State Regulations Pertaining to Services, Waivers and Variances

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ALABAMA

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Alabama regulations do not contain specific content for Service Waivers and Variances.

ALASKA

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7 AAC 12.612. Licensure of critical access hospitals
(e) In addition to the requirement of reapplication for licensure under (d) of this section, if a critical access hospital proposes to change its hours of operation to less than 24 hours per day, each day of the year, the hospital must (2) obtain a waiver under 7 AAC 12.670(i) from the requirement of 7 AAC 12.670(g) that the hospital have a registered nurse on duty at all times.

7 AAC 12.870. Emergency care service
(h) Except as provided in 7 AAC 12.150(h), the department may waive compliance with, or grant a variance from, a requirement in this section if the commissioner determines that an equivalent alternative is provided and the safety and well-being of patients is assured. If a facility wishes to obtain a waiver or variance, its governing body must apply in writing to the commissioner and must include in the application (1) the justification for the waiver; (2) an explanation of the reasons why the particular requirement cannot be satisfied; (3) a description of the equivalent alternative proposed; and (4) if the application for waiver involves fire safety or other municipal or state requirements, evidence that it has been reviewed by the appropriate municipal or state authorities.

7 AAC 12.925. Accredited entities
(a) An entity licensed under this chapter with a current accreditation from a nationally recognized organization with standards the department determines meet the intent of AS 47.32 and this chapter may submit a written request to the department for a waiver of a biennial inspection by the department under AS 47.32.060. The entity must submit a
separate request for each licensing period during which the accrediting organization inspected the entity. The entity must include with the request a copy of the accrediting organization's most recent report of inspection, and a plan of correction and proof of corrective action if applicable.

(b) The department will waive its biennial inspection under AS 47.32.060 during the licensing period in which the accrediting organization conducted an inspection if the entity passed that inspection or has corrected any deficiencies noted by the accrediting organization. The inspection waiver will be in effect for the remainder of that licensing period unless revoked under (c) of this section.

(c) Nothing in this section precludes the department from responding to a complaint received under AS 47.32.090, and from taking any necessary action under AS 47.32.130 or 47.32.140. If the entity fails to fulfill any plan of correction developed under AS 47.32.130 or 47.32.140, the waiver from inspection will be revoked.

ARIZONA

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Arizona regulations do not contain specific content for Service Waivers and Variances.

ARKANSAS

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512 CHARGE NURSE

512.4 The Director of Nursing Services shall not serve as charge nurse in a Skilled Nursing Facility with an average daily total occupancy of seventy-one (71) or more patients. Waivered Licensed Practical Nurses shall not serve as charge nurse unless they have passed the State Pool Examination or Public Health Proficiency Examination.

520.4 EXCEPTIONS TO MINIMUM STAFFING RATIOS

520.4.1 Upon an increase in a facility’s resident census, the facility shall be exempt from any corresponding increase in staffing ratios for a period of nine (9) consecutive shifts beginning with the first shift following the midnight census for the date of the expansion of the resident census.

520.4.2 When residents are relocated or transferred from facilities due to natural disaster, emergency or as a result of state or federal action, the Department of Human Services may waive, for a period of no more than three (3) months from the date of transfer, some or all of
any required increase in direct-care staff for the facility or facilities to whom the residents are relocated or transferred. Waivers will only be granted for good cause shown, and upon telephone, facsimile or written request. A grant of a waiver is within the sole discretion of the Office of Long Term Care. Facilities may apply for a waiver by writing the Director of the Office of Long Term Care. The written request should state, at a minimum:

a. The date of the transfer for each resident;
b. The number of residents transferred for each date in which residents were received from another facility;
c. The anticipated date by which the facility will be able to meet the increased number of minimum staff for the total number of residents of the entire facility, including all residents received in transfer;
d. The name of the facility from which the residents were transferred; and,
e. A brief explanation as to why the facility’s staffing cannot be increased prior to the anticipated increase date set out in c, above.

B. Restrictions
1. The Department shall not approve a program offered by or in a nursing facility which, in the previous two years:
(A) has operated under a waiver of the nurse staffing requirements in excess of 48 hours during the week;

A. Transition
The initial implementation of these training and testing requirements have covered three basic phases:
1. Deemed Equivalence Waivers -
A nursing assistant shall be deemed to have satisfied the requirement of completing a training and competency evaluation program approved by the State if the nursing assistant:
  a. Completed a program that offered a minimum of 60 hours of nursing assistant training before July 1, 1989 and if such received before July 1, 1989 up to 15 hours of supervised and practical nursing assistant training or regular in-service nursing assistant education (initial training must be at least 75 hours); or
  b. Completed a course of at least 100 hours of nursing assistant training and was found competent (whether or not by the State) before January 1, 1989; or
  c. Has served as a nursing assistant at one or more facilities of the same employer in the State for at least 24 consecutive months before December 19, 1989.
  
  Individuals will not qualify for these waivers if they have not provided nursing or nursing-related services for a period of 24 months or longer since completing training. They will be required to complete a new training program and state test to obtain current certification. Facilities who wish to obtain certification for the above described individuals should submit to OLTC Form DMS-798, Exemption/Reciprocity Request Form, with attached copies of documents/certificates verifying course completion, number of hours in course, etc.

NURSING ASSISTANT TRAINING PROGRAM (NATP) APPLICATION INSTRUCTIONS
1. Review Rules and Regulations for the Arkansas Long Term Care Facility Nursing Assistant Training Program. Pay special attention to Section IV. B. Implementation Requirements, C. Nursing Assistant Trainee Activities, and Section V.
2. Respond to all application items in compliance with the standards (above) and as required within instructions for each item.
3. Obtain agreements from any and all nursing facilities that will be used as clinical training or testing sites and attach a copy of each agreement. Agreements must either (a) be current, i.e. signed by facility authority within the past six months, or (b) specify the time period for which the agreement is valid. Facility authority is the facility administrator or corporate officer who is a designated authority.

4. Mail application with original notarized signatures along with attachments to:
Arkansas Department of Health and Human Services
Division of Medical Services
Office of Long Term Care
Nursing Assistant Training Program
Slot S405
P.O. Box 8059
Little Rock, AR 72203-8059

You Need to Know:
- Incomplete applications will be returned, which will delay the approval of your program.
- If the application contains errors or discrepancies, you will be notified within 15 days of Department’s receipt of the application and you will be given an opportunity to make corrections. This may delay the date of approval of your program.
- You should allow AT LEAST 20 DAYS from the date you mail your application before inquiring about the status of the application.
- Training shall not be conducted until approval for instructors, classrooms and/or clinical sites has been received by the training program.
- Programs offered in or by nursing facilities that have been subject to one or more of the following actions will not be approved as per Arkansas Code 20-70-01 et seq.:
  1. Waiver for nurse staffing requirements in excess of 48 hours during the week;
  2. Extended or partial extended survey*;
  3. Assessment of civil money penalty in excess of $5000;
  4. Denial of payment for new admissions for Medicare/Medicaid;
  5. Appointment of temporary management;
  6. Transfer of residents;
  7. Termination from Medicare/Medicaid;
  8. Closure of facility.
- Nursing facilities that are prohibited due to one of the actions above will not be approved as a clinical training or testing site for any nursing assistant training program. Sanctioned nursing facilities may apply for a training waiver by submitting a written request to this office.

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§ 72329.1. Nursing Service-Staff.
(3) Unless granted a waiver pursuant to subsection (j), facilities shall use the following ratios:
(A) On the day shift, the ratio shall be at least one direct caregiver for every 5 patients or fraction thereof;
(B) On the evening shift, the ratio shall be at least one direct caregiver for every 8 patients or fraction thereof; and,
(C) On the night shift, the ratio shall be at least one direct caregiver for every 13 patients or fraction thereof.
(D) There shall be one licensed nurse for every 8 or fewer patients, based on the facility census for the 24 hour period. These are not in addition to the requirements in subparagraphs (A) through (C) above, and may be assigned to shifts as required by the facility, subject to other statutory and regulatory requirements.
(4) "Day shift" refers to the 8-hour period during which a facility's patients require the greatest amount of care. "Evening shift" refers to the 8-hour period when the facility's patients require more than minimal care. "Night shift" refers to the 8-hour period during which a facility's patients require the least amount of care. A facility that uses other than 8-hour shifts for its direct caregivers shall seek a waiver under subsection (j) to continue that practice.
(j) The facility may request a waiver for the staff-to-patient ratio in accordance with Section 1276.65 of the Health and Safety Code as long as the facility continues to meet the 3.2 nursing hours per patient day requirement.
(1) The facility shall submit a written request for a waiver with substantiating information to the Department. The facility shall request the waiver by using the program flexibility procedures specified in Section 72213, and the Department shall process the request as required by Section 1276 of the Health and Safety Code.
(2) The facility shall notify the Department if there has been a change in the substantiating information. A request for a waiver with substantiating information included shall be updated and resubmitted annually.
Article 3 – Licensing Examination
(8) If the applicant and the preceptor provide compelling evidence that previous work experience of the applicant directly relates to nursing home administrator duties, the program may accept a waiver exception to a portion of the AIT program that requires 1,000 hours.

COLORADO
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1.4 EXCEPTIONS TO RULES. The requirements of these regulations do not prohibit the use of alternate concepts, methods, procedures, techniques, equipment, or personnel qualifications or conducting pilot projects. A facility may request waivers or exceptions to these regulations pursuant to 6 CCR 1011-1, Chapter II, General Licensure Standards, Part 4, waiver of regulations for health care entities.
8.2 STAFFING. The facility shall employ social services staff qualified as provided in Subsections 8.2.1 and 8.2.2 and sufficient in number to meet the social and emotional needs of the residents.
8.2.4 Any facility located in a rural area as defined by subsection 7.6.1 may apply for a waiver under Part 4 of chapter II of the qualifications for a social services staff member under this section if it demonstrates that it has made a good faith effort to hire staff with the required qualifications, but that qualified social services staff are unavailable in the area.

19.8 PHYSICAL FACILITIES. In addition to the physical plant requirements of these regulations, the facility shall provide at least 10 square feet per resident (excluding hallways) of common areas within the secure unit.

19.8.3 In accordance with 6 CCR 1011-1, Chapter II, Part 4, a facility may seek a waiver from the standards required in Part 18 of this Chapter that may be detrimental to resident needs, safety, or health.

(c) Waiver.

(1) The commissioner or his/her designee, in accordance with the general purpose and intent of these regulations, may waive provisions of these regulations if the commissioner determines that such waiver would not endanger the life, safety or health of any patient. The commissioner shall have the power to impose conditions which assure the health, safety and welfare of patients upon the grant of such waiver, or to revoke such waiver upon a finding that the health, safety, or welfare of any patient has been jeopardized.

(2) Any facility requesting a waiver shall apply in writing to the department. Such application shall include:

(A) The specific regulations for which the waiver is requested;
(B) Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the facility upon enforcement of the regulations;
(C) The specific relief requested; and
(D) Any documentation which supports the application for waiver.

(3) In consideration of any application for waiver, the commissioner or his/her designee may consider the following:

(A) The level of care provided;
(B) The maximum patient capacity;
(C) The impact of a waiver on care provided;
(D) Alternative policies or procedures proposed.

(4) The Department reserves the right to request additional information before processing an application for waiver.

(5) Any hearing which may be held in conjunction with an application for waiver shall be held in conformance with Chapter 54 of the Connecticut General Statutes and department regulations.

(3) Issuance and renewal of license.

(C) Each license shall specify the maximum licensed bed capacity for each level of care, and shall list on its face the names of the administrator, medical director, and director of nurses,
and notations as to waivers of any provision of this code. No facility shall have more
patients than the number of beds for which it is licensed.

DELAWARE
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2.7 Food Service Manager
2.7.1 For facilities subject to 16 Delaware Code, §1164, an individual who meets the
statutory requirements for a food service manager. A facility may seek a waiver of the
statutory requirements if an insufficient pool of applicants exists. The facility must
demonstrate the inability to hire a person who meets the requirements after a recruitment
process of at least 90 days duration that included advertising in at least two newspapers of
general circulation and one trade journal, offering a competitive salary. If those conditions
are met, the Division may waive the education requirement for an applicant who meets the
requirements of a "person in charge" as defined in the current Delaware Food Code.

11.0 Waivers and Severability
11.1 Waivers may be granted by the Division of Long Term Care Residents Protection for
good cause.
11.2 Should any section, sentence, clause or phrase of these regulations be legally declared
unconstitutional or invalid for any reason, the remainder of said regulations shall not be
affected thereby.

DISTRICT OF COLUMBIA
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3211. NURSING PERSONNEL
3211.5 The Department of Health may consider a waiver of the staffing requirements in
subsection 3211.3 for a facility that has had, within the previous three (3) years, no
deficiencies related to resident care that have exceeded the federal C level in scope and
severity (no actual harm; potential for only minimal harm). The Department may also
consider a waiver for a facility that has had, within the previous three (3) years, one (1)
deficiency related to resident care at the federal D level in scope and severity (an isolated
incident; no actual harm; potential for more than minimal harm), if the facility has
demonstrated an otherwise good level of care.
Florida regulations do not contain specific content for Service Waivers and Variances.

GEORGIA

290-5-8-.03 Administration.
(1) Each nursing home shall be under the supervision of a licensed nursing home administrator.
An administrator may serve as the administrator of not more than one facility, except that two facilities having common ownership or management located on the same premises may be served by a single administrator. Distinct part facilities sharing a common roof shall be considered one facility. In exceptional circumstances, a waiver may be granted by the Department for a period of six months. Existing facilities not currently meeting this requirement would be exempt for a period of two years from the effective date of this regulation. If an existing facility should undergo a change of administrators during this two-year period, such facility would be required to comply with the regulations.

290-5-8-.17 Patient Capacity.
(1) The number of beds provided shall be indicated on each permit and provisional permit.
(2) The number of patients receiving care within the home shall not exceed the number of beds shown on the permit. In exceptional cases, temporary waivers, not to exceed thirty (30) days, may be granted by the Department.

HAWAII

"Waiver" means an exemption from a specific rule or regulation which may be granted to a facility for a specified period of time at the discretion of the director. No waiver shall be for a duration longer than one year.

§11-94-3 Licensing.
(e) The director shall prescribe the content and form of the license, and may authorize a waiver or waivers for a particular facility.
37. **Waiver or Variance.** A waiver or variance to these rules and minimum standards in whole or in part that may be granted under the following conditions: (12-31-91) a. Good cause is shown for such waiver and the health, welfare or safety of patients/residents will not be endangered by granting such a waiver; (1-1-88) b. Precedent shall not be set by granting of such waiver. The waiver may be renewed annually if sufficient written justification is presented to the Licensing Agency.

02. **Minimum Staffing Requirements.**

f. Waiver of Registered Nurse as Supervising or Charge Nurse. In the event that a facility is unable to hire registered nursing personnel to meet these regulation requirements, a licensed practical nurse will satisfy the requirements so long as: (1-1-88) i. The facility continues to seek a registered nurse at a compensation level at least equal to that prevailing in the community; (1-1-88) ii. A documented record of efforts to secure employment of registered nursing personnel is maintained in the facility; (1-1-88) iii. The facility shall maintain at least forty (40) hours a week R.N. coverage. (1-1-88)

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**ILLINOIS**

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**Section 300.315 Supported Congregate Living Arrangement Demonstration**

a) A facility or location approved to participate in the Supported Congregate Living Arrangement Demonstration authorized by Section 4.02b of the Illinois Act on the Aging [20 ILCS 105/4.02b] and requesting a waiver of the Act and this Part shall submit to the Department a *joint waiver request* with the Department on Aging or documentation that the Department on Aging failed to *act upon* a waiver application within 60 days after the applicant submitted a request to the Department on Aging. (Section 4.02b of the Illinois Act on the Aging)

b) The waiver application shall include the following:

1) a specific listing of those portions of the Act and this Part for which a waiver is being requested; and

2) the applicant’s proposed Program Plan.

c) The proposed Program Plan shall describe *the types of residents to be served and the services that will be provided in the Supported Congregate Living Arrangement Demonstration.* (Section 3-102.2 of the Act)

d) The Department will evaluate the waiver application based on the criteria in Section 300.320 of this Part. The applicant shall be notified within 10 days after the Department’s waiver determination.

e) *The Department may revoke the waiver if* the Department determines that the Supported Congregate Living Arrangement Demonstration:
1) is not in compliance with the Program Plan submitted in accordance with subsection (b) of this Section (Section 3-102.2 of the Act);
2) is not in compliance with the Department’s waiver approval conditions; or
3) has been terminated from the demonstration by the Department on Aging.

Section 300.320 Waivers
a) Upon application by a facility, the Director may grant or renew the waiver of the facility’s compliance with a rule or standard for a period not to exceed the duration of the current license or, in the case of an application for license renewal, the duration of the renewal period. (Section 3-303.1 of the Act)
b) The waiver may be conditioned upon the facility taking action prescribed by the Director as a measure equivalent to compliance. (Section 3-303.1 of the Act)
c) In determining whether to grant or renew a waiver, the Director shall consider:
   1) the duration and basis for any current waiver with respect to the same rule or standard;
   2) the continued validity of extending the waiver on the same basis;
   3) the effect upon the health and safety of residents;
   4) the quality of resident care (whether the waiver would reduce the overall quality of the resident care below that required by the Act or this Part);
   5) the facility’s history of compliance with the Act and this Part (the existence of a consistent pattern of violation of the Act or this Part); and
   6) the facility’s attempts to comply with the particular rule or standard in question. (Section 3-303.1 of the Act)
d) The Department shall renew waivers relating to physical plant standards issued pursuant to this Section at the time of the indicated reviews, unless it can show why such waivers should not be extended for the following reasons:
   1) the condition of the physical plant has deteriorated or its use substantially changed so that the basis upon which the waiver was issued is materially different; or
   2) the facility is renovated or substantially remodeled in such a way as to permit compliance with the applicable rules and standards without substantial increase in cost. (Section 3-303.1 of the Act)

Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information

g) If the results of the background check are inconclusive, the facility shall initiate a fingerprint-based check, unless the fingerprint check is waived by the Director of Public Health based on verification by the facility that the resident is completely immobile or that the resident meets other criteria related to the resident’s health or lack of potential risk, such as the existence of a severe, debilitating physical, medical, or mental condition that nullifies any potential risk presented by the resident. (Section 2-201.5(b) of the Act) The facility shall arrange for a fingerprint-based background check or request a waiver from the Department within 5 days after receiving inconclusive results of a name-based background check. The fingerprint-based background check shall be conducted within 25 days after receiving the inconclusive results of the name-based check.

h) A waiver issued pursuant to Section 2-201.5 of the Act shall be valid only while the resident is immobile or while the criteria supporting the waiver exist. (Section 2-201.5(b) of the Act)
i) The facility shall provide for or arrange for any required fingerprint based checks to be taken on the premises of the facility. If a fingerprint based check is required, the facility shall arrange for it to be conducted in a manner that is respectful of the resident’s dignity and that minimizes any emotional or physical hardship to the resident. (Section 2-201.5(b) of the Act) If a facility is unable to conduct a fingerprint-based background check in compliance with this Section, then it shall provide conclusive evidence of the resident’s immobility or risk nullification of the waiver issued pursuant to Section 2-201.5 of the Act.

k) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based background check are pending; while the results of a request for waiver of a fingerprint-based check are pending; and/or while the Criminal History Analysis Report is pending.

