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Subpart 1. Health care practitioner. When attending a case, suspected case, carrier, or death from any of the diseases in part 4605.7040 or a pregnancy under part 4605.7044, a health care practitioner shall report to the commissioner according to part 4605.7040 or 4605.7044, unless previously reported, the information specified in part 4605.7090.

Subp. 2. Health care facilities. Hospitals, nursing homes, medical clinics, or other health care facilities shall designate that all individual health care practitioners report as specified in subpart 1; or the health care facility shall designate an infection preventionist or other person as responsible to report to the commissioner, according to part 4605.7040 or 4605.7044, knowledge of a case, suspected case, carrier, or death from any of the diseases and syndromes in part 4605.7040 or a pregnancy under part 4605.7044, and the information specified in part 4605.7090.

Subp. 3. Medical laboratories.

A. All medical laboratories shall provide to the commissioner, within one working day of completion, the results of microbiologic cultures, examinations, immunologic assays for the presence of antigens and antibodies, and any other laboratory tests, which are indicative of the presence of any of the diseases in part 4605.7040 and the information specified in part 4605.7090 as is known.

B. All medical laboratories shall forward to the Minnesota Department of Health, Public Health Laboratory, all clinical materials specified in this chapter upon a positive laboratory finding for the disease or condition, or upon request of the commissioner in relation to a case or suspected case reported under this chapter.

C. All laboratories must report to the Minnesota Department of Health the results of all CD4+ lymphocyte counts and percents and the results of all HIV, hepatitis B, and hepatitis C viral detection laboratory tests.

D. If a medical laboratory forwards clinical materials out of state for testing, the originating medical laboratory retains the duty to comply with this subpart, either by:

1. reporting the results and submitting the clinical materials to the commissioner; or

2. ensuring that the results are reported and materials submitted to the commissioner.

Subp. 4. Comprehensive reports. An institution, facility, or clinic, staffed by health care practitioners and having medical laboratories that are required to report, as in subparts 1, 2, and 3, except subpart 3, item C, may upon written notification to the commissioner designate a single person or group of persons to report cases, suspected cases, carriers,
deaths, or results of medical laboratory cultures, examinations, and assays for any of the
diseases listed in part 4605.7040 or a pregnancy under part 4605.7044 to the commissioner.

Subp. 5. **Veterinarians and veterinary medical laboratories.** The commissioner of
health shall, under the following circumstances, request certain reports of clinical diagnosis
of disease in animals, reports of laboratory tests on animals, and clinical materials from
animals:

A. the disease is common to both animals and humans;

B. the disease may be transmitted directly or indirectly to and between humans
and animals;

C. the persons who are afflicted with the disease are likely to suffer complications,
disability, or death as a result; and

D. investigation based upon veterinarian and veterinary medical laboratory
reports will assist in the prevention and control of disease among humans.

Subp. 6. **Others.** Unless previously reported, it shall be the duty of every other
licensed health care provider who provides care to any patient who has or is suspected
of having any of the diseases listed in part 4605.7040 or a pregnancy under part 4605.7044
to report to the commissioner, according to part 4605.7040 or 4605.7044, as much of the
information specified in part 4605.7090 as is known.

Subp. 7. **Out of state testing.** Persons and entities that are required to report under
subpart 1, 2, or 6 and that send clinical materials out of state for testing are responsible for
ensuring that results are reported and clinical materials are submitted to the commissioner
as required under this chapter.

**Statutory Authority:** *MS s 144.05; 144.072; 144.0742; 144.12; 144.122*

**History:** *9 SR 2584; 20 SR 858; 30 SR 247; 35 SR 1967; 41 SR 829*

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4605.7040 DISEASE AND REPORTS; CLINICAL MATERIALS SUBMISSIONS.

Cases, suspected cases, carriers, and deaths due to the following diseases and infectious agents shall be reported. When submission of clinical materials is required under this part, submissions shall be made to the Minnesota Department of Health, Public Health Laboratory.

A. Diseases reportable immediately by telephone to the commissioner:

   (1) anthrax (Bacillus anthracis). Submit clinical materials;
   (2) botulism (Clostridium botulinum);
   (3) brucellosis (Brucella spp.). Submit clinical materials;
   (4) cholera (Vibrio cholerae). Submit clinical materials;
   (5) diphtheria (Corynebacterium diphtheriae). Submit clinical materials;
   (6) free-living amebic infection (including at least: Acanthamoeba spp., Naegleria fowleri, Balamuthia spp., Sappinia spp). Submit clinical materials;
   (7) hemolytic uremic syndrome. Submit clinical materials;
   (8) measles (rubeola). Submit clinical materials;
   (9) meningococcal disease (Neisseria meningitidis) (all invasive disease). Submit clinical materials;
   (10) Middle East Respiratory Syndrome (MERS). Submit clinical materials;
   (11) orthopox virus. Submit clinical materials;
   (12) plague (Yersinia pestis). Submit clinical materials;
   (13) poliomyelitis. Submit clinical materials;
   (14) Q fever (Coxiella burnetii). Submit clinical materials;
   (15) rabies (animal and human cases and suspected cases);
   (16) rubella and congenital rubella syndrome. Submit clinical materials;
   (17) severe acute respiratory syndrome (SARS). Submit clinical materials;
   (18) smallpox (variola). Submit clinical materials;
   (19) tularemia (Francisella tularensis). Submit clinical materials; and
   (20) viral hemorrhagic fever (including but not limited to Ebola virus disease and Lassa fever). Submit clinical materials.

B. Diseases reportable within one working day:

   (1) amebiasis (Entamoeba histolytica/dispar);
(2) anaplasmosis (Anaplasma phagocytophilum);
(3) arboviral disease, including, but not limited to, La Crosse encephalitis, eastern equine encephalitis, western equine encephalitis, St. Louis encephalitis, West Nile virus disease, Powassan virus disease, and Jamestown Canyon virus disease;
(4) babesiosis (Babesia spp.);
(5) blastomycosis (Blastomyces dermatitidis);
(6) campylobacteriosis (Campylobacter spp.). Submit clinical materials;
(7) carbapenem-resistant Enterobacteriaceae (CRE). Submit clinical materials;
(8) cat scratch disease (infection caused by Bartonella species);
(9) chancroid (Haemophilus ducreyi);
(10) Chikungunya virus disease;
(11) Chlamydia trachomatis infections;
(12) coccidioidomycosis;
(13) Cronobacter sakazakii in infants under one year of age. Submit clinical materials;
(14) cryptosporidiosis (Cryptosporidium spp.). Submit clinical materials;
(15) cyclosporiasis (Cyclospora spp.). Submit clinical materials;
(16) dengue virus infection;
(17) Diphyllobothrium latum infection;
(18) ehrlichiosis (Ehrlichia spp.);
(19) encephalitis (caused by viral agents);
(20) enteric Escherichia coli infection (E. coli O157:H7, other Shiga toxin-producing (enterohemorrhagic) E. coli, enteropathogenic E. coli, enteroinvasive E. coli, enteroaggregative E. coli, enterotoxigenic E. coli, or other pathogenic E. coli). Submit clinical materials;
(21) giardiasis (Giardia intestinalis);
(22) gonorrhea (Neisseria gonorrhoeae infections);
(23) Haemophilus influenzae disease (all invasive disease). Submit clinical materials;
(24) hantavirus infection;
(25) hepatitis (all primary viral types including A, B, C, D, and E);
(26) histoplasmosis (*Histoplasma capsulatum*);
(27) human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS);
(28) influenza (unusual case incidence, critical illness, or laboratory confirmed cases). Submit clinical materials;
(29) Kawasaki disease;
(30) *Kingella* spp. (invasive only). Submit clinical materials;
(31) legionellosis (*Legionella* spp.). Submit clinical materials;
(32) leprosy (Hansen's disease) (*Mycobacterium leprae*);
(33) leptospirosis (*Leptospira interrogans*);
(34) listeriosis (*Listeria monocytogenes*). Submit clinical materials;
(35) Lyme disease (*Borrelia burgdorferi* and other *Borrelia* spp.);
(36) malaria (*Plasmodium* spp.);
(37) meningitis (caused by viral agents);
(38) mumps. Submit clinical materials;
(39) neonatal sepsis (bacteria isolated from a sterile site, excluding coagulase-negative *Staphylococcus*) less than seven days after birth. Submit clinical materials;
(40) pertussis (*Bordetella pertussis*). Submit clinical materials;
(41) psittacosis (*Chlamydophila psittaci*);
(42) retrovirus infections;
(43) salmonellosis, including typhoid (*Salmonella* spp.). Submit clinical materials;
(44) shigellosis (*Shigella* spp.). Submit clinical materials;
(45) Spotted fever rickettsiosis (*Rickettsia* spp. infections, including Rocky Mountain spotted fever);
(46) *Staphylococcus aureus* (only vancomycin-intermediate *Staphylococcus aureus* (VISA), vancomycin-resistant *Staphylococcus aureus* (VRSA), and death or critical illness due to community-associated *Staphylococcus aureus* in a previously healthy individual). Submit clinical materials;
(47) streptococcal disease (all invasive disease caused by Groups A and B streptococci and S. pneumoniae [including urine antigen laboratory-confirmed pneumonia]). Except for urine, submit clinical materials;

(48) syphilis (Treponema pallidum);

(49) tetanus (Clostridium tetani);

(50) toxic shock syndrome. Submit clinical materials;

(51) toxoplasmosis (Toxoplasma gondii);

(52) transmissible spongiform encephalopathy;

(53) trichinosis (Trichinella spiralis);

(54) tuberculosis (Mycobacterium tuberculosis complex) (pulmonary or extrapulmonary sites of disease, including clinically diagnosed disease). Latent tuberculosis infection is not reportable. Submit clinical materials;

(55) typhus (Rickettsia spp.);

(56) varicella (chickenpox). Submit clinical materials;

(57) Vibrio spp. Submit clinical materials;

(58) yellow fever;

(59) yersiniosis, enteric (Yersinia spp.). Submit clinical materials;

(60) zika virus disease; and

(61) zoster (shingles) (all cases <18 years old; other unusual case incidence or complications regardless of age). Submit clinical materials.

Statutory Authority: MS s 144.05; 144.072; 144.0742; 144.12; 144.122

History: 9 SR 2584; 20 SR 858; 30 SR 247; 41 SR 829

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4658.4540 LAUNDRY AREA; NEW CONSTRUCTION.
4658.4545 MECHANICAL ROOMS; NEW CONSTRUCTION.
4658.4550 FILTERS; NEW CONSTRUCTION.
4658.4590 PENALTIES FOR MECHANICAL SYSTEMS; NEW CONSTRUCTION RULE VIOLATIONS.

ELECTRICAL SYSTEMS; NEW CONSTRUCTION

4658.4600 DISTRIBUTION PANEL BOARDS; NEW CONSTRUCTION.
4658.4605 CORRIDOR RECEPTACLES; NEW CONSTRUCTION.
4658.4610 SWITCHES AND RECEPTACLES; NEW CONSTRUCTION.
4658.4615 INTERIOR LIGHTING; NEW CONSTRUCTION.
4658.4620 FIRE ALARM SYSTEMS; NEW CONSTRUCTION.
4658.4625 BEDROOM RECEPTACLES; NEW CONSTRUCTION.
4658.4630 NIGHT LIGHTS; NEW CONSTRUCTION.
4658.4635 NURSE CALL SYSTEM; NEW CONSTRUCTION.
4658.4640 EMERGENCY ELECTRIC SERVICE; NEW CONSTRUCTION.
4658.4690 PENALTIES FOR ELECTRICAL SYSTEMS; NEW CONSTRUCTION RULE VIOLATIONS.

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4658.5000 BEDROOM DESIGN, EXISTING CONSTRUCTION.
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4658.5025 TOILET ROOMS AND SANITARY FIXTURES; EXISTING CONSTRUCTION.
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4658.5035 HANDWASHING FACILITIES; EXISTING CONSTRUCTION.
4658.5040 ROOM LABELING; EXISTING CONSTRUCTION.
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4658.5090 PENALTIES FOR RESIDENT AREAS; EXISTING CONSTRUCTION RULE VIOLATIONS.

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4658.5100 DINING, DAYROOM, AND ACTIVITY AREAS; EXISTING CONSTRUCTION.
4658.5190 PENALTIES FOR SUPPORTIVE SERVICES; EXISTING CONSTRUCTION RULE VIOLATIONS.

DIETARY, LAUNDRY, AND OTHER FACILITIES;
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4658.5200 FOOD SERVICE EQUIPMENT; EXISTING CONSTRUCTION.
4658.5205 LAUNDRY; EXISTING CONSTRUCTION.
4658.5210 SOILED LINEN COLLECTION ROOM; EXISTING CONSTRUCTION.
4658.5215 LAUNDRY EQUIPMENT; EXISTING CONSTRUCTION.
4658.5220 CLEAN LINEN STORAGE; EXISTING CONSTRUCTION.
4658.5225 LAUNDRY FOR PERSONAL CLOTHING; EXISTING CONSTRUCTION.
4658.5230 REFUSE; EXISTING CONSTRUCTION.
4658.5235 FACILITIES FOR PERSONNEL; EXISTING CONSTRUCTION.
4658.5240 REHABILITATIVE SERVICES AREAS; EXISTING CONSTRUCTION.
4658.5245 BARBER AND BEAUTY SHOP SERVICES ROOM; EXISTING CONSTRUCTION.
4658.5290 PENALTIES FOR DIETARY, LAUNDRY, AND OTHER SERVICES; EXISTING CONSTRUCTION RULE VIOLATIONS.

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4658.5300 AREA HEAT PROTECTION; EXISTING CONSTRUCTION.
4658.5305 NONSKID SURFACES; EXISTING CONSTRUCTION.
4658.5310 GLASS PROTECTION; EXISTING CONSTRUCTION.
4658.5315 CEILINGS, WALLS, AND FLOORS; EXISTING CONSTRUCTION.
4658.5390 PENALTIES FOR CONSTRUCTION DETAILS; EXISTING CONSTRUCTION RULE VIOLATIONS.

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4658.5400 HEATING SYSTEM; EXISTING CONSTRUCTION.
4658.5405 VENTILATION REQUIREMENTS; EXISTING CONSTRUCTION.
4658.5410 MECHANICAL ROOMS; EXISTING CONSTRUCTION.
4658.5415 FILTERS; EXISTING CONSTRUCTION.
4658.5490 PENALTIES FOR HEATING AND VENTILATION SYSTEMS; EXISTING CONSTRUCTION RULE VIOLATIONS.

ELECTRICAL SYSTEMS; EXISTING CONSTRUCTION
4658.5500 DISTRIBUTION PANEL BOARDS; EXISTING CONSTRUCTION.
4658.5505 INTERIOR LIGHTING; EXISTING CONSTRUCTION.
4658.5510 FIRE ALARM SYSTEMS; EXISTING CONSTRUCTION.
4658.5515 NURSE CALL SYSTEM; EXISTING CONSTRUCTION.
4658.5520 EMERGENCY ELECTRIC SERVICE; EXISTING CONSTRUCTION.
4658.5590 PENALTIES FOR ELECTRICAL SYSTEMS; EXISTING CONSTRUCTION RULE VIOLATIONS.
LICENSING

4658.0010 DEFINITIONS.

Subpart 1. Scope. The terms used in parts 4658.0010 to 4658.5590 have the meanings given them in this part.

Subp. 1a. Addition of new resident services. "Addition of new resident services" means the commencement of a resident service, such as physical or occupational therapy, that is not being provided for the residents as of November 12, 1996.

Subp. 1b. Changes in existing resident services. "Changes in existing resident services" means the conversion of existing facility space used for resident services from one function to another function.

Subp. 2. Convalescent and nursing care (C&NC) unit. "Convalescent and nursing care (C&NC) unit" means a nursing home unit operated in conjunction with a hospital where there is a direct physical connection between the unit and the hospital which permits the movement of the residents and the provision of services without going outside the building or buildings involved. The units are subject to this chapter.

Subp. 3. Department. "Department" means the Minnesota Department of Health.

Subp. 4. Existing facility. "Existing facility" means a licensed nursing home or nursing home space that was in place before November 13, 1995. All existing facilities will be deemed to be in substantial compliance with the physical plant requirements for new construction, except as noted in this chapter. Existing facilities must, at a minimum, maintain compliance with the rules applicable at the time of their construction.

Subp. 4a. Food service equipment. "Food service equipment" means all machinery, appliances, equipment, or supplies which are used in the storage, preparation, or serving of food as part of the nursing home's food service program.

Subp. 4b. Food storage equipment. "Food storage equipment" means food service equipment that is used in the cold and dry storage of food and supplies as part of the nursing home's food service program.

Subp. 5. Licensee. "Licensee" means the person or governing body to whom the license is issued. The licensee is responsible for compliance with this chapter.

Subp. 5a. New construction. "New construction" means any addition to, or replacement of, a nursing home after November 12, 1996, that results in new facility space for the operation of the nursing home. The term new construction as used in this chapter includes the erection of new facility space, addition to existing facility space, and any existing facility space converted in order to be licensed under this chapter.

Subp. 6. Nurse. "Nurse" means a registered nurse or a licensed practical nurse licensed by the Minnesota Board of Nursing, or exempt from licensure and practicing in accordance with Minnesota Statutes, sections 148.171 to 148.285.

Subp. 7. Nurse practitioner. "Nurse practitioner" means a registered nurse who has graduated from a program of study designed to prepare a registered nurse for advanced practice as a nurse practitioner and who is certified through a national professional nursing organization listed in part 6330.0350.

Subp. 7a. Nursing area. "Nursing area" means an area within the nursing home that is served by a single nurses' station.
Subp. 8. Nursing assistant. "Nursing assistant" means a nursing home employee who is assigned by the director of nursing services to provide or assist in the provision of nursing or nursing-related services under the supervision of a registered nurse. Nursing assistant includes nursing assistants employed by nursing pool companies but does not include a licensed health professional.

Subp. 9. Nursing care. "Nursing care" has the meaning given it in Minnesota Statutes, section 144A.01, subdivision 6.

Subp. 10. Nursing home. "Nursing home" has the meaning given it in Minnesota Statutes, section 144A.01, subdivision 5.

Subp. 11. Nursing personnel. "Nursing personnel" means registered nurses, licensed practical nurses, and nursing assistants.

Subp. 12. Physician. "Physician" means a person licensed by the Minnesota Board of Medical Practice, or exempt from licensure, and practicing in accordance with Minnesota Statutes, chapter 147.

Subp. 13. Physician designee. "Physician designee" means a nurse practitioner or physician assistant who has been authorized in writing by the physician to perform medical functions.

Subp. 13a. Redecoration. "Redecoration" means the repainting of walls or ceilings, or the covering or recovering of walls, ceilings, or floors with suitable interior finishing materials.

Subp. 13b. Remodel. "Remodel" means reconstruction of existing facility space, including floors, walls, and ceilings. Remodel includes reconstruction work necessary to change the function of the facility space or to facilitate a change in operating capability or physical composition of existing equipment, fixtures, or appurtenances.

Subp. 13c. Replace-in-kind. "Replace-in-kind" means the removal of mechanical or electrical equipment or construction materials from facility space and subsequent installation of new or used equipment or construction materials with similar operating capability, function, and physical composition.


Subp. 14a. Room. "Room" means a space within the facility that has access to the corridor and is totally enclosed with permanently constructed full height walls.


Subp. 15. Time periods. "Time periods" means the minimum and maximum time allowed to complete an activity. For purposes of this chapter, time periods means:

A. "Weekly" means a time period which requires an activity to be completed at least 52 times a year within intervals ranging from six to eight days.

B. "Monthly" means a time period which requires an activity to be completed at least 12 times a year within intervals ranging from 27 to 33 days.

C. "Quarterly" means a time period which requires an activity to be performed at least four times a year within intervals ranging from 81 to 99 days.

Subp. 16. Volunteer. "Volunteer" means a person who, without monetary or other compensation, provides services to residents or to the nursing home.
4658.0015 COMPLIANCE WITH REGULATIONS AND STANDARDS.

A nursing home must operate and provide services in compliance with all applicable federal, state, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in a nursing home.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303; 21 SR 196
Published Electronically: October 11, 2007

4658.0020 LICENSING IN GENERAL.

Subpart 1. Required. For the purpose of this chapter, a state license is required for a facility where nursing home care is provided for five or more aged or infirm persons who are not acutely ill.

Subp. 2. License fees. Each application for either an initial or renewal license to operate a nursing home must be accompanied by a fee based upon the formula as provided by Minnesota Statutes, section 144.122. A bed must be licensed if it is available for use by residents. If the number of licensed beds is increased during the term of the license, a full year's fee for each additional bed must be paid. There is no refund for a decrease in licensed beds.

Subp. 3. License expiration date. Initial and renewal licenses are issued for one year and expire on the anniversary date of issuance. A license renewal must be applied for on an annual basis.

Subp. 4. License to be posted. The license must be posted at the main entrance of a nursing home.

Subp. 5. Separate licenses. Separate licenses are required for institutions maintained on separate, noncontiguous premises even though operated under the same management. A separate license is not required for separate buildings maintained by the same owner on the same premises.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: October 11, 2007

4658.0025 PROCEDURES FOR LICENSING NURSING HOMES.

Subpart 1. Initial licensure. For the purpose of this part, initial licensure applies to newly constructed facilities designed to operate as a nursing home and to other facilities not already licensed as a nursing home. Applicants for initial licensure must complete the license application form supplied by the department. An application for initial licensure must be submitted at least 90 days before the requested date for licensure and must be accompanied by a license fee based upon the formula as provided by Minnesota Statutes, section 144.122.
To be issued a license, an applicant must file with the department a current copy of the architectural and engineering plans and specifications of the facility as prepared and certified by an architect or engineer registered to practice in Minnesota.

If the applicant for licensure is a corporation, it must submit with the application a copy of its articles of incorporation and bylaws. A foreign corporation must also submit a copy of its certificate of authority to do business in Minnesota. The department will issue the initial license as of the date the department determines that the nursing home is in compliance with parts 4655.0090 to 4655.9342, 4658.0010 to 4658.1365, 4660.0090 to 4660.9940, and Minnesota Statutes, sections 144A.01 to 144A.16, unless the applicant requests a later date.

Subp. 2. Renewed licenses. An applicant for license renewal must complete the license application form supplied by the department. An application must be submitted at least 60 days before the expiration of the current license and must be accompanied by a license fee based upon the formula as provided by Minnesota Statutes, section 144.122. The department will issue a renewed license if a nursing home continues to satisfy the requirements of parts 4655.0090 to 4655.9342, 4658.0010 to 4658.1365, 4660.0100 to 4660.9940, and Minnesota Statutes, sections 144A.01 to 144A.16.

If the licensee is a corporation, it must submit any amendments to its articles of incorporation or bylaws with the renewal application.

If the renewal application specifies a different licensed capacity from that provided on the current license, the licensee must comply with subpart 6. If the changes are not approved before the current license expires, the renewed license will be issued without reflecting the requested changes.

Subp. 3. Transfer of interest; notice. A controlling person, as defined in Minnesota Statutes, section 144A.01, subdivision 4, who transfers a beneficial interest in the nursing home must notify the department, in writing, at least 14 days before the date of the transfer. The written notice must contain the name and address of the transferor, the name and address of the transferee, the nature and amount of the transferred interests, and the date of the transfer.

Subp. 4. Transfer of interest; expiration of license. A transfer of a beneficial interest will result in the expiration of the nursing home's license:

A. If the transferred beneficial interest exceeds ten percent of the total beneficial interest in the licensee, in the structure in which the nursing home is located, or in the land upon which the nursing home is located, and if, as the result of the transfer, the transferee then possesses a beneficial interest in excess of 50 percent of the total beneficial interest in the licensee, in the structure in which the nursing home is located, or in the land upon which the nursing home is located; or

B. If the transferred beneficial interest exceeds 50 percent of the total beneficial interest in the licensee, in the structure in which the nursing home is located, or in the land upon which the nursing home is located.

Under either of these conditions, the nursing home license expires at the time of relicensure, 90 days after the date of the transfer, or 90 days after the date when notice of transfer is received, whichever date is later. If the current license expires before the end of the 90-day period, the licensee must apply for a renewed license in accordance with subpart 2. The department must notify the licensee by certified mail at least 60 days before the license expires.

Subp. 5. Transfer of interest; relicensure. A controlling person may apply for relicensure by submitting the license application form at least 60 days before the license expiration date. Application for
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relicensure must be accompanied by a license fee based upon the formula as provided by Minnesota Statutes, section 144.122. Payment of any outstanding penalty assessments must be submitted before the application for relicensure may be acted upon by the department. If the applicant for relicensure is a corporation, it must submit a copy of its current articles of incorporation and bylaws with the license application. A foreign corporation must also submit a copy of its certificate of authority to do business in Minnesota. The department will relicense the nursing home as of the date the commissioner determines that the prospective licensee complies with parts 4655.0090 to 4655.9342, 4658.0010 to 4658.1365, 4660.0100 to 4660.9940, and Minnesota Statutes, sections 144A.01 to 144A.16, unless the applicant requests a later date. The former licensee remains responsible for the operation of the nursing home until the nursing home is relicensed.

Subp. 6. Amendment to the license. If the nursing home requests a change in its licensed capacity or in its license classification, it must submit the request on the application for amendments to the license. This application must be submitted at least 30 days before the requested date of change and if an increase in the number of licensed beds is requested, accompanied by a fee based upon the formula as provided by Minnesota Statutes, section 144.122. The department will amend the license as of the date the department determines that the nursing home is in compliance with parts 4655.0090 to 4655.9342, 4658.0010 to 4658.1365, 4660.0100 to 4660.9940, and Minnesota Statutes, sections 144A.01 to 144A.16, unless a later date is requested by the licensee. The amendment to a license is effective for the remainder of the nursing home's licensure year.

Subp. 7. Issuing conditions or limitations on the license. The department must attach to the license any conditions or limitations necessary according to subpart 8 to assure compliance with the laws and rules governing the operation of the nursing home or to protect the health, treatment, safety, comfort, and well-being of the nursing home residents. A condition or limitation may be attached to a license at any time.

Subp. 8. Reasons for conditions or limitations. In deciding to condition or limit a license the department must consider:

A. the nature and number of correction orders or penalty assessments issued to the nursing home or to other nursing homes having some or all of the same controlling persons;
B. the permitting, aiding, or abetting of the commission of any illegal act in the nursing home by any of the controlling persons or employees of the nursing home;
C. the performance of any acts contrary to the welfare of the residents in a nursing home by a controlling person or employee;
D. the condition of the physical plant or physical environment;
E. the existence of any outstanding variances or waivers; or
F. the number or types of residents the nursing home is able to provide for.

Subp. 9. Types of conditions or limitations. The department must impose one or more of the following conditions or limitations for reasons determined under subpart 8:

A. restrictions on the number or types of residents to be admitted or permitted to remain in the nursing home;
B. restrictions on the inclusion of specified individuals as controlling persons or managerial employees; or
C. imposition of schedules for the completion of specified activities.
Subp. 10. **Statement of conditions or limitations.** The department must notify the applicant or licensee, in writing, of its decision to issue a conditional or limited license. The department must inform the applicant or licensee of the reasons for the condition or limitation and of the right to appeal.

Unless otherwise specified, a condition or limitation remains valid as long as the licensee of the nursing home remains unchanged or as long as the reason for the condition or limitation exists. The licensee must notify the department when the reasons for the condition or limitation no longer exist. If the department determines that the condition or limitation is no longer required, it will be removed from the license.

The existence of a condition or limitation must be noted on the face of the license. If the condition or limitation is not fully stated on the license, the department’s licensure letter containing the full text of the condition or limitation must be posted alongside the license in an accessible and visible location.

Subp. 11. **Effect of a condition or limitation.** A condition or limitation has the force of law. If a licensee fails to comply with a condition or limitation, the department may issue a correction order or assess a fine or it may suspend, revoke, or refuse to renew the license in accordance with Minnesota Statutes, section 144A.11.

If the department assesses a fine, the fine is $250. The fine accrues on a daily basis according to Minnesota Statutes, section 144A.10.

Subp. 12. **Appeal procedure.** The applicant or licensee may contest the issuance of a conditional or limited license by requesting a contested case proceeding under the Administrative Procedure Act, Minnesota Statutes, sections 14.57 to 14.69, within 15 days after receiving the notification described in subpart 10. The request for a hearing must set out in detail the reasons why the applicant contends that a conditional or limited license should not be issued.

Subp. 13. **License application forms.** The department will furnish the applicant or the licensee with the necessary forms to obtain initial or renewed licensure or to request relicensure of the nursing home after a transfer of interest. The license forms must require that the information described in subparts 14 to 16 be provided.

Subp. 14. **General information.** General information means:

A. the name, address, and telephone number of the nursing home;
B. the name of the county in which the nursing home is located;
C. the legal property description of the land upon which the nursing home is located;
D. the licensed bed capacity;
E. the designation of the classification of ownership, for example, state, county, city, city and county, hospital district, federal, corporation, nonprofit corporation, partnership, sole proprietorship, or other entity;
F. the name and address of the controlling person or managerial employee who will be responsible for communicating with the commissioner of health on all matters relating to the nursing home license and on whom personal service of all notices and orders will be served; and
G. the location and square footage of the floor space constituting the facility.

Subp. 15. **Disclosure of controlling persons.** According to Minnesota Statutes, section 144A.03, the nursing home license application must identify the name and address of all controlling persons of the nursing home, as defined in Minnesota Statutes, section 144A.01, subdivision 4.
Subp. 16. **Disclosure of managerial employees.** A nursing home license application must identify the name and address of all administrators, assistant administrators, directors of nursing, medical directors, and all other managerial employees, as defined in Minnesota Statutes, section 144A.01, subdivision 8, and indicate their previous work experience in nursing homes during the past two years.

**Statutory Authority:** MS s 144A.04; 144A.08; 256B.431  
**History:** 20 SR 303  
**Published Electronically:** October 2, 2013

**4658.0030 CAPACITY PRESCRIBED.**

Each license must specify the maximum allowable number of residents to be cared for at any one time. No number of residents in excess of that number may reside in the nursing home. The maximum number of licensed beds is determined by the amount of space that is available in the facility as specified in chapter 4660.

**Statutory Authority:** MS s 144A.04; 144A.08; 256B.431  
**History:** 20 SR 303  
**Published Electronically:** October 11, 2007

**4658.0035 EVALUATION.**

A nursing home is subject to evaluation and approval by the department of the nursing home's physical plant and its operational aspects before a change in ownership, classification, capacity, or an addition of services which necessitates a change in the nursing home's physical plant.

**Statutory Authority:** MS s 144A.04; 144A.08; 256B.431  
**History:** 20 SR 303  
**Published Electronically:** October 11, 2007

**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.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.0045 PENALTIES FOR LICENSING RULE VIOLATIONS.

Penalty assessments will be assessed on a daily basis for violations of parts 4658.0010 to 4658.0035 and are as follows:

A. part 4658.0020, subparts 1, 2, and 3, $250;

B. part 4658.0020, subparts 4 and 5, $50;

C. part 4658.0025, $250;

D. part 4658.0030, $100; and
ADMINISTRATION AND OPERATIONS

4658.0050 LICENSEE.

Subpart 1. General duties. The licensee of a nursing home is responsible for its management, control, and operation. A nursing home must be managed, controlled, and operated in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Subp. 2. Specific duties. The licensee must develop written bylaws or policies for the management and operation of the nursing home and for the provision of resident care, which must be available to all members of the governing body, and must assume legal responsibility for matters under its control, for the quality of care rendered and for compliance with laws and rules relating to the safety and sanitation of nursing homes, or which otherwise relate directly to the health, welfare, and care of residents.

Subp. 3. Responsibilities. A licensee is responsible for the duties in items A to F.

A. Full disclosure of each person having an interest of ten percent or more of the ownership of the home to the department with any change reported in writing within 14 days after the licensee knew of or should have known of the transfer, whichever occurs first. In case of corporate ownership, the name and address of each officer and director must be specified. If the home is organized as a partnership, the name and address of each partner must be furnished. In the case of a home operated by a lessee, the persons or business entities having an interest in the lessee organization must be reported and an executed copy of the lease agreement furnished. If the home is operated by the holder of a franchise, disclosure must be made as to the franchise holder who must also furnish an executed copy of the franchise agreement.

B. Appointment of a licensed nursing home administrator who is responsible for the operation of the home in accordance with law and established policies and whose authority to serve as administrator is delegated in writing.

C. Notification of the termination of service of the administrator and the appointment of a replacement within five working days in writing to the department. If a licensed nursing home administrator is not available to assume the position immediately, notification to the department must include the name of the person temporarily in charge of the home. The governing body of a nursing home must not employ an individual as the permanent administrator until it is determined that the individual qualifies for licensure as a nursing home administrator in Minnesota under Minnesota Statutes, section 144A.04. The governing body of the nursing home must not employ an individual as an acting administrator or person temporarily in charge for more than 30 days unless that individual has secured an acting administrator license, as required by Minnesota Statutes, section 144A.27.

D. Provision of an adequate and competent staff and maintenance of professional standards in the care of residents and operation of the nursing home.

E. Provision of facilities, equipment, and supplies for care consistent with the needs of the residents.
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F. Provision of evidence of adequate financing, proper administration of funds, and the maintenance of required statistics. A nursing home must have financial resources at the time of initial licensure to permit full service operation of the nursing home for six months without regard to income from resident fees.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: October 2, 2013

4658.0055 ADMINISTRATOR.

Subpart 1. Designation. A nursing home must designate a licensed nursing home administrator to be in immediate charge of the operation and administration of the nursing home, whether that individual is the licensee or a person designated by the licensee. The individual must have authority to carry out the provisions of this chapter and must be charged with the responsibility of doing so.

Subp. 2. [Repealed, L 2001 c 69 s 2]

Subp. 3. Administrator's absence; requirements. The administrator must not leave the premises without delegating authority to a person who is at least 21 years of age and capable of acting in an emergency and without giving information as to where the administrator can be reached. At no time may a nursing home be left without competent supervision. The person left in charge must have the authority to act in an emergency.

Subp. 4. Notice of person in charge. The name of the person in charge at the time must be posted at the main entrance of the nursing home.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303; L 2001 c 69 s 2
Published Electronically: October 11, 2007

4658.0060 RESPONSIBILITIES OF ADMINISTRATOR.

The administrator is responsible for the:

A. maintenance, completion, and submission of reports and records as required by the department;

B. formulation of written policies, procedures, and programs for operation, management, and maintenance of the nursing home;

C. current personnel records for each employee according to part 4658.0130;

D. written job descriptions for all positions which define responsibilities, duties, and qualifications that are readily available for all employees;

E. work assignments consistent with qualifications and the work load;

F. maintenance of a weekly time schedule which shows each employee's name, job title, hours of work, and days off for each day of the week. The schedule must be dated and communicated to employees. The schedules and time cards, payroll records, or other written documentation of actual time worked and paid for must be kept on file in the home for three years;
G. orientation for new employees and volunteers and provision of a continuing in-service education program for all employees and volunteers to give assurance that they understand the proper method of carrying out all procedures;

H. establishment of a recognized accounting system; and

I. the development and maintenance of channels of communications with employees, including:

1. distribution of written personnel policies to employees;
2. regularly scheduled meetings of supervisory personnel;
3. an employee suggestion system; and
4. employee evaluation.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.0065 RESIDENT SAFETY AND DISASTER PLANNING.

Subpart 1. Safety program. A nursing home must develop and implement an organized safety program in accordance with a written safety plan. The written plan must be included in the orientation and in-service training programs of all employees and volunteers to ensure safety of residents at all times.

Subp. 2. Security of physical plant. A nursing home must have a method of ensuring the security of exit doors leading directly to the outside which are not under direct observation from the nurses’ station.

Subp. 3. Written disaster plan. A nursing home must have a written disaster plan specific to the nursing home with procedures for the protection and evacuation of all persons in the case of fire or explosion or in the event of floods, tornadoes, or other emergencies. The plan must include information and procedures about the location of alarm signals and fire extinguishers, frequency of drills, assignments of specific tasks and responsibilities of the personnel on each shift, persons and local emergency departments to be notified, precautions and safety measures during tornado alerts, procedures for evacuation of all persons during fire or floods, planned evacuation routes from the various floor areas to safe areas within the building, or from the building when necessary, and arrangements for temporary emergency housing in the community in the event of total evacuation.

Subp. 4. Availability of disaster plan. Copies of the disaster plan containing the basic emergency procedures must be posted at all nurses' stations, kitchens, laundries, and boiler rooms. Complete copies of the detailed disaster plan must be available to all supervisory personnel.

Subp. 5. Drills. Residents do not need to be evacuated during a drill except when an evacuation drill is planned in advance.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007
4658.0070 QUALITY ASSESSMENT AND ASSURANCE COMMITTEE.

A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

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4658.0075 OUTSIDE RESOURCES.

If a nursing home does not employ a qualified professional person to furnish a specific service to be provided by the nursing home, the nursing home must have that service furnished to residents under a written agreement with a person or agency outside the nursing home. The written agreement must specify that the service meets professional standards and principles that apply to professionals providing services in a nursing home, and that the service meets the same standards as required by this chapter.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.0085 NOTIFICATION OF CHANGE IN RESIDENT HEALTH STATUS.

A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for:

A. an accident involving the resident which results in injury and has the potential for requiring physician intervention;

B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;

C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;

D. a decision to transfer or discharge the resident from the nursing home; or

E. expected and unexpected resident deaths.
4658.0090 USE OF OXYGEN.

A nursing home must develop and implement policies and procedures for the safe storage and use of oxygen.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.0095 AVAILABILITY OF LICENSING RULES.

A copy of this chapter must be made available by a nursing home upon request for the use of all nursing home personnel, residents, and family members.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.0100 EMPLOYEE ORIENTATION AND IN-SERVICE EDUCATION.

Subpart 1. Orientation and initial training. All personnel must be instructed in the requirements of the law and the rules pertaining to their respective duties and the instruction must be documented. All personnel must be informed of the policies of the nursing home, and procedure manuals must be readily available to guide them in the performance of their duties.

Subp. 2. In-service education. A nursing home must provide in-service education. The in-service education must be sufficient to ensure the continuing competence of employees, must address areas identified by the quality assessment and assurance committee, and must address the special needs of residents as determined by the nursing home staff. A nursing home must provide an in-service training program in rehabilitation for all nursing personnel to promote ambulation; aid in activities of daily living; assist in activities, self-help, maintenance of range of motion, and proper chair and bed positioning; and in the prevention or reduction of incontinence.

Subp. 3. Reference materials. Textbooks, periodicals, dictionaries, and other reference materials must be available and kept current. A nursing home must review the currency of these reference materials at least annually.

