supervision until the criminal history check or criminal history record information is obtained and the individual is eligible for that employment or clinical privileges. If required under this subdivision, the covered facility shall provide on-site supervision of an individual in the covered facility on a conditional basis under this subsection by an individual who has undergone a criminal history check conducted in compliance with this section. A covered facility may permit an individual in the covered facility on a conditional basis under this subsection to have regular direct access to or provide direct services to patients or residents in the covered facility without supervision if all of the following conditions are met:

(*i*) The covered facility, at its own expense and before the individual has direct access to or provides direct services to patients or residents of the covered facility, conducts a search of public records on that individual through the internet criminal history access tool maintained by the department of state police and the results of that search do not uncover any information that would indicate that the individual is not eligible to have regular direct access to or provide direct services to patients or residents under this section.

(*ii*) Before the individual has direct access to or provides direct services to patients or residents of the covered facility, the individual signs a statement in writing that he or she has resided in this state without interruption for at least the immediately preceding 12-month period.

(*iii*) If applicable, the individual provides to the department of state police a set of fingerprints on or before the expiration of 10 business days following the date the individual was conditionally employed or granted conditional clinical privileges under this subsection.

(6) The department shall develop and distribute a model form for the statements required under subsection (5)(b) and (c). The department shall make the model form available to covered facilities upon request at no charge.

(7) If an individual is employed as a conditional employee or is granted conditional clinical privileges under subsection (5), and the information under subsection (3) or report under subsection (4) does not confirm the individual's statement under subsection (5)(b)(*i*) to (*iii*), the covered facility shall terminate the individual's employment or clinical privileges as required by subsection (1).

(8) An individual who knowingly provides false information regarding his or her identity, criminal convictions, or substantiated findings on a statement described in subsection (5)(b)(*i*) to (*iii*) is guilty of a misdemeanor punishable by imprisonment for not more than 93 days or a fine of not more than $500.00, or both.

(9) A staffing agency or covered facility shall use criminal history record information obtained under subsection (3) or (4) only for the purpose of evaluating an applicant's qualifications for employment, an independent contract, or clinical privileges in the position for which he or she has applied and for the purposes of subsections (5) and (7). A staffing agency or covered facility or an employee of the staffing agency or covered facility shall not disclose criminal history record information obtained under subsection (3) or (4) to a person who is not directly involved in evaluating the applicant's qualifications for employment, an independent contract, or clinical privileges. An individual who knowingly uses or disseminates the criminal history record information obtained under subsection (3) or (4) in violation of this subsection is guilty of a misdemeanor punishable by imprisonment for not more than 93 days or a fine of not more than $1,000.00, or both. Except for a knowing or intentional release of false information, a staffing agency or covered facility has no liability in connection with a criminal history check conducted in compliance with this section or the release of criminal history record information under this subsection.

(10) Upon consent of an applicant as required in subsection (3) and upon request from a staffing agency or covered facility that has made a good faith offer of employment or an independent contract or clinical privileges to the applicant, the relevant licensing or regulatory department shall review the criminal history record information, if any, and notify the requesting staffing agency or covered facility of the information in the manner prescribed in subsection (4). Until the department of state police can participate with the Federal Bureau of Investigation's automatic notification system similar to the system required of the state police under subsection (13) and federal regulations allow the federal criminal record to be used for subsequent authorized uses, as determined in an order issued by the department, a staffing agency or covered facility may rely on the criminal history record information provided by the relevant licensing or regulatory department under this subsection and a request to the Federal Bureau of Investigation to make a subsequent determination of the existence of any national criminal history pertaining to the applicant is not necessary if all of the following requirements are met:

(a) The criminal history check was conducted during the immediately preceding 12-month period.

(b) The applicant has been continuously employed by the staffing agency or a covered facility, adult foster

care facility, or mental health facility since the criminal history check was conducted in compliance with this section or meets the continuous employment requirement of this subdivision other than being on layoff status for less than 1 year from a covered facility, adult foster care facility, or mental health facility.

(c) The applicant can provide evidence acceptable to the relevant licensing or regulatory department that he or she has been a resident of this state for the immediately preceding 12-month period.

(11) As a condition of continued employment, each employee, independent contractor, or individual granted clinical privileges shall do each of the following:

(a) Agree in writing to report to the staffing agency or covered facility immediately upon being arraigned for 1 or more of the criminal offenses listed in subsection (1)(a) to (g), upon being convicted of 1 or more of the criminal offenses listed in subsection (1)(a) to (g), upon becoming the subject of an order or disposition described under subsection (1)(h), and upon being the subject of a substantiated finding of neglect, abuse, or misappropriation of property as described in subsection (1)(i). Reporting of an arraignment under this subdivision is not cause for termination or denial of employment.

(b) If a set of fingerprints is not already on file with the department of state police, provide the department of state police with a set of fingerprints.

(12) In addition to sanctions set forth in section 20165, a licensee, owner, administrator, or operator of a staffing agency or covered facility who knowingly and willfully fails to conduct the criminal history checks as required under this section is guilty of a misdemeanor punishable by imprisonment for not more than 1 year or a fine of not more than $5,000.00, or both.

(13) The department of state police and the Federal Bureau of Investigation shall store and retain all fingerprints submitted under this section and provide for an automatic notification if and when subsequent criminal information submitted into the system matches a set of fingerprints previously submitted under this section. Upon such notification, the department of state police shall immediately notify the department and the department shall immediately contact each respective staffing agency or covered facility with which that individual is associated. Information in the database established under this subsection is confidential, is not subject to disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, and shall not be disclosed to any person except for purposes of this act or for law enforcement purposes.

(14) The department shall maintain an electronic web-based system to assist staffing agencies and covered facilities required to check relevant registries and conduct criminal history checks of its employees, independent contractors, and individuals granted privileges and to provide for an automated notice to those staffing agencies and covered facilities for those individuals inputted in the system who, since the initial criminal history check, have been convicted of a disqualifying offense or have been the subject of a substantiated finding of abuse, neglect, or misappropriation of property. The department may charge a staffing agency a 1-time set-up fee of up to $100.00 for access to the electronic web-based system under this section.

(15) As used in this section:

(a) "Adult foster care facility" means an adult foster care facility licensed under the adult foster care facility licensing act, 1979 PA 218, MCL 400.701 to 400.737.

(b) "Convicted" means either of the following:

(*i*) For a crime that is not a relevant crime, a final conviction, the payment of a fine, a plea of guilty or nolo contendere if accepted by the court, or a finding of guilt for a criminal law violation or a juvenile adjudication or disposition by the juvenile division of probate court or family division of circuit court for a violation that if committed by an adult would be a crime.

(*ii*) For a relevant crime described under 42 USC 1320a-7(a), convicted means that term as defined in 42 USC 1320a-7.

(c) "Covered facility" means a health facility or agency that is a nursing home, county medical care facility, hospice, hospital that provides swing bed services, home for the aged, or home health agency.

(d) "Criminal history check conducted in compliance with this section" includes a criminal history check conducted under this section, under section 134a of the mental health code, 1974 PA 258, MCL 330.1134a, or under section 34b of the adult foster care facility licensing act, 1979 PA 218, MCL 400.734b.

(e) "Direct access" means access to a patient or resident or to a patient's or resident's property, financial information, medical records, treatment information, or any other identifying information.