Section 300.625 Identified Offenders

a) The facility shall review the results of the criminal history background checks immediately upon receipt of those checks. If the results of the background check are inconclusive, the facility shall initiate a fingerprint based check unless the fingerprint-based check is waived by the Director of Public Health based on verification by the facility that the resident is completely immobile or that the resident meets other criteria related to the resident’s health or lack of potential risk, such as the existence of a severe, debilitating physical, medical, or mental condition that nullifies any potential risk presented by the resident. (Section 2-201.5(b) of the Act) The facility shall arrange for a fingerprint-based background check or request a waiver from the Department within 5 days after receiving inconclusive results of a name-based background check. The fingerprint based background check shall be conducted within 25 days after receiving the inconclusive results of the name-based check.

b) A waiver issued pursuant to Section 2-201.5 of the Act shall be valid only while the resident is immobile or while the criteria supporting the waiver exist.

d) If a fingerprint-based check is required, the facility shall arrange for it to be conducted in a manner that is respectful of the resident’s dignity and that minimizes any emotional or physical hardship to the resident. (Section 2-201.5(b) of the Act) If a facility is unable to conduct a fingerprint-based background check in compliance with this Section, then it shall provide conclusive evidence of the resident’s immobility or risk nullification of the waiver issued pursuant to Section 2-201.5(b) of the Act.

e) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based check are pending; while the results of a request for a waiver of a fingerprint-based check are pending; and/or while the Criminal History Analysis Report is pending.

Section 300.660 Nursing Assistants

b) The facility shall ensure that each nursing assistant complies with one of the following conditions:

1) Is approved on the Department’s Nurse Aide Registry. "Approved" means that the nurse aide has met the training or equivalency requirements of Section 300.663 of this Part and does not have a disqualifying criminal background check without a waiver.

Section 300.3060 Nursing Unit

b) Resident Bedroom.
1) Single resident bedrooms shall contain at least 100 square feet of usable floor area. Multiple resident bedrooms shall contain at least 80 square feet per bed of usable floor area. Minimum usable floor area shall be exclusive of toilet rooms, closets, lockers, wardrobes, alcoves, vestibules, or clearly definable entryways. Those bedrooms for which facilities had waivers to this subsection (b)(1) on (and continuously since) December 24, 1987, and which have at least 90 square feet for single bedrooms and 70 square feet per bed for multi-bedrooms are exempt from this subsection (b)(1). Those bedrooms for which facilities had waivers to this subsection (b)(1) on (and continuously since) December 24, 1987, but which have less than 90 square feet for single bedrooms and 70 square feet per bed multi-bedrooms, continue to be subject to waiver procedures on an annual basis (See Section 300.320).

B) Based upon approval of the program narrative, the Department will consider a waiver of this subsection for Intermediate Care Facilities.

INDIANA
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410 IAC 16.2-3.1-2 Licenses
Authority: IC 16-28-1-7; IC 16-28-1-12
Affected: IC 16-18-2-167; IC 16-28-1-10; IC 16-28-2-2; IC 16-28-2-4; IC 16-28-5-7
Sec. 2. (a) Any person, in order to lawfully operate a health facility as defined in IC 16-18-2-167, shall first obtain an authorization to occupy the facility or a license from the director. The applicant shall notify the director, in writing, before the applicant begins to operate a facility that is being purchased or leased from another licensee. Failure to notify the director precludes the issuance of a full license.

(k) For a good cause shown, waiver of any nonstatutory provisions of this rule may be granted by the executive board for a specified period in accordance with IC 16-28-1-10.

410 IAC 16.2-3.1-17 Nursing services
(f) A facility may request a waiver from either the requirement that a nursing facility provide a registered nurse for at least eight (8) consecutive hours a day, seven (7) days a week, or provide a registered nurse as the director of nursing, as specified in subsection (b), if the following conditions are met:
(1) The facility demonstrates to the satisfaction of the state that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel.
(2) The state determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility.
(3) The state finds that, for any periods in which registered nursing services are not available, a registered nurse or physician is obligated to respond immediately to telephone calls from the facility.
(4) A waiver granted under the conditions listed in this subsection is subject to annual state review.
(5) Effective October 1, 1990, in granting or renewing a waiver, a facility may be required by the state to use other qualified, licensed personnel.

(6) The state agency granting a waiver of such requirements provides notice of the waiver to the state long term care ombudsman and the protection and advocacy system in the state for the mentally ill and mentally retarded.

(7) The nursing facility that is granted such a waiver by the state notifies residents of the facility.

(g) For purposes of IC 16-28-5-1, a breach of:
(1) subsection (a), (c), or (d) is a deficiency; and
(2) subsection (b), (e), or (f) is a noncompliance.

410 IAC 16.2-5-1.2 Residents' rights

(l) If the facility participates in the Medicaid waiver or residential care assistance programs, or both, the facility must provide to residents written information about how to apply for Medicaid benefits and room and board assistance.

645—141.9(147,155) License renewal.

141.9(7) Persons licensed to practice as nursing home administrators shall keep their renewal licenses displayed in a conspicuous public place at the primary site of practice.

141.9(8) Mandatory reporter requirements.

a. A licensee who, in the scope of professional practice or in the licensee's employment responsibilities, attends, counsels or treats children in Iowa shall indicate on the renewal application completion of two hours of training in child abuse identification and reporting in the previous five years or condition(s) for waiver of this requirement as identified in paragraph “e.”

b. A licensee who, in the course of employment, examines, attends, counsels or treats adults in Iowa shall indicate on the renewal application completion of two hours of training in dependent adult abuse identification and reporting in the previous five years of condition(s) for waiver of this requirement as identified in paragraph “e.”

The course shall be a curriculum approved by the Iowa department of public health abuse education review panel.
d. The licensee shall maintain written documentation for five years after mandatory training as identified in paragraphs “a” to “c,” including program date(s), content, duration, and proof of participation.

e. The requirement for mandatory training for identifying and reporting child and dependent adult abuse shall be suspended if the board determines that suspension is in the public interest or that a person at the time of license renewal:
   (1) Is engaged in active duty in the military service of this state or the United States.
   (2) Holds a current waiver by the board based on evidence of significant hardship in complying with training requirements, including an exemption of continuing education requirements or extension of time in which to fulfill requirements due to a physical or mental disability or illness as identified in 645—Chapter 143.

f. The board may select licensees for audit of compliance with the requirements in paragraphs “a” to “e.”

KANSAS

26-39-102. Admission, transfer, and discharge rights of residents in adult care homes. (4) An admission agreement shall not include a general waiver of liability for the health and safety of residents.

KENTUCKY

Section 4. Existing Facilities With Waivers.
(1) The Inspector General shall deem an existing health care facility to be in compliance with a facility specification requirement, even though the facility does not meet fully the applicable requirement, if:
   The Inspector General has previously granted, to the facility, a waiver for the requirement;
   The facility is licensed by the cabinet;
   The facility is in good standing as of the effective date of this administrative regulation; and
   The waived requirement does not adversely affect the health, safety, or welfare of a resident or patient.

If the Inspector General determines that the waived requirement has adversely affected patient or resident health, safety or welfare, then:
The Inspector General shall notify the facility by certified mail of the findings and the need to comply with the applicable administrative regulations; and
(b) The health facility shall submit a written plan to ensure compliance, pursuant to Section 2(5)(b) of this administrative regulation.

Section 5. Variances.

(1) The Inspector General may grant a health care facility a variance from a facility specification requirement if the facility establishes that the variance will:
- Improve the health, safety, or welfare of a resident or patient; or
- Promote the same degree of health, safety, or welfare of a resident or patient as would prevail without the variance.

(2) A facility shall submit a request for a variance, in writing, to the Office of the Inspector General, Cabinet for Health Services. The request shall include:
   - All pertinent information about the facility;
   - The specific provision of the administrative regulation affected;
   - The specific reason for the request; and
   - Evidence in support of the request.

(3) The Inspector General shall review and approve or deny the request for variance. The Inspector General may request additional information from the facility as is necessary to render a decision. A variance may be granted with or without a stipulation or restriction. The Inspector General shall revoke a variance previously granted if the Inspector General determines the variance has not:
   - Improved the health, safety, or welfare of a patient or resident; or
   - Promoted the same degree of health, safety, or welfare of a patient or resident that would prevail without the variance.

1. The Inspector General shall notify the health facility, by certified mail, of a decision to revoke a variance and the need to comply with the applicable regulatory requirement.

2. The health facility shall submit a written plan to ensure compliance, pursuant to Section 2(5)(b) of this administrative regulation.

Section 6. Variance Hearings. (1) A health care facility dissatisfied with a decision to deny, modify, or revoke a variance or a request for a variance may file a written request for a hearing with the Secretary of the Cabinet for Health Services. The request shall be received by the secretary of the cabinet within twenty (20) days of the date the healthcare facility receives notice of the decision to deny, modify, or revoke the variance or request for a variance.

(2) An administrative hearing shall be conducted in accordance with KRS Chapter 13B.

(2) Registered nurse.

(3) Licensed nurse waiver. Waiver of requirement to provide licensed nurses on a twenty-four (24) hour basis. A facility may request a waiver from the requirement that a nursing facility provide a registered nurse for at least eight (8) consecutive hours a day, seven (7) days a week, as specified in subsection (2) of this section, and the requirement that a nursing facility provide licensed nurses on a twenty-four (24) hour basis, including a charge nurse as specified in subsection (1) of this section, if the following conditions are met:
   - The facility demonstrates to the satisfaction of the cabinet that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel;
   - The cabinet determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility;
   - A waiver granted under the conditions listed in this subsection is subject to revocation if the cabinet finds that the health and safety of the residents is threatened.
In granting or renewing a waiver, a facility may be required by the cabinet to use other qualified, licensed personnel.

The facility shall have a non-call system which provides for an immediate response by a registered nurse or a physician for those times when licensed nursing services are not available.

Registered nurse waiver. Waiver of the requirement to provide services of a registered nurse for more than forty (40) hours a week, including a director of nursing specified in subsection (2) of this section, may be granted if the cabinet finds that the facility:

(a) Is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area;
(b) Has one (1) full-time registered nurse who is regularly on duty at the facility forty (40) hours a week; and
(c) Either:
   1. Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a forty-eight (48) hour period; or
   2. Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty.

A waiver of the registered nurse requirement under paragraph (a) of this subsection is subject to revocation if the cabinet finds that the health and safety of the residents is threatened.

When a waiver is granted a facility shall inform the residents, their legal representatives, and members of their immediate family.

Section 9. Waiver or Extensions of Continuing Education. (1) The board may, in individual cases involving medical disability, illness, or undue hardship as determined by the board, grant waivers of the minimum continuing education requirements or extensions of time within which to fulfill the requirements or make the required reports.

(2) A written request for waiver or extension of time involving medical disability or illness shall be submitted by the person holding a license and shall be accompanied by a verifying document signed by a licensed physician.

(3) Waivers of the minimum continuing education requirements or extensions of time within which to fulfill the continuing education requirements shall be granted by the board for a period of time not to exceed one (1) calendar year.

(4) If the medical disability or illness upon which a waiver or extension has been granted continues beyond the period of the waiver or extension, the person holding licensure shall reapply for the waiver or extension.

M. Exceptions to these Licensing Requirements
1. Where any requirement on an existing nursing home would impose a financial hardship but would not adversely affect the health and safety of any resident, the existing nursing home may submit a request for exception (waiver) to the department.

2. Where a more stringent requirement on an existing nursing home would impose an unreasonable hardship, the existing nursing home may submit a written request for exception, along with supporting documentation, to the department.

§9717. Administration
A. Facility Administrator. All facilities are required to have full-time administrators. Full-time administrators are persons who are licensed, currently registered and engaged in the day-to-day management of the facility. The administrator’s duties shall conform to the following standards.

c. The Department shall allow nursing facilities 30 days from the date of the change in the position to fill the resulting vacancy in the administrator position. There shall be no waiver provisions for this position.

§9919. Other Environmental Conditions
F. A hard surfaced off-the-road parking area to provide parking for one car per five licensed beds shall be provided. This requirement is minimum and may be exceeded by local ordinances. Where this requirement would impose an unreasonable hardship, a written request for a lesser amount may be submitted to the department for waiver consideration.

2.I. Waiver Provisions
Where structural changes in an existing facility are necessary for such facility to comply with the provisions of these regulations and the change would result in an unreasonable hardship to the owners or operators, the Department may grant a waiver of one or more of the specific provisions of these regulations to an operator or owner, in accordance with the following requirements:

2.I.1. Prior to the issuance or renewal of any license, the facility must make written application requesting a waiver to the Department. Such application shall contain a written justification for the request and shall state the specific provisions of these regulations for which a waiver is being requested, and shall document what steps the facility is taking or will take to bring such facility into compliance with those provisions of these regulations, for which a waiver is requested.

2.I.2. The Department may request additional information before making a decision as to granting or denying an application for a waiver.

2.I.3. No waiver shall extend beyond the term of the license and a new waiver shall be required when the license of the facility is renewed. Failure of a facility to implement reasonable steps in order to bring the facility into conformance with these regulations shall be
grounds for the denial of a waiver.
2.1.4. No waiver or waivers shall be granted if there would be an adverse effect to the health or safety of the residents of a facility.
2.1.5. The facility will be notified in writing when a waiver is granted, and the specific area for which a waiver has been granted shall be noted on the license.

20.A.1. Requirements for Each Facility
The facility must provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. Each licensed facility shall:

u. Be accessible to and functional for residents, personnel and the public. All facilities shall comply with all Federal and State regulations regarding access and usability by the physically handicapped. At the discretion of the Department, time-limited waivers for existing facilities may be requested.

Elevators and Dumbwaiters Each facility shall:
. Have an elevator if beds are located on floors above street level;
. Have the installation and maintenance of elevators, chair glides, and dumbwaiters comply with all applicable codes;
. Assure that elevators are of sufficient size to accommodate a wheeled stretcher. At the discretion of the Department, time-limited waivers for existing facilities may be requested.

ALZHEIMER’S/DEMENTIA CARE UNITS
d. Waivers
. All physical plant construction or conversion waivers for existing Alzheimer’s/Dementia Care Units are to be submitted in accordance with Chapter 2.I. of these regulations.

Any new construction or bed conversions for Alzheimer’s/Dementia Care Units approved after the effective date of these regulations are not eligible for waivers.

MARYLAND

.02 License Required.
G. Waiver of Provisions. If a facility experiences practical difficulties or unnecessary hardships in complying with the provisions of this chapter, and can demonstrate that granting a waiver will not adversely affect the health and safety of its residents, the Secretary may waive any provision of this chapter. A waiver granted to a facility is effective for the period specified in the waiver. A waiver may be revoked at any time if a facility violates a condition of the waiver or if it appears to the Secretary that the health or safety of residents residing in the facility would be adversely affected by the continuation of the waiver.

.03 Licensing Procedure.
(6) Transfer or Assignment of License. If the sale, transfer, assignment, or lease of a facility
causes a change in the person or persons who control or operate the facility, the facility shall be considered a "new facility" and the licensee shall conform to all regulations applicable at the time of transfer of operations. The transfer of any stock which results in a change of the person or persons who control the facility, or a 25 percent or greater change in any form of ownership interest, constitutes a sale. For purposes of Life Safety Code enforcement, the facility is considered as an existing facility if it has been in continuous use as a nursing home. Waivers may be granted under Regulation .02F of this chapter.

26 Physical Plant General Requirements.
Agency Note: In existing structures, the Department will entertain requests for waivers on items which will not endanger the health and safety of persons using the facility; patients and visitors; and for those items, if corrected, which will result in an unreasonable hardship upon the facility, that is, cause substantial financial burden.

The Department will consider and approve waiver requests for admission of residents with mental health problems to non CSF facilities when special circumstances arise. Special circumstances which may require a waiver request might include: a married couple which desires not to be separated and a resident who would be geographically separated from his/her family, or community supports (eg., church, medical care).

**Responsible Person** shall mean an individual 21 years of age or older, who has received a high school diploma, is of good moral character, with ability to make mature and accurate judgments and with no mental or physical disabilities or personality disturbances that could interfere with adequate performance of duties and responsibilities. The responsible person shall also have the ability to communicate orally and in writing in English and the primary language used by patients and residents of a facility. **Exception:** Persons employed in this capacity on July 1, 1987 shall have at least four years within which to earn a Massachusetts High School Equivalency Certificate or may qualify for a waiver of the High School requirement under 105 CMR 153.030(B) if they can demonstrate at least five years experience as a responsible person.

(3) Charge Nurse: The charge nurse shall be a registered nurse or a licensed practical nurse; provided that, in a Level I or II unit, a practical nurse licensed by waiver may serve in such capacity only if she/he has received a passing grade either on the Massachusetts written state licensure examination given in the years 1958, 1959, 1960 by the Board of Registration in Nursing or on the federal Public Health Service Proficiency Examination for Practical Nurses Licensed by Waiver given periodically by the Department in accordance with federal regulations. The charge nurse shall be responsible for the performance of total nursing care of the patients in his/her unit during his/her tour of duty with the assistance of ancillary nursing personnel.

(a) When a resident who has been determined, following his/her consent and evaluation, to be a Community Support Resident, is admitted to a Community Support Facility, or to a
Resident Care Facility (by waiver) a written agreement must be signed between certain referring public or private agencies or institutions and the accepting facility.

(C) Supervision and administration of medication shall be as follows:
(c) The administration of all other controlled substances must be approved by the Department through a written waiver request pursuant to 105 CMR 153.030(B).