Subp. 4. Coordination of in-service education programs. In a nursing home with over 90 beds, one person must be designated as responsible for coordination of all in-service education programs.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007
4658.0105 COMPETENCY.

A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.0110 INCIDENT AND ACCIDENT REPORTING.

All persons providing services in a nursing home must report any accident or injury to a resident, and the nursing home must immediately complete a detailed incident report of the accident or injury and the action taken after learning of the accident or injury.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.0115 WORK PERIOD.

A nursing home must not schedule a person to duty for more than one consecutive work period except in a documented emergency. For purposes of this chapter, a documented emergency means situations where replacement staff are not able to report to duty for the next shift due to adverse weather conditions, natural disasters, illness, strike, or other documented situations where normally scheduled staff are no longer available. For purposes of this chapter, a normal work period must not exceed 12 hours. For purposes of this chapter, documentation of an emergency means a written record of the emergency. Documentation on the work schedule is one method of providing written record of the emergency.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.0120 EMPLOYEE POLICIES.

Subpart 1. Keys. The person in charge of a nursing home on each work shift must have the ability to open all doors and locks in the nursing home except the business office.

Subp. 2. Requirements for staff. A nursing home must have at least one responsible person awake, dressed, and on duty at all times. The person must be at least 21 years of age and capable of performing the required duties of evacuating the residents.

Subp. 3. Identification of staff. Each employee and volunteer must wear a badge which includes name and position.
4658.0125 PERSONAL BELONGINGS.

Personnel must not keep personal belongings in the food service or resident areas. Provision must be made elsewhere for storage.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: October 11, 2007

4658.0130 EMPLOYEES' PERSONNEL RECORDS.

A current personnel record must be maintained for each employee and be stored in a confidential manner. The personnel records for at least the most recent three-year period must be maintained by the nursing home. The records must be available to representatives of the department and must contain:

A. the person's name, address, telephone number, gender, Minnesota license, certification, or registration number, if applicable, and similar identifying data;
B. a list of the individual's training, experience, and previous employment;
C. the date of employment, type of position currently held, hours of work, and attendance records; and
D. the date of resignation or discharge.

Employee health information, including the record of all accidents and those illnesses reportable under part 4605.7040, must be maintained and stored in a separate employee medical record.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: October 11, 2007

4658.0135 POLICY RECORDS.

Subpart 1. Availability of policies. All policies and procedures directly related to resident care adopted by the home must be placed on file and be made available upon request to nursing home personnel, residents, legal representatives, and designated representatives.

Subp. 2. Admission policies. Admission policies must be made available upon request to prospective residents, family members, legal representatives, and designated representatives.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: October 11, 2007
4658.0140 TYPE OF ADMISSIONS.

Subpart 1. Selection of residents. The administrator, in cooperation with the director of nursing services and the medical director, is responsible for the admission of residents to the home according to the admission policies of the nursing home.

Subp. 2. Residents not accepted. Unless otherwise provided by law, including laws against discrimination, residents must not be admitted or retained for whom care cannot be provided in keeping with their known physical, mental, or behavioral condition. Prospective residents who are denied admission must be informed of the reason for the denial of their admission.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: October 11, 2007

4658.0145 AGREEMENT AS TO RATES AND CHARGES.

Subpart 1. Written agreement. At the time of admission, there must be a written agreement between the nursing home and the resident, the resident's agent, or the resident's guardian, which includes:

A. the base rate and what services and items are provided by the nursing home and are included in that base rate;
B. extra charges for care or services;
C. obligations concerning payment of the rates and charges; and
D. the refund policy of the home.

All residents' bills must be itemized for services rendered.

Subp. 2. Notification of rates and charges. Annually, and when there is any change, a nursing home must inform the resident of services available in the nursing home and of charges for those services, including any charges for services not covered under Medicare or Medicaid or by the nursing home's per diem rate. A nursing home must inform the resident or the resident's agent or guardian before any change in the charges for services not covered under Medicare or Medicaid or by the nursing home's per diem rate.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: October 11, 2007

4658.0150 INSPECTION BY DEPARTMENT.

All areas of a nursing home and all records related to the care and protection of residents including resident and employee records must be open for inspection by the department at all times for the purposes of enforcing this chapter.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: October 11, 2007
4658.0155 REPORTS TO DEPARTMENT.

Reports regarding statistical data and services furnished must be submitted on forms furnished by the department. Copies must be retained by the nursing home.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

PENALTIES

4658.0190 PENALTIES FOR ADMINISTRATION AND OPERATIONS RULE VIOLATIONS.

Penalty assessments will be assessed on a daily basis for violations of parts 4658.0050 to 4658.0155 and are as follows:

A. part 4658.0050, subpart 1, $250;
B. part 4658.0050, subpart 2, $100;
C. part 4658.0050, subpart 3, item A, $250;
D. part 4658.0050, subpart 3, items B to F, $100;
E. part 4658.0055, subparts 1 to 3, $100;
F. part 4658.0055, subpart 4, $50;
G. part 4658.0060, items A, F, H, and I, $50;
H. part 4658.0060, items B, C, D, E, and G, $100;
I. part 4658.0065, $200;
J. part 4658.0070, $100;
K. part 4658.0075, $100;
L. part 4658.0085, $350;
M. part 4658.0090, $500;
N. part 4658.0095, $50;
O. part 4658.0100, subparts 1 and 2, $100;
P. part 4658.0100, subpart 3, $50;
Q. part 4658.0100, subpart 4, $300;
R. part 4658.0105, $300;
S. part 4658.0110, $100;
T. part 4658.0115, $100;
U. part 4658.0120, subpart 1, $100;
V. part 4658.0120, subpart 2, $500;
W. part 4658.0120, subpart 3, $50;
4658.0191 PENALTIES FOR VIOLATIONS OF RESIDENTS' BILL OF RIGHTS.

Penalty assessments for violations of Minnesota Statutes, section 144.651, are as follows:

A. Minnesota Statutes, section 144.651, subdivision 4, $100;
B. Minnesota Statutes, section 144.651, subdivision 5, $250;
C. Minnesota Statutes, section 144.651, subdivision 6, $250;
D. Minnesota Statutes, section 144.651, subdivision 7, $100;
E. Minnesota Statutes, section 144.651, subdivision 8, $100;
F. Minnesota Statutes, section 144.651, subdivision 9, $250;
G. Minnesota Statutes, section 144.651, subdivision 10, $250;
H. Minnesota Statutes, section 144.651, subdivision 11, $100;
I. Minnesota Statutes, section 144.651, subdivision 12, $250;
J. Minnesota Statutes, section 144.651, subdivision 13, $500;
K. Minnesota Statutes, section 144.651, subdivision 14, $500;
L. Minnesota Statutes, section 144.651, subdivision 15, $250;
M. Except as noted in item N, a $100 penalty assessment must be issued for a violation of Minnesota Statutes, section 144.651, subdivision 16;
N. A $250 penalty assessment must be issued for a violation of that portion of Minnesota Statutes, section 144.651, subdivision 16, which states: "Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility."
O. Minnesota Statutes, section 144.651, subdivision 17, $100;
P. Minnesota Statutes, section 144.651, subdivision 18, $250;
Q. Minnesota Statutes, section 144.651, subdivision 19, $250;
R. Minnesota Statutes, section 144.651, subdivision 20, $250;
S. A $250 penalty assessment must be issued for a violation of the portions of Minnesota Statutes, section 144.651, subdivision 21, which state: "Patients and residents may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose." and "Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician in the medical record.";
T. A $250 penalty assessment must be issued for a violation of the portions of Minnesota Statutes, section 144.651, subdivision 21, which state: "Patients and residents shall have access, at their expense, to writing instruments, stationery, and postage." and "There shall be access to a telephone where patients and residents can make and receive calls as well as speak privately. Facilities which are unable to provide a private area shall make reasonable arrangements to accommodate the privacy of patients' or residents' calls.”;
U. Minnesota Statutes, section 144.651, subdivision 22, $250;
V. Minnesota Statutes, section 144.651, subdivision 23, $250;
W. Minnesota Statutes, section 144.651, subdivision 24, $100;
X. Minnesota Statutes, section 144.651, subdivision 25, $250;
Y. Minnesota Statutes, section 144.651, subdivision 26, $250;
Z. Minnesota Statutes, section 144.651, subdivision 27, $250;
AA. Minnesota Statutes, section 144.651, subdivision 28, $250;
BB. Minnesota Statutes, section 144.651, subdivision 29, $250;
CC. Minnesota Statutes, section 144.651, subdivision 30, $250; and
DD. Minnesota Statutes, section 144.652, subdivision 1, $100.

Statutory Authority: MS s 144A.04; 144A.08

History: 21 SR 196

Published Electronically: October 11, 2007

4658.0192 NURSING HOME STATUTES; FINES.

Penalty assessments for violations of Minnesota Statutes, chapter 144A, are as follows:
A. Minnesota Statutes, section 144A.04, subdivision 4, $100;
B. Minnesota Statutes, section 144A.04, subdivision 6, $100;
C. A $100 penalty assessment must be issued for a violation of those portions of Minnesota Statutes, section 144A.10, subdivision 3, which state: "A copy of each correction order and notice of noncompliance, and copies of any documentation supplied to the commissioner of health or the commissioner of human services under section 144A.03 or 144A.05 shall be kept on file at the nursing home and shall be made available for viewing by any person upon request. Except as otherwise provided by this subdivision, a copy of each correction order and notice of noncompliance received by the nursing
home after its most recent inspection or reinspection shall be posted in a conspicuous and readily accessible place in the nursing home.” and “All correction orders and notices of noncompliance issued to a nursing home owned and operated by the state or political subdivision of the state shall be circulated and posted at the first public meeting of the governing body after the order or notice is issued. Confidential information protected by section 13.05 or 13.46 shall not be made available or posted as provided in this subdivision unless it may be made available or posted in a manner authorized by chapter 13.”;

D. Minnesota Statutes, section 144A.13, subdivision 1, $100;

E. except as noted in item F, a $100 penalty assessment must be issued for a violation of Minnesota Statutes, section 144A.13, subdivision 2;

F. a $250 penalty assessment must be issued for a violation of that portion of Minnesota Statutes, section 144A.13, subdivision 2, which states: "No controlling person or employee of a nursing home shall retaliate in any way against a complaining nursing home resident and no nursing home resident may be denied any right available to the resident under chapter 504B.”; and

G. Minnesota Statutes, section 144A.16, $100.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196; L 1999 c 199 art 2 s 35
Published Electronically: October 11, 2007

4658.0193 REPORTING MALTREATMENT OF VULNERABLE ADULTS; FINES.

Penalty assessments for violations of Minnesota Statutes, section 626.557, are as follows:

A. Minnesota Statutes, section 626.557, subdivision 3, $250;

B. Minnesota Statutes, section 626.557, subdivision 3a, $100;

C. Minnesota Statutes, section 626.557, subdivision 4, $100;

D. Minnesota Statutes, section 626.557, subdivision 4a, $100;

E. Minnesota Statutes, section 626.557, subdivision 14, $100; and

F. Minnesota Statutes, section 626.557, subdivision 17, $250.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

RESIDENT RIGHTS

4658.0200 POLICIES CONCERNING RESIDENTS.

Subpart 1. Visitors. A nursing home must provide access to a resident by relatives and guardians, and to any entity or individual that provides health, social, legal, advocacy, or religious services to the resident, subject to the resident's right to deny or withdraw consent at any time. A nursing home must also provide access to others who are visiting the resident with the resident's consent. A nursing home may restrict visits when the visits pose a health or safety risk to a resident or otherwise violate a resident's rights.
Subp. 2. **Telephones.** A nursing home must provide at least one non-coin-operated telephone which is accessible to residents at all times in case of emergency. A resident must have access to a telephone at a convenient location within the building for personal use. A nursing home may charge the resident for actual long distance charges that the resident incurs.

Subp. 3. **Mail.** A resident must receive mail unopened unless the resident or the resident's legal guardian, conservator, representative payee, or other person designated in writing by the resident has requested in writing that the mail be reviewed. The outgoing mail must not be censored.

Subp. 4. **Funds and possessions.** A nursing home may not handle the personal major business affairs of a resident without written legal authorization by the resident or the resident's legal guardian, conservator, representative payee, or other person designated in writing by the resident.

Subp. 5. **Smoking in bed.** A resident must not be permitted to smoke in bed unless the resident's condition requires that the resident remain in bed, and the smoking is directly supervised by a staff member.

Subp. 6. **Permitted smoking.** Smoking is permitted in the nursing home only as provided by Minnesota Statutes, sections 16B.24, subdivision 9, and 144.411 to 144.417.

Subp. 7. **Pet animals.** Pet animals may be kept on the premises of a nursing home only according to part 4638.0200.

**Statutory Authority:** MS s 144A.04; 144A.08  
**History:** 21 SR 196  
**Published Electronically:** October 11, 2007

### 4658.0205 PROCEDURE AT DEATH.

When a resident dies in a nursing home, the administrator, nurse, or other employee designated by the administrator must contact a relative, guardian, legal representative, other person designated in writing by the resident, or the placement agency regarding the death and the desired funeral arrangements. The body must be accorded privacy until removed from the nursing home. Where reasonably possible, no body may remain in a nursing home for more than 12 hours.

**Statutory Authority:** MS s 144A.04; 144A.08  
**History:** 21 SR 196  
**Published Electronically:** October 11, 2007

### 4658.0210 ROOM ASSIGNMENTS.

Subpart 1. **Room assignments and furnishings.** A nursing home must attempt to accommodate a resident's preferences on room assignments, roommates, and furnishings whenever possible.

Subp. 2. **Room assignment complaints.** A nursing home must develop and implement written policies and procedures for addressing resident complaints, including complaints regarding room assignments and roommates. At a minimum, the policies and procedures must include the following:

A. a mechanism for informal dispute resolution of room assignment and roommate complaints; and

B. a procedure for documenting the complaint and its resolution.
4658.0215 ADMINISTRATION OF MEDICATIONS.

The right of residents to self-administer medications must be provided as allowed under part 4658.1325, subpart 4. Medications may be added to food only as provided under part 4658.1325, subpart 6.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.0220 FREEDOM FROM CORPORAL PUNISHMENT AND INVOLUNTARY SECLUSION.

A resident must be free from corporal punishment and involuntary seclusion.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

RESIDENT PERSONAL FUNDS ACCOUNT

4658.0250 ADMISSION POLICIES.

The admission policies of a nursing home must specify the manner of protecting personal funds of the residents, according to parts 4658.0250 to 4658.0280.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.0255 AUTHORIZATION.

Subpart 1. Written authorization. The personal funds of a resident must not be accepted for safekeeping without written authorization from the resident or from the resident's legal guardian, conservator, representative payee, or other person designated in writing by the resident. For purposes of this chapter, "representative payee" means an individual designated by the Social Security Administration to receive Social Security benefits on behalf of the resident.

Subp. 2. Copy retained. A copy of the written authorization must be retained in the resident's records.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007
4658.0260 PERSONAL FUND ACCOUNTING AND RECORDS.

Subpart 1. No commingling of resident and nursing home funds. The personal funds of a resident must not be commingled with the funds of a nursing home or with the funds of any person other than residents of the nursing home, unless otherwise authorized by law.

Subp. 2. Resident funds not used by nursing home. The personal funds of a resident must not be used for the purpose of the nursing home or any other resident and must be maintained free from any liability that the nursing home incurs.

Subp. 3. Accounting system. A nursing home must establish and maintain a system that ensures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the nursing home on the resident's behalf.

Subp. 4. Financial record. The resident's financial record must be available through quarterly statements and on request to the resident or the resident's legal guardian, conservator, representative payee, or other person designated in writing by the resident.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.0265 DEPOSIT OF PERSONAL FUNDS.

A nursing home, except for veterans homes under Minnesota Statutes, section 198.265, must deposit a resident's personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the nursing home's operating accounts, and that credits all interest earned on the resident's account to the resident's account. Pooled accounts must separately account for each resident's share.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.0270 WITHDRAWAL OF FUNDS FROM THE ACCOUNT.

Upon the request of the resident or the resident's legal guardian, conservator, representative payee, or other person designated in writing by the resident, a nursing home must return all or any part of a resident's funds given to the nursing home for safekeeping, including interest, if any, accrued from deposits. A nursing home must develop a policy specifying the period of time during which funds can be withdrawn. The policy must ensure that the ability to withdraw funds is provided in accordance with the needs of the resident and must specify whether or not the nursing home allows residents to obtain funds to meet unanticipated needs on days when withdrawal periods are not scheduled. A nursing home must notify residents of the policy governing the withdrawal of funds. Funds kept outside of the nursing home must be returned within five business days.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007
4658.0275 RETURN OF FUNDS AFTER DISCHARGE OR DEATH.

Subpart 1. **Discharge of a resident.** Upon discharge of a resident, the resident's funds must be returned to the resident or resident's legal guardian, conservator, representative payee, or other person designated in writing by the resident, with a written accounting in exchange for a signed receipt. If a resident's bed is being held for anticipated readmission, the resident's funds need not be returned. Funds which are maintained outside of the nursing home must be returned within five business days.

Subp. 2. **Death of a resident.** Upon the death of a resident, a nursing home must convey the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196

**Published Electronically:** October 11, 2007

4658.0290 PENALTIES FOR RESIDENT RIGHTS RULE VIOLATIONS.

Penalty assessments will be assessed on a daily basis for violations of parts 4658.0200 to 4658.0275 and are as follows:

A. part 4658.0200, subpart 1, $250;
B. part 4658.0200, subpart 2, $100;
C. part 4658.0200, subparts 3 and 4, $250;
D. part 4658.0200, subpart 5, $500;
E. part 4658.0200, subpart 7:
   (1) part 4638.0200, subpart 2, $50; and
   (2) part 4638.0200, subpart 3, $150;
F. part 4658.0205, $100;
G. part 4658.0210, subpart 1, $250;
H. part 4658.0210, subpart 2, $50;
I. part 4658.0220, $500;
J. part 4658.0250, $50;
K. part 4658.0255, subpart 1, $250;
L. part 4658.0255, subpart 2, $50; and
M. parts 4658.0260 to 4658.0275, $100.

**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196

**Published Electronically:** September 25, 2009
4658.0300 USE OF RESTRAINTS.

Subpart 1. Definitions. For purposes of this part, the following terms have the meanings given.

A. "Physical restraints" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, and wheelchair safety bars. Physical restraints also include practices which meet the definition of a restraint, such as tucking in a sheet so tightly that a resident confined to bed cannot move; bed rails; chairs that prevent rising; or placing a resident in a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails are considered a restraint if they restrict freedom of movement. If the bed rail is used solely to assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room or area do not, in and of themselves, restrict freedom of movement and should not be considered restraints.

B. "Chemical restraints" means any psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms.

C. "Discipline" means any action taken by the nursing home for the purpose of punishing or penalizing a resident.

D. "Convenience" means any action taken solely to control resident behavior or maintain a resident with a lesser amount of effort that is not in the resident's best interest.

E. "Emergency measures" means the immediate action necessary to alleviate an unexpected situation or sudden occurrence of a serious and urgent nature.

Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

Subp. 3. Emergency use of restraint.

A. If a resident exhibits behavior which becomes a threat to the health or safety of the resident or others, the nurse or person in charge of the nursing home, if other than a nurse, must take temporary, emergency measures to protect the resident and other persons in the nursing home, and the physician must be called immediately.

B. If a restraint is needed, a physician's order must be obtained which specifies the duration and circumstances under which the restraint is to be used.

C. The resident's legal representative or interested family member must be notified when temporary emergency measures are taken.

Subp. 4. Decision to apply restraint. The decision to apply a restraint must be based on the comprehensive resident assessment. The least restrictive restraint must be used and incorporated into the comprehensive plan of care. The comprehensive plan of care must allow for progressive removal or the progressive use of less restrictive means. A nursing home must obtain an informed consent for a resident placed in a physical or chemical restraint. A physician's order must be obtained for a physical or chemical restraint which specifies the duration and circumstances under which the restraint is to be used, including
the monitoring interval. Nothing in this part requires a resident to be awakened during the resident's normal sleeping hours strictly for the purpose of releasing restraints.

Subp. 5. Physical restraints. At a minimum, for a resident placed in a physical restraint, a nursing home must also:

A. develop a system to ensure that the restrained resident is monitored at the interval specified in the written order from the physician;

B. assist the resident as often as necessary for the resident's safety, comfort, exercise, and elimination needs;

C. provide an opportunity for motion, exercise, and elimination for not less than ten minutes during each two-hour period in which a restraint is employed; and

D. release the resident from the restraint as quickly as possible.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303; 21 SR 196
Published Electronically: September 25, 2009

4658.0350 PENALTIES FOR RESTRAINTS RULE VIOLATIONS.

Penalty assessments will be assessed on a daily basis for violations of part 4658.0300 and are as follows:

A. part 4658.0300, subpart 2, $500;
B. part 4658.0300, subpart 3, items A and B, $500;
C. part 4658.0300, subpart 3, item C, $50;
D. part 4658.0300, subpart 4, first paragraph, $250;
E. part 4658.0300, subpart 4, items A to D, $300; and
F. part 4658.0300, subpart 4, item E, $500.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: October 11, 2007

RESIDENT ASSESSMENT AND PLAN OF CARE

4658.0400 COMPREHENSIVE RESIDENT ASSESSMENT.

Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405.

Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information:
NURSING HOMES 4658.0405

Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative.

Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).
Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.

Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: October 11, 2007

4658.0420 PENALTIES FOR COMPREHENSIVE ASSESSMENT AND PLAN OF CARE RULE VIOLATIONS.

Penalty assessments will be assessed on a daily basis for violations of parts 4658.0400 and 4658.0405 and are as follows:

A. part 4658.0400, $300; and

B. part 4658.0405, $300.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: October 11, 2007

CLINICAL RECORDS

4658.0430 HEALTH INFORMATION MANAGEMENT SERVICE.

Subpart 1. Health information management. A nursing home must maintain health information management services, including clinical records, in accordance with accepted professional standards and practices, federal regulations, and state statutes pertaining to the content of the clinical record, health care data, computerization, confidentiality, retention, and retrieval. For purposes of this part, "health information management" means the collection, analysis, and dissemination of data to support decisions related to: disease prevention and resident care; effectiveness of care; reimbursement and payment; planning, research, and policy analysis; and regulations.

Subp. 2. Quality of health information. A nursing home must develop and utilize a mechanism for auditing the quality of its health information management services.

Subp. 3. Person responsible for health information management. A nursing home must designate a person to be responsible for health information management.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: October 11, 2007
4658.0435 CONFIDENTIALITY OF CLINICAL RECORDS AND INFORMATION.

Subpart 1. Maintaining confidentiality of records. Information in the clinical records, regardless of form or storage methods, must be kept confidential according to Minnesota Statutes, chapter 13 and sections 144.291 to 144.298 and 144.651, and federal regulations. A resident's clinical information in a nursing home must be considered confidential but it must be made available to all persons in the nursing home who are responsible for the care of the resident. The clinical information must be open to inspection by representatives of the Department of Health and others legally authorized to obtain access.

Subp. 2. Electronic transmission of health care data. If a nursing home chooses to transmit or receive health care data by electronic means, the nursing home must develop and comply with policies and procedures to ensure the confidentiality, security, and verification of the transmission and receipt of information authorized to be transmitted by electronic means. A durable copy of the transmission must be placed in the resident's clinical record.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303; L 2007 c 147 art 10 s 15

Published Electronically: October 11, 2007

4658.0440 ABBREVIATIONS.

A nursing home must have an explanation key available for abbreviations or symbols used in documentation and the collection of data and information.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.0445 CLINICAL RECORD.

Subpart 1. Unit record. A resident's clinical record must be started at admission and incorporated into a central unit record system. The clinical record must contain sufficient information to identify the resident, contain a record of resident assessments, the comprehensive plan of care, progress notes on the implementation of the care plan, and a summary of the resident's condition at the time of discharge.

Subp. 2. Form of entries and authentication. Data collected must be timely, accurate, and complete. All entries must be entered, authenticated, and dated by the person making the entry. If a nursing home uses an electronic paperless means of storing the clinical record, the nursing home must comply with part 4658.0475. All entries must be made as soon as possible after the observation or treatment in order to keep the clinical record current. In cases where authentication is done electronically or by rubber stamp, safeguards to prevent unauthorized use must be in place, and a rubber stamp may be used only if allowed by the licensing rules for that health care professional. Nursing assistants may document in the nursing notes if allowed by nursing home policy.

Subp. 3. Classification systems. All diagnoses and procedures must be accurately and comprehensively coded to ensure accurate resident medical profiles.

Subp. 4. Admission information. Identification information must be collected and maintained for each resident upon admission and must include, at a minimum:
4658.0450 NURSING HOMES

A. the resident's legal name and preferred name;
B. previous address;
C. social security number;
D. gender;
E. marital status;
F. date and place of birth;
G. date and hour of admission;
H. advance directives, and Do Not Resuscitate (DNR) and Do Not Intubate (DNI) status, if any;
I. name, address, and telephone number of designated relative or significant other, if any;
J. name, address, and telephone number of person to be notified in an emergency;
K. legal representative, designated representative, or representative payee, if any;
L. religious affiliation, place of worship, and clergy member;
M. hospital preference; and
N. name of attending physician.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303; 21 SR 196

Published Electronically: October 11, 2007

4658.0450 CLINICAL RECORD CONTENTS.

Subpart 1. In general. Each resident's clinical record, including nursing notes, must include:

A. the condition of the resident at the time of admission;
B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I;
C. the resident's height and weight, according to part 4658.0520, subpart 2, item J;
D. the resident's general condition, actions, and attitudes;
E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel;
F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods;
G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication;
H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810;
I. reports of laboratory examinations;
J. dates and times of all treatments and dressings;
K. dates and times of visits by all licensed health care practitioners;
L. visits to clinics or hospitals;
M. any orders or instructions relative to the comprehensive plan of care;
N. any change in the resident's sleeping habits or appetite;
O. pertinent factors regarding changes in the resident's general conditions; and
P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400.

Subp. 2. **Physician and professional services.** The clinical record must contain the recording requirements of parts 4658.0710 to 4658.0725.

Subp. 3. **Nursing services.** The clinical record must contain the recording requirements of parts 4658.0515 to 4658.0530.

Subp. 4. **Dietary and food services.** The clinical record must contain the recording requirements of parts 4658.0600 and 4658.0625.

Subp. 5. **Resident personal funds account.** The clinical record must contain the recording requirements of part 4658.0255.

Subp. 6. **Activities.** The clinical record must contain the recording requirements of part 4658.0900.

Subp. 7. **Social services.** The clinical record must contain the recording requirements of parts 4658.1015 and 4658.1020.

**Statutory Authority:** *MS s 144A.04; 144A.08; 256B.431*

**History:** 20 SR 303; 21 SR 196

**Published Electronically:** *October 11, 2007*

### 4658.0455 TELEPHONE AND ELECTRONIC ORDERS.

A. Orders received by telephone, facsimile machine, or other electronic means must be kept confidential according to Minnesota Statutes, sections 144.291 to 144.298, 144.651, and 144.652.

B. Orders received by telephone or other electronic means, not including facsimile machine, must be immediately recorded or placed in the resident's record by the person authorized by the nursing home and must be countersigned by the ordering health care practitioner authorized to prescribe at the time of the next visit, or within 60 days, whichever is sooner.

C. Orders received by facsimile machine must have been signed by the ordering health practitioner authorized to prescribe, and must be immediately recorded or a durable copy must be placed in the resident's clinical record by the person authorized by the nursing home.

**Statutory Authority:** *MS s 144A.04; 144A.08; 256B.431*

**History:** 20 SR 303; L 2007 c 147 art 10 s 15

**Published Electronically:** *October 11, 2007*
4658.0460 MASTER RESIDENT RECORD.

A permanent record must be kept listing at a minimum the full name of the resident, resident identification number, date of birth, date of admission, date of discharge, and discharge disposition. The master resident record must be kept in such a manner that total admissions, discharges, deaths, and resident days can be calculated, and an alphabetical listing of residents can be created.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: October 11, 2007

4658.0465 TRANSFER, DISCHARGE, AND DEATH.

Subpart 1. Discharge summary at death. When a resident dies, the nursing home must compile a discharge summary that includes the date, time, and cause of death.

Subp. 2. Other discharge. When a resident is transferred or discharged for any reason other than death, the nursing home must compile a discharge summary that includes the date and time of transfer or discharge, reason for transfer or discharge, transfer or discharge diagnoses, and condition.

Subp. 3. Transfer or discharge to another facility. When a resident is transferred or discharged to another health care facility or program, the nursing home must send the discharge summary compiled according to subpart 2, and pertinent information about the resident's immediate care and sufficient information to ensure continuity of care prior to or at the time of the transfer or discharge to the other health care facility or program. Additional information not necessary for the resident's immediate care may be sent to the new health care facility or program at the time of or after the transfer or discharge.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: October 11, 2007

4658.0470 RETENTION, STORAGE, AND RETRIEVAL.

Subpart 1. Retention. A resident's records must be preserved for a period of at least five years following discharge or death.

Subp. 2. Storage. Space must be provided for the safe and confidential storage of residents' clinical records. Records of current residents must be stored on site.

Subp. 3. Retrieval. If records of discharged residents are stored off site, policies and procedures must be developed and implemented by clinical record personnel and the nursing home administration for the confidentiality, retention, and timely retrieval of records within one working day. The policies and procedures must specify who is authorized to retrieve a record. Off-site archived copies of clinical databases must be protected against fire, flood, and other emergencies. The policies must address the location and retention of records if the nursing home discontinues operation.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: October 11, 2007
4658.0475 COMPUTERIZATION.

If a nursing home is converting to an electronic paperless health information management system:

A. policies and procedures must be established and maintained that require password protection of the clinical database;

B. any outside contract for health information management services must include a provision that the company providing the services assumes responsibility for maintaining the confidentiality of all health information within its control;

C. audit trails must be developed for computer applications to determine the source and date of all entries and deletions;

D. backup systems must be implemented and maintained;

E. preventative maintenance must be implemented and maintained;

F. there must be a plan for preparing, securing, and retaining archived copies of computerized clinical databases;

G. procedures must be implemented for preparing and securing daily, weekly, and monthly archived copies of computerized clinical databases; and

H. there must be confidentiality and protection from unauthorized use of active and archived computerized clinical databases.

**Statutory Authority:** MS s 144A.04; 144A.08; 256B.431

**History:** 20 SR 303

**Published Electronically:** October 11, 2007

4658.0490 PENALTIES FOR CLINICAL RECORDS RULE VIOLATIONS.

Penalty assessments will be assessed on a daily basis for violations of parts 4658.0430 to 4658.0475 and are as follows:

A. part 4658.0430, $300;

B. part 4658.0435, $250;

C. part 4658.0440, $50;

D. part 4658.0445, subpart 1, $300;

E. part 4658.0445, subpart 2, $300;

F. part 4658.0445, subpart 3, $300;

G. part 4658.0445, subpart 4, $100;

H. part 4658.0450, $300;

I. part 4658.0455, item A, $250;

J. part 4658.0455, item B, $300;

K. part 4658.0455, item C, $300;

L. part 4658.0460, $50;
4658.0500 DIRECTOR OF NURSING SERVICES.

Subpart 1. Qualifications and duties. A nursing home must have a director of nursing services who is a registered nurse.

Subp. 2. Requirement of full-time employment. A director of nursing services must be employed full time, no less than 35 hours per week, and be assigned full time to the nursing services of the nursing home.

Subp. 3. Assistant to director. A nursing home must designate a nurse to be responsible for the duties of the director of nursing services related to the provision of resident services in the director's absence.

Subp. 4. Education. A person newly appointed to the position of the director of nursing services must have training in rehabilitation nursing, gerontology, nursing service administration, management, supervision, and psychiatric or geriatric nursing before or within the first 12 months after appointment as director of nursing services.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.0505 RESPONSIBILITIES; DIRECTOR OF NURSING SERVICES.

The written job description for the director of nursing services must include responsibility for:

A. the total nursing care of residents and the accuracy of the nursing care records;

B. establishing and implementing procedures for the provision of nursing care and delegated medical care, developing nursing policy and procedure manuals that must be available at each nurse's station, and developing written job descriptions for each category of nursing personnel;

C. planning and conducting orientation programs for new nursing personnel, volunteers, and temporary staff, and continuing in-service education for all nursing home staff in nursing homes under 90 beds, if no one is designated as responsible for all in-service education;

D. determining with the administrator the numbers and levels of nursing personnel to be employed;
E. participating in recruitment, selection, and termination of nursing personnel;
F. assigning, supervising, and evaluating the performance of all nursing personnel;
G. delegating and monitoring nonnursing responsibilities to other staff consistent with their training, experience, competence, and legal authorization, and with nursing home policy;
H. participating in the selection of prospective residents based on nursing care needed and nursing personnel competencies available;
I. assuring that a comprehensive plan of care is established and implemented for each resident and that the plan is reviewed at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B;
J. coordinating nursing services for the residents in the nursing home with other resident care services provided both within and outside the nursing home;
K. participating in planning, decision making, and budgeting for nursing care;
L. interacting with physicians to plan care for residents; and
M. assuring that discharge and transfer planning for residents is conducted.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: October 11, 2007

4658.0510 NURSING PERSONNEL.

Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements.

Subp. 2. Minimum hour requirements. The minimum number of hours of nursing personnel to be provided is:

A. For nursing homes not certified to participate in the medical assistance program, a minimum of two hours of nursing personnel per resident per 24 hours.

B. For nursing homes certified to participate in the medical assistance program, the nursing home is required to comply with Minnesota Statutes, section 144A.04, subdivision 7.

Subp. 3. On-site coverage. A nurse must be employed so that on-site nursing coverage is provided eight hours per day, seven days per week.

Subp. 4. On call coverage. A registered nurse must be on call during all hours when a registered nurse is not on duty.

Subp. 5. Assignment of duties. Nursing personnel must not perform duties for which they have not had proper and sufficient training. Duties assigned to nursing personnel must be consistent with their training, experience, competence, and credentialing.

Subp. 6. Duties. Nursing personnel must be employed and used for nursing duties only. A nursing home must provide sufficient additional staff for housekeeping, dietary, laundry, and maintenance duties and those persons must not provide nursing care.
ADEQUATE AND PROPER NURSING CARE.

Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.

Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:

A. evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded;

B. clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors;

C. a shampoo at least weekly and assistance with daily hair grooming as needed;

D. assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed;

E. assistance as needed with oral hygiene to keep the mouth, teeth, or dentures clean. Measures must be used to prevent dry, cracked lips;

F. proper care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed;

G. bed linen changed weekly, or more often as needed. Beds must be made daily and straightened as necessary;

H. clean clothing and a neat appearance. Residents must be dressed during the day whenever possible;

I. monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly; and
J. recording resident height and weight at the time of admission and weight at least monthly thereafter.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 2, 2013

4658.0525 REHABILITATION NURSING CARE.

Subpart 1. Program required. A nursing home must have an active program of rehabilitation nursing care directed toward assisting each resident to achieve and maintain the highest practicable physical, mental, and psychosocial well-being according to the comprehensive resident assessment and plan of care described in parts 4658.0400 and 4658.0405. Continuous efforts must be made to encourage ambulation and purposeful activities.

Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:

A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion.

Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:

A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and

B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.

Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval.

Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that:

A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and

B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.
Subp. 6. **Activities of daily living.** Based on the comprehensive resident assessment, a nursing home must ensure that:

A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to:
   1. bathe, dress, and groom;
   2. transfer and ambulate;
   3. use the toilet;
   4. eat; and
   5. use speech, language, or other functional communication systems; and

B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

Subp. 7. **Nasogastric tubes, gastrostomy tubes, and feeding syringes.** Based on the comprehensive resident assessment, a nursing home must ensure that:

A. a resident who has been able to eat enough independently or with assistance is not fed by nasogastric tube or feeding syringe unless the resident's clinical condition demonstrates that use of a nasogastric tube or feeding syringe was unavoidable; and

B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function.

Subp. 8. **Prosthetic devices.** A nursing home must assist residents to adjust to their disabilities and to use their prosthetic devices.

Subp. 9. **Hydration.** Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted.

**Statutory Authority:** MS s 144A.04; 144A.08; 256B.431

**History:** 20 SR 303

**Published Electronically:** *October 11, 2007*

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**4658.0530 ASSISTANCE WITH EATING.**

Subpart 1. **Nursing personnel.** Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician.

Subp. 2. **Volunteers.** Volunteers may assist residents with eating if the following conditions are met:
A. the nursing home has a policy allowing that assistance. The policy must specify whether family members are allowed to assist their immediate relatives with eating and, if allowed, what training is required for family members;

B. the resident has been assessed and a determination made that the resident may be safely fed by a volunteer, and that is documented in the comprehensive plan of care;

C. the resident has agreed, or an immediate family member, the legal guardian, or designated representative has agreed for the resident, to be fed by a volunteer;

D. the volunteer has completed a training program on assisting residents with eating, which, at a minimum, meets the training and competency standards for eating assistance contained in the nursing assistant training curriculum;

E. the director of nursing services must be responsible for the monitoring of all persons, including family members, performing this activity; and

F. there are mechanisms in place to ensure appropriate reporting to nursing personnel of observations made by the volunteer during meal time.

Subp. 3. **Risk of choking.** A resident identified in the comprehensive resident assessment, and as addressed in the comprehensive plan of care, as being at risk of choking on food must be continuously monitored by nursing personnel when the resident is eating so that timely emergency intervention can occur if necessary.

**Statutory Authority:** MS s 144A.04; 144A.08; 256B.431

**History:** 20 SR 303

**Published Electronically:** October 11, 2007

### 4658.0580 PENALTIES FOR NURSING SERVICES RULE VIOLATIONS.

Penalty assessments will be assessed on a daily basis for violations of parts 4658.0500 to 4658.0530 and are as follows:

A. part 4658.0500, subpart 1, $300;
B. part 4658.0500, subpart 2, $300;
C. part 4658.0500, subpart 3, $100;
D. part 4658.0500, subpart 4, $300;
E. part 4658.0505, items A to C, $300;
F. part 4658.0505, items D to F, $100;
G. part 4658.0505, item G, $300;
H. part 4658.0505, item H, $100;
I. part 4658.0505, item I, $300;
J. part 4658.0505, items J to M, $100;
K. part 4658.0510, subpart 1, $300;
L. part 4658.0510, subparts 2 to 5, $500;


4658.0510, subpart 6, $300;
N. part 4658.0515, $300;
O. part 4658.0520, subpart 1, $350;
P. part 4658.0520, subpart 2, items A to H, $350;
Q. part 4658.0520, subpart 2, items I to J, $300;
R. part 4658.0525, $350; and
S. part 4658.0530, $350.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: October 11, 2007

DIETARY SERVICE

4658.0600 DIETARY SERVICE.

Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food.

