Assisted Living: Tools for High-Risk, Frequently Cited Areas

August 13, 2026

Welcome and Introduction

Co-Designed By:

- Minnesota Department of Health (MDH)
- Stratis Health
- Assisted Living and Home Care Providers

Purpose

- Support regulatory compliance
- Reduce confusion
- Prevent costly mistakes
- Improve understanding of licensing and compliance expectations

Objectives

By the end of this session, participants will:

- Apply practical resources to strengthen documentation, monitoring, and internal oversight processes.
- Describe how providers can use self-audits and monitoring tools to identify gaps before a survey occurs.
- Identify tools that support compliance in highly cited assisted living regulatory areas.

Important Note

This material was prepared by Stratis Health under contract with the Minnesota Department of Health (MDH).

Use of this tool is not mandated by MDH, nor does its completion ensure regulatory compliance.

Providers remain responsible for meeting all applicable statutory and regulatory requirements.

Compliance Support Tools for Assisted Living Facilities

Service Plans

Staff Records & Training

Quality Management

Medication Management

Staffing Plan

Service Plan

Service Plan Writing Guide

Required Elements Checklist for Service Plan Templates

Service Plan Compliance Review Worksheet

Service Plan Update and Documentation Review Guide

Service Plan Digital Record Self-Audit

Individual Resident Service Plan Audit Tool

Service Plan Writing Guide

DEPARTMENT OF HEALTH

Service Plan Writing Guide

Developing Clear, Individualized, and Person-Centered Service Plans for Assisted Living and Home Care Providers

Purpose

Minnesota Statute 144G.70, Subdivision 4 (assisted living) and Minnesota Statute 144A.4791, Subdivision 9 (home care) require service plans to reflect an individual's assessed needs, preferences, services, and agreed-upon supports and to be updated when changes occur.

Service plans must be:

- Based on assessments.
- Co-developed with the individual and, when applicable, their representative.
- Reviewed and revised when there is a change in the individual's needs, preferences, or services.

Why Service Plans Matter
Service plans help ensure individuals receive services that are: • Based on their assessed needs. • Consistent with their preferences and choices. • Delivered consistently by staff. • Updated when needs, services, or conditions change. A well-written service plan helps staff understand what services to provide, how to provide them, and what is important to the individual. The plan also supports communication among staff, individuals, representatives, and other members of the care team.

Because service plans often involve multiple staff, systems, and documentation requirements, it can be challenging to ensure they remain complete, individualized, and consistently followed.

This guide provides practical strategies and examples to help staff develop clear, individualized, and person-centered service plans that support consistent service delivery and compliance with Minnesota requirements. This guide can help you:

- Develop new service plans.
- Update existing service plans.
- Incorporate individual preferences and choices.
- Document staffing responsibilities.
- Develop meaningful contingency plans.

Incorporating Individual Preferences and Goals

Preferences help make a service plan individualized and person-centered. When documenting preferences, ask "If a new staff member read this service plan, would they understand what is important to this individual and how those preferences affect service delivery?"

What to Document	Best Practices
• Preferred daily routines • Preferred schedule for services • Food preferences • Language needs • Cultural considerations • Religious practices • Social preferences • Activity preferences • Preferences regarding who provides services • Personal goals that affect service delivery	• Document preferences that affect service delivery. • Include goals when they influence services. • Describe how staff will support preferences and goals.

Example:

Less Specific Documentation	More Specific Documentation
Assist with meals.	Individual prefers breakfast after 8 a.m. Staff provide meal set-up assistance and cueing as needed.
Individual wants to continue participating in social activities.	Individual prefers card games and attending weekly music programs. Staff offer reminders 30 minutes before activities begin.

Service Plan Compliance Review Worksheet

Services to be Provided

Review whether services are clearly described, based on the current assessment, and reflect the individual's needs and preferences.

Review Item	Yes (X)	No (X)	Where Documented
All services the individual receives are included in the service plan.			
Services reflect the individual's assessed needs, preferences, and goals.			
The frequency of each service is documented.			
Service instructions provide enough detail for staff to deliver services consistently.			
Individual preferences, choices, routines, or goals are included when relevant to service delivery. *(e.g., personal preferences, cultural considerations, routines, lifestyle choices, care goals)*			

Service Plan Update and Documentation Review Guide

Changes That May Require Updates

Use this section when an event or change occurs, such as a condition change, incident, new service, or staffing change.