(C) Safety and Personal Protection.
(10) There shall be at least one functioning telephone on each floor or in each unit where patients, residents or personnel reside. These telephones shall be free of locks and shall be available for use in emergency for both incoming and outgoing calls. In addition, all facilities shall provide at least one telephone for patient or resident use, which may be coin operated, that is located so as to assure privacy during use; is a single line without an extension; is placed and positioned at a height so that the equipment is fully accessible to individuals in wheelchairs; is equipped with sound amplification for those with hearing disabilities and so identified with instructions for use. For existing facilities, the Division may grant a waiver of 105 CMR 150.015(C)(10) if it is demonstrated that enforcement would result in unreasonable hardship upon the facility. All facilities shall comply with the provisions of 105 CMR 150.015(C)(10) by December 23, 1983 except that it the facility demonstrates that major structural changes are necessary, compliance shall be achieved by June 23, 1984.

153.007: Other Licensing Requirements
(E) No facility shall admit any additional Community Support Residents after July 1, 1987 with the exception of those facilities receiving licensure as a CSF under 105 CMR 153.007(C) except in the following circumstances:
(1) facilities granted a waiver pursuant to 105 CMR 153.031(B); and
(2) facilities seeking to readmit a resident who may need CSF services for stabilization following a period of hospitalization for an acute episode of mental illness.

153.031: Special Projects and Waivers
(A) Proposals for special projects for innovative delivery of services related to long-term care facilities will be considered. However, no such plan shall be implemented without prior written approval of the Department. Such plans shall be implemented only on an experimental basis and subject to renewal of approval by the Department at such time periods as the Department shall fix. (B) The Commissioner or his designee may waive the applicability to a particular facility of one or more of the requirements imposed by 105 CMR 153.000, 105 CMR 150.000: Licensing of Long-Term Care Facilities and 105 CMR 151.000: General Standards of Construction: Long-Term Care Facilities upon finding that:
(1) the facility's non-compliance does not affect the health or safety of its residents and does not limit the facility's capacity to give adequate care; and
(2) the facility has instituted compensating features or has undertaken a special project under 105 CMR 153.030(A) acceptable to the Department; and
(3) the facility provides to the Commissioner or his designee written documentation supporting its request for a waiver.

156.130: Nurses' Aides Who May Substitute Equivalency Evaluation for Training Course
The following individuals are eligible for equivalency evaluation in lieu of completion of a training course to satisfy the requirements of 105 CMR 156.000. If such individuals choose not to take the equivalency evaluation in lieu of the training course, they shall be considered
new employees subject to the requirements set forth in 105 CMR 156.120.

(A) Individuals who have completed training equivalent to the minimum standard curriculum.

(1) Such individuals shall have completed one of the following within the two years preceding the commencement of employment to be eligible for the equivalency evaluation:
(a) Documented successful completion of long-term care nurses’ aides training programs regulated by other states;
(b) Documented successful completion of a clinical course in an approved school of nursing, in accordance with 244 CMR 6.00, which included hands-on care skills as specified in the minimum standard curriculum.

(2) Such nurses’ aides shall successfully complete an equivalency evaluation in accordance with 105 CMR 156.400 as follows:
(a) Nurses’ aides, described in 105 CMR 156.130(A)(1), whose employment in a Massachusetts long-term care facility commenced prior to the date of promulgation of these regulations shall successfully complete an equivalency evaluation on or before June 30, 1989;
(b) Nurses’ aides, described in 105 CMR 156.130(A)(1), who are hired on or after the date of promulgation and prior to January 1, 1989 shall successfully complete equivalency evaluation on or before March 31, 1989;
(c) Nurses’ aides, described in 105 CMR 156.130(A)(1), hired on or after January 1, 1989 shall successfully complete evaluation within 90 days subsequent to the commencement of employment.

(B) Nurses’ aides whose employment by a licensed long-term care facility or temporary help agency commenced prior to the promulgation of 105 CMR 156.000.

(1) Such nurses’ aides shall meet the following eligibility requirements:
(a) Have completed a nurses’ aide training course within the preceding two years; or
(b) Have been employed as a nurses’ aide by a long-term care facility or by a temporary help agency and assigned to long-term care facilities one year out of the past three years on a full-time basis or at least 100 days in the year prior to promulgation with no interruption in employment greater than ten weeks.

(2) Such nurses’ aides shall successfully complete an equivalency evaluation in accordance with 105 CMR 156.400 on or before June 30, 1989.

(C) The Commissioner or his or her designee may waive the qualifications for individuals permitted to take the equivalency evaluation in lieu of the training course imposed by 105 CMR 156.130(A) and (B) upon finding that:

(1) The individual has had the following experience:
(a) Employment as a nurses’ aide for one year out of the past three years on a full-time basis or at least 100 in the year prior to proposed evaluation with no interruption in employment greater than ten weeks; and
(b) Provision of direct care services to the elderly including but not limited to bathing, grooming, and feeding during the employment period specified above in 105 CMR 156.130(C)(1)(a); and
(c) Provision of such direct care services in an institutional setting including a chronic or acute care hospital.

(2) The proposed waiver does not jeopardize the health or safety of the facility’s residents and does not limit the facility’s capacity to give adequate care.
(3) The facility provides to the Commissioner or his or her designee written documentation supporting its request for a waiver.

(4) Such nurses' aides shall successfully complete an equivalency evaluation in accordance with 105 CMR 156.400 as follows:
(a) Nurses' aides, for whom a waiver has been obtained pursuant to 105 CMR 156.130(C), whose employment in a long-term care facility commenced prior to January 1, 1989 shall successfully complete equivalency evaluation on or before March 31, 1989;
(b) Nurses' aides, for whom a waiver has been obtained pursuant to 105 CMR 156.130(C) and who are hired on or after January 1, 1989 shall successfully complete evaluation within 90 days subsequent to the commencement of employment.

(D) A facility shall not continue to employ an individual as a nurses' aide who does not successfully complete an evaluation as pursuant to the provisions of 105 CMR 156.130.

156.210: Qualifications of the Instructor

— (3) The Commissioner or his or her designee may waive the qualifications of the instructor imposed by 105 CMR 156.210(A)(1) and (2) upon finding that:

—. (a) The proposed instructor has obtained sufficient experience in the care of long-term care residents and teaching adults how to provide such health care to ensure that he or she may train nurses' aides to perform the objectives outlined in the minimum standard curriculum described in 105 CMR 156.320, and

—. (b) The training provider provides to the Commissioner or his or her designee written documentation supporting its request for a waiver.

(B) Other health care professionals such as dieticians, social workers, physical therapists, occupational therapists, and others may teach lessons or modules of a nurses' aides training course.

MICHIGAN

333.20115 Rules defining or differentiating health facility or agency; republication of certain rules; waiver or modification; “abortion” defined.

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 in which 50% or more of the
patients annually served at the facility undergo an abortion must be licensed under this article as a freestanding surgical outpatient facility.

(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 in which 50% or more of the patients annually served in the freestanding surgical outpatient facility undergo an abortion. 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 in which 50% or more of the patients annually served in the freestanding surgical outpatient facility undergo an abortion, if both of the following conditions are met:
   (a) The freestanding surgical outpatient facility was in existence and operating on the effective date of the amendatory act that added this subsection.
   (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) As used in this subsection, “abortion” means that term as defined in section 17015.

333.20145 Construction permit; certificate of need as condition of issuance; rules; information required for project not requiring certificate of need; 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 pursuant to 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 March 1998. 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 it does not include the cost of equipment that is not fixed equipment.

333.20155 Visits to health facilities and agencies, clinical laboratories, nursing homes, hospices, and hospitals; purposes; waiver; confidentiality of accreditation information; limitation and effect; consultation engineering survey; summary of substantial noncompliance or deficiencies and hospital response; investigations or inspections; prior notice; misdemeanor; consultation visits; record; periodic reports; access to documents; confidentiality; disclosure; delegation of functions; voluntary inspections; forwarding evidence of violation to licensing agency; reports; clarification of terms; clinical process guidelines; clinical advisory committee; definitions.
(3) The department shall make a biennial visit to each hospital for survey and evaluation for the purpose of licensure. Subject to subsection (6), the department may waive the biennial visit required by this subsection if a hospital, as part of a timely application for license renewal, requests a waiver and submits both of the following and if all of the requirements of subsection (5) are met:
(a) Evidence that it is currently fully accredited by a body with expertise in hospital accreditation whose hospital accreditations are accepted by the United States department of health and human services for purposes of section 1865 of part C of title XVIII of the social security act, 42 USC 1395bb.

(b) A copy of the most recent accreditation report for the hospital issued by a body described in subdivision (a), and the hospital’s responses to the accreditation report.

(4) Except as provided in subsection (8), accreditation information provided to the department under subsection (3) 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 shall return the accreditation information to the hospital within a reasonable time after a decision on the waiver request is made.

(5) The department shall grant a waiver under subsection (3) if the accreditation report submitted under subsection (3)(b) is less than 2 years 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 in the report, in complaints involving the hospital, or in any other information available to the department. If the accreditation report is 2 or more years old, the department may do 1 of the following:

(a) Grant an extension of the hospital’s current license until the next accreditation survey is completed by the body described in subsection (3)(a).

(b) Grant a waiver under subsection (3) based on the accreditation report that is 2 or more years old, on condition that the hospital promptly submit the next accreditation report to the department.

(c) Deny the waiver request and conduct the visits required under subsection (3).

(6) This section does not prohibit the department from citing a violation of this part during a survey, conducting investigations or inspections pursuant 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.

(7) 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(10).

### 333.20161 Fees and assessments for health facility and agency licenses and certificates of need; medicaid reimbursement rates; use of quality assurance assessment; tax levy; "medicaid" defined.

(10) 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 shall be calculated in accordance with the state standardized travel regulations of the department of management and budget in effect at the time of the travel.

(13) The quality assurance assessment collected under subsection (1)(g) and all federal matching funds attributed to that assessment shall be used only for the following purposes and under the following specific circumstances:
(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 pursuant 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 nonmedicare 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 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 nonmedicare patient days of care provided within the immediately preceding year by those nursing homes and long-term care units with more than 39, but less than the maximum number of licensed beds necessary to secure federal approval. The quality assurance assessment, as provided under this subparagraph, shall be assessed in the first quarter after federal approval of the waiver and shall be subsequently assessed on October 1 of each following year, and is payable on a quarterly basis, 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.

Subp. 8. Reasons for conditions or limitations. In deciding to condition or limit a license the department must consider:
E. the existence of any outstanding variances or waivers; or

4658.0040 VARIANCE AND WAIVER.
Subpart 1. **Request for variance or waiver.** A nursing home may request that the department grant a variance or waiver from the provisions of this chapter. A request for a variance or waiver must be submitted to the department in writing. Each request must contain:
A. the specific part or parts for which the variance or waiver is requested;
B. the reasons for the request;
C. the alternative measures that will be taken if a variance or waiver is granted;
D. the length of time for which the variance or waiver is requested; and
E. other relevant information necessary to properly evaluate the request for the variance or waiver.

Subp. 2. **Criteria for evaluation.** The decision to grant or deny a variance or waiver must be based on the department's evaluation of the following criteria:
A. whether the variance or waiver adversely affects the health, treatment, comfort, safety, or well-being of a resident;
B. whether the alternative measures to be taken, if any, are equivalent to or superior to those prescribed in this chapter; and
C. whether compliance with the part or parts would impose an undue burden upon the applicant.

Subp. 3. **Notification of variance.** The department must notify the applicant in writing of its decision. If a variance or waiver is granted, the notification must specify the period of time for which the variance or waiver is effective and the alternative measures or conditions, if any, to be met by the applicant.

Subp. 4. **Effect of alternative measures or conditions.** Alternative measures or conditions attached to a variance or waiver have the force and effect of this chapter and are subject to the issuance of correction orders and penalty assessments in accordance with Minnesota Statutes, section 144A.10. The amount of fines for a violation of this part is that specified for the particular rule for which the variance or waiver was requested.

Subp. 5. **Renewal.** A request for the renewal of a variance or waiver must be submitted in writing at least 45 days before its expiration date. Renewal requests must contain the information specified in subpart 1. A variance or waiver must be renewed by the department if the applicant continues to satisfy the criteria in subparts 2 and 3, and demonstrates compliance with the alternative measures or conditions imposed at the time the original variance or waiver was granted.

Subp. 6. **Denial, revocation, or refusal to renew.** The department must deny, revoke, or refuse to renew a variance or waiver if it is determined that the criteria in subparts 2 and 3 are not met. The applicant must be notified in writing of the reasons for the decision and informed of the right to appeal the decision.

Subp. 7. **Appeal procedure.** An applicant may contest the denial, revocation, or refusal to renew a variance or waiver by requesting a contested case hearing under Minnesota Statutes, chapter 14. The applicant must submit, within 15 days of the receipt of the department's decision, a written request for a hearing. The request for hearing must set forth in detail the reasons why the applicant contends the decision of the department should be reversed or modified. At the hearing, the applicant has the burden of proving that it satisfied the criteria specified in subparts 2 and 3, except in a proceeding challenging the revocation of a variance or waiver.
4658.2020 STATEMENT OF OPERATIONS.
A nursing home must develop and implement a statement of operations for a secured unit, which must include, at a minimum:
D. a list of any environmental changes or adaptations, and any necessary waivers for them granted by the department.

4658.3005 COMPLIANCE WITH RULES.
Subp. 3. Reclassification. As a condition for reclassification of a boarding care home to a nursing home, the physical plant must be in compliance with all new construction requirements for nursing homes in this chapter. The department shall consider waiver requests under part 4658.0040 from a facility that is in substantial compliance with the new construction requirements in parts 4658.3500 to 4658.4690.

MISSISSIPPI
Downloaded January 2011

115.03 Criminal History Record Checks.
1. Except as otherwise provided in this paragraph, no employee hired on or after July 01, 2003, shall be permitted to provide direct patient care until the results of the criminal history record check revealed no disqualifying record or the employee has been granted a waiver. Provided the covered entity has documented evidence of submission of fingerprints for the background check, any person may be employed and provide direct patient care on a temporary basis pending the results of the criminal history record check but any employment offer, contract, or arrangement with the person shall be voidable, if he/she receives a disqualifying criminal record check and no waiver is granted.
2. The covered entity may, in its discretion, allow any employee unable to sign the affidavit required by paragraph (7) of this subsection or any employee applicant aggrieved by the employment decision under this subsection to appear before the covered entity’s hiring officer, or his or her designee, to show mitigating circumstances that may exist and allow the employee or employee applicant to be employed at the covered entity. The covered entity, upon report and recommendation of the hiring officer, may grant waivers for those mitigating circumstances, which shall include, but not be limited to: (1) age at which the crime was committed; (2) circumstances surrounding the crime; (3) length of time since the conviction and criminal history since the conviction; (4) work history; (5) current employment and character references; and (6) other evidence demonstrating the ability of the individual does not pose a threat to the health or safety of the patients in the licensed facility.

137.01 Building Classification.
c. Authority to Waiver. The licensing agency may waive certain requirements in the regulations at its discretion for facilities licensed as a facility in a state-owned and state-operated mental institution provided the health and safety of residents will not be endangered.
19 CSR 30-81.010 General Certification Requirements
PURPOSE: This rule sets forth application procedures and general certification require-
ments for nursing facilities certified under the Title XIX (Medicaid) program and skilled
nursing facilities under Title XVIII (Medicare), and procedures to be followed by nursing
facilities when requesting a nurse staffing waiver.
(14) An NF may request a waiver of nurse staffing requirements to the extent the facility is
unable to meet the requirements including the areas of twenty-four (24)-hour licensed
nurse coverage, the use of a registered nurse for eight (8) consecutive hours seven (7) days
per week and the use of a registered nurse as director of nursing.
(A) Requests for waivers shall be made in writing to the director of the Section for Long
Term Care.
(B) Requests for waivers will be considered only from facilities licensed under Chapter 198,
RSMo as ICFs which do not have a nursing pool agency that is within fifty
(50) miles, within state boundaries, and which can supply the needed nursing personnel.
(C) The department shall consider each request for a waiver and shall approve or dis-
approve the request in writing postmarked within thirty (30) working days of receipt or, if
additional information is needed, shall request from the facility the additional information
or documentation within ten (10) working days of receipt of the request.
(D) Approval of a nurse waiver request shall be based on an evaluation of whether the
facility has been unable, despite diligent efforts—including offering wages at the com-
community prevailing rate for nursing facilities— to recruit the necessary personnel. Diligent
effort shall mean prominently advertising for the necessary nursing personnel in a variety
of local and out-of-the-area publications, including newspapers and journals within a fifty
(50)-mile radius, and which are within state boundaries; contacts with nursing schools in
the area; and participation in job
fairs. The operator shall submit evidence of the diligent effort including:
1. Copies of newspapers and journal advertisements, correspondence with nursing
   schools and vocational programs, and any other relevant material;
2. If there is a nursing pool agency within fifty (50) miles which is within state boundaries
   and the agency cannot consistently supply the necessary personnel on a per diem basis
to the facility, the operator shall submit a letter from the agency so stating;
3. Copies of current staffing patterns including the number and type of nursing staff on
   each shift and the qualifications of licensed nurses;
4. A current Resident Census and Condition of Residents, Form CMS-672 (10/98),
   incorporated by reference in this rule and available through the Centers for Medicare
   and Medicaid website: http://www.cms.hhs.gov/forms/, or by mail at: Centers for
   Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244-1850.
   This rule does not incorporate any subsequent amendments or additions;
5. Evidence that the facility has a registered nurse consultant required under 19 CSR 30-
   85.042 and evidence that the facility has made arrangements to assure registered nurse
   involvement in the coordination of the assessment process as required under 42 CFR
   483.20(3);
6. Location of the nurses' stations and any other pertinent physical feature information
   the facility chooses to provide;
7. Any other information deemed important by the facility including personnel procedures, promotions, staff orientation and evaluation, scheduling practices, benefit programs, utilization of supplemental agency personnel, physician-nurse collaboration, support services to nursing personnel and the like; and
8. For renewal requests, the information supplied shall show diligent efforts to recruit appropriate personnel throughout the prior waiver period. Updates of prior submitted information in other areas are acceptable.

(E) In order to meet the conditions specified in federal regulation 42 CFR 483.30, the following shall be considered in granting approval:
1. There is assurance that a registered nurse or physician is available to respond immediately to telephone calls from the facility for periods of time in which licensed nursing services are not available;
2. There is assurance that if a facility requesting a waiver has or admits after receiving a waiver any acutely ill or unstable residents requiring skilled nursing care, the skilled care shall be provided in accordance with state licensure rule 19 CSR 30-85.042; and
3. The facility has not received a Class I notice of noncompliance in resident care within one hundred twenty (120) days of the waiver request or the department has not conducted an extended survey in the facility within one (1) year of the waiver request. Any facility which receives a Class I notice of noncompliance in resident care or an extended survey while under waiver status will not have the waiver renewed unless the problem has been corrected and steps have been taken to prevent recurrence. If a facility received more than one (1) Class I notice of noncompliance in resident care during a waiver period, the department will consider revocation of the waiver.