Subp. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served.

Subp. 3. Availability of diet manuals. The most recent edition of diet manuals must be readily available in the dietary department.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 19 SR 1803
Published Electronically: October 11, 2007

4658.0605 DIRECTION OF DIETARY DEPARTMENT.

Subpart 1. Dietitian. The nursing home must employ a qualified dietitian either full time, part time, or on a consultant basis. For purposes of this chapter, a "qualified dietitian" means a person who:

A. is registered by the Commission on Dietetic Registration of the American Dietetic Association;

B. is licensed under Minnesota Statutes, section 148.624; or

C. has a bachelor's degree in dietetics, food and nutrition, or food service management plus experience in long-term care and ongoing continuing education in identification of dietary needs, and planning and implementation of dietary programs.

Subp. 2. Director of dietary service. If a qualified dietitian is not employed full time, the administrator must designate a director of dietary service who is enrolled in or has completed, at a minimum, a dietary manager course, and who receives frequently scheduled consultation from a qualified
dietitian. The number of hours of consultation must be based upon the needs of the nursing home. Directors of dietary service hired before May 28, 1995, are not required to complete a dietary manager course.

**Statutory Authority:** MS s 144A.04; 144A.08; 256B.431

**History:** 19 SR 1803

**Published Electronically:** October 11, 2007

### 4658.0610 DIETARY STAFF REQUIREMENTS.

**Subpart 1. Sufficient personnel.** The nursing home must employ sufficient personnel competent to carry out the functions of the dietary service. "Sufficient personnel" means enough staff to plan, prepare, and serve palatable, attractive, and nutritionally adequate meals at proper temperatures and appropriate times.

Subp. 2. **Health.** The dietary staff must be free from symptoms of communicable disease and from open, infected wounds.

Subp. 3. **Grooming.** Dietary staff must wear clean outer garments. Hairnets or other hair restraints must be worn to prevent the contamination of food, utensils, and equipment. Hair spray is not an acceptable hair restraint.

Subp. 4. **Hygiene.** Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a handwashing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed.

Subp. 5. **Tobacco use.** Employees must not use tobacco in any form while on duty to handle, prepare, or serve food, or clean utensils and equipment.

Subp. 6. **Eating.** All employees must consume food only in areas designated for employee dining. An employee dining area must not be designated if consuming food in that location could cause contamination of other food, equipment, or utensils. This subpart does not apply to cooks or other persons designated by the cook who test the food for flavor and palatability.

Subp. 7. **Sanitary conditions.** Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.

Subp. 8. **Food handling guide.** A current copy of the department's food handling guide entitled "Information for Food Service Personnel in Hospitals and Related Care Facilities" must be readily available for reference by all dietary personnel.

**Statutory Authority:** MS s 144A.04; 144A.08; 256B.431

**History:** 19 SR 1803

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### 4658.0615 FOOD TEMPERATURES.

Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms.
4658.0620 FREQUENCY OF MEALS.

Subpart 1. Time of meals. The nursing home must provide at least three meals daily at regular times. There must be no more than 14 hours between a substantial evening meal and breakfast the following day. A "substantial evening meal" means an offering of three or more menu items at one time, one of which is a high-quality protein such as meat, fish, eggs, or cheese.

Subp. 2. Snacks. The nursing home must offer evening snacks daily. "Offer" means having snacks available and making the resident aware of that availability.

Subp. 3. Time between meals. Up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group, such as the resident council, agrees to this meal span and a nourishing evening snack is provided.

Subp. 4. Dining room. Meals are to be served in a specified dining area consistent with the resident's choice and plan of care.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 19 SR 1803; 21 SR 196

Published Electronically: October 11, 2007

4658.0625 MENUS.

Subpart 1. Menu planning. All menus must be planned in advance, dated, and followed. Any changes in the meals actually served must be of equal nutritional value. The general menu for a seven-day period must be posted prior to the start of that seven-day period at a location readily accessible to residents, and any changes to the general menu must be noted on that posted menu. All menus and any changes for the current and following seven-day periods must be posted in the dietary area. Records of menus and of foods purchased must be filed for six months. A variety of foods must be provided. A file of tested recipes adjusted to a yield appropriate for the size of the home must be maintained.

Subp. 2. Food habits and customs. There must be adjustment to the food habits, customs, likes, and appetites of individual residents including condiments, seasonings, and salad dressings. There must be resident involvement in menu planning.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 19 SR 1803

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4658.0630 RETURNED FOOD.

Returned portions of food and beverages from individual servings may be reused if the food or beverage is served in a sealed wrapper or container which has not been unwrapped or opened and is not potentially hazardous.
4658.0635 CONDIMENTS.

Condiments, seasonings, and salad dressing for resident use must be provided in individual packages or from dispensers.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 19 SR 1803
Published Electronically: October 11, 2007

4658.0640 MILK.

Fluid milk and fluid milk products used must be pasteurized and must meet Grade A quality standards in Minnesota Statutes, chapter 32. The milk must be dispensed directly from the original container in which it was packaged, shipped, and received. This container may be individual portions, mechanically refrigerated bulk milk dispenser, or a commercially filled container of not more than one gallon capacity. Dry milk may not be reconstituted and served as fluid milk. Dry milk may be added to fluid milk and other foods to increase nutrient density. Dry milk, dry milk products, and commercial nondairy products may be used in instant dessert and whipped products or for cooking and baking.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 19 SR 1803
Published Electronically: October 11, 2007

4658.0645 ICE.

Ice must be stored and handled in a sanitary manner. Stored ice must be kept in an enclosed container. If the container is not mechanically cooled, it must be cleaned at least daily and more often if needed. If an ice scoop is used, the scoop must be stored separately to prevent the handle from contact with the ice.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 19 SR 1803
Published Electronically: October 11, 2007

4658.0650 FOOD SUPPLIES.

Subpart 1. **Food.** All food must be clean, wholesome, free from spoilage, free from adulteration and misbranding, and safe for human consumption. Canned or preserved food which has been processed in a place other than a commercial food-processing establishment is prohibited for use by nursing homes.

Subp. 2. **Food brought into nursing home.** Nonprohibited food items from noncommercial sources such as fresh produce, game, and fish may be brought into the nursing home in accordance with nursing home policy.
Subp. 3. **Food containers.** Food, whether raw or prepared, if removed from the container or package in which it was obtained, must be stored in a clean, covered container. The container need not be covered during necessary periods of preparation or service.

Subp. 4. **Storage of nonperishable food.** Containers of nonperishable food must be stored a minimum of six inches above the floor in a manner that protects the food from splash and other contamination, and that permits easy cleaning of the storage area. Containers may be stored on equipment such as dollies, racks, or pallets, provided the equipment is easily movable and constructed to allow for easy cleaning. Nonperishable food and containers of nonperishable food must not be stored under exposed or unprotected sewer lines or similar sources of potential contamination. The storage of nonperishable food in toilet rooms or vestibules is prohibited.

Subp. 5. **Storage of perishable food.** All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage.

Subp. 6. **Prohibited storage.** The storage of detergents, cleaners, pesticides, and other nonfood items not related to the operation of the dietary service, including employees' personal items, is prohibited in food storage areas. The nursing home may store dry goods and paper products related to the dietary service in the food storage area.

Subp. 7. **Vending machines.** Storage and dispensing of food and beverages in vending machines must be in accordance with chapter 4626, and in accordance with any applicable local ordinances.

**Statutory Authority:** *MS s 31.101; 31.11; 144.05; 144.12; 144A.04; 144A.08; 157.011; 256B.431*

**History:** 19 SR 1803; 23 SR 519

**Published Electronically:** October 11, 2007

### 4658.0655 TRANSPORT OF FOOD.

The food service system must be capable of keeping food hot or cold until served. A dumbwaiter or conveyor, which cab or carrier is used for the transport of food and soiled dishes, must be sanitized immediately after the transportation of soiled dishes is complete, and prior to the transporting of food. The dumbwaiter or conveyor, which cab or carrier is used for the transport of soiled linens, may not be used for the transport of food or soiled dishes.

**Statutory Authority:** *MS s 144A.04; 144A.08; 256B.431*

**History:** 19 SR 1803

**Published Electronically:** October 11, 2007

### 4658.0660 FLOOR CLEANING AND TRASH.

Subpart 1. **Cleaning during food preparation.** There must be no sweeping or mopping in the food preparation or service areas of the kitchen during the time of food preparation or service, except when necessary to prevent accidents.

Subp. 2. **Nondietary activity trash, restrictions.** Trash or refuse unrelated to dietary activities must not be transported through food preparation areas or food storage areas for disposal or incineration.
Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 19 SR 1803
Published Electronically: October 11, 2007

4658.0665 DISHES AND UTENSILS REQUIREMENTS.

The requirements in items A to E apply to the use of dishes and utensils.

A. Only dishes and utensils with the original smooth finishes may be used. Cracked, chipped, scratched, or permanently stained dishes, cups, or glasses or damaged, corroded, or open seamed utensils or cookware must not be used. All tableware and cooking utensils must be kept in closed storage compartments.

B. Accessories for food appliances must be provided with protective covers unless in enclosed storage.

C. Enclosed lowerators for dishes are acceptable.

D. Clean spoons, knives, and forks must be touched only by their handles. Clean cups, glasses, bowls, plates, and similar items must be handled without contact with inside surfaces or surfaces that contact the user’s mouth.

E. Dishes or plate settings must not be set out on the tables more than two hours before serving time.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 19 SR 1803
Published Electronically: October 11, 2007

4658.0670 DISHWASHING.

Subpart 1. Requirements. The dishwashing operation must provide separation in the handling of soiled and clean dishes and utensils, and must conform with either part 4658.0675 or 4658.0680 for washing, rinsing, sanitizing, and drying.

Subp. 2. Sanitization; storage. All utensils and equipment must be thoroughly cleaned, and food-contact surfaces of utensils and equipment must be given sanitization treatment and must be stored in such a manner as to be protected from contamination. Cleaned and sanitized equipment and utensils must be handled in a way that protects them from contamination.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 19 SR 1803
Published Electronically: October 11, 2007

4658.0675 MECHANICAL CLEANING AND SANITIZING.

Subpart 1. Generally. Mechanical cleaning and sanitizing must be done in the manner described by subparts 2 to 8.

Subp. 2. Cleaning and sanitizing. Cleaning and sanitizing may be done by spray-type or immersion utensil washing machines or by any other type of machine or device if it is demonstrated that it thoroughly
cleans, sanitizes equipment and utensils, and meets the requirements of Standard No. 3, spray-type dishwashing machines, issued by NSF International, June 1982. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. These machines and devices must be properly installed and maintained in good repair. Machines and devices must be operated according to manufacturers' instructions, which must be posted nearby. Utensils and equipment placed in the machine must be exposed to all washing cycles. Automatic detergent dispensers, wetting agent dispensers, and liquid sanitizer injectors must be properly installed and maintained.

Subp. 3. **Drainboards.** Drainboards must be provided and be of adequate size for the proper handling of soiled utensils before washing and for cleaned utensils following sanitization, and must be located and constructed so as not to interfere with the proper use of the dishwashing facilities. This does not preclude the use of easily movable dish tables for the storage of soiled utensils or the use of easily movable dish tables for the storage of clean utensils following sanitization.

Subp. 4. **Preparing to clean.** Equipment and utensils must be flushed or scraped and, when necessary, soaked to remove gross food particles and soil before being washed in a dishwashing machine unless a prewash cycle is a part of the dishwashing machine operation. Equipment and utensils must be placed in racks, trays, or baskets, or on conveyors, in a way that food-contact surfaces are exposed to the unobstructed application of detergent wash and clean rinse water and that permits free draining.

Subp. 5. **Chemical sanitization.** Single-tank machines, stationary-rack machines, door-type machines, and spray-type glass washers using chemicals for sanitization may be used, provided that:

A. wash water temperatures, addition of chemicals, rinse water temperatures, and chemical sanitizers used are in conformance with NSF International Standard No. 3, incorporated by reference in subpart 2, and Standard No. 29, Detergent and Chemical Feeders for Commercial Spray-Type Dishwashing Machines, issued by NSF International, November 1992. These standards are incorporated by reference. They are available through the Minitex interlibrary loan system. They are not subject to frequent change;

B. a test kit or other device that accurately measures the parts per million concentration of the sanitizing solution must be available and be used, and a log of the test results must be maintained for the previous three months;

C. containers for storing the sanitizing agent must be installed in such a manner as to ensure that operators maintain an adequate supply of sanitizing compound; and

D. a visual or audible warning device must be provided for the operator to easily verify when the sanitizing agent is depleted.

Subp. 6. **Hot water sanitization.** Machines using hot water for sanitizing may be used provided that wash water and pumped rinse water are kept clean and water is maintained at not less than the temperature specified by NSF International Standard No. 3, incorporated by reference in subpart 2, under which the machine is evaluated. A pressure gauge must be installed with a valve immediately adjacent to the supply side of the control valve in the final rinse line provided that this requirement does not pertain to a dishwashing machine with a pumped final rinse.

Subp. 7. **Air drying.** Dishes and utensils must be air dried before being stored or must be stored in a self-draining position. Properly racked sanitized dishes and utensils may complete air drying in proper storage places, if available.

Subp. 8. **Cleaning of dishwashing machines.** Dishwashing machines must be cleaned at least once a day, or more frequently if required, in accordance with the manufacturer's recommendation.
4658.0680 MANUAL CLEANING AND SANITIZING.

Subpart 1. Generally. Manual cleaning and sanitizing must be done in the manner described in subparts 2 to 9.

Subp. 2. Three compartment sink. For manual washing, rinsing, and sanitizing of utensils and equipment, a sink with at least three compartments must be provided and be used. Sink compartments must accommodate food preparation equipment and utensils, and each compartment of the sink must be supplied with hot and cold potable running water. Fixed equipment and utensils and equipment too large to be cleaned in sink compartments must be washed manually or cleaned through pressure spray methods.

Subp. 3. Drainboards. Drainboards must be provided at each end for proper handling of soiled utensils before washing and for cleaned utensils following sanitizing and must be located so as not to interfere with the proper use of the utensil washing facilities.

Subp. 4. Preparing to clean. Equipment and utensils must be preflushed or prescraped and, when necessary, presoaked to remove gross food particles and soil.

Subp. 5. Manual dishwashing process. Except for fixed equipment and utensils too large to be cleaned in sink compartments, manual washing, rinsing, and sanitizing must be conducted in the following manner:

A. sinks must be cleaned before use;

B. equipment and utensils must be thoroughly washed in the first compartment with a detergent in accordance with the detergent manufacturer's instructions;

C. equipment and utensils must be rinsed free of detergent and abrasives with clean water in the second compartment; and

D. equipment and utensils must be sanitized in the third compartment according to subpart 6.

Subp. 6. Sanitization methods. The food-contact surfaces of all equipment and utensils must be sanitized by one of the following methods:

A. immersion for at least one-half minute in clean, hot water at a temperature of at least 170 degrees Fahrenheit (77 degrees centigrade);

B. immersion for at least one minute in a clean solution containing at least 50 parts per million, but no more than 200 parts per million, of available chlorine as a hypochlorite and at a temperature of at least 75 degrees Fahrenheit (24 degrees centigrade);

C. immersion for at least one minute in a clean solution containing at least 12.5 parts per million, but not more than 25 parts per million, of available iodine and having a pH range which the manufacturer has demonstrated to be effective and at a temperature of at least 75 degrees Fahrenheit (24 degrees centigrade);

D. immersion in a clean solution containing any other chemical sanitizing agent allowed under Code of Federal Regulations, title 21, section 178.1010, that will provide at least the equivalent bactericidal
effect of a solution containing 50 parts per million of available chlorine as a hypochlorite at a temperature of at least 75 degrees Fahrenheit (24 degrees centigrade) for one minute; or

E. for equipment too large to sanitize by immersion, but in which steam can be confined, treatment with steam free from materials or additives other than those specified in Code of Federal Regulations, title 21, section 173.310.

Equipment too large to sanitize by immersion must be rinsed, sprayed, or swabbed with a sanitizing solution of at least twice the required strength for that particular sanitizing solution.

Subp. 7. **Hot water sanitization.** When hot water is used for sanitizing, the following equipment must be provided and used:

A. an integral heating device or fixture installed in, on, or under the sanitizing compartment of the sink capable of maintaining the water at a temperature of at least 170 degrees Fahrenheit (77 degrees centigrade);

B. a numerically scaled indicating thermometer, accurate to plus or minus three degrees Fahrenheit (plus or minus two degrees centigrade) convenient to the sink for frequent checks of water temperature; and

C. dish baskets or other equipment of such size and design to permit complete immersion of the tableware, kitchenware, and equipment in the hot water.

Subp. 8. **Chemical sanitization.** When chemicals are used for sanitization, they must not have concentrations higher than the maximum permitted under Code of Federal Regulations, title 21, section 178.1010, and a test kit or other device that accurately measures the parts per million concentration of the solution must be provided and used, and a log of the test results must be maintained for the previous three months.

Subp. 9. **Air drying.** All dishes and utensils must be air dried before being stored or must be stored in a self-draining position. Properly racked sanitized dishes and utensils may complete air drying in proper storage places, if available.

**Statutory Authority:** *MS s 144A.04; 144A.08; 256B.431*

**History:** 19 SR 1803

**Published Electronically:** *October 2, 2013*

**4658.0685 Penalties for Dietary and Food Services and Sanitation Rule Violations.**

Penalty assessments for violations of parts 4658.0600 to 4658.0680 are as follows:

A. part 4658.0600, subpart 1, $350;
B. part 4658.0600, subpart 2, $350;
C. part 4658.0600, subpart 3, $100;
D. part 4658.0605, subpart 1, $350;
E. part 4658.0605, subpart 2, $300;
F. part 4658.0610, subpart 1, $300;
G. part 4658.0610, subpart 2, $350;
H. part 4658.0610, subpart 3, $350;
I. part 4658.0610, subpart 4, $350;
J. part 4658.0610, subpart 5, $350;
K. part 4658.0610, subpart 6, $50;
L. part 4658.0610, subpart 7, $350;
M. part 4658.0610, subpart 8, $350;
N. part 4658.0615, $350;
O. part 4658.0620, subpart 1, $350;
P. part 4658.0620, subpart 2, $350;
Q. part 4658.0620, subpart 3, $350;
R. part 4658.0620, subpart 4, $100;
S. part 4658.0625, subpart 1, $300;
T. part 4658.0625, subpart 2, $300;
U. part 4658.0630, $350;
V. part 4658.0635, $350;
W. part 4658.0640, $350;
X. part 4658.0645, $350;
Y. part 4658.0650, subpart 1, $350;
Z. part 4658.0650, subpart 2, $350;
AA. part 4658.0650, subpart 3, $350;
BB. part 4658.0650, subpart 4, $350;
CC. part 4658.0650, subpart 5, $350;
DD. part 4658.0650, subpart 6, $350;
EE. part 4658.0650, subpart 7, $350;
FF. part 4658.0655, $350;
GG. part 4658.0660, subpart 1, $300;
HH. part 4658.0660, subpart 2, $300;
II. part 4658.0665, $300; and
JJ. parts 4658.0670 to 4658.0680, $300.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 19 SR 1803

Published Electronically: October 11, 2007
MEDICAL AND DENTAL SERVICES

4658.0700 MEDICAL DIRECTOR.

Subpart 1. **Designation.** A nursing home must designate a physician to serve as medical director.

Subp. 2. **Duties.** The medical director, in conjunction with the administrator and the director of nursing services, must be responsible for:

A. the development of resident care policies and procedures that are to be approved by the licensee;

B. implementation of resident care policies;

C. the development of standards of practice for medical care to provide guidance to attending physicians;

D. the medical direction and coordination of medical care in the nursing home, including serving as liaison with attending physicians, and periodic evaluation of the adequacy and appropriateness of health professional and supportive staff and services to meet the medical needs of residents;

E. surveillance of the health status of the nursing home's employees as it relates to the performance of their assigned duties;

F. periodic advisement to the director of nursing services to ensure a quality level of delegated medical care provided to residents; and

G. participation, or designation of another physician for participation, on the quality assessment and assurance committee as required by part 4658.0070.

**Statutory Authority:** Ms 144A.04; 144A.08; 256B.431

**History:** 20 SR 303

**Published Electronically:** October 11, 2007

4658.0705 MEDICAL CARE AND TREATMENT.

Subpart 1. **Physician supervision.** A nursing home must ensure that each resident has a physician designated to authorize and supervise the medical care and treatment of the resident during the resident's stay in the nursing home, and must ensure that another physician is available to supervise the resident's medical care when the attending physician is unavailable.

Subp. 2. **Availability of physicians for emergency and advisory care.**

A. A nursing home must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency, and to act in an advisory capacity.

B. The name and telephone number of the emergency physician must be readily available at all times.

C. A nursing home must develop and maintain policies and procedures regarding obtaining medical intervention when the resident's attending physician or the emergency physician does not respond to a request for medical care or is not available in a timely manner.
Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: October 11, 2007

4658.0710 ADMISSION ORDERS AND PHYSICIAN EVALUATIONS.

Subpart 1. Physical examination. A resident must have a current admission medical history and complete physical examination performed and recorded by a physician, physician assistant, or nurse practitioner within five days before or within seven days after admission.

Subp. 2. Admission orders. A nursing home must have physician orders for a resident's admission and immediate care at the time of admission.

Subp. 3. Frequency of physician evaluations.

A. A resident must be evaluated by a physician at least once every 30 days for the first 90 days after admission, and then whenever medically necessary. A physician visit is considered timely if it occurs within ten days after the date the visit was required.

B. Except as provided in this item, all required physician visits must be made by the physician personally. At the option of the physician, required visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner according to parts 5600.2600 to 5600.2670, chapters 6330 and 6340, and Minnesota Statutes, sections 147.34 and 148.235.

Subp. 4. Physician visits. At each visit, a physician or physician's designee must:

A. review the resident's comprehensive plan of care, including medications and treatments, and progress notes;

B. write, sign, and date physician progress notes; and

C. sign and date all orders.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: October 11, 2007

4658.0715 MEDICAL INFORMATION FOR CLINICAL RECORD.

A physician or physician designee must provide the following information for the clinical record:

A. the report of the admission history and physical examination;

B. the admitting diagnosis;

C. a description of the general medical condition, including disabilities and limitations;

D. a report of subsequent physical examinations;

E. instructions relative to the resident's total program of care;

F. written orders for all medications with stop dates, treatments, rehabilitations, and any medically prescribed special diets;

G. progress notes;
4658.0725 PROVIDING ROUTINE AND EMERGENCY ORAL HEALTH SERVICES.

Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies.

Subp. 2. Annual dental visit.

A. Within 90 days after admission, a resident must be referred for an initial dental examination unless the resident has received a dental examination within the six months before admission.

B. After the initial dental examination, a nursing home must ask the resident if the resident wants to see a dentist and then provide any necessary help to make the appointment, on at least an annual basis. This opportunity for an annual dental checkup must be provided within one year from the date of the initial dental examination or within one year from the date of the examination done within the six months before admission.
Subp. 3. Emergency dental services.

A. A nursing home must provide, or obtain from an outside resource, emergency dental services to meet the needs of each resident. Emergency dental services include services needed to treat: an episode of acute pain in teeth, gums, or palate; broken or otherwise damaged teeth; or any other problem of the oral cavity, appropriately treated by a dentist, that requires immediate attention.

B. When emergency dental problems arise, a nursing home must contact a dentist within 24 hours, describe the dental problem, and document and implement the dentist's plans and orders.

Subp. 4. Dental records. For each dental visit, the clinical record must include the name of the dentist or dental hygienist, date of the service, specific dental services provided, medications administered, medical or dental consultations, and follow-up orders.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.0730 NURSING HOME REQUIREMENTS.

Subpart 1. Training. Nursing home staff providing daily oral care must be trained and competent to provide daily oral care for residents.

Subp. 2. Written agreement. A nursing home must maintain a written dental provider agreement with at least one dentist, licensed by the Board of Dentistry, who agrees to provide:

A. routine and emergency dental care for the nursing home's residents;
B. consultation on the nursing home's oral health policies and procedures; and
C. oral health training for nursing home staff.

Subp. 3. Making appointments. A nursing home must assist residents in making dental appointments and arranging for transportation to and from the dentist's office.

Subp. 4. On-site services. A nursing home must arrange for on-site dental services for residents who cannot travel, if those services are available in the community.

Subp. 5. List of dentists. A nursing home must maintain a list of dentists in the service area willing and able to provide routine or emergency dental services for the nursing home's residents. Copies of the list must be readily accessible to nursing personnel.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.0750 PENALTIES FOR PHYSICIAN AND DENTAL SERVICES RULE VIOLATIONS.

Penalty assessment will be assessed on a daily basis for violations of parts 4658.0700 to 4658.0730 and are as follows:

A. part 4658.0700, subpart 1, $100;
B. part 4658.0700, subpart 2, items A to F, $300;
C. part 4658.0700, subpart 2, item G, $100;
D. part 4658.0705, subpart 1, $300;
E. part 4658.0705, subpart 2, item A, $300;
F. part 4658.0705, subpart 2, item B, $100;
G. part 4658.0705, subpart 2, item C, $300;
H. part 4658.0710, subpart 1, $350;
I. part 4658.0710, subpart 2, $300;
J. part 4658.0710, subpart 3, item A, $350;
K. part 4658.0710, subpart 3, item B, $300;
L. part 4658.0710, subpart 4, $100;
M. part 4658.0715, $350;
N. part 4658.0720, subpart 1, $300;
O. part 4658.0720, subpart 2, $100;
P. part 4658.0725, subpart 1, $350;
Q. part 4658.0725, subparts 2 and 3, $300;
R. part 4658.0725, subpart 4, $100;
S. part 4658.0730, subparts 1 to 4, $300; and
T. part 4658.0730, subpart 5, $100.

Statutory Authority: MS 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: September 25, 2009

INFECTION CONTROL

4658.0800 INFECTION CONTROL.

Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.

Subp. 2. Direction of program. A nursing home must assign one person, either a registered nurse or a physician, the responsibility of directing infection control activities in the nursing home.

Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.

Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following:

A. surveillance based on systematic data collection to identify nosocomial infections in residents;
B. a system for detection, investigation, and control of outbreaks of infectious diseases;
C. isolation and precautions systems to reduce risk of transmission of infectious agents;
D. in-service education in infection prevention and control;
E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections;
F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815;
G. a system for reviewing antibiotic use;
H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and
I. methods for maintaining awareness of current standards of practice in infection control.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: September 25, 2009

4658.0805 PERSONS PROVIDING SERVICES.
All persons providing services, including volunteers, with a communicable disease as listed in part 4605.7040 or with infected skin lesions must not be permitted to work in the nursing home unless it is determined that the person's condition will permit the person to work without endangering the health and safety of residents and other staff. The employee health policies required in part 4658.0800, subpart 4, item F, must address grounds for excluding persons from work and for reinstating persons to work due to a communicable disease or infected skin lesions.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431
History: 20 SR 303
Published Electronically: October 11, 2007

4658.0810 RESIDENT TUBERCULOSIS PROGRAM.
Subpart 1. Tuberculosis test at admission. A resident's clinical record must contain a report of a tuberculin test within the three months prior to admission or within 72 hours after admission, administered in conformance with the general guidelines for surveillance and diagnosis as found in Morbidity and Mortality Weekly Report (MMWR), Recommendations and Reports, July 13, 1990, Vol. 39, No. RR-10; "Prevention and Control of Tuberculosis in Facilities Providing Long-Term Care to the Elderly; Recommendations of the Advisory Committee for Elimination of Tuberculosis," as issued by the Centers for Disease Control and Prevention. This guideline is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change.

Subp. 2. Identification; evaluation; treatment. A nursing home must develop and implement policies and procedures addressing the identification, evaluation, and initiation of treatment for residents who may have active tuberculosis in accordance with Morbidity and Mortality Weekly Report (MMWR),
October 28, 1994, Vol. 43, No. RR-13; section II.C. of the "Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Facilities, 1994," issued by the Centers for Disease Control and Prevention, October 28, 1994. This guideline is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.0815 EMPLOYEE TUBERCULOSIS PROGRAM.

Subpart 1. Responsibility of nursing home. A nursing home must ensure that all employees, prior to employment and as otherwise indicated in this part, show freedom from active tuberculosis according to this part. A nursing home must establish a tuberculosis counseling, screening, and prevention program for all employees, in accordance with Morbidity and Mortality Weekly Report (MMWR), October 28, 1994, Vol. 43, No. RR-13; section II.J. of the "Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Facilities, 1994," issued by the Centers for Disease Control and Prevention. This guideline is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change.

Subp. 2. Tuberculin test. All employees, unless certified in writing by a physician to have had a positive reaction or other medical contraindication to a standard intradermal tuberculin test, must have an intradermal tuberculin test with purified protein derivative (Mantoux) within three months prior to employment.

Subp. 3. Written documentation of compliance. Reports or copies of reports of the tuberculin test or chest X-ray must be maintained by the nursing home.

Subp. 4. Evaluation of symptoms. All employees exhibiting symptoms consistent with tuberculosis must be evaluated within 72 hours.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.0820 FOOD POISONING AND DISEASE REPORTING.

Any occurrence of food poisoning or reportable disease as listed in part 4605.7040 must be reported immediately to the Minnesota Department of Health, Acute Disease Epidemiology Division, 717 Delaware Street SE, Minneapolis, Minnesota 55414 (612-623-5414).

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007
4658.0850 PENALTIES FOR INFECTION CONTROL RULE VIOLATIONS.

Penalty assessments will be assessed on a daily basis for violations of parts 4658.0800 to 4658.0820 and are as follows:

A. part 4658.0800, $300;
B. part 4658.0805, $300;
C. part 4658.0810, $200;
D. part 4658.0815, subparts 1 and 2, $200;
E. part 4658.0815, subpart 3, $50;
F. part 4658.0815, subpart 4, $300; and
G. part 4658.0820, $100.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

RECREATIONAL PROGRAM

4658.0900 ACTIVITY AND RECREATION PROGRAM.

Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program.

Subp. 2. Frequency of program activities. The activity and recreation program must be regularly scheduled every day, except that a nursing home may establish a policy designating holidays or other days that are exempt from scheduled activities. A schedule of the activities and recreation programming must be posted in a location readily accessible to residents at least one week in advance.

Subp. 3. Activity and recreation program director. The activity and recreation program director must be a person who is trained or experienced to direct the activity and recreation staff and program at that nursing home.

Subp. 4. Staff assistance with activities. Sufficient staff must be assigned to assist with the implementation of the activity and recreation program, as determined by the needs of the residents and the nursing home.

Subp. 5. Space, equipment, and materials. The activity and recreation program must be provided with space both within the nursing home and out-of-doors. Appropriate and adequate equipment and materials must be provided to meet the needs of the activity and recreation program.

Subp. 6. Prohibition on charges. A nursing home may not charge a resident for any portion of the activity and recreation program required in subpart 1. A nursing home may charge a resident for social events and entertainment offered outside the scope of the regularly scheduled activity and recreation program, if the event is requested by the resident and the nursing home informs the resident that there will be a charge.
4658.0950 PENALTIES FOR ACTIVITY AND RECREATION PROGRAM RULE VIOLATIONS.
Penalty assessments will be assessed on a daily basis for violations of part 4658.0900 and are as follows:

A. subparts 1, 3, and 6, $300; and
B. subparts 2, 4, and 5, $100.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

SPIRITUAL NEEDS

4658.0960 SPIRITUAL NEEDS.
A nursing home must provide opportunities for the residents' spiritual needs to be met.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.0990 PENALTIES FOR SPIRITUAL NEEDS RULE VIOLATIONS.
A $250 penalty assessment will be assessed on a daily basis for a violation of part 4658.0960.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

SOCIAL SERVICES

4658.1000 DEFINITIONS.
Subpart 1. Scope. For the purposes of this chapter, the following terms have the meanings given them.

Subp. 2. Medically related social services. "Medically related social services" means services provided by the nursing home's staff to assist residents in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs.

Subp. 3. Qualified social worker. Until June 30, 1996, "qualified social worker" means an individual with at least a bachelor's degree in a social work or a human services field, with at least one year of supervised social work experience in a health care setting working directly with individuals. Effective
July 1, 1996, "qualified social worker" means an individual licensed as a social worker by the Minnesota Board of Social Work according to Minnesota Statutes, chapter 148B.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.1005 SOCIAL SERVICES.

Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services.

Subp. 2. Social worker. A nursing home must employ a qualified social worker or a social services designee. A nursing home with more than 120 beds must have at least one filled qualified social worker position. The person or persons filling the qualified social worker position must be assigned full time to the social services of the nursing home and must fill at least one full-time equivalent position of at least 35 hours per week.

Subp. 3. Admission history and assessment. A psychosocial history and assessment must be completed for each new resident within 14 days after admission. The psychosocial history and assessment must contain sufficient information related to the resident's condition to develop care planning goals based on that resident's needs and strengths and may be used as a part of the comprehensive resident assessment required by part 4658.0400. The psychosocial history and assessment must be included in the resident's clinical record.

Subp. 4. Updating the assessment. The psychosocial assessment must be reviewed at least annually and updated as necessary.

Subp. 5. Providing social services. Social services must be provided on the basis of identified social service needs of each resident, according to the comprehensive resident assessment and comprehensive plan of care described in parts 4658.0400 and 4658.0405.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.1090 PENALTIES FOR SOCIAL SERVICES RULE VIOLATIONS.

Penalty assessments will be assessed on a daily basis for violations of parts 4658.1000 to 4658.1005 and are as follows:

A. part 4658.1005, subparts 1, 3, and 4, $300; and
B. part 4658.1005, subparts 2 and 5, $350.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007
BARBER AND BEAUTY SHOP SERVICES

4658.1100 BARBER AND BEAUTY SHOP SERVICES.
A nursing home must provide or arrange for the provision of barber and beauty shop services.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.1190 PENALTIES FOR BARBER AND BEAUTY SHOP SERVICES RULE VIOLATIONS.
A $100 penalty assessment will be assessed on a daily basis for violations of part 4658.1100.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

REHABILITATIVE SERVICES

4658.1200 SPECIALIZED REHABILITATIVE SERVICES.
Subpart 1. Definitions. For purposes of this part, the following terms have the meanings given them.

A. "Qualified personnel" means professional staff who are licensed, certified, or registered in accordance with applicable state laws and rules, and are educated to perform the particular service safely and competently.

B. "Specialized rehabilitative services" means restorative therapy and specialized maintenance therapy including, but not limited to, physical therapy, occupational therapy, and speech therapy.

Subp. 2. Provision of services. If specialized rehabilitative services are required in the resident's comprehensive plan of care, the nursing home must:

A. provide the required services; or

B. obtain the required services from an outside source according to part 4658.0075.

Subp. 3. Qualified personnel. Specialized rehabilitative services must be provided by qualified personnel under the written order of a physician or other health care practitioner authorized to prescribe.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.1290 PENALTIES FOR SPECIALIZED REHABILITATIVE SERVICES RULE VIOLATIONS.
Penalty assessments will be assessed on a daily basis for violations of part 4658.1200 and are as follows:

A. part 4658.1200, subpart 2, $350; and
B. part 4658.1200, subpart 3, $300.

Statutory Authority: MS s 144A.04; 144A.08

History: 21 SR 196

Published Electronically: October 11, 2007

MEDICATIONS

4658.1300 MEDICATIONS AND PHARMACY SERVICES; DEFINITIONS.

Subpart 1. Controlled substances. "Controlled substances" has the meaning given in Minnesota Statutes, section 152.01, subdivision 4.

Subp. 2. Schedule II drugs. "Schedule II drugs" means drugs with a high potential for abuse that have established medical uses as defined in Minnesota Statutes, section 152.02, subdivision 3.

Subp. 3. Pharmacy services. "Pharmacy services" means services to ensure the accurate acquiring, receiving, and administering of all drugs to meet the needs of each resident.

Subp. 4. Drug regimen. "Drug regimen" means all prescribed and over-the-counter medications a resident is taking.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.1305 PHARMACIST SERVICE CONSULTATION.

A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who:

A. provides consultation on all aspects of the provision of pharmacy services in the nursing home;

B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.1310 DRUG REGIMEN REVIEW.

A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration,
April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change.

B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician.

C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.1315 UNNECESSARY DRUG USAGE.

Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

A. in excessive dose, including duplicate drug therapy;

B. for excessive duration;

C. without adequate indications for its use; or

D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued.

In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25(1)(1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change.

Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment
4658.1320 MEDICATION ERRORS.

A nursing home must ensure that:

A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25(m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means:

1. a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or

2. the administration of expired medications.

B. It is free of any significant medication error. A significant medication error is:

1. an error which causes the resident discomfort or jeopardizes the resident's health or safety; or

2. medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity.

C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.1325 ADMINISTRATION OF MEDICATIONS.

Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services.

Subp. 2. Staff designated to administer medications. A nurse or unlicensed nursing personnel, as described in part 4658.1360, must be designated as responsible for the administration of medications during each work period.

Subp. 3. List of staff to administer medications. A list of staff authorized to administer medications must be available at each nursing station.

Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician.
Subp. 5. **Medications administered by injection.** Medications for injection may be given only by a physician, physician assistant, registered nurse, nurse practitioner, or licensed practical nurse, or may be self-administered by a resident in accordance with subpart 4.

Subp. 6. **Medications added to food.** Adding medication to a resident's food must be prescribed by the resident's physician and the resident, or the resident's legal guardian or designated representative, must consent to having medication added to food. This subpart does not apply to adding medication to food if the sole purpose is for resident ease in swallowing.

Subp. 7. **Administration requirements.** The administration of medications must include the complete procedure of checking the resident's record, transferring individual doses of the medication from the resident's prescription container, and distributing the medication to the resident.

Subp. 8. **Documentation of administration.** The name, date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized person who administered and observed the same must be recorded in the resident's clinical record. Documentation of the administration must take place following the administration of the medication. If administration of the medication was not completed as prescribed, the documentation must include the reason the administration was not completed, and the follow-up that was provided, such as notification of a registered nurse or the resident's attending physician.

**Statutory Authority:** MS s 144A.04; 144A.08; 256B.431

**History:** 20 SR 303; L 2014 c 291 art 4 s 58

**Published Electronically:** July 3, 2014

### 4658.1330 WRITTEN AUTHORIZATION FOR ADMINISTERING DRUGS.

All medications, including those brought into a nursing home by a resident, must be administered only in accordance with a written order signed by a health care practitioner licensed to prescribe in Minnesota except that order may be given by telephone provided that the order is done according to part 4658.0455.

**Statutory Authority:** MS s 144A.04; 144A.08; 256B.431

**History:** 20 SR 303

**Published Electronically:** October 11, 2007

### 4658.1335 STOCK MEDICATIONS.

Subpart 1. **Stock supply medications.** Only medications obtainable without prescription may be retained in general stock supply and must be kept in the original labeled container.

