



State Examination Bibliography Supplemental Information

Entry Level Minimums to assist the new Director:

Minnesota Landlord and Tenants: Rights and Responsibilities

The direct link is: <https://www.ag.state.mn.us/Consumer/Handbooks/LT/default.asp>

Summary:

- Minnesota licensed assisted living facility are required to comply with existing landlord-tenant laws.
- Current law applies only to the licensed assisted living facility and not skilled care.
- LALD's should understand fair housing laws but they are separate and mandated from the landlord-tenant laws.
- The federal and state combined housing laws were originated to prevent and address discrimination in housing.
- Landlord-Tenant Law covers significant areas including when a lease is required, limitations on how the tenant can use the premises, and the process for removing a tenant from the building.
- If an assisted living facility has under six units, a written lease is not required for landlord tenant laws, but all Assisted Living facilities must have an assisted living contract covering many of the same tenant communication and points required for the resident to understand and agree.
- A landlord must safeguard a former tenant's property for 28 days after a tenant moves out.
- Cash rent payments are allowed but a written receipt is required.
- Eviction of a resident has multiple items to consider, in an eviction event, law enforcement are permitted to physically remove a tenant from the premises.
- Establishment of fees with landlord tenant laws identify security deposits within the Minnesota law but are silent for community, pet, or other similar unique fees.
- Privacy and entrance into the unit is addressed in the law. Basically, the only reason to enter without permission is for a resident health and welfare check.
- Minnesota law requires that a disabled person, or a family with a disabled family member, must be given priority to accessible units. The law requires that the owner must inform non-disabled people and families that do not include a disabled family member of the possibility that they may have to move to a non-disability-equipped rental unit.
- Minnesota law gives tenants (depending on income and amount of rent paid) a partial refund for the property taxes they pay indirectly through their rent. To be eligible a tenant must rent a property tax-paying unit and apply to the State of Minnesota.



Long-term Care Consultation Services:

The direct link is: <https://www.revisor.mn.gov/statutes/cite/256.975#stat.256.975.7>

Summary

- An assisted living provider according to state law requires you inform prospective residents before signing or executing a contract, they must be offered help to compare their housing options through the Senior LinkAge Line. It's important that Assisted Living providers share this information early in the contract process.
- Senior LinkAge Line materials are available to help explain as older adults make plans and decisions about services and housing.
- The Senior LinkAge Line specialist will make sure the prospective resident looked at all options available to them. The goal is to limit the times a move is made. At the end of the discussion with the prospective resident, the Senior LinkAge Line will issue a verification code. The code means they have talked about their choices and answered any questions they may have. The code is good for life and will be shared with the facility representative prior to signing a lease.
- Some people are exempt and do not have to be offered the option of options counseling before they sign a contract. The settings that are exempt can be found in [144G.08](#) subd. 7. Settings that are exempt can still refer people to the Senior LinkAge Line for support with decision making.
- If the person wants to remain in their home or needs help at home while on a waiting list, you can submit a referral by calling the Senior LinkAge Line.

Marketing:

Summary

- BELTSS does not address the LALD's professional need to market your community. The Director is overall responsible in Minn. Rule 6400.7095 (P) to avoid any issues related to 'fraudulent, misleading or deceptive advertising with respect to the facility'.
- A critical marketing concept is building initial trust and this new relationship with a potential resident. Marketing follows the mantra of 'say what you do and do what you say'. Identify your services and meet those expectations you list.
- You cannot advertise services for dementia care unless you hold a Minnesota Department of Health Assisted Living Facility with Dementia Care license, which is separate from or in addition to the Assisted Living Facility license.
- Images are easily found over the internet, but not all of them are free. In fact, every image has a copyright. Photographers and graphic designers earn money by selling their rights.



