



Rules of Department of Health and Senior Services

Division 30—Division of Regulation and Licensure Chapter 82—General Licensure Requirements

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**Title 19—DEPARTMENT OF
HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and
Licensure
Chapter 82—General Licensure
Requirements**

**19 CSR 30-82.010 General Licensure
Requirements**

PURPOSE: This rule sets forth general licensure and application procedures and outlines the request for an exception procedure related to long-term care facility licensure.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Persons wishing to operate a skilled nursing facility, intermediate care facility, assisted living facility, or residential care facility shall complete form MO 580-2631 (8-07), Application for License to Operate a Long-Term Care Facility, incorporated by reference in this rule and available through the Department of Health and Senior Services' (department's) website at www.dhss.mo.gov, or by mail at: Department of Health and Senior Services, Section for Long-Term Care Regulation, Licensure Unit, PO Box 570, Jefferson City, MO 65102-0570, telephone: (573) 526-8524. This rule does not incorporate any subsequent amendments or additions. The application shall be signed by a person with the express authority to sign on behalf of the operator, who shall attest by signature that the information submitted is true and correct to the best of the applicant's knowledge and belief and that all required documents are either included with the application or are currently on file with the department. The completed application form may be submitted by mail or electronically. If submitted electronically, send the completed application to LTCapplication@dhss.mo.gov. The application fee for application processing should be submitted by separate mail. If submitted by mail, send the application form and fee to Department of Health and Senior Services, Section for Long-Term Care Regulation, Fee Receipts, PO Box 570, 920 Wildwood, Jef-

erson City, MO 65102. One (1) application may be used to license multiple facilities if located on the same premises.

(A) The applicant shall submit the following documents and information as listed in the application:

1. Financial information demonstrating that the applicant has the financial capacity to operate the facility;

2. A document disclosing the location, capacity, and type of licensure and certification of any support buildings, wings, or floors housing residents on the same or adjoining premises or plots of ground;

3. A document disclosing the name, address, and type of license of all other long-term care facilities owned or operated by either the applicant or by the owner of the facility for which the application is being submitted;

4. A copy of any executed management contracts between the applicant and the manager of the facility;

5. A copy of any executed contract conveying the legal right to the facility premises, including, but not limited to, leases, subleases, rental agreements, contracts for deed, and any amendments to those contracts;

6. A copy of any contract by which the facility's land, building, improvements, furnishings, fixtures, or accounts receivable are pledged in whole or in part as security, if the value of the asset pledged is greater than five hundred dollars (\$500);

7. A nursing home surety bond or non-cancelable escrow agreement, if the applicant holds or will hold facility residents' personal funds in trust;

8. A document disclosing the name, address, title, and percentage of ownership of each affiliate of any general partnership, limited partnership, general business corporation, nonprofit corporation, limited liability company, or governmental entity which owns or operates the facility or is an affiliate of an entity which owns or operates the facility. If an affiliate is a corporation, partnership, or LLC, a list of the affiliate's affiliates must also be submitted. As used in this rule, the word "affiliate" means:

A. With respect to a partnership, each partner thereof;

B. With respect to a limited partnership, the general partner and each limited partner with an interest of five percent (5%) or more in the limited partnership;

C. With respect to a corporation, each person who owns, holds, or has the power to vote five percent (5%) or more of any class of securities issued by the corporation, and each officer and director;

D. With respect to an LLC, the LLC

managers and members with an interest of five percent (5%) or more;

9. If applicable, a document stating the name and nature of any additional businesses in operation on the facility premises and the document issued by the division giving its prior written approval for each business;

10. A list of all principals in the operation of the facility and their addresses and titles and, so that the department may verify the information disclosed pursuant to paragraphs (1)(A)11. and (1)(A)12. of this rule, the Social Security numbers or employer identification numbers of the operator and all principals in the operation of the facility. As used in this rule, "principal" means officer, director, owner, partner, key employee, or other person with primary management or supervisory responsibilities;

11. Disclosure concerning whether the operator or any principals in the operation of the facility are excluded from participation in the Title XVIII (Medicare) or Title XIX (Medicaid) program of any state or territory;

12. Disclosure concerning whether the operator or any principals in the operation of the facility have ever been convicted of a felony in any state or federal court concerning conduct involving either management of a long-term care facility or the provision or receipt of health care services;

13. Emergency telephone, fax, and email contact information for the facility administrator, director of nursing, and the operator's corporate office; and

14. Disclosure concerning whether the facility has a Department of Mental Health (DMH) license.

(B) Every facility that provides specialized Alzheimer's or dementia care services, as defined in sections 198.500 to 198.515, RSMo, by means of an Alzheimer's special care unit or program shall submit to the department with the licensure application or renewal, the following:

1. Form MO 580-2637, Alzheimer's Special Care Services Disclosure (2-07), incorporated by reference in this rule and available through the department's website: www.dhss.mo.gov, or by mail at: Department of Health and Senior Services, Section for Long-Term Care Regulation, Licensure Unit, PO Box 570, Jefferson City, MO 65102-0570, telephone: (573) 526-8524. This rule does not incorporate any subsequent amendments or additions. The form shall be completed showing how the care provided by the special care unit or program differs from care provided in the rest of the facility in the following areas:



A. The Alzheimer's special care unit's or program's written statement of its overall philosophy and mission which reflects the needs of residents afflicted with dementia;

B. The process and criteria for placement in, or transfer or discharge from, the unit or program;

C. The process used for assessment and establishment of the plan of care and its implementation, including the method by which the plan of care evolves and is responsive to changes in condition;

D. Staff training and continuing education practices;

E. The physical environment and design features appropriate to support the functioning of cognitively impaired adult residents;

F. The frequency and types of resident activities;

G. The involvement of families and the availability of family support programs;

H. The costs of care and any additional fees; and

I. Safety and security measures; and

2. Form *Guide to Selecting an Alzheimer's Special Care Unit* (6/06) #455, incorporated by reference in this rule and available through the department's website: at <http://www.dhss.mo.gov/Ombudsman>, or by mail at: Department of Health and Senior Services, Section for Long-Term Care Regulation, Licensure Unit, PO Box 570, Jefferson City, MO 65102-0570, telephone: (573) 526-8524 or a document of choice which contains, but is not limited to, all information on selecting an Alzheimer's special care unit or program that is contained in the *Guide to Selecting an Alzheimer's Special Care Unit* (6/06) #455. This rule does not incorporate any subsequent amendments or additions.

(C) If, after filing an application, the operator identifies an error or if any information changes the issuance of the license, including but not limited to, a change in the administrator, board of directors, officers, level of care, number of beds, or change in the name of the operating entity, the operator shall—

1. Submit the correction or additional information to the department's Licensure and Certification Unit in a letter. The letter shall be signed by a person with express authority to sign on behalf of the operator attesting by signature that the information being submitted is true and correct to the best of the operator's knowledge and belief; or

2. Submit the correction or additional information to the department's Licensure and Certification Unit. The additional information may be submitted electronically or by mail. Information shall be submitted using form

MO 580-2623 (8-07), Corrections For Long-Term Care Facility License Application, incorporated by reference in this rule and available through the Department of Health and Senior Services' (department's) website at www.dhss.mo.gov, or by mail at: Department of Health and Senior Services, Section for Long-Term Care Regulation, Licensure Unit, PO Box 570, Jefferson City, MO 65102-0570, telephone: (573) 526-8524. This rule does not incorporate any subsequent amendments or additions. The completed correction form shall be signed by a person with express authority to sign on behalf of the operator attesting by signature that the information submitted is true and correct to the best of the operator's knowledge and belief and shall be submitted by electronic mail to LTCapplication@dhss.mo.gov, or by mail to: Department of Health and Senior Services, Section for Long-Term Care Regulation, Fee Receipts, PO Box 570, 920 Wildwood, Jefferson City, MO 65102.

(D) If, as a result of an application review, the department requests a correction or additional information, the operator, within ten (10) working days of receipt of the written request shall—

1. Submit the correction or additional information to the department in a letter attesting by signature that the information being submitted is true and correct to the best of the operator's knowledge and belief; or

2. Submit the correction or additional information using form MO 580-2623 (8-07), Corrections For Long-Term Care Facility License Application referenced in paragraph (1)(C)2. of this rule.