Subp. 2. **Emergency medication supply.** A nursing home may have an emergency medication supply which must be approved by the QAA committee. The contents, maintenance, and use of the emergency medication supply must comply with part 6800.6700.

Subp. 3. **Prohibitions.** No prescription drug supply for one resident may be used or saved for the use of another resident in the nursing home.
Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.1340 MEDICINE CABINET AND PREPARATION AREA.

Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys.

Subp. 2. Storage of Schedule II drugs. A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.1345 LABELING OF DRUGS.

Drugs used in the nursing home must be labeled in accordance with part 6800.6300.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.1350 DISPOSITION OF MEDICATIONS.

Subpart 1. Drugs given to discharged residents. Current medications, except controlled substances listed in Minnesota Statutes, section 152.02, subdivision 3, belonging to a resident must be given to the resident, or the resident's legal guardian or designated representative, when discharged or transferred and must be recorded on the clinical record.

Subp. 2. Destruction of medications.

A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years.

B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record.

Subp. 3. Loss or spillage. When a loss or spillage of a prescribed Schedule II drug occurs, an explanatory notation must be made in a Schedule II record. The notation must be signed by the person
4658.1355 MEDICATION REFERENCE BOOK.

A nursing home must maintain at least one current medication reference book. For the purposes of this part, "current" means material published within the previous two years.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303

Published Electronically: October 11, 2007

4658.1360 ADMINISTRATION OF MEDICATIONS BY UNLICENSED PERSONNEL.

Subpart 1. Authorization. The director of nursing services may delegate medication administration to unlicensed personnel according to Minnesota Statutes, sections 148.171, subdivision 15, and 148.262, subdivision 7.

Subp. 2. Training. Unlicensed nursing personnel who administer medications in a nursing home must:

A. have completed a nursing assistant training program approved by the department; and

B. have completed a standardized medication administration training program for unlicensed personnel in nursing homes which is offered through a Minnesota postsecondary educational institution that includes, at a minimum, instruction on the following:

(1) the complete procedure of checking the resident's medication record;
(2) preparation of the medication for administration;
(3) administration of the medication to the resident;
(4) assisting residents with self-administration as necessary;
(5) documentation after administration of the date, time, dosage, and method of administration of all medications, or the reason for not administering the medication as ordered, and the signature of the nurse or authorized person who administered and observed the same; and
(6) the type of information regarding medication administration reportable to a nurse.

Subp. 3. Documentation of training course. A nursing home must keep written documentation verifying completion of the required course by all unlicensed nursing personnel administering medications.

Subp. 4. Medication administration. A person who completes the required training course, and has been delegated the responsibility, may administer medication, whether oral, suppository, eye drops, ear drops, inhalant, or topical, if:
A. the medications are regularly scheduled; and

B. in the case of pro re nata (PRN) medications, the administration of the medication is authorized by a nurse or reported to a nurse within a time period that is specified by nursing home policy prior to the administration.

Statutory Authority: MS s 144A.04; 144A.08; 256B.431

History: 20 SR 303; L 1999 c 172 s 18

Published Electronically: October 11, 2007

4658.1365 PENALTIES FOR MEDICATIONS AND PHARMACY SERVICES RULE VIOLATIONS.

Penalty assessments will be assessed for violations of parts 4658.1300 to 4658.1360 and are as follows:

A. part 4658.1305, $300;
B. part 4658.1310, $300;
C. part 4658.1315, $300;
D. part 4658.1320, $500;
E. part 4658.1325, subpart 1, $500;
F. part 4658.1325, subpart 2, $300;
G. part 4658.1325, subpart 3, $50;
H. part 4658.1325, subpart 4, $250;
I. part 4658.1325, subpart 5, $500;
J. part 4658.1325, subpart 6, $250;
K. part 4658.1325, subpart 7, $350;
L. part 4658.1325, subpart 8, $300;
M. part 4658.1330, $350;
N. part 4658.1335, $300;
O. part 4658.1340, $300;
P. part 4658.1345, $300;
Q. part 4658.1350, $300;
R. part 4658.1355, $100;
S. part 4658.1360, subpart 1, $350;
T. part 4658.1360, subpart 2, $300;
U. part 4658.1360, subpart 3, $50; and
V. part 4658.1360, subpart 4, $350.
4658.1400 PHYSICAL ENVIRONMENT.

A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.1405 RESIDENT UNITS.

The following items must be provided for each resident:

A. a bed of proper size and height for the convenience of the resident, a clean, comfortable mattress, and clean bedding, appropriate for the weather and resident's comfort, that are in good condition. Each bed must have a clean bedspread. A moisture-proof mattress or mattress cover must be provided for all residents confined to bed and for other beds as necessary. Rollaway type beds, cots, or folding beds must not be used;

B. a chair or place for the resident to sit other than the bed;

C. a place adjacent or near the bed to store personal possessions, such as a bedside table with a drawer;

D. clean bath linens provided daily or more often as needed; and

E. a bed light conveniently located and of an intensity to meet the needs of the resident while in bed or in an adjacent chair.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 2, 2013

4658.1410 LINEN.

Nursing home staff must handle, store, process, and transport linens so as to prevent the spread of infection according to the infection control program and policies as required by part 4658.0800. These laundering policies must comply with the manufacturer's instructions for the laundering equipment and products and include a wash formula addressing the time, temperature, water hardness, bleach, and final pH.
4658.1415 PLANT HOUSEKEEPING, OPERATION, AND MAINTENANCE.

Subpart 1. Direction of housekeeping and plant management. One or more persons, qualified through education and experience, must be assigned the responsibility of direction of housekeeping and plant management.

Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program.

Subp. 3. Grounds. The grounds must be maintained with regard to the health, comfort, safety, and well-being of the residents. Driveways, walks, outside steps, and ramps must be maintained in good condition for access and safe use at all times.

Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.

Subp. 5. Written program. A nursing home must develop and implement a written program for routine daily housekeeping duties and any special cleaning necessary.

Subp. 6. Heating, air conditioning, and ventilation. A nursing home must operate and maintain the mechanical systems to provide comfortable and safe temperatures, air changes, and humidity levels. Temperatures in all resident areas must be maintained according to items A to C.

A. For construction of a new physical plant, a nursing home must maintain a temperature range of 71 degrees Fahrenheit to 81 degrees Fahrenheit at all times.

B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season.

C. Variations of the temperatures required by items A and B are allowed if the variations are based on documented resident preferences.

Subp. 7. Hot water temperature. Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to 115 degrees Fahrenheit at the fixtures.

Subp. 8. Janitor's closet. The janitor's closet and all other areas used by the environmental services personnel must be kept clean.

Subp. 9. Storage of supplies. Supplies must be stored above the floor to facilitate cleaning of the storage area. Supplies must be identified. Toxic substances must be clearly identified and stored in a locked enclosure. Sterile supplies must be stored to maintain sterility and integrity in packaging. All substances, such as cleaning agents, bleaches, detergents, disinfectants, pesticides, paints, and flammable liquids, must be stored separately from all food and drugs.
4658.1490 NURSING HOMES

Subp. 10. **Boiler water additives.** Precautions must be taken to ensure that the type and concentration of boiler water additives is not harmful if steam is used for humidification or comes into direct contact with food.

Subp. 11. **Insect and rodent control.** Any condition on the site or in the nursing home conducive to the harborage or breeding of insects, rodents, or other vermin must be eliminated immediately. A continuous pest control program must be maintained by qualified personnel.

**Statutory Authority:** MS s 144A.04; 144A.08
**History:** 21 SR 196

**Published Electronically:** October 2, 2013

4658.1420 SOLID WASTE DISPOSAL.

Solid wastes, including garbage, rubbish, recyclables, and other refuse must be collected, stored, and disposed of in a manner that will not create a nuisance or fire hazard, nor provide a breeding place for insects or rodents. Accumulation of combustible material or waste in unassigned areas is prohibited.

**Statutory Authority:** MS s 144A.04; 144A.08
**History:** 21 SR 196

**Published Electronically:** October 11, 2007

4658.1425 OZONE GENERATORS.

Ozone generators are prohibited.

**Statutory Authority:** MS s 144A.04; 144A.08
**History:** 21 SR 196

**Published Electronically:** October 11, 2007

4658.1490 PENALTIES FOR ENVIRONMENTAL SERVICES RULE VIOLATIONS.

Penalty assessments will be assessed on a daily basis for violations of parts 4658.1400 to 4658.1425 and are as follows:

A. part 4658.1400, $200;
B. part 4658.1405, $150;
C. part 4658.1410, $200;
D. part 4658.1415, subpart 1, $300;
E. part 4658.1415, subparts 2 to 7, $200;
F. part 4658.1415, subpart 8, $150;
G. part 4658.1415, subparts 9 to 11, $200;
H. part 4658.1420, $200; and
I. part 4658.1425, $150.
SPECIALIZED UNITS

4658.2000 SECURED UNITS.

Subpart 1. Secured unit, definition. For purposes of parts 4658.2000 to 4658.2090, "secured unit" means a nursing home unit in which a resident's horizontal and vertical access in or out of the unit is restricted.

Subp. 2. Locked unit, definition. For purposes of parts 4658.2000 to 4658.2090, "locked unit" means a nursing home unit in which a resident's access is restricted because the doors to the unit are locked from the outside. A locked unit is a form of secured unit.

Subp. 3. Criteria for assignment to secured unit. A resident may be assigned to placement in a secured unit only if the results of a comprehensive resident assessment as required by part 4658.0400 indicate that resident requires a more secure environment and there is a physician's written order for placement in a secured unit. A resident may choose to reside in a secured unit if the comprehensive resident assessment and plan of care as required by parts 4658.0400 and 4658.0405 determine that placement in a secured unit is appropriate for that resident.

Subp. 4. Approval by state fire marshal. Fire safety systems and locking arrangements must be reviewed and approved by the state fire marshal according to part 4658.4030 before operation as a secured unit.

Subp. 5. Approval by department. A secured unit must be approved by the department according to part 4658.4030 before operation as a secured unit. Any significant change to the statement of operations for the secured unit, as required by part 4658.2020, must be reviewed and approved by the department before making the change.
4658.2010 PHYSICAL PLANT REQUIREMENTS.

The physical plant of the secured unit must include, at a minimum, resident bedrooms, a central bathing area, dayroom, dining room, nurses' station, clean utility room, and soiled utility room. The dining room and dayroom spaces in the secured unit must comply with part 4658.4200. The construction of a new secured unit physical plant, or any physical plant changes that meet the definition of "new construction" in part 4658.0010, subpart 5a, must be in compliance with the requirements for new construction in parts 4658.3500 to 4658.4690.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

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:

A. a statement of the philosophy and objectives of the unit;
B. a description of the population to be served;
C. a list of the admission and discharge criteria; and
D. a list of any environmental changes or adaptations, and any necessary waivers for them granted by the department.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.2030 SPECIALIZED CARE UNIT.

Subpart 1. Specialized care unit, defined. For purposes of this part, "specialized care unit" means any nursing unit within a nursing home designed and advertised for a specific population.

Subp. 2. Statement of operations. A nursing home must develop and implement a statement of operations for the specialized care unit, which must include, at a minimum:

A. the philosophy and objectives of the unit;
B. the intended population of the unit; and
C. admission and discharge criteria for the unit.

Subp. 3. Availability of statement of operations. A nursing home must make the statement of operations for the specialized care unit available to the department and to the public.
4658.2090 PENALTIES FOR SPECIALIZED UNITS RULE VIOLATIONS.

Penalty assessments for violations of parts 4658.2000 to 4658.2030 shall be assessed on a daily basis and are as follows:

A. part 4658.2000, subpart 2, $300;
B. part 4658.2000, subpart 3, $200;
C. part 4658.2000, subpart 4, $200;
D. part 4658.2010, $200;
E. part 4658.2020, $100;
F. part 4658.2030, subpart 2, $100; and
G. part 4658.2030, subpart 3, $50.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

PHYSICAL PLANT LICENSURE, EXISTING AND NEW

4658.3000 LICENSURE.

The commissioner of health must be notified directly in writing about proposed planning for all new construction, remodeling, changes in existing service, function or bed capacity, addition of new services, sale, and change of ownership.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.3005 COMPLIANCE WITH RULES.

Subpart 1. New construction. New construction must be according to the requirements for new construction in parts 4658.3500 to 4658.4690.

Subp. 2. Existing facilities. All existing facilities must be in compliance with the physical plant requirements for new construction, except as noted in this chapter. When additional beds are added to existing facilities, the required dayroom and dining room areas must be based on the bed capacity of the entire facility. Compliance with the standards for new construction for existing facilities must be for the areas involved and to the extent that the existing structure will permit.

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.
Subp. 5. **Redecoration.** A nursing home must maintain specification sheets for all wall, floor, or ceiling covering materials, except paint. The materials and installation must be in accordance with the Life Safety Code.

Subp. 6. **Remodeling.** New construction standards apply only to those materials, space, and equipment being remodeled. The new construction plan requirements of parts 4658.3500 to 4658.4090 apply to all remodeling projects.

Subp. 7. **Replace-in-kind.** The department must be notified in writing prior to all replace-in-kind projects, except in the case of an emergency. Changes in space required for the replacement equipment must be only to the extent required by the newer equipment.

**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196

**Published Electronically:** October 11, 2007

### 4658.3090 PENALTIES; RULE VIOLATIONS.

Penalty assessments for violations of parts 4658.3000 to 4658.3005 shall be assessed on a daily basis and are as follows:

A. part 4658.3000, $100;

B. part 4658.3005, subparts 2 and 4, $200; and

C. part 4658.3005, subparts 5 to 7, $100.

**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196

**Published Electronically:** October 2, 2013

NEW CONSTRUCTION; PLANS

### 4658.3500 INCORPORATION BY REFERENCE; NEW CONSTRUCTION.

Subpart 1. **Scope.** For purposes of this chapter, the documents in subparts 2 to 6 are incorporated by reference. They can be found at the Minnesota Law Library, 25 Rev. Dr. Martin Luther King Jr. Blvd., Saint Paul, Minnesota 55155. They are also available through the Minitex interlibrary loan system. They are subject to frequent change. If any of the documents in subparts 2 to 6 are amended, then the amendments to the documents are also incorporated by reference. All construction, installations, and equipment must conform to the codes and standards in this part, provided that the requirements of such codes or standards are not inconsistent with the requirements of these regulations.
Subp. 2. Minnesota Rules. The following documents are also available from the Print Communications Division, 117 University Avenue, Saint Paul, Minnesota 55155:

A. chapters 1300 to 1365, the Minnesota State Building Code;
B. chapter 4714, the Minnesota Plumbing Code; and
C. chapter 4626, the Minnesota Food Code.

Subp. 3. NSF international standards and criteria. The following documents are also available from the NSF International, ATTN: Publications, P.O. Box 130140, Ann Arbor, Michigan 48113-0140:

A. Standard No. 1, Soda Fountain and Luncheonette Equipment, June 1984;
B. Standard No. 2, Food Equipment, May 1992;
C. Standard No. 3, Commercial Spray-Type Dishwashing Machines, June 1982;
D. Standard No. 4, Commercial Cooking, Rethermalization and Powered Hot Food Holding Equipment, May 1992;
F. Standard No. 6, Dispensing Freezers, February 1989;
G. Standard No. 7, Food Service Refrigerators & Storage Freezers, May 1990;
H. Standard No. 8, Commercial Powered Food Preparation Equipment, November 1992;
K. Standard No. 18, Manual Food and Beverage Dispensing Equipment, November 1990;
L. Standard No. 25, Vending Machines for Food & Beverages, November 1990;
M. Standard No. 26, Pot, Pan, and Utensil Washers, December 1980;
N. Standard No. 29, Detergent & Chemical Feeders for Commercial Spray-Type Dishwashing Machines, November 1992;
O. Standard No. 35, Laminated Plastics for Surfacing Food Service Equipment, November 1991;
P. Standard No. 51, Plastic Materials and Components Used in Food Equipment, May 1978; and
Q. Criteria C-2, Special Equipment and/or Devices (Food Service Equipment), November 1983.

Subp. 4. NFPA documents. The following documents are also available from the National Fire Protection Association, Batterymarch Park, Quincy, Massachusetts 02269:

A. Life Safety Code, National Fire Protection Association, NFPA No. 101, 1985 edition; and

Subp. 5. ANSI/ASME document. The following document, published by the American National Standards Institute and the American Society of Mechanical Engineers, is also available from the American


**Statutory Authority:** MS s 31.101; 31.11; 144.05; 144.08; 144.12; 144A.04; 144A.08; 157.011

**History:** 21 SR 196; 23 SR 519; 40 SR 71

**Published Electronically:** April 1, 2016

4658.3590 PENALTIES FOR INCORPORATIONS BY REFERENCE; NEW CONSTRUCTION

RULE VIOLATIONS.

A $200 penalty shall be assessed on a daily basis for violations of part 4658.3500.

**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196

**Published Electronically:** October 11, 2007

4658.4000 PREPARATION OF PLANS; NEW CONSTRUCTION.

Architectural and engineering plans and specifications for new construction must be prepared and signed by architects and engineers who are registered in Minnesota and in accordance with the requirements by the Board of Architecture, Engineering, Land Surveying, Landscape Architecture, and Interior Design.

**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196

**Published Electronically:** October 11, 2007

4658.4005 APPROVAL OF PLANS; NEW CONSTRUCTION.

Preliminary plans and final working drawings and specifications for proposed construction must be submitted to the commissioner of health for review and approval. Preliminary plans must be approved before the preparation of final working drawings is undertaken. Final working drawings and specifications must be approved before construction is begun.

**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196

**Published Electronically:** October 11, 2007

4658.4010 PRELIMINARY PLANS; NEW CONSTRUCTION.

A. Preliminary plans must be drawn to scale, show basic dimensions, and indicate the general layout and space arrangement of the proposed building or area and must include a site plan when applicable. Plans must indicate assignments of rooms and areas, and must show bed capacities and fixed equipment.
B. The plans should include consideration for future expansion of a nursing home by consideration of the site, orientation of the structure on the site, parking, and resident, dietary, and laundry areas. If a laundry is not contemplated initially, provision must be made for its possible future location.

Statutory Authority: MS s 144A.04; 144A.08

History: 21 SR 196

Published Electronically: October 2, 2013

4658.4015 FINAL PLANS; NEW CONSTRUCTION.

Final architectural plans and specifications must include elevations and sections through the building showing types of construction, and must indicate dimensions and assignments of rooms and areas, room finishes, door types and hardware, elevations and details of nurses' stations, utility rooms, toilets and bathing areas, and large-scale layouts of dietary and laundry areas. Plans must show location of fixed equipment and sections and details of elevators, chutes, and other conveying systems. Fire walls and smoke partitions must be indicated. The roof plan must show all mechanical installations. The site plan, if applicable, must indicate the proposed and existing buildings, topography, roadways, walks, and utility service lines.

Statutory Authority: MS s 144A.04; 144A.08

History: 21 SR 196

Published Electronically: October 11, 2007

4658.4020 FINAL MECHANICAL AND ELECTRICAL PLANS; NEW CONSTRUCTION.

Final mechanical and electrical plans and specifications must address the complete layout and type of all installations, systems, and equipment to be provided according to this chapter. Heating plans must include heating elements, piping, thermostatic controls, pumps, tanks, heat exchangers, boilers, breeching, and accessories. Ventilation plans must include room air quantities, ducts, fire and smoke dampers, exhaust fans, humidifiers, and air handling units. Plumbing plans must include a fixtures and equipment fixture schedule; water supply and circulating piping, pumps, tanks, riser diagrams, and building drains; the size, location, and elevation of water and sewer services; and the building fire protection systems. Electrical plans must include fixtures and equipment, receptacles, switches, power outlets, circuits, power and light panels, transformers, and service feeders. Plans must show location of nurse call signals, telephones, fire alarm stations and detectors, and emergency lighting.

Statutory Authority: MS s 144A.04; 144A.08

History: 21 SR 196

Published Electronically: October 11, 2007

4658.4025 START OF CONSTRUCTION; NEW CONSTRUCTION.

Subpart 1. Notification to department. The department must be notified in writing within seven days after beginning construction. Unless construction is begun within one year after approval of final working drawings and specifications, the drawings must be resubmitted for renewal of review and approval.
Subp. 2. **Approval of construction changes.** All construction must be executed according to the approved final plans and specifications. Subsequent construction changes addressed by this chapter must be approved by the department before the changes are made.

**Statutory Authority:** *MS s 144A.04; 144A.08*

**History:** *21 SR 196*

**Published Electronically:** *October 2, 2013*

### 4658.4030 FINAL INSPECTION; NEW CONSTRUCTION.

The department must be notified at least 30 days before the completion of construction so that arrangements can be made for a final inspection by the department and by the state fire marshal. Completion means the entire construction, equipment, staffing patterns, and services. Mechanical and electrical systems must be completed and tested for performance and safety in accordance with specifications and state requirements before new construction can be licensed and residents admitted.

**Statutory Authority:** *MS s 144A.04; 144A.08*

**History:** *21 SR 196*

**Published Electronically:** *October 11, 2007*

### 4658.4035 PLAN SAFEKEEPING; NEW CONSTRUCTION.

At least one set of complete plans of the entire facility, including changes resulting from remodeling or alterations, must be kept on file in the nursing home.

**Statutory Authority:** *MS s 144A.04; 144A.08*

**History:** *21 SR 196*

**Published Electronically:** *October 11, 2007*

### 4658.4040 SITE; NEW CONSTRUCTION.

A nursing home must be so located as to protect at all times the health, comfort, and safety of residents. The factors in selecting the site for a new nursing home must include the following in items A to J.

A. Public utilities must be available.

B. The water supply must be obtained from an approved public water supply system. If none is available, water must be obtained from a water supply system whose location, construction, and operation complies with parts 4720.0010 to 4720.4600 and, where applicable, parts 4725.0050 to 4725.7450. Plans and specifications for a private water supply system must be approved before construction of the system or the nursing home is started.

C. Sewage and other liquid wastes must be discharged into an approved public sewer system where available. If none is available, sewage must be collected, treated, and disposed of in a sewage disposal system which is designed, located, constructed, and operated according to chapter 7080. Plans and specifications for a private sewage disposal system must be approved before construction of the system or the nursing home is started.
D. The site must be no closer than 300 feet to the right-of-way of a railroad main line or to the property line of industrial developments which are nuisance-producing or hazardous to health under state or local law.

E. The site must not be located within 85 feet of underground or 300 feet of aboveground storage tanks or warehouses containing flammable liquids.

F. The site must be publicly accessible to fire department services, medical services, and community activities.

G. The topography must provide good natural drainage and not be subject to flooding.

H. Adequate all-weather roads and walks must be provided within the lot lines to the primary entrance and the service entrance, including employees' and visitors' parking at the site.

I. The primary entrance must be accessible for the elderly and individuals with disabilities.

J. The site must include space for outdoor activities.

Statutory Authority: MS s 115.03; 115.55; 115.56; 144A.04; 144A.08

History: 21 SR 196; 24 SR 426

Published Electronically: October 2, 2013

4658.4090 PENALTIES FOR PLANS; NEW CONSTRUCTION RULE VIOLATIONS.

Penalty assessments for violations of parts 4658.4000 to 4658.4040 shall be assessed on a daily basis and are as follows:

A. parts 4658.4000 to 4658.4035, $100; and

B. part 4658.4040, $200.

Statutory Authority: MS s 144A.04; 144A.08

History: 21 SR 196

Published Electronically: October 11, 2007

RESIDENT AREAS; NEW CONSTRUCTION

4658.4100 RESIDENTS' BEDROOM REQUIREMENTS, CAPACITIES; NEW CONSTRUCTION.

At least five percent of the rooms must be designed for single person occupancy (one bed), and must have private toilet rooms. No room may have more than two beds. No toilet room may be shared by more than two bedrooms.

Statutory Authority: MS s 144A.04; 144A.08

History: 21 SR 196

Published Electronically: October 11, 2007

4658.4105 BEDROOM DESIGN; NEW CONSTRUCTION.

Subpart 1. Design. Each bedroom must be designed and equipped for adequate nursing care, comfort, and privacy of residents, including full visual privacy of residents.
Subp. 2. **Usable floor area.** The usable floor area and the arrangement and shape of the bedroom must provide space for furnishings, for the free movement of residents with physical disabilities, and for nursing procedures. "Usable floor area" does not include spaces occupied by toilet rooms, vestibules, permanently installed wardrobes, lockers, closets, or heating units. The usable floor area per bed must be at least 100 square feet per resident in double bedrooms, and at least 120 square feet in single bedrooms.

Subp. 3. **Access to exit.** Each bedroom must have direct access to an exit corridor.

Subp. 4. **Bedroom shape.** The shape of the bedroom must allow for the capability of a bed arrangement that provides at least three feet of floor space at both sides and the foot end of each bed.

Subp. 5. **Window.** Each bedroom must have at least one window to the outdoors.

Subp. 6. **Window area.** The window area must not be less than one-eighth of the required usable floor area, and the window sill must not be higher than two feet six inches above the floor. The entire window area must face an open outdoor space not less than 30 feet deep, and must provide an unobstructed angle of vision within this space of not less than 65 degrees. The 30-foot-deep open outside space must be measured perpendicular to the plane of the window. The 65 degree unobstructed angle of vision must include the perpendicular bisector of the window. Figure #1 illustrates these requirements:

![Diagram](image_url)
Subp. 7. **Floor at grade level.** Each bedroom must have a floor at or above grade level. An energy conservation berm as detailed in the diagram below is permitted. The following three diagrams illustrate acceptable methods of compliance with this subpart.

Subp. 8. **Distance from nurses' station.** Bedrooms must be located not more than 140 feet from the nurses' station.

**Statutory Authority:** *MS s 144A.04; 144A.08*

**History:** 21 SR 196; L 2005 c 56 s 2

**Published Electronically:** October 11, 2007
4658.4110 BEDROOM DOORS; NEW CONSTRUCTION.

Subpart 1. **Written policy.** A nursing home must develop a written policy regarding the use of locks on bedroom doors. The policy must address whether or not doors can be locked while the resident is in the room.

Subp. 2. **Door locks.** All bedroom door locks must permit exit from the room by a simple operation without the use of a key. All locks must be openable with a master key which is located at each nurses' station.

Subp. 3. **Door.** The door to the corridor must be of fire-resistive construction in accordance with the Minnesota State Building Code, open into the bedroom, and have a nominal width of 44 inches. Bedroom doors must not open directly to an area where services are provided.

**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196

**Published Electronically:** October 11, 2007

4658.4115 CLOTHES WARDROBE OR CLOSET; NEW CONSTRUCTION.

A nursing home must provide each resident with individual wardrobe or closet space in the resident's bedroom with clothes racks and shelves accessible to the resident. Locks may be provided, with keys for the residents when a pass key is available at the nurses' station.

**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196

**Published Electronically:** October 11, 2007

4658.4120 HANDRAILS AND CORRIDORS; NEW CONSTRUCTION.

Subpart 1. **Handrails.** Securely anchored, durable handrails must be provided on both sides of corridors used by residents. If a length of corridor space between doorways is 60 inches or less, a handrail is not necessary for that portion of the corridor. The handrails must be mounted at a height of 32 to 34 inches to the top of the handrail. The handrail must be a round or oval section, 1-1/2 to two inches in diameter, and the clear distance between the handrail and wall must be 1-1/2 inches. The handrail must be designed to provide the means for a full hand grip around the handrail. Wall bracket supports must be provided at least six feet on center, and the mounted brackets must be capable of supporting a load of not less than 250 pounds. The following two diagrams illustrate two acceptable handrails.
Subp. 2. **Corridor width.** The unobstructed width of all corridors in resident areas must be at least eight feet. All exits must comply with the Minnesota State Building Code.

**Statutory Authority:** *MS s 144A.04; 144A.08*

**History:** *21 SR 196*

**Published Electronically:** *October 11, 2007*
4658.4125 NURSING AREA; NEW CONSTRUCTION.

Subpart 1. Nurses' station. At least one nurses' station must be provided per resident floor. A nurses' station may serve more than one nursing area on the same floor if the maximum distance from resident bedrooms does not exceed that required in part 4658.4105, subpart 8. The nurses' station must be equipped to receive resident calls through a communication system from resident rooms and toilet and bathing facilities.

Subp. 2. Location. Each nursing station must be located to provide for observation of corridors, residents, and resident calls. Private space must be provided for charting, storage of charts and supplies, and medicine preparation. The medication preparation area may be within the nurses' station or the clean utility room. Each nurses' station must contain facilities for cleanup and handwashing.

Subp. 3. Staff toilet. A separate staff toilet room must be provided near the nurses' station.

Subp. 4. Clean utility room. A clean utility room must be provided within each nursing area. The clean utility room must contain a sink with institutional fittings. Cabinets and shelving must be provided for the storage of materials and supplies.

Subp. 5. Soiled utility room. A separate soiled utility room must be provided within each nursing area. It must contain handwashing facilities and a clinical service sink for disposal of waste materials and the cleanup of soiled linen and utensils. Cabinets and shelving must be provided for the storage of materials and supplies.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4130 NOURISHMENT AREA; NEW CONSTRUCTION.

Subpart 1. Equipment. A nourishment area must be provided for serving between-meal refreshments. It may serve more than one nursing area, and may be located contiguous to a dayroom. The nourishment area must be provided with a work counter and sink, storage cabinets, and a refrigerator. The equipment may be residential-type equipment as long as the nourishment area is not used as part of the dietary department.

Subp. 2. Range disconnect switch. If the nourishment area includes an electric range that is accessible to the residents, a key-operated disconnect switch, with indicator light, must be provided for that range. The disconnect switch and indicator light must be readily accessible for staff.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4135 TOILET ROOMS AND SANITARY FIXTURES; NEW CONSTRUCTION.

Subpart 1. Design and equipment. Toilet rooms for residents, personnel, and the public must be designed and equipped according to part 4658.4145, except as noted in this part. A nursing home must have at least one toilet and one sink for four beds, and at least one shower or tub for 20 beds, excluding toilets for personnel or the public, and toilets in central bathing and other service areas. At least one toilet room must
be designed and equipped according to part 4658.4150 and available for public use. Each toilet room must include a sink. All sinks must be provided with hot and cold water.

Subp. 2. **Showers and tubs.** There must be at least one shower and one tub in each nursing home.

**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196

**Published Electronically:** October 11, 2007

**4658.4140 PROVISION OF RESIDENT TOILET ROOMS; NEW CONSTRUCTION.**

Each resident toilet room must be directly accessible from the bedroom. A toilet room may serve two bedrooms, but no more than four beds, if residents are of the same sex. Hinged doors must swing out, or must be double acting and provided with an emergency-type release stop. Privacy door locks must be of a type which can be opened by staff in an emergency. Sliding doors must be surface mounted. Folding doors and pocket doors are prohibited.

**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196

**Published Electronically:** October 11, 2007

**4658.4145 TOILET ROOM LAYOUT; NEW CONSTRUCTION.**

The layout for a toilet room must include items A to J.

A. The door opening must have a clear opening of at least 32 inches. Hinged doors must swing out, or must be double acting and provided with an emergency-type release stop.

B. The center of the toilet must be located 18 inches from the side wall and there must be at least three feet of unobstructed space in front of the bowl. No basic interior room dimension may be less than 42 inches.

C. The toilet must be mounted at a height of not less than 17 inches nor more than 19 inches above the floor, measured to the top of the seat. The bowl must be elongated with an open-front seat.

D. Flush valves must be a quiet operating type.

E. The paper holder must be securely anchored on the side wall near the toilet, six inches above the seat, and six to 12 inches in front of the seat with both dimensions measured to the center of the holder.

F. A vertical grab bar, at least 18 inches long, must be provided on the side wall near the toilet. The low end must be mounted at a height of ten inches above the toilet seat and at a distance of 12 inches in front of the seat. A grab bar on each side of the toilet is recommended.

G. Grab bars must have an outside diameter of 1-1/4 to 1-1/2 inches, and must provide a clearance of 1-1/2 inches between the grab bar and the wall. Grab bars must be securely anchored to sustain a load of 250 pounds for five minutes.

H. The sink, with or without a counter top, must be mounted at a height of 32 to 34 inches above the floor, measured to the top edge.

I. A towel bar must be provided at a height of 42 to 44 inches above the floor. It must be a horizontal grab bar.
4658.4150 PHYSICALLY ACCESSIBLE TOILET ROOMS; NEW CONSTRUCTION.

The layout for physically accessible toilet rooms must include items A to M.

A. Toilet rooms for wheelchair users must be arranged to allow movement for the frontal, oblique, and lateral angle approach.

B. The door opening must have a clear opening of at least 32 inches, and must be located within an area in front of the toilet. Hinged doors must swing out, or must be double acting and be provided with an emergency-type release stop. Privacy door locks must be of a type which can be opened by staff in an emergency.

C. The center of the toilet must be located 18 inches from the side wall and there must be at least four feet of unobstructed space in front of the bowl. All basic interior room dimensions must be at least 66 inches.

D. The toilet must be mounted at a height of 17 to 19 inches above the floor, measured to the top of the seat. The bowl must be elongated with an open front seat.

E. Flush valves must be a quiet operating type.

F. The paper holder must be securely anchored on the side wall near the toilet, 19 to 25 inches above the floor, and six to 12 inches in front of the seat with both dimensions measured to the center of the holder.

G. An L-shaped grab bar, each leg at least 18 inches long, must be provided, securely anchored on the side wall near the toilet. The low end of the vertical leg must be mounted at a height of ten inches above the toilet seat and at a distance of 12 inches in front of the seat, and the horizontal grab bar must extend toward the back wall.

H. A horizontal grab bar must be mounted on the wall at the rear of the toilet at a height of 33 to 36 inches above the floor. The grab bar must be at least 36 inches long.

I. Grab bars must have an outside diameter of 1-1/4 to 1-1/2 inches, and must provide a clearance of 1-1/2 inches between the grab bar and the wall. Grab bars must be securely anchored to sustain a load of 250 pounds for five minutes.

J. The sink, with or without a counter top, must be accessible and must not interfere with general wheelchair movements. It must be mounted at a height of 34 inches above the floor, measured to the top edge, and must provide a vertical clearance of at least 27 inches for knee space. A standard-type sink which meets these conditions is acceptable.

K. A towel bar must be provided at a height of 42 to 44 inches. It must be a horizontal grab bar.

L. If a mirror is provided, and is mounted flush to the wall, the bottom of the mirror must be placed at a height of 36 inches and the top at a height of at least 66 inches. Tilting mirrors are allowed provided they are mounted to meet the needs of the residents.
M. A shelf large enough to accommodate a resident's personal toilet accessories must be provided at a height of 32 to 36 inches, unless space is provided by a suitable sink or a counter.

Statutory Authority: MS s 144A.04; 144A.08

History: 21 SR 196; L 2005 c 56 s 2

Published Electronically: October 2, 2013

4658.4155 CENTRAL BATHING AREA; NEW CONSTRUCTION.

Subpart 1. Fixtures. Bathing fixtures must be provided in accordance with part 4658.4135.

Subp. 2. General requirements.

A. In bathing areas with more than one fixture, each bathtub or shower area must be provided with privacy curtains or wall dividers.

B. If a toilet is located within an open area with multiple bathing fixtures, the toilet area must be provided with privacy curtains or stall partitions.

C. All bathtub and shower areas must be designed for assisted bathing.

D. The bathing area must have direct access to a toilet room or space without going through the general corridor, and the toilet room or space must allow space for assistance of residents according to part 4658.4150.

E. Bathtubs and showers must be provided with a nonslip bottom or floor surface and at least one grab bar, securely anchored, must be provided at each fixture.

F. If towel bars are provided, they must be horizontal grab bars, securely anchored.

G. A bar soap holder, if provided, must be without handles and recessed.

H. The door or doors to the bathing area must have privacy door locks. Hinged doors must swing out, or they must be double acting and be provided with an emergency-type release stop.

Subp. 3. Shower areas.

A. Central showers must not be less than 48 inches by 48 inches, or 54 inches by 42 inches with the long side open, without a curb, and with a 32-inch high splash protection.

B. The shower area must have controls located near the splash protection for easy reach by both resident and attendant. A flexible hose hand shower must be provided.

C. A vertical, nonslip grab bar, 24 inches long, must be provided at the shower and at the shower entrance location. The low end of the grab bar must be 36 inches above the floor. Horizontal grab bars inside the wet areas must be mounted at a height of 54 inches above the floor.

Subp. 4. Bathtub areas.

A. The location of the tub and the design of the central bathing area must allow a minimum of four feet of clearance around the working areas of the tub.

B. A pedestal used to elevate a standard-type bathtub must be provided with a finished cleanable surface, and include a toe space.

C. A flexible hose hand shower must be provided.
D. Horizontal or vertical grab bars must be located in proximity to the tub in order to accommodate safe use of the tub and the requirements of the bathing program, including drying of residents. These grab bars must be either wall-mounted or part of the tub design and construction.

Statutory Authority: MS s 144A.04; 144A.08

History: 21 SR 196

Published Electronically: October 11, 2007

4658.4160 DRINKING FOUNTAINS; NEW CONSTRUCTION.

Refrigerated drinking fountains must be provided in resident areas, the recreational or activities area, and in or near the dining area.

Statutory Authority: MS s 144A.04; 144A.08

History: 21 SR 196

Published Electronically: October 11, 2007

4658.4165 HANDWASHING FACILITIES; NEW CONSTRUCTION.

Handwashing facilities must be available for persons providing services to residents. Single-service towels must be available at all times. Use of a common towel is prohibited.

Statutory Authority: MS s 144A.04; 144A.08

History: 21 SR 196

Published Electronically: October 11, 2007

4658.4170 STORAGE; NEW CONSTRUCTION.

Subpart 1. Equipment and supplies.

A. A storage room or rooms must be provided in each nursing area.

B. Total storage area within the nursing home for the storage of equipment and supplies must be provided in the amount of at least 15 square feet per bed including space for the storage of:

1. clean items and supplies in a clean utility room;
2. supplies and equipment for the activities program;
3. supplies and equipment in the barber and beauty shop room;
4. wheelchairs, walkers, and other adaptive equipment; and
5. bulk paper products.

C. Space for storage of food and linens must be provided in addition to the required storage area in item B.

Subp. 2. Housekeeping supplies. An area for the storage of housekeeping supplies and equipment must be provided in each janitor's closet.

Subp. 3. Yard maintenance equipment and supplies. Separate enclosed storage space for the storage of yard maintenance equipment and supplies must be provided outside the nursing home.
**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196

**Published Electronically:** October 11, 2007

### 4658.4175 JANITOR'S CLOSET; NEW CONSTRUCTION.

A janitor's closet must be provided for each resident floor or nursing area.