Event	Documentation Update
Individual Assessment or Condition Change	• Services to be provided • Staffing responsibilities (if support needs change) • Contingency plan (if risks change) • Individual and/or representative participation and agreement (if preferences, decisions, or services change) • Fire safety evacuation plan (AL Only)
New Service Added or Discontinued	• Services to be provided • Staffing assignments • Contingency plan (if service affects risk or continuity) • Service documentation requirements (logs, notes, records, or tracking tools)
Incident or Significant Event Occurs *(e.g., fall, hospitalization, emergency room visit, change in functioning)*	• Services to be provided (interventions may change) • Assessment (if new risks or support needs are identified) • Contingency plan • Staffing responsibilities (supervision or assistance needs) • Individual/representative communication
Staffing Change	• Staffing section • Services to be provided (if responsibility for service delivery changes) • Task lists or assignments • Contingency plan (coverage during disruptions) • Fire safety evacuation plan (AL Only)

Digital Record Audit

DEPARTMENT OF HEALTH

Service Plan Digital Record Self-Audit

Use this tool to confirm that required service plan elements are documented in your electronic record and can be easily located for both care delivery and survey review.

This tool is based on service plan regulatory requirements in Minnesota Statute 144G.70, Subdivision 4 for assisted living providers and Minnesota Statute 144A.4791, Subdivision 9 for home care providers.

Ensuring that service plan information is clearly documented, current, and accessible supports the safety of individuals served by helping staff deliver accurate and consistent care. It also supports regulatory compliance by demonstrating that required elements are present, aligned, and readily available during a survey.

How to Use This Tool

For each data element listed below:

- Identify where the information is documented in your electronic system (e.g., service plan section, assessment module, task list, medication administration record [MAR], or scanned documents).
- If the information is documented in multiple locations, list the primary location used for care delivery and staff reference.
- Confirm the information is current, accessible, and consistent with the service plan.

Data Element	System Location of Documentation
Services provided	
Frequency of services	
Individual served preferences	
Individual served risks	
Staff roles/responsibilities	
Individuals serviced/representative signatures and agreement	
Other	

Individual Resident Service Plan Audit Tool

Resident Service Plan Audit

Resident Name/Identifier:			
Date of Birth or Medical Record Number (MRN) (if used):			
Reviewed By:			
Audit Date:		**Next Review Due:**	

Service Initiation and Timelines

Required Elements	Met	Not Met	Notes/Location
Temporary service plan completed if the full assessment is not complete (not to exceed 72 hours)			
Service plan completed within 14 days of service initiation			

Staff Record

- Staff Qualification and Training Requirements
- Individual Staff Orientation and Training Record
- Staff Record Documentation and Tracking Tool
- Individual Annual Staff Training Compliance Record
- Unlicensed Personnel Training and Competency Record
- Annual Staff Training Plan and Tracking Log
- Policy and Procedure Staff Review Log

Staff Qualification and Training Requirements

DEPARTMENT OF HEALTH

Staff Qualification and Training Requirements

This document serves as a reference guide to support understanding of assisted living facility staff-related requirements under Minnesota Statute 144G.

Use this resource to:

- Understand staff roles and qualifications (e.g., registered nurse [RN], licensed assisted living director [LALD], unlicensed personnel [ULP]).
- Identify required training and competency expectations.
- Clarify delegation and supervision requirements.
- Support interpretation and application of regulatory requirements.

Licensed Staff Requirements

Licensed Health Professionals and Nurses

- Must hold current Minnesota license or registration to practice.
- Have skills, knowledge, and experience to assess resident needs, plan appropriate services to meet resident needs, implement services, and supervise staff if assigned.

Licensed Assisted Living Director (LALD)

- Must be licensed or permitted by the Minnesota Board of Executives for Long-Term Services and Supports (BELTSS) and affiliated as the director of record.
- Must complete 30 hours of continuing education every two years approved by BELTSS or the National Association of Long-Term Care Administrator Boards (NAB).
- Assisted Living with Dementia Care LALD must complete 10 hours of dementia-related continuing education annually.
- Must use BELTSS LALD Continuing Education Attestation and Record to document and track completed continuing education. Documentation must be readily available upon request.