(F) The facility shall cooperate with the department in providing the proper documentation. For renewal requests, the request and proper documentation shall be submitted to the department at least forty-five (45) days prior to the ending date of the current waiver period. If any changes occur during a waiver period that affect the status of the waiver, a letter shall be submitted to the deputy director of institutional services within ten (10) days of the changes. The request for a waiver or renewal of a waiver shall be denied if the facility fails to abide by these previously mentioned time frames.

(G) If a waiver request is denied, the department shall notify the facility in writing and within twenty (20) days, the facility shall submit to the department a written plan for how the facility will recruit the required personnel. If appropriate personnel are not hired within two (2) months, the department shall initiate enforcement proceedings.

Chapter 82—General Licensure Requirements 19 CSR 30-82
(C) The department shall only grant exceptions to licensure requirements set out in rules imposed by the department and cannot grant exceptions to requirements established by state statute or federal regulations. Operators wishing to obtain waivers of regulations under Title XVIII or Title XIX of the Social Security Act shall follow procedures established by the Centers for Medicare and Medicaid (CMS).

19 CSR 30-82.060 Hiring Restrictions—Good Cause Waiver
PURPOSE: This rule is being promulgated to establish the procedure by which persons with criminal convictions may seek a waiver allowing them to be employed by health care and mental health providers despite the hiring restrictions found in section 660.317, RSMo. The waivers are to be for “good cause” as defined by that statute. This rule sets forth both the procedure for seeking waivers and the facts and circumstances to be considered by the Department of Social Services in determining “good cause.”
(1) Definitions.
(A) Applicant means a person who has been or would be rejected for employment by a
provider due to the hiring restrictions found in section 660.317, RSMo.
(B) Department means the Department of Health and Senior Services.
(C) Determination means the decision issued by the director of the Department of Health
and Senior Services or the director's designee based on the factual, procedural or causal
issues of the request for waiver.
(D) Director means the director of the Department of Health and Senior Services.
(E) Good Cause Waiver means a finding that it is reasonable to believe that the restrictions
imposed by section 660.317, RSMo, on the employment of an applicant may be waived after
an examination of the applicant's prior work history and other relevant factors is conducted
and demonstrates that such applicant does not present a risk to the health or safety of
residents, patients or clients if employed by a provider.
(F) Provider means any person, corporation or association who—

1. Is licensed as an operator pursuant to Chapter 198, RSMo;
2. Provides in-home services under contract with the Department of Health and Senior
   Services;
3. Employs nurses or nursing assistants for temporary or intermittent placement in
   health care facilities;

1. Is an entity licensed pursuant to Chapter 197, RSMo;
2. Is a public or private facility, day program, residential facility or specialized service
   operated, funded or licensed by the Department of Mental Health; or

6. Is a licensed adult day care provider.
(G) Reference means a written statement of character, qualification or ability issued on
behalf of the applicant by a person who is not related to or residing with the applicant
requesting a good cause waiver.
(H) Sponsor means the current or potential employer of the applicant, or a training pro-
gram, agency or school in which the applicant is or was a student enrolled for the purpose
of earning a professional license, certification or otherwise becoming qualified to perform
the duties of an occupation.

(2) Any person who is not eligible for employment by a provider due to the hiring
restrictions found in section 660.317, RSMo, may apply to the director for a good cause
waiver. If the director, or the director's designee, determines that the applicant has
demonstrated good cause, such restrictions prohibiting such persons from being hired by a
provider shall be waived and such persons may be so employed unless rejected for
employment on other grounds. Hiring restrictions based on the Department of Health and
Senior Services' employee disqualification list established pursuant to section 660.315,
RSMo, are not subject to a waiver.
(3) The director, or the director's designee, shall accept an application for a good cause
waiver only if the application—
(A) Is submitted in writing by the applicant on the form provided by the department;
(B) Is legible;
(C) Is signed by the applicant;
(D) Includes an indication of the type of waiver that is being requested;
(E) Includes a complete history of residency since the earliest disqualifying offense or
   incident;
(F) Includes a complete employment history since the age of eighteen (18) years;
(G) Includes an attached explanation written by the applicant as to why the applicant
believes he or she no longer poses a risk to the health, safety or welfare of residents,
patients or clients;
(H) Includes an attached description written by the applicant of the events that resulted in
each disqualifying offense or incident;
(I) Includes attached documentation on the applicant’s professional, vocational or occu-
pational licensure, certification or registration
history and current status, if any, in this state and any other state;
(J) Includes at least one (1) reference letter from a sponsor. If the applicant is not able to
obtain a sponsor, the applicant shall so state, shall identify those potential sponsors who
have been approached by the applicant, and shall submit three (3) reference letters from
individuals knowledgeable of the applicant’s character or work history who are not related
to or residing with the applicant;
(K) Includes a criminal history record from the Missouri State Highway Patrol if requesting
a waiver of disqualifying criminal offenses;
(L) Includes a certified court document for each disqualifying criminal offense. If such
document is not obtainable, a written and signed statement from the court indicating that
no such record exists must be submitted;
(M) Includes certified investigative reports from the Department of Social Services if
requesting a waiver of child abuse or neglect findings or a waiver of foster parent license
denial, revocation, or involuntary suspension;
(N) Includes certified investigative reports or other documentation of the incident(s) which
resulted in the applicant’s inclusion on all other lists in the Family Care Safety Registry for
which waiver is requested; and
(O) If in addition to the criminal offense(s) for which the applicant is requesting a waiver
the applicant has any pending felony or misdemeanor charges, includes a statement
explaining the circumstances and certified copies of the charging documents for all pending
criminal charges; and, in the case of an applicant seeking a position with an in-home
services provider agency or home health agency, if in addition to the circumstances related
to the listing on any of the background checklists of the Family Care Safety Registry for
which the applicant is requesting a waiver the applicant has any pending circumstances
which if established would lead to an additional listing on any of the background checklists
of the Family Care Safety Registry, includes a statement explaining the circumstances and
certified copies of documents relating to those circumstances.
(4) The director, or the director’s designee, will not consider any application for a good
cause waiver unless it is fully completed, signed by the applicant, and contains all required
attachments.
(5) Each completed application will be reviewed by a good cause waiver committee of two
(2) or more employees of the department. The director shall determine the size of the
committee and shall, from time to time, appoint members to serve on the committee.
(A) If the applicant seeks a good cause waiver of placement on the disqualification list
maintained by the Department of Mental Health, the director shall appoint an employee of
the Department of Mental Health recommended by the director of the Department of Mental
Health to serve on the good cause waiver committee.
(B) A member of the good cause waiver committee shall recuse himself or herself in a good
cause waiver review in which the member’s impartiality might reasonably be questioned,
including but not limited to instances where the committee member has a personal bias or
prejudice concerning the applicant, or personal knowledge of evidentiary facts concerning
the application for good cause waiver.
(6) The department may, at any time during the application process or review thereof,
request additional information from the applicant. If the applicant fails to supply any
requested additional information within thirty
(30) calendar days of the date of the request, unless the applicant requests and the depart-
ment grants an extension, the department will consider the application for good cause waiv-
er to be withdrawn by the applicant.
(7) The department may request the applicant, prior to the completion of the review, to
appear in person to answer questions about his or her application. If the applicant is
requested to appear in person, the department, in its sole discretion, shall determine the
location for the appearance and may conduct any such proceedings using electronic means,
including but not limited to telephonic or video conferencing. The department shall review
and may investigate the information contained in each application for completeness,
accuracy and truthfulness. The burden of proof shall be upon the applicant to demonstrate
that he or she no longer poses a risk to the health, safety or welfare of residents, patients or
clients. The following factors shall be considered in determining whether a good cause
waiver should be granted:
(A) The applicant’s age at the time the crime was committed or at the time the incident
occurred that resulted in the applicant being listed on the background checklists in the
Family Care Safety Registry;
(B) The circumstances surrounding the crime or surrounding the incident that resulted in
the applicant being listed on the background checklists in the Family Care Safety Registry;
(C) The length of time since the conviction or since the occurrence of the incident that
resulted in the applicant being listed on the background checklists in the Family Care Safety
Registry;
(D) The length of time since the applicant completed his or her sentence for the dis-
qualifying conviction(s), whether or not the applicant was confined, conditionally released,
on parole or probation;
(E) The applicant’s entire criminal history and entire history of all incidents that resulted in
the applicant being listed on the background checklists in the Family Care Safety Registry,
including whether that history shows a repetitive pattern of offenses or incidents;
(F) The applicant’s prior work history;
(G) Whether the applicant had been employed in good standing by a provider but
subsequently became ineligible for employment due to the hiring restrictions in section
660.317, RSMo;
(H) Whether the applicant has been convicted or found guilty of, or pled guilty or nolo
contendere to any offense displaying extreme brutality or disregard for human welfare or
safety;
(I) Whether the applicant has omitted a material fact or misrepresented a material fact
pertaining to his or her criminal or employment history or to his or her history of incidents
that resulted in his or her being listed on the background checklists in the Family Care
Safety Registry;
(J) Whether the applicant has ever been listed on the Employee Disqualification List
maintained by the department as provided in section 660.315, RSMo;
(K) Whether the applicant’s criminal offenses were committed, or the incidents that
resulted in the applicant being listed on the background checklists in the Family Care Safety
Registry occurred, during the time he or she was acting as a provider or as an employee for
a provider;
(L) Whether the applicant has, while disqualified from employment by a provider, obtained employment by fraud, deceit, deception or misrepresentation, including misrepresentation of his or her identity;
(M) Whether the applicant has ever had a professional or occupational license, certification, or registration revoked, suspended, or otherwise disciplined;
(N) Any other information relevant to the applicant's employment background or past actions indicating whether he or she would pose a risk to the health, safety or welfare of residents, patients or clients; and
(O) Whether the applicant has supplied all information requested by the department.
(8) If, at the time of an application for a waiver, or during the waiver consideration process, the applicant has been charged or indicted for, but not convicted of, any of the crimes covered under the provisions of section 660.317, RSMo, the division will hold the request for waiver in abeyance while such charges are pending or until a court of competent jurisdiction enters a judgment or order disposing of the matter.
(9) Each applicant who submits a waiver application meeting the requirements of section (3) of this rule shall be notified in writing by the director, or the director's designee, as to whether his or her application has resulted in a determination of good cause or no good cause. Such notification shall be effective if sent to the applicant's address given on the application.
(10) Any good cause waiver granted to an applicant applies only to:
(A) The specific disqualifying conviction(s), finding(s) of guilt, plea(s) of guilty or nolo contendere, as contained in the certifying copies of the court documents which are required in the application; and/or
(B) The incident(s) that resulted in the applicant being listed on the background checklists in the Family Care Safety Registry, as contained in the investigative reports or other supporting documentation required in the application or subsequently requested by the department.
(11) Any good cause waiver granted to an applicant applies only to those disqualifying criminal convictions on incidents that resulted in the applicant being listed on the background checklists in the Family Care Safety Registry, as covered under the provisions of section 660.317, RSMo, and shall not apply to any other hiring restriction or exclusion imposed by any other federal or state laws or regulations.
(12) The director, or the director's designee, may withdraw a good cause waiver if it receives information or finds that—
(A) The applicant has omitted a material fact or misrepresented a material fact in seeking a good cause waiver;
(B) The applicant has been subsequently convicted or found guilty of, or pled guilty or nolo contendere to any class A or B felony violation of Chapter 565, 566, or 569, RSMo, or any violation of subsection 3 of section 198.070, RSMo, or section 568.020, RSMo, in this state or any other state;
(C) Such applicant is a prospective or current employee of an in-home services provider or home health agency and has been subsequently involved in an incident that results in the applicant being listed on any of the background checklists in the Family Care Safety Registry;
(D) The applicant has omitted, misrepresented or failed to disclose or provide any of the information required by section 660.317, RSMo, or the provisions of this rule; or
(E) There has been a material change in the circumstances upon which the good cause waiver was granted.
(13) If the good cause waiver is withdrawn by the department, the notice of such withdrawal shall be mailed by the department to the applicant's last known address, with a copy of the notice sent to the applicant's last known employer, if any.

(14) No applicant may be employed in a direct care or direct service position with a provider during the pendency of a request for waiver unless the applicant has been continuously employed by that provider prior to August 28, 2003. If an applicant is employed on or after August 28, 2003, he or she may be employed following submission of a completed waiver application on a conditional basis to provide in-home services or home health services to any in-home services client or home health patient during the pendency of that waiver application if:

(A) The disqualifying crime is not one that would preclude employment pursuant to subsection 6 of section 660.317, RSMo; and

(B) The applicant is not listed on the Department of Health and Senior Services' employee disqualification list established pursuant to section 660.315, RSMo.

(15) If a waiver is denied to an applicant employed on or after August 28, 2003, on a conditional basis, the conditional employment shall immediately terminate.

(16) Applicants who have been denied a good cause waiver, or who have had their good cause waivers withdrawn by the department, may reapply one (1) time every twelve (12) months, or whenever the circumstances related to the disqualifying conviction(s) have changed.

(17) Each provider shall be responsible for—

(A) Requesting criminal background checks on all prospective employees, regardless of waiver status, in accordance with the provisions of sections 660.317 and 43.540, RSMo; and

(B) Contacting the department to confirm the validity of a prospective employee's good cause waiver prior to hiring the prospective employee if the prospective employee reveals the existence of a good cause waiver or reveals the existence of an otherwise disqualifying circumstance.

(18) Each in-home services provider or home health provider shall also be responsible for—

(A) Requesting Family Care Safety Registry background screenings on all prospective employees, regardless of waiver status, in accordance with the provisions of section 660.317.7, RSMo; and

(B) Contacting the department to confirm the validity of a prospective employee's good cause waiver prior to hiring the prospective employee if the prospective employee reveals the existence of a good cause waiver or reveals the existence of an otherwise disqualifying circumstance.

(19) All applications for good cause waivers and related documents shall become permanent records maintained by the department.

Chapter 84—Training Program for Nursing Assistants 19 CSR

(C) In order to be approved, the applicant shall have an area which will be designated during training sessions as a classroom with sufficient space to allow fifteen (15) students to be seated with room for note-taking, appropriate equipment as needed for teaching the course, approved instructors and clinical supervisors, and shall assure that the instructor and each student has a manual for the state-approved course. Any ICF/SNF which has received a Notice of Noncompliance related to administration and resident care from the division in the two (2)-year period prior to application for approval shall not be eligible for approval and if this Notice is issued after approval, approval shall be withdrawn by the division within ninety (90) days and the certifying agencies shall be notified of the
withdrawal of approval. Students already enrolled in a class in this facility, however, may complete their course if a Notice is issued after a course has begun. However, a noncompliant facility where an extended or partially extended survey has been completed may apply in writing to the division requesting permission for approval to train and test nurse assistants for certification. The approval for each separate class may be granted to teach and test in the facility but not by the facility staff. If approval is granted for a waiver for a certified facility or exception for a licensed-only facility, the division shall require certain criteria to be met, depending on the issues such as time and distance to other training agencies in the area.

Chapter 86—Residential Care Facilities and Assisted Living Facilities

(A) A facility may apply in writing to the department for a waiver of this section for a specific employee.

(B) The department may issue a written waiver to a facility upon determination that a waiver would be consistent with the public health and safety. In making this determination, the department shall consider the duties of the employee, the circumstances surrounding the conviction, the length of time since the conviction was entered, whether a waiver has been granted by the department’s Bureau of Narcotics and Dangerous Drugs pursuant to 19 CSR 30-1.034 when the facility is registered with that agency, whether a waiver has been granted by the federal Drug Enforcement Administration (DEA) pursuant to 21 CFR 1301.76 when the facility is also registered with that agency, the security measures taken by the facility to prevent the theft and diversion of controlled substances, and any other factors consistent with public health and safety.

II/III

Hourly limitation waivable by department or department's designee. The department or the department’s designee may waive the 24-hour limitation related to recovery care beds, as defined in 50-5-101, as that limitation applies to a particular bed, if the attending physician of the individual occupying the bed determines that the waiver is medically appropriate. The waiver may be granted by the department before or after the 24-hour limitation is exceeded.

37.40.338 BED HOLD PAYMENTS

(7) The department may allow therapeutic home visits for trial placement in the Home and Community Services (Medicaid Waiver) program.

37.40.405 SWING-BED HOSPITALS, SPECIAL SERVICE REQUIREMENTS (1)

(b) Except when a waiver is obtained under (4), the hospital must determine that no appropriate nursing facility bed is available to the Medicaid patient within a 25 mile radius of the swing-bed hospital. The hospital is required to maintain written documentation of inquiries to nursing facilities about the availability of a nursing facility bed and indicating that if a bed is not available, the hospital will provide swing-bed services to the patient. The swing-bed hospital is encouraged to enter into availability agreements with Medicaid-
participating nursing facilities in its geographic region that require the nursing facility to notify the hospital of the availability of nursing facility beds and dates when beds will be available.

(4) A provider may request a waiver of the determination requirement of (1)(b) for an acute care patient of the swing-bed hospital or may request for a swing-bed patient a waiver of the transfer requirement of (2) when the recipient's attending physician verifies in writing that either the recipient's condition would be endangered by transfer to an appropriate nursing facility bed within a 25 mile radius of the swing-bed hospital or that the individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

(a) The waiver request and physician's written verification must be submitted to the Department of Public Health and Human Services, Senior and Long Term Care Division, 2030 11th Avenue, P.O. Box 4210, Helena, MT 59640-4210. Waiver approvals granted by county offices will not be valid or effective for purposes of this rule.

(b) The waiver request and physician's written verification must be received by the nursing facility services bureau within five working days of admission to the swing-bed or within five days of availability of an appropriate nursing facility bed and the provider must obtain written approval from the Medicaid services bureau prior to billing for services provided after the date of admission to the swing-bed or the date of availability of an appropriate nursing facility bed.

(2) General rule Full time employees.