(E) A new facility shall submit an application for an original license not less than thirty (30) days before the anticipated opening date. The department must approve the application before a licensure inspection is scheduled. Sixty (60) days after its receipt, the department shall consider any application for an original license withdrawn if it is submitted without all the required information and documents. If intending to continue with licensure, the operator shall submit a new application and fee along with all necessary documents.

(F) An operator shall submit a relicensure application thirty (30) to ninety (90) days prior to the existing license's expiration date.

(G) If, during the license's effective period, an operator which is a partnership, limited partnership, or corporation undergoes any of the changes described in section 198.015.4, RSMo, or a new corporation, partnership, limited partnership, limited liability company, or other entity assumes facility operation, within ten (10) working days of

the effective date of that change, the operator shall submit an application for a new license.

(H) The department shall issue each license only for the premises and operator named in the application. This license shall cover the entire premises unless stipulated otherwise and shall not be transferable. If the licensed operator of a facility is replaced by another operator, the new operator shall apply for a new license before the effective date of the change. A change of operator shall include a change in form of business as well as a change of person. Upon receipt of the application and receipt of confirmation that the change of operator has taken place, the department shall grant the new operator a temporary operating permit of sufficient duration to allow the department time to evaluate the application, conduct any necessary inspection(s) to determine substantial compliance with the law and the rules, and to either issue or deny a license to the new operator. The new operator shall be subject to all the terms and conditions under which the previous operator's license or temporary operating permit was issued. This includes any existing statement of deficiencies, plans of correction and compliance with any additional requirements imposed by the department as a result of any existing substantial noncompliance. The new operator, however, shall apply to the department for renewal in his/her/its name for any exception to the rules that had been granted the previous operator under the provisions of section (3) of this rule.

(I) The operator shall accompany each application for a license to operate a long-term care facility (skilled nursing facility, intermediate care facility, assisted living facility or residential care facility) with a license fee of one hundred dollars (\$100) for those facilities which have a resident capacity of at least three (3) but less than twenty-five (25), three hundred dollars (\$300) for those facilities which have a resident capacity of twenty-five through one hundred (25-100), and six hundred dollars (\$600) for those facilities with a capacity of over one hundred (100+). The operator shall submit a separate fee for each facility's license application. This fee is nonrefundable unless the facility withdraws the application within ten (10) days of receipt by the department. The department will issue a license for a period of no more than two (2) years for the premises and operator named in the application. If the license is for less than two (2) years, the department will prorate the fees accordingly.

(J) An operator may apply for licenses for two (2) or more different levels of care located on the same premises either by submitting one (1) application or by submitting a separate



application for each level of care. If an operator elects to submit one (1) application for two (2) or more levels of care located on the same premises—

1. The application shall specify separately the number of beds of each level of care being applied for;

2. The application shall be accompanied by a license fee for each level of care applied for, as required by subsection (1)(I) of this rule; and

3. An application for two (2) or more levels of care on the same premises shall indicate one (1) facility name only.

(K) The department shall issue a separate license for each level of care located on the same premises, whether applied for by one (1) application or more than one (1). If the operator uses one (1) application for two (2) or more levels of care on the same premises, the department shall issue licenses with one (1) expiration date. If two (2) or more levels of care have existing licenses with different expiration dates and the operator elects to apply for licenses for the levels of care by submitting one (1) relicensure application, the expiration dates of the licenses issued shall be two (2) years subsequent to the expiration date of the license of the level of care expiring earliest following receipt of the application by the department. Fees for unused portions of licenses resulting from the submission of one (1) application for two (2) or more levels of care are nonrefundable.

(L) After receiving a license application, the department shall review the application, investigate the applicant and the statements sworn to in the application for license and conduct any necessary inspections. A license shall be issued if—

1. The department has determined that the application is complete, and that all necessary documents have been filed with the application including an approved nursing home bond or noncancelable escrow agreement if personal funds of residents are held in trust;

2. The department has determined that the statements in the application are true and correct;

3. The department has determined that the facility and the operator are in substantial compliance with the provisions of sections 198.003–198.096, RSMo, and the corresponding rules;

4. The department has determined that the applicant has the financial capacity to operate the facility;

5. The department has verified that the administrator of a residential care facility that was licensed as a residential care facility II on August 27, 2006 and chooses to continue to

meet all laws, rules, and regulations that were in place on August 27, 2006 for a residential care facility II, assisted living facility, an intermediate care facility, or a skilled nursing facility is currently licensed by the Missouri Board of Nursing Home Administrators under the provisions of Chapter 344, RSMo;

6. The department has received the fee required by subsection (1)(I) of this rule;

7. The applicant meets the definition of operator as defined in 19 CSR 30-83.010;

8. The applicant has received a Certificate of Need, if required, or has received a determination from the Certificate of Need Program that no certificate is required, has completed construction, and is in substantial compliance with the licensure rules and laws;

9. The department has determined that neither the operator, owner, or any principals in the operation of the facility have ever been convicted of an offense concerning the operation of a long-term care facility or other health care facility or, while acting in a management capacity, ever knowingly acted or knowingly failed to perform any duty which materially and adversely affected the health, safety, welfare, or property of a resident;

10. The department has determined that neither the operator, owner, or any principals in the operation of the facility are excluded from participation in the Title XVIII (Medicare) or Title XIX (Medicaid) program of any state or territory;

11. The department has determined that neither the operator, owner, or any principals in the operation of the facility have ever been convicted of a felony in any state or federal court concerning conduct involving either management of a long-term care facility or the provision or receipt of health care services; and

12. The department has determined that all fees due the state have been paid.

(M) If, during the period in which a license is in effect, a change occurs which causes the statements in the application to no longer be correct, including change of administrator, or if any document is executed which replaces, succeeds or amends any of the documents filed with the application, within ten (10) working days of the effective date of the change, the operator shall—

1. Submit a letter to the department's Licensure and Certification Unit that contains a correction of the application with notification of the effective date of the change and a copy of any new documents. The operator must ensure the letter is signed by a person with the express authority to sign on behalf of the operator, who shall attest by signature that the information being submitted is true and

correct to the best of the operator's knowledge and belief; or

2. Submit to the department a correction of the application and a copy of any new documentation and information by submitting form Corrections for Long-Term Care Facility License Application referenced in paragraph (1)(C)2. of this rule.

(N) If from an analysis of financial information submitted with the application, or if from information obtained during the term of a license, the operator appears insolvent or shows a tendency toward insolvency, the department shall have the right to request additional financial information from the operator. Within ten (10) working days after receiving a written request from the department, the operator shall—

1. Submit to the department the additional information requested in a letter accompanied by a statement attesting by signature that the information being submitted is true and correct to the best of the operator's knowledge and belief; or

2. Submit the financial information to the department on form Corrections for Long-Term Care Facility License Application referenced in paragraph (1)(C)2. of this rule.

(O) A license applicant's financial information, data, and records submitted to the department as required by this rule, including, but not limited to, copies of any Internal Revenue Service forms, shall be open for inspection and be released only—

1. To designated employees of the department;

2. To the applicant furnishing this information or to his/her representative as designated in writing;

3. To the director of the department or to his/her representative as designated in writing;

4. To the state auditor or his/her representative as designated in writing;

5. To appropriate committees of the General Assembly or their representatives as designated in writing;

6. In any judicial or administrative proceeding brought under the Omnibus Nursing Home Act; or

7. When so ordered by a court of competent jurisdiction.

(P) To obtain a license for an additional level of care on the premises, the licensed operator shall submit a written request by electronic mail to LTCApplication@dhss.mo.gov, or mail to the department for the issuance of a license for the desired level of care. The request shall indicate the level of care, the number of beds desired, the name and address of the facility, the name and address of the operator, and shall include the signature of the



operator. The request shall be signed by a person with the express authority to sign on behalf of the operator, who shall attest by signature that the information submitted is true and correct to the best of the operator's knowledge and belief. The licensure fee shall accompany this request. Requests are subject to department approval. The operator shall submit this request no less than sixty (60) days prior to the initiation date of the new level of care. The department shall coordinate this license's expiration date with that of the original license and the department shall prorate the license fee accordingly.

(Q) To request issuance of an amended license or temporary operating permit currently in effect, the operator shall—

1. Submit a written request to the department containing the request for amendment, the date the operator would like the amendment to be effective, and the number of the license or temporary operating permit to be amended; and

2. Submit a fee for the issuance of the amended license or temporary operating permit as required by subsection (1)(R) of this rule.