Clinical Nurse Supervisor (CNS)

- Must be an RN licensed in Minnesota.
- Must demonstrate competency in accordance with Minnesota Statutes section 144G.60, Subdivision 3(b) in the following:
  - Assessing resident needs.
  - Developing and implementing service plans.
  - Supervising staff if assigned.

Individual Staff Orientation and Training Record

DEPARTMENT OF HEALTH

Assisted Living Individual Staff Orientation and Training Record

Instructions

Use this worksheet to document required orientation and training for each assisted living facility staff member. Training topics are aligned with Minnesota Statute 144G.63, unless otherwise noted, and must be completed before the staff member provides services to residents. Record the date completed and location of supporting documentation for each topic.

Staff Name:		**Start Date:**	
Title:		**First Date Providing Services to Residents:**	
Current Licensure or Certification:		**License/Certification Expiration Date:**	
Current Job Description (include date if applicable):		**Background Study Date:**	

Topic	Date Completed	Location of Documentation	Compliance Verified (Y/N)
Foundational Training			
Overview of Minnesota Assisted Living Statutes Chapter 144G			
Review of facility policies and procedures			
Assisted living bill of rights and staff responsibilities			
Resident rights and complaint processes (OHFC)			
Consumer advocacy services			
Health Insurance Portability and Accountability Act (HIPAA)			
Safety and Emergency Preparedness			
Handling emergencies and use of emergency services			
Reporting maltreatment of vulnerable adults (Minnesota Adult Abuse Reporting Center [MAARC])			

Staff Record Documentation and Tracking Tool

Staff Name:	
Title:	

Requirement	Location of Documentation
Evidence of current professional licensure, registration, or certification if required (e.g., registered nurse [RN], licensed practical nurse [LPN], licensed assisted living director [LALD], Nursing Aide Registry [NAR], other healthcare-related license)	
Documentation of completed orientation	
Documentation of completed required annual training	
Documentation of required infection prevention and control training	
Documentation of completed competency evaluations	

Individual Annual Staff Training Compliance Record

Topic	Time (HH:mm)	Date Completed	Location of Documentation
Foundational Training			
Assisted living bill of rights and staff responsibilities			
Review of organization's policies and procedures			
Health Insurance Portability and Accountability Act (HIPAA)			
Safety and Emergency Preparedness			
Reporting maltreatment of vulnerable adults (Minnesota Adult Abuse Reporting Center [MAARC])			
Emergency and Disaster Training Minnesota Statute 144G.42, Subdivision 10			
Training on Fire Safety and Evacuation Plans (at least twice per year) Minnesota Statute 144G.45, Subdivision 2			

Unlicensed Personnel Training and Competency Record

Staff Name:			
Title/Position:			
Verification of NAR:		**Expiration Date:**	

Topic	Training/Education		Competency	
	Date	Location of Documentation	Date	Location of Documentation
Documentation and Reporting				
Documentation requirements for all services provided				
Reporting changes in the condition of the individual served to the designated supervisor				
Infection Control and Environmental Safety				
Basic infection prevention and control, including blood-borne pathogens				
Maintaining a clean and safe environment				
Personal Care and Activities of Daily Living (ADLs) Appropriate and safe techniques in personal hygiene and grooming, including:				
Hair care and bathing				
Care of teeth, gums, and oral prosthetic devices				
Care and use of hearing aids				
Dressing and assisting with toileting				

Annual Staff Training Plan and Tracking Log

DEPARTMENT OF HEALTH

Annual Staff Training Plan and Tracking Log (Organization-Level)

Instructions

Use this worksheet to plan, track, and monitor required all-staff education and training across the calendar or fiscal year.

This tool supports required ongoing staff training compliance with Minnesota Statutes Chapter 144G.63, unless otherwise noted.

For each topic:

- Record the date last completed.
- Identify future training needs and planned dates.
- Indicate the delivery method (e.g., in-person, online module, staff meeting).

This tool is intended for organization-level planning and does not replace individual staff training records.

Provider Name:	
Location:	
License Number:	
Training Period:	

Topic	Date last completed	Future Training Planned	Delivery Method
Foundational Training			
Assisted living bill of rights and staff responsibilities			
Review of facility policies and procedures			
Health Insurance Portability and Accountability Act (HIPAA)			
Safety and Emergency Preparedness			
Reporting maltreatment of vulnerable adults (Minnesota Adult Abuse Reporting Center [MAARC])			
Emergency and Disaster Training Minnesota Statute 144G.42, Subdivision 10			
Training on Fire Safety and Evacuation Plans (at least twice per year) Minnesota Statute 144G.45, Subdivision 2			

Policy and Procedure Staff Review Log

DEPARTMENT OF HEALTH

Policy and Procedure Staff Review Log

Instructions

Use this log to document staff review of organizational policies and procedures. Enter each policy or procedure title, the date the staff member reviewed the content, and the staff member's initials to acknowledge completion.

