Minnesota Rules, Table of Chapters

Table of contents for Chapter 4658

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.

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HIST: 20 SR 303

Current as of 01/19/05

Minnesota Rules, Table of Chapters

Table of contents for Chapter 4658

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 144.335 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.

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Current as of 01/19/05

Minnesota Rules, Table of Chapters

Table of contents for Chapter 4658

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.

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Current as of 01/19/05

Minnesota Rules, Table of Chapters

Table of contents for Chapter 4658

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:

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.

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Current as of 01/19/05

Minnesota Rules, Table of Chapters

Table of contents for Chapter 4658

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.

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HIST: 20 SR 303; 21 SR 196

Current as of 01/19/05

Minnesota Rules, Table of Chapters

Table of contents for Chapter 4658

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 144.335, 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.

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Current as of 01/19/05

Minnesota Rules, Table of Chapters

Table of contents for Chapter 4658

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.

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Current as of 01/19/05

Minnesota Rules, Table of Chapters

Table of contents for Chapter 4658

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.

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Current as of 01/19/05

Minnesota Rules, Table of Chapters

Table of contents for Chapter 4658

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.

STAT AUTH: MS s 144A.04; 144A.08; 256B.431

HIST: 20 SR 303

Table of contents for Chapter 4658

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.

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Current as of 01/19/05

Minnesota Rules, Table of Chapters

Table of contents for Chapter 4658

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;

M. part 4658.0465, subpart 1, $50;

N. part 4658.0465, subpart 2, $100;

O. part 4658.0465, subpart 3, $300;

P. part 4658.0470, $100; and

Q. part 4658.0475, $300.

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Current as of 01/19/05

Minnesota Rules, Table of Chapters

Table of contents for Chapter 4658

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.

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Current as of 01/19/05

Minnesota Rules, Table of Chapters

Table of contents for Chapter 4658

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.

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HIST: 20 SR 303

Current as of 01/19/05

Minnesota Rules, Table of Chapters

Table of contents for Chapter 4658

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.

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HIST: 20 SR 303

Current as of 01/19/05

Minnesota Rules, Table of Chapters

Table of contents for Chapter 4658

4658.0520 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 must be 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.

J. Recording resident height and weight at the time of admission and weight at least monthly thereafter.

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Current as of 01/19/05

Minnesota Rules, Table of Chapters

Table of contents for Chapter 4658

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.

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Current as of 01/19/05

Minnesota Rules, Table of Chapters

Table of contents for Chapter 4658

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.

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Current as of 01/19/05

Minnesota Rules, Table of Chapters

Table of contents for Chapter 4658

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;

M. part 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.

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