(R) If an operator initiates a request to amend a license or temporary operating permit currently in effect, the department requires the following fees:

1. If the request is for an increase in bed capacity, the operator shall submit a fee with the request which is the greater of—

A. The amount that would have been required by subsection (1)(I) of this rule if the increase in bed capacity has been included in the application, less any amount actually paid under that subsection; or

B. Fifty dollars (\$50); and

2. If the request is for a decrease in resident capacity or any other change, the operator shall submit a fee of twenty-five dollars (\$25) with the request.

(S) The department shall approve all requests for bed changes prior to issuance of an amended license or temporary operating permit. The effective date of the amended license or temporary operating permit shall be no earlier than the date the department approved the request for bed change.

(T) If the department issues a temporary operating permit, and then subsequently issues a regular license, the licensing period shall include the period of operation under the temporary operating permit. The licensing period shall also include any period during which the department was enjoined or stayed from revoking or denying a license or rendering the temporary operating permit null and void.

(U) Unless an operator indicates otherwise, all the rooms and space on the premises and all persons eighteen (18) years of age and over living on the premises shall be considered as part of the facility and its licensed capacity or staff and shall be subject to compliance with all rules governing the operation of a licensed facility. If an operator, when applying or reapplying for a license, wants to exclude some portion of the premises from being licensed or wants to exclude a relative as a resident, a statement to that effect shall be filed as a separate document indicating the use which will be made of that area of the premises and who or what occupies the area, and what the relationship is of the relative(s) being excluded. The statement shall be signed by a person with the express authority to sign on behalf of the operator, who shall attest by signature that the information submitted is true and correct to the best of the operator's knowledge and belief.

(V) The operator shall not provide care in any area on the premises to any related person who requires protective oversight unless there has been a written request to the department to consider any portion of the facility for private use and that indicates facility staff shall not be used at any time to care for the relative(s). Prior to the area being used in that manner, the operator shall submit the request for the department's approval. The department, after investigation, shall approve or disapprove the request in writing within thirty (30) days and shall issue or reissue the license indicating clearly which portion of the premises is excluded from licensure or which specific relative(s) is/are not considered a resident(s).

(2) If a facility was licensed under Chapter 197 or 198, RSMo, and was in operation before September 28, 1979, or if an application was on file or construction plans were approved prior to September 28, 1979, the facility shall comply with construction, fire safety and physical plant rules applicable to an existing or existing licensed facility provided there has been continuous operation of the facility under a license or temporary operating permit issued by the division. If, however, there was an interruption in the operation of the facility due to license denial, license revocation, or voluntary closure, the facility may be relicensed utilizing the same fire safety, construction, and physical plant rules that were applicable prior to the license denial, license revocation, or voluntary closure provided that the facility reapplies for a license within one (1) year of the date of the denial, revocation, or voluntary closure. Regardless of licensure, application, or con-

struction plan approval date, intermediate care facilities and skilled nursing facilities shall comply with the fire safety standards published in 19 CSR 30-85.022.

(A) If a facility changes from a skilled nursing or intermediate care facility to any other level, or if the facility changes from an assisted living facility to a residential care facility, the facility shall comply with construction, fire safety, and physical plant rules applicable to an existing or existing licensed facility as defined in 19 CSR 30-83.010.

(B) If the facility changes from a residential care facility to any other level or if an assisted living facility changes to an intermediate care or skilled nursing facility, the facility shall comply with construction, fire safety, and physical plant rules applicable to a new or newly licensed facility as defined in 19 CSR 30-83.010.

(C) The facility shall comply with the rules applicable to a new or newly licensed facility if an application for relicensure has not been filed with the department within one (1) year of the license denial, license revocation, or voluntary closure. All such facilities seeking licensure as an assisted living facility shall also comply with the requirements of 19 CSR 30-86.047 and, if applicable, 19 CSR 30-86.045.

(3) Licensed Facility Closures.

(A) If a licensed facility discontinues operation as evidenced by the fact that no residents are in care or at any time the department is unable to freely gain entry into the facility to conduct an inspection, the facility shall be considered closed. The department shall notify the operator in writing requesting the voluntary surrender of the license. If the department does not receive the license within thirty (30) days, it shall be void. If the operator should choose to again license the facility, the operator shall submit a complete application. The provisions of section (1) shall apply.

(B) If any licensed skilled nursing facility or intermediate care facility is required to temporarily close for two (2) years or less from the effective date of the temporary closure due to staffing shortages as a result of a COVID-19 vaccine mandate first issued in emergency regulation by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) on November 4, 2021, effective on November 5, 2021, or any amendment changes or amendments thereafter, then the skilled nursing and intermediate care facilities shall do the following:

1. The facility operator shall submit a closure plan to the department which is in



compliance with state and federal law, including 42 CFR part 483.15(c) (detailed in federal deficiency F623 in the *State Operations Manual* appendix PP), 42 CFR part 483.70(l) (detailed in federal deficiency F845 in the *State Operations Manual* appendix PP), and 42 CFR 483.70(m) (detailed in federal deficiency F846 in the *State Operations Manual* appendix PP). The *State Operations Manual* appendix PP revised November 22, 2017, is incorporated by reference in this rule, as published by the Centers for Medicare and Medicaid Services and is available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf or the United States Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244. This rule does not incorporate any subsequent amendments or additions. After review of the temporary closure plan, the department shall either approve or disapprove the plan;

2. Facilities with approved closure plans by the department shall ensure that all residents residing at the facility are provided discharge notices in accordance with federal and state law and the facility shall assist all residents with discharge planning in accordance with federal and state law;

3. Facilities with approved closure plans by the department shall enter into a consent agreement with the department for a probationary license. These facilities shall agree to discharge all residents by the effective date of the temporary closure and to admit no residents while the facility is temporarily closed;

4. Temporary closure of facilities shall not be allowed past two (2) years from the effective date of the temporary closure. The effective date of the temporary closure is the date the last resident left the facility;

5. Facilities shall be reopened within two (2) years of the effective date of the temporary closure. Prior to reopening, the department shall conduct a full survey/inspection and the facility may be approved by the department to reopen after this survey or inspection. Facilities shall not reopen until approved by the department;

6. Facilities shall be reopened by the facility operator which initiated the temporary closure and a change of operator may not occur during this period of temporary closure;

7. Facilities shall submit plans of corrections, applications, licensure, and certification fees in accordance with state law regardless of temporary closure status;

8. Facilities approved by the department to be temporarily closed will be noted as temporarily closed on state directories. The

department will communicate temporary closure status of these facilities approved for temporary closure to CMS; and

9. Facilities not approved for temporary closure by the department which have closed or those facilities which stayed closed longer than two (2) years from the effective date of the temporary closure shall be considered closed. The department shall notify the operator in writing requesting the voluntary surrender of the license. If the department does not receive the license within thirty (30) days, it shall be void. If the operator should choose to again license the facility, the operator shall submit a complete application. The provisions of section (1) shall apply.

(4) The department may grant exceptions for specified periods of time to any rule imposed by the department if the department has determined that the exception to the rule would not potentially jeopardize the health, safety, or welfare of any residents of a long-term care facility.

(A) The owner or operator of the facility shall make requests for exceptions in writing to the director of the department. These requests shall contain—

1. A copy of the latest Statement of Deficiencies which shows a violation of the rule being cited, if the exception request is being made as a result of a deficiency issued during an inspection of the facility;

2. The section number and text of the rule being cited;

3. If applicable, specific reasons why compliance with the rule would impose an undue hardship on the operator, including an estimate of any additional cost that might be involved;

4. An explanation of any extenuating factors that may be relevant; and

5. A complete description of the individual characteristics of the facility or residents, or of any other factors that would safeguard the health, safety, and welfare of the residents if the exception were granted.

(B) With the advice of the division's licensure inspection field staff, the department will consider any requests that contain all the information required in subsection (4)(A). The department shall notify the operator, in writing, of the decision on any request for an exception, stating the reason(s) for acceptance or denial, and, if granted, the length of time the exception is to be in effect and any additional corrective factors upon which acceptance may be conditioned.

(C) The department shall only grant exceptions to licensure requirements set out in rules imposed by the department and cannot grant exceptions to requirements established

by state statute or federal regulations. Operators wishing to obtain waivers of regulations under Title XVIII or Title XIX of the Social Security Act shall follow procedures established by the Centers for Medicare and Medicaid (CMS).