**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196

**Published Electronically:** October 11, 2007

### 4658.4180 ROOM LABELING; NEW CONSTRUCTION.

All bedrooms must be labeled using a system of numbers. All service rooms must be labeled.

**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196

**Published Electronically:** October 11, 2007

### 4658.4190 PENALTIES FOR RESIDENT AREAS; NEW CONSTRUCTION RULE VIOLATIONS.

Penalty assessments for violations of parts 4658.4100 to 4658.4180 shall be assessed on a daily basis and are as follows:

A. part 4658.4100, $150;
B. part 4658.4105, subpart 1, $200;
C. part 4658.4105, subpart 2, $150;
D. part 4658.4105, subparts 3 to 5, $200;
E. part 4658.4105, subpart 6, $150;
F. part 4658.4105, subpart 7, $200;
G. part 4658.4105, subpart 8, $150;
H. part 4658.4110, subpart 1, item A, $100;
I. part 4658.4110, subpart 1, item B, $500;
J. part 4658.4110, subpart 2, $200;
K. part 4658.4115, $150;
L. part 4658.4120, $200;
M. part 4658.4125, subpart 1, $150;
N. part 4658.4125, subparts 2 and 3, $200;
O. part 4658.4130, subpart 1, $150;
P. part 4658.4130, subpart 2, $200;
Q. part 4658.4135, $150;  
R. part 4658.4140, $150;  
S. part 4658.4145, items A to E, $150;  
T. part 4658.4145, items F and G, $200;  
U. part 4658.4145, items H to J, $150;  
V. part 4658.4150, items A to F, $150;  
W. part 4658.4150, items G to I, $200;  
X. part 4658.4150, items J to M, $150;  
Y. part 4658.4155, subpart 2, items A to D, $150;  
Z. part 4658.4155, subpart 2, items E and F, $200;  
AA. part 4658.4155, subpart 2, items G and H, $150;  
BB. part 4658.4155, subpart 3, items A and B, $150;  
CC. part 4658.4155, subpart 3, item C, $200;  
DD. part 4658.4155, subpart 4, items A to C, $150;  
EE. part 4658.4155, subpart 4, item D, $200;  
FF. part 4658.4160, $150;  
GG. part 4658.4165, $150;  
HH. part 4658.4170, $150;  
II. part 4658.4175, $150; and  
JJ. part 4658.4180, $50.

Statutory Authority: MS s 144A.04; 144A.08

History: 21 SR 196

Published Electronically: October 11, 2007

SUPPORTIVE SERVICES; NEW CONSTRUCTION

4658.4200 DINING, DAYROOM, AND ACTIVITY AREAS, REQUIRED FLOOR AREA; NEW CONSTRUCTION.

Subpart 1. Total area. The total area set aside for dining, dayroom, and activities must be at least 40 square feet per bed, with a minimum of five square feet per bed for each type of area.

Subp. 2. Space for adult day care. Additional space must be provided, according to part 9555.9730, for dining, dayroom, and activities areas if the nursing home is offering a day care program.

Statutory Authority: MS s 144A.04; 144A.08

History: 21 SR 196

Published Electronically: October 11, 2007
4658.4205 DAYROOM; NEW CONSTRUCTION.

Dayroom space must not include areas used for corridor traffic or chapels with fixed pews. Dayrooms must be located convenient to the bedroom areas and there must be at least one on each bedroom floor in multistory construction. Dayrooms must be provided with natural lighting.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4210 DINING AREA; NEW CONSTRUCTION.

The dining area must be separate from the kitchen. The dining area or areas must have windows facing the outdoors.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4215 ACTIVITIES AREA; NEW CONSTRUCTION.

Display space for individual resident’s projects must be provided. A counter, physically accessible handwashing facility, and a single-service towel dispenser must be provided within an activities area. If provided, a ceramic kiln must be installed in accordance with the Uniform Mechanical Code.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196; L 2005 c 56 s 2
Published Electronically: October 11, 2007

4658.4290 PENALTIES FOR SUPPORTIVE SERVICES; NEW CONSTRUCTION RULE VIOLATIONS.

A $150 penalty shall be assessed on a daily basis for violations of parts 4658.4200 to 4658.4215.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

DIETARY, LAUNDRY, AND OTHER FACILITIES; NEW CONSTRUCTION

4658.4300 KITCHEN AREA; NEW CONSTRUCTION.

Subpart 1. In general. The kitchen must be located conveniently to the service entrance, food storage areas, and dining area. Door openings to food preparation areas must be located away from entrances to soiled linen or utility rooms, trash rooms, or a laundry. The kitchen area must be arranged for efficient operation and must contain sufficient space and equipment for the type of food service selected. If a commercial food service is used, or if meals are provided by another facility, the kitchen areas and equipment must be designed to provide for the safe and sanitary storage, processing, and handling of such
food. The kitchen area must be subjected only to that traffic which is directly related to the functions of the food service. Food storage areas must be located to avoid delivery traffic through the kitchen area.

A kitchen and food storage area designed for limited food preparation should be arranged for possible future expansion in case a nursing home reverts to a standard-type food service at a later date. Doors with locks must be provided to secure the kitchen and food storage areas during off-hours.

Subp. 2. Storage for nonperishable food. A well-ventilated storeroom must be provided for day storage and for the reserve food supply. The maximum temperature of the storeroom must not exceed 85 degrees Fahrenheit. The storeroom must have storage capacity for at least one week's supplies. Shelving must be finished with a washable surface, and the bottom shelf must be at least six inches above the floor. Floor drains must not be provided.

Subp. 3. Storage facilities. Mechanical refrigeration or hot food storage facilities must be provided to ensure the maintenance of potentially hazardous food at required temperatures. Each storage facility must be provided with a numerically scaled-temperature indicating device accurate to plus or minus three degrees Fahrenheit (plus or minus two degrees centigrade) located to measure the air temperature in the warmest part of the refrigeration facility or the coldest part of the hot holding facility. Temperature-indicating devices must be securely fastened and located to be easily readable. Where it is impractical to install fixed temperature-indicating devices on equipment such as cold table tops, steam tables, processing lines, kettles, heat lamps, or portable transport carriers, a product thermometer of metal stem type construction, numerically scaled, and accurate to plus or minus two degrees Fahrenheit (plus or minus one degree centigrade) must be provided and used to check internal food temperatures. Floor drains, directly connected to the building sewer system, must not be provided inside the room.

Subp. 4. Storage for dishes and utensils. Enclosed storage must be provided for all china, glasses, flatware, and other food service utensils, including cooking utensils, pots, and pans. Dishes and utensils must not be stored in the dishwashing area.

Subp. 5. Janitor's closet. The dietary department must be provided with its own janitor's closet with a floor receptor or service sink, and storage for housekeeping supplies and equipment.

Subp. 6. Sinks. At least one sink with a single-service towel dispenser must be provided in the food preparation area and in the clean end of the dishwashing area. Mirrors must not be installed in food preparation areas. The use of a common towel is prohibited.

Subp. 7. Toilet room. A toilet room must be accessible for the dietary staff. It must not open directly into any food service area. It must contain a toilet, sink, mirror, and a single-service towel dispenser. The use of a common towel is prohibited.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
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food service cabinets must be NSF International approved. The complete food storage equipment does not require NSF International approval. Sufficient separation must be provided between each piece of equipment and between equipment and walls to permit easy and effective cleaning, or the equipment must be placed with a tight fit and the joints sealed. Equipment which is not sealed at the floor must have casters or be installed on sanitary legs that provide at least six inches clearance between the equipment and the floor. Aisles between equipment must have a minimum width of four feet to allow room for traffic in work areas and to permit movement of mobile equipment.

Subp. 2. **Food carts.** Floor space designated for the storage of all food carts must be provided within the kitchen area.

Subp. 3. **Cutting boards.** Cutting boards or similar use table tops must be constructed of nonporous, smooth, and cleanable material, and be free of cracks, crevices, and open seams.

Subp. 4. **Scullery sink.** For manual washing, rinsing, and sanitizing of utensils and equipment, a sink with at least three compartments must be provided and used. Sink compartments must be large enough to permit the accommodation of the equipment and utensils and each compartment of the sink must be supplied with hot and cold potable running water. Drain boards must be provided at each end for proper handling of soiled utensils before washing and for cleaned utensils following sanitizing and must be located so as not to interfere with the proper use of the utensil washing facilities. If a mechanical dishwasher or a mechanical utensil washer is used for the sanitizing of pots and pans, a sanitizing compartment is not required and a two-compartment scullery sink is acceptable as used according to parts 4658.0675 and 4658.0680.

**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196

**Published Electronically:** October 11, 2007

### 4658.4310 DISHWASHING AREA; NEW CONSTRUCTION.

The dishwashing area must be separate from the food preparation area, and must be arranged and equipped as follows in items A to D.

A. Soiled dishes must arrive at the soiled dish counter without passing through the clean dish side of the dishwashing area or through the food preparation area of the kitchen. The soiled dish counter must include provisions for prerinse of dishes and disposal of garbage.

B. Facilities with more than 30 beds must provide a commercial hood-type or conveyor dishwasher. The area containing the dishwasher and the soiled dish spray rinse must be separated from the food preparation area and the clean dish storage area by a wall protection.

C. Facilities with 30 or fewer beds must be equipped with a minimum of an under-counter-type dishwasher that complies with NSF International Standard No. 3.

D. Clean dishes must be returned directly from the clean dish counter to a clean area for storage. The clean dish counter must be at least four feet long in facilities with pass-through type dishwashers. If necessary, provision must be made for the return of empty dish racks to the dishwasher area.

**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196

**Published Electronically:** October 2, 2013
4658.4315 WASHING OF FOOD CARTS; NEW CONSTRUCTION.

A separate area, equipped with a floor drain, must be provided for the cleaning of food carts.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4320 WASHING OF GARBAGE CANS; NEW CONSTRUCTION.

An area, separated from the dietary area, equipped with a floor drain, must be provided for the washing of garbage cans.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4325 LAUNDRY, SIZE AND LOCATION; NEW CONSTRUCTION.

Subpart 1. Laundry. The laundry, if provided in the facility, must be sized and equipped to handle the laundering of all linen and personal clothing to be processed in the facility.

Subp. 2. Entrance. The entrance to a soiled linen collection room or to a laundry processing room must be located away from resident living areas and the entrance to the kitchen. Door widths to laundry areas must allow for movement of equipment and linen carts.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4330 SOILED LINEN COLLECTION ROOM; NEW CONSTRUCTION.

Subpart 1. Soiled linen collection room. A separate, enclosed soiled linen collection room must be provided for the collection, storage, and sorting of soiled linen to be processed in the laundry processing room or by an outside laundry service.

Subp. 2. Location. The soiled linen collection room must be located at the soiled side of the laundry processing room. A soiled linen collection room for facilities with outside laundry service must be located near the service entrance.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4335 LAUNDRY PROCESSING ROOM; NEW CONSTRUCTION.

The laundry processing room must be arranged and equipped to allow for the orderly, progressive flow of work from the soiled area to the clean area. The layout of the processing area must minimize linen transportation and avoid cross-traffic between clean and soiled operations. Laundry operations must be
physically separated by a floor area. The processing room must provide space for the storage of supplies and equipment. Space for storage of laundry carts must be provided within the laundry area. Handwashing facilities must be available for the area. A two-compartment laundry tub must be provided and must be of a material with a nonabsorbent, smooth, permanent finish. A laundry tub may be provided with fittings for the required handwashing facilities.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4340 LAUNDRY EQUIPMENT; NEW CONSTRUCTION.

The laundry equipment must be of commercial type and must be of sufficient size and quantity for the size of the facility. The washer installation must be constructed of materials capable of meeting the operating requirements in part 4658.1410. The washer must be capable of measuring and displaying internal water temperatures.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4345 CLEAN LINEN STORAGE; NEW CONSTRUCTION.

Rooms, closets, or enclosed carts must be provided for the storage of clean linen.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4350 LAUNDRY FOR PERSONAL CLOTHING; NEW CONSTRUCTION.

Provision must be made for the washing of personal clothing either within or outside the facility. Residential-grade equipment may be used for the washing of personal clothing.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4355 REFUSE; NEW CONSTRUCTION.

Subpart 1. Refuse area. An outside, fenced area or a separate room must be provided for holding trash and garbage prior to disposal. It must be located convenient to the service entrance and be sized to accommodate the refuse volume and the chosen type of disposal system.

Subp. 2. Incinerator. An incinerator, if provided, must be in a separate room, or in a designated area within the boiler or heater room, or outdoors. An incinerator, if provided, must comply with parts 7011.1201 to 7011.1285.
4658.4360 COVERED ENTRANCE AREA; NEW CONSTRUCTION.

At least one covered entrance area must be provided to protect residents from weather. The covered entrance must extend from the curb line to the building.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4365 FACILITIES FOR PERSONNEL; NEW CONSTRUCTION.

Locker and toilet facilities must be provided for personnel.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4370 REHABILITATIVE SERVICES AREAS; NEW CONSTRUCTION.

Subpart 1. Specialized rehabilitative services area. Each specialized rehabilitative therapy service provided must be provided space and equipment for exercise and treatment which meets the needs of a medically directed therapy program and of the residents receiving services. Each treatment area must be designed and equipped to protect residents' visual privacy. A lavatory or sink must be conveniently located to all rehabilitative services areas. Space for administrative activities and storage of supplies and equipment must be provided for any rehabilitative service provided.

Subp. 2. Physical therapy area. The physical therapy area must be provided with a lavatory or sink with institutional fittings and a single-service towel dispenser.

Subp. 3. Physical therapy area toilet room. A toilet room must be located within or adjacent to the physical therapy area. Access to this toilet room must be provided from within the physical therapy area. This toilet room may also serve the general corridor. The toilet room must comply with the requirements for physically accessible toilet rooms in part 4658.4150.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196; L 2005 c 56 s 2
Published Electronically: October 11, 2007

4658.4375 BARBER AND BEAUTY SHOP SERVICES; NEW CONSTRUCTION.

A room must be provided and equipped for barber and beauty shop services.
Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4390 PENALTIES FOR DIETARY, LAUNDRY, AND OTHER SERVICES; NEW CONSTRUCTION RULE VIOLATIONS.

Penalty assessments for violations of parts 4658.4300 to 4658.4375 shall be assessed on a daily basis and are as follows:

A. parts 4658.4300 to 4658.4345, $200;
B. part 4658.4350, $100;
C. part 4658.4355, $150;
D. part 4658.4360, $200; and
E. parts 4658.4365 to 4658.4375, $150.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

CONSTRUCTION DETAILS

4658.4400 AREA HEAT PROTECTION; NEW CONSTRUCTION.

Floors and walls for resident living areas which are overheated due to adjoining heat sources must be insulated or otherwise protected to prevent the surface from exceeding a temperature of 85 degrees Fahrenheit.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4405 DOOR HANDLES; NEW CONSTRUCTION.

Lever-type door handles must be provided on all hinged doors to resident areas.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4410 DUMBWAITERS AND CONVEYORS; NEW CONSTRUCTION.

Enclosed dumbwaiter pits and conveyor spaces must be provided with access for cleaning. Operation of dumbwaiters must comply with parts 5205.0400 to 5205.0490.
4658.4415 ELEVATORS; NEW CONSTRUCTION.

Subpart 1. Elevators. Shaft enclosures and elevator installations must be provided in accordance with part 4658.3500, subpart 5. Elevators must be provided in all facilities where residents occupy or use more than the entrance or first floor level.

Subp. 2. Elevator cab size. At least one elevator must have an inside cab dimension of at least five feet wide and seven feet deep. The car doors must have a clear opening of at least three feet, eight inches.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4420 EXTERIOR MECHANICAL SHAFTS; NEW CONSTRUCTION.

Exterior shafts serving equipment for resident areas must be constructed to prevent accumulation of dirt, leaves, or snow.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4425 FLOOR JOINTS; NEW CONSTRUCTION.

Thresholds and expansion joint covers must be flush with the floor, except at exterior doors. Adjacent dissimilar floor materials must be flush with each other to provide an unbroken surface.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4430 NONSKID SURFACES; NEW CONSTRUCTION.

Stairways, ramps, bathtubs, and showers must be provided with nonslip surfaces.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4435 GLASS PROTECTION; NEW CONSTRUCTION.

Any full height window or glass partition of clear glass which has the sill placed at or up to 18 inches above floor level must be constructed of safety glass and must be provided with a railing or some other
structural safety barrier at a height of at least 30 inches above the floor. Glass doors must be constructed of safety glass and must be provided with a push bar or with decals or markings.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4440 LINEN AND TRASH CHUTES; NEW CONSTRUCTION.

The minimum diameter of a gravity-type chute must be two feet. The ceiling space between shaft walls and the discharge end of the chute must be sealed to prevent odors from leaking into the enclosing shaft space.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4445 OVERHEAD PIPING; NEW CONSTRUCTION.

Overhead piping must not be exposed in dietary areas, clean storage, and clean linen areas. Waste lines over food preparation areas, food storage areas, clean storage areas, and electrical panels are prohibited. Plumbing waste lines and vents must not be located within ventilation plenums.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4450 PROTECTION RAILINGS; NEW CONSTRUCTION.

Protection railings, 42 inches high, must be provided for top landings of stairs, window wells, and open air shafts in areas accessible to residents.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4455 CEILING HEIGHTS; NEW CONSTRUCTION.

Minimum ceiling heights must be provided as follows in items A to C.

A. Boiler room ceilings must be at least five feet higher than the top of the boiler unit and at least two feet, six inches above the main boiler head and connecting piping with a minimum total height of nine feet.

B. Ceilings in corridors, storage rooms, resident toilet rooms, and other minor rooms must not be less than seven feet, six inches.

C. Ceilings in all other rooms must not be less than eight feet.
Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
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4658.4460 CEILINGS, WALLS, AND FLOORS; NEW CONSTRUCTION.

Ceilings, walls, and floors must be of a type or finish to permit good maintenance including frequent washing, cleaning, or painting. Walls in areas subject to local wetting must be provided with a hard, nonabsorbent surface. Floors in areas subject to local wetting must be finished with a smooth, hard, nonslip, nonabsorbent surface. In dietary areas, floor surfaces must be grease resistant. Carpeting in resident areas must be of high density, low-pile construction which is cleanable and facilitates wheeled traffic.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4490 PENALTIES FOR CONSTRUCTION DETAILS, CHUTES, AND ELEVATORS; NEW CONSTRUCTION RULE VIOLATIONS.

Penalty assessments for violations of parts 4658.4400 to 4658.4460 shall be assessed on a daily basis and are as follows:

A. part 4658.4400, $200;
B. part 4658.4405, $150;
C. part 4658.4410, $200;
D. part 4658.4415, $200;
E. part 4658.4420, $150;
F. parts 4658.4425 to 4658.4450, $200;
G. part 4658.4455, $150; and
H. part 4658.4460, $200.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

MECHANICAL SYSTEMS; NEW CONSTRUCTION

4658.4500 PLUMBING SYSTEMS; NEW CONSTRUCTION.

Subpart 1. Installation. All plumbing systems must be installed and tested according to this chapter and chapter 4714, the Minnesota Plumbing Code.

Subp. 2. Area drainage. Roofs, basements, tunnels, pits, shafts, areaways, courts, yards, and drives must be properly drained to eliminate intrusion of rain water or groundwater into the building. Floor drains
in exterior areaways and similar installations must be provided with a running trap located inside the building to prevent freeze-up in the winter.

Subp. 3. **Pipe insulation.** Sufficient insulation must be provided for all water and steam piping to assure proper functioning of the systems, provide safety against burns, and to prevent undesirable condensation or heat transfer in areas for residents.

Subp. 4. **Hot water supply.** Circulating hot water must be provided in all hot water mains and in risers more than three stories high to assure hot water at the fixtures. The domestic hot water heating equipment must be installed, operated, and maintained according to chapter 4714, the Minnesota Plumbing Code. The domestic hot water heating equipment must have sufficient capacity and recovery to supply water at minimum temperatures at the point of use as follows:

A. resident bedrooms and service areas, 105 degrees Fahrenheit, with a maximum temperature at the point of use of 115 degrees Fahrenheit;

B. mechanical dishwashing, 180 degrees Fahrenheit;

C. washers in the laundry, 160 degrees Fahrenheit; and

D. mechanical sanitizing of nursing utensils, 180 degrees Fahrenheit.

If a thermostatically controlled mixing valve is used, it must be of the “fail-safe” type which prevents flow of hot water in case the cold water supply fails. Heaters must be insulated and provided with a thermometer.

Subp. 5. **Dishwashing machine.** The dishwashing machine must be of a commercial type equal to the standards established by NSF International Standard No. 3, and must be of a size that can accommodate food trays. The water supply line at the machine must be provided with a pressure-reducing valve, pressure gauge, and vacuum breaker. The rinse water flow pressure must be maintained between 15 and 25 pounds per square inch at the machine by the use of a pressure reducing valve. A pressure gauge must be installed immediately after the reducing valve. A recirculation system and pump must be provided if the final rinse water heater is located more than five feet from the dishwasher. The drain must be an indirect waste connection to a trapped floor drain, or it must be a trapped connection to a branch with a floor drain without a backwater valve in the horizontal branch.

Subp. 6. **Floor drains.** Floor drains must not be installed in areas for food storage. Floor drains must not be directly connected to ventilation equipment or air supply plenums.

**Statutory Authority:** *MS s 144A.04; 144A.08*

**History:** 21 SR 196; 40 SR 71

**Published Electronically:** April 1, 2016

**4658.4505 PLUMBING; NEW CONSTRUCTION.**

Subpart 1. **Institutional fittings.** Institutional fittings must include a mixing faucet, gooseneck spout or other approved spout, wrist-action controls, and an open grid strainer on the waste in the sinks.

The spout must provide a minimum vertical distance of five inches from its discharge point to the rim of the fixture, and a minimum horizontal bowl clearance of seven inches between the discharge point and the inside face of the rim.
The blades on wrist-action controls must not exceed 4-1/2 inches in length, except that handles on clinical sinks must not be less than six inches long.

Subp. 2. **Flushing rim service sinks or clinical sinks.** Flushing rim service sinks or clinical sinks must have an integral trap in which the upper portion of a visible trap seal provides a water surface. A bedpan cleaning device must be included at the clinical sink in soiled utility rooms. If a spray nozzle is included, there must be a way to control the water flow and pressure from the nozzle to minimize aerosolization.

Subp. 3. **Sterilizer vent systems.** All sterilizers requiring vapor vents must be connected with a vapor venting system extending up through the roof independent of the plumbing fixture vent system. The vertical riser pipe must be provided with a drip line which discharges into the drainage system through an air gap or open waste fixture. The connection between the fixture and the vertical vent riser pipe must be made by means of a horizontal offset. Vent material must be erosion and corrosion resistant.

**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196

**Published Electronically:** October 11, 2007

4658.4510 HEATING AND COOLING; NEW CONSTRUCTION.

Subpart 1. **Design and installation.** Heating and cooling systems must be capable of maintaining a temperature of 71 degrees Fahrenheit to 81 degrees Fahrenheit in all resident areas. Areas must be zoned according to use and exposure, and must be provided with thermostatic temperature controls. The humidification system must be capable of maintaining a space humidity between 25 percent relative humidity and 50 percent relative humidity.

Subp. 2. **Isolation of major components.** A means of isolating major sections or components in the heating and cooling systems must be provided. Supply and return mains, and risers of space heating and cooling systems must be valved to isolate the various sections of each system. Each piece of equipment must be valved at the supply and return ends. Any pump on which the heating and cooling systems are dependent should be installed in duplicate for standby service in a nursing home.

Subp. 3. **Controls and gauges.** All valves and controls must be placed for convenient access and use, and thermometers and gauges must be mounted for easy observation.

Subp. 4. **Heating and cooling elements.** Heating and cooling elements must be located so as not to interfere with beds in residents' rooms. Tubing and casing of gravity-type heating and cooling convectors must be mounted at least four inches above the floor and be provided with removable sturdy covers in order to facilitate cleaning.

Subp. 5. **Forced flow room units.** Cabinets for forced flow heating or cooling units must be sturdy and must be mounted either continuously along the floor with a tight fit or at least four inches above the floor. Outside air must be filtered. The interior air grill for recirculation must be located not less than four inches above the floor, on floor mounted units. Fans or blowers must be of a quiet operating type, and the fan or blower housing must not be directly connected to the metal of the unit cabinet. Recirculated air must be passed through the filter. The filter must be replaceable from within the room.

**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196

**Published Electronically:** October 11, 2007
4658.4515 VENTILATION REQUIREMENTS; NEW CONSTRUCTION.

Mechanical supply and exhaust ventilation must be provided for all areas according to part 4658.4520. The systems must be designed and balanced to provide the pressure relationships described in part 4658.4520. Areas not covered in part 4658.4520 must be ventilated according to the Minnesota State Building Code. Areas requiring an equal or positive pressure relationship to adjacent areas according to part 4658.4520 must be provided with tempered makeup air. All air-supply and air-exhaust systems must be mechanically operated. Required exhaust ventilation must not be activated by a light switch. All fans serving exhaust systems must be located at the discharge end of the system. The ventilation rates shown in part 4658.4520 are minimum acceptable rates, and do not preclude the use of higher ventilation rates if the rates do not result in undesirable velocities in resident areas.

Statutory Authority: MS s 144A.04; 144A.08

History: 21 SR 196

Published Electronically: October 11, 2007
**4658.4520 VENTILATION PRESSURE RELATIONSHIPS AND VENTILATION FOR CERTAIN AREAS IN NURSING HOMES; EXISTING AND NEW CONSTRUCTION.**

<table>
<thead>
<tr>
<th>Area Designation</th>
<th>Pressure Relationship to Adjacent Areas</th>
<th>All Supply Air From Outdoors</th>
<th>Minimum Air Changes of Outdoor Air Per Hour</th>
<th>Minimum Total Air Changes Per Hour</th>
<th>All Exhaust Directly To Outdoors</th>
<th>Recirculated Within Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Bedroom</td>
<td>0</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Dayroom, Activity Area</td>
<td>0</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Resident Corridor</td>
<td>0</td>
<td>-</td>
<td>2</td>
<td>4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Dining Room, Therapy</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>6</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Medication Room</td>
<td>+</td>
<td>-</td>
<td>2</td>
<td>4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Clean Utility Room</td>
<td>+</td>
<td>-</td>
<td>2</td>
<td>4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Soiled Utility Room</td>
<td>-</td>
<td>-</td>
<td>10</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Toilet Room</td>
<td>-</td>
<td>-</td>
<td>10</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Bathing Area</td>
<td>-</td>
<td>-</td>
<td>10</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Barber and Beauty Room</td>
<td>-</td>
<td>-</td>
<td>10</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Janitor's Closet</td>
<td>-</td>
<td>-</td>
<td>10</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Sterilizer Equip. Room</td>
<td>-</td>
<td>-</td>
<td>10</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Garbage Room, Can Washing</td>
<td>-</td>
<td>-</td>
<td>10</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Trash Collection Room</td>
<td>-</td>
<td>-</td>
<td>10</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Food Preparation, Nourishment</td>
<td>0</td>
<td>-</td>
<td>2</td>
<td>10</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Dishwashing, Food Cart Cleaning Area</td>
<td>-</td>
<td>-</td>
<td>10</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Dietary Storage</td>
<td>0</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>
Symbols:

Air Pressure Relationships:

+ = Positive;
- = Negative;
0 = Neutral

Air Changes, Supply, Exhaust:

- = Optional

Areas with equal or positive pressure relationships to adjacent areas must be provided with tempered make-up air.

Statutory Authority: MS s 144A.04; 144A.08

History: 21 SR 196

Published Electronically: October 11, 2007

4658.4525 FRESH AIR INTAKES; NEW CONSTRUCTION.

Fresh air intakes for ventilation systems must be located at least 25 feet away from a ventilation exhaust, combustion exhaust, or driveway or parking area. The bottom of fresh air intakes serving central air systems must be located as high as possible, but at least four feet above grade, or, if installed through the roof, at least two feet above roof level. Air intakes for individual room units must be at least one foot, six inches above outside grade. Any exhaust system or waste chute vent must terminate at least 25 feet away from windows that can be opened.

Statutory Authority: MS s 144A.04; 144A.08

History: 21 SR 196

Published Electronically: October 11, 2007

4658.4530 HEIGHT OF REGISTERS; NEW CONSTRUCTION.

Wall openings for air supply or return must be located at least four inches above the floor.
4658.4535 DIETARY AREA; NEW CONSTRUCTION.

Subpart 1. Food preparation areas. The minimum ventilation requirements of part 4658.4520 for food preparation areas must be provided by either a combination of general ventilation and the range hood, or by general room ventilation. If hood ventilation is needed to meet the minimum air changes per hour, the hood must be operating at all times that the food preparation area is in use.

Subp. 2. Dishwashing area. The minimum exhaust requirements of part 4658.4520 for the dishwashing area must be provided by either a combination of general ventilation and the exhaust from the mechanical dishwasher or by general ventilation. If dishwasher hood ventilation is needed to meet the minimum air changes per hour, the hood must be operating at all times that the dishwashing area is in use.

Subp. 3. Exhaust ducts. All exhaust ducts must be provided with access panels for cleaning.

4658.4540 LAUNDRY AREA; NEW CONSTRUCTION.

Air in the laundry must be vented away from the finishing and ironing area and toward the extracting and washing area. The general air movement must be from the clean area to the soiled area, and must be of sufficient volume to remove steam, odors, and excessive heat. Dryers must be provided with a lint collector. Horizontal exhaust ducts must exhaust to the outside. The ducts must be provided with access panels for cleaning.

4658.4545 MECHANICAL ROOMS; NEW CONSTRUCTION.

Mechanical rooms with equipment using liquefied petroleum gas (LPG) or flammable liquid fuels producing vapors heavier than air must be provided with continuous mechanical outdoor air ventilation that provide a pressure which is equal to or greater than atmospheric, to remove accumulations of gas or vapor at the floor level. A relief or exhaust vent must be located within 12 inches below the ceiling, and a relief or exhaust vent must be located within 12 inches above the floor.
4658.4500 FILTERS; NEW CONSTRUCTION.

Subpart 1. Air supply. All air supplied to the nursing home must be free from harmful particulate matter, any type of combustion products or contaminates, obnoxious odors, or exhausted air from the building or adjoining property.

Subp. 2. Filters. All outside air introduced into living and service areas of a nursing home must be filtered. Return air to central ventilation systems must be filtered. All central ventilation or air conditioning systems must be equipped with a minimum of one filter bed. The filter bed must be located upstream of the air conditioning equipment, unless a prefilter is employed. If a prefilter is employed, the prefilter must be upstream of the equipment and the main filter may be located further downstream. Filter frames must be durable and proportioned to provide an airtight fit with the enclosing ductwork.

Subp. 3. Filter efficiencies. Filters installed in all central ventilation or air conditioning systems must have a minimum efficiency of 25 percent. All filter efficiencies must be average atmospheric dust spot efficiencies tested according to the American Society of Heating, Refrigerating, and Air-Conditioning Engineers, Inc. (ASHRAE) Standard No. 52.1-1992.

Subp. 4. Autoclave room. If there is a large autoclave in the nursing home, it must be located in a separate room provided with supply and exhaust ventilation. If an autoclave is built into a separate equipment room, the equipment room must be provided with exhaust ventilation.

Statutory Authority: MS s 144A.04; 144A.08

History: 21 SR 196

Published Electronically: October 11, 2007

4658.4590 PENALTIES FOR MECHANICAL SYSTEMS; NEW CONSTRUCTION RULE VIOLATIONS.

A $200 penalty shall be assessed on a daily basis for violations of parts 4658.4500 to 4658.4550.

Statutory Authority: MS s 144A.04; 144A.08

History: 21 SR 196

Published Electronically: October 11, 2007

ELECTRICAL SYSTEMS; NEW CONSTRUCTION

4658.4600 DISTRIBUTION PANEL BOARDS; NEW CONSTRUCTION.

Subpart 1. Circuit index. All circuits in light and power panels must be identified with a typewritten index. Doors on electrical panel boards accessible to residents must be equipped with a lock.

Subp. 2. Panel boards. Lighting and appliance panel boards must be provided for the circuits on each floor, except for emergency system circuits.

Statutory Authority: MS s 144A.04; 144A.08

History: 21 SR 196

Published Electronically: October 11, 2007
4658.4615 NURSING HOMES

4658.4605 CORRIDOR RECEPTACLES; NEW CONSTRUCTION.

Single receptacles on a separate circuit for equipment such as floor cleaning machines must be installed approximately 50 feet apart in all corridors and within 25 feet of ends of corridors.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4610 SWITCHES AND RECEPTACLES; NEW CONSTRUCTION.

Switches must be placed between 42 inches and 48 inches above the floor. Convenience outlets for electrical appliances must be located to avoid danger in wet areas.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4615 INTERIOR LIGHTING; NEW CONSTRUCTION.

A source of lighting must be provided in every room in the nursing home. Lighting levels in all areas of the nursing home must be adequate and comfortable. "Adequate lighting" means levels of illumination suitable to tasks the resident chooses to perform or the nursing home staff must perform. The installation of rheostats to provide varying levels of illumination in resident areas deemed appropriate by the nursing home is acceptable. "Comfortable lighting" means lighting that minimizes glare and provides maximum resident control, where feasible, of the intensity, location, and direction of illuminations so that visually impaired residents can maintain or enhance independent functioning.

The design of the lighting system must:

A. minimize direct, reflected, and contrast glare;
B. provide consistent and even illumination of wall surfaces and floors;
C. be residential in appearance;
D. incorporate lamp colors that do not distort the true color of people, objects, or architectural elements; and
E. be energy efficient.

Where feasible, indirect lighting by fluorescent lamps concealed by architectural molding or wall sconces is preferred. Electronic ballasts must be used for all fluorescent light fixtures. Full spectrum fluorescent and halogen lamps must not be used for task lighting. The lighting system must use natural light to the fullest extent possible in conjunction with artificial lighting. Illumination levels at transitions between outside daylight and interior light levels at entry ways must be equalized.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007
4658.4620 FIRE ALARM SYSTEMS; NEW CONSTRUCTION.

Fire alarm systems and sprinkler systems must be provided in accordance with chapter 1305.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4625 BEDROOM RECEPTACLES; NEW CONSTRUCTION.

Each resident bedroom must have a minimum of two duplex receptacles mounted on the wall at the head of the bed, and one receptacle mounted on each side of the bed, for a total of four electrical outlets per bed. In addition to the receptacles at the head and side of each bed, each resident bedroom must be provided with two additional duplex receptacles, conveniently located on adjacent walls for resident use. At least one receptacle must be located between 16 inches and 20 inches above the floor, and be accessible for resident use.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4630 NIGHT LIGHTS; NEW CONSTRUCTION.

Each resident bedroom must be provided with a night light.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4635 NURSE CALL SYSTEM; NEW CONSTRUCTION.

The nurses' station must be equipped with a communication system designed to receive calls from the resident and nursing service areas required by this part. The communication system, if electrically powered, must be connected to the emergency power supply. Nurse calls and emergency calls must be capable of being inactivated only at the points of origin. A central annunciator must be provided where the door is not visible from the nurses’ station.

A. A nurse call must be provided for each resident's bed. Call cords, buttons, or other communication devices must be placed where they are within reach of each resident. A call from a resident must register at the nurses' station, activate a light outside the resident bedroom, and activate a duty signal in the medication room, nourishment area, clean utility room, soiled utility room, and sterilizing room. In multicitycorridor nursing units, visible signal lights must be provided at corridor intersections.

B. An emergency call must be provided in each resident toilet room, in all areas used for resident bathing, dayrooms, therapy areas, and activity areas. If a pull cord is provided it must extend to within six inches above the floor. A push-button type emergency call must be installed at a height of 24 inches. An emergency call must register a call from a resident at the nurses' station, activate a duty signal in the medication room, nourishment area, clean utility room, soiled utility room, and sterilizing room, and

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activate a signal light by the bedroom door. The emergency duty signal must provide a visual signal light and an audible alarm.

C. If a nurse call system provides two-way voice communication, it must be equipped with an indicator light at each call station which lights and remains lighted as long as the voice circuit is operating. Nurse calls of this type may be capable of being inactivated at the nurses’ station.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4640 EMERGENCY ELECTRIC SERVICE; NEW CONSTRUCTION.

To provide electricity during an interruption of the normal electrical power supply that affects medical care, or safety of the occupants, an emergency source of electrical power must be provided and connected to certain circuits for lighting and the nurse call system. The emergency system must provide lighting for the nurses' station, telephone switchboard, resident corridors, exits, the boiler or heating system room, and, if provided, the emergency generator room. The emergency electrical service must assure functioning of the fire detection, alarm, and suppression systems, and the life support systems. Emergency electrical service must be provided by one of the following methods:

A. a battery-operated system with automatic controls and recharging if effective for four or more hours; or

B. an on-site emergency generator.

The emergency generator, if provided, must be operated and tested in accordance with the manufacturer's instructions. It is recommended that the emergency generator system include all items necessary for the functioning of the heating system. An automatic transfer switch is recommended.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.4690 PENALTIES FOR ELECTRICAL SYSTEMS; NEW CONSTRUCTION RULE VIOLATIONS.

Penalty assessments for violations of parts 4658.4600 to 4658.4640 shall be assessed on a daily basis and are as follows:

A. part 4658.4600, subpart 1, $50;
B. part 4658.4600, subpart 2, $200;
C. parts 4658.4605 to 4658.4630, $200; and
D. parts 4658.4635 and 4658.4640, $350.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007
RESIDENT AREAS; EXISTING CONSTRUCTION

4658.5000 BEDROOM DESIGN, EXISTING CONSTRUCTION.

Subpart 1. **Design.** Each resident bedroom must be designed and equipped for adequate nursing care, comfort, and privacy of residents, including full visual privacy of residents.

Subp. 2. **Usable floor area.** The usable floor area per bed must be at least 70 square feet for three- or four-bed rooms, at least 80 square feet for two-bed rooms, and at least 100 square feet for single bedrooms. The usable floor area and the arrangement and shape of the bedroom must provide space for furnishings, for the free movement of residents with physical disabilities, and for nursing procedures. "Usable floor area" does not include spaces occupied by toilet rooms, vestibules, permanently installed wardrobes, lockers, closets, or heating units.

Subp. 3. **Access to exit.** Each bedroom must have direct access to an exit corridor.

Subp. 4. **Bedroom shape.** The shape of the bedroom must allow for the capability of a bed arrangement which provides at least three feet of floor space at both sides and the foot end of each bed.

Subp. 5. **Distance from nurses' station.** Resident bedrooms must be located within 140 feet from the nurses' station.