(f) "Home health agency" means a person certified by Medicare whose business is to provide to individuals in their places of residence other than in a hospital, nursing home, or county medical care facility 1 or more of the following services: nursing services, therapeutic services, social work services, homemaker services, home health aide services, or other related services.

(g) "Independent contract" means a contract entered into by a covered facility with an individual who provides the contracted services independently or a contract entered into by a covered facility with a staffing agency that complies with the requirements of this section to provide the contracted services to the covered

facility on behalf of the staffing agency.

(h) "Medicare" means benefits under the federal Medicare program established under title XVIII of the social security act, 42 USC 1395 to 1395*lll*.

(i) "Mental health facility" means a psychiatric facility or other facility defined in 42 USC 1396d(d) as described under the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106.

(j) "Staffing agency" means an entity that recruits candidates and provides temporary and permanent qualified staffing for covered facilities, including independent contractors.

(k) "Under the facility's control" means an individual employed by or under independent contract with a covered facility for whom the covered facility does both of the following:

(*i*) Determines whether the individual who has access to patients or residents may provide care, treatment, or other similar support service functions to patients or residents served by the covered facility.

(*ii*) Directs or oversees 1 or more of the following:

(A) The policy or procedures the individual must follow in performing his or her duties.

(B) The tasks performed by the individual.

(C) The individual's work schedule.

(D) The supervision or evaluation of the individual's work or job performance, including imposing discipline or granting performance awards.

(E) The compensation the individual receives for performing his or her duties.

(F) The conditions under which the individual performs his or her duties.

History: Add. 2006, Act 28, Eff. Apr. 1, 2006;—Am. 2008, Act 123, Imd. Eff. May 9, 2008;—Am. 2008, Act 443, Imd. Eff. Jan. 9, 2009;—Am. 2008, Act 444, Eff. Oct. 31, 2010;—Am. 2010, Act 291, Imd. Eff. Dec. 16, 2010;—Am. 2014, Act 66, Imd. Eff. Mar. 28, 2014;—Am. 2017, Act 167, Eff. Feb. 11, 2018.

Compiler's note: Enacting section 1 of Act 28 of 2006 provides:

"Enacting section 1. (1) Section 20173 of the public health code, 1978 PA 368, MCL 333.20173, is repealed effective April 1, 2006.

"(2) Section 20173a of the public health code, 1978 PA 368, MCL 333.20173a, as added by this amendatory act, takes effect April 1, 2006, since the department has secured the necessary federal approval to utilize federal funds to reimburse those facilities for the costs incurred for requesting a national criminal history check to be conducted by the federal bureau of investigation and the department has filed written notice of that approval with the secretary of state. The department shall issue a medicaid policy bulletin regarding the payment and reimbursement for the criminal history checks by April 1, 2006.

"(3) Section 20173b of the public health code, 1978 PA 368, MCL 333.20173b, as added by this amendatory act, takes effect the date this amendatory act is enacted."

Popular name: Act 368

333.20173b Individual disqualified or denied employment pursuant to MCL 333.20173, 333.20173a, or 330.1134a; appeal; report to legislature; "business day" defined.

Sec. 20173b. (1) An individual who has been disqualified from or denied employment by a health facility or agency that is a nursing home, county medical care facility, hospice, hospital that provides swing bed services, home for the aged, or home health agency or by a psychiatric facility or other facility defined in 42 USC 1396d(d) based on a criminal history check conducted pursuant to section 20173 or 20173a or pursuant to section 134a of the mental health code, 1974 PA 258, MCL 330.1134a, respectively, may appeal to the department if he or she believes that the criminal history report is inaccurate, and the appeal shall be conducted as a contested case hearing pursuant to the administrative procedures act of 1969. The individual shall file the appeal with the director of the department within 15 business days after receiving the written report of the criminal history check unless the conviction contained in the criminal history report is one that may be expunged or set aside. If an individual has been disqualified or denied employment based on a conviction that may be expunged or set aside, then he or she shall file the appeal on a form provided by the department within 15 business days after a court order granting or denying his or her application to expunge or set aside that conviction is granted. If the order is granted and the conviction is expunged or set aside, then the individual shall not be disqualified or denied employment based solely on that conviction. The director shall review the appeal and issue a written decision within 30 business days after receiving the appeal. The decision of the director is final.

(2) Beginning February 17, 2007 and each year thereafter for the next 3 years, the department shall provide the legislature with a written report regarding the appeals process implemented under this section for employees subject to criminal history checks. The report shall include, but is not limited to, for the immediately preceding year the number of applications for appeal received, the number of inaccuracies found and appeals granted with regard to the criminal history checks conducted under section 20173a, the average number of days necessary to complete the appeals process for each appeal, and the number of appeals rejected without a hearing and a brief explanation of the denial.

(3) As used in this section, "business day" means a day other than a Saturday, Sunday, or any legal

holiday.

History: Add. 2006, Act 28, Imd. Eff. Feb. 17, 2006;—Am. 2014, Act 66, Imd. Eff. Mar. 28, 2014.

Compiler's note: Enacting section 1 of Act 28 of 2006 provides:

"Enacting section 1. (1) Section 20173 of the public health code, 1978 PA 368, MCL 333.20173, is repealed effective April 1, 2006.

"(2) Section 20173a of the public health code, 1978 PA 368, MCL 333.20173a, as added by this amendatory act, takes effect April 1, 2006, since the department has secured the necessary federal approval to utilize federal funds to reimburse those facilities for the costs incurred for requesting a national criminal history check to be conducted by the federal bureau of investigation and the department has filed written notice of that approval with the secretary of state. The department shall issue a medicaid policy bulletin regarding the payment and reimbursement for the criminal history checks by April 1, 2006.

"(3) Section 20173b of the public health code, 1978 PA 368, MCL 333.20173b, as added by this amendatory act, takes effect the date this amendatory act is enacted."

333.20174 Practice agreement; designation of physician by health facility or agency.

Sec. 20174. A health facility or agency may designate 1 or more physicians to enter into a practice agreement under section 17047 or 17547.

History: Add. 2016, Act 379, Eff. Mar. 22, 2017.

Popular name: Act 368

333.20175 Maintaining record for each patient; confidentiality; wrongfully altering or destroying records; noncompliance; fine; licensing and certification records as public records; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge.

Sec. 20175. (1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization. Unless a longer retention period is otherwise required under federal or state laws or regulations or by generally accepted standards of medical practice, a health facility or agency shall keep and retain each record for a minimum of 7 years from the date of service to which the record pertains. A health facility or agency shall maintain the records in such a manner as to protect their integrity, to ensure their confidentiality and proper use, and to ensure their accessibility and availability to each patient or his or her authorized representative as required by law. A health facility or agency may destroy a record that is less than 7 years old only if both of the following are satisfied:

(a) The health facility or agency sends a written notice to the patient at the last known address of that patient informing the patient that the record is about to be destroyed, offering the patient the opportunity to request a copy of that record, and requesting the patient's written authorization to destroy the record.