This tool may be used to support compliance with Minnesota assisted living requirements under Minnesota Statute 144G.61 and 144G.63 and home care requirements under Minnesota Statute 144A.4796, which require staff training on applicable policies, procedures, and job responsibilities.

Organizations may tailor this template to include policies relevant to staff roles and responsibilities. Reviews should occur at orientation and periodically thereafter (e.g., annually or when policies are updated).

Staff Name:	
Title:	

Policy/Procedure Title	Date Reviewed	Staff Initials

Quality Management

Your Quality Management Plan

How to Use Data to Support Quality Management

Data Source Inventory

Quality Measure Development Worksheet

Quality Measure Tracking Log

Quality Review and Action Summary Record

Your Quality Management Plan

Purpose Statement	Explain why quality management activities are conducted and how these activities support dignified, safe, appropriate care based on your size and services.
Scope	Define the services, settings, and populations included in the quality management plan. This should align directly with the services you are licensed to provide and actually deliver. The scope should clearly reflect where services occur (e.g., assisted living setting, client homes) and which residents or clients are included.
Governance and Responsibility	Identify who is responsible for ensuring quality management activities occur and to clarify that accountability for quality rests with the organization's leadership, even when tasks are delegated.
Periodic Review of Resident or Client Services	Describe how resident or client services are routinely reviewed, who participates in the review, how often reviews occur, how changes in individual needs are identified and addressed, and how feedback from residents, clients, and families informs quality management activities.
Review of Complaints	Explain how complaints are received, documented, reviewed for patterns, and used to determine whether changes in services, staffing, or procedures are needed.
Review of Other Issues	Describe how incidents, events, or other concerns are reviewed to understand what occurred, identify contributing factors, and prevent similar issues from occurring in the future.
Determining and Implementing Changes	Explain how decisions are made when quality concerns are identified, how changes are implemented, and how the organization checks whether those changes were effective.
Documentation of Quality Management Activities	Confirm that quality management reviews, decisions, and actions are documented, retained, and available as required for surveys, investigations, or license renewal.

How to Use Data to Support Quality Management

DEPARTMENT OF HEALTH

How to Use Data to Support Quality Management

Why This Matters

As a provider, you may feel confident that you offer high-quality services, but how do you *know?*

Quality management helps you see whether your services are working like they should be, catch problems early, prevent repeat issues, and show surveyors that quality is actively monitored and managed. Quality management is not about paperwork or complex data. It is about paying attention, learning from what happens, and making changes when needed.

What Statute Requires

Minnesota statute requires all assisted living (144G.42 Subd. 2) and home care (144A.479 Subd. 3) providers engage in quality management. This means monitoring the quality of services provided; reviewing problems, incidents, and complaints; and using that information to make improvements. Quality management activities should be practical, proportional to the size of the organization, and focused on dignity, safety, and quality.

What does "proportional" mean?

Proportional means doing what makes sense for your organization.

Examples:

- A small provider may track a few key issues and review them during routine staff or leadership meetings.
- A larger provider may track more items, use spreadsheets or reports, and review data more formally.

The Minnesota Department of Health does not require a certain number of quality measures. Surveyors expect that your activities match your size, services, and risks.

Data Source Inventory

X	Data Source	Record Location	Responsible Role
Incident and Event Data			
	Incident reports (e.g., falls, injuries)		
	Medication error reports		
	Infection control logs		
	Other:		
Complaints and Feedback			
	Complaint or grievance log		
	Resident or client complaints (verbal or written)		
	Family feedback or concerns		
	Resident council (when present, if applicable)		
	Family council (when present)		
	Other:		

Quality Measure Development Worksheet

EXAMPLE

Measure Name	Purpose and Goal	Definition	Data Source	Monitoring Plan	Strategic Priority
EXAMPLE: Preventable falls	*Reduce falls with injury by 10% over a six-month period to improve resident safety*	***Include:** All resident falls resulting in injury* ***Exclude:** Falls caused by major medical events (e.g., stroke, seizure)*	*Incident reports*	*Review monthly, track results quarterly for six months and continue monitoring after each fall*	*Safety*