**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196; L 2005 c 56 s 2

**Published Electronically:** October 11, 2007

4658.5005 BEDROOM DOOR LOCKS; EXISTING CONSTRUCTION.

Subpart 1. **Written policy.** A nursing home must develop a written policy regarding the use of locks on resident bedroom doors. The policy must address whether or not doors can be locked while the resident is in the room.

Subp. 2. **Door locks.** Door locks must permit exit from the room by a simple operation without the use of a key. Door locks must be openable with a master key which is located at each nurses' station.

**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196

**Published Electronically:** October 11, 2007

4658.5010 CLOTHES WARDROBE OR CLOSET; EXISTING CONSTRUCTION.

A nursing home must provide each resident with individual wardrobe or closet space in the resident's bedroom with clothes racks and shelves accessible to the resident. Locks may be provided, with keys for the residents, when a pass key is provided at the nurses' station.

**Statutory Authority:** MS s 144A.04; 144A.08

**History:** 21 SR 196

**Published Electronically:** October 11, 2007
4658.5015 CORRIDOR HANDRAILS; EXISTING CONSTRUCTION.

Securely anchored, durable handrails must be provided on both sides of corridors used by residents. If a length of corridor space between doorways is 60 inches or less, a handrail is not necessary for that portion of the corridor.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5020 NURSING AREA; EXISTING CONSTRUCTION.

Subpart 1. Nurses’ station. At least one nurses’ station must be provided per resident floor. A nurses’ station may serve more than one nursing area on the same floor if the maximum distance from resident bedrooms does not exceed that required in part 4658.5000, subpart 5. The nurses’ station must be equipped to receive resident calls through a communication system from resident rooms and toilet and bathing facilities.

Subp. 2. Clean utility room. A clean utility room must be provided within each nursing area.

Subp. 3. Soiled utility room. A separate soiled utility room must be provided within each nursing area. It must contain handwashing facilities and a clinical service sink for disposal of waste materials and the cleanup of soiled linen and utensils. Cabinets and shelving must be provided for the storage of materials and supplies.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5025 TOILET ROOMS AND SANITARY FIXTURES; EXISTING CONSTRUCTION.

A nursing home must have at least one toilet and one sink for eight beds, and at least one shower or tub for 20 beds. When the licensed bed capacity is increased, the requirements under part 4658.4135 apply to the new addition. In resident toilet rooms where grab bars or towel bars are not provided, bars must be installed according to part 4658.4145 to the extent that the room arrangements will permit. A toilet room must have a sink and all sinks must be provided with hot and cold water.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5030 CENTRAL BATHING AREA; EXISTING CONSTRUCTION.

Subpart 1. Fixtures. Bathing fixtures must be provided in accordance with part 4658.5025.

Subp. 2. Bathing areas.

A. In bathing areas with more than one fixture, each bathtub or shower area must have privacy curtains or wall dividers.
B. Bathtubs and showers must have a nonslip bottom or floor surface, and at least one grab bar, securely anchored, must be provided at each fixture.

C. If a toilet is located within an open area with multiple bathing fixtures, the toilet area must have privacy curtains or stall partitions.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5035 HANDWASHING FACILITIES; EXISTING CONSTRUCTION.

Handwashing facilities must be available for persons providing services to residents. Single-service towels must be available. Use of a common towel is prohibited.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5040 ROOM LABELING; EXISTING CONSTRUCTION.

All bedrooms must be labeled using a system of numbers. All service rooms must be labeled.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5090 PENALTIES FOR RESIDENT AREAS; EXISTING CONSTRUCTION RULE VIOLATIONS.

Penalty assessments for violations of parts 4658.5000 to 4658.5040 shall be assessed on a daily basis and are as follows:

A. part 4658.5000, subpart 1, $200;
B. part 4658.5000, subpart 2, $150;
C. part 4658.5000, subpart 3, $200;
D. part 4658.5000, subpart 4, $200;
E. part 4658.5000, subpart 5, $150;
F. part 4658.5005, subpart 1, $100;
G. part 4658.5005, subpart 2, $500;
H. part 4658.5010, $150;
I. part 4658.5015, $200;
J. part 4658.5020, subpart 1, $150;
K. part 4658.5020, subparts 2 and 3, $200;
L. part 4658.5025, $150;
M. part 4658.5030, subpart 2, item A, $150;
N. part 4658.5030, subpart 2, item B, $200;
O. part 4658.5030, subpart 2, item C, $150;
P. part 4658.5035, $200; and
Q. part 4658.5040, $50.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

SUPPORTIVE SERVICES; EXISTING CONSTRUCTION

4658.5100 DINING, DAYROOM, AND ACTIVITY AREAS; EXISTING CONSTRUCTION.

Subpart 1. Area. A nursing home must provide areas for dining, dayroom, and activities.

Subp. 2. Space for adult day care. Additional space must be provided, in accordance with part 9555.9730, for dining, dayroom, and activity areas if the nursing home is offering an adult day care program.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5190 PENALTIES FOR SUPPORTIVE SERVICES; EXISTING CONSTRUCTION RULE VIOLATIONS.

A $150 penalty shall be assessed on a daily basis for violations of part 4658.5100.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

DIETARY, LAUNDRY, AND OTHER FACILITIES; EXISTING CONSTRUCTION

4658.5200 FOOD SERVICE EQUIPMENT; EXISTING CONSTRUCTION.

Subpart 1. Food service equipment. All food service equipment being replaced must be of a type that complies with the requirements of part 4658.3500, subpart 3.

Subp. 2. Cutting boards. Cutting boards or similar use table tops must be constructed of nonporous, smooth, and cleanable material, and be free of cracks, crevices, and open seams.

Subp. 3. Scullery sink. For manual washing, rinsing, and sanitizing of utensils and equipment, a sink with at least three compartments must be provided and used. Sink compartments must be large enough to permit the accommodation of the equipment and utensils, and each compartment of the sink must be
supplied with hot and cold potable running water. Drain boards must be provided at each end for proper handling of soiled utensils before washing and for cleaned utensils following sanitizing and must be located so as not to interfere with the proper use of the utensil washing facilities. If the mechanical dishwasher or a mechanical utensil washer is used for the sanitizing of pots and pans, a sanitizing compartment is not required and a two-compartment scullery sink is acceptable if used according to parts 4658.0675 and 4658.0680.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5205 LAUNDRY; EXISTING CONSTRUCTION.

A laundry, if provided in the nursing home, must be sized and equipped to handle the laundering of all linen and personal clothing to be processed in the nursing home.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5210 SOILED LINEN COLLECTION ROOM; EXISTING CONSTRUCTION.

A separate, enclosed soiled linen room must be provided for the collection, storage, and sorting of soiled linen to be processed in the laundry processing room or by an outside laundry service.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5215 LAUNDRY EQUIPMENT; EXISTING CONSTRUCTION.

Laundry equipment must be of commercial type and must be of sufficient size and quantity for the size of the facility. The washer installation must be constructed of materials capable of meeting the operating requirements in part 4658.1410. Any new or replacement washer must be capable of measuring and displaying internal water temperatures.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5220 CLEAN LINEN STORAGE; EXISTING CONSTRUCTION.

Rooms, closets, or enclosed carts must be provided for the storage of clean linen.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007
4658.5225 LAUNDRY FOR PERSONAL CLOTHING; EXISTING CONSTRUCTION.

Provision must be made for the washing of personal clothing either within or outside the facility. Residential-grade equipment may be used for the washing of personal clothing.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5230 REFUSE; EXISTING CONSTRUCTION.

Subpart 1. Refuse area. An outside, fenced area or a separate room must be provided for holding trash and garbage prior to disposal. It must be located conveniently to the service entrance and be sized to accommodate the refuse volume and the chosen type of disposal system.

Subp. 2. Incinerator. An incinerator, if provided, must be in a separate room, or in a designated area within the boiler or heater room, or outdoors. An incinerator, if provided, must comply with parts 7011.1201 to 7011.1285.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5235 FACILITIES FOR PERSONNEL; EXISTING CONSTRUCTION.

Locker and toilet facilities must be provided for personnel.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5240 REHABILITATIVE SERVICES AREAS; EXISTING CONSTRUCTION.

Subpart 1. Specialized rehabilitative therapy area. A specialized rehabilitative therapy service, if provided, must be provided space and equipment for exercise and treatment which meets the needs of a medically directed therapy program and of the residents receiving services. Each treatment area must be designed and equipped to protect residents' visual privacy. A lavatory or sink must be conveniently located to all rehabilitative service areas. Space for administrative activities and storage of supplies and equipment must be provided for any rehabilitative service provided.

Subp. 2. Physical therapy area. A physical therapy area, if provided, must have a lavatory or sink with institutional fittings and a single-service towel dispenser. A toilet room must be located convenient to the physical therapy area.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007
4658.5245 BARBER AND BEAUTY SHOP SERVICES ROOM; EXISTING CONSTRUCTION.

In buildings constructed after 1972, a room must be provided and equipped for barber and beauty shop services.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5290 PENALTIES FOR DIETARY, LAUNDRY, AND OTHER SERVICES; EXISTING CONSTRUCTION RULE VIOLATIONS.

Penalty assessments for violations of parts 4658.5200 to 4658.5245 shall be assessed on a daily basis and are as follows:

A. parts 4658.5200 to 4658.5220, $200;
B. part 4658.5225, $100; and
C. parts 4658.5230 to 4658.5245, $150.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

CONSTRUCTION DETAILS; EXISTING CONSTRUCTION

4658.5300 AREA HEAT PROTECTION; EXISTING CONSTRUCTION.

Floors and walls for resident living areas which are overheated due to adjoining heat sources must be insulated or otherwise protected to prevent the surface from exceeding a temperature of 85 degrees Fahrenheit.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5305 NONSKID SURFACES; EXISTING CONSTRUCTION.

Stairways, ramps, bathtubs, and showers must have nonslip surfaces.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5310 GLASS PROTECTION; EXISTING CONSTRUCTION.

All full height windows, glass partitions, or glass doors must have decals or markings.
4658.5315 CEILINGS, WALLS, AND FLOORS; EXISTING CONSTRUCTION.

Ceilings, walls, and floors must be of a type or finish to permit good maintenance including frequent washing, cleaning, or painting. Walls in areas subject to local wetting must have a hard, nonabsorbent surface. Floors in areas subject to local wetting must be finished with a smooth, hard, nonslip, nonabsorbent surface. In dietary areas, floor surfaces must be grease resistant. Carpeting in resident areas must be of high density, low-pile construction which is cleanable and facilitates wheeled traffic.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5390 PENALTIES FOR CONSTRUCTION DETAILS; EXISTING CONSTRUCTION RULE VIOLATIONS.

A $200 penalty shall be assessed on a daily basis for violations of part 4658.5300.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

MECHANICAL SYSTEMS; EXISTING CONSTRUCTION

4658.5400 HEATING SYSTEM; EXISTING CONSTRUCTION.

The heating system must be capable of maintaining a minimum temperature of 71 degrees Fahrenheit in all resident areas during the heating season.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5405 VENTILATION REQUIREMENTS; EXISTING CONSTRUCTION.

Existing facilities must have mechanical exhaust ventilation in the kitchen, laundry, soiled linen collection room, soiled utility rooms, and toilet areas, except if the toilet area is private or semiprivate, and is provided with window ventilation. Ventilation must be provided according to part 4658.4520.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007
4658.5410 MECHANICAL ROOMS; EXISTING CONSTRUCTION.

Mechanical rooms below grade, located in buildings constructed after 1972, with equipment using liquefied petroleum gas, must have continuous mechanical ventilation providing a pressure which is equal to or greater than atmospheric.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5415 FILTERS; EXISTING CONSTRUCTION.

All air supplied to the nursing home must be free from harmful particulate matter, any type of combustion products or contaminates, obnoxious odors, or exhausted air from the building or adjoining property.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5490 PENALTIES FOR HEATING AND VENTILATION SYSTEMS; EXISTING CONSTRUCTION RULE VIOLATIONS.

A $200 penalty shall be assessed on a daily basis for violations of parts 4658.5400 to 4658.5415.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

ELECTRICAL SYSTEMS; EXISTING CONSTRUCTION

4658.5500 DISTRIBUTION PANEL BOARDS; EXISTING CONSTRUCTION.

All circuits in light and power panels must be identified with a typewritten index. Doors on electrical panel boards accessible to residents must be equipped with a lock.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5505 INTERIOR LIGHTING; EXISTING CONSTRUCTION.

A source of interior lighting must be provided in every room in the nursing home. Each resident bedroom must be provided with a reading light for each occupant. Lighting levels in all areas of the nursing home must be suitable to tasks the resident chooses to perform or the nursing home staff must perform. A nursing home may install rheostats to provide varying levels of illumination in resident areas.
4658.5510 FIRE ALARM SYSTEMS; EXISTING CONSTRUCTION.

Fire alarm systems and sprinkler systems must be provided according to chapter 1305.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5515 NURSE CALL SYSTEM; EXISTING CONSTRUCTION.

A communication system must be provided in a nursing home. It must register a call from the resident at the nursing station and activate a signal light by the bedroom door.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007

4658.5520 EMERGENCY ELECTRIC SERVICE; EXISTING CONSTRUCTION.

To provide electricity during an interruption of the normal electrical power supply that affects medical care, or safety of the occupants, an emergency source of electrical power must be provided and connected to certain circuits for lighting and the nurse call system. The emergency system must provide lighting for the nurses' station, telephone switchboard, resident corridors, exits, the boiler or heating system room, and, if provided, the emergency generator room. The emergency electrical service must assure functioning of the fire detection, alarm, and suppression systems, and the life support systems. Emergency electrical service must be provided by one of the following methods:

A. a battery-operated system with automatic controls and recharging if effective for four or more hours; or

B. an on-site emergency generator.

The emergency generator, if provided, must be operated and tested according to the manufacturer's instructions. It is recommended that the emergency generator system include all items necessary for the functioning of the heating system. An automatic transfer switch is recommended.

Statutory Authority: MS s 144A.04; 144A.08
History: 21 SR 196
Published Electronically: October 11, 2007
4658.5590 PENALTIES FOR ELECTRICAL SYSTEMS; EXISTING CONSTRUCTION RULE VIOLATIONS.

Penalty assessments for violations of parts 4658.5500 to 4658.5520 shall be assessed on a daily basis and are as follows:

A. part 4658.5500, $50;
B. parts 4658.5505 and 4658.5510, $200; and
C. parts 4658.5515 and 4658.5520, $350.

Statutory Authority: MS s 144A.04; 144A.08

History: 21 SR 196

Published Electronically: October 11, 2007
4638.0200 PET ANIMALS IN HEALTH CARE FACILITIES.

Subpart 1. Definition. As used in this part, "health care facility" means a hospital, nursing home, boarding care home, or supervised living facility licensed by the Minnesota Department of Health under Minnesota Statutes, sections 144.50 to 144.56 or 144A.01 to 144A.16.

Subp. 2. Written policy. Every health care facility shall establish a written policy specifying whether or not pet animals will be allowed on the facility's premises. If pet animals are allowed on the premises, the policy must specify whether or not individual patients or residents will be permitted to keep pets. This policy must be developed only after consultation with facility staff and with patients or residents, as appropriate.

Subp. 3. Conditions. If pet animals other than fish are allowed on the premises, the following requirements must be met:

A. Written policies and procedures must be developed and implemented which specify the conditions for allowing pet animals on the premises.

B. The policies and procedures must:

   (1) describe the types of pet animals allowed on the facility's premises. This policy must be developed in consultation with a veterinarian and a physician;

   (2) describe the procedures for maintaining and monitoring the health and behavior of animals kept on the facility's premises. These procedures must be in accordance with a veterinarian's recommendations. A copy of these recommendations must be maintained in the facility; and

   (3) identify those areas in the facility, in addition to those areas described in item F, where pet animals shall not be permitted.

C. Regardless of the ownership of any pet, the health care facility shall assume overall responsibility for any pets within or on the premises of the facility.

D. The health care facility shall ensure that no pet jeopardizes the health, safety, comfort, treatment, or well-being of the patients, residents, or staff.

E. A facility employee shall be designated, in writing, as being responsible for monitoring or providing the care to all pet animals and for ensuring the cleanliness and maintenance of facilities used to house pets. This rule does not preclude residents, patients, or other individuals from providing care to pet animals.

F. Except for guide dogs accompanying a blind or deaf individual and except in supervised living facilities with a licensed bed capacity of 15 beds or less, pet animals shall not be permitted in kitchen areas, in medication storage and administration areas, or in clean or sterile supply storage areas.
Statutory Authority: MS s 144.573; 144A.30

History: L 1987 c 384 art 2 s 1

Published Electronically: October 3, 2013
6800.6100 SCOPE.

The provisions of parts 6800.6100 to 6800.6700 are applicable to pharmaceutical services provided to patients in long-term care facilities, provided, however, that parts 6800.0100 to 6800.5600 shall also be applicable to such pharmaceutical services, unless specifically exempted by parts 6800.6100 to 6800.6700 or are in direct conflict therewith, in which case parts 6800.6100 to 6800.6700 shall apply.

Statutory Authority: MS s 151.06

Published Electronically: September 21, 2011
6800.6200 PRESCRIPTION ORDER COMMUNICATION.

Subpart 1. Verbal or telephone orders. Notwithstanding any other provisions of parts 6800.0100 to 6800.9700, a licensed pharmacist, registered nurse, or licensed practical nurse who is employed by a licensed facility and who is authorized by the facility's administrator and is acting on the behalf of the prescriber, may communicate to the pharmacy provider a prescription drug order lawfully ordered by a practitioner authorized to prescribe drugs or devices pursuant to Minnesota Statutes, section 151.37. Whenever possible, these prescription drug orders shall be transmitted via facsimile or secure electronic format, to the pharmacy in an order format which produces a direct copy of the chart order, which the prescriber will sign at a later date. The pharmacy provider shall record on the prescription drug order the name of the person who transmits the order in addition to the other required information. This subpart does not apply to prescription drug orders for Schedule II controlled substances as defined by part 6800.4220.

Subp. 2. Written orders. A copy of a written prescription drug order, signed by the prescriber, may be delivered to the pharmacy by an individual authorized by the facility.

Subp. 3. Schedule II orders. Except as provided in part 6800.3000, subparts 2 and 3, Schedule II controlled substances shall be dispensed only upon receipt of an original written prescription drug order manually signed by the prescribing individual practitioner or upon an oral order reduced to writing given in emergency situations as allowed by these criteria:

A. immediate administration of the controlled substance is necessary for the proper treatment of the intended ultimate user;

B. no appropriate alternative treatment is available, including administration of a drug which is not a controlled substance under schedule II of Minnesota Statutes, chapter 152 and parts 6800.4200 to 6800.4250; and

C. it is not reasonably possible for the prescribing practitioner to provide a written prescription drug order to be presented to the person dispensing the controlled substance, prior to dispensing.

Statutory Authority: MS s 151.06; 151.102; 152.02

History: 18 SR 1145; 23 SR 1597; 31 SR 1673; 36 SR 237

Published Electronically: September 21, 2011
6800.6300 PRESCRIPTION LABELING.

Subpart 1. Minimum information. All prescription containers, other than those dispensed pursuant to part 6800.3750, shall be properly labeled in accordance with part 6800.3400 and shall also contain at least the following additional information: quantity of drug dispensed; date of original issue, or in the case of a refill, the most recent date; and expiration date of all time dated drugs.

Subp. 2. Directions for use. Directions for use on labels of medications shall be changed only by a pharmacist acting on the instructions of the prescriber or the prescriber's agent. Personnel of the facility may affix supplemental labels alerting staff to a change in the directions for use when a corresponding change is made on the appropriate medication administration record, in accordance with procedures approved by the facility's quality assurance and assessment committee. Subsequent refills of the medication shall be appropriately labeled with the directions for use in effect at the time of dispensing.

Statutory Authority: MS s 151.06

History: 9 SR 1656; 17 SR 1279; 18 SR 1145

Published Electronically: September 21, 2011
6800.6500 CONSULTING SERVICES TO LICENSED NURSING HOMES.

Subpart 1. Written agreement. A pharmacist providing pharmacy consultative services to a licensed nursing home shall devote a sufficient number of hours during regularly scheduled visits to the facility for the purpose of reviewing the quality of the pharmaceutical services provided to the facility residents. There shall be a written agreement, separate and apart from that provided to pharmacists supplying prescription drug services to residents, for the pharmaceutical consultative services between the facility and the consulting services provider which shall be available for review by the board.

Subp. 2. Responsibilities. The pharmacist shall be responsible for, but not limited to, the following:

A. preparation and revision of policies and procedures governing the pharmaceutical services;

B. development, coordination, and direction or supervision of all pharmaceutical services provided in the facility;

C. review of the drug regimen of each resident and preparation of appropriate reports and recommendations including at least a review of all drugs currently ordered; information concerning the patient's condition as it relates to drug therapy; and medication administration records, physician progress notes, nurses' notes, and laboratory test results;

D. reporting, in writing, irregularities in the storage, dispensing, and administration of drugs and other matters relating to the review of the drug regimen, to the administrator, and other appropriate health professionals as may be determined by the administrator and consultant pharmacist;

E. preparing, at least quarterly, a written report on the status of the pharmaceutical service and staff performance and submitting this report to the administrator and the quality assurance and assessment committee;

F. developing policies for destroying, in the prescribed manner, any unused portion of prescription drugs remaining in the facility after the death or discharge of the patient or resident for whom they were prescribed or any prescriptions permanently discontinued;

G. providing in-service training to nursing personnel;

H. developing policies for the issuance of medications to residents who are going on leave from the facility. These policies may allow the preparation, by the facility's licensed or registered nurses responsible for overseeing medication administration, of up to a 72-hour supply of medications in paper envelopes or other more suitable containers for use by a resident temporarily leaving the facility at times when the resident's pharmacy is closed or cannot supply the needed medication in a timely manner. A container may hold
only one medication. A label on the container shall include the date, the resident's name, the facility, the name of the medication, its strength, dose, and time of administration, and the initials of the person preparing the medication and label; and

   I. preparation of policies and procedures for the disposition of medications. The policies and procedures must conform with the requirements of parts 4658.1350 and 6800.2350.

Subp. 3. [Repealed, 36 SR 237]

Statutory Authority: MS s 151.06

History: 18 SR 1145; 36 SR 237

Published Electronically: September 21, 2011
6800.6600 FREEDOM OF CHOICE.

No pharmacist shall participate in any agreement or plan which infringes on any patient's right to freedom of choice as to the provider of prescription services.

Statutory Authority: *MS s 151.06*

Published Electronically: *September 21, 2011*
6800.6700 DRUGS FOR USE IN EMERGENCY KITS.

Subpart 1. Authorization upon request. A pharmacy may provide, upon a written or oral request from the quality assurance and assessment committee, limited supplies of drugs for use in an emergency kit. The drugs remain the property of the pharmacy.

Subp. 2. Emergency drug supplies. Only emergency drug supplies determined by the quality assurance and assessment committee necessary for patient care in life threatening emergencies may be made available. The drugs in the emergency kit are the responsibility of the pharmacist and, therefore, shall not be used or altered in any way except as outlined in this subpart. The emergency drug supplies shall comply with the following in items A to F.

A. The drugs shall be limited to the extent possible to a 72-hour supply of any one emergency drug in either sealed ampules, vials, or prefilled syringes. If an emergency drug is not available in parenteral form, a supply in an alternate dosage form may be provided. Notwithstanding these restrictions, if the quality assurance and assessment committee considers it necessary, up to a 72-hour supply of each of a maximum of 15 different oral pharmaceuticals, not counting oral antibiotics, restricted to therapeutic categories related to symptomatic patient distress or emergencies may be stocked. An unlimited number of oral antibiotics may be stocked in 72-hour supplies of each. Inclusion of other oral legend drugs is permissible only through the granting of a variance by the board. Drugs in the supply shall be properly labeled, including beyond-use dates and lot numbers.

B. The emergency drug supply shall be stored in a container which is sealed by the pharmacist or the pharmacist’s agent with a tamperproof seal that must be broken to gain access to the drugs, and shall be placed in a locked area.

C. The pharmacist shall be notified by the health care facility when drugs from the emergency kit have been used or when the seal has been broken.

D. Drugs used from the kit shall be replaced by submitting a prescription drug order for the used item to the pharmacist within 72 hours and the supply shall be resealed by the pharmacist or the pharmacist’s agent.

E. The pharmacist shall see that the contents of the kit are accurately listed on the container and accounted for.

F. The supply shall be checked and inventoried monthly by the pharmacist who is responsible for control of the kit.
Subp. 3. **Controlled substances.** Emergency kits may contain limited supplies of controlled substances only if:

A. the controlled substances are supplied by a licensed pharmacy duly registered with the Federal Drug Enforcement Administration;

B. the emergency kit is kept in a locked medicine room or medicine cabinet;

C. access to the emergency kit is limited to the following individuals:

   (1) a licensed professional nurse who is employed by the facility and who has been directed by a physician to administer a drug from the kit;

   (2) a consultant pharmacist or other licensed pharmacist designated by the facility's pharmaceutical services committee; or

   (3) a licensed medical practitioner;

D. the emergency kit does not contain more than six single doses of any controlled substance narcotic analgesic;

E. the dispensing pharmacy keeps a complete record of each controlled substance stored in the emergency kit, including the name of the drug, the strength of the drug, and the number of doses provided;

F. the facility keeps a complete record of the use of controlled substances from the kit for two years, including the patient's name, the date of use, the name of the drug used, the strength of the drug, the number of doses used, and the signature of the person administering the dose; and

G. the controlled substances stored in the emergency kit are used only in a situation deemed an emergency by a licensed practitioner in conformity with the following provisions:

   (1) immediate administration of the controlled substance is necessary for the proper treatment of the intended ultimate user;

   (2) no appropriate alternative treatment is available, including administration of a drug which is not a controlled substance; and

   (3) it is not reasonably possible for the prescribing practitioner to provide prior to administration a written prescription drug order to be presented to a pharmacist for dispensing of the controlled substance.

Subp. 4. **Excluded controlled substances.** Controlled substance stimulants in oral dosage forms may not be included in emergency kits.
Subp. 5. **Penalty.** If any of the provisions of this part are violated, the board may suspend or revoke a pharmacy's privilege to maintain an emergency kit of drug supplies at the noncompliant facility.

**Statutory Authority:** *MS s 151.06; 151.102*

**History:** *18 SR 1145; 23 SR 1597; 36 SR 237*

**Published Electronically:** *October 11, 2013*
6800.6800 STAFF PROTECTION FROM HIV TRANSMISSION.

A pharmacy may provide to a nursing home a separate supply of medications containing the prophylaxis regimen currently recommended by the Centers for Disease Control for the prevention of HIV due to accidental contact with contaminated body fluids by health care workers.

Statutory Authority: MS s 151.06; 151.102

History: 23 SR 1597

Published Electronically: September 21, 2011
626.557 REPORTING OF MALTREATMENT OF VULNERABLE ADULTS.

Subdivision 1. Public policy. The legislature declares that the public policy of this state is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment; to assist in providing safe environments for vulnerable adults; and to provide safe institutional or residential services, community-based services, or living environments for vulnerable adults who have been maltreated.

In addition, it is the policy of this state to require the reporting of suspected maltreatment of vulnerable adults, to provide for the voluntary reporting of maltreatment of vulnerable adults, to require the investigation of the reports, and to provide protective and counseling services in appropriate cases.

Subd. 2. [Repealed, 1995 c 229 art 1 s 24]

Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.

Subd. 3a. Report not required. The following events are not required to be reported under this section:

(1) A circumstance where federal law specifically prohibits a person from disclosing patient identifying information in connection with a report of suspected maltreatment, unless the vulnerable adult, or the vulnerable adult's guardian, conservator, or legal representative, has consented to disclosure in a manner which conforms to federal requirements. Facilities whose patients or residents are covered by such a federal law shall seek consent to the disclosure of suspected maltreatment from each patient or resident, or a guardian, conservator, or legal representative, upon the patient's or resident's admission to the facility. Persons who
are prohibited by federal law from reporting an incident of suspected maltreatment shall immediately seek consent to make a report.

(2) Verbal or physical aggression occurring between patients, residents, or clients of a facility, or self-abusive behavior by these persons does not constitute abuse unless the behavior causes serious harm. The operator of the facility or a designee shall record incidents of aggression and self-abusive behavior to facilitate review by licensing agencies and county and local welfare agencies.

(3) Accidents as defined in section 626.5572, subdivision 3.

(4) Events occurring in a facility that result from an individual's error in the provision of therapeutic conduct to a vulnerable adult, as provided in section 626.5572, subdivision 17, paragraph (c), clause (4).

(5) Nothing in this section shall be construed to require a report of financial exploitation, as defined in section 626.5572, subdivision 9, solely on the basis of the transfer of money or property by gift or as compensation for services rendered.

Subd. 4. Reporting. (a) Except as provided in paragraph (b), a mandated reporter shall immediately make an oral report to the common entry point. The common entry point may accept electronic reports submitted through a web-based reporting system established by the commissioner. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, to the extent necessary to comply with this subdivision.

(b) A boarding care home that is licensed under sections 144.50 to 144.58 and certified under Title 19 of the Social Security Act, a nursing home that is licensed under section 144A.02 and certified under Title 18 or Title 19 of the Social Security Act, or a hospital that is licensed under sections 144.50 to 144.58 and has swing beds certified under Code of Federal Regulations, title 42, section 482.66, may submit a report electronically to the common entry point instead of submitting an oral report. The report may be a duplicate of the initial report the facility submits electronically to the commissioner of health to comply with the reporting requirements under Code of Federal Regulations, title 42, section 483.13. The commissioner of health may modify these reporting requirements to include items required under paragraph (a) that are not currently included in the electronic reporting form.

Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section.

(b) A facility with an internal reporting procedure that receives an internal report by a mandated reporter shall give the mandated reporter a written notice stating whether the facility has reported the incident to the common entry point. The written notice must be provided within two working days and in a manner that protects the confidentiality of the reporter.
(c) The written response to the mandated reporter shall note that if the mandated reporter is not satisfied with the action taken by the facility on whether to report the incident to the common entry point, then the mandated reporter may report externally.

(d) A facility may not prohibit a mandated reporter from reporting externally, and a facility is prohibited from retaliating against a mandated reporter who reports an incident to the common entry point in good faith. The written notice by the facility must inform the mandated reporter of this protection from retaliatory measures by the facility against the mandated reporter for reporting externally.

Subd. 5. Immunity; protection for reporters. (a) A person who makes a good faith report is immune from any civil or criminal liability that might otherwise result from making the report, or from participating in the investigation, or for failure to comply fully with the reporting obligation under section 609.234 or 626.557, subdivision 7.

(b) A person employed by a lead investigative agency or a state licensing agency who is conducting or supervising an investigation or enforcing the law in compliance with this section or any related rule or provision of law is immune from any civil or criminal liability that might otherwise result from the person's actions, if the person is acting in good faith and exercising due care.

(c) A person who knows or has reason to know a report has been made to a common entry point and who in good faith participates in an investigation of alleged maltreatment is immune from civil or criminal liability that otherwise might result from making the report, or from failure to comply with the reporting obligation or from participating in the investigation.

(d) The identity of any reporter may not be disclosed, except as provided in subdivision 12b.

(e) For purposes of this subdivision, "person" includes a natural person or any form of a business or legal entity.

Subd. 5a. Financial institution cooperation. Financial institutions shall cooperate with a lead investigative agency, law enforcement, or prosecuting authority that is investigating maltreatment of a vulnerable adult and comply with reasonable requests for the production of financial records as authorized under section 13A.02, subdivision 1. Financial institutions are immune from any civil or criminal liability that might otherwise result from complying with this subdivision.

Subd. 6. Falsified reports. A person or facility who intentionally makes a false report under the provisions of this section shall be liable in a civil suit for any actual damages suffered by the reported facility, person or persons and for punitive damages up to $10,000 and attorney fees.

Subd. 7. Failure to report. A mandated reporter who negligently or intentionally fails to report is liable for damages caused by the failure. Nothing in this subdivision imposes vicarious liability for the acts or omissions of others.

Subd. 8. Evidence not privileged. No evidence regarding the maltreatment of the vulnerable adult shall be excluded in any proceeding arising out of the alleged maltreatment on the grounds of lack of competency under section 595.02.

Subd. 9. Common entry point designation. (a) Each county board shall designate a common entry point for reports of suspected maltreatment, for use until the commissioner of human services establishes a common entry point. Two or more county boards may jointly designate a single common entry point. The commissioner of human services shall establish a common entry point effective July 1, 2015. The common entry point is the unit responsible for receiving the report of suspected maltreatment under this section.
(b) The common entry point must be available 24 hours per day to take calls from reporters of suspected maltreatment. The common entry point shall use a standard intake form that includes:

1. the time and date of the report;
2. the name, address, and telephone number of the person reporting;
3. the time, date, and location of the incident;
4. the names of the persons involved, including but not limited to, perpetrators, alleged victims, and witnesses;
5. whether there was a risk of imminent danger to the alleged victim;
6. a description of the suspected maltreatment;
7. the disability, if any, of the alleged victim;
8. the relationship of the alleged perpetrator to the alleged victim;
9. whether a facility was involved and, if so, which agency licenses the facility;
10. any action taken by the common entry point;
11. whether law enforcement has been notified;
12. whether the reporter wishes to receive notification of the initial and final reports; and
13. if the report is from a facility with an internal reporting procedure, the name, mailing address, and telephone number of the person who initiated the report internally.

(c) The common entry point is not required to complete each item on the form prior to dispatching the report to the appropriate lead investigative agency.

(d) The common entry point shall immediately report to a law enforcement agency any incident in which there is reason to believe a crime has been committed.

(e) If a report is initially made to a law enforcement agency or a lead investigative agency, those agencies shall take the report on the appropriate common entry point intake forms and immediately forward a copy to the common entry point.

(f) The common entry point staff must receive training on how to screen and dispatch reports efficiently and in accordance with this section.

(g) The commissioner of human services shall maintain a centralized database for the collection of common entry point data, lead investigative agency data including maltreatment report disposition, and appeals data. The common entry point shall have access to the centralized database and must log the reports into the database and immediately identify and locate prior reports of abuse, neglect, or exploitation.

(h) When appropriate, the common entry point staff must refer calls that do not allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might resolve the reporter's concerns.

(i) A common entry point must be operated in a manner that enables the commissioner of human services to:
(l) track critical steps in the reporting, evaluation, referral, response, disposition, and investigative process to ensure compliance with all requirements for all reports;

(2) maintain data to facilitate the production of aggregate statistical reports for monitoring patterns of abuse, neglect, or exploitation;

(3) serve as a resource for the evaluation, management, and planning of preventative and remedial services for vulnerable adults who have been subject to abuse, neglect, or exploitation;

(4) set standards, priorities, and policies to maximize the efficiency and effectiveness of the common entry point; and

(5) track and manage consumer complaints related to the common entry point.

(j) The commissioners of human services and health shall collaborate on the creation of a system for referring reports to the lead investigative agencies. This system shall enable the commissioner of human services to track critical steps in the reporting, evaluation, referral, response, disposition, investigation, notification, determination, and appeal processes.

Subd. 9a. Evaluation and referral of reports made to common entry point. (a) The common entry point must screen the reports of alleged or suspected maltreatment for immediate risk and make all necessary referrals as follows:

(1) if the common entry point determines that there is an immediate need for emergency adult protective services, the common entry point agency shall immediately notify the appropriate county agency;

(2) if the report contains suspected criminal activity against a vulnerable adult, the common entry point shall immediately notify the appropriate law enforcement agency;

(3) the common entry point shall refer all reports of alleged or suspected maltreatment to the appropriate lead investigative agency as soon as possible, but in any event no longer than two working days;

(4) if the report contains information about a suspicious death, the common entry point shall immediately notify the appropriate law enforcement agencies, the local medical examiner, and the ombudsman for mental health and developmental disabilities established under section 245.92. Law enforcement agencies shall coordinate with the local medical examiner and the ombudsman as provided by law; and

(5) for reports involving multiple locations or changing circumstances, the common entry point shall determine the county agency responsible for emergency adult protective services and the county responsible as the lead investigative agency, using referral guidelines established by the commissioner.

(b) If the lead investigative agency receiving a report believes the report was referred by the common entry point in error, the lead investigative agency shall immediately notify the common entry point of the error, including the basis for the lead investigative agency's belief that the referral was made in error. The common entry point shall review the information submitted by the lead investigative agency and immediately refer the report to the appropriate lead investigative agency.

Subd. 9b. Response to reports. Law enforcement is the primary agency to conduct investigations of any incident in which there is reason to believe a crime has been committed. Law enforcement shall initiate a response immediately. If the common entry point notified a county agency for emergency adult protective services, law enforcement shall cooperate with that county agency when both agencies are involved and shall exchange data to the extent authorized in subdivision 12b, paragraph (g). County adult protection shall initiate a response immediately. Each lead investigative agency shall complete the investigative process for
Subd. 9c. **Lead investigative agency; notifications, dispositions, determinations.** (a) Upon request of the reporter, the lead investigative agency shall notify the reporter that it has received the report, and provide information on the initial disposition of the report within five business days of receipt of the report, provided that the notification will not endanger the vulnerable adult or hamper the investigation.

(b) Upon conclusion of every investigation it conducts, the lead investigative agency shall make a final disposition as defined in section 626.5572, subdivision 8.

(c) When determining whether the facility or individual is the responsible party for substantiated maltreatment or whether both the facility and the individual are responsible for substantiated maltreatment, the lead investigative agency shall consider at least the following mitigating factors:

1. whether the actions of the facility or the individual caregivers were in accordance with, and followed the terms of, an erroneous physician order, prescription, resident care plan, or directive. This is not a mitigating factor when the facility or caregiver is responsible for the issuance of the erroneous order, prescription, plan, or directive or knows or should have known of the errors and took no reasonable measures to correct the defect before administering care;

2. the comparative responsibility between the facility, other caregivers, and requirements placed upon the employee, including but not limited to, the facility's compliance with related regulatory standards and factors such as the adequacy of facility policies and procedures, the adequacy of facility training, the adequacy of an individual's participation in the training, the adequacy of caregiver supervision, the adequacy of facility staffing levels, and a consideration of the scope of the individual employee's authority; and

3. whether the facility or individual followed professional standards in exercising professional judgment.

(d) When substantiated maltreatment is determined to have been committed by an individual who is also the facility license holder, both the individual and the facility must be determined responsible for the maltreatment, and both the background study disqualification standards under section 245C.15, subdivision 4, and the licensing actions under section 245A.06 or 245A.07 apply.