(5) When the department issues a notice of noncompliance to a facility pursuant to the Omnibus Nursing Home Act (section 198.026, RSMo), the department, only after affording the facility operator a reasonable opportunity to remedy the situation, shall—

(A) Make every reasonable effort to provide residents of the facility or their legally authorized representatives or designees, if any—

1. A written notice of the noncompliance;

2. A list of other licensed facilities appropriate to the resident's needs; and

3. A list of agencies that will assist the resident if he/she moves from the facility; and

(B) After providing the information required by subsection (5)(A) and allowing a time period for the residents of the facility to relocate if they wish, notify the Social Security Administration in writing that a notice of noncompliance has been issued to the facility, and the effective date of the notice. If the facility achieves substantial compliance with standards and rules later, the department shall notify the Social Security Administration of the effective date of the facility's substantial compliance.

(6) A licensed facility shall comply with the provisions of Title VI of the Civil Rights Act 1964, as amended; Section 504 of the Rehabilitation Act of 1973; Title IX of the Education Amendment of 1972; the Age Discrimination Act of 1975; the Omnibus Budget and Reconciliation Act of 1982; the Americans with Disabilities Act of 1990; and the Keyes Amendment to the Social Security Act. No person shall be denied admission to, be denied benefits of, or be subjected to discrimination under any program, activity, or service provided by the facility based on his/her race, color, national origin, sex, religion, age, or disability, including Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS). Every licensed facility shall complete and sign form MO 580-2622 (9-05), Assurance of Compliance, incorporated by reference in this rule and available through the department's website at www.dhss.mo.gov or by telephone at (573) 526-8505 and file the form with the application for licensure or relicensure. This rule does not incorporate any subsequent



amendments or additions.

(7) The department shall make available by Internet at www.dhss.mo.gov to interested individuals or without charge a single copy of—

(A) A complete set of the standards promulgated for each type of facility;

(B) An explanation of the procedures used in the state to ensure the enforcement of standards;

(C) A list of any facilities granted exception from a standard, including the justification for the exception; and

(D) A list of any facilities issued notices of noncompliance, including the details of the noncompliance.

(8) Every skilled nursing facility, intermediate care facility, residential care facility, and assisted living facility issued a license or temporary operating permit by the department shall submit the required certificate of need quarterly surveys to the department on or before the fifteenth day of the first month following the previous Social Security quarter. (For example, for the Social Security quarter ending December 31, the due date is by January 15; for the Social Security quarter ending March 31, the due date is by April 15; for the Social Security quarter ending June 30, the due date is by July 15; and for the Social Security quarter ending September 30, the due date is by October 15). The information shall be submitted on the ICF/SNF Certificate of Need Quarterly Survey form or the RCF/ALF Certificate of Need Quarterly Survey form obtained from the Missouri Certificate of Need Program, PO Box 570, Jefferson City, MO 65102.

AUTHORITY: sections 198.018, 198.073, 198.076, and 198.079, RSMo 2016.* This rule was originally filed as 13 CSR 15-10.010. Emergency rule filed Sept. 7, 1979, effective Sept. 28, 1979, expired Jan. 24, 1980. Original rule filed Sept. 7, 1979, effective Jan. 12, 1980. Emergency amendment filed Jan. 15, 1980, effective Jan. 25, 1980, expired May 1, 1980. Amended: Filed Jan. 15, 1980, effective May 11, 1980. Amended: Filed Dec. 10, 1980, effective May 11, 1981. Amended: Filed Dec. 7, 1981, effective May 11, 1982. Rescinded and readopted: Filed July 13, 1983, effective Oct. 13, 1983. Emergency amendment filed Aug. 1, 1984, effective Aug. 13, 1984, expired Dec. 10, 1984. Amended: Filed Sept. 12, 1984, effective Dec. 13, 1984. Amended: Filed June 17, 1986, effective Oct. 24, 1986. Amended: Filed Aug. 1, 1988, effective Nov. 10, 1988. Emergency amendment filed Aug. 14, 1992,

effective Aug. 28, 1992, expired Dec. 25, 1992. Rescinded and readopted: Filed April 14, 1993, effective Oct. 10, 1993. Amended: Filed Feb. 13, 1998, effective Sept. 30, 1998. Moved to 19 CSR 30-82.010, effective Aug. 28, 2001. Amended: Filed Aug. 23, 2006, effective April 30, 2007. Amended: Filed March 13, 2008, effective Oct. 30, 2008. ** Emergency amendment filed Nov. 10, 2021, effective Nov. 29, 2021, expired May 27, 2022. Amended: Filed Nov. 10, 2021, effective May 30, 2022.

*Original authority: 198.018, RSMo 1979, amended 1984, 1987, 1988, 1994, 2007, 2014; 198.073, RSMo 1979, amended 1984, 1992, 1999, 2006, 2007; 198.076, RSMo 1979, amended 1984, 2007; and 198.079, RSMo 1979, amended 2007.

**Pursuant to Executive Order 21-07, 19 CSR 30-82.010, paragraphs (4)(A)1.-3. and subsection (4)(B) was suspended from April 22, 2020 through August 31, 2021.

19 CSR 30-82.015 Long-Term Care Receiverships

PURPOSE: This rule establishes guidelines for the determination of qualified receivers, maintenance of the list of receivers, and the selection and removal of receivers.

(1) A person requesting to act as a receiver shall submit a completed application to the department. The application shall include the following information:

(A) Full name of the receiver, date of birth and Social Security number;

(B) Information that establishes the receiver has the necessary experience to operate a long-term care facility or the ability to contract with another party for the operation of a facility; and

(C) Information that establishes the receiver has the financial capacity to operate a long-term care facility as a receiver in compliance with state laws and regulations.

(2) Based on the information submitted in the application, if the applicant has the necessary experience to operate a long-term care facility or the ability to contract with another party for the operation of a facility and the financial capacity to operate a facility, and the applicant does not have any disqualifying characteristics, the applicant will be approved to be a receiver. Disqualifying characteristics are defined as:

(A) The applicant has been convicted of a felony offense in any state or federal court arising out of conduct involving the operation or management of a long-term care facility or other health care facility or the provision or receipt of health care;

(B) The applicant has ever knowingly acted or knowingly failed to perform any duty which materially and adversely affected the

health, safety, welfare or property of a resident of a long-term care facility, while acting in a management capacity; or

(C) The applicant is under exclusion from participation in the Title XVIII (Medicare) or Title XIX (Medicaid) program of any state or territory.

(3) Once a completed application is received and approved, the person will be placed on the list of qualified receivers. Receivers will be placed on the list in the order their completed application was received. If two (2) or more completed applications are received on the same day, and any two (2) or more are approved, they will be placed on the list of qualified receivers in alphabetical order according to the receivers' last names.

(4) If any of the information in an application changes, or if a qualified receiver has any change of status, including a change in disqualifying characteristics, that could affect his/her ability to serve as a receiver, he/she must notify the department in writing within ten (10) working days. Given the additional information, the department will make a determination as to whether the receiver remains qualified to act as a receiver. If the receiver is no longer qualified, his/her name will be removed from the list of qualified receivers. The department will notify the receiver in writing of the removal.

(5) If the department otherwise becomes aware of a change in any information in the application or a change in status of a qualified receiver that affects the receiver's ability to serve as a receiver, the department may remove the receiver from the list of qualified receivers. The department will notify the receiver in writing of the removal.

(6) If a receiver no longer wishes to be included on the list of qualified receivers, the receiver shall notify the department in writing of his/her desire to be removed from the list and the effective date of the removal.

AUTHORITY: sections 198.009, RSMo 2000 and 198.105, RSMo Supp. 2003.* Emergency rule filed Sept. 12, 2003, effective Sept. 22, 2003, expired March 19, 2004. Original rule filed Sept. 12, 2003, effective Feb. 29, 2004.

*Original authority: 198.009, RSMo 1979, amended 1993, 1995 and 198.105, RSMo 1979, amended 1984, 2003.

19 CSR 30-82.020 Classification of Rules

PURPOSE: This rule adds to the classification of the standards for long-term care facilities as cited in chapters 13 CSR 15-12, 13



CSR 15-14, 13 CSR 15-15 and 13 CSR 15-16 and as required in section 198.085.1, RSMo.