Quality Measure Development Worksheet

Measure Name	Purpose and Goal	Definition	Data Source	Monitoring Plan	Strategic Priority

Quality Measure Tracking Log

Measure Name:	*Hospital readmission within 30 days of discharge.*				
Starting Point:	*Q4 2025: 6 hospital readmissions within 30 days for the quarter*				
Goal:	*Reduce 30-day rehospitalizations from 6 to 2 or fewer per quarter within 12 months.*				
Status:	**No change**	**Improvement noted**	**Goal met**	**Goal sustained**	**Goal exceeded**
Period	**Actual result**	**Status**	**Notes or comments**		
Q1 2026	6 30-day hospital readmissions	No change	Review showed delays in first post-discharge visit and incomplete communication from hospital. Actions: implemented requirement for initial visit within 48 hours of discharge and improved intake of discharge information.		
Q2 2026	5 30-day hospital readmissions	Improvement noted	Issues tied to gaps in communication between providers and caregivers. Actions: standardized communication process with primary care providers and ensured caregivers understood discharge instructions.		
Q3 2026	3 30-day hospital readmissions	Improvement noted	Remaining readmissions linked to missed early warning signs. Actions: added structured symptom check protocols at each visit and escalation guidelines for staff.		
Q4 2026	3 30-day hospital readmissions	Sustained improvement	Practices sustained: timely first visits, structured monitoring, and improved coordination with providers and family caregivers. Continue monitoring and targeted follow-up.		

Quality Review and Action Summary Record

EXAMPLE

Date of Review	03/31/2026

Type of Review		**Review Frequency**	
X Routine scheduled review	☐ Leadership/management meeting	☐ Monthly	☐ Annually
☐ Quality committee meeting	☐ Post-incident or issue-specific review	**X** Quarterly	☐ As needed

Measure	**Summary of Review and Decision**		**Notes**	**Follow-Up**
30-day Hospital Readmissions	**Goal Status:** ☐ Goal met ☐ Strong Improvement ☐ Moderate Improvement ☐ Mild Improvement ☐ Goal not met	**Action:** X Continue monitoring ☐ Training X Policy change X Improvement project	Rehospitalizations remain above target but show early improvement. Review identified key drivers including delayed post-discharge follow-up, incomplete medication reconciliation, and gaps in communication with primary care providers. Actions implemented: • Standardized post-discharge review within 48 hours • Medication reconciliation process added for all returning residents/clients • Improved coordination with providers for follow-up appointments • Increased monitoring during first 14 days post-discharge	**Person:** Director of nursing **Review Date:** 06/30/2026

Medication Management

Medication Management Policy and Procedure Self-Audit

Medication Management Self-Audit Tool

Medication Management: Common Survey Findings (2026)

Medication Management Policy and Procedure Self-Audit

Section 1: Policy and Procedure Review

General Medication Management Policies and Procedures

Audit Item	Compliant	Needs Attention	Not Applicable	Notes
General Medication Management Policies and Procedures Review written medication management policies and procedures to determine if they address the following requirements:				
Are current and available to staff.				
Are developed under the supervision of a registered nurse (RN), licensed health professional, or pharmacist.				
Address sources of medications including: • Prescribed medications. • Non-prescribed medication. • Over-the counter medications. • Dietary supplements (not prescribed). • Medications provided by the individual served, family members, legal representatives, designated representatives, or other caregivers.				
Address requesting and receiving prescription medications.				
Address receipt, documentation, and handling of verbal prescription orders.				

Medication Management Self-Audit Tool

Individual Record Review - Prescriptions and Orders

High-Risk Survey Area
Deficiencies in this area are commonly cited during surveys and may affect health and safety. Review carefully.

Review the individual's record to verify required prescriptions, medication orders, and related documentation are complete, current, and accurately maintained.

While many medication orders are now transmitted electronically, staff should continue to follow established procedures for verbal orders, including repeating the order back to the prescribing clinician to verify accuracy before documentation and implementation.

Audit Item	Compliant	Needs Attention	Not Applicable	Notes
A current, valid prescription is maintained for each medication managed by the provider.				
Medication orders match the Medication Administration Record (MAR).				
Medication orders are renewed at least every 12 months or within required timeframes.				
Current orders are maintained for all controlled substances, when applicable.				
Verbal orders are accepted only by authorized staff, as permitted by policy and regulation.				
Verbal orders are documented and authenticated according to provider policy and applicable requirements.				