(e) The lead investigative agency shall complete its final disposition within 60 calendar days. If the lead investigative agency is unable to complete its final disposition within 60 calendar days, the lead investigative agency shall notify the following persons provided that the notification will not endanger the vulnerable adult or hamper the investigation: (1) the vulnerable adult or the vulnerable adult's guardian or health care agent, when known, if the lead investigative agency knows them to be aware of the investigation; and (2) the facility, where applicable. The notice shall contain the reason for the delay and the projected completion date. If the lead investigative agency is unable to complete its final disposition by a subsequent projected completion date, the lead investigative agency shall again notify the vulnerable adult or the vulnerable adult's guardian or health care agent, when known if the lead investigative agency knows them to be aware of the investigation, and the facility, where applicable, of the reason for the delay and the revised projected completion date.
completion date provided that the notification will not endanger the vulnerable adult or hamper the investigation. The lead investigative agency must notify the health care agent of the vulnerable adult only if the health care agent's authority to make health care decisions for the vulnerable adult is currently effective under section 145C.06 and not suspended under section 524.5-310 and the investigation relates to a duty assigned to the health care agent by the principal. A lead investigative agency's inability to complete the final disposition within 60 calendar days or by any projected completion date does not invalidate the final disposition.

(f) Within ten calendar days of completing the final disposition, the lead investigative agency shall provide a copy of the public investigation memorandum under subdivision 12b, paragraph (b), clause (1), when required to be completed under this section, to the following persons: (1) the vulnerable adult, or the vulnerable adult's guardian or health care agent, if known, unless the lead investigative agency knows that the notification would endanger the well-being of the vulnerable adult; (2) the reporter, if the reporter requested notification when making the report, provided this notification would not endanger the well-being of the vulnerable adult; (3) the alleged perpetrator, if known; (4) the facility; and (5) the ombudsman for long-term care, or the ombudsman for mental health and developmental disabilities, as appropriate.

(g) If, as a result of a reconsideration, review, or hearing, the lead investigative agency changes the final disposition, or if a final disposition is changed on appeal, the lead investigative agency shall notify the parties specified in paragraph (f).

(h) The lead investigative agency shall notify the vulnerable adult who is the subject of the report or the vulnerable adult's guardian or health care agent, if known, and any person or facility determined to have maltreated a vulnerable adult, of their appeal or review rights under this section or section 256.021.

(i) The lead investigative agency shall routinely provide investigation memoranda for substantiated reports to the appropriate licensing boards. These reports must include the names of substantiated perpetrators. The lead investigative agency may not provide investigative memoranda for inconclusive or false reports to the appropriate licensing boards unless the lead investigative agency's investigation gives reason to believe that there may have been a violation of the applicable professional practice laws. If the investigation memorandum is provided to a licensing board, the subject of the investigation memorandum shall be notified and receive a summary of the investigative findings.

(j) In order to avoid duplication, licensing boards shall consider the findings of the lead investigative agency in their investigations if they choose to investigate. This does not preclude licensing boards from considering other information.

(k) The lead investigative agency must provide to the commissioner of human services its final dispositions, including the names of all substantiated perpetrators. The commissioner of human services shall establish records to retain the names of substantiated perpetrators.

Subd. 9d. Administrative reconsideration; review panel. (a) Except as provided under paragraph (e), any individual or facility which a lead investigative agency determines has maltreated a vulnerable adult, or the vulnerable adult or an interested person acting on behalf of the vulnerable adult, regardless of the lead investigative agency's determination, who contests the lead investigative agency's final disposition of an allegation of maltreatment, may request the lead investigative agency to reconsider its final disposition. The request for reconsideration must be submitted in writing to the lead investigative agency within 15 calendar days after receipt of notice of final disposition or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the vulnerable adult or the vulnerable adult's guardian or health care agent. If mailed, the request for reconsideration must be postmarked and sent to the...
lead investigative agency within 15 calendar days of the individual's or facility's receipt of the final disposition. If the request for reconsideration is made by personal service, it must be received by the lead investigative agency within 15 calendar days of the individual's or facility's receipt of the final disposition. An individual who was determined to have maltreated a vulnerable adult under this section and who was disqualified on the basis of serious or recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted in writing within 30 calendar days of the individual's receipt of the notice of disqualification under sections 245C.16 and 245C.17. If mailed, the request for reconsideration of the maltreatment determination and the disqualification must be postmarked and sent to the lead investigative agency within 30 calendar days of the individual's receipt of the notice of disqualification. If the request for reconsideration is made by personal service, it must be received by the lead investigative agency within 30 calendar days after the individual's receipt of the notice of disqualification.

(b) Except as provided under paragraphs (e) and (f), if the lead investigative agency denies the request or fails to act upon the request within 15 working days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045, may submit to the commissioner of human services a written request for a hearing under that statute. The vulnerable adult, or an interested person acting on behalf of the vulnerable adult, may request a review by the Vulnerable Adult Maltreatment Review Panel under section 256.021 if the lead investigative agency denies the request or fails to act upon the request, or if the vulnerable adult or interested person contests a reconsidered disposition. The lead investigative agency shall notify persons who request reconsideration of their rights under this paragraph. The request must be submitted in writing to the review panel and a copy sent to the lead investigative agency within 30 calendar days of receipt of notice of a denial of a request for reconsideration or of a reconsidered disposition. The request must specifically identify the aspects of the lead investigative agency determination with which the person is dissatisfied.

(c) If, as a result of a reconsideration or review, the lead investigative agency changes the final disposition, it shall notify the parties specified in subdivision 9c, paragraph (f).

(d) For purposes of this subdivision, "interested person acting on behalf of the vulnerable adult" means a person designated in writing by the vulnerable adult to act on behalf of the vulnerable adult, or a legal guardian or conservator or other legal representative, a proxy or health care agent appointed under chapter 145B or 145C, or an individual who is related to the vulnerable adult, as defined in section 245A.02, subdivision 13.

(e) If an individual was disqualified under sections 245C.14 and 245C.15, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and reconsideration of the disqualification under sections 245C.21 to 245C.27, reconsideration of the maltreatment determination and requested reconsideration of the disqualification shall be consolidated into a single reconsideration. If reconsideration of the maltreatment determination is denied and the individual remains disqualified following a reconsideration decision, the individual may request a fair hearing under section 256.045. If an individual requests a fair hearing on the maltreatment determination and the disqualification, the scope of the fair hearing shall include both the maltreatment determination and the disqualification.

(f) If a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. As provided for under section 245A.08, the scope of the contested case hearing must include
the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing must not be conducted under section 256.045. Except for family child care and child foster care, reconsideration of a maltreatment determination under this subdivision, and reconsideration of a disqualification under section 245C.22, must not be conducted when:

(1) a denial of a license under section 245A.05, or a licensing sanction under section 245A.07, is based on a determination that the license holder is responsible for maltreatment or the disqualification of a license holder based on serious or recurring maltreatment;

(2) the denial of a license or licensing sanction is issued at the same time as the maltreatment determination or disqualification; and

(3) the license holder appeals the maltreatment determination or disqualification, and denial of a license or licensing sanction.

Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment determination or disqualification, but does not appeal the denial of a license or a licensing sanction, reconsideration of the maltreatment determination shall be conducted under sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the disqualification shall be conducted under section 245C.22. In such cases, a fair hearing shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.

If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under chapter 245C, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

(g) Until August 1, 2002, an individual or facility that was determined by the commissioner of human services or the commissioner of health to be responsible for neglect under section 626.5572, subdivision 17, after October 1, 1995, and before August 1, 2001, that believes that the finding of neglect does not meet an amended definition of neglect may request a reconsideration of the determination of neglect. The commissioner of human services or the commissioner of health shall mail a notice to the last known address of individuals who are eligible to seek this reconsideration. The request for reconsideration must state how the established findings no longer meet the elements of the definition of neglect. The commissioner shall review the request for reconsideration and make a determination within 15 calendar days. The commissioner's decision on this reconsideration is the final agency action.

(1) For purposes of compliance with the data destruction schedule under subdivision 12b, paragraph (d), when a finding of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, the date of the original finding of a substantiated maltreatment must be used to calculate the destruction date.

(2) For purposes of any background studies under chapter 245C, when a determination of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, any prior disqualification of the individual under chapter 245C that was based on this determination of maltreatment shall be rescinded, and for future background studies under chapter 245C the commissioner must not use the previous determination of substantiated maltreatment as a basis for disqualification or as a basis for referring the individual's maltreatment history to a health-related licensing board under section 245C.31.

Subd. 9e. Education requirements. (a) The commissioners of health, human services, and public safety shall cooperate in the development of a joint program for education of lead investigative agency investigators in the appropriate techniques for investigation of complaints of maltreatment. This program must be developed.
by July 1, 1996. The program must include but need not be limited to the following areas: (1) information collection and preservation; (2) analysis of facts; (3) levels of evidence; (4) conclusions based on evidence; (5) interviewing skills, including specialized training to interview people with unique needs; (6) report writing; (7) coordination and referral to other necessary agencies such as law enforcement and judicial agencies; (8) human relations and cultural diversity; (9) the dynamics of adult abuse and neglect within family systems and the appropriate methods for interviewing relatives in the course of the assessment or investigation; (10) the protective social services that are available to protect alleged victims from further abuse, neglect, or financial exploitation; (11) the methods by which lead investigative agency investigators and law enforcement workers cooperate in conducting assessments and investigations in order to avoid duplication of efforts; and (12) data practices laws and procedures, including provisions for sharing data.

(b) The commissioner of human services shall conduct an outreach campaign to promote the common entry point for reporting vulnerable adult maltreatment. This campaign shall use the Internet and other means of communication.

(c) The commissioners of health, human services, and public safety shall offer at least annual education to others on the requirements of this section, on how this section is implemented, and investigation techniques.

(d) The commissioner of human services, in coordination with the commissioner of public safety shall provide training for the common entry point staff as required in this subdivision and the program courses described in this subdivision, at least four times per year. At a minimum, the training shall be held twice annually in the seven-county metropolitan area and twice annually outside the seven-county metropolitan area. The commissioners shall give priority in the program areas cited in paragraph (a) to persons currently performing assessments and investigations pursuant to this section.

(e) The commissioner of public safety shall notify in writing law enforcement personnel of any new requirements under this section. The commissioner of public safety shall conduct regional training for law enforcement personnel regarding their responsibility under this section.

(f) Each lead investigative agency investigator must complete the education program specified by this subdivision within the first 12 months of work as a lead investigative agency investigator.

A lead investigative agency investigator employed when these requirements take effect must complete the program within the first year after training is available or as soon as training is available.

All lead investigative agency investigators having responsibility for investigation duties under this section must receive a minimum of eight hours of continuing education or in-service training each year specific to their duties under this section.

Subd. 10. Duties of county social service agency. (a) When the common entry point refers a report to the county social service agency as the lead investigative agency or makes a referral to the county social service agency for emergency adult protective services, or when another lead investigative agency requests assistance from the county social service agency for adult protective services, the county social service agency shall immediately assess and offer emergency and continuing protective social services for purposes of preventing further maltreatment and for safeguarding the welfare of the maltreated vulnerable adult. The county shall use a standardized tool made available by the commissioner. The information entered by the county into the standardized tool must be accessible to the Department of Human Services. In cases of suspected sexual abuse, the county social service agency shall immediately arrange for and make available to the vulnerable adult appropriate medical examination and treatment. When necessary in order to protect the vulnerable adult from further harm, the county social service agency shall seek authority to remove the vulnerable adult from the situation in which the maltreatment occurred. The county social service agency
may also investigate to determine whether the conditions which resulted in the reported maltreatment place other vulnerable adults in jeopardy of being maltreated and offer protective social services that are called for by its determination.

(b) County social service agencies may enter facilities and inspect and copy records as part of an investigation. The county social service agency has access to not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, that are maintained by facilities to the extent necessary to conduct its investigation. The inquiry is not limited to the written records of the facility, but may include every other available source of information.

(c) When necessary in order to protect a vulnerable adult from serious harm, the county social service agency shall immediately intervene on behalf of that adult to help the family, vulnerable adult, or other interested person by seeking any of the following:

1. a restraining order or a court order for removal of the perpetrator from the residence of the vulnerable adult pursuant to section 518B.01;
2. the appointment of a guardian or conservator pursuant to sections 524.5-101 to 524.5-502, or guardianship or conservatorship pursuant to chapter 252A;
3. replacement of a guardian or conservator suspected of maltreatment and appointment of a suitable person as guardian or conservator, pursuant to sections 524.5-101 to 524.5-502; or
4. a referral to the prosecuting attorney for possible criminal prosecution of the perpetrator under chapter 609.

The expenses of legal intervention must be paid by the county in the case of indigent persons, under section 524.5-502 and chapter 563.

In proceedings under sections 524.5-101 to 524.5-502, if a suitable relative or other person is not available to petition for guardianship or conservatorship, a county employee shall present the petition with representation by the county attorney. The county shall contract with or arrange for a suitable person or organization to provide ongoing guardianship services. If the county presents evidence to the court exercising probate jurisdiction that it has made a diligent effort and no other suitable person can be found, a county employee may serve as guardian or conservator. The county shall not retaliate against the employee for any action taken on behalf of the ward or protected person even if the action is adverse to the county's interest. Any person retaliated against in violation of this subdivision shall have a cause of action against the county and shall be entitled to reasonable attorney fees and costs of the action if the action is upheld by the court.

Subd. 10a. [Repealed, 1995 c 229 art 1 s 24]

Subd. 10b. Investigations; guidelines. Each lead investigative agency shall develop guidelines for prioritizing reports for investigation. When investigating a report, the lead investigative agency shall conduct the following activities, as appropriate:

1. interview of the alleged victim;
2. interview of the reporter and others who may have relevant information;
3. interview of the alleged perpetrator;
4. examination of the environment surrounding the alleged incident;
(5) review of pertinent documentation of the alleged incident; and

(6) consultation with professionals.

Subd. 11. [Repealed, 1995 c 229 art 1 s 24]

Subd. 11a. [Repealed, 1995 c 229 art 1 s 24]

Subd. 12. [Repealed, 1995 c 229 art 1 s 24]

Subd. 12a. [Repealed, 1983 c 273 s 8]

Subd. 12b. Data management. (a) In performing any of the duties of this section as a lead investigative agency, the county social service agency shall maintain appropriate records. Data collected by the county social service agency under this section are welfare data under section 13.46. Notwithstanding section 13.46, subdivision 1, paragraph (a), data under this paragraph that are inactive investigative data on an individual who is a vendor of services are private data on individuals, as defined in section 13.02. The identity of the reporter may only be disclosed as provided in paragraph (c).

Data maintained by the common entry point are confidential data on individuals or protected nonpublic data as defined in section 13.02. Notwithstanding section 138.163, the common entry point shall maintain data for three calendar years after date of receipt and then destroy the data unless otherwise directed by federal requirements.

(b) The commissioners of health and human services shall prepare an investigation memorandum for each report alleging maltreatment investigated under this section. County social service agencies must maintain private data on individuals but are not required to prepare an investigation memorandum. During an investigation by the commissioner of health or the commissioner of human services, data collected under this section are confidential data on individuals or protected nonpublic data as defined in section 13.02. Upon completion of the investigation, the data are classified as provided in clauses (1) to (3) and paragraph (c).

(1) The investigation memorandum must contain the following data, which are public:

(i) the name of the facility investigated;

(ii) a statement of the nature of the alleged maltreatment;

(iii) pertinent information obtained from medical or other records reviewed;

(iv) the identity of the investigator;

(v) a summary of the investigation's findings;

(vi) statement of whether the report was found to be substantiated, inconclusive, false, or that no determination will be made;

(vii) a statement of any action taken by the facility;

(viii) a statement of any action taken by the lead investigative agency; and

(ix) when a lead investigative agency's determination has substantiated maltreatment, a statement of whether an individual, individuals, or a facility were responsible for the substantiated maltreatment, if known.
The investigation memorandum must be written in a manner which protects the identity of the reporter and of the vulnerable adult and may not contain the names or, to the extent possible, data on individuals or private data listed in clause (2).

(2) Data on individuals collected and maintained in the investigation memorandum are private data, including:

(i) the name of the vulnerable adult;

(ii) the identity of the individual alleged to be the perpetrator;

(iii) the identity of the individual substantiated as the perpetrator; and

(iv) the identity of all individuals interviewed as part of the investigation.

(3) Other data on individuals maintained as part of an investigation under this section are private data on individuals upon completion of the investigation.

(c) After the assessment or investigation is completed, the name of the reporter must be confidential. The subject of the report may compel disclosure of the name of the reporter only with the consent of the reporter or upon a written finding by a court that the report was false and there is evidence that the report was made in bad faith. This subdivision does not alter disclosure responsibilities or obligations under the Rules of Criminal Procedure, except that where the identity of the reporter is relevant to a criminal prosecution, the district court shall do an in-camera review prior to determining whether to order disclosure of the identity of the reporter.

(d) Notwithstanding section 138.163, data maintained under this section by the commissioners of health and human services must be maintained under the following schedule and then destroyed unless otherwise directed by federal requirements:

(1) data from reports determined to be false, maintained for three years after the finding was made;

(2) data from reports determined to be inconclusive, maintained for four years after the finding was made;

(3) data from reports determined to be substantiated, maintained for seven years after the finding was made; and

(4) data from reports which were not investigated by a lead investigative agency and for which there is no final disposition, maintained for three years from the date of the report.

(e) The commissioners of health and human services shall annually publish on their websites the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigation under this section, and the resolution of those investigations. On a biennial basis, the commissioners of health and human services shall jointly report the following information to the legislature and the governor:

(1) the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigations under this section, the resolution of those investigations, and which of the two lead agencies was responsible;

(2) trends about types of substantiated maltreatment found in the reporting period;
(3) if there are upward trends for types of maltreatment substantiated, recommendations for addressing and responding to them;

(4) efforts undertaken or recommended to improve the protection of vulnerable adults;

(5) whether and where backlogs of cases result in a failure to conform with statutory time frames and recommendations for reducing backlogs if applicable;

(6) recommended changes to statutes affecting the protection of vulnerable adults; and

(7) any other information that is relevant to the report trends and findings.

(f) Each lead investigative agency must have a record retention policy.

(g) Lead investigative agencies, prosecuting authorities, and law enforcement agencies may exchange not public data, as defined in section 13.02, if the agency or authority requesting the data determines that the data are pertinent and necessary to the requesting agency in initiating, furthering, or completing an investigation under this section. Data collected under this section must be made available to prosecuting authorities and law enforcement officials, local county agencies, and licensing agencies investigating the alleged maltreatment under this section. The lead investigative agency shall exchange not public data with the vulnerable adult maltreatment review panel established in section 256.021 if the data are pertinent and necessary for a review requested under that section. Notwithstanding section 138.17, upon completion of the review, not public data received by the review panel must be destroyed.

(h) Each lead investigative agency shall keep records of the length of time it takes to complete its investigations.

(i) A lead investigative agency may notify other affected parties and their authorized representative if the lead investigative agency has reason to believe maltreatment has occurred and determines the information will safeguard the well-being of the affected parties or dispel widespread rumor or unrest in the affected facility.

(j) Under any notification provision of this section, where federal law specifically prohibits the disclosure of patient identifying information, a lead investigative agency may not provide any notice unless the vulnerable adult has consented to disclosure in a manner which conforms to federal requirements.

Subd. 13. [Repealed, 1995 c 229 art 1 s 24]

Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.

(b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.
(c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.

Subd. 15. [Repealed, 1995 c 229 art 1 s 24]

Subd. 16. [Repealed, 2014 c 262 art 4 s 9]

Subd. 17. Retaliation prohibited. (a) A facility or person shall not retaliate against any person who reports in good faith suspected maltreatment pursuant to this section, or against a vulnerable adult with respect to whom a report is made, because of the report.

(b) In addition to any remedies allowed under sections 181.931 to 181.935, any facility or person which retaliates against any person because of a report of suspected maltreatment is liable to that person for actual damages, punitive damages up to $10,000, and attorney fees.

(c) There shall be a rebuttable presumption that any adverse action, as defined below, within 90 days of a report, is retaliatory. For purposes of this clause, the term "adverse action" refers to action taken by a facility or person involved in a report against the person making the report or the person with respect to whom the report was made because of the report, and includes, but is not limited to:

(1) discharge or transfer from the facility;

(2) discharge from or termination of employment;

(3) demotion or reduction in remuneration for services;

(4) restriction or prohibition of access to the facility or its residents; or

(5) any restriction of rights set forth in section 144.651.

Subd. 18. Outreach. The commissioner of human services shall maintain an aggressive program to educate those required to report, as well as the general public, about the requirements of this section using a variety of media. The commissioner of human services shall print and make available the form developed under subdivision 9.

Subd. 19. [Repealed, 1995 c 229 art 1 s 24]

Subd. 20. Cause of action for financial exploitation; damages. (a) A vulnerable adult who is a victim of financial exploitation as defined in section 626.5572, subdivision 9, has a cause of action against a person who committed the financial exploitation. In an action under this subdivision, the vulnerable adult is entitled to recover damages equal to three times the amount of compensatory damages or $10,000, whichever is greater.

(b) In addition to damages under paragraph (a), the vulnerable adult is entitled to recover reasonable attorney fees and costs, including reasonable fees for the services of a guardian or conservator or guardian ad litem incurred in connection with a claim under this subdivision.
(c) An action may be brought under this subdivision regardless of whether there has been a report or final disposition under this section or a criminal complaint or conviction related to the financial exploitation.

Subd. 21. Contested case hearing. When an appeal of a lead investigative agency determination results in a contested case hearing under chapter 245A or 245C, the administrative law judge shall notify the vulnerable adult who is the subject of the maltreatment determination and, if known, a guardian of the vulnerable adult appointed under section 524.5-310, or a health care agent designated by the vulnerable adult in a health care directive that is currently effective under section 145C.06, and whose authority to make health care decisions is not suspended under section 524.5-310, of the hearing. The notice must be sent by certified mail and inform the vulnerable adult of the right to file a signed written statement in the proceedings. A guardian or health care agent who prepares or files a written statement for the vulnerable adult must indicate in the statement that the person is the vulnerable adult's guardian or health care agent and sign the statement in that capacity. The vulnerable adult, the guardian, or the health care agent may file a written statement with the administrative law judge hearing the case no later than five business days before commencement of the hearing. The administrative law judge shall include the written statement in the hearing record and consider the statement in deciding the appeal. This subdivision does not limit, prevent, or excuse the vulnerable adult from being called as a witness testifying at the hearing or grant the vulnerable adult, the guardian, or health care agent a right to participate in the proceedings or appeal the administrative law judge's decision in the case. The lead investigative agency must consider including the vulnerable adult victim of maltreatment as a witness in the hearing. If the lead investigative agency determines that participation in the hearing would endanger the well-being of the vulnerable adult or not be in the best interests of the vulnerable adult, the lead investigative agency shall inform the administrative law judge of the basis for this determination, which must be included in the final order. If the administrative law judge is not reasonably able to determine the address of the vulnerable adult, the guardian, or the health care agent, the administrative law judge is not required to send a hearing notice under this subdivision.

History: 1980 c 542 s 1; 1981 c 311 s 39; 1982 c 393 s 3,4; 1982 c 424 s 130; 1982 c 545 s 24; 1982 c 636 s 5,6; 1983 c 273 s 1-7; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1985 c 150 s 1-6; 1985 c 293 s 6,7; 1Sp1985 c 14 art 9 s 75; 1986 c 444; 1987 c 110 s 3; 1987 c 211 s 2; 1987 c 352 s 11; 1987 c 378 s 17; 1987 c 384 art 2 s 1; 1988 c 543 s 13; 1989 c 209 art 2 s 1; 1991 c 181 s 2; 1994 c 483 s 1; 1994 c 636 art 2 s 60-62; 1Sp1994 c 1 art 2 s 34; 1995 c 189 s 8; 1995 c 229 art 1 s 1-21; 1996 c 277 s 1; 1996 c 305 art 2 s 66; 2000 c 465 s 3-5; 1Sp2001 c 9 art 5 s 31; art 14 s 30,31; 2002 c 289 s 4; 2002 c 375 art 1 s 22,23; 2002 c 379 art 1 s 113; 2003 c 15 art 1 s 33; 2004 c 146 art 3 s 45; 2004 c 288 art 1 s 80; 2005 c 56 s 1; 2005 c 98 art 2 s 17; 2005 c 136 art 5 s 5; 1Sp2005 c 4 art 1 s 55,56; 2006 c 253 s 21; 2007 c 112 s 55,56; 2007 c 147 art 7 s 75; art 10 s 15; 2009 c 119 s 11-16; 2009 c 142 art 2 s 46,47; 2009 c 159 s 107; 2010 c 329 art 2 s 6; 2010 c 352 art 1 s 23; 2010 c 382 s 81; 2011 c 28 s 9-14,17; 2012 c 216 art 9 s 30,31; 2013 c 63 s 17; 2013 c 108 art 2 s 41-43; art 8 s 57; 2014 c 192 art 2 s 1; 2014 c 291 art 8 s 17; 2015 c 78 art 6 s 23-25
626.5571 MULTIDISCIPLINARY ADULT PROTECTION TEAM.

Subdivision 1. Establishment of team. A county may establish a multidisciplinary adult protection team comprised of the director of the local welfare agency or designees, the county attorney or designees, the county sheriff or designees, and representatives of health care. In addition, representatives of mental health or other appropriate human service agencies, representatives from local tribal governments, and adult advocate groups may be added to the adult protection team.

Subd. 2. Duties of team. A multidisciplinary adult protection team may provide public and professional education, develop resources for prevention, intervention, and treatment, and provide case consultation to the local welfare agency to better enable the agency to carry out its adult protection functions under section 626.557 and to meet the community's needs for adult protection services. Case consultation may be performed by a committee of the team composed of the team members representing social services, law enforcement, the county attorney, health care, and persons directly involved in an individual case as determined by the case consultation committee. Case consultation is a case review process that results in recommendations about services to be provided to the identified adult and family.

Subd. 3. Information sharing. The local welfare agency may make available to members of the team for case consultation all records collected and maintained by the agency under section 626.557 and in connection with case consultation. Any member of the case consultation committee may share data, acquired in the member's professional capacity, with the committee to assist the committee in its function. Members prohibited from disclosing patient identifying information because of federal or state law shall seek consent from each patient or resident, or a guardian, conservator or legal representative, for the disclosure of appropriate data to the case consultation committee.

History: 1988 c 575 s 1; 2005 c 98 art 3 s 23; 2011 c 28 s 15
626.5572 DEFINITIONS.

Subdivision 1. **Scope.** For the purpose of section 626.557, the following terms have the meanings given them, unless otherwise specified.

Subd. 2. **Abuse.** "Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;

(2) the use of drugs to injure or facilitate crime as defined in section 609.235;

(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and

(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and

(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.

(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

(e) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C or 252A, or section 253B.03 or 524.5-313, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult or, where permitted under law, to provide nutrition and hydration parenterally or through intubation. This paragraph does not enlarge or diminish rights otherwise held under law by:
(1) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or

(2) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct.

(f) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult.

(g) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:

(1) a person, including a facility staff person, when a consensual sexual personal relationship existed prior to the caregiving relationship; or

(2) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship.

Subd. 3. Accident. "Accident" means a sudden, unforeseen, and unexpected occurrence or event which:

(1) is not likely to occur and which could not have been prevented by exercise of due care; and

(2) if occurring while a vulnerable adult is receiving services from a facility, happens when the facility and the employee or person providing services in the facility are in compliance with the laws and rules relevant to the occurrence or event.

Subd. 4. Caregiver. "Caregiver" means an individual or facility who has responsibility for the care of a vulnerable adult as a result of a family relationship, or who has assumed responsibility for all or a portion of the care of a vulnerable adult voluntarily, by contract, or by agreement.

Subd. 5. Common entry point. "Common entry point" means the entity responsible for receiving reports of alleged or suspected maltreatment of a vulnerable adult under section 626.557.

Subd. 6. Facility. (a) "Facility" means a hospital or other entity required to be licensed under sections 144.50 to 144.58; a nursing home required to be licensed to serve adults under section 144A.02; a facility or service required to be licensed under chapter 245A; a home care provider licensed or required to be licensed under sections 144A.43 to 144A.482; a hospice provider licensed under sections 144A.75 to 144A.755; or a person or organization that offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under sections 256B.0625, subdivision 19a, 256B.0651 to 256B.0654, 256B.0659, or 256B.85.

(b) For services identified in paragraph (a) that are provided in the vulnerable adult's own home or in another unlicensed location, the term "facility" refers to the provider, person, or organization that offers, provides, or arranges for personal care services, and does not refer to the vulnerable adult's home or other location at which services are rendered.

Subd. 7. False. "False" means a preponderance of the evidence shows that an act that meets the definition of maltreatment did not occur.
Subd. 8. Final disposition. "Final disposition" is the determination of an investigation by a lead investigative agency that a report of maltreatment under Laws 1995, chapter 229, is substantiated, inconclusive, false, or that no determination will be made. When a lead investigative agency determination has substantiated maltreatment, the final disposition also identifies, if known, which individual or individuals were responsible for the substantiated maltreatment, and whether a facility was responsible for the substantiated maltreatment.

Subd. 9. Financial exploitation. "Financial exploitation" means:

(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:

(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or

(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.

(b) In the absence of legal authority a person:

(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;

(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or

(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

(c) Nothing in this definition requires a facility or caregiver to provide financial management or supervise financial management for a vulnerable adult except as otherwise required by law.

Subd. 10. Immediately. "Immediately" means as soon as possible, but no longer than 24 hours from the time initial knowledge that the incident occurred has been received.

Subd. 11. Inconclusive. "Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Subd. 12. Initial disposition. "Initial disposition" is the lead investigative agency's determination of whether the report will be assigned for further investigation.

Subd. 13. Lead investigative agency. "Lead investigative agency" is the primary administrative agency responsible for investigating reports made under section 626.557.

(a) The Department of Health is the lead investigative agency for facilities or services licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding care homes, hospice providers, residential facilities that are also federally certified as intermediate care facilities that serve people with developmental disabilities, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Health for the care of vulnerable adults. "Home care provider" has the meaning provided in section 144A.43, subdivision 4, and applies when care or services are delivered...
in the vulnerable adult's home, whether a private home or a housing with services establishment registered under chapter 144D, including those that offer assisted living services under chapter 144G.

(b) The Department of Human Services is the lead investigative agency for facilities or services licensed or required to be licensed as adult day care, adult foster care, community residential settings, programs for people with disabilities, family adult day services, mental health programs, mental health clinics, chemical dependency programs, the Minnesota sex offender program, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Human Services.

(c) The county social service agency or its designee is the lead investigative agency for all other reports, including, but not limited to, reports involving vulnerable adults receiving services from a personal care provider organization under section 256B.0659.

Subd. 14. Legal authority. "Legal authority" includes, but is not limited to: (1) a fiduciary obligation recognized elsewhere in law, including pertinent regulations; (2) a contractual obligation; or (3) documented consent by a competent person.

Subd. 15. Maltreatment. "Maltreatment" means abuse as defined in subdivision 2, neglect as defined in subdivision 17, or financial exploitation as defined in subdivision 9.

Subd. 16. Mandated reporter. "Mandated reporter" means a professional or professional's delegate while engaged in: (1) social services; (2) law enforcement; (3) education; (4) the care of vulnerable adults; (5) any of the occupations referred to in section 214.01, subdivision 2; (6) an employee of a rehabilitation facility certified by the commissioner of jobs and training for vocational rehabilitation; (7) an employee or person providing services in a facility as defined in subdivision 6; or (8) a person that performs the duties of the medical examiner or coroner.

Subd. 17. Neglect. "Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:

(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:
(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or

(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; or

(2) the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult;

(3) the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:

   (i) a person including a facility staff person when a consensual sexual personal relationship existed prior to the caregiving relationship; or

   (ii) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship; or

(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:

   (i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;

   (ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;

   (iii) the error is not part of a pattern of errors by the individual;

   (iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;

   (v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and

   (vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

(d) Nothing in this definition requires a caregiver, if regulated, to provide services in excess of those required by the caregiver's license, certification, registration, or other regulation.

(e) If the findings of an investigation by a lead investigative agency result in a determination of substantiated maltreatment for the sole reason that the actions required of a facility under paragraph (c), clause (5), item (iv), (v), or (vi), were not taken, then the facility is subject to a correction order. An individual will not be found to have neglected or maltreated the vulnerable adult based solely on the facility's not having taken the actions required under paragraph (c), clause (5), item (iv), (v), or (vi). This must not alter the lead investigative agency's determination of mitigating factors under section 626.557, subdivision 9c, paragraph (c).
Subd. 18. **Report.** "Report" means a statement concerning all the circumstances surrounding the alleged or suspected maltreatment, as defined in this section, of a vulnerable adult which are known to the reporter at the time the statement is made.

Subd. 19. **Substantiated.** "Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

Subd. 20. **Therapeutic conduct.** "Therapeutic conduct" means the provision of program services, health care, or other personal care services done in good faith in the interests of the vulnerable adult by: (1) an individual, facility, or employee or person providing services in a facility under the rights, privileges and responsibilities conferred by state license, certification, or registration; or (2) a caregiver.

Subd. 21. **Vulnerable adult.** (a) "Vulnerable adult" means any person 18 years of age or older who:

(1) is a resident or inpatient of a facility;

(2) receives services required to be licensed under chapter 245A, except that a person receiving outpatient services for treatment of chemical dependency or mental illness, or one who is served in the Minnesota sex offender program on a court-hold order for commitment, or is committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253B, is not considered a vulnerable adult unless the person meets the requirements of clause (4);

(3) receives services from a home care provider required to be licensed under sections 144A.43 to 144A.482; or from a person or organization that offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under section 256B.0625, subdivision 19a, 256B.0651, 256B.0653, 256B.0654, 256B.0659, or 256B.85; or

(4) regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

(ii) because of the dysfunction or infirmity and the need for care or services, the individual has an impaired ability to protect the individual's self from maltreatment.

(b) For purposes of this subdivision, "care or services" means care or services for the health, safety, welfare, or maintenance of an individual.

**History:** 1995 c 229 art 1 s 22; 2000 c 319 s 3; 1Sp2001 c 9 art 14 s 32; 2002 c 252 s 23,24; 2002 c 379 art 1 s 113; 2004 c 146 art 3 s 46; 2006 c 212 art 3 s 41; 2007 c 112 s 57; 2008 c 326 art 2 s 15; 2009 c 79 art 6 s 20,21; art 8 s 75; 2009 c 119 s 17; 2009 c 142 art 2 s 48; 2011 c 28 s 16,17; 2012 c 216 art 9 s 32; 2013 c 108 art 8 s 58; 2014 c 262 art 4 s 9; art 5 s 6; 2015 c 78 art 6 s 26-28; 2016 c 158 art 1 s 210,211
626.5573 NEGLIGENCE ACTIONS.

A violation of sections 626.557 to 626.5572 shall be admissible as evidence of negligence, but shall not be considered negligence per se.

History: 1995 c 229 art 1 s 23
CHAPTER 145B
LIVING WILL

145B.01 CITATION.

This chapter may be cited as the "Minnesota Living Will Act."

History: 1989 c 3 s 1; 1991 c 148 s 1

145B.011 APPLICATION OF CHAPTER.

This chapter applies only to living wills executed before August 1, 1998. If a document purporting to be a living will is executed on or after August 1, 1998, its legal sufficiency, interpretation, and enforcement must be determined under the provisions of chapter 145C in effect on the date of its execution.

History: 1998 c 399 s 2

145B.02 DEFINITIONS.

Subdivision 1. Applicability. The definitions in this section apply to this chapter.

Subd. 2. Living will. "Living will" means a writing made according to section 145B.03.

Subd. 3. Health care. "Health care" means care, treatment, services, or procedures to maintain, diagnose, or treat an individual's physical condition when the individual is in a terminal condition.

Subd. 4. Health care decision. "Health care decision" means a decision to begin, continue, increase, limit, discontinue, or not begin any health care.

Subd. 5. Health care facility. "Health care facility" means a hospital or other entity licensed under sections 144.50 to 144.58; a nursing home licensed to serve adults under section 144A.02; or a home care provider licensed under sections 144A.43 to 144A.47.

Subd. 6. Health care provider. "Health care provider" means a person, health care facility, organization, or corporation licensed, certified, or otherwise authorized or permitted by the laws of this state to administer health care directly or through an arrangement with other health care providers.

Subd. 7. HMO. "HMO" means an organization licensed under sections 62D.01 to 62D.30.
Subd. 8. **Terminal condition.** "Terminal condition" means an incurable or irreversible condition for which the administration of medical treatment will serve only to prolong the dying process.

**History:** 1989 c 3 s 2; 1991 c 148 s 6; 2008 c 277 art 1 s 17

### 145B.03 LIVING WILL.

Subdivision 1. **Scope.** A competent adult may make a living will of preferences or instructions regarding health care. These preferences or instructions may include, but are not limited to, consent to or refusal of any health care, treatment, service, procedure, or placement. A living will may include preferences or instructions regarding health care, the designation of a proxy to make health care decisions on behalf of the declarant, or both.

Subd. 2. **Requirements for executing a living will.** (a) A living will is effective only if it is signed by the declarant and two witnesses or a notary public.

(b) A living will must state:

(1) the declarant's preferences regarding whether the declarant wishes to receive or not receive artificial administration of nutrition and hydration; or

(2) that the declarant wishes the proxy, if any, to make decisions regarding the administering of artificially administered nutrition and hydration for the declarant if the declarant is unable to make health care decisions and the living will becomes operative. If the living will does not state the declarant's preferences regarding artificial administration of nutrition and hydration, the living will shall be enforceable as to all other preferences or instructions regarding health care, and a decision to administer, withhold, or withdraw nutrition and hydration artificially shall be made pursuant to section 145B.13. However, the mere existence of a living will or appointment of a proxy does not, by itself, create a presumption that the declarant wanted the withholding or withdrawing of artificially administered nutrition or hydration.

(c) The living will may be communicated to and then transcribed by one of the witnesses. If the declarant is physically unable to sign the document, one of the witnesses shall sign the document at the declarant's direction.

(d) Neither of the witnesses can be someone who is entitled to any part of the estate of the declarant under a will then existing or by operation of law. Neither of the witnesses nor the notary may be named as a proxy in the living will. Each witness shall substantially make the following declaration on the document:

"I certify that the declarant voluntarily signed this living will in my presence and that the declarant is personally known to me. I am not named as a proxy by the living will."

Subd. 3. **Guardian.** Except as otherwise provided in the living will, designation of a proxy is considered a nomination of a guardian for purposes of sections 524.5-101 to 524.5-502.

**History:** 1989 c 3 s 3; 1991 c 148 s 6; 2004 c 146 art 3 s 2

### 145B.04 SUGGESTED FORM.

A living will executed after August 1, 1989, under this chapter must be substantially in the form in this section. Forms printed for public distribution must be substantially in the form in this section.