(b) The health facility or agency receives written authorization from the patient or his or her authorized representative agreeing to the destruction of the record. Except as otherwise provided under federal or state laws and regulations, records required to be maintained under this subsection may be destroyed or otherwise disposed of after being maintained for 7 years. If records maintained in accordance with this section are subsequently destroyed or otherwise disposed of, those records shall be shredded, incinerated, electronically deleted, or otherwise disposed of in a manner that ensures continued confidentiality of the patient's health care information and any other personal information relating to the patient. If records are destroyed or otherwise disposed of as provided under this subsection, the department may take action including, but not limited to, contracting for or making other arrangements to ensure that those records and any other confidential identifying information related to the patient are properly destroyed or disposed of to protect the confidentiality of patient's health care information and any other personal information relating to the patient. Before the department takes action in accordance with this subsection, the department, if able to identify the health facility or agency responsible for the improper destruction or disposal of the medical records at issue, shall send a written notice to that health facility or agency at the last known address on file with the department and provide the health facility or agency with an opportunity to properly destroy or dispose of those medical records as required under this subsection unless a delay in the proper destruction or disposal may compromise the patient's confidentiality. The department may assess the health facility or agency with the costs incurred by the department to enforce this subsection. In addition to the sanctions set forth in section 20165, a hospital that fails to comply with this subsection is subject to an administrative fine of $10,000.00.

(2) A hospital shall take precautions to assure that the records required by subsection (1) are not wrongfully altered or destroyed. A hospital that fails to comply with this subsection is subject to an administrative fine of $10,000.00.

(3) Unless otherwise provided by law, the licensing and certification records required by this article are public records.

(4) Departmental officers and employees shall respect the confidentiality of patient clinical records and

shall not divulge or disclose the contents of records in a manner that identifies an individual except pursuant to court order or as otherwise authorized by law.

(5) A health facility or agency that employs, contracts with, or grants privileges to a health professional licensed or registered under article 15 shall report the following to the department not more than 30 days after it occurs:

(a) Disciplinary action taken by the health facility or agency against a health professional licensed or registered under article 15 based on the licensee's or registrant's professional competence, disciplinary action that results in a change of employment status, or disciplinary action based on conduct that adversely affects the licensee's or registrant's clinical privileges for a period of more than 15 days. As used in this subdivision, "adversely affects" means the reduction, restriction, suspension, revocation, denial, or failure to renew the clinical privileges of a licensee or registrant by a health facility or agency.

(b) Restriction or acceptance of the surrender of the clinical privileges of a licensee or registrant under either of the following circumstances:

(*i*) The licensee or registrant is under investigation by the health facility or agency.

(*ii*) There is an agreement in which the health facility or agency agrees not to conduct an investigation into the licensee's or registrant's alleged professional incompetence or improper professional conduct.

(c) A case in which a health professional resigns or terminates a contract or whose contract is not renewed instead of the health facility taking disciplinary action against the health professional.

(6) Upon request by another health facility or agency seeking a reference for purposes of changing or granting staff privileges, credentials, or employment, a health facility or agency that employs, contracts with, or grants privileges to health professionals licensed or registered under article 15 shall notify the requesting health facility or agency of any disciplinary or other action reportable under subsection (5) that it has taken against a health professional licensed or registered under article 15 and employed by, under contract to, or granted privileges by the health facility or agency.

(7) For the purpose of reporting disciplinary actions under this section, a health facility or agency shall include only the following in the information provided:

(a) The name of the licensee or registrant against whom disciplinary action has been taken.

(b) A description of the disciplinary action taken.

(c) The specific grounds for the disciplinary action taken.

(d) The date of the incident that is the basis for the disciplinary action.

(8) The records, data, and knowledge collected for or by individuals or committees assigned a professional review function in a health facility or agency, or an institution of higher education in this state that has colleges of osteopathic and human medicine, are confidential, shall be used only for the purposes provided in this article, are not public records, and are not subject to court subpoena.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1986, Act 174, Imd. Eff. July 7, 1986;—Am. 1993, Act 79, Eff. Apr. 1, 1994;—Am. 2000, Act 319, Imd. Eff. Oct. 24, 2000;—Am. 2006, Act 481, Imd. Eff. Dec. 22, 2006.

Compiler's note: Section 3 of Act 174 of 1986 provides: “This amendatory act shall only apply to contested cases filed on or after July 1, 1986.”

Popular name: Act 368

333.20175a Agreement with another health facility to protect, maintain, and provide access to records; closure of health facility; noncompliance; fine; definitions.

Sec. 20175a. (1) If a health facility or agency is unable to comply with section 20175, the health facility or agency shall employ or contract, arrange, or enter into an agreement with another health facility or agency or a medical records company to protect, maintain, and provide access to those records required under section 20175(1).

(2) If a health facility or agency closes or otherwise ceases operation, the health facility or agency shall not abandon the records required to be maintained under section 20175(1) and shall send a written notice to the department that specifies who will have custody of the medical records and how a patient may request access to or copies of his or her medical records and shall do either of the following:

(a) Transfer the records required under section 20175(1) to any of the following:

(*i*) A successor health facility or agency.

(*ii*) If designated by the patient or his or her authorized representative, to the patient or a specific health facility or agency or a health care provider licensed or registered under article 15.

(*iii*) A health facility or agency or a medical records company with which the health facility or agency had contracted or entered into an agreement to protect, maintain, and provide access to those records required under section 20175(1).

(b) In accordance with section 20175(1), as long as the health facility or agency sends a written notice to

the last known address of each patient for whom he or she has provided medical services and receives written authorization from the patient or his or her authorized representative, destroy the records required under section 20175(1). The notice shall provide the patient with 30 days to request a copy of his or her record or to designate where he or she would like his or her medical records transferred and shall request from the patient within 30 days written authorization for the destruction of his or her medical records. If the patient fails to request a copy or transfer of his or her medical records or to provide the health facility or agency with written authorization for the destruction, then the health facility or agency shall not destroy those records that are less than 7 years old but may destroy, in accordance with section 20175(1), those that are 7 years old or older.

(3) Nothing in this section shall be conducted to create or change the ownership rights to any medical records.

(4) A person that fails to comply with this section is subject to an administrative fine of not more than $10,000.00 if the failure was the result of gross negligence or willful and wanton misconduct.

(5) As used in this section:

(a) "Medical record" or "record" means information, oral or recorded in any form or medium, that pertains to a patient's health care, medical history, diagnosis, prognosis, or medical condition and that is maintained by a licensee in the process of providing medical services.

(b) "Medical records company" means a person who contracts for or agrees to protect, maintain, and provide access to medical records for a health facility or agency in accordance with section 20175.

(c) "Patient" means an individual who receives or has received health care from a health care provider or health facility or agency. Patient includes a guardian, if appointed, and a parent, guardian, or person acting in loco parentis, if the individual is a minor, unless the minor lawfully obtained health care without the consent or notification of a parent, guardian, or other person acting in loco parentis, in which case the minor has the exclusive right to exercise the rights of a patient under this section with respect to his or her medical records relating to that care.

History: Add. 2006, Act 481, Imd. Eff. Dec. 22, 2006.

Popular name: Act 368

333.20176 Notice of violation; investigation of complaints; notice of proposed action; public record; appeal; reinvestigation.

Sec. 20176. (1) A person may notify the department of a violation of this article or of a rule promulgated under this article that the person believes exists. The department shall investigate each written complaint received and shall notify the complainant in writing of the results of a review or investigation of the complaint and any action proposed to be taken. Except as otherwise provided in sections 20180, 21743(1)(d), and 21799a, the name of the complainant and the charges contained in the complaint are a matter of public record.