All skills listed in the MNASCC must be satisfactorily passed prior to eligibility to complete the State Competency Evaluation Program (SCEP). For individuals with limited handicaps which preclude satisfactory completion of all skills listed on the checklist, a waiver may be approved by the SA. Waiver requests are to be in writing and list the skills, and the reasons, the individual is unable to physically perform the skill. (Example: an individual is hearing impaired and not able to accurately take a blood pressure). Nurse aides may not perform any skill which is waived. Waivers will be reviewed, evaluated and approved on an individual basis. Waivers, if any, will be recorded on the individual's official Certification of Competency notice provided by the SA.

Amended May 15, 1997 by H.R.

968. A waiver may be authorized in a State if the State:

1. Determines there is no other such program offered within a reasonable distance of the facility;
2. Assures, through an oversight effort, that an adequate environment exists for operating the program; and
3. Provides notice of such determination and assurances to the State Long-Term Care Ombudsman.

The State may approve NATCEP in (but not by) nursing facilities that are prohibited from approval if the nursing facility: --in the case of a facility which applies for program approval, be denied approval of the nurse aide training and competency evaluation program for 24 consecutive months (2 years) from the date that any of these penalties were imposed. --before being allowed to conduct a program, be required to resubmit a request for approval of a new program or re-approval of a previous program at such time any of these penalties have expired.
Waiver of prohibition of nurse aide training and competency evaluation programs in nursing facilities.

Nursing facilities which have been subjected to any remedy described in 483.151(b)(2) may apply to the SA, in writing, for a waiver of the prohibition of providing nurse aide training and competency evaluation in a facility if the facility meets the following:
1. There are no other nurse aide training and competency evaluation programs in, or within a reasonable distance from, the community in which the nursing facility is located.

12-006.04C2a Registered Nurse Waiver in a Nursing Facility: The Department may waive the requirement that a nursing facility certified under Title XIX of the federal Social Security Act, as amended, use the services of a registered nurse for at least eight consecutive hours per day, seven days per week, if:

1. The facility demonstrates to the satisfaction of the Department that it has been unable despite diligent efforts, including offering wages at the community prevailing rate for nursing facilities, to recruit appropriate personnel;
2. The Department determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility; and
3. The Department finds that, for any periods in which a registered nurse is not available, a registered nurse or physician is obligated to respond immediately to telephone calls from the facility; or
4. The Department of Health and Human Services Finance and Support has been granted any waiver by the federal government of staffing standards for certification under Title XIX of the federal Social Security Act, as amended, and the requirements of subdivisions of 12-006.04C2a, items 1-3, have been met.

A waiver granted under this section is subject to annual review by the Department. As a condition of granting or renewing a waiver, a facility may be required to employ other qualified personnel. The Department may grant a waiver under this section if it determines that the waiver will not cause the State of Nebraska to fail to comply with any of the applicable requirements of Medicaid so as to make the state ineligible for the receipt of all funds to which it might otherwise be entitled.

12-006.04C2b Registered Nurse Waiver in a Skilled Nursing Facility: The Department may waive, for up to one year, the requirement that a skilled nursing facility certified under Title XVIII of the Federal Social Security Act, as amended, use the services of a registered nurse for more than 40 hours per week if:

1. The facility is located in a non-urban area where the supply of skilled nursing facility services is not sufficient to meet the needs of individuals residing in the area;
2. The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours per week; and
3. The facility has:
   a. Only residents whose physician has indicated through orders or admission or progress notes that the residents do not require the services of a registered nurse or a physician for more than 40 hours per week; and
   b. Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide the necessary services on days when the regular, full-time registered nurse is not on duty.

A waiver granted under this subsection is subject to annual review by the Department. As a condition of granting or renewing a waiver, a facility may be required to employ other qualified licensed personnel.

12-006.04C4 24-Hour Nurse Staffing Waiver in a Nursing Facility: The Department may waive the requirement that a nursing facility certified under Title XIX of the federal Social Security Act, as amended, use the services of a licensed nurse on a 24-hour basis seven days per week, including the requirement for a charge nurse on each tour of duty, if:

1. The facility demonstrates to the satisfaction of the Department that it has been unable, despite diligent efforts, including offering wages at the community prevailing rate for nursing facilities, to recruit appropriate personnel;
2. The Department determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility; and
3. The Department finds that, for any periods in which licensed nursing services are not available, a licensed registered nurse or physician is obligated to respond immediately to telephone calls from the facility or hospital; or
4. The Department of Health and Human Services Finance and Support has been granted any waiver by the federal government of staffing standards for certification under Title XIX of the federal Social Security Act, as amended, and the requirements of 175 NAC 12-006.04C4, items 1-3 have been met.

A waiver granted under this section is subject to annual review by the Department. As a condition of granting or renewing a waiver, a facility may be required to employ other qualified licensed personnel. The Department may grant a waiver under this section if it determines that the waiver will not cause the State of Nebraska to fail to comply with any of the applicable requirements of Medicaid so as to make the state ineligible for the receipt of all funds to which it might otherwise be entitled.

12-006.04C5 24-Hour Nurse Staffing Waiver in a Skilled Nursing Facility: The Department may waive the requirement that a skilled nursing facility use licensed nurses on a 24-hour basis, seven days a week, including the requirement for a charge nurse each tour of duty, if:

1. The facility demonstrates to the satisfaction of the Department that it has been unable, despite diligent efforts including but not limited to offering wages equal to or greater than the community prevailing wage rate being paid nurses at nursing facilities, to hire enough licensed nurses to fulfill such requirements;
2. The Department determines that a waiver of the requirement will not endanger the health or safety of residents of the facility; and,
3. The Department finds that, for any period in which staffing requirements cannot be met, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility.

A waiver granted under this subsection is subject to annual review by the Department. As a condition of granting or renewing a waiver, a facility may be required to employ other qualified licensed personnel.

12-006.04C6 Notification of Waiver

12-006.04C6a The Department will provide notice of the granting of a waiver to the office of the state long-term care ombudsman and to Nebraska Advocacy Services or any successor designated for the protection of and advocacy for persons with mental illness or mental retardation.

12-006.04C6b The skilled nursing facility or nursing facility granted a waiver must provide written notification to each resident of the facility or, if appropriate, to the guardian, designee, or immediate family of the resident.

12-007 PHYSICAL PLANT STANDARDS: The facility must be designed, constructed and maintained in a manner that is safe, clean, and functional for the type of care and treatment to be provided. The physical plant standards for facilities, which include support services, care and treatment areas, construction standards, building systems and waivers, are set forth below.

12-007.05 Waivers: The Department may waive any provision of 175 NAC 12 relating to construction or physical plant requirements of a licensed facility upon proof by the licensee satisfactory to the Department that:
1. The waiver would not unduly jeopardize the health, safety, or welfare of the persons residing in the facility;
2. The provision would create an unreasonable hardship for the facility; and
3. The waiver would not cause the State of Nebraska to fail to comply with any applicable requirements of Medicare or Medicaid so as to make the state ineligible for the receipt of all funds to which it might otherwise be entitled.

12-007.05A Unreasonable Hardship: In evaluating the issue of unreasonable hardship, the Department will consider the following:

1. The estimated cost of the modification or installation;
2. The extent and duration of the disruption of the normal use of areas used by persons residing in the facility resulting from construction work;
3. The estimated period over which the cost would be recovered through reduced insurance premiums and increase reimbursement related to costs;
4. The availability of financing; and
5. The remaining useful life of the building.

12-007.05B Waiver Terms and Conditions: A waiver may be granted under terms and conditions and for a period of time as are applicable and appropriate to the waiver. Terms and conditions and period of waiver include but are not limited to:
1. Waivers that are granted to meet the special needs of a resident remain in effect as long as required by the resident;
2. Waivers may be granted for a period of time that ends at the time the conditions of approval no longer exist;
3. Waivers may be granted to permit a facility time to come into compliance with the physical plant standards for a period of one year. Upon submission of proof of ongoing progress, the waiver may be continued for an additional year; and
4. An applicant or licensee must submit any request for waiver of any construction or physical plant requirements set forth in 175 NAC 12. An applicant for a waiver may construct a request for waiver form or obtain a form from the Department.

12-007.05C Denial of Waiver: If the Department denies a facility's request for waiver, the facility may request an administrative hearing as provided in the Administrative Procedure Act and the Department’s rules and regulations adopted and promulgated under the APA.

NEVADA

Nevada regulations do not contain specific content for Service Waivers and Variances.

NEW HAMPSHIRE

Construction, Alterations or Renovations.
(i) The department's health facilities administration shall be the authority having jurisdiction for the application of the AIA “Guidelines for Design and Construction of Health Care Facilities,” Nursing Facilities chapter, 2006 edition, and shall negotiate compliance and grant waivers in accordance with He-P 803.10 as appropriate.
(j) Waivers granted by the department for construction or renovation purposes shall not require annual renewal.
Waivers.
(a) Applicants or licensees seeking waivers of specific rules in He-P 803 shall submit a written request for a waiver to the commissioner that includes:
(1) The specific reference to the rule for which a waiver is being sought;
(2) A full explanation of why a waiver is necessary;
(3) A full explanation of alternatives proposed by the applicant or license holder, which shall be equally as protective of public health and residents as the rule from which a waiver is sought; and
(4) The period of time for which the waiver is sought.
(b) Waivers shall not exceed 12 months, or the current license expiration date, except as allowed by He-P 803.18(f) and He-P 803.07(j).
(c) A request for waiver shall be granted if the commissioner determines that the alternative proposed by the applicant or licensee:
(1) Meets the objective or intent of the rule;
(2) Does not have the potential to negatively impact the health or safety of the residents; and
(3) Does not negatively affect the quality of resident services.
(d) The licensee’s subsequent compliance with the alternatives approved in the waiver shall be considered equivalent to complying with the rule from which waiver was sought.
(e) Waivers shall not be transferable.
(f) When a licensee wishes to renew the waiver beyond the approved period of time, the licensee shall apply for a new waiver by submitting the information required by (a) above:
(1) When the licensee submits its application for license renewal pursuant to He-P 803.06(c); or
(2) At least 15 days prior to the expiration of the waiver if the waiver expires on a date other than the expiration date of the licensing certificate.
(g) The request to renew a waiver shall be subject to (b) through (f) above.

Personnel
(d) Unless a waiver is granted in accordance with He-P 803.10 and (e) below, the licensee shall not make a final offer of employment for any position if the individual:
(1) Has been convicted of any felony in this or any other state;
(2) Has been convicted for sexual assault, other violent crime, assault, fraud, abuse, neglect or exploitation;
(3) Has had a finding by the department or any administrative agency in this or any other state for assault, fraud, abuse, neglect or exploitation or any person; or
(4) Otherwise poses a threat to the health, safety or well-being of residents.
(e) The department shall grant a waiver of (d) above if, after reviewing the underlying circumstances, it determines that the person does not pose a threat to the health, safety or well-being of residents.
(f) The waiver in (e) above shall be permanent unless additional convictions or findings under (d) above occur.
(g) The department shall review the information in (d) above and notify the licensee that the individual can no longer be employed if, after investigation, it determines that the individual poses a threat to the health, safety or well-being of a resident.
(m) An individual need not re-disclose any of the matters in (l)(8) and (l)(9) above if the documentation is available and the department has previously reviewed the material and granted a waiver so that the individual can continue employment.
26:2H-1 et seq., and amendments thereto, and the standards in this chapter, waive sections of this chapter if, in his or her opinion, such waiver would not endanger the life, safety, or health of the facility's residents or the public.

(b) A facility seeking a waiver of the standards in this chapter shall apply in writing to the Director of the Long-Term Care Licensing and Certification Program of the Department.

(c) A written application for waiver shall include at least the following:
1. The nature of the waiver requested;
2. The specific standards for which a waiver is requested;
3. Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the facility or any individual upon full compliance;
   An alternative proposal which would ensure resident safety; and
   Documentation to support the application for waiver.

(d) The Department reserves the right to request additional information before processing an application for waiver.

(e) The Department shall issue to the facility written confirmation of either a grant or denial of any waiver request.

8:39-2.9 Chronic hemodialysis services
(a) If a facility provides hemodialysis services to its own long-term care residents only, the following conditions shall be met:
1. The facility shall be authorized to provide the service by the Long-Term Care Licensing and Certification Program of the Department subsequent to the submission and review of the information contained in this subchapter. The application shall describe how the standards in (a)2 through 4 below will be met. The facility shall comply with ambulatory care requirements for a chronic dialysis provider, in accordance with N.J.A.C. 8:43A-24, and the application shall describe how such compliance will be achieved. Waivers from the nine station minimum requirement at N.J.A.C. 8:43A-24.2 shall be considered on an individual basis;

8:34-1.8 Waiver
(a) After due consideration, the Department, upon recommendation from the Board, may waive any provisions of this chapter for good cause, if such a waiver would not endanger the health, safety, or welfare of residents in a nursing home.
(b) An individual seeking a waiver of the provisions in this chapter shall apply in writing to the Executive Director of the Board.
(c) A written application for waiver shall include the following:
   1. The nature of the waiver requested;
   2. The specific provision for which a waiver is requested;
   3. Reasons for requesting a waiver;
   4. An alternative proposal which would ensure the health and safety of the residents; and
   5. Documentation to support the waiver application.

SUBCHAPTER 4. ADMINISTRATIVE EXPERIENCE REQUIREMENT
(d) The Board may waive, in accordance with N.J.A.C. 8:34-1.8, and after review of an individual's application, some or all of the hours required to meet the administrative experience requirement set forth at N.J.A.C. 8:34-4.2(a). This may include a waiver of any of
the hours set forth at N.J.A.C. 8:34-4.2(b)1-9.

SUBCHAPTER 7. CONTINUING EDUCATION
8:34-7.7 Waiver of continuing education credits
(a) The Board or its designee may, in accordance with N.J.A.C. 8:34-1.8, waive all or part of
the continuing education requirement for the licensing period. All such requests to the
Board by the licensee shall be in writing and accompanied by written documentation
supporting the reasons for the request.
(b) Waivers shall be granted for one licensure period at a time. If the situation for which the
waiver was granted continues, the licensee shall reapply in writing to the Board for a
renewal of the waiver.

NEW MEXICO
Downloaded January 2011

JJ. "WAIVE/WAIVERS" means to refrain from pressing or enforcing compliance with a
portion or portions of these regulations for a limited period of time provided the health,
safety, or welfare of residents and staff are not in danger. Waivers are issued at the sole
discretion of the Licensing Authority. [7-1-60, 5-2-89, 10-31-96, 6-15-98; 7.9.2.7 NMAC - Rn,
7 NMAC 9.2.7, 8-31-00]

7.9.2.21 WAIVERS AND VARIANCES:
A. DEFINITIONS: As used in this section:
(1) Waiver: means the grant of an exemption from a requirement of these regulations.
(2) Variance: means the granting of an alternate requirement in place of a requirement of
these regulations.
B. REQUIREMENTS FOR WAIVERS AND VARIANCES: A waiver or variance may be
granted if the Department finds that the waiver or variance will not adversely affect the
health, safety, or welfare of any resident and that:
(1) Strict enforcement of a requirement would result in unreasonable hardship on the
facility or on a resident.
(2) An alternative to a rule, including new concepts, methods, procedures, techniques,
equipment, personnel qualifications, or the conducting of pilot projects, is in the interest of
better care or management.
C. APPLICATIONS:
(1) All applications for waiver or variance from the requirements of these regulations
shall be made in writing to the Department, specifying the following:
(a) The rule from which the waiver or variance is requested;
(b) The time period for which the waiver or variance is requested;
(c) If the request is for a variance, the specific alternative action which the facility proposes;
(d) The reasons for the request; and
(e) Justification that the goal or purpose of the rule or regulations would be satisfied.
(2) Requests for a waiver or variance may be made at any time.
(3) The Department may require additional information from the facility prior to acting on the request.

D. GRANTS AND DENIALS:
(1) The Department at its discretion shall grant or deny each request for waiver or variance in writing. A notice of denials shall contain the reasons for denial.
(2) The terms of a requested variance may be modified upon agreement between the Department and a facility.
(3) The Department may impose such conditions on the granting of a waiver or variance which it deems necessary.
(4) The Department may limit the duration of any waiver or variance.
(5) The Department’s action on a request for a waiver is not subject to administrative appeal.

E. REVOCATION: The Department may revoke a waiver or variance if:
(1) It is determined that the waiver or variance is adversely affecting the health, safety or welfare of the resident’s; or
(2) The facility has failed to comply with the variance as granted; or
(3) The licensee notifies the Department in writing that it wishes to relinquish the waiver or variance and be subject to the rule previously waived or varied;
(4) Required by a change in law. [5-2-89; 7.9.2.21 NMAC - Rn, 7 NMAC 9.2.21, 8-31-00]

7.9.2.34 LICENSE LIMITATIONS:
B. CARE LEVELS: No person who requires care greater than that which the facility is licensed to provide may be admitted to or retained in the facility, unless under waiver according to State guidelines.

7.9.2.71 PHYSICAL ENVIRONMENT:
A. GENERAL: The buildings of the nursing facility shall be constructed and maintained so that they are functional for diagnosis and treatment and for the delivery services appropriate to the needs of the community and with due for protecting the health and safety of the patients. The provisions of this section apply to all new, remodeled and existing construction unless otherwise noted. Existing waivers at the time these regulations are enacted would continue to be accepted unless it is determined that the facility is unable to protect the health and safety of the resident.

D. FIRE PROTECTION:
(3) Existing facilities: Any existing facility shall be considered to have met the requirements of this subsection if, prior to the promulgation of this chapter, the facility complied with and continues to comply with the applicable provisions of the 1967, 1973, or 1981 edition of the Life Safety Code, with or without waivers.

NEW YORK
Downloaded January 2011

New York regulations do not contain specific content for Service Waivers and Variances.
10A NCAC 13D .2303  NURSE STAFFING REQUIREMENTS
(e) An exception to meeting the minimum staffing requirements shall be reported to the Department at the end of each month. Staffing waivers granted by the federal government for Medicare and Medicaid certified beds shall be accepted for licensure purposes.

33-07-03.2-04. Waiver provision.
Any provisions of this chapter or chapter 33-07-04.2 may be waived by the department for a specified period in specific instances, provided such a waiver does not adversely affect the health and safety of the residents and would result in unreasonable hardship upon the facility. A waiver may be granted for a specific period of time not to exceed one year and shall expire on December thirty-first of the year issued.