Customized Living Services – Elderly Waiver, CADI, BI Services

The direct link is:

https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ID_000852

Summary:

- Waiver and Alternative Care (AC) programs provide home and community-based services (HCBS) to meet the needs of people with disabilities and older adults. A person must be a Minnesota resident and meet eligibility requirements specific to each waiver/AC program. Waiver/AC programs must meet federal and other guidelines and is based on an agreement between Department of Human Services (DHS) and the federal Centers for Medicare & Medicaid Services (CMS).
- People with disabilities or older Minnesotans who need certain [levels of care](#) may qualify for waiver/AC programs. These programs are available to people who choose to reside in the community and meet eligibility criteria, such as:
 - **Elderly Waiver (EW):** Program that funds home and community-based services for people age 65 years and older who require the level of medical care provided in a nursing home and choose to reside in the community. EW promotes community living and independence with services and supports that address each person's individual needs and choices.
 - **Community Access for Disability Inclusion (CADI) Waiver:** Program that provides home and community-based services to children and adults with disabilities who require the level of care provided in a nursing facility. These services are an alternative to institutionalization.
 - **Brain Injury (BI) Waiver:** Program that provides home and community-based services to children and adults with a diagnosis of brain injury who require the level of care provided in a specialized nursing facility or neurobehavioral hospital.
- Covered Services for all three types of waivers may include:
 - **Customized Living (CL):** is an individualized package of regularly scheduled, health-related and supportive services provided to a person age 18 years or older who resides in a qualified setting and
 - **24-hour Customized Living:** is customized living services provided with 24-hour supervision. CL and 24-hour CL are enrollment-required services through DHS.
- Customized living (CL) and 24-hour CL services include component services designed to meet the person's assessed needs and goals. The component services are grouped into the six categories :
- Activities of Daily Living (ADL) assistance, assistance with mental health, cognitive or behavioral concerns, health related assistance, home management tasks, non-medical transportation, and socialization.



- Beginning on Aug. 1, 2021, a CL or 24-hour CL provider must be licensed as one of the following:
 - Assisted living facility this includes assisted living facilities with dementia care
 - Comprehensive home care provider
- For BI and CADI, a CL or 24-hour CL provider who does not have a foster care license and provides services in settings of one to four people (or five with a DHS-approved permanent fifth-bed license or temporary fifth-bed variance), must both:
 - Be licensed as an assisted living facility.

Minnesota Food Code Summary:

The direct link is: <https://www.revisor.mn.gov/rules/4626/>

Summary:

- All assisted living facilities **shall offer to provide or make available** at least the following services to residents:
 - At least three nutritious meals daily, with snacks available seven days per week.
 - Food is prepared according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines.
 - Facilities must include seasonal fresh fruit and fresh vegetables.
 - Menus must be prepared at least one week in advance and made available to all residents.
 - The facility must encourage residents' involvement in menu planning.
 - Meal substitutions must be of similar nutritional value if a resident refuses a food that is served.
 - Residents must be informed in advance of menu changes.
- All Assisted Living facilities that prepare and serve food need a Certified Food Protection Manager (CFPM) full-time. There is no exception to having a CFPM based on size of facility. ServSafe certificate may count toward this requirement. Renewal requirements must include Minnesota credential as renewals are 3 years compared to ServSafe of 5 years.
- CFPM is responsible to identify hazards in the daily operation, coordinate food safety training and prevention of foodborne illness, and ongoing inspections daily operations.
- CFPM can train individuals designated as the Person in Charge (PIC).
- The PIC is required during all hours of operation and must know how to prevent transmission of foodborne disease, know the symptoms associated with foodborne diseases, the importance of personal hygiene and handwashing, time, and temperature control for safety food maintenance, managing cross contamination.
- Food must be received, stored, date marked, prepared in a safe manner and food must be protected from all contaminants.



- A neighborhood kitchen may use equipment other than ANSI-certified equipment to heat and serve food previously cooked in an approved, primary commercial kitchen. A neighborhood kitchen may also prepare and serve food other than raw animal foods if grease or moisture does not accumulate on adjacent surfaces. ANSI-certified food service equipment is not required at assisted living establishments that prepare foods only for same-day service.
- Ventilation hood systems and devices must be sufficient in number and capacity to prevent grease or condensation. Adequate ventilation and make-up air is required for equipment that produces excessive steam, condensation, vapors, obnoxious odors, smoke, and fumes.
- There are two types of mechanical ware washing machines primarily used in food service: chemical sanitizing and hot water sanitizing. Chemical sanitizing machines must not be less than 120 degrees whereas hot water sanitizing may not be less than 150 degrees to 165 degrees, depending on rack and multi-tank.