(2) Except as otherwise provided in section 21799a, a complainant who is aggrieved by the decision of the department under this section may appeal to the director. After review of an appeal under this subsection, the director may order the department to reinvestigate the complaint.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1994, Act 52, Imd. Eff. Mar. 31, 1994.

Popular name: Act 368

333.20176a Health facility or agency; prohibited conduct; violation; fine.

Sec. 20176a. (1) A health facility or agency shall not discharge or discipline, threaten to discharge or discipline, or otherwise discriminate against an employee regarding the employee's compensation, terms, conditions, location, or privileges of employment because the employee or an individual acting on behalf of the employee does either or both of the following:

(a) In good faith reports or intends to report, verbally or in writing, the malpractice of a health professional or a violation of this article, article 7, article 8, or article 15 or a rule promulgated under this article, article 7, article 8, or article 15.

(b) Acts as an expert witness in a civil action involving medical malpractice or in an administrative action.

(2) In addition to the sanctions set forth in section 20165, a health facility or agency that violates subsection (1) is subject to an administrative fine of not more than $10,000.00 for each violation.

History: Add. 1993, Act 79, Eff. Apr. 1, 1994;—Am. 1994, Act 52, Imd. Eff. Mar. 31, 1994;—Am. 2013, Act 268, Imd. Eff. Dec. 30, 2013.

Popular name: Act 368

333.20177 Action to restrain, enjoin, or prevent establishment, maintenance, or operation of health facility or agency.

Sec. 20177. Notwithstanding the existence and pursuit of any other remedy, the director, without posting a

bond, may request the prosecuting attorney or attorney general to bring an action in the name of the people of this state to restrain, enjoin, or prevent the establishment, maintenance, or operation of a health facility or agency in violation of this article or rules promulgated under this article.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20178 Nursing home, home for the aged, or county medical care facility; description of services to patients or residents with Alzheimer's disease; contents; "represents to the public" defined.

Sec. 20178. (1) Beginning not more than 90 days after the effective date of the amendatory act that added this section, a health facility or agency that is a nursing home, home for the aged, or county medical care facility that represents to the public that it provides inpatient care or services or residential care or services, or both, to persons with Alzheimer's disease or a related condition shall provide to each prospective patient, resident, or surrogate decision maker a written description of the services provided by the health facility or agency to patients or residents with Alzheimer's disease or a related condition. A written description shall include, but not be limited to, all of the following:

(a) The overall philosophy and mission reflecting the needs of patients or residents with Alzheimer's disease or a related condition.

(b) The process and criteria for placement in or transfer or discharge from a program for patients or residents with Alzheimer's disease or a related condition.

(c) The process used for assessment and establishment of a plan of care and its implementation.

(d) Staff training and continuing education practices.

(e) The physical environment and design features appropriate to support the function of patients or residents with Alzheimer's disease or a related condition.

(f) The frequency and types of activities for patients or residents with Alzheimer's disease or a related condition.

(g) Identification of supplemental fees for services provided to patients or residents with Alzheimer's disease or a related condition.

(2) As used in this section, "represents to the public" means advertises or markets the facility as providing specialized Alzheimer's or dementia care services.

History: Add. 2000, Act 500, Imd. Eff. Jan. 11, 2001.

Popular name: Act 368

333.20179 Artificial insemination services on anonymous basis; use of frozen sperm; testing sperm donor for presence of HIV or antibody to HIV; violation; liability; definitions.

Sec. 20179. (1) A health facility or agency licensed under this article that provides artificial insemination services on an anonymous basis shall use only frozen sperm, and shall test each potential sperm donor for the presence in the donor of HIV or an antibody to HIV. The donated sperm shall be frozen, stored, and quarantined for not less than 6 months. Before frozen sperm is used for artificial insemination, and not less than 6 months after the date of the donation, the health facility or agency shall take a second blood sample from the donor and have that blood sample tested for HIV or an antibody to HIV. If at any time the test results are positive, the health facility or agency licensed under this article shall not use the sperm of the donor for artificial insemination purposes.

(2) A health facility or agency licensed under this article that violates this section shall be liable in a civil action for damages for the loss or damage resulting from the violation.

(3) As used in this section:

(a) "Anonymous basis" means that the recipient of the sperm does not know the identity of the donor, but the health facility or agency licensed under this article that provides the artificial insemination services or collects the sperm from the donor does know the identity of the donor.

(b) "HIV" means human immunodeficiency virus.

History: Add. 1988, Act 487, Eff. July 1, 1989.

Popular name: Act 368

333.20180 Health facility or agency; person making or assisting in originating, investigating, or preparing report or complaint; immunity and protection from civil or criminal liability; disclosure of identity; notice; "hospital" defined.

Sec. 20180. (1) A person employed by or under contract to a health facility or agency or any other person acting in good faith who makes a report or complaint including, but not limited to, a report or complaint of a

violation of this article or a rule promulgated under this article; who assists in originating, investigating, or preparing a report or complaint; or who assists the department in carrying out its duties under this article is immune from civil or criminal liability that might otherwise be incurred and is protected under the whistleblowers' protection act, 1980 PA 469, MCL 15.361 to 15.369. A person described in this subsection who makes or assists in making a report or complaint, or who assists the department as described in this subsection, is presumed to have acted in good faith. The immunity from civil or criminal liability granted under this subsection extends only to acts done pursuant to this article.

(2) Unless a person described in subsection (1) otherwise agrees in writing, the department shall keep the person's identity confidential until disciplinary proceedings under this article are initiated against the subject of the report or complaint and the person making or assisting in originating, investigating, or preparing the report or complaint is required to testify in the disciplinary proceedings. If disclosure of the person's identity is considered by the department to be essential to the disciplinary proceedings and if the person is the complainant, the department shall give the person an opportunity to withdraw the complaint before disclosure.

(3) Subject to subsection (4), a person employed by or under contract to a hospital is immune from civil or criminal liability that might otherwise be incurred and shall not be discharged, threatened, or otherwise discriminated against by the hospital regarding that person's compensation or the terms, conditions, location, or privileges of that person's employment if that person reports to the department, verbally or in writing, an issue related to the hospital that is an unsafe practice or condition that is not a violation of this article or a rule promulgated under this article. The protections afforded under this subsection do not limit, restrict, or diminish, in any way, the protections afforded under the whistleblowers' protection act, 1980 PA 469, MCL 15.361 to 15.369.

(4) Except as otherwise provided in subsection (5), a person employed by or under contract to a hospital is eligible for the immunity and protection provided under subsection (3) only if the person meets all of the following conditions before reporting to the department the issue related to the hospital that is an unsafe practice or condition that is not a violation of this article or a rule promulgated under this article:

(a) The person gave the hospital 60 days' written notice of the issue related to the hospital that is an unsafe practice or condition that is not a violation of this article or a rule promulgated under this article. A person who provides a hospital written notice as provided under this subdivision shall not be discharged, threatened, or otherwise discriminated against by the hospital regarding that person's compensation or the terms, conditions, location, or privileges of that person's employment. Within 60 days after receiving a written notice of an issue related to the hospital that is an unsafe practice or condition, the hospital shall provide a written response to the person who provided that written notice.