(1) All rules relating to long-term care facilities licensed by the Division of Aging, other than those rules which are informational in character, shall be followed by a notation at the end of each rule, section, subsection or pertinent part. This notation shall consist of a Roman numeral(s). These Roman numerals refer to the class (either class I, class II or class III) of standard as designated in section 198.085.1, RSMo and will be used when that rule, section, subsection or portion of a rule carrying the notation is violated by the facility.

(2) In those instances where a particular rule, section, subsection or portion of a rule is followed by a notation consisting of more than one (1) Roman numeral, the lower classification shall be applied unless the division can show that the higher classification is merited because of the extent of the violation, the violations effect on residents or the impact when combined with other deficiencies. The division, on the Statement of Deficiency, shall indicate for the operator which classification has been applied and if the higher one is used, for what reason.

(3) A violation of a class I standard is one which would present either an imminent danger to the health, safety or welfare of any resident or a substantial probability that death or serious physical harm would result. If a violation of a class I standard is not immediately corrected, or corrective action instituted, the division shall proceed as required under section 198.029, RSMo. The division shall also take all other necessary steps to protect the health, safety or welfare of a resident which may include: initiation of license revocation action under section 198.036, RSMo; initiation of an action under section 198.067, RSMo; injunctive relief or assessment of a civil penalty, initiation of an action under section 198.070.6, RSMo; protection of residents from further abuse or neglect; initiation of an action under section 198.105 or 198.108, RSMo for appointment of a receiver; and appointment of a monitor under section 198.103, RSMo.

(4) A violation of a class II standard is one which has a direct or immediate relationship to the health, safety or welfare of any resident, but which does not create any imminent danger. When a violation is noted, the operator shall either correct the violation immediately or prior to the time of the reinspection or shall be correcting it in accordance with

the time schedules set out in the operator's approved plan of correction, as provided for under section 198.026.2, RSMo. If not, or the plan of correction is not approved and the violation not corrected, the violation will constitute substantial noncompliance under the Omnibus Nursing Home Act. After review by the division director or his/her designee, the division may initiate any action authorized by law, including those provided for in sections 198.026, 198.036, 198.067, 198.070.6, 198.103, 198.105 and 198.108, RSMo. Where specific standards are set out in sections 198.003–198.186, RSMo and are not otherwise classified, those standards will be treated as class II standards.

(5) A violation of a class III standard is one which has an indirect or a potential impact on the health, safety or welfare of any resident. When a violation is noted, the operator shall either correct the violation immediately or prior to the time of the reinspection, or shall be correcting it in accordance with the time schedules set out in the operator's approved plan of correction as provided for under section 198.026, RSMo. If not, if the plan of correction is not approved and the violation not corrected, a point value of one (1) point each will be noted for violations of each distinct class III standard not corrected; however, the points will not be assessed if there are five (5) or fewer class III standards violated.

(A) If the points total twenty (20) or more points, the facility will be deemed to be in substantial noncompliance under the Omnibus Nursing Home Act and the division may initiate any action as authorized by law, including issuance of a notice of noncompliance, as provided under section 198.026, RSMo.

(B) If the points total less than twenty (20) points, the points will remain on the facility's record until the time the violations are corrected and are noted as corrected during a reinspection. If during the reinspection a class III standard violated in the prior inspection continues to be violated, the previously assessed points will be doubled unless the operator immediately corrects the violation. If after the reinspection the points for all previously noted and left uncorrected violations of distinct class III standards total twenty (20) or more, the facility will be deemed to be in substantial noncompliance under the Omnibus Nursing Home Act and the division may take action as provided under section 198.026, RSMo.

(C) The division shall not revoke an operator's license to operate a long-term care facility for violations of class III standards unless—

1. The uncorrected violations taken all together present either an imminent danger to the health, safety or welfare of any resident or a substantial probability of death or serious physical harm; or

2. The operator or his/her agent knowingly acted or knowingly omitted any duty which would materially and adversely affect the health, safety, welfare or property of a resident.

(D) Points will not be assessed for class III violations if the operator can show that the violation had been corrected since it was initially noted, that the operator made a good faith effort, as judged by the division, to stay in compliance and that the violation again occurred for reasons beyond the operator's control.

(6) The division shall not initiate any action against an operator as authorized by law, including issuance of a notice of noncompliance for uncorrected violations of class II or III standards, unless the facility's record, the cited violations and the circumstances are reviewed by the director of the division or his/her designee.

*AUTHORITY: sections 198.009 and 198.085.1, RSMo 1986. * This rule was originally filed as 13 CSR 15-10.020. Original rule filed Dec. 10, 1981, effective May 13, 1982. Amended: Filed July 13, 1983, effective Oct. 13, 1983. Moved to 19 CSR 30-82.020, effective Aug. 28, 2001.*

**Original authority: 198.009, RSMo 1979 and 198.085, RSMo 1979, amended 1984.*

19 CSR 30-82.030 Assessment of Availability of Beds

(Rescinded March 30, 2020)

AUTHORITY: sections 197.318, RSMo Supp. 1992 and 198.009, RSMo 1986. This rule was originally filed as 13 CSR 15-10.030. Emergency rule filed June 17, 1986, effective June 27, 1986, expired Oct. 24, 1986. Original rule filed June 17, 1986, effective Oct. 24, 1986. Moved to 19 CSR 30-82.030, effective Aug. 28, 2001. Rescinded: Filed Aug. 28, 2019, effective March 30, 2020.

19 CSR 30-82.050 Transfer and Discharge Procedures

PURPOSE: This rule provides instructions for persons who are discharged from a licensed long-term care facility under involuntary circumstances. When this proposed rule becomes effective it will replace 13 CSR



15-9.010(17) which will be rescinded by subsequent rulemaking. This rule also includes the provisions of section 198.088, RSMo, applicable to transfer or discharge and the notice and due process required of all licensed facilities.

(1) For the purposes of this rule, the following terms shall be defined as follows:

(A) Transfer means moving a resident from one institutional setting to another institutional setting for care and under circumstances where the releasing facility has decided that it will not readmit the resident or a legally authorized representative of the resident has not consented or agreed with the transfer. Unless indicated otherwise from the context of this rule, a transfer shall be deemed the same as a discharge;

(B) Discharge means releasing from a facility or refusing to readmit a resident from a community setting under circumstances where the resident or a legally authorized representative of the resident has not consented or agreed with the move or decision to refuse readmittance. Refusal to readmit a former resident shall not constitute a discharge if the former resident has been absent from the facility for more than ninety (90) days;

(C) Consent to or agreement with transfer or discharge means one of the following:

1. The resident or a legally authorized representative of the resident has consented to, agreed with, or requested the discharge; or

2. The resident's treating physician has ordered the transfer and the releasing facility intends to readmit the resident if requested to do so;

(D) Consent of the resident means that the resident, with sufficient mental capacity to fully understand the effects and consequences of the transfer or discharge, consents to or agrees with the transfer or discharge; and

(E) Legally authorized representative of a resident means a duly appointed guardian or an attorney-in-fact who has current and valid power to make health care decisions for the resident.

(2) The facility shall permit each resident to remain in the facility unless—

(A) The transfer or discharge is appropriate because the resident's welfare and the resident's needs cannot be met by the facility;

(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(C) The safety of individuals in the facility

is endangered;

(D) The health of individuals in the facility would otherwise be endangered;

(E) The resident has failed, after reasonable and appropriate notice, to pay for (or have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge that resident only allowable charges under Medicaid; or

(F) The facility ceases to operate.

(3) When the facility transfers or discharges a resident under any of the circumstances specified in subsections (2)(A)–(E), the resident's clinical record shall be documented. The facility shall ensure that documentation for the transfer or discharge is obtained from—

(A) The resident's personal physician when transfer or discharge is necessary under subsections (2)(A)–(B); and

(B) A physician when transfer or discharge is necessary under subsection (2)(D); and

(C) The facility administrator or the facility director of nursing in all circumstances.