CLIA Waiver:

The Direct link is: www.cms.gov/regulations-and-guidance/legislation/clia

Summary:

- CLIA requires every facility that tests human specimens for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, a human being to meet certain Federal requirements. If your facility performs tests for these purposes, it is considered, under the law, to be a laboratory. Facilities only collecting or preparing specimens (or both) or only serving as a mailing service are not considered laboratories. CLIA applies even if only one or a few basic tests are performed, and even if you are not charging for testing.
- The CLIA application (Form CMS-116) collects information about your laboratory's operation which is necessary to determine the fees to be assessed, to establish baseline data and to fulfill the statutory requirements for CLIA. This information will also provide an overview of your facility's laboratory operation. All information submitted should be based on the facility's laboratory operation as of the date of form completion.
- Waived tests are not exempt from CLIA. Facilities performing only those tests categorized as waived must apply for a CLIA certificate of waiver. These types of test may include blood glucose, influenza, INR. As defined by CLIA, waived tests are categorized as "simple laboratory examinations and procedures that have an insignificant risk of an erroneous result." The Food and Drug Administration (FDA) determines which tests meet these criteria when it reviews manufacturer's applications for test system waiver.



- A facility will need a CLIA certificate for **each** site that performs testing, **unless** the site qualifies for one of the exceptions, if testing locations are within a hospital and are located at contiguous buildings on the same campus and under common direction, the site may file a single application for the laboratory sites within the same physical location or street address.
- The state agency that monitors CLIA Waivers or may be able to answer questions related to CLIA is the Minnesota Department of Health CLIA program.
- Certificates must be renewed every two years.
- Providers must update the CLIA Program at the Minnesota Department of Health when there are changes (such as the named laboratory director).

Emergency Planning Interpretative Guidelines for Long-term Care Facilities– Appendix Z:

The direct link is: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_z_emergprep.pdf

Summary:

- Hazard Identification: Providers must use an “all-hazards” approach identifying any hazards that may affect them in their location.
- Hazard Mitigation: Activities taken to eliminate or reduce the probability of an event or reduce its severity or consequences.
- Preparedness: Addresses how the provider or supplier will meet the needs of patients and includes staff training for emergency plan, testing the plan, and revising the plan.
- Response: Response activities address the immediate and short-term effects of an emergency.
- Recovery: Implemented to help return the facility to its usual state or “new normal”.
- Development of an emergency plan is based on a risk assessment.
- Perform risk assessment using an all-hazards approach, focusing on capacities & capabilities.
- Update the emergency plan at least annually.
- An all-hazards approach might include: Hazards likely in the geographic area specific to location of the provider, care related emergencies, Equipment & power failures, Interruption in communication such as cyberattacks.
- A facility’s emergency plan must address the resident population, including: Persons at risk, types of services the facility must be able to provide in an emergency, how to maintain continuity of operations and delegation of authority and succession plans.
- Policies and procedures on the emergency plan should include subsistence needs, evacuation plans, procedures for sheltering in place, and tracking patients and staff during an emergency and communication plan. Subsistence needs (food, water, medical, pharmaceutical supplies, alternate energy) and how much is needed for staff and residents



- Plans should include: Means to shelter in place, a system for care and treatment services and medical documentation, arrangements with other facilities for evacuation locations and transportation, a system to track the location of staff and residents, 1135 Waiver and facility responsibilities in the provision of care and treatment during a declared public health emergency in alternate care sites.
- The facility must: Complete initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
- Provide emergency preparedness training at least annually.
- Maintain documentation of all emergency preparedness training. Demonstrate staff knowledge of emergency procedures.
- The facility must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures.

The facility must:

1. Participate in an annual full-scale exercise that is community-based; or when a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (If the facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event).

2. Conduct an additional annual exercise that may include but is not limited to the following: A second full-scale exercise that is community-based or an individual, facility based functional exercise; or a mock disaster drill; or a tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

- The communication plan must include the following:
 1. A method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health providers to maintain the continuity of care.
 2. A means, in the event of an evacuation, to release resident information as permitted.
 3. A means of providing information about the general condition and location of residents under the facility's care as permitted.
- Facilities must have a means of providing information about the facility's needs and the abilities to aid in assistance of the authority having jurisdiction (local and State emergency management agencies, local and state public health departments, the Incident Command Center, the Emergency Operations Center, or designee).
- Occupancy reporting is considered, but not limited to, reporting the number of patients currently at the facility receiving treatment and care or the facility's occupancy percentage.



