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INITIAL ASSESSMENTS AND CONTINUING ASSESSMENTS; UNIFORM ASSESSMENT TOOL

Subpart 1. Uniform Assessment Tool.

A. A facility must use the Department's uniform assessment tool when developing a resident's service plan.

B. The Commissioner must update the uniform assessment tool at least annually on the Department's website.

Subp. 2. Nursing Assessment.

A. A resident's nursing assessment must be:

1) performed before the resident executes an assisted living contract or moves into the facility, whichever is earlier;

2) updated and changed as appropriate within the first 14 calendar days after assisted living services are first provided;

3) reviewed and any updates must be documented each time a resident has a significant change in condition as defined under subpart 10; and

4) documented and dated.

Subp. 3. Assessment Elements.

A resident's nursing assessment conducted using the uniform assessment tool must address the following:

A. resident routines and preferences, including:

1) customary routines, including sleep schedule, dietary and social needs, leisure activities, and any other routine that is important to the resident's quality of life; and

2) spiritual and cultural preferences;

B. activities of daily living, including:

1) toileting, bowel, and bladder management;

2) dressing, grooming, bathing, and personal hygiene;

3) mobility, including ambulation, transfers, and assistive devices; and

4) eating, dental status, and assisted devices;

C. independent activities of daily living, including:

1) ability to manage medications;

2) housework and laundry; and

3) transportation;

D. physical health status, including

1) a list of current diagnoses;

2) a list of medications and frequency of use;

3) a list of visits in the last year to health practitioners, emergency rooms, hospitals, or nursing facilities; and

4) vital signs if indicated by diagnoses, health problems, or medications;

E. mental-health issues, including:

1) presence of depression, thought disorders, or behavioral or mood problems;

2) history of treatment; and

3) effective nondrug interventions;

F. cognition, including:

1) memory;

2) orientation;

3) confusion; and

4) decision-making abilities;

G. communication and sensory capabilities, including:

1) hearing;

2) vision;

3) speech;

4) assistive communication and sensory devices; and

5) the ability to understand and be understood;

H. pain, including pharmaceutical and non-pharmaceutical interventions;

I. skin conditions;

J. nutrition habits, fluid preferences, and weight, if indicated;

K. list of treatments, including type, frequency, and level of assistance needed;

L. nursing needs, including potential to receive nursing-delegated services; and

M. risk indicators, including:

1) fall risk or history of falls;

2) emergency-evacuation ability;

3) complex medication regimen;

4) history of dehydration or unexplained weight loss or weight gain;

5) recent losses;

6) unsuccessful prior placements;

7) elopement risk or history;

8) smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and

9) alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician.

N. who has decision-making authority for the resident, including:

1) the presence of any advanced directive or other legal document that establishes a substitute decision-maker;

2) the presence of any legal document that establishes a resident's current substitute decision-maker; and

3) the scope of decision-making authority of a substitute decision maker under subitems (1) and (2).

Subp. 4. Individualized Initial Review.

A. A potential resident who is only receiving assisted living services in section 144G.08, subdivision 9, clauses (1) to (5) shall complete an individualized initial review of the resident's needs and preferences in accordance to Items A-C and N in Subpart 3.

B. The initial review must be completed within 30 days of the start of assisted living services.

Subp. 5. Assessor; Qualifications.

A. A registered nurse shall complete a nursing assessment or reassessment for a prospective resident or resident.

B. A staff member who meets the qualifications set forth in Minnesota Statutes section 144G.60, subd. 3(b) shall conduct the individualized initial review and following reviews.

C. A facility's assisted living director must ensure that only trained and qualified staff perform assessments and reviews.

Subp. 6. Resident Reassessment or Review Documentation.

A. The most recent reassessment or review, including documented updates of a resident's change of condition, must be in the resident's current record and available to staff.

B. If the reassessment of review is revised and updated:

1) changes must be dated and initialed.

C. Twenty-four months of past assessments and reviews must be kept in a resident's record in an accessible, on-site location.

Subp. 7. Ongoing Reassessments and Monitoring following a Nursing Assessment.

For each resident who received a nursing assessment, an assisted living facility must:

A. conduct ongoing resident reassessment and monitoring within 90 days from the last date of the previous assessment or reassessment;

B. complete a reassessment specifically focusing on a resident's identified problems and related issues:

1) consistent with the resident's change in condition as specified under subpart 10; or

2) when the resident's service plan no longer addresses the resident's needs and preferences; and

C. ensure the staff person performing the ongoing reassessments is qualified to perform them.

Subp. 8. Ongoing Reviews and Monitoring Following an Individualized Initial Review.

For each resident who received an individualized initial review, an assisted living facility must:

A. conduct ongoing resident monitoring and review within 90 days from the last date of the review;

B. complete a review specifically focusing on a resident's identified problems and related issues:

1) consistent with the resident's change in condition as specified under subpart 10; or

2) when the resident's service plan no longer addresses the resident's needs and preferences; and

C. ensure the staff person performing the ongoing reviews is qualified to perform them.

Subp. 9. Resident Participation.

To the extent possible, an assisted living facility must directly involve each resident or prospective resident in the resident's assessments, individualized initial reviews, reassessments, and reviews. Additionally, a resident's designated representative or legal representative must be included in the resident's assessments, initial reviews, reassessments and reviews.

Subp. 10. Change of Condition and Monitoring.

A. For purposes of this part, the following definitions have the meanings given:

1) "short-term change of condition" means a change in a resident's health or functioning that is expected to resolve or be reversed with minimal intervention or that is an established, predictable, cyclical pattern associated with a previously diagnosed condition; and

2) "significant change of condition" means a major deviation from a resident's most recent evaluation that may affect multiple areas of functioning and that is not expected to be short term and imposes a significant risk to the resident.

B. If a resident experiences a significant change of condition, a facility must:

1) evaluate the resident;

2) refer the resident to the facility's qualified assessor under Subpart 5;

3) document the change; and

4) update the service plan as needed.

C. If a resident experiences a short-term change of condition, a facility must determine and document what action or intervention is needed for the resident. In addition:

1) the determined action or intervention must be communicated to staff on each shift; and

2) the documentation or staff instructions or interventions must be resident specific and made part of the resident's record with weekly progress noted until the condition is resolved.

D. A facility must have written policies to ensure a resident monitoring-and-reporting system is implemented 24 hours a day. The policies must specify staff responsibilities and identify criteria for notifying the assisted living director, qualified assessor under Subpart 5, or health care provider. A facility must:

1) monitor each resident consistent with the resident's evaluated needs and service plan;
2) train staff to identify changes in a resident's physical, emotional, and mental functioning and document and report on the resident's change of condition;
3) have a reporting protocol that includes a designated staff person, 24-hours a day, seven days a week, who can determine if a change in a resident's condition requires further action; and
4) communicate in writing to direct care staff on each shift a resident's change of condition and any required interventions.