(b) The person had no reasonable expectation that the hospital had taken or would take timely action to address the issue related to the hospital that is an unsafe practice or condition that is not a violation of this article or a rule promulgated under this article.

(5) Subsection (4) does not apply if the person employed by or under contract to a hospital is required by law to report the issue related to the hospital that is an unsafe practice or condition that is not a violation of this article or a rule promulgated under this article before the expiration of the 60 days' notice required under subsection (4).

(6) A hospital shall post notices and use other appropriate means to keep a person employed by or under contract to the hospital informed of their protections and obligations under this section. The notices shall be in a form approved by the department. The notice shall be made available on the department's internet website and shall be posted in 1 or more conspicuous places where notices to persons employed by or under contract to a hospital are customarily posted.

(7) As used in this section, “hospital” means a hospital licensed under article 17.

History: Add. 1994, Act 52, Imd. Eff. Mar. 31, 1994;—Am. 2002, Act 731, Imd. Eff. Dec. 30, 2002.

Popular name: Act 368

333.20181 Abortion; admitting patient not required; refusal to perform, participate in, or allow; immunity.

Sec. 20181. A hospital, clinic, institution, teaching institution, or other health facility is not required to admit a patient for the purpose of performing an abortion. A hospital, clinic, institution, teaching institution, or other health facility or a physician, member, or associate of the staff, or other person connected therewith, may refuse to perform, participate in, or allow to be performed on its premises an abortion. The refusal shall be with immunity from any civil or criminal liability or penalty.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20182 Abortion; objection; participation in medical procedures not required; immunity.

Sec. 20182. A physician, or other individual who is a member of or associated with a hospital, clinic, institution, teaching institution, or other health facility, or a nurse, medical student, student nurse, or other employee of a hospital, clinic, institution, teaching institution, or other health facility in which an abortion is performed, who states an objection to abortion on professional, ethical, moral, or religious grounds, is not required to participate in the medical procedures which will result in abortion. The refusal by the individual to participate does not create a liability for damages on account of the refusal or for any disciplinary or discriminatory action by the patient, hospital, clinic, institution, teaching institution, or other health facility against the individual.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20183 Abortion; refusal to give advice; refusal to participate in; immunity.

Sec. 20183. (1) A physician who informs a patient that he or she refuses to give advice concerning, or participate in, an abortion is not liable to the hospital, clinic, institution, teaching institution, health facility, or patient for the refusal.

(2) A civil action for negligence or malpractice or a disciplinary or discriminatory action may not be maintained against a person refusing to give advice as to, or participating in, an abortion based on the refusal.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20184 Rights of individuals, staff members, and employees previously participating in, or expressing willingness to participate in, termination of pregnancy.

Sec. 20184. A hospital, clinic, institution, teaching institution, or other health facility which refuses to allow abortions to be performed on its premises shall not deny staff privileges or employment to an individual for the sole reason that the individual previously participated in, or expressed a willingness to participate in, a termination of pregnancy. A hospital, clinic, institution, teaching institution, or other health facility shall not discriminate against its staff members or other employees for the sole reason that the staff members or employees have participated in, or have expressed a willingness to participate in, a termination of pregnancy.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20188 Repealed. 2004, Act 119, Eff. Nov. 27, 2005.

Compiler's note: The repealed section pertained to creation of commission on patient safety.

Popular name: Act 368

333.20191 Emergency patient; test for presence of infectious agent; positive test results; duties of health facility; notice; request for testing; confidentiality; rules; disclosure as misdemeanor; liability; definitions.

Sec. 20191. (1) If a police officer, fire fighter, individual licensed under section 20950 or 20952, or another individual assists an emergency patient who is subsequently transported to a health facility or transports an emergency patient to a health facility, and if the emergency patient, as part of the treatment rendered by the health facility or pursuant to a request made under subsection (2), is tested for the presence in the emergency patient of an infectious agent and the test results are positive, or is tested pursuant to a request made under subsection (2) for the presence in the emergency patient of the infectious agent of HIV or HBV and the test results are positive or negative, the health facility shall do all of the following:

(a) Subject to subsection (4) and subdivision (b), if the test results are positive for an infectious agent and the individual meets 1 of the following requirements, notify the individual on a form provided by the department that he or she may have been exposed to an infectious agent and, if the test results of a test conducted pursuant to subsection (2) are negative for the infectious agent of HIV or HBV, notify the individual of that fact:

(*i*) The individual is a police officer, fire fighter, or individual licensed under section 20950 or 20952.

(*ii*) The individual demonstrates in writing to the health facility that he or she was exposed to the blood, body fluids, or airborne agents of the emergency patient or participated in providing assistance to the emergency patient or transportation of the emergency patient to the health facility. An individual who makes a request under subsection (2) is exempt from the requirements of this subparagraph.

(b) Subject to subsection (4), if the test results indicate that the emergency patient is HIV infected, the

health facility shall not reveal that the infectious agent is HIV unless the health facility has received a written request for notification from an individual described in subdivision (a)(*i*) or (*ii*). This subdivision does not apply if the test results indicate that the emergency patient is not HIV infected.

(c) Subject to subsection (4), on a form provided by the department, notify the individual described in subdivision (a), at a minimum, of the appropriate infection control precautions to be taken and the approximate date of the potential exposure. If the emergency patient is tested pursuant to a request made under subsection (2) for the presence in the emergency patient of the infectious agent of HIV or HBV, or both, and if the test results are positive or negative, the health facility also shall notify the individual described in subdivision (a) on the form provided by the department that he or she should be tested for HIV infection or HBV infection, or both, and counseled regarding both infectious agents.

(2) A police officer, fire fighter, individual licensed under section 20950 or 20952, or other individual who assists an emergency patient who is subsequently transported to a health facility or who transports an emergency patient to a health facility and who sustains a percutaneous, mucous membrane, or open wound exposure to the blood or body fluids of the emergency patient may request that the emergency patient be tested for HIV infection or HBV infection, or both, pursuant to this subsection. The police officer, fire fighter, individual licensed under section 20950 or 20952, or other individual shall make a request to a health facility under this subsection in writing on a form provided by the department and before the emergency patient is discharged from the health facility. The request form shall be dated and shall contain at a minimum the name and address of the individual making the request and a description of the individual's exposure to the emergency patient's blood or other body fluids. The request form shall contain a space for the information required under subsection (3) and a statement that the requester is subject to the confidentiality requirements of subsection (5) and section 5131. The request form shall not contain information that would identify the emergency patient by name. A health facility that receives a request under this subsection shall accept as fact the requester's description of his or her exposure to the emergency patient's blood or other body fluids, unless the health facility has reasonable cause to believe otherwise. The health facility shall make a determination as to whether or not the exposure described in the request was a percutaneous, mucous membrane, or open wound exposure pursuant to R 325.70001 to R 325.70018 of the Michigan administrative code. If the health facility determines that the exposure described in the request was a percutaneous, mucous membrane, or open wound exposure, the health facility shall test the emergency patient for HIV infection or HBV infection, or both, as indicated in the request. A health facility that performs a test under this subsection may charge the individual requesting the test for the reasonable and customary charges of the test. The individual requesting the test is responsible for the payment of the charges if the charges are not payable by the individual's employer, pursuant to an agreement between the individual and the employer, or by the individual's health care payment or benefits plan. A health facility is not required to provide HIV counseling pursuant to section 5133(1) to an individual who requests that an emergency patient be tested for HIV under this subsection, unless the health facility tests the requesting individual for HIV.