H) If a resident needs services or accommodations beyond that which a residential care facility is authorized to provide or beyond that which the specific facility provides, refuses needed services, or fails to obtain needed services for which the resident agreed to be responsible under the resident agreement required by rule 3701-17-57 of the Administrative Code, the residential care facility shall take the following action:
(1) Except in emergency situations, the residential care facility shall meet with the resident, and, if applicable, the resident's sponsor and discuss the resident's condition, the options available to the resident including whether the needed services may be provided through a Medicaid waiver program, and the consequences of each option;
310:675-7-8.1. Administrative records
(a) The administrator shall be responsible for the preparation, supervision, and filing of records.
(b) There shall be a separate, organized file in the business office for each resident. The file shall include current information about the resident and the resident’s family. The file shall also include a written record of all financial arrangements and transactions involving the individual resident’s funds. A written contract between the resident, or his representative, or, if the resident is a minor, his parent, or representative, and the facility or its agent or the waiver of same shall also be in this file.
(1) If the source of payment for the resident’s care is, in full or in part, from public funds, there shall be a contract between the facility and the agency providing the funds. An individual contract between such resident and the nursing facility is not required.
(2) A resident may sign a waiver if the resident does not wish to have a contract with the facility.

310:675-13-12. Direct care staffing
(d) There shall be a licensed nurse on duty twenty-four hours per day; provided however, that a facility licensed as a specialized facility for the developmentally disabled shall only be required to provide 24 hour nursing when it has a resident who has a medical care plan. The department may waive this requirement when the facility demonstrates it has been unable, despite diligent effort, to recruit licensed nurses. The Department shall determine that a waiver of this requirement will not endanger the health or safety of the residents.

411-085-0040 Alternative Methods, Waivers
(1) APPLICATION. While all nursing facilities are required to maintain compliance with The Department’s rules, these requirements do not prohibit the use of alternative concepts, methods, procedures, techniques, equipment, facilities, personnel qualifications, or the conducting of pilot projects or research. Requests for waivers to the rules must:
(a) Be submitted to The Department in writing;
(b) Identify the specific rule for which a waiver is requested;
(c) Describe the special circumstances relied upon to justify the waiver;
(d) Describe what alternatives were considered, if any, and why alternatives (including compliance) were not selected;
(e) Demonstrate that the proposed waiver is desirable to maintain or improve the quality of care for the residents, will maintain or improve resident potential for self-direction and self-care, and will not jeopardize resident health and safety; and
(f) Identify the proposed duration of the waiver.
(2) APPROVAL PERIOD. Upon finding that the licensee has satisfied the conditions of this rule, The Department may grant a waiver for a specified period of time, not to exceed a period of three years.

(3) REVOCATION. The Department may revoke any waiver or variance issued by The Department immediately upon finding that the facility's operation under the waiver or variance has endangered, or if continued would endanger, the health or safety of one or more residents.

(4) IMPLEMENTATION. The facility may implement a waiver only after written approval from The Department.

Nursing Services: Staffing

(3) MINIMUM STAFFING, GENERALLY. Resident service needs must be the primary consideration in determining the number and categories of nursing personnel needed. Nursing staff must be sufficient in quantity and quality to provide nursing services for each resident as needed, including restorative services that enable each resident to achieve and maintain the highest practicable degree of function, self-care and independence, as determined by the resident's care plan. Such staffing must be provided even though it exceeds other requirements specified by this rule or specified in any waiver.

(4) MINIMUM LICENSED NURSE STAFFING.

(e) The facility must have a licensed charge nurse on each shift, 24 hours per day.

(C) Section (4)(e) of this rule may be waived by the Seniors and People with Disabilities Division (SPD). The request for waiver must comply with OAR 411-085-0040 and must be reviewed annually. This waiver shall be considered by SPD if the facility certifies that:

(i) it has been unable to recruit appropriate personnel despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities);

(ii) The waiver must not endanger the health or safety of residents; and

(iii) A RN or physician is available and obligated to immediately respond to telephone calls from the facility.

411-087-0030 Waivers for Physical Environment Requirements

(1) Request. Any request for a waiver of these building requirements (OAR 411, division 087) shall comply with OAR 411-085-0040

(2) Duration. The Division may grant waivers for building requirements for a period not to exceed ten years; however, such waiver may be rescinded if the Division determines continuance of the waiver has a potential adverse impact on resident well-being, privacy or dignity.

(a) Whirlpool Tubs. The number of whirlpool tubs in facilities which have been continuously licensed since January 1, 1992 without modification of number or type of bathtubs/showers shall be considered to be in compliance with subsection (4)(b) of this rule unless otherwise provided by OAR 411-087-0010. Facilities which lack the required number of therapeutic tubs shall have a hospital-type tub on each floor which does not have a therapeutic whirlpool tub. As of January 1, 2000, all facilities shall have at least one therapeutic whirlpool tub (waivers may be provided on a case-by-case basis);
CLOCK HOURS REQUIREMENT
(f) A licensee who cannot meet the overall continuing education clock hour requirement in section (a) or (d) due to illness, emergency or hardship may apply to the Board in writing prior to the end of the renewal period for an extension of time to complete the clock hours. A licensee who cannot meet any other requirement in this section due to illness, emergency or hardship may apply to the Board in writing prior to the end of the renewal period for a waiver of the requirement. An extension or waiver request must explain why compliance is impossible, and include appropriate documentation. An extension or waiver request will be evaluated by the Board on a case-by-case basis.

RHODE ISLAND

Section 7.0 Change of Ownership, Operation and/or Location
7.3 Thirty (30) days prior to voluntary cessation of any facility license, the resident, his/her guardian or decision-maker, and the Department of Health shall be notified. The facility shall provide the Department with a plan for orderly closure, and transfer of residents and records.
7.3.1 In the event that a facility seeks a variance from the required thirty (30) day notice of closure of the facility, reasonable advance notice of the hearing for the variance shall be given by the facility to the resident, his or her guardian, or relative so appointed or elected to be his or her decision-maker, and an opportunity to be present at the hearing shall be granted to the person so designated.

7.3.2 In the event of the voluntary closure of a facility, which closure is the result of a variance from the required thirty (30) day notice of closure, granted by the Director, reasonable advance notice of the closure shall be given by the facility to the resident, his or her guardian, or relative so appointed or elected to be his or her decision-maker.

Section 31.0 Social Services
31.3 Notwithstanding any provisions in §§ 5-39.1-1 – 5-39.1-14 or any other general or public law to the contrary, any nursing facility licensed under Chapter 17 of Title 23 that employs a social worker or social worker designee who meets all of the criteria in section 31.4 below shall be granted a variance to the "qualified social worker" provisions stated herein.

Section 38.0 New Construction, Addition or Modification
38.2 All plans for new construction or the renovation, alteration, extension, modification or conversion of an existing facility that may affect compliance with sections 41.0, 43.0, 44.0,
45.0, 46.0, and 52.0 herein, and reference 15, shall be reviewed by a Rhode Island licensed architect. Said architect shall certify that the plans conform to the construction requirements of sections 41.0, 43.0, 44.0, 45.0, 46.0, and 52.0 herein, and reference 15, prior to construction. The facility shall maintain a copy of the plans reviewed and the architect’s signed certification, for review by the Department of Health upon request. 38.2.1 In the event of non-conformance for which the facility seeks a variance, the general procedures outlined in section 54.0 shall be followed. Variance requests shall include a written description of the entire project, details of the non-conformance for which the variance is sought and alternate provisions made, as well as detailing the basis upon which the request is made. The Department may request additional information while evaluating variance requests. 38.2.2 If variances are granted, a licensed architect shall certify that the plans conform to all construction requirements of sections 41.0, 43.0, 44.0, 45.0, 46.0, and 52.0 herein, and reference 15, except those for which variances were granted, prior to construction. The facility shall maintain a copy of the plans reviewed, the variance(s) granted and the architect’s signed certification, for review by the Department upon request.

PART VI Confidentiality - Variance and Appeal Procedure

Section 53.0 Confidentiality
53.1 Disclosure of any health care information relating to individuals shall be subject to all the statutory and regulatory provisions pertaining to confidentiality including but not limited to the provisions of reference 17.

Section 54.0 Variance Procedure
54.1 The licensing agency may grant a variance from the provisions of a rule or regulation in a specific case if it finds that a literal enforcement of such provision will result in unnecessary hardship to the applicant and that such a variance will not be contrary to the public interest, public health and/or health and safety of residents. Variances shall not be granted for the provisions of these regulations found in sections 2.0, 9.0, 16.0, 19.0, 22.0, 24.0, 25.0, 27.11, 48.0, 49.0, 51.0, and 53.0. 54.2 A request for a variance shall be filed by an applicant in writing, setting forth in detail the basis upon which the request is made.

a) Upon the filing of each request for variance with the licensing agency, and within a reasonable time thereafter, the licensing agency shall notify the applicant by certified mail of its approval or in the case of a denial, a hearing date, time and place may be scheduled if the facility appeals the denial.

54.3 At a hearing held in furtherance of an appeal from a denial for a variance in accordance with section 54.2 (a) above, the applicant shall present his case to the Director or his designee for quasi-judicial matters, and shall have the burden of persuading the Director or his designee as aforesaid, through the introduction of clear and convincing evidence, that a literal enforcement of the rules will result in unnecessary hardship, and that a variance will not be contrary to the public interest, public health and/or health and safety of residents. 54.4 Nursing facilities that provide care in accordance with alternative service delivery models may be eligible for a variance in accordance with the requirements contained herein.

Section 55.0 Deficiencies and Plans of Correction
55.3 A facility which received a notice of deficiencies must submit a plan of corrections to the licensing agency within fifteen (15) days of the date of the notice of deficiencies. The plan of corrections shall detail any requests for variances as well as document the reasons therefor.

**SOUTH CAROLINA**

**1008. Laboratory Services**
A. Laboratory services required in connection with the care or treatment to be performed shall be provided or arrangements made to obtain such services.
B. Laboratories that examine materials derived from the human body for diagnosis, prevention, or treatment purposes shall be certified by the Centers for Medicare and Medicaid Services (CMS). Some laboratory tests, i.e., blood sugar levels or hemoglobin, may not require the certification; however a Clinical Laboratories Improvement Amendments (CLIA) "Certificate of Waiver" shall be obtained from the Department’s CLIA Program if those tests are performed.

**SOUTH DAKOTA**

**44:04:04:07.03. Prevention and control of influenza.** Nursing facilities and assisted living centers shall arrange for influenza vaccination to be completed annually for all residents. Residents admitted after completion of the vaccination program and before April 1 must be offered influenza vaccine when they are admitted. Influenza vaccination may be waived for residents because of religious beliefs, medical contraindication, or refusal by the resident. Documentation of vaccination or its waiver must be recorded in the resident’s medical or care record.

**TENNESSEE**

**1200-08-06-.04 ADMINISTRATION.**
(4) Upon the unexpected loss of the facility administrator, the facility shall proceed according to
the following provisions:
(a) The term “unexpected loss” means the absence of a nursing home administrator due to serious illness or incapacity, unplanned hospitalization, death, resignation with less than thirty (30) days notice or unplanned termination.
(b) The facility must notify the department within twenty-four (24) hours after notice of the unexpected loss of the administrator. Notification to the department shall identify an individual to be responsible for administration of the facility for the immediate future not to exceed thirty (30) days. This responsible individual need not be licensed as an administrator and may be the facility’s director of nursing.
(c) Within seven (7) days of notice of the unexpected loss, the facility must request a waiver of the appropriate regulations from the board.
(d) On or before the expiration of thirty (30) days after notice of the unexpected loss, the facility shall appoint a temporary administrator to serve until either a permanent administrator is employed or the request for a waiver is considered by the board, whichever occurs first. The temporary administrator shall be any of the following:
1. A full-time administrator licensed in Tennessee or any other state;
2. One (1) or more part-time administrators licensed in Tennessee. Part-time shall not be less than twenty (20) hours per week; or,
3. A full-time candidate for licensure as a Tennessee administrator who has completed the required training and the application process. Such candidate shall be scheduled for the next licensure exam and is eligible for the continued administrator role only with the successful completion of that exam.
(e) The procedures set forth above shall be followed until the next regularly scheduled meeting of the board in which the board considers the facility’s application for a waiver. After reviewing the circumstances, the board may grant, refuse or condition a waiver as necessary to protect the health, safety and welfare of the residents in the facility.
(f) Any facility which follows these procedures shall not be subject to a civil penalty for absence of an administrator at any time preceding the board’s consideration of the facility’s request for a waiver.

TEXAS

Sec. 242.047. ACCREDITATION REVIEW TO SATISFY INSPECTION OR CERTIFICATION REQUIREMENTS. (a) The department shall accept an annual accreditation review from the Joint Commission on Accreditation of Health Organizations for a nursing home instead of an inspection for renewal of a license under Section 242.033 and in satisfaction of the requirements for certification by the department for participation in the medical assistance program under Chapter 32, Human Resources Code, and the federal Medicare program, but only if:
(5) the department has:
(A) determined whether a waiver or authorization from a federal agency is necessary under federal law, including for federal funding purposes, before the department accepts an annual accreditation review from the joint commission:

(i) instead of an inspection for license renewal purposes;

(ii) as satisfying the requirements for certification by the department for participation in the medical assistance program; or

(iii) as satisfying the requirements for certification by the department for participation in the federal Medicare program; and

(B) obtained any necessary federal waivers or authorizations.

FACILITY CONSTRUCTION  **RULE §19.302 Waivers**

The Texas Department of Human Services (DHS) may grant a waiver for certain provisions of the physical plant and environment which, in DHS’s opinion, would be impractical for the facility to meet. In granting the waiver, DHS will determine that there will be no adverse effect on resident health and safety and the requirement, if not waived, would impose an unreasonable hardship on the facility. DHS may require offsetting or equivalent provisions in granting a waiver.

**RULE §19.344 Plans, Approvals, and Construction Procedures**

At the option of the applicant, the Texas Department of Human Services (DHS) will review plans for new buildings, additions, conversion of buildings not licensed by DHS, or remodeling of existing licensed facilities. DHS will, within 30 days, inform the applicant in writing of the results of the review. If the plans comply with DHS’s architectural requirements, DHS may not subsequently change the architectural requirement applicable to the project unless the change is required by federal law or the applicant fails to complete the project within two years. DHS may grant a waiver of this two-year period for delays due to unusual circumstances. There is no time limit to complete a project, only a time limit for completing a project using requirements that have been revised after the project was reviewed.

NURSING SERVICES  **RULE §19.1001 Nursing Services**

The facility must have sufficient staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Nursing services to children must be provided by staff who have been instructed and have demonstrated competence in the care of children. Care and services are to be provided as specified in §19.901 of this title (relating to Quality of Care).

(3) Waiver of requirement to provide licensed nurses on a 24-hour basis. (A) To the extent that a facility is unable to meet the requirements of paragraphs (1)(B) and (2)(A) of this section, the state may waive these requirements with respect to the facility, if

(i) the facility demonstrates to the satisfaction of the Texas Department of Human Services (DHS) that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel;

(ii) DHS determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility;

(iii) the state finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility; and

(iv) the waivered facility has a full-time registered or licensed vocational nurse on the day
shift seven days a week. For purposes of this requirement, the starting time for the day shift
must be between 6 a.m. and 9 a.m. The facility must specify in writing the schedule that it
follows.

(B) A waiver granted under the conditions listed in this paragraph is subject to annual
state review.

(C) In granting or renewing a waiver, a facility may be required by the state to use other
qualified, licensed personnel.

(D) The state agency granting a waiver of these requirements provides notice of the
waiver to the state long term care ombudsman (established under §307(a)(12) of the Older
Americans Act of 1965) and the protection and advocacy system in the state for the
mentally ill and mentally retarded.

(E) The nursing facility that is granted a waiver by the state notifies residents of the
facility (or, when appropriate, the guardians or legal representatives of the residents) and
members of their immediate families of the waiver.

(4) Waiver of the requirement to provide services of a registered nurse for more than 40
hours a week in a Medicare skilled nursing facility (SNF).

(A) The secretary of the U.S. Department of Health and Human Services (secretary) may
waive the requirement that a Medicare SNF provide the services of a registered nurse for
more than 40 hours a week, including a director of nursing specified in paragraph (2) of this
section, if the secretary finds that:

(i) the facility is located in a rural area and the supply of Medicare SNF services in the
area is not sufficient to meet the needs of individuals residing in the area;

(ii) the facility has one full-time registered nurse who is regularly on duty at the facility
40 hours a week; and

(iii) the facility either has:

(I) only residents whose physicians have indicated (through physician's orders or
admission notes) that they do not require the services of a registered nurse or a physician
for a 48-hour period; or

(II) made arrangements for a registered nurse or a physician to spend time at the
facility, as determined necessary by the physician, to provide necessary skilled nursing
services on days when the regular full-time registered nurse is not on duty.

(B) The secretary provides notice of the waiver to the state long term care ombudsman
(established under §307(a)(12) of the Older Americans Act of 1965) and the protection and
advocacy system in the state for the mentally ill and mentally retarded.

(C) The SNF that is granted a waiver by the state notifies residents of the facility (or, when
appropriate, the guardians or legal representatives of the residents) and members of their
immediate families of the waiver.

(D) A waiver of the registered nurse requirement under subparagraph (A) of this
paragraph is subject to annual renewal by the secretary.

(5) Request for waiver concerning staffing levels. The facility must request a waiver through
the local DHS Long Term Care-Regulatory unit, in writing, at any time the administrator
determines that staffing will fall, or has fallen, below that required in paragraphs (1) and (2)
of this section for a period of 30 days or more out of any 45 days.

The following information must be included in the request/notification:
beginning date when facility was/is unable to meet staffing requirements;
type waiver requested (24-hour licensed nurse or seven-day-per-week RN);
(iii) projected number of hours per month staffing reduced for 24-hour licensed
nurse waiver or seven-dayper-week RN waiver; and
(iv) staffing adjustments made due to inability to meet staffing requirements.

(B) Waivers for licensed-only or certified facilities will be granted by Long Term Care-
Regulatory staff. Waivers for a Medicare SNF receive final approval from the Health Care
Financing Administration.

(C) If a facility, after requesting a waiver, is later able to meet the staffing requirements of
paragraphs (1) and
(2) of this section, Long Term Care-Regulatory staff must be notified, in writing, of the
effective date that staffing meets requirements.

(D) Verification that the facility appropriately made a request and notification will be
done at the time of survey.

(E) Amounts paid to Medicaid-certified facilities in the per diem payment to meet the
staffing requirements of paragraphs (1) and (2) of this section may be adjusted if staffing
requirements are not met.

(6) Duration of waiver. Approved waivers are valid throughout the facility licensure or
certification period, unless approval is withdrawn. During the relicensure or recertification
survey, the determination is made for approval or denial for the next facility licensure or
certification period if a waiver continues to be necessary. The facility requests a
redetermination for a waiver from the Long Term Care-Regulatory staff at the time the
survey is scheduled. At other times if a request is made, the Long Term Care-Regulatory
staff may schedule a visit for waiver determination.