- The types of “needs” a facility may have during an emergency and should communicate to the appropriate authority would include but is not limited to, shortage of provisions such as food, water, medical supplies, assistance with evacuation and transfers, etc.
- Facilities are required to share emergency preparedness plans and policies with their residents, family members, and resident representatives, respectively.
- Other options include providing instructions on how to contact the facility in the event of an emergency on the public website or to include the information as part of the facility’s check-in procedures.

Tuberculosis Control in Minnesota Health Care Settings

The direct link is <https://www.health.state.mn.us/diseases/tb/rules/tbregmanual.pdf>

Summary:

- Tuberculosis (TB) is a serious disease caused by *Mycobacterium tuberculosis*. There are two phases: latent infection and active disease. Active TB disease most often affects the lungs but can involve any part of the body.
- TB is transmitted through the air; extended close contact with someone with infectious TB disease is typically required for TB to spread.
- The MDH TB Prevention and Control Program collaborates with clinicians and local health departments to ensure that persons with TB receive effective and timely treatment and that contact investigations are performed to minimize the spread of TB.
- Providers must designate and document a qualified person or team with primary responsibility for the TB infection control program.
- Providers must have a current written TB risk assessment, reviewed, and updated periodically.
- Providers must have a written infection control plan that includes: Procedures for handling persons with active TB disease; and Documentation of initial and ongoing TB-related training and education for all health care workers.
- Results of baseline TB screening of all paid and unpaid health care workers are documented. All reports or copies of tuberculin skin tests (two-step TSTs), IGRAs/TB blood tests for *M. tuberculosis*, medical evaluation (if appropriate), TB history and symptom screen, and chest radiograph results are maintained in the health care worker’s employee file. Baseline screening includes two-step skin testing (unless the TB blood test was used).
- If the setting was classified as “medium risk” or higher, results of **serial** TB screening of all paid and unpaid health care workers are documented. All reports or copies of tuberculin skin tests (TSTs), IGRAs/TB blood tests for *M. tuberculosis*, medical evaluation, TB symptom screen, and chest radiograph results were maintained in the health care worker’s employee file.



Bed Rail Safety:

The direct link is: <https://www.fda.gov/medical-devices/consumer-products/bed-rail-safety>

Summary:

- Bed rails are used by many people to help create a supportive and assistive sleeping environment in homes, assisted living facilities and residential care facilities. This type of equipment has many commonly used names, including side rails, bed side rails, half rails, safety rails, bed handles, assist bars, or grab bars, hospital bed rails, and adult portable bed rails.
- Many portable bed rail products can be purchased by consumers on websites and in stores without a prescription and without the recommendation of a health care provider. Other types of bed rails are considered medical devices and subject to FDA oversight. A portable bed rail is any bed rail product or device that is attachable and removable from a bed, not designed as part of the bed by the manufacturer and is installed on or used along the side of a bed. These rails are used on beds intended for consumers and are intended to 1) reduce the risk of falling from the bed, 2) assist the consumer in repositioning in the bed, or 3) assist the consumer in transitioning into or out of the bed.
- Many death and injury reports related to entrapment and falls for both adult portable bed rail products and hospital bed rails have been reported to the U.S. Consumer Product Safety Commission (CPSC) and the U.S. Food and Drug Administration (FDA). All bed rails should be used with caution, especially with older adults and people with altered mental status, physical limitations, and certain medical conditions.
- While portable bed rails can be effective, bed rails should be checked regularly to make sure they remain firmly installed, that the patient is using them for the intended purposes and to watch for areas of possible entrapment.
- When using adult portable bed rails 1) Make sure the individual is a good candidate for using bed rails. Alternatives include lowering the bed and using concave mattresses which can help reduce rolling off the bed 2) Remember that not all bed rails, mattresses and bed frames are interchangeable. Check with the manufacturer to make sure the different pieces you're using are compatible 3) Follow the manufacturer's instructions to ensure a proper fit (no gaps should exist between the rail and the mattress). Be aware that gaps can be created by an individual's movements, or a shifting of the bed's position.