(3) A health facility shall comply with this subsection if the health facility receives a request under subsection (2) and determines either that there is reasonable cause to disbelieve the requester's description of his or her exposure or that the exposure was not a percutaneous, mucous membrane, or open wound exposure and as a result of the determination the health facility is not required to test the emergency patient for HIV infection or HBV infection, or both. A health facility shall also comply with this subsection if the health facility receives a request under subsection (2) and determines that the exposure was a percutaneous, mucous membrane, or open wound exposure, but is unable to test the emergency patient for HIV infection or HBV infection, or both. The health facility shall state in writing on the request form the reasons for disbelieving the requester's description of his or her exposure, the health facility's exposure determination, or the inability to test the emergency patient, as applicable. The health facility shall transmit a copy of the completed request form to the requesting individual within 2 days after the date the determination is made that the health facility has reasonable cause to disbelieve the requester's description of his or her exposure or that the exposure was not a percutaneous, mucous membrane, or open wound exposure or within 2 days after the date the health facility determines that it is unable to test the emergency patient for HIV infection or HBV infection, or both.

(4) The notification required under subsection (1) shall occur within 2 days after the test results are obtained by the health facility or after receipt of a written request under subsection (1)(b). The notification shall be transmitted to the potentially exposed individual or, upon request of the individual, to the individual's primary care physician or other health professional designated by the individual, as follows:

(a) If the potentially exposed individual provides his or her name and address or the name and address of the individual's primary care physician or other health professional designated by the individual to the health facility or if the health facility has a procedure that allows the health facility in the ordinary course of its business to determine the individual's name and address or the name and address of the individual's primary

care physician or other health professional designated by the individual, the health facility shall notify the individual or the individual's primary care physician or other health professional designated by the individual directly at that address.

(b) If the potentially exposed individual is a police officer, fire fighter, or individual licensed under section 20950 or 20952, and if the health facility does not have the name of the potentially exposed individual or the individual's primary care physician or other health professional designated by the individual, the health facility shall notify the appropriate police department, fire department, or life support agency that employs or dispatches the individual. If the health facility is unable to determine the employer of an individual described in this subdivision, the health facility shall notify the medical control authority or chief elected official of the governmental unit that has jurisdiction over the transporting vehicle.

(c) A medical control authority or chief elected official described in subdivision (b) shall notify the potentially exposed individual or the individual's primary care physician or other health professional designated by the individual or, if unable to notify the potentially exposed individual or the individual's primary care physician or other health professional designated by the individual, shall document in writing the notification efforts and reasons for being unable to make the notification.

(5) The notice required under subsection (1) shall not contain information that would identify the emergency patient who tested positive for an infectious agent or who tested positive or negative for the presence in the emergency patient of the infectious agent of HIV or HBV. The information contained in the notice is confidential and is subject to this section, the rules promulgated under section 5111, and section 5131. A person who receives confidential information under this section shall disclose the information to others only to the extent consistent with the authorized purpose for which the information was obtained.

(6) The department shall promulgate rules to administer this section. The department shall develop and distribute the forms required under subsections (1)(a) and (c) and (2).

(7) Except as otherwise provided in this subsection, a person who discloses information regarding an infectious agent in violation of subsection (5) is guilty of a misdemeanor. This subsection does not apply to the disclosure of information regarding a serious communicable disease or infection, if the disclosure is subject to rules promulgated under section 5111 or to section 5131.

(8) A person or governmental entity that makes a good faith effort to comply with subsection (1), (2), (3), or (4) is immune from any civil liability or criminal penalty based on compliance or the failure to comply.

(9) As used in this section:

(a) "Emergency patient" means an individual who is transported to an organized emergency department located in and operated by a hospital licensed under this article or a facility other than a hospital that is routinely available for the general care of medical patients.

(b) "HBV" means hepatitis B virus.

(c) "HBV infected" or "HBV infection" means the status of an individual who is tested as HBsAg-positive.

(d) "Health facility" means a health facility or agency as defined in section 20106.

(e) "HIV" means human immunodeficiency virus.

(f) "HIV infected" means that term as defined in section 5101.

(g) "Infectious agent" means that term as defined in R 325.9031 of the Michigan administrative code.

(h) "Life support agency" means that term as defined in section 20906.

(i) "Serious communicable disease or infection" means that term as defined in section 5101.

History: Add. 1988, Act 490, Eff. Mar. 30, 1989;—Am. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 1994, Act 419, Eff. Mar 30, 1995;—Am. 2010, Act 119, Imd. Eff. July 13, 2010.

Popular name: Act 368

333.20192 Do-not-resuscitate order; execution not required.

Sec. 20192. A health facility or agency shall not require the execution of a do-not-resuscitate order under the Michigan do-not-resuscitate procedure act as a condition for admission or receipt of services.

History: Add. 1996, Act 192, Eff. Aug. 1, 1996.

Popular name: Act 368

333.20192a POST form as condition for admission or receipt of services; requirement prohibited.

Sec. 20192a. A health facility or agency shall not require the execution of a POST form under part 56B as a condition for admission or the receipt of services.

History: Add. 2017, Act 154, Eff. Feb. 6, 2018.

Popular name: Act 368

333.20193 Compliance.

Sec. 20193. A health facility or agency shall comply with part 138.

History: Add. 1990, Act 21, Eff. June 4, 1990.

Popular name: Act 368

333.20194 Pamphlets; display; distribution; model standardized complaint form; availability.

Sec. 20194. (1) Subject to subsections (2), (3), and (4), a health facility or agency, except a health facility or agency licensed under part 209, and including a health facility that is not licensed under this article but holds itself out as providing medical services, shall conspicuously display in the patient waiting areas or other common areas of the health facility or agency copies of a pamphlet developed by the department of consumer and industry services outlining the procedure for filing a complaint against a health facility or agency with the department and the procedure for filing a complaint against an individual who is licensed or registered under article 15 and employed by, under contract to, or granted privileges by the health facility or agency. The pamphlet shall be developed and distributed by the department of consumer and industry services after consultation with appropriate professional associations.

(2) The department of consumer and industry services shall develop the pamphlets required under subsection (1) in languages that are appropriate to the ethnic composition of the patient population where the pamphlet will be displayed. The department shall use large, easily readable type and nontechnical, easily understood language in the pamphlet. The department shall periodically distribute copies of the pamphlet to each health facility or agency and to each unlicensed health facility described in subsection (1).

(3) The department of consumer and industry services shall include a model standardized complaint form in the pamphlet described in subsection (1). The department may develop a separate model standardized complaint form that is specific to a particular health facility or agency or category of health facilities and agencies. The department shall develop a model standardized complaint form that is specific to nursing homes. The department shall include on the model standardized complaint form, at a minimum, simple instructions on how to file a complaint, including with the nursing home as required under section 21723, the department, the state long-term care ombudsman, the Michigan protection and advocacy service, inc., and the health care fraud unit of the department of attorney general. The department shall distribute copies of the model standardized complaint form simultaneously with copies of the pamphlet as required under subsection (2). The nursing home shall conspicuously display and make available multiple copies of the pamphlet and model standardized complaint form with the complaint information required to be posted under section 21723 in the patient waiting areas or other common areas of the nursing home that are easily accessible to nursing home patients and their visitors, as described in subsection (1), and shall provide a copy of the pamphlet and complaint form to each nursing home resident or the resident's surrogate decision maker upon admission to the nursing home. The department shall include on the model standardized complaint form a telephone number for the receipt of oral complaints.