(4) Before a facility transfers or discharges a resident, the facility shall—

(A) Send written notice to the resident in a language and manner reasonably calculated to be understood by the resident. The notice must also be sent to any legally authorized representative of the resident and to at least one (1) family member. In the event that there is no family member known to the facility, the facility shall send a copy of the notice to the appropriate regional coordinator of the Missouri State Ombudsman's office;

(B) Include in the written notice the following information:

1. The reason for the transfer or discharge;

2. The effective date of transfer or discharge;

3. The resident's right to appeal the transfer or discharge notice to the director of the Department of Health and Senior Services or his/her designated hearing official within thirty (30) days of the receipt of the notice;

4. That a request for a hearing should be sent to Department of Health and Senior Services Appeals Unit, PO Box 570, 912 Wildwood Drive 3rd floor, Jefferson City, Missouri 65102-0570, by fax to (573) 751-0247, or by email to DHSS.Appeals@health.mo.gov and the phone number for the appeals unit is (573) 522-1699;

5. That filing an appeal will allow a resident to remain in the facility until the hearing is held unless a hearing official finds otherwise;

6. The location to which the resident is being transferred or discharged;

7. The name, address, and telephone number of the designated regional long-term care ombudsman office;

8. For Medicare and Medicaid certified facility residents with developmental disabilities, the mailing address and telephone number of the Missouri Protection and Advocacy Agency, 925 South Country Club Drive, Jefferson City, MO 65109, (573) 893-3333, or the current address and telephone number of the protection advocacy agency if it has changed. The protection and advocacy agency is responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act. For Medicare and Medicaid certified facility residents with mental illness, the address and telephone number of Missouri Protection and Advocacy Agency, the agency responsible for persons with mental illness under the Protection and Advocacy for Mentally Ill Individuals Act; and

(C) Record and document in detail in each affected resident's record the reason for the transfer or discharge. The recording of the reason for the transfer or discharge shall be entered into the resident's record prior to the date the resident receives notice of the transfer or discharge, or prior to the time when the transferring or discharging facility decides to transfer or discharge the resident.

(5) The notice of transfer or discharge described in this rule shall be made by the facility no less than thirty (30) days before the resident is to be transferred or discharged. In the case of an emergency discharge, the notice shall be made as soon as practicable before the discharge when it is specifically alleged in the notice that—

(A) The safety of individuals in the facility would be endangered under subsection (2)(C) of this rule and the notice contains specific facts upon which the facility has based its determination that the safety of said individuals would be so endangered;

(B) The health of individuals in the facility would be endangered under subsection (2)(D) of this rule and the notice contains specific facts upon which the facility has based its determination that the safety of said individuals would be so endangered;

(C) The resident's health has improved sufficiently to allow a more immediate transfer or discharge under subsection (2)(B) of this rule;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs under subsection (2)(A) of this rule; or



(E) The resident has not resided in the facility for thirty (30) days.

(6) Any resident of a facility who receives notice of discharge from the facility in which he/she resides may file an appeal of the notice with the Department of Health and Senior Services Appeals Unit, PO Box 570, 912 Wildwood Drive 3rd floor, Jefferson City, Missouri 65102-0570, by fax to (573) 751-0247, or by email to DHSS.Appeals@health.mo.gov within thirty (30) days of the date the resident received the discharge notice from the facility. The resident's legal guardian, the resident's attorney-in-fact appointed under sections 404.700-404.725, RSMo (Durable Power of Attorney Law of Missouri) or pursuant to sections 404.800-404.865, RSMo (Durable Power of Attorney for Health Care Act), or any other individual may file an appeal on the resident's behalf. A Nursing Facility Transfer or Discharge Hearing Request form (MO Form 886-3245) to request a hearing may be obtained from the Department of Health and Senior Services or the regional ombudsman. However, the use of a form is not required in order to file a request for a hearing. The request for a hearing shall be verified in writing by the resident, his/her legal guardian, attorney-in-fact, or any other party requesting a hearing on the resident's behalf by attesting to the truth of the resident's request for a hearing.

(7) The director of the Department of Health and Senior Services shall designate a hearing official to hear and decide the resident's appeal.

(A) The designated hearing official shall notify the resident, the state long-term care ombudsman and the facility that the request for a hearing has been received and that a hearing has been scheduled.

(B) The hearing may be held by telephone conference call or in person at any location the designated hearing official deems reasonably appropriate to accommodate the resident's needs.

(8) The discharge of the resident shall be stayed at the time the request for a hearing was filed unless the facility can show good cause why the resident should not remain in the facility until a written hearing decision has been issued by the designated hearing official. Good cause shall include, but is not limited to, those exceptions when the facility may notify the resident of a discharge from the facility with less than thirty (30) days notice as set forth in section (5) of this rule.

(A) The facility may show good cause for discharging the resident prior to a hearing

decision being issued by the designated hearing official by filing a written Motion to Set Aside the Stay with the Department of Health and Senior Services Appeals Unit at the address, fax number, or email address in paragraph (4)(B)4. The facility must provide a copy of the Motion to Set Aside the Stay to the resident, or to the resident's legally authorized representative and to at least one (1) family member, if one is known. In the event that a resident has no legally authorized representative and no known family members, then a copy of the Motion to Set Aside the Stay must be provided to the Missouri State Long-Term Care Ombudsman's Office.

(B) Within five (5) days after a written Motion to Set Aside the Stay has been filed with the Department of Health and Senior Services Appeals Unit the designated hearing official shall schedule a hearing to determine whether the facility has good cause to discharge the resident prior to a written hearing decision being issued. Notice of the good cause hearing need not be in writing. All parties and representatives who received a copy of the Motion to Set Aside the Stay under subsection (8)(A) of this rule shall also be notified of the good cause hearing.

1. The designated hearing official shall have the discretion to consolidate the facility's good cause hearing with the discharge hearing requested by the resident. In the case of an emergency discharge, an expedited hearing shall be held upon the request of the resident, legally authorized representative, family member, and in a case where notice was required to be sent to the regional ombudsman, to the state long-term care ombudsman, so long as the parties waive the ten- (10-) day notice requirement specified in section (9).

2. Subsequent to the good cause hearing, the designated hearing official shall issue an order granting or denying the facility's Motion to Set Aside the Stay. If the facility's good cause hearing and the resident's discharge hearing were consolidated, the order shall also set forth whether the facility may discharge the resident.

(9) Written notice of a hearing shall contain the date and time for the hearing and shall be mailed to the facility, the resident or the resident's legally authorized representative, and to any and all parties in interest, including any family members who received notice of the discharge, that are known to the designated hearing official. The written notice shall be mailed to the parties at least ten (10) days prior to the hearing.

(10) If the facility's good cause hearing and the resident's discharge hearing were not consolidated and the designated hearing official issues an order denying the facility's Motion to Set Aside the Stay, the designated hearing official shall schedule the discharge hearing subsequent to the date the order which denied the facility's motion was issued. After the hearing, the designated hearing official shall issue a written decision setting forth whether the facility may discharge the resident. The written decision shall be mailed to the facility, the resident or the resident's legally authorized representative and counsels for all parties, if any. If the state long-term care ombudsman's office received notice of the discharge, a copy of the hearing decision shall be sent to the ombudsman's office. If a member of the resident's family received notice of the discharge, a copy of the hearing decision shall be mailed to the family member upon request.

(11) The burden of showing that the facility has complied with all requirements for appropriate discharge of the resident shall be upon the facility. The resident may provide any additional evidence competent to show that the facility has not met its burden.

(12) The resident may obtain legal counsel, represent him/herself or use a relative, a friend or other spokesperson. All natural parties, including residents, sole proprietors of a facility and a partner of a facility operated in the partnership form of business, may represent themselves in a *pro se* capacity on behalf of the facility. Corporate operators of a facility may only be represented by an attorney licensed to practice law in Missouri.

(13) Hearings shall be subject to the hearing procedures found in 42 CFR Chapter IV, Part 483, subpart E, and the Missouri Administrative Procedures Act, specifically sections 536.070 through 536.080, RSMo, which include, but are not limited to, oral and written evidence, witnesses, objections, official notices, affidavits, transcripts, depositions and other discovery methods, sanctions, oral arguments and written briefs. Written medical statements by a physician, psychiatrist or psychologist shall be admitted as relevant and probative evidence and shall be given due weight in consideration by the director or his/her designated hearing official. An audiotape recording of the hearing shall be made unless it is agreed by both parties to substitute a certified transcript.

(14) If the decision is that there is no cause for discharge, the resident shall be permitted



to remain in the facility. If the decision is in the facility’s favor, the resident shall be granted an additional ten (10) days after the decision is received for purpose of relocation, and the facility shall assist the resident in making suitable arrangements for relocation. If the resident prevails and has already been discharged, the facility shall notify the resident, the qualified representative, or any other responsible party who will assure that the resident is made aware of the decision and that the resident may return to the facility. In the event that there are no beds available, the facility shall admit the resident to occupy the first available bed without regard to any waiting list maintained by the facility.