Pharmacy/Drug Diversion

The Direct Link is: <https://www.health.state.mn.us/facilities/patientsafety/drugdiversion/index.html>

Summary:

- Controlled substance diversion is widespread across healthcare, and national organizations recommend that all health care facilities develop a controlled substance diversion prevention program.
- Controlled substance diversion is a serious safety and quality issue that has an impact on residents' quality of care and life, while also increasing the risk of misuse of diverted medications in the community and contributing to an overarching opioid crisis in Minnesota.
- While clinicians are responsible for their practice, leaders are responsible for the environment in which they practice.
- A troubling diversion trend exists across the industry. In the absence of definitive evidence, health care workers who divert controlled substances are often able to quit in lieu of being fired. They are able to move from facility to facility, diverting medications from each location and from the residents and patients in their care, sometimes over a period of years.
- It is highly recommended that leaders report clinicians who are governed by a state board when there is a suspicion of diversion. The board may then complete an appropriate investigation and ensure their licensed and certified clinicians are practicing safely.
- Experts recommend interventions to improve facility process in each stage of the controlled substance life cycle (Prescribing and dispensing, procurement and delivery, storage and security, preparation and administration, documentation, and destruction/waste).

Electronic Monitoring:

The direct link is: <https://www.revisor.mn.gov/statutes/cite/144.6502>

Summary:

- Minnesotans residing in nursing homes, boarding care homes, assisted living facilities or special dementia units, and assisted living facilities have the choice to electronically monitor their activities as part of [Minnesota's Electronic Monitoring Law](#).
- Electronic monitoring is the placement of a camera, audio recorder, or video streaming device in a resident's room or private living unit to help the resident or representative monitor the resident or their activities. As part of the Elder Care and Vulnerable Adult Protection Act of 2019, the electronic monitoring law is one of a series of protections for elderly and vulnerable Minnesotans that took effect January 1, 2020.



- The facility must post a sign at each facility entrance accessible to visitors that states: “Electronic monitoring devices, including security cameras and audio devices, may be present to record person and activities.”
- Before placing an electronic monitoring device, a resident or resident’s representative must: 1) Give written consent 2) If they have a roommate, get written consent from the roommate or the roommate’s representative
- If the resident lacks capacity to make decisions, the law allows for resident representatives to make the electronic monitoring decision on behalf of the resident. The law also prohibits persons from knowingly interfering with electronic monitoring under certain circumstances.
- Facilities must make the consent forms available to the residents and inform residents of their option to conduct electronic monitoring, the form should include the written consent, date signed, type of electronic monitoring, list of standard conditions or restrictions, turning off/on during resident cares, exam, visits by visitors and any other condition or restriction by the resident or roommate on the use of electronic monitoring and acknowledgment that the resident consents to the Office of Ombudsman for Long-Term Care and its representatives disclosing information from the form.
- Facility staff must be notified before placing a video camera or recording device. There are situations, however, such as fear of retaliation, where the use of an electronic monitoring device for 14 days may be used without notifying the facility. The ombudsman for Long-term care must be notified in this circumstance.

Background Studies:

The direct link is: <https://www.revisor.mn.gov/statutes/cite/144.057>

Summary:

- Before the Minnesota Commissioner of Health issues a provisional license, a license as a result of an approved change of ownership, or renews a license, a managerial official or a natural person who is an owner with direct ownership interest is required to undergo a background study. Background studies should consist of the following:
 - individuals providing services that have direct contact "Direct contact" - face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the program.
 - Current or prospective employees or contractors of the applicant who will have direct contact with persons served by the facility, agency, or program.
 - Volunteers or student volunteers who will have direct contact with persons served by the program to provide program services if the contact is not under the continuous, direct supervision by an individual listed in clause.



- All other employees in assisted living facilities or assisted living facilities with dementia care licensed.
- A disqualification of an individual shall disqualify the individual from positions allowing direct contact or access to patients or residents receiving services. "Access" means physical access to a client or the client's personal property without continuous, direct supervision.
- The commissioner may set aside the disqualification if the commissioner finds that the individual has submitted sufficient information to demonstrate that the individual does not pose a risk of harm to any person served by the applicant, license holder, or other entities.
- The facility may be required to provide continuous, direct supervision, which means an individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program.
- If the individual under study resides outside Minnesota, the study must include a check for substantiated findings of maltreatment of adults and children in the individual's state of residence when the information is made available by that state, and must include a check of the National Crime Information Center database
- Current Minnesota laws require all applicants for an individual Professional License (Administrators, Directors, MD's, RN's, Social Workers) to complete the national FBI/BCA criminal background check. This is a separate process for individual professional licenses only.