(4) The department may continue to distribute the complaint pamphlets within its possession on the effective date of the amendatory act that added this subsection until the department's stock is exhausted or until October 1, 2003, whichever is sooner. Beginning October 1, 2003, the department shall only distribute the complaint pamphlets and model standardized complaint forms that are in compliance with subsections (2) and (3).

(5) The department shall make the complaint pamphlet and the model standardized complaint form available to the public on the department's internet website. The department shall take affirmative action toward the development and implementation of an electronic filing system that would allow an individual to file a complaint through the website.

History: Add. 1993, Act 79, Eff. Apr. 1, 1994;—Am. 2003, Act 3, Imd. Eff. Apr. 22, 2003.

Popular name: Act 368

333.20197 Human cloning in facility owned or operated by health facility or agency.

Sec. 20197. (1) A health facility or agency shall not allow a licensee or registrant under article 15 or any other individual to engage in or attempt to engage in human cloning in a facility owned or operated by the health facility or agency.

(2) Subsection (1) does not prohibit a health facility or agency from allowing a licensee or registrant under article 15 or any other individual from engaging in scientific research or cell-based therapies not specifically prohibited by that subsection.

(3) A health facility or agency that violates subsection (1) is subject to the administrative penalties prescribed in section 20165(4).

(4) This section does not give a person a private right of action.

(5) As used in this section, "human cloning" means that term as defined in section 16274.

History: Add. 1998, Act 108, Eff. Mar. 23, 1999.

Popular name: Act 368

333.20198 Health facility, agency inpatient facility, or residential facility; prohibited conduct; violation as misdemeanor; penalty; nonapplicability of subsections (1) and (2).

Sec. 20198. (1) Subject to subsection (3), an individual shall not enter upon the premises of a health facility or agency that is an inpatient facility, an outpatient facility, or a residential facility for the purpose of engaging in an activity that would cause a reasonable person to feel terrorized, frightened, intimidated, threatened, harassed, or molested and that actually causes a health facility or agency employee, patient, resident, or visitor to feel terrorized, frightened, intimidated, threatened, harassed, or molested. This subsection does not prohibit constitutionally protected activity or conduct that serves a legitimate purpose.

(2) An individual who violates subsection (1) is guilty of a misdemeanor, punishable by imprisonment for not more than 1 year or a fine of not less than $1,000.00 or more than $10,000.00, or both.

(3) Subsections (1) and (2) do not apply to a nursing home covered under sections 21763(5) and 21799c(1)(c).

History: Add. 1998, Act 270, Eff. Mar. 23, 1999.

Popular name: Act 368

333.20199 Violations; penalties.

Sec. 20199. (1) Except as provided in subsection (2) or section 20142, a person who violates this article or a rule promulgated or an order issued under this article is guilty of a misdemeanor, punishable by fine of not more than $1,000.00 for each day the violation continues or, in case of a violation of sections 20551 to 20554, a fine of not more than $1,000.00 for each occurrence.

(2) A person who violates sections 20181 to 20184 is guilty of a misdemeanor, punishable by imprisonment for not more than 6 months, or a fine of not more than $2,000.00, or both.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.20201 Policy describing rights and responsibilities of patients or residents; adoption; posting; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.

Sec. 20201. (1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization that is subject to chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3573, the health facility or agency shall post the policy at a public place in the health facility or agency and shall provide the policy to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.

(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following:

(a) A patient or resident shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, sexual preference, or source of payment.

(b) An individual who is or has been a patient or resident is entitled to inspect, or receive for a reasonable fee, a copy of his or her medical record upon request in accordance with the medical records access act, 2004 PA 47, MCL 333.26261 to 333.26271. Except as otherwise permitted or required under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164, a third party shall not be given a copy of the patient's or resident's medical record without prior authorization of the patient or resident.

(c) A patient or resident is entitled to confidential treatment of personal and medical records, and may refuse their release to a person outside the health facility or agency except as required because of a transfer to another health care facility, as required by law or third party payment contract, or as permitted or required under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164.

(d) A patient or resident is entitled to privacy, to the extent feasible, in treatment and in caring for personal needs with consideration, respect, and full recognition of his or her dignity and individuality.

(e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse.

(f) A patient or resident is entitled to refuse treatment to the extent provided by law and to be informed of the consequences of that refusal. If a refusal of treatment prevents a health facility or agency or its staff from providing appropriate care according to ethical and professional standards, the relationship with the patient or resident may be terminated upon reasonable notice.

(g) A patient or resident is entitled to exercise his or her rights as a patient or resident and as a citizen, and to this end may present grievances or recommend changes in policies and services on behalf of himself or herself or others to the health facility or agency staff, to governmental officials, or to another person of his or her choice within or outside the health facility or agency, free from restraint, interference, coercion, discrimination, or reprisal. A patient or resident is entitled to information about the health facility's or agency's policies and procedures for initiation, review, and resolution of patient or resident complaints.

(h) A patient or resident is entitled to information concerning an experimental procedure proposed as a part of his or her care and has the right to refuse to participate in the experimental procedure without jeopardizing his or her continuing care.

(i) A patient or resident is entitled to receive and examine an explanation of his or her bill regardless of the source of payment and to receive, upon request, information relating to financial assistance available through the health facility or agency.

(j) A patient or resident is entitled to know who is responsible for and who is providing his or her direct care, to receive information concerning his or her continuing health needs and alternatives for meeting those needs, and to be involved in his or her discharge planning, if appropriate.

(k) A patient or resident is entitled to associate and have private communications and consultations with his or her physician or a physician's assistant with whom the physician has a practice agreement, with his or her advanced practice registered nurse, with his or her attorney, or with any other individual of his or her choice and to send and receive personal mail unopened on the same day it is received at the health facility or agency, unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse. A patient's or resident's civil and religious liberties, including the right to independent personal decisions and the right to knowledge of available choices, shall not be infringed and the health facility or agency shall encourage and assist in the fullest possible exercise of these rights. A patient or resident may meet with, and participate in, the activities of social, religious, and community groups at his or her discretion, unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse.

(*l*) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician, by a physician's assistant with whom the physician has a practice agreement, or by an advanced practice registered nurse, for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician, physician's assistant, or advanced practice registered nurse who authorized the restraint. In case of a chemical restraint, the physician, or the advanced practice registered nurse who authorized the restraint, shall be consulted within 24 hours after the commencement of the chemical restraint.

(m) A patient or resident is entitled to be free from performing services for the health facility or agency that are not included for therapeutic purposes in the plan of care.

(n) A patient or resident is entitled to information about the health facility or agency rules and regulations affecting patient or resident care and conduct.

(o) A patient or resident is entitled to adequate and appropriate pain and symptom management as a basic and essential element of his or her medical treatment.