AUTHORITY: sections 192.2000, 198.009, and 198.088, RSMo 2016. This rule was originally filed as 13 CSR 15-10.050. Original rule filed Feb. 13, 1998, effective Sept. 30, 1998. Moved to 19 CSR 30-82.050, effective Aug. 28, 2001. Amended: Filed Sept. 1, 2021, effective March 30, 2022.*

Original authority: 192.2000, RSMo 1984, amended 2014; 198.009, RSMo 1979, amended 1993, 1995; and 198.088, RSMo 1997, amended 1988, 1989, 1994.

19 CSR 30-82.060 Hiring Restrictions—Good Cause Waiver

PURPOSE: This rule is being promulgated to establish the procedure by which persons with criminal convictions may seek a waiver allowing them to be employed by health care and mental health providers despite the hiring restrictions found in section 660.317, RSMo. The waivers are to be for “good cause” as defined by that statute. This rule sets forth both the procedure for seeking waivers and the facts and circumstances to be considered by the Department of Social Services in determining “good cause.”

(1) Definitions.

(A) Applicant means a person who has been or would be rejected for employment by a provider due to the hiring restrictions found in section 660.317, RSMo.

(B) Department means the Department of Health and Senior Services.

(C) Determination means the decision issued by the director of the Department of Health and Senior Services or the director’s designee based on the factual, procedural or causal issues of the request for waiver.

(D) Director means the director of the Department of Health and Senior Services.

(E) Good Cause Waiver means a finding that it is reasonable to believe that the restrictions imposed by section 660.317, RSMo, on

the employment of an applicant may be waived after an examination of the applicant’s prior work history and other relevant factors is conducted and demonstrates that such applicant does not present a risk to the health or safety of residents, patients or clients if employed by a provider.

(F) Provider means any person, corporation or association who—

1. Is licensed as an operator pursuant to Chapter 198, RSMo;

2. Provides in-home services under contract with the Department of Health and Senior Services;

3. Employs nurses or nursing assistants for temporary or intermittent placement in health care facilities;

4. Is an entity licensed pursuant to Chapter 197, RSMo;

5. Is a public or private facility, day program, residential facility or specialized service operated, funded or licensed by the Department of Mental Health; or

6. Is a licensed adult day care provider.

(G) Reference means a written statement of character, qualification or ability issued on behalf of the applicant by a person who is not related to or residing with the applicant requesting a good cause waiver.

(H) Sponsor means the current or potential employer of the applicant, or a training program, agency or school in which the applicant is or was a student enrolled for the purpose of earning a professional license, certification or otherwise becoming qualified to perform the duties of an occupation.

(2) Any person who is not eligible for employment by a provider due to the hiring restrictions found in section 660.317, RSMo, may apply to the director for a good cause waiver. If the director, or the director’s designee, determines that the applicant has demonstrated good cause, such restrictions prohibiting such persons from being hired by a provider shall be waived and such persons may be so employed unless rejected for employment on other grounds. Hiring restrictions based on the Department of Health and Senior Services’ employee disqualification list established pursuant to section 660.315, RSMo, are not subject to a waiver.

(3) The director, or the director’s designee, shall accept an application for a good cause waiver only if the application—

(A) Is submitted in writing by the applicant on the form provided by the department;

(B) Is legible;

(C) Is signed by the applicant;

(D) Includes an indication of the type of waiver that is being requested;

(E) Includes a complete history of residency since the earliest disqualifying offense or incident;

(F) Includes a complete employment history since the age of eighteen (18) years;

(G) Includes an attached explanation written by the applicant as to why the applicant believes he or she no longer poses a risk to the health, safety or welfare of residents, patients or clients;

(H) Includes an attached description written by the applicant of the events that resulted in each disqualifying offense or incident;

(I) Includes attached documentation on the applicant’s professional, vocational or occupational licensure, certification or registration history and current status, if any, in this state and any other state;

(J) Includes at least one (1) reference letter from a sponsor. If the applicant is not able to obtain a sponsor, the applicant shall so state, shall identify those potential sponsors who have been approached by the applicant, and shall submit three (3) reference letters from individuals knowledgeable of the applicant’s character or work history who are not related to or residing with the applicant;

(K) Includes a criminal history record from the Missouri State Highway Patrol if requesting a waiver of disqualifying criminal offenses;

(L) Includes a certified court document for each disqualifying criminal offense. If such document is not obtainable, a written and signed statement from the court indicating that no such record exists must be submitted;

(M) Includes certified investigative reports from the Department of Social Services if requesting a waiver of child abuse or neglect findings or a waiver of foster parent license denial, revocation, or involuntary suspension;

(N) Includes certified investigative reports or other documentation of the incident(s) which resulted in the applicant’s inclusion on all other lists in the Family Care Safety Registry for which waiver is requested; and

(O) If in addition to the criminal offense(s) for which the applicant is requesting a waiver the applicant has any pending felony or misdemeanor charges, includes a statement explaining the circumstances and certified copies of the charging documents for all pending criminal charges; and, in the case of an applicant seeking a position with an in-home services provider agency or home health agency, if in addition to the circumstances related to the listing on any of the background checklists of the Family Care Safety Registry for which the applicant is requesting a waiver the applicant has any



pending circumstances which if established would lead to an additional listing on any of the background checklists of the Family Care Safety Registry, includes a statement explaining the circumstances and certified copies of documents relating to those circumstances.

(4) The director, or the director's designee, will not consider any application for a good cause waiver unless it is fully completed, signed by the applicant, and contains all required attachments.

(5) Each completed application will be reviewed by a good cause waiver committee of two (2) or more employees of the department. The director shall determine the size of the committee and shall, from time to time, appoint members to serve on the committee.

(A) If the applicant seeks a good cause waiver of placement on the disqualification list maintained by the Department of Mental Health, the director shall appoint an employee of the Department of Mental Health recommended by the director of the Department of Mental Health to serve on the good cause waiver committee.

(B) A member of the good cause waiver committee shall recuse himself or herself in a good cause waiver review in which the member's impartiality might reasonably be questioned, including but not limited to instances where the committee member has a personal bias or prejudice concerning the applicant, or personal knowledge of evidentiary facts concerning the application for good cause waiver.

(6) The department may, at any time during the application process or review thereof, request additional information from the applicant. If the applicant fails to supply any requested additional information within thirty (30) calendar days of the date of the request, unless the applicant requests and the department grants an extension, the department will consider the application for good cause waiver to be withdrawn by the applicant.

(7) The department may request the applicant, prior to the completion of the review, to appear in person to answer questions about his or her application. If the applicant is requested to appear in person, the department, in its sole discretion, shall determine the location for the appearance and may conduct any such proceedings using electronic means, including but not limited to telephonic or video conferencing. The department shall review and may investigate the information contained in each application for completeness, accuracy and truthfulness. The

burden of proof shall be upon the applicant to demonstrate that he or she no longer poses a risk to the health, safety or welfare of residents, patients or clients. The following factors shall be considered in determining whether a good cause waiver should be granted:

(A) The applicant's age at the time the crime was committed or at the time the incident occurred that resulted in the applicant being listed on the background checklists in the Family Care Safety Registry;

(B) The circumstances surrounding the crime or surrounding the incident that resulted in the applicant being listed on the background checklists in the Family Care Safety Registry;

(C) The length of time since the conviction or since the occurrence of the incident that resulted in the applicant being listed on the background checklists in the Family Care Safety Registry;

(D) The length of time since the applicant completed his or her sentence for the disqualifying conviction(s), whether or not the applicant was confined, conditionally released, on parole or probation;

(E) The applicant's entire criminal history and entire history of all incidents that resulted in the applicant being listed on the background checklists in the Family Care Safety Registry, including whether that history shows a repetitive pattern of offenses or incidents;

(F) The applicant's prior work history;

(G) Whether the applicant had been employed in good standing by a provider but subsequently became ineligible for employment due to the hiring restrictions in section 660.317, RSMo;

(H) Whether the applicant has been convicted or found guilty of, or pled guilty or *nolo contendere* to any offense displaying extreme brutality or disregard for human welfare or safety;

(I) Whether the applicant has omitted a material fact or misrepresented a material fact pertaining to his or her criminal or employment history or to his or her history of incidents that resulted in his or her being listed on the background checklists in the Family Care Safety Registry;

(J) Whether the applicant has ever been listed on the Employee Disqualification List maintained by the department as provided in section 660.315, RSMo;

(K) Whether the applicant's criminal offenses were committed, or the incidents that resulted in the applicant being listed on the background checklists in the Family Care Safety Registry occurred, during the time he or she was acting as a provider or as an

employee for a provider;

(L) Whether the applicant has, while disqualified from employment by a provider, obtained employment by fraud, deceit, deception or misrepresentation, including misrepresentation of his or her identity;

(M) Whether the applicant has ever had a professional or occupational license, certification, or registration revoked, suspended, or otherwise disciplined;

(N) Any other information relevant to the applicant's employment background or past actions indicating whether he or she would pose a risk to the health, safety or welfare of residents, patients or clients; and

(O) Whether the applicant has supplied all information requested by the department.

