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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:

A. medically defined conditions and prior medical history;

B. medical status measurement;

C. physical and mental functional status;

- D. sensory and physical impairments;
- E. nutritional status and requirements;
- F. special treatments or procedures;
- G. mental and psychosocial status;
- H. discharge potential;
- I. dental condition;
- J. activities potential;
- K. rehabilitation potential;
- L. cognitive status;
- M. drug therapy; and
- N. resident preferences.

Subp. 3. **Frequency.** Comprehensive resident assessments must be conducted:

- A. within 14 days after the date of admission;
- B. within 14 days after a significant change in the resident's physical or mental condition; and
- C. at least once every 12 months.

Subp. 4. **Review of assessments.** A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment.

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4658.0405 COMPREHENSIVE PLAN OF CARE.

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.

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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.

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