(7) Requirements for waiver approval. To be approved for a waiver, the nursing facility
must meet all of the requirements stated in this subchapter and the requirements specified
throughout this chapter. In some instances, the survey agency may require additional
conditions or arrangements such as:
- an additional licensed vocational nurse on day-shift duty when the registered nurse
  is absent;
- modification of nursing services operations; and
- modification of the physical environment relating to nursing services.

(8) Denial or withdrawal of a waiver. Denial or withdrawal of a waiver may be
made at any time if any of the following conditions exist:
- requirements for a waiver are not met on a continuing basis;
- the quality of resident care is not acceptable; or
- justified complaints are found in areas affecting resident care.

(9) Requirement that SNFs be in a rural area. A SNF (Medicare) must be in a rural
area for waiver consideration, as specified in paragraph (4) of this section. A rural area is
any area outside the boundaries of a standard metropolitan statistical area. Rural areas are
defined and designated by the federal Office of Management and Budget; are determined by
population, economic, and social requirements; and are subject to revisions.

NURSING SERVICES RULE §19.1004 Director of Nursing Services

If a nursing facility, as a result of waivered status, employs a licensed vocational nurse to
supervise and direct nursing services, the facility must have an agreement with a registered
nurse who must provide the vocational nurse at least four hours of consultation in the
facility per week.
RULE §19.1701  Physical Environment

The facility must be designed, constructed, equipped, and maintained to protect the health and ensure the safety of residents, personnel, and the public.

(1) Life safety from fire
   (B) After consideration of the findings of the Texas Department of Human Services (DHS) for Medicare/Medicaid certified facilities, the Health Care Financing Administration (HCFA) may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship on the facility, but only if the waiver does not adversely affect the health and safety of residents or personnel.

RULE §19.2108  Emergency Suspension and Closing Order

(E) if absolutely necessary, to prevent transport over substantial distances, DHS will grant a waiver to a receiving facility to temporarily exceed its licensed capacity, provided the health and safety of residents is not compromised and the facility can meet the increased demands for direct care personnel and dietary services. A facility may exceed its licensed capacity under these circumstances, monitored by DHS staff, until residents can be transferred to a permanent location;

RULE §19.2111  Suspension of Admissions

(a) If the commissioner finds that a nursing facility has committed an act for which a civil penalty may be imposed under §242.065, Health and Safety Code, the commissioner may order the nursing facility to immediately suspend admissions. For the purpose of this remedy, the Texas Department of Human Services defines an admission as the entry into a facility of a new resident or of a resident who has been absent from the facility for 24 or more hours.

(1) A waiver to allow a resident to be admitted may be considered by the commissioner or his designee.

(2) In determining whether to grant a waiver under paragraph (1) of this subsection, factors that the commissioner or his or her designee may consider include, but are not limited to:
   the reason(s) for which admissions at the facility are suspended;
   the facility’s ability to correct the reasons for which admissions at the facility are suspended;
   (C) the relation between the reasons for which admissions at the facility are suspended and the health care needs of the resident who seeks to return to the facility;
   (D) whether the resident who wants to return to the facility has a spouse or relative in the facility; or
   (E) the effect that barring the resident’s return to the facility or other alternative placement will have on the ability of the resident to maintain contact with the resident’s attending physician, family, responsible party, and agent (if any) under a medical power of attorney.

RULE §19.2322  Medicaid Bed Allocation Requirements

(a) Definitions. The words and terms, when used in this section, have the following meanings, unless the context clearly indicates otherwise.

(1) Applicant--The entity requesting a bed allocation waiver or exemption.
(2) Assignment of rights--The conveyance of all rights to a specific number of allocated Medicaid beds from a nursing facility or entity to another entity for purposes of constructing a new nursing facility or for any other use as authorized by these rules.

(3) Bed allocation--The process by which the Texas Department of Human Services (DHS) controls the number of nursing facility beds that are eligible to become Medicaid-certified in each nursing facility.

(4) Bed certification--The process by which DHS certifies compliance with state and federal Medicaid requirements for a specified number of Medicaid beds within a nursing facility.

(5) Licensee--The entity, which includes controlling persons, that is:

(A) an applicant for licensure by DHS under Chapter 242 of the Texas Health and Safety Code and Medicaid certification;
(B) licensed by DHS under Chapter 242 of the Texas Health and Safety Code; or
(C) licensed under Chapter 242 of the Texas Health and Safety Code and holds the contract to provide Medicaid services.

(6) Lien holder--The entity that holds a lien against the physical plant.

(7) Multiple-facility owner--An entity that owns, controls, or operates under lease two or more nursing facilities within or across state lines.

(8) Occupancy rate--The number of residents occupying certified Medicaid beds divided by the number of certified Medicaid beds in a nursing facility.

(9) Physical plant--The land and attached structures to which beds are allocated or for which an application for bed allocation has been submitted.

(10) Property owner--The person or entity that owns a physical plant.

(11) Transfer of beds--The conveyance of a specific number of allocated Medicaid beds from a nursing facility or entity to an existing licensed nursing facility. The nursing facility may use the transferred Medicaid beds to increase the number of Medicaid-certified beds currently licensed or to increase the number of Medicaid certified beds when additional licensed beds are added to the nursing facility in the future.

(b) Purpose. The purpose of this section is to control the number of Medicaid beds for which DHS contracts, to improve the quality of resident care by selective and limited allocation of Medicaid beds, and to promote competition.

(c) Bed allocation general requirements. The allocation of Medicaid beds represents an opportunity for the property owner or the lessee of a nursing facility to obtain a Medicaid nursing facility contract for a specific number of Medicaid-certified beds.

(1) Medicaid beds are allocated to a nursing facility and remain at the physical plant to which they originally were allocated, unless beds are assigned or transferred in accordance with these requirements.

(2) When Medicaid beds are allocated to a nursing facility as a result of actions by the licensee, the beds remain allocated to the physical plant, even when the licensee ceases operating the nursing facility, unless the beds are subsequently assigned or transferred in accordance with these requirements.

(3) Notwithstanding any language in subsections (f) and (g) of this section and the fact that applicants for bed allocation waivers and exemptions may be licensees or property owners, beds are allocated to the physical plant and the rights to all allocated Medicaid beds belong to the property owner, subject to any and all valid physical plant liens.

(d) Control of beds. Except as specified in this section, DHS does not accept applications for a Medicaid contract for nursing facility beds from any nursing facility that was not granted:

a valid certificate of need (CON) by the Texas Health Facilities Commission before September 1, 1985;
a waiver by DHS before January 1, 1993; or
(3) other valid order that had the effect of authorizing the operation of the nursing facility at the bed capacity for which participation is sought.

(e) Quality of care. Unless specifically exempted from this requirement, applicants for Medicaid bed allocation waivers or exemptions and any controlling persons must demonstrate a history of providing quality care.

(1) In determining if an applicant or a controlling person has a history of providing quality care, DHS may consider the provisions detailed in §19.214(a) of this title (relating to Criteria for Denying a License or Renewal of a License).

(A) Additionally, DHS will determine an applicant to have demonstrated a history of quality of care if, within the preceding 24 months, an applicant has not received any of the following sanctions:
- termination of Medicaid and/or Medicare certification;
- termination of Medicaid contract;
- denial, suspension, or revocation of nursing facility license;
- cumulative Medicaid and/or Medicare civil monetary penalties totaling more than $5,000 per facility;
- civil penalties pursuant to §242.065 of the Texas Health and Safety Code; or
denial of payment for new admissions; and

(B) DHS finds no clear pattern of substantial or repeated licensing and Medicaid sanctions, including administrative penalties and/or other sanctions.

(2) Nursing facilities that have received any of the sanctions listed under paragraph (1) of this subsection within the previous 24 months are not eligible for an allocation of additional Medicaid beds. In the case of sanctions that are appealed, either administratively or judicially, an application will be suspended until the appeal has been resolved. Sanctions that have been administratively withdrawn or were subsequently reversed upon administrative or judicial appeal will not be considered.

(3) When the applicant for an allocation of additional Medicaid beds is a multiple-facility owner or a multiple-facility owner owns an applicant nursing facility, the multiple-facility owner must demonstrate an overall record of providing quality care in addition to the applicant facility's meeting the quality-of-care requirements in this subsection.

(4) When a licensee has operated a nursing facility for less than 24 months, the nursing facility must establish at least a 12-month compliance record in which the nursing facility has not received any of the sanctions listed under paragraph (1) of this subsection.

(5) When the applicant has no history of operating nursing facilities, DHS will review the compliance record of health-care facilities operated, managed, or otherwise controlled by controlling parties of the applicant. If the controlling parties or the applicant has never operated, managed, or otherwise controlled any health-care facilities, a compliance review will not be required.

(6) The commissioner, or the commissioner's designee, may make an exception to any of the requirements in this subsection if it is determined the needs of Medicaid recipients in a local community will be served best by granting a Medicaid bed allocation waiver or exemption. In determining whether to make an exception to the quality-of-care requirements, the commissioner or the commissioner’s designee may consider the following:

(A) the overall compliance record of the waiver or exemption applicant;
(B) the current availability of Medicaid beds in facilities providing a high quality of care in the local community;
   the level of support for the waiver or exemption from the local community;
   how a waiver or exemption will improve the overall quality of care for nursing facility residents; and
   the age and condition of nursing facility physical plants in the local community.

(f) Exemptions. Under the following circumstances, DHS may grant an exemption of the policy stated in subsection (d) of this section. All exemption actions must comply with the requirements in this subsection and with requirements of the Centers for Medicare and Medicaid Services (CMS) regarding bed additions and reductions. When a bed allocation exemption is approved, the licensee must comply with the requirements contained in §19.201 of this title (relating to Criteria for Licensing) at the time of licensure and/or Medicaid certification of the new beds or nursing facility.

(1) Replacement Medicaid nursing facilities and beds. Currently allocated Medicaid beds may be replaced through the construction of one or more new nursing facilities.
   (A) The applicant must either own the physical plant to which the beds are allocated or possess a valid assignment of rights to the Medicaid beds.
   (B) Assignment of the Medicaid beds to the replacement nursing facility must be approved by all lien holders of the physical plant to which the beds are allocated.
   (C) Replacement nursing facility applicants, including those who obtained the rights to the beds through a valid assignment of rights, must comply with the history of quality-of-care requirements in subsection (e) of this section, unless the applicant for a replacement nursing facility is the current property owner.
   (D) Replacement facilities will be granted an increase of up to 25% of the currently allocated Medicaid beds, if the applicant complies with the history of quality-of-care requirements in subsection (e) of this section. The additional allocation of beds may not be transferred or assigned until they are certified at the replacement facility.
   (E) The replacement nursing facility must be located in the same county in which the Medicaid beds currently are allocated.

(2) Transfer of Medicaid beds. Allocated Medicaid beds currently certified or certified previously may be transferred to another physical plant.
   (A) The applicant must own the physical plant to which the beds are allocated or must present DHS with one of the following:
      (i) a valid Medicaid bed transfer agreement that specifies the number of additional Medicaid beds to be allocated to the receiving nursing facility; or
      (ii) a valid assignment of rights to currently allocated Medicaid beds that specifies the number of additional Medicaid beds to be allocated to the receiving nursing facility.
   (B) If the Medicaid beds currently are allocated to a specific physical plant, the current property owner and all current lien holders must approve the transfer agreement.
   (C) The receiving licensee must comply with the history of quality-of-care requirements in subsection (e) of this section.
   (D) Both facilities must be located in the same county.

(3) High-occupancy facilities. Medicaid-certified nursing facilities with high occupancy rates may periodically receive bed allocation increases.
   (A) The occupancy rate of the Medicaid beds of the applicant nursing facility must be at least 90% for nine of the previous 12 months.
(B) The application for additional Medicaid beds may be no greater than 10% (rounded to the nearest whole number) of the current number of Medicaid-certified nursing facility beds.

(C) The applicant nursing facility must comply with the history of quality-of-care requirements in subsection (e) of this section.

(D) The applicant nursing facility may reapply for additional Medicaid beds no sooner than nine months from the date of the previous allocation increase.

(E) Medicaid beds allocated to a nursing facility under this requirement may only be certified at the applicant facility. The additional allocation of beds may not be transferred or assigned until they are certified at the applicant facility.

(4) Non-certified nursing facilities. Licensed nursing facilities that do not have Medicaid-certified beds may receive an initial allocation of Medicaid beds.

(A) The application for Medicaid beds may be no greater than 10% (rounded to the nearest whole number) of the current licensed nursing facility beds.

(B) The applicant licensee must comply with the history of quality-of-care requirements in subsection (e) of this section.

(C) After the applicant receives an allocation of Medicaid beds, the licensee may reapply in accordance with provisions of paragraph (3) of this subsection.

(D) Facilities that have Medicaid beds allocated under provisions of the Alzheimer’s waiver may apply for general Medicaid beds in accordance with paragraph (3) or (4) of this subsection. The beds allocated under the Alzheimer’s waiver provisions will be excluded from this computation; for example, a 120-bed nursing facility with 60 Alzheimer waiver beds would be eligible for 10% of the 60 remaining beds or six additional Medicaid beds.

(5) Low-capacity facilities. For purposes of efficiency, nursing facilities with a Medicaid bed capacity of less than 60 may receive additional Medicaid beds to increase their capacity up to a total of 60 Medicaid beds.

(A) The nursing facility must be licensed for less than 60 beds and have a current certification of less than 60 Medicaid beds.

(B) The nursing facility must have been Medicaid-certified before June 1, 1998.

(C) The applicant licensee must comply with the history of quality-of-care requirements in subsection (e) of this section.

(D) Facilities that have a Medicaid capacity of less than 60 beds due to the loss of Medicaid beds under provisions in subsection (h) of this section are not eligible for this exemption.

(6) Spend-down Medicaid beds. Licensed nursing facilities may receive temporary spend-down Medicaid beds for residents who have "spent down" to become eligible for Medicaid, but for whom no Medicaid bed is available. Approval of spend-down Medicaid beds allows a nursing facility to exceed temporarily its allocated Medicaid bed capacity.

(A) The applicant nursing facility must have a Medicaid contract. If the nursing facility is not currently Medicaid-certified, the licensee must be approved for Medicaid certification and obtain a Medicaid contract.

(B) All Medicaid or dually certified beds must be occupied by Medicaid or Medicare recipients at the time of application.

(C) The application for a spend-down Medicaid bed must include documentation that the person for whom the spend-down bed is requested:

(i) was not eligible for Medicaid at the time of the resident’s most recent admission to the nursing facility; and
(ii) was a resident of the nursing facility for at least the immediate three months before becoming eligible for Medicaid, excluding hospitalizations.

(D) The nursing facility is eligible to receive Medicaid benefits effective the date the resident meets Medicaid eligibility requirements.

(E) The nursing facility must assign a permanent Medicaid bed to the resident as soon as one becomes available.

(F) Facilities with multiple residents in spend-down beds must assign permanent Medicaid beds to those residents in the same order the residents were admitted to spend-down beds.

(G) The assignment of residents in spend-down beds to permanent Medicaid beds must precede the admission of new residents to permanent beds.

(H) The nursing facility must notify DHS immediately upon the death or permanent discharge of the resident or transfer of the resident to a permanent Medicaid bed. Failure of the nursing facility to notify DHS of these occurrences in a timely manner is basis for denying applications for spend-down Medicaid beds.

(I) The nursing facility is not required to comply with quality-of-care requirements in subsection (e) of this section.

(g) Waivers. The commissioner or the commissioner’s designee may grant a waiver of the policy stated in subsection (d) of this section under certain conditions. Applicants must meet the following conditions to be eligible for the specific waivers in subsection (h) of this section.

The applicant must meet the quality-of-care requirement stated in subsection (e) of this section.

Every waiver application must include identification of all controlling parties of the applicant entity.

(3) At the time of licensure and/or Medicaid certification of the allocated beds, the licensee must comply with the requirements contained in §19.201 of this title.

(4) Approved waivers may be assigned by the applicant to another entity under the following circumstances.

(A) Waivers may be assigned to another entity controlled by the majority owners of the waiver.

(B) Waivers may be assigned to the entity that owns the facility at the time of certification. Assignment of the waiver under these circumstances will be approved by DHS only if the entity that owns the facility at the time of certification complies with subsection (e) of this section and the waiver applicant is the licensee of the new facility. Control of the allocated beds after initial Medicaid certification is subject to subsection (c) of this section.

(C) Assignment of waivers under circumstances listed in subparagraphs (A) and (B) of this paragraph must be reported to DHS.

(5) Any additional controlling parties of the new entity must be reported to DHS. The validity of the waiver will be contingent on the new controlling parties’ compliance with the quality-of-care requirements in subsection (e) of this section.

(6) Waiver applicants who submit false information will not be eligible for a waiver. Waivers issued based on false information provided by the applicant are void.

(7) Waiver applications will be considered in the order in which they are received.

(h) Specific waivers. Waivers may be granted if it is determined that Medicaid beds are necessary for the following circumstances.

(1) Community needs waiver. A community needs waiver is designed to meet the needs of communities that do not have reasonable access to quality nursing facility care.