"Health Care Living Will

Notice:
This is an important legal document. Before signing this document, you should know these important facts:

(a) This document gives your health care providers or your designated proxy the power and guidance to make health care decisions according to your wishes when you are in a terminal condition and cannot do so. This document may include what kind of treatment you want or do not want and under what circumstances you want these decisions to be made. You may state where you want or do not want to receive any treatment.

(b) If you name a proxy in this document and that person agrees to serve as your proxy, that person has a duty to act consistently with your wishes. If the proxy does not know your wishes, the proxy has the duty to act in your best interests. If you do not name a proxy, your health care providers have a duty to act consistently with your instructions or tell you that they are unwilling to do so.

(c) This document will remain valid and in effect until and unless you amend or revoke it. Review this document periodically to make sure it continues to reflect your preferences. You may amend or revoke the living will at any time by notifying your health care providers.

(d) Your named proxy has the same right as you have to examine your medical records and to consent to their disclosure for purposes related to your health care or insurance unless you limit this right in this document.

(e) If there is anything in this document that you do not understand, you should ask for professional help to have it explained to you.

TO MY FAMILY, DOCTORS, AND ALL THOSE CONCERNED WITH MY CARE:

I, .........................., born on ........ (birthdate), being an adult of sound mind, willfully and voluntarily make this statement as a directive to be followed if I am in a terminal condition and become unable to participate in decisions regarding my health care. I understand that my health care providers are legally bound to act consistently with my wishes, within the limits of reasonable medical practice and other applicable law. I also understand that I have the right to make medical and health care decisions for myself as long as I am able to do so and to revoke this living will at any time.

(1) The following are my feelings and wishes regarding my health care (you may state the circumstances under which this living will applies):

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(2) I particularly want to have all appropriate health care that will help in the following ways (you may give instructions for care you do want):

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I particularly do not want the following (you may list specific treatment you do not want in certain circumstances):

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(4) I particularly want to have the following kinds of life-sustaining treatment if I am diagnosed to have a terminal condition (you may list the specific types of life-sustaining treatment that you do want if you have a terminal condition):

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(5) I particularly do not want the following kinds of life-sustaining treatment if I am diagnosed to have a terminal condition (you may list the specific types of life-sustaining treatment that you do not want if you have a terminal condition):

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(6) I recognize that if I reject artificially administered sustenance, then I may die of dehydration or malnutrition rather than from my illness or injury. The following are my feelings and wishes regarding artificially administered sustenance should I have a terminal condition (you may indicate whether you wish to receive food and fluids given to you in some other way than by mouth if you have a terminal condition):

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(7) Thoughts I feel are relevant to my instructions. (You may, but need not, give your religious beliefs, philosophy, or other personal values that you feel are important. You may also state preferences concerning the location of your care.)

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(8) Proxy Designation. (If you wish, you may name someone to see that your wishes are carried out, but you do not have to do this. You may also name a proxy without including specific instructions regarding your care. If you name a proxy, you should discuss your wishes with that person.)

If I become unable to communicate my instructions, I designate the following person(s) to act on my behalf consistently with my instructions, if any, as stated in this document. Unless I write instructions that limit my proxy's authority, my proxy has full power and authority to make health care decisions for me. If a guardian is to be appointed for me, I nominate my proxy named in this document to act as my guardian.

Name: ..........................................................
Address: ..........................................................
Phone Number: .............................................
Relationship: (If any) ....................................

If the person I have named above refuses or is unable or unavailable to act on my behalf, or if I revoke that person's authority to act as my proxy, I authorize the following person to do so:

Name: ..........................................................
Address: ..........................................................
Phone Number: .............................................
Relationship: (If any) ....................................

I understand that I have the right to revoke the appointment of the persons named above to act on my behalf at any time by communicating that decision to the proxy or my health care provider.

(9) Organ Donation After Death. (If you wish, you may indicate whether you want to be an organ donor upon your death.) Initial the statement which expresses your wish:

..... In the event of my death, I would like to donate my organs. I understand that to become an organ donor, I must be declared brain dead. My organ function may be maintained artificially on a breathing machine, (i.e., artificial ventilation), so that my organs can be removed.

Limitations or special wishes: (If any)...........................................................................................................
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I understand that, upon my death, my next of kin may be asked permission for donation. Therefore, it is in my best interests to inform my next of kin about my decision ahead of time and ask them to honor my request.

I (have) (have not) agreed in another document or on another form to donate some or all of my organs when I die.

..... I do not wish to become an organ donor upon my death.
DATE: .............................................................
SIGNED: .........................................................
STATE OF .........................................................
...........................................................................
COUNTY OF .......................................................

Subscribed, sworn to, and acknowledged before me by .......... on this .... day of ..........., ....
...........................................................................

NOTARY PUBLIC

OR

(Sign and date here in the presence of two adult witnesses, neither of whom is entitled to any part of your estate under a will or by operation of law, and neither of whom is your proxy.)

I certify that the declarant voluntarily signed this living will in my presence and that the declarant is personally known to me. I am not named as a proxy by the living will, and to the best of my knowledge, I am not entitled to any part of the estate of the declarant under a will or by operation of law.

Witness .......................................................... Address ..............................................................
Witness .......................................................... Address ..............................................................

Reminder: Keep the signed original with your personal papers.
Give signed copies to your doctors, family, and proxy."

History: 1989 c 3 s 4; 1991 c 148 s 6; 1992 c 535 s 1; 1995 c 211 s 1; 1998 c 254 art 1 s 107; 2005 c 10 art 4 s 2

145B.05 WHEN OPERATIVE.

A living will becomes operative when it is delivered to the declarant's physician or other health care provider. The physician or provider must comply with it to the fullest extent possible, consistent with reasonable medical practice and other applicable law, or comply with the notice and transfer provisions of sections 145B.06 and 145B.07. The physician or health care provider shall continue to obtain the declarant's informed consent to all health care decisions if the declarant is capable of informed consent.

History: 1989 c 3 s 5; 1991 c 148 s 6

145B.06 COMPLIANCE WITH LIVING WILL.

Subdivision 1. By health care provider. (a) A physician or other health care provider shall make the living will a part of the declarant's medical record. If the physician or other health care provider is unwilling at any time to comply with the living will, the physician or health care provider must promptly notify the declarant and document the notification in the declarant's medical record. After notification, if a competent
declarant fails to transfer to a different physician or provider, the physician or provider has no duty to transfer
the patient.

(b) If a physician or other health care provider receives a living will from a competent declarant and
does not advise the declarant of unwillingness to comply, and if the declarant then becomes incompetent or
otherwise unable to seek transfer to a different physician or provider, the physician or other health care
provider who is unwilling to comply with the living will shall promptly take all reasonable steps to transfer
care of the declarant to a physician or other health care provider who is willing to comply with the living
will.

Subd. 2. By proxy. A proxy designated to make health care decisions and who agrees to serve as proxy
may make health care decisions on behalf of a declarant to the same extent that the declarant could make
the decision, subject to limitations or conditions stated in the living will. In exercising this authority, the
proxy shall act consistently with any desires the declarant expresses in the living will or otherwise makes
known to the proxy. If the declarant's desires are unknown, the proxy shall act in the best interests of the
declarant.

History: 1989 c 3 s 6; 1991 c 148 s 6

145B.07 TRANSFER OF CARE.

If a living will is delivered to a physician or other health care provider who transfers care of patients to
other health care providers, or if a living will is delivered to a health care provider, including a health care
facility or HMO that delivers patient care through an arrangement with individual providers, the physician
or other health care provider receiving a living will shall make reasonable efforts:

(1) to ensure that an agreement with the patient to comply with the living will will be honored by others
who provide health care to that patient; or

(2) to identify and deliver the living will to the individual providers and facilitate the declarant's discussion
with those individuals whose agreement to comply with the living will is required.

History: 1989 c 3 s 7; 1991 c 148 s 6

145B.08 ACCESS TO MEDICAL INFORMATION BY PROXY.

Unless a living will under this chapter provides otherwise, a proxy has the same rights as the declarant
to receive information regarding proposed health care, to receive and review medical records, and to consent
to the disclosure of medical records for purposes related to the declarant's health care or insurance.

History: 1989 c 3 s 8; 1991 c 148 s 6

145B.09 REVOCATION.

Subdivision 1. General. A living will under this chapter may be revoked in whole or in part at any time
and in any manner by the declarant, without regard to the declarant's physical or mental condition. A
revocation is effective when the declarant communicates it to the attending physician or other health care
provider. The attending physician or other health care provider shall note the revocation as part of the
declarant's medical record.

Subd. 2. Effect of marriage dissolution or annulment on designation of proxy. Unless a living will
under this chapter expressly provides otherwise, if after executing a living will the declarant's marriage is
dissolved or annulled, the dissolution or annulment revokes any designation of the former spouse as a proxy to make health care decisions for the declarant.

**History:** 1989 c 3 s 9; 1991 c 148 s 6

145B.10 [Repealed, 1993 c 312 s 17]

145B.105 PENALTIES.

Subdivision 1. **Gross misdemeanor offenses.** Whoever commits any of the following acts is guilty of a gross misdemeanor:

(1) willfully conceals, cancels, defaces, or obliterates a living will of a declarant without the consent of the declarant;

(2) willfully conceals or withholds personal knowledge of a revocation of a living will;

(3) falsifies or forges a living will or a revocation of a living will;

(4) coerces or fraudulently induces another to execute a living will; or

(5) requires or prohibits the execution of a living will as a condition for being insured for or receiving all or some health care services.

Subd. 2. **Felony offenses.** Whoever commits an act prohibited under subdivision 1 is guilty of a felony if the act results in bodily harm to the declarant or to the person who would have been a declarant but for the unlawful act.

**History:** 1993 c 312 s 1

145B.11 EFFECT ON INSURANCE.

The making or effectuation of a living will under this chapter does not affect the sale, procurement, issuance, or validity of a policy of life insurance or annuity, nor does it affect, impair, or modify the terms of an existing policy of life insurance or annuity or the liability of the party issuing the policy or annuity contract.

**History:** 1989 c 3 s 11; 1991 c 148 s 6

145B.12 WHAT IF THERE IS NO LIVING WILL OR PROXY?

Subdivision 1. **No presumption created.** If an individual has not executed or has revoked a living will under this chapter, a presumption is not created with respect to:

(1) the individual's intentions concerning the provision of health care; or

(2) the appropriate health care to be provided.

Subd. 2. **Nutrition or hydration.** Nothing in this chapter shall be construed to authorize or justify the withholding or withdrawal of artificially administered nutrition or hydration from any person who has not issued a living will or designated a proxy under this chapter.

**History:** 1989 c 3 s 12; 1991 c 148 s 6
145B.13 REASONABLE MEDICAL PRACTICE REQUIRED.

In reliance on a patient's living will, a decision to administer, withhold, or withdraw medical treatment after the patient has been diagnosed by the attending physician to be in a terminal condition must always be based on reasonable medical practice, including:

(1) continuation of appropriate care to maintain the patient's comfort, hygiene, and human dignity and to alleviate pain;

(2) oral administration of food or water to a patient who accepts it, except for clearly documented medical reasons; and

(3) in the case of a living will of a patient that the attending physician knows is pregnant, the living will must not be given effect as long as it is possible that the fetus could develop to the point of live birth with continued application of life-sustaining treatment.

History: 1989 c 3 s 13; 1991 c 148 s 6

145B.14 CERTAIN PRACTICES NOT CONDONED.

Nothing in this chapter may be construed to condone, authorize, or approve mercy killing, euthanasia, suicide, or assisted suicide.

History: 1989 c 3 s 14

145B.15 RECOGNITION OF PREVIOUSLY EXECUTED LIVING WILL.

A living will that substantially complies with section 145B.03, but is made before August 1, 1989, is an effective living will under this chapter.

History: 1989 c 3 s 15; 1991 c 148 s 6

145B.16 RECOGNITION OF DOCUMENT EXECUTED IN ANOTHER STATE.

A living will executed in another state is effective if it substantially complies with this chapter.

History: 1989 c 3 s 16; 1991 c 148 s 6

145B.17 EXISTING RIGHTS.

Nothing in this chapter impairs or supersedes the existing rights of any patient or any other legal right or legal responsibility a person may have to begin, continue, withhold, or withdraw health care. Nothing in this chapter prohibits lawful treatment by spiritual means through prayer in lieu of medical or surgical treatment when treatment by spiritual means has been authorized by the declarant.

History: 1989 c 3 s 17
CHAPTER 145C

HEALTH CARE DIRECTIVES

145C.01 DEFINITIONS.

Subd. 1. Applicability. The definitions in this section apply to this chapter.

Subd. 1a. Act in good faith. "Act in good faith" means to act consistently with a legally sufficient health care directive of the principal, a living will executed under chapter 145B, a declaration regarding intrusive mental health treatment executed under section 253B.03, subdivision 6d, or information otherwise made known by the principal, unless the actor has actual knowledge of the modification or revocation of the information expressed. If these sources of information do not provide adequate guidance to the actor, "act in good faith" means acting in the best interests of the principal, considering the principal's overall general health condition and prognosis and the principal's personal values to the extent known. Notwithstanding any instruction of the principal, a health care agent, health care provider, or any other person is not acting in good faith if the person violates the provisions of section 609.215 prohibiting assisted suicide.

Subd. 1b. Decision-making capacity. "Decision-making capacity" means the ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision.

Subd. 2. Health care agent. "Health care agent" means an individual age 18 or older who is appointed by a principal in a health care power of attorney to make health care decisions for the principal. "Health care agent" may also be referred to as "agent."

Subd. 3. Health care power of attorney. "Health care power of attorney" means an instrument appointing one or more health care agents to make health care decisions for the principal.

Subd. 4. Health care. "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a person's physical or mental condition. "Health care" includes the provision of nutrition or hydration parenterally or through intubation but does not include any treatment, service, or procedure that violates the provisions of section 609.215 prohibiting assisted suicide. "Health care" also includes the establishment of a person's abode within or without the state and personal security safeguards for a person, to the extent decisions on these matters relate to the health care needs of the person.

Subd. 5. Health care decision. "Health care decision" means the consent, refusal of consent, or withdrawal of consent to health care.

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Subd. 5a. **Health care directive.** "Health care directive" means a written instrument that complies with section 145C.03 and includes one or more health care instructions, a health care power of attorney, or both; or a durable power of attorney for health care executed under this chapter before August 1, 1998.

Subd. 6. **Health care provider.** "Health care provider" means a person, health care facility, organization, or corporation licensed, certified, or otherwise authorized or permitted by the laws of this state to administer health care directly or through an arrangement with other health care providers, including health maintenance organizations licensed under chapter 62D.

Subd. 7. **Health care facility.** "Health care facility" means a hospital or other entity licensed under sections 144.50 to 144.58, a nursing home licensed to serve adults under section 144A.02, a home care provider licensed under sections 144A.43 to 144A.47, an adult foster care provider licensed under chapter 245A and Minnesota Rules, parts 9555.5105 to 9555.6265, a community residential setting licensed under chapter 245D, or a hospice provider licensed under sections 144A.75 to 144A.755.

Subd. 7a. **Health care instruction.** "Health care instruction" means a written statement of the principal's values, preferences, guidelines, or directions regarding health care.

Subd. 8. **Principal.** "Principal" means an individual age 18 or older who has executed a health care directive.

Subd. 9. **Reasonably available.** "Reasonably available" means able to be contacted and willing and able to act in a timely manner considering the urgency of the principal's health care needs.

**History:** 1993 c 312 s 2; 1998 c 254 art 1 s 36; 1998 c 399 s 3-11; 2002 c 252 s 20,24; 2004 c 288 art 6 s 16; 2013 c 108 art 8 s 2

**145C.02 HEALTH CARE DIRECTIVE.**

A principal with the capacity to do so may execute a health care directive. A health care directive may include one or more health care instructions to direct health care providers, others assisting with health care, family members, and a health care agent. A health care directive may include a health care power of attorney to appoint a health care agent to make health care decisions for the principal when the principal, in the judgment of the principal's attending physician, lacks decision-making capacity, unless otherwise specified in the health care directive.

**History:** 1993 c 312 s 3; 1998 c 399 s 12

**145C.03 REQUIREMENTS.**

Subdivision 1. **Legal sufficiency.** To be legally sufficient in this state, a health care directive must:

1. be in writing;
2. be dated;
3. state the principal's name;
4. be executed by a principal with capacity to do so with the signature of the principal or with the signature of another person authorized by the principal to sign on behalf of the principal;
5. contain verification of the principal's signature or the signature of the person authorized by the principal to sign on behalf of the principal, either by a notary public or by witnesses as provided under this chapter; and
(6) include a health care instruction, a health care power of attorney, or both.

Subd. 2. Individuals ineligible to act as health care agent. (a) An individual appointed by the principal under section 145C.05, subdivision 2, paragraph (b), to make the determination of the principal's decision-making capacity is not eligible to act as the health care agent.

(b) The following individuals are not eligible to act as the health care agent, unless the individual appointed is related to the principal by blood, marriage, registered domestic partnership, or adoption, or unless the principal has otherwise specified in the health care directive:

(1) a health care provider attending the principal on the date of execution of the health care directive or on the date the health care agent must make decisions for the principal; or

(2) an employee of a health care provider attending the principal on the date of execution of the health care directive or on the date the health care agent must make decisions for the principal.

Subd. 3. Individuals ineligible to act as witnesses or notary public. (a) A health care agent or alternate health care agent appointed in a health care power of attorney may not act as a witness or notary public for the execution of the health care directive that includes the health care power of attorney.

(b) At least one witness to the execution of the health care directive must not be a health care provider providing direct care to the principal or an employee of a health care provider providing direct care to the principal on the date of execution. A person notarizing a health care directive may be an employee of a health care provider providing direct care to the principal.

History: 1993 c 312 s 4; 1998 c 399 s 13

145C.04 EXECUTED IN ANOTHER STATE.

(a) A health care directive or similar document executed in another state or jurisdiction is legally sufficient under this chapter if it:

(1) complies with the law of the state or jurisdiction in which it was executed; or

(2) complies with section 145C.03.

(b) Nothing in this section shall be interpreted to authorize a directive or similar document to override the provisions of section 609.215 prohibiting assisted suicide.

History: 1993 c 312 s 5; 1998 c 399 s 14

145C.05 SUGGESTED FORM; PROVISIONS THAT MAY BE INCLUDED.

Subdivision 1. Content. A health care directive executed pursuant to this chapter may, but need not, be in the form contained in section 145C.16.

Subd. 2. Provisions that may be included. (a) A health care directive may include provisions consistent with this chapter, including, but not limited to:

(1) the designation of one or more alternate health care agents to act if the named health care agent is not reasonably available to serve;

(2) directions to joint health care agents regarding the process or standards by which the health care agents are to reach a health care decision for the principal, and a statement whether joint health care agents may act independently of one another;
(3) limitations, if any, on the right of the health care agent or any alternate health care agents to receive, review, obtain copies of, and consent to the disclosure of the principal's medical records or to visit the principal when the principal is a patient in a health care facility;

(4) limitations, if any, on the nomination of the health care agent as guardian for purposes of sections 524.5-202, 524.5-211, 524.5-302, and 524.5-303;

(5) a document of gift for the purpose of making an anatomical gift, as set forth in chapter 525A, or an amendment to, revocation of, or refusal to make an anatomical gift;

(6) a declaration regarding intrusive mental health treatment under section 253B.03, subdivision 6d, or a statement that the health care agent is authorized to give consent for the principal under section 253B.04, subdivision 1a;

(7) a funeral directive as provided in section 149A.80, subdivision 2;

(8) limitations, if any, to the effect of dissolution or annulment of marriage or termination of domestic partnership on the appointment of a health care agent under section 145C.09, subdivision 2;

(9) specific reasons why a principal wants a health care provider or an employee of a health care provider attending the principal to be eligible to act as the principal's health care agent;

(10) health care instructions by a woman of child bearing age regarding how she would like her pregnancy, if any, to affect health care decisions made on her behalf; and

(11) health care instructions regarding artificially administered nutrition or hydration.

(b) A health care directive may include a statement of the circumstances under which the directive becomes effective other than upon the judgment of the principal's attending physician in the following situations:

(1) a principal who in good faith generally selects and depends upon spiritual means or prayer for the treatment or care of disease or remedial care and does not have an attending physician, may include a statement appointing an individual who may determine the principal's decision-making capacity; and

(2) a principal who in good faith does not generally select a physician or a health care facility for the principal's health care needs may include a statement appointing an individual who may determine the principal's decision-making capacity, provided that if the need to determine the principal's capacity arises when the principal is receiving care under the direction of an attending physician in a health care facility, the determination must be made by an attending physician after consultation with the appointed individual.

If a person appointed under clause (1) or (2) is not reasonably available and the principal is receiving care under the direction of an attending physician in a health care facility, an attending physician shall determine the principal's decision-making capacity.

(c) A health care directive may authorize a health care agent to make health care decisions for a principal even though the principal retains decision-making capacity.

**History:** 1993 c 312 s 6; 1995 c 211 s 2; 1998 c 399 s 15,16; 2004 c 146 art 3 s 3; 2007 c 120 art 2 s 4; 2007 c 147 art 9 s 22

**145C.06 WHEN EFFECTIVE.**

A health care directive is effective for a health care decision when:
(1) it meets the requirements of section 145C.03, subdivision 1; and

(2) the principal, in the determination of the attending physician of the principal, lacks decision-making capacity to make the health care decision; or if other conditions for effectiveness otherwise specified by the principal have been met.

A health care directive is not effective for a health care decision when the principal, in the determination of the attending physician of the principal, recovers decision-making capacity; or if other conditions for effectiveness otherwise specified by the principal have been met.

**History:** 1993 c 312 s 7; 1998 c 399 s 17

### 145C.07 AUTHORITY AND DUTIES OF HEALTH CARE AGENT.

#### Subdivision 1. Authority.
The health care agent has authority to make any particular health care decision only if the principal lacks decision-making capacity, in the determination of the attending physician, to make or communicate that health care decision; or if other conditions for effectiveness otherwise specified by the principal have been met. The physician or other health care provider shall continue to obtain the principal's informed consent to all health care decisions for which the principal has decision-making capacity, unless other conditions for effectiveness otherwise specified by the principal have been met. An alternate health care agent has authority to act if the primary health care agent is not reasonably available to act.

#### Subd. 2. Health care agent as guardian.
Unless the principal has otherwise specified in the health care directive, the appointment of the health care agent in a health care directive is considered a nomination of a guardian for purposes of sections 524.5-101 to 524.5-502.

#### Subd. 3. Duties.
In exercising authority under a health care directive, a health care agent has a duty to act in good faith. A health care agent or any alternate health care agent has a personal obligation to the principal to make health care decisions authorized by the health care power of attorney, but this obligation does not constitute a legal duty to act.

#### Subd. 4. Inconsistencies among documents.
In the event of inconsistency between the appointment of a proxy under chapter 145B or section 253B.03, subdivision 6d, or of a health care agent under this chapter, the most recent appointment takes precedence. In the event of other inconsistencies among documents executed under this chapter, under chapter 145B, or under sections 253B.03, subdivision 6d, or 524.5-101 to 524.5-502, or other legally sufficient documents, the provisions of the most recently executed document take precedence only to the extent of the inconsistency.

#### Subd. 5. Visitation.
A health care agent may visit the principal when the principal is a patient in a health care facility regardless of whether the principal retains decision-making capacity, unless:

(1) the principal has otherwise specified in the health care directive;

(2) a principal who retains decision-making capacity indicates otherwise; or

(3) a health care provider reasonably determines that the principal must be isolated from all visitors or that the presence of the health care agent would endanger the health or safety of the principal, other patients, or the facility in which the care is being provided.

**History:** 1993 c 312 s 8; 1998 c 399 s 18; 2004 c 146 art 3 s 4,5; 2007 c 147 art 9 s 23
145C.08 AUTHORITY TO REVIEW MEDICAL RECORDS.

A health care agent acting pursuant to a health care directive has the same right as the principal to receive, review, and obtain copies of medical records of the principal, and to consent to the disclosure of medical records of the principal, unless the principal has otherwise specified in the health care directive.

History: 1993 c 312 s 9; 1998 c 399 s 19

145C.09 REVOCATION OF HEALTH CARE DIRECTIVE.

Subdivision 1. Revocation. A principal with the capacity to do so may revoke a health care directive in whole or in part at any time by doing any of the following:

(1) canceling, defacing, obliterating, burning, tearing, or otherwise destroying the health care directive instrument or directing another in the presence of the principal to destroy the health care directive instrument, with the intent to revoke the health care directive in whole or in part;

(2) executing a statement, in writing and dated, expressing the principal's intent to revoke the health care directive in whole or in part;

(3) verbally expressing the principal's intent to revoke the health care directive in whole or in part in the presence of two witnesses who do not have to be present at the same time; or

(4) executing a subsequent health care directive, to the extent the subsequent instrument is inconsistent with any prior instrument.

Subd. 2. Effect of marriage dissolution, annulment, or termination of domestic partnership. Unless the principal has otherwise specified in the health care directive, the appointment by the principal of the principal's spouse or registered domestic partner as health care agent under a health care power of attorney is revoked by the commencement of proceedings for dissolution, annulment, or termination of the principal's marriage or commencement of proceedings for termination of the principal's registered domestic partnership.

Subd. 3. Power of a court to declare a health care directive unenforceable. A court may declare a health care directive unenforceable if it finds, by clear and convincing evidence, that the health care directive was executed under coercion or fraudulent inducement as prohibited by section 145C.13, subdivision 1, clause (4), or if it finds that the health care directive is not legally sufficient under section 145C.03 or 145C.04.

History: 1993 c 312 s 10; 1998 c 399 s 20; 2003 c 12 art 2 s 1; 2010 c 254 s 1

145C.10 PRESUMPTIONS.

(a) The principal is presumed to have the capacity to execute a health care directive and to revoke a health care directive, absent clear and convincing evidence to the contrary.

(b) A health care provider or health care agent may presume that a health care directive is legally sufficient absent actual knowledge to the contrary. A health care directive is presumed to be properly executed, absent clear and convincing evidence to the contrary.

(c) A health care agent, and a health care provider acting pursuant to the direction of a health care agent, are presumed to be acting in good faith, absent clear and convincing evidence to the contrary.

(d) A health care directive is presumed to remain in effect until the principal modifies or revokes it, absent clear and convincing evidence to the contrary.
(e) This chapter does not create a presumption concerning the intention of an individual who has not
executed a health care directive and, except as otherwise provided by section 145C.15, does not impair or
supersede any right or responsibility of an individual to consent, refuse to consent, or withdraw consent to
health care on behalf of another in the absence of a health care directive.

(f) A copy of a health care directive is presumed to be a true and accurate copy of the executed original,
absent clear and convincing evidence to the contrary, and must be given the same effect as an original.

(g) When a patient lacks decision-making capacity and is pregnant, and in reasonable medical judgment
there is a real possibility that if health care to sustain her life and the life of the fetus is provided the fetus
could survive to the point of live birth, the health care provider shall presume that the patient would have
wanted such health care to be provided, even if the withholding or withdrawal of such health care would be
authorized were she not pregnant. This presumption is negated by health care directive provisions described
in section 145C.05, subdivision 2, paragraph (a), clause (10), that are to the contrary, or, in the absence of
such provisions, by clear and convincing evidence that the patient's wishes, while competent, were to the
contrary.

History: 1993 c 312 s 11; 1998 c 399 s 21

145C.11 IMMUNITIES.

Subdivision 1. Health care agent. A health care agent is not subject to criminal prosecution or civil
liability if the health care agent acts in good faith.

Subd. 2. Health care provider. (a) With respect to health care provided to a patient with a health care
directive, a health care provider is not subject to criminal prosecution, civil liability, or professional
disciplinary action if the health care provider acts in good faith and in accordance with applicable standards
of care.

(b) A health care provider is not subject to criminal prosecution, civil liability, or professional disciplinary
action if the health care provider relies on a health care decision made by the health care agent and the
following requirements are satisfied:

(1) the health care provider believes in good faith that the decision was made by a health care agent
appointed to make the decision and has no actual knowledge that the health care directive has been revoked;
and

(2) the health care provider believes in good faith that the health care agent is acting in good faith.

(c) A health care provider who administers health care necessary to keep the principal alive, despite a
health care decision of the health care agent to withhold or withdraw that treatment, is not subject to criminal
prosecution, civil liability, or professional disciplinary action if that health care provider promptly took all
reasonable steps to:

(1) notify the health care agent of the health care provider's unwillingness to comply;

(2) document the notification in the principal's medical record; and

(3) permit the health care agent to arrange to transfer care of the principal to another health care provider
willing to comply with the decision of the health care agent.

History: 1993 c 312 s 12; 1998 c 399 s 22
145C.12 PROHIBITED PRACTICES.

Subdivision 1. Health care provider. A health care provider, health care service plan, insurer, self-insured employee welfare benefit plan, or nonprofit hospital plan may not condition admission to a facility, or the providing of treatment or insurance, on the requirement that an individual execute a health care directive.

Subd. 2. Insurance. A policy of life insurance is not legally impaired or invalidated in any manner by the withholding or withdrawing of health care pursuant to the direction of a health care agent appointed pursuant to this chapter, or pursuant to the implementation of health care instructions under this chapter.

History: 1993 c 312 s 13; 1998 c 399 s 23

145C.13 PENALTIES.

Subdivision 1. Gross misdemeanor offenses. Whoever commits any of the following acts is guilty of a gross misdemeanor:

(1) willfully conceals, cancels, defaces, or obliterates a health care directive of a principal without the consent of the principal;

(2) willfully conceals or withholds personal knowledge of a revocation of a health care directive;

(3) falsifies or forges a health care directive or a revocation of the instrument;

(4) coerces or fraudulently induces another to execute a health care directive; or

(5) requires or prohibits the execution of a health care directive as a condition for being insured for or receiving all or some health care services.

Subd. 2. Felony offenses. Whoever commits an act prohibited under subdivision 1 is guilty of a felony if the act results in bodily harm to the principal or to the person who would have been a principal but for the unlawful act.

History: 1993 c 312 s 14; 1998 c 399 s 25

145C.14 CERTAIN PRACTICES NOT CONDONED.

Nothing in this chapter may be construed to condone, authorize, or approve mercy killing or euthanasia.

History: 1993 c 312 s 15

145C.15 DUTY TO PROVIDE LIFE-SUSTAINING HEALTH CARE.

(a) If a proxy acting under chapter 145B or a health care agent acting under this chapter directs the provision of health care, nutrition, or hydration that, in reasonable medical judgment, has a significant possibility of sustaining the life of the principal or declarant, a health care provider shall take all reasonable steps to ensure the provision of the directed health care, nutrition, or hydration if the provider has the legal and actual capability of providing the health care either itself or by transferring the principal or declarant to a health care provider who has that capability. Any transfer of a principal or declarant under this paragraph must be done promptly and, if necessary to preserve the life of the principal or declarant, by emergency means. This paragraph does not apply if a living will under chapter 145B or a health care directive indicates an intention to the contrary.

(b) A health care provider who is unwilling to provide directed health care under paragraph (a) that the provider has the legal and actual capability of providing may transfer the principal or declarant to another
health care provider willing to provide the directed health care but the provider shall take all reasonable steps to ensure provision of the directed health care until the principal or declarant is transferred.

(c) Nothing in this section alters any legal obligation or lack of legal obligation of a health care provider to provide health care to a principal or declarant who refuses, has refused, or is unable to pay for the health care.

History: 1993 c 312 s 16; 1998 c 399 s 26

145C.16 SUGGESTED FORM.

The following is a suggested form of a health care directive and is not a required form.

HEALTH CARE DIRECTIVE

I, ..........................., understand this document allows me to do ONE OR BOTH of the following:

PART I: Name another person (called the health care agent) to make health care decisions for me if I am unable to decide or speak for myself. My health care agent must make health care decisions for me based on the instructions I provide in this document (Part II), if any, the wishes I have made known to him or her, or must act in my best interest if I have not made my health care wishes known.

AND/OR

PART II: Give health care instructions to guide others making health care decisions for me. If I have named a health care agent, these instructions are to be used by the agent. These instructions may also be used by my health care providers, others assisting with my health care and my family, in the event I cannot make decisions for myself.

PART I: APPOINTMENT OF HEALTH CARE AGENT

THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS FOR ME IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF

(I know I can change my agent or alternate agent at any time and I know I do not have to appoint an agent or an alternate agent)

NOTE: If you appoint an agent, you should discuss this health care directive with your agent and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I blank and go to Part II.

When I am unable to decide or speak for myself, I trust and appoint ...................... to make health care decisions for me. This person is called my health care agent.

Relationship of my health care agent to me:...........................................................................................................

Telephone number of my health care agent:...........................................................................................................

Address of my health care agent:............................................................................................................................

(OPTIONAL) APPOINTMENT OF ALTERNATE HEALTH CARE AGENT: If my health care agent is not reasonably available, I trust and appoint ................. to be my health care agent instead.

Relationship of my alternate health care agent to me:.............................................................................................
Telephone number of my alternate health care agent:.........................................................................................

Address of my alternate health care agent:......................................................................................................

THIS IS WHAT I WANT MY HEALTH CARE AGENT TO BE ABLE TO DO IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF

(I know I can change these choices)

My health care agent is automatically given the powers listed below in (A) through (D). My health care agent must follow my health care instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest.

Whenever I am unable to decide or speak for myself, my health care agent has the power to:

(A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatment, service, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about intrusive mental health treatment.

(B) Choose my health care providers.

(C) Choose where I live and receive care and support when those choices relate to my health care needs.

(D) Review my medical records and have the same rights that I would have to give my medical records to other people.

If I DO NOT want my health care agent to have a power listed above in (A) through (D) OR if I want to LIMIT any power in (A) through (D), I MUST say that here:

..........................................................................................................................................................................
..........................................................................................................................................................................
..........................................................................................................................................................................

My health care agent is NOT automatically given the powers listed below in (1) and (2). If I WANT my agent to have any of the powers in (1) and (2), I must INITIAL the line in front of the power; then my agent WILL HAVE that power.

    ....  (1)  To decide whether to donate any parts of my body, including organs, tissues, and eyes, when I die.

    ....  (2)  To decide what will happen with my body when I die (burial, cremation).

If I want to say anything more about my health care agent's powers or limits on the powers, I can say it here:

..........................................................................................................................................................................
..........................................................................................................................................................................
..........................................................................................................................................................................

PART II: HEALTH CARE INSTRUCTIONS
NOTE: Complete this Part II if you wish to give health care instructions. If you appointed an agent in Part I, completing this Part II is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in Part I, you MUST complete some or all of this Part II if you wish to make a valid health care directive.

These are instructions for my health care when I am unable to decide or speak for myself. These instructions must be followed (so long as they address my needs).

THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE

(I know I can change these choices or leave any of them blank)

I want you to know these things about me to help you make decisions about my health care:

My goals for my health care:..........................................................................................................................................................................
........................................................................................................................................................................................................
........................................................................................................................................................................................................

My fears about my health care:...................................................................................................................................................................
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My spiritual or religious beliefs and traditions:........................................................................................................................................
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My beliefs about when life would be no longer worth living:............................................................................................................
........................................................................................................................................................................................................
........................................................................................................................................................................................................

My thoughts about how my medical condition might affect my family:
........................................................................................................................................................................................................
........................................................................................................................................................................................................
........................................................................................................................................................................................................

THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE

(I know I can change these choices or leave any of them blank)

Many medical treatments may be used to try to improve my medical condition or to prolong my life. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries, dialysis, antibiotics, and blood transfusions. Most medical treatments can be tried for a while and then stopped if they do not help.

I have these views about my health care in these situations:

(Note: You can discuss general feelings, specific treatments, or leave any of them blank)
If I had a reasonable chance of recovery, and were temporarily unable to decide or speak for myself, I would want:

If I were dying and unable to decide or speak for myself, I would want:

If I were permanently unconscious and unable to decide or speak for myself, I would want:

If I were completely dependent on others for my care and unable to decide or speak for myself, I would want:

In all circumstances, my doctors will try to keep me comfortable and reduce my pain. This is how I feel about pain relief if it would affect my alertness or if it could shorten my life:

There are other things that I want or do not want for my health care, if possible:

Who I would like to be my doctor:

Where I would like to live to receive health care:

Where I would like to die and other wishes I have about dying:

My wishes about donating parts of my body when I die:
My wishes about what happens to my body when I die (cremation, burial):

..........................................................................................................................................................
..........................................................................................................................................................
..........................................................................................................................................................

Any other things:

..........................................................................................................................................................
..........................................................................................................................................................
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..........................................................................................................................................................

PART III: MAKING THE DOCUMENT LEGAL

This document must be signed by me. It also must either be verified by a notary public (Option 1) OR
witnessed by two witnesses (Option 2). It must be dated when it is verified or witnessed.

I am thinking clearly, I agree with everything that is written in this document, and I have made this
document willingly.

..........................................................................................................................................................
My Signature
Date signed: ........................................................
Date of birth: ........................................................
Address: .........................................................................................................................
..................................................................................................................................................

If I cannot sign my name, I can ask someone to sign this document for me.

..........................................................................................................................................................
Signature of the person who I asked to sign this document for me.
..........................................................................................................................................................
Printed name of the person who I asked to sign this document for me.

..........................................................................................................................................................

Option 1: Notary Public

In my presence on ............... (date), ............... (name) acknowledged his/her signature on this
document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.
I am not named as a health care agent or alternate health care agent in this document.

..........................................................................................................................................................
(Signature of Notary) .............................................................................................. (Notary Stamp)

Option 2: Two Witnesses

Two witnesses must sign. Only one of the two witnesses can be a health care provider or an employee
of a health care provider giving direct care to me on the day I sign this document.
Witness One:

(i) In my presence on ............ (date), ............ (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

(ii) I am at least 18 years of age.

(iii) I am not named as a health care agent or an alternate health care agent in this document.

(iv) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (A), I must initial this box: [ ]

I certify that the information in (i) through (iv) is true and correct.

..............................................................................................................................
(Signature of Witness One)

Address: ...............................................................................................................................................
...............................................................................................................................................

Witness Two:

(i) In my presence on ............ (date), ............ (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

(ii) I am at least 18 years of age.

(iii) I am not named as a health care agent or an alternate health care agent in this document.

(iv) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (A), I must initial this box: [ ]

I certify that the information in (i) through (iv) is true and correct.

..............................................................................................................................
(Signature of Witness Two)

Address: ...............................................................................................................................................
...............................................................................................................................................

REMINDER: Keep this document with your personal papers in a safe place (not in a safe deposit box). Give signed copies to your doctors, family, close friends, health care agent, and alternate health care agent. Make sure your doctor is willing to follow your wishes. This document should be part of your medical record at your physician's office and at the hospital, home care agency, hospice, or nursing facility where you receive your care.

**History:** 1998 c 399 s 24; 1999 c 14 s 1