(3) The following additional requirements for the policy described in subsection (2) apply to licensees under parts 213 and 217:

(a) The policy shall be provided to each nursing home patient or home for the aged resident upon

admission, and the staff of the facility shall be trained and involved in the implementation of the policy.

(b) Each nursing home patient may associate and communicate privately with persons of his or her choice. Reasonable, regular visiting hours, which shall be not less than 8 hours per day, and which shall take into consideration the special circumstances of each visitor, shall be established for patients to receive visitors. A patient may be visited by the patient's attorney or by representatives of the departments named in section 20156, during other than established visiting hours. Reasonable privacy shall be afforded for visitation of a patient who shares a room with another patient. Each patient shall have reasonable access to a telephone. A married nursing home patient or home for the aged resident is entitled to meet privately with his or her spouse in a room that ensures privacy. If both spouses are residents in the same facility, they are entitled to share a room unless medically contraindicated and documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse.

(c) A nursing home patient or home for the aged resident is entitled to retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the rights of other patients or residents, or unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse. Each nursing home patient or home for the aged resident shall be provided with reasonable space. At the request of a patient, a nursing home shall provide for the safekeeping of personal effects, money, and other property of a patient in accordance with section 21767, except that a nursing home is not required to provide for the safekeeping of a property that would impose an unreasonable burden on the nursing home.

(d) A nursing home patient or home for the aged resident is entitled to the opportunity to participate in the planning of his or her medical treatment. The attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse, shall fully inform the nursing home patient of the patient's medical condition unless medically contraindicated as documented in the medical record by a physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse. Each nursing home patient shall be afforded the opportunity to discharge himself or herself from the nursing home.

(e) A home for the aged resident may be transferred or discharged only for medical reasons, for his or her welfare or that of other residents, or for nonpayment of his or her stay, except as provided by title XVIII or title XIX. A nursing home patient may be transferred or discharged only as provided in sections 21773 to 21777. A nursing home patient or home for the aged resident is entitled to be given reasonable advance notice to ensure orderly transfer or discharge. Those actions shall be documented in the medical record.

(f) A nursing home patient or home for the aged resident is entitled to be fully informed before or at the time of admission and during stay of services available in the facility, and of the related charges including any charges for services not covered under title XVIII, or not covered by the facility's basic per diem rate. The statement of services provided by the facility shall be in writing and shall include those required to be offered on an as-needed basis.

(g) A nursing home patient or home for the aged resident is entitled to manage his or her own financial affairs, or to have at least a quarterly accounting of personal financial transactions undertaken in his or her behalf by the facility during a period of time the patient or resident has delegated those responsibilities to the facility. In addition, a patient or resident is entitled to receive each month from the facility an itemized statement setting forth the services paid for by or on behalf of the patient and the services rendered by the facility. The admission of a patient to a nursing home does not confer on the nursing home or its owner, administrator, employees, or representatives the authority to manage, use, or dispose of a patient's property.

(h) A nursing home patient or a person authorized by the patient in writing may inspect and copy the patient's personal and medical records. The records shall be made available for inspection and copying by the nursing home within a reasonable time, not exceeding 1 week, after the receipt of a written request.

(i) If a nursing home patient desires treatment by a licensed member of the healing arts, the treatment shall be made available unless it is medically contraindicated, and the medical contraindication is justified in the patient's medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse.

(j) A nursing home patient has the right to have his or her parents, if a minor, or his or her spouse, next of kin, or patient's representative, if an adult, stay at the facility 24 hours a day if the patient is considered terminally ill by the physician responsible for the patient's care, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse.

(k) Each nursing home patient shall be provided with meals that meet the recommended dietary allowances for that patient's age and sex and that may be modified according to special dietary needs or ability to chew.

(*l*) Each nursing home patient has the right to receive representatives of approved organizations as

provided in section 21763.

(4) A nursing home, its owner, administrator, employee, or representative shall not discharge, harass, or retaliate or discriminate against a patient because the patient has exercised a right protected under this section.

(5) In the case of a nursing home patient, the rights enumerated in subsection (2)(c), (g), and (k) and subsection (3)(d), (g), and (h) may be exercised by the patient's representative.

(6) A nursing home patient or home for the aged resident is entitled to be fully informed, as evidenced by the patient's or resident's written acknowledgment, before or at the time of admission and during stay, of the policy required by this section. The policy shall provide that if a patient or resident is adjudicated incompetent and not restored to legal capacity, the rights and responsibilities set forth in this section shall be exercised by a person designated by the patient or resident. The health facility or agency shall provide proper forms for the patient or resident to provide for the designation of this person at the time of admission.

(7) This section does not prohibit a health facility or agency from establishing and recognizing additional patients' rights.

(8) As used in this section:

(a) "Advanced practice registered nurse" means that term as defined in section 17201.

(b) "Patient's representative" means that term as defined in section 21703.

(c) "Practice agreement" means an agreement described in section 17047, 17547, or 18047.

(d) "Title XVIII" means title XVIII of the social security act, 42 USC 1395 to 1395*lll*.

(e) "Title XIX" means title XIX of the social security act, 42 USC 1396 to 1396w-5.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1982, Act 354, Imd. Eff. Dec. 21, 1982;—Am. 1998, Act 88, Imd. Eff. May 13, 1998;—Am. 2001, Act 240, Imd. Eff. Jan. 8, 2002;—Am. 2006, Act 38, Imd. Eff. Mar. 2, 2006;—Am. 2011, Act 210, Imd. Eff. Nov. 8, 2011;—Am. 2016, Act 379, Eff. Mar. 22, 2017;—Am. 2016, Act 499, Eff. Apr. 9, 2017.

Popular name: Act 368

Popular name: Patient Rights

333.20202 Responsibilities of patient or resident.

Sec. 20202. (1) A patient or resident is responsible for following the health facility rules and regulations affecting patient or resident care and conduct.

(2) A patient or resident is responsible for providing a complete and accurate medical history.

(3) A patient or resident is responsible for making it known whether he or she clearly comprehends a contemplated course of action and the things he or she is expected to do.

(4) A patient or resident is responsible for following the recommendations and advice prescribed in a course of treatment by the physician.

(5) A patient or resident is responsible for providing information about unexpected complications that arise in an expected course of treatment.

(6) A patient or resident is responsible for being considerate of the rights of other patients or residents and health facility personnel and property.

(7) A patient or resident is responsible for providing the health facility with accurate and timely information concerning his or her sources of payment and ability to meet financial obligations.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20203 Guidelines; immunity; other remedies at law neither expanded nor diminished.

Sec. 20203. (1) The rights and responsibilities prescribed in sections 20201 and 20202 are guidelines for health facilities, facility staff, facility employees, patients, and residents. An individual shall not be civilly or criminally liable for failure to comply with those sections.

(2) Sections 20201 and 20202 shall not be construed to expand or diminish other remedies at law available to a patient or resident under this code or the statutory and common law of this state.

(3) The department shall develop guidelines to assist health facilities and agencies in the implementation of sections 20201 and 20202.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20211 Summary of activities; availability of list and current inspection reports.

Sec. 20211. (1) Every 6 months the department shall issue a summary of its activities in relation to licensing and regulation and shall cause the information to be made available to the news media and all persons who make a written request to receive copies of the information.

(2) The list and current inspection reports shall be available for inspection and copying.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.
Popular name: Act 368