(A) The applicant must submit a study, prepared by an independent professional
experienced at preparing demographic studies, that documents:
   an immediate need for additional Medicaid beds in the community;
   Medicaid residents in the community do not have reasonable access to quality
   nursing facility care; and
   (iii) substantial community support for the new nursing facility or beds.
(B) Applicants must disclose if they have served as a trustee of a nursing facility within
the previous 24 months.
(2) Criminal justice waiver. The criminal justice waiver is designed to meet the needs of
the Texas Department of Criminal Justice (TDCJ). The applicant must document that:
   (A) the waiver is needed to meet the identified and determined nursing facility needs of
   TDCJ; and
   (B) the new nursing facility is approved by TDCJ to serve persons under their supervision
   who have been released on parole, mandatory supervision, or special needs parole under
   the Code of Criminal Procedure, Article 42.18.
(3) Under-served minority waiver. The under-served minority waiver is designed to meet
the needs of minority communities that do not have adequate nursing facility care. For
purposes of this waiver, the term minority means black, Hispanic, Asian or Pacific Islander,
American Indian, or Alaskan native. The applicant must submit a study, prepared by an
independent professional experienced at preparing demographic studies, that documents:
   (A) the new nursing facility or beds will serve a ZIP code that has a minority population
greater than 50% according to the most recent U.S. census; and
   (B) minority residents in the ZIP code in which the nursing facility or beds will be located
do not have reasonable access to quality nursing facility care.
(4) Alzheimer’s waiver. The Alzheimer’s waiver is designed to meet the needs of
communities that do not have reasonable access to Alzheimer’s nursing facility services.
The applicant must document that:
   (i) the nursing facility is affiliated with a medical school operated by the state;
   (ii) the nursing facility will participate in ongoing research programs for the care
and treatment of persons with Alzheimer’s disease;
   (iii) the nursing facility will be designed to separate and treat residents with
Alzheimer’s disease by stage and functional level;
   (iv) the nursing facility will obtain and maintain voluntary certification as an
Alzheimer’s nursing facility in accordance with §§19.2204, 19.2206, 19.2208 of this title
(relating to Voluntary Certification of Facilities for Care of Persons with Alzheimer’s
Disease; General Requirements for a Certified Facility; and Standards for Certified
Alzheimer’s Facilities); and
   (v) only residents with Alzheimer’s disease or related dementia will be admitted to the
Alzheimer’s Medicaid beds.
(B) The applicant must submit a study, prepared by an independent professional
experienced at preparing demographic studies, that documents the need for the number of
Medicaid Alzheimer’s beds requested.
(5) Teaching nursing facility waiver. A teaching nursing facility waiver is designed to meet
the statewide needs for providing training and practical experience for health-care
professionals. The applicant must submit documentation that the nursing facility:
   is affiliated with a state-supported medical school;
   is located on land owned or controlled by the state-supported medical school; and
   serves as a teaching nursing facility for physicians and related health-care
professionals.
(6) Rural county waiver. A rural county waiver is designed to meet the needs of
rural areas of the state that do not have reasonable access to quality nursing facility care. For purposes of this waiver, a rural county is one that has a population of 100,000 or less according to the most recent census, and has no more than two Medicaid-certified nursing facilities. DHS will approve no more than 120 additional Medicaid beds per county per year and no more than 500 additional Medicaid beds statewide in a calendar year under this waiver provision. The waivers will be considered on a first-come, first-served basis. Requests received in a year in which the 500-bed limit has been met will be carried over to the next year. The waiver must be requested by the county commissioner’s court.

(A) The commissioner’s court must notify DHS of its intent to consider a rural county waiver and obtain verification from DHS that the county complies with the definition of rural county.

(B) The commissioner’s court must publish a notice in the Texas Register and in a newspaper of general circulation in the county. The notice must seek:

(i) comments on whether a new Medicaid nursing facility should be requested; and

(ii) proposals from persons or entities interested in providing additional Medicaid-certified beds in the county, including persons or entities currently operating Medicaid-certified facilities with high occupancy rates. Persons or entities that submit false information will be eliminated from the process.

(C) The commissioner’s court must determine whether to proceed with the waiver request after considering all comments and proposals received in response to the notices provided under subparagraph (B) of this paragraph. In determining whether to proceed with the waiver request, the commissioner’s court must consider:

the demographic and economic needs of the county;

the quality of existing Medicaid nursing facilities in the county;

(iii) the quality of the proposals submitted, including a review of the past history of care provided, if any, by the person or entity submitting the proposal; and

(iv) the degree of community support for additional Medicaid nursing facility services.

(D) The commissioner’s court must document the comments received, proposals offered and factors considered in subparagraph (C) of this paragraph.

(E) The commissioner’s court, if it decides to proceed with the waiver request, must submit a recommendation that DHS issue a waiver to a person or entity who submitted a proposal for new or additional Medicaid beds. The recommendation must include:

(i) the name, address, and telephone number of the person or entity recommended for contracting for the Medicaid beds;

(ii) the location, if the commissioner’s court desires to identify one, of the recommended nursing facility;

(iii) the number of beds recommended; and

(iv) the information listed in subparagraph (D) of this paragraph used to make the recommendation.

(7) State veterans homes. State veterans homes, authorized and built under the auspices of the State Veterans Land Board, must meet all requirements for Medicaid participation.

(i) Time Limits and Extensions.

(1) With the exception of transferred Medicaid beds and temporary Medicaid beds, all beds approved under the exemption provisions of subsection (f) of this section must be constructed, licensed, and certified within 24 months of the exemption approval.

(2) Medicaid beds transferred in accordance with subsection (f)(2) of this section must be certified within six months of the exemption approval.
(3) Time limits applicable to temporary Medicaid beds are specified in subsection (f)(6) of this section.

(4) All facilities and beds approved in accordance with waiver provisions of subsection (h) of this section must be constructed, licensed, and certified within 24 months of the waiver approval.

(5) With the exception of transferred Medicaid beds and temporary Medicaid beds, applicants for exemptions and waivers must submit a progress report every 12 months after approval of the exemption or waiver. The exemption or waiver may be declared void if the applicant fails or refuses to provide the progress report as required or if the progress report contains false information.

(6) At the discretion of the commissioner or the commissioner's designee, deadlines specified in this section may be extended. The applicant must submit evidence of good-faith efforts to meet the deadline and/or evidence that delays were beyond the applicant's control.

(7) Applicants who receive an extension of their waiver of exemption must submit a progress report every six months after approval of the extension until the nursing facility beds are certified. The exemption or waiver may be declared void if the applicant fails or refuses to provide the progress report as required or if the progress report contains false information.

(8) Failure to meet the requirements of this section is grounds for loss of the Medicaid bed allocation.

(j) Loss of Medicaid Beds.

(1) Loss of Medicaid beds based on sanctions.

(A) A Medicaid nursing facility operated by the person or entity who also owns the property will lose the allocation of all Medicaid beds assigned to the nursing facility property if the nursing facility’s license is denied or revoked.

(B) A Medicaid nursing facility operated by one person or entity and owned by another person or entity will lose the allocation of Medicaid beds if two or more of the following actions occur within a 42-month period:

   (i) licensure denial;
   (ii) licensure revocation; or
   (iii) Medicaid termination.

(C) DHS may waive this loss of allocation of Medicaid beds in order to facilitate a change of ownership or other actions that would protect the health and safety of residents or assure reasonable access to quality nursing facility care.

(2) Voluntary decertification of Medicaid beds.

(A) Facilities may request to voluntarily decertify Medicaid beds.

(B) The licensee must submit written approval of the Medicaid bed reduction signed by the property owner and all physical plant lien holders.

(C) Medicaid beds voluntarily decertified will result in reduction of allocated Medicaid beds equal to the number of beds decertified.

(D) Facilities that voluntarily decertify Medicaid beds are eligible to receive an increased allocation of Medicaid beds if the facility qualifies for a bed allocation waiver or exemption.

(3) Nursing facility ceases to operate.

(A) The property owner of a nursing facility that closes or ceases to participate in the Medicaid program must inform DHS in writing of the intended future use of the Medicaid beds within 90 days of closure.
(B) Unless the Medicaid beds will be used for a replacement nursing facility, the allocated beds must be recertified within 12 months of the date the Medicaid contract was terminated.

(C) Time limits in subparagraphs (A) and (B) of this paragraph may be extended in accordance with subsection (i)(6) of this section.

(D) Failure to meet the requirements of this paragraph is grounds for loss of the Medicaid bed allocation.

(k) Informal review procedures.

(1) Applicants may request an informal review of DHS actions regarding bed allocations. The request must be submitted within 30 days of notification of the action.

(2) The request for the informal review and all documentation or evidence that forms the basis for the informal review must be submitted in writing.

(3) The commissioner or the commissioner’s designee will conduct the informal review.

(l) Loss of Medicaid beds based on low occupancy.

(1) DHS may review Medicaid bed occupancy rates annually for the purpose of de-allocating and decertifying unused Medicaid beds. The Medicaid bed occupancy reports for the most recent six-month period that DHS has validated will be used to determine the bed occupancy rate of each nursing facility.

(2) Medicaid beds will be de-allocated and decertified in facilities that have an average occupancy rate below 70%. The number of beds to be decertified is calculated by subtracting the preceding six-month average occupancy rate of Medicaid-certified beds from 70% of the number of allocated certified beds and dividing the difference by 2, rounding the final figure down if necessary. For example, for a facility with 100 Medicaid-certified beds and a 50% occupancy rate, the difference between 70% (70 beds) and 50% (50 beds) is 20 beds, divided by 2, is 10 beds to be decertified.

(3) Medicaid beds in a nursing facility that has obtained a replacement nursing facility exemption are not subject to the de-allocation and decertification process.

(4) Medicaid beds in a new or replacement physical plant or a newly constructed wing of an existing physical plant will be exempt from this de-allocation and decertification process until the new physical plant or new wing has been certified for two years.

(5) Medicaid beds that have been subject to a change of ownership within the past 24 months are exempt from the de-allocation and decertification process.

(6) Medicaid beds allocated to a closed nursing facility are exempt from this de-allocation and decertification process.

(7) Nursing facilities that lose Medicaid beds through this process are eligible to receive an additional allocation of Medicaid beds at a later date if the facility qualifies for a bed allocation waiver or exemption.

(8) The de-allocation and decertification of unused beds does not affect the licensed capacity of the nursing facility.

(m) Medicaid occupancy reports.

(1) Medicaid nursing facilities must submit occupancy reports to DHS each month.

(A) The occupancy data must be reported on a form prescribed by DHS. The form must be completed in accordance with instructions and the occupancy data must be accurate and verifiable. The completed report must be submitted to DHS no later than the fifth day of the month following the reporting period.

(B) The Medicaid occupancy rate will be determined by calculating the monthly average of the number of persons who occupy Medicaid beds.
(C) All persons residing in Medicaid-certified beds, including Medicaid recipients, Medicare recipients, private-pay residents, or residents with other sources of payment, will be included in the calculation.

(D) Failure or refusal to submit accurate occupancy reports in a timely manner may result in the nursing facility’s vendor payment being held in abeyance until the report is submitted.

(2) DHS will determine nursing facility and county occupancy rates based on the data submitted by the nursing facilities.

(A) The occupancy data will be used to determine eligibility for and/or compliance with waiver and exemption requirements. The occupancy data also will be used to determine if Medicaid beds should be decertified based on low occupancy.

(B) The occupancy data will be made available to nursing facilities, licensees, property owners, waiver or exemption applicants, and others in accordance with public disclosure requirements.

(C) Inaccurate or falsified occupancy data is grounds to disqualify facilities from eligibility for bed allocation exemptions and waivers. DHS may refuse to accept corrections to bed occupancy data submitted more than six months after the due date of the occupancy report.

(n) School-age residents. Any bed allocation waiver or exemption applicant that serves or plans to serve school-age residents must provide written notice to the affected local education agency (LEA) of its intent to establish or expand a nursing facility within the LEA’s boundary.

Selection and Contracting Procedures for Adding Medicaid Beds in High-Occupancy Areas

(a) Definitions. The words and terms, when used in this section, have the following meanings, unless the context clearly indicates otherwise.

(1) County occupancy rate--The number of residents occupying certified Medicaid beds in a county divided by the number of Medicaid beds allocated in the county. This calculation includes Medicaid beds that currently are certified and Medicaid beds that have been allocated but are not currently certified. In the four most populous counties, the occupancy rate will be calculated for each county-commissioner precinct.

(2) Open solicitation period--A time period in which licensees, property owners and other entities may apply for an allocation of Medicaid beds in high-occupancy counties or precincts.

(3) Applicants for the secondary waiver process must demonstrate a history of quality care as specified in §19.2322(e) of this title.

(4) Applicants must provide the name and address of the applicant entity, the name, address, and telephone number of the contact person, the name and address of all controlling parties of the applicant entity and the number of Medicaid beds requested.

(5) At the end of the secondary solicitation period, DHS will determine if any applicant is eligible for additional Medicaid beds. If multiple applicants are eligible, the applicant that will receive the allocation of beds will be chosen by a lottery selection. Applicants who submit false information are not eligible for the allocation of Medicaid beds. Medicaid beds allocated based on false information are not eligible for Medicaid certification and the allocation is revoked.

(6) Medicaid beds allocated under this provision may only be transferred to another entity controlled by the same majority owners. Transfers under these circumstances must be reported to DHS.
(c) Family members or a designated responsible person may administer medications from a package set up by a licensed practitioner or licensed pharmacist which identifies the medication and time to administer. If a family member or designated responsible person assists with medication administration, they shall sign a waiver indicating that they agree to assume the responsibility to fill prescriptions, administer medication, and document that the medication has been administered. Facility staff may not serve as the designated responsible person.

8.1 Life Safety from Fire
(a) The facility must meet the applicable provisions of the Vermont Fire Prevention and Building Code.
(b) After consideration of state licensing agency findings, the Vermont Department of Labor and Industry may waive specific provisions of the Vermont Fire Prevention and Building Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of residents or personnel.

12VAC5-371-50. Functional design features.
A. In order to avoid costly errors and unnecessary redesign, applicants or licensees are required to present their building plans to the center after acceptance of the final plan layout by the owner. Precontract document approval of the plan ensures acceptance of the basic architectural footprint and serves as the basis for approval of "fast track" construction for nursing facilities pursuing this approach. The applicant or licensees shall notify the center of deviations in the contract documents from the approved preliminary plans. Contract documents containing deviations from
approved preliminary plans are required to comply with these regulations and will be reviewed again to ensure compliance. Variances for out of compliance conditions as a result of deviations from the approved preliminary documents will not be granted.

12VAC5-371-80. Variances.
A. The center can authorize variances only to its own licensing standards, not to regulations of another agency or to any requirements in federal, state, or local laws.
B. A nursing facility may request a variance to a particular standard or requirement contained in this chapter when the standard or requirement poses a special hardship and when a variance to it would not endanger the safety or well-being of residents, employees, or the public.
C. Upon finding that the enforcement of one or more of the standards would be clearly impractical, the center shall have the authority to waive, either temporarily or permanently, the enforcement of one or more of these standards, provided safety, resident care and services are not adversely affected.
D. The center may rescind or modify a variance if (i) conditions change; (ii) additional information becomes known which alters the basis for the original decision; (iii) the facility fails to meet any conditions attached to the variance; or (iv) results of the variance jeopardize the safety, comfort, or well-being of residents, employees and the public.
E. Consideration of a variance is initiated when a written request is submitted to the Director of the Center for Quality Health Care Services and Consumer Protection. The center may provide consultation in the development of the written request and throughout the variance process.
F. The request for a variance must describe the special hardship to the existing program or to a planned innovative or pilot program caused by the enforcement of the requirements. When possible, the request should include proposed alternatives to meet the purpose of the requirements which will ensure the protection and well-being of residents, employees, and the public.
G. The center shall notify the facility of the receipt of the request for a variance. The center may attach conditions to the granting of the variance in order to protect persons in care.
H. When the decision is to deny a request for a variance, the reason shall be provided in writing to the licensee.
I. When a variance is denied, expires, or is rescinded, routine enforcement of the standard or portion of the standard shall be resumed. The nursing facility may at any time withdraw a request for a variance.

388-97-0560
Personal property.
(2) The nursing home must:
(a) Not request or require residents to sign waivers of potential liability for losses of personal property; and
(b) Have a system in place to safeguard personal property within the nursing home that protects the personal property and yet allows the resident to use his or her property.

388-97-2500
Resident room size variance.
The director of residential care services, aging and disability services administration, or their designee, may permit exceptions to WAC 388-97-2420 (1)(a) and 388-97-2440(1) when the nursing home demonstrates in writing that the exception:
(1) Is in accordance with the special needs of the resident; and
(2) Will not adversely affect any resident’s health or safety.

WEST VIRGINIA

1.7. Variances From This Rule. 1.7.a. The department may grant a variance from any provision of this rule if it determines that: 1.7.a.1. Strict compliance would impose a substantial hardship on the licensee; 1.7.a.2. The licensee will otherwise meet the goal of the rule; and 1.7.a.3. A variance will not result in less protection of the health, safety and welfare of the residents. 1.7.b. A variance shall not be granted from a provision pertaining to residents’ rights. 1.7.b.1. Separate federal variance procedures may apply for provisions of this rule and are contained in the federal nursing home regulations. 1.7.b.2. Requests for variances from West Virginia fire safety and building construction requirements shall be addressed to the appropriate authorities. 1.8. Enforcement. -- This rule is enforced by the secretary of the Department of Health and Human Resources or his or her lawful designee.

WISCONSIN

HFS 132.21 Waivers and variances. (1) DEFINITIONS.
As used in this section:
(a) "Waiver" means the grant of an exemption from a requirement of this chapter.
(b) "Variance" means the granting of an alternate requirement in place of a requirement of this chapter.
(2) REQUIREMENTS FOR WAIVERS OR VARIANCES. A waiver or variance may be granted if the department finds that the waiver or variance will not adversely affect the health, safety, or welfare of any resident and that:
(a) Strict enforcement of a requirement would result in unreasonable hardship on the facility or on a resident; or  
(b) An alternative to a rule, including new concepts, methods, procedures, techniques, equipment, personnel qualifications, or the conducting of pilot projects, is in the interests of better care or management.

(3) PROCEDURES. (a) Applications. 1. All applications for waiver or variance from the requirements of this chapter shall be made in writing to the department, specifying the following:  
   a. The rule from which the waiver or variance is requested;  
   b. The time period for which the waiver or variance is requested;  
   c. If the request is for a variance, the specific alternative action which the facility proposes;  
   d. The reasons for the request; and  
   e. Justification that sub. (2) would be satisfied.  
2. Requests for a waiver or variance may be made at any time.  
3. The department may require additional information from the facility prior to acting on the request.  
(b) Grants and denials. 1. The department shall grant or deny each request for waiver or variance in writing. Notice of denials shall contain the reasons for denial. If a notice of denial is not issued within 60 days after the receipt of a complete request, the waiver or variance shall be automatically approved.  
2. The terms of a requested variance may be modified upon agreement between the department and a facility.  
3. The department may impose such conditions on the granting of a waiver or variance which it deems necessary.  
4. The department may limit the duration of any waiver or variance.  
(c) Hearings. 1. Denials of waivers or variances may be contested by requesting a hearing as provided by ch. 227, Stats.  
2. The licensee shall sustain the burden of proving that the denial of a waiver or variance was unreasonable.  
(d) Revocation. The department may revoke a waiver or variance if:  
1. It is determined that the waiver or variance is adversely affecting the health, safety or welfare of the residents; or  
2. The facility has failed to comply with the variance as granted; or  
3. The licensee notifies the department in writing that it wishes to relinquish the waiver or variance and be subject to the rule previously waived or varied; or  
4. Required by a change in law.

Wyoming regulations do not contain specific content for Service Waivers and Variances.