Medication Management: Common Survey Findings (2026)

Section 1: Policies and Procedures for Clinical Oversight and Supervision

Surveyors may review the organization's medication management policy manual to make sure it is current, comprehensive, and reflects appropriate clinical oversight. This includes reviewing policy revision dates and evaluating whether medication management practices are implemented, monitored, and supervised in accordance with applicable regulatory requirements.

Note: Oversight and supervision requirements vary by provider type. Assisted living providers should refer to Minnesota Statute 144G.71, and home care providers should refer to Minnesota Statute 144A.4792 for applicable requirements.

Common Survey Findings

- Medication orders were implemented before required verification was completed.
- Medication reconciliation was not completed or documented when required.
- Clinical oversight activities were incomplete, missing, or not documented.
- Delegation of medication-related tasks was not adequately documented.
- Required staff competency evaluations were missing, overdue, or incomplete.
- Medication administration record (MAR) inaccuracies were not identified or corrected through routine oversight.
- Medication records lacked individualized instructions.
- Staff could not explain medication administration procedures or required follow-up actions.

Staffing Plan Effectiveness Assessment

Guide to Writing Your Staffing Plan

Guide to Writing Your Staffing Plan

The purpose of the staffing plan is to ensure that you always have enough staff to meet the scheduled (and reasonably foreseeable unscheduled) needs of each resident. The staffing plan should be based on resident assessments, service plans, acuity levels, and emergency situations. This resource guide describes:

- Regulatory staffing requirements for assisted living providers per Minnesota Statutes Chapter 144G
- What is included in a staffing plan
- How to develop a staffing plan
- Strategies to maintain, document, and assess your staffing plan over time

To support staffing plan development and ongoing monitoring in your organization, you can utilize the **Staffing Plan Effectiveness Assessment Worksheet** to evaluate staffing adequacy twice per year (as required by statute).

Regulatory Requirements

The State of Minnesota requires all assisted living providers to follow the minimum standards listed below, per Minnesota Statute 144G.41 and Minnesota Administrative Rules Part 4659.0180. Assisted living providers that also provide dementia care have additional requirements to ensure residents always receive safe care, per Minnesota Statute 144G.81, Subd. 4.

General Staffing Requirements

One or more persons must be:

- Awake and available onsite 24 hours per day, seven days per week
- Located in the same building, in an attached building, or on a contiguous campus with the facility to respond within a reasonable amount of time
- Responsible for responding to the requests of residents for assistance with health or safety needs
- Capable of communicating with residents
- Capable of providing or summoning the appropriate assistance
- Capable of following directions

A minimum of *two* direct care staff must be scheduled and available to whenever a resident's assessment and service plan requires the assistance of two direct care staff for scheduled, reasonably foreseeable, and unscheduled needs.

Guide to Writing Your Staffing Plan

Staffing Plan Effectiveness Assessment Worksheet

DEPARTMENT OF HEALTH

Staffing Plan Effectiveness Assessment Worksheet

Purpose: This assessment is used to evaluate the effectiveness of the staffing plan. It should be completed at least twice per year and whenever significant changes occur in resident census, acuity, services provided, or staffing patterns. The assessment helps determine whether staffing levels are sufficient to meet resident needs and reasonably foreseeable unscheduled needs. Because this document is designed to encourage a thorough analysis of your facility's staffing plan, it includes factors that do not appear in the Staffing Plan Guide and Worksheet [link].

Facility Name:		**Resident Census:**	
Assessment Date:		**Reference Period:**	
Completed By:		**Staffing Plan Revision Needed?**	☐ Yes ☐ No

Estimating Staffing Time for Resident Care

Instructions: Use the tables below to estimate the amount of staff time needed to provide resident care and services during a typical day, week, or month. Choose one time period and use it consistently throughout the worksheet.

For each service:

- Identify the staff position(s) that provide the service.
- Record how many times the service is provided during the selected time period.
- Estimate the average number of minutes needed to complete the service one time.
- Calculate the total staff time required for that service.

Access

- MDH Assisted Living Forms and Self-Audit Tools
- Email Questions to health.assistedliving@state.mn.us

Thank You!