(8) If, at the time of an application for a waiver, or during the waiver consideration process, the applicant has been charged or indicted for, but not convicted of, any of the crimes covered under the provisions of section 660.317, RSMo, the division will hold the request for waiver in abeyance while such charges are pending or until a court of competent jurisdiction enters a judgment or order disposing of the matter.

(9) Each applicant who submits a waiver application meeting the requirements of section (3) of this rule shall be notified in writing by the director, or the director's designee, as to whether his or her application has resulted in a determination of good cause or no good cause. Such notification shall be effective if sent to the applicant's address given on the application.

(10) Any good cause waiver granted to an applicant applies only to:

(A) The specific disqualifying conviction(s), finding(s) of guilt, plea(s) of guilty or *nolo contendere*, as contained in the certifying copies of the court documents which are required in the application; and/or

(B) The incident(s) that resulted in the applicant being listed on the background checklists in the Family Care Safety Registry, as contained in the investigative reports or other supporting documentation required in the application or subsequently requested by the department.

(11) Any good cause waiver granted to an applicant applies only to those disqualifying criminal convictions on incidents that resulted in the applicant being listed on the background checklists in the Family Care Safety Registry, as covered under the provisions of section 660.317, RSMo, and shall not apply to any other hiring restriction or exclusion



imposed by any other federal or state laws or regulations.

(12) The director, or the director's designee, may withdraw a good cause waiver if it receives information or finds that—

(A) The applicant has omitted a material fact or misrepresented a material fact in seeking a good cause waiver;

(B) The applicant has been subsequently convicted or found guilty of, or pled guilty or *nolo contendere* to any class A or B felony violation of Chapter 565, 566, or 569, RSMo, or any violation of subsection 3 of section 198.070, RSMo, or section 568.020, RSMo, in this state or any other state;

(C) Such applicant is a prospective or current employee of an in-home services provider or home health agency and has been subsequently involved in an incident that results in the applicant being listed on any of the background checklists in the Family Care Safety Registry;

(D) The applicant has omitted, misrepresented or failed to disclose or provide any of the information required by section 660.317, RSMo, or the provisions of this rule; or

(E) There has been a material change in the circumstances upon which the good cause waiver was granted.

(13) If the good cause waiver is withdrawn by the department, the notice of such withdrawal shall be mailed by the department to the applicant's last known address, with a copy of the notice sent to the applicant's last known employer, if any.

(14) No applicant may be employed in a direct care or direct service position with a provider during the pendency of a request for waiver unless the applicant has been continuously employed by that provider prior to August 28, 2003. If an applicant is employed on or after August 28, 2003, he or she may be employed following submission of a completed waiver application on a conditional basis to provide in-home services or home health services to any in-home services client or home health patient during the pendency of that waiver application if:

(A) The disqualifying crime is not one that would preclude employment pursuant to subsection 6 of section 660.317, RSMo; and

(B) The applicant is not listed on the Department of Health and Senior Services' employee disqualification list established pursuant to section 660.315, RSMo.

(15) If a waiver is denied to an applicant employed on or after August 28, 2003, on a conditional basis, the conditional employment shall immediately terminate.

(16) Applicants who have been denied a good cause waiver, or who have had their good cause waivers withdrawn by the department, may reapply one (1) time every twelve (12) months, or whenever the circumstances related to the disqualifying conviction(s) have changed.

(17) Each provider shall be responsible for—

(A) Requesting criminal background checks on all prospective employees, regardless of waiver status, in accordance with the provisions of sections 660.317 and 43.540, RSMo; and

(B) Contacting the department to confirm the validity of a prospective employee's good cause waiver prior to hiring the prospective employee if the prospective employee reveals the existence of a good cause waiver or reveals the existence of an otherwise disqualifying circumstance.

(18) Each in-home services provider or home health provider shall also be responsible for—

(A) Requesting Family Care Safety Registry background screenings on all prospective employees, regardless of waiver status, in accordance with the provisions of section 660.317.7, RSMo; and

(B) Contacting the department to confirm the validity of a prospective employee's good cause waiver prior to hiring the prospective employee if the prospective employee reveals the existence of a good cause waiver or reveals the existence of an otherwise disqualifying circumstance.

(19) All applications for good cause waivers and related documents shall become permanent records maintained by the department.

*AUTHORITY: sections 660.017, RSMo 2000, 660.050 and 660.317, RSMo Supp. 2003. * This rule was originally filed as 13 CSR 15-10.060. Emergency rule filed March 1, 1999, effective March 30, 1999, expired Jan. 10, 2000. Original rule filed March 1, 1999, effective Sept. 30, 1999. Moved to 19 CSR 30-82.060, effective Aug. 28, 2001. Emergency amendment filed Oct. 15, 2003, effective Oct. 26, 2003, expired April 22, 2004. Amended: Filed Oct. 15, 2003, effective April 30, 2004.*

**Original authority: 660.017, RSMo 1993, amended 1995; 660.050, RSMo 1984, amended 1988, 1992, 1993, 1994, 1995, 2001; and 660.317, RSMo 1996, amended 1997, 1998, 2002, 2003.*

19 CSR 30-82.070 Alzheimer's Demonstration Projects
(Rescinded September 30, 2013)

AUTHORITY: section 198.534, RSMo Supp. 1999. This rule was originally filed as 13 CSR 15-10.070. Emergency rule filed April 14, 2000, effective April 24, 2000, expired Feb. 1, 2001. Original rule filed April 14, 2000, effective Nov. 30, 2000. Moved to 19 CSR 30-82.070, effective Aug. 28, 2001. Rescinded: Filed March 11, 2013, effective Sept. 30, 2013.

19 CSR 30-82.080 Nursing Facility Quality of Care Improvement Program

PURPOSE: This rule explains the requirements for receiving funding from the Nursing Facility Quality of Care (NFQC) Fund to improve the quality of service the facility provides to its residents.

(1) Definitions.

(A) Qualified Facility—Any facility licensed pursuant to Chapter 198, RSMo, that has received a Class I or Uncorrected Class II Notice of Noncompliance within the past twelve (12) months in one (1) of the following areas:

1. For Residential Care Facility I (RCF I) and Residential Care Facility II (RCF II):

A. Administrative, Personnel and Resident Care (19 CSR 30-86.042);

B. Dietary (19 CSR 30-86.052); or

C. Resident Rights (19 CSR 30-88.010);

2. For Skilled Nursing Facility (SNF) and Intermediate Care Facility (ICF):

A. Administration and Resident Care (19 CSR 30-85.042)

B. Dietary (19 CSR 30-85.052); or

C. Resident Rights (19 CSR 30-88.010).

(B) Quality Improvement Project for Missouri (QIPMO) consultation—Provides technical assistance and support to nursing facility staff throughout the state in order to improve the quality of care in nursing facilities using the Minimum Data Set (MDS) and on-site clinical consultation.

(2) Selection of Qualified Facilities.

(A) Qualified facilities may submit a written request to the department for funds from the Nursing Facility Quality of Care (NFQC) Fund to pay for QIPMO assistance and support. The department will provide a written response to the qualified facility's request approving or disapproving the use of NFQC funding for QIPMO assistance. In the absence of extraordinary circumstances, a qualified facility shall receive no more than one thousand dollars (\$1,000) per request. A qualified facility which wishes to receive more than one thousand dollars (\$1,000) per



request must separately justify reimbursement in excess of one thousand dollars (\$1,000) by setting forth the extraordinary circumstances justifying reimbursement in excess of one thousand dollars (\$1,000). The department may, in its sole discretion, approve reimbursement in excess of one thousand dollars (\$1,000).

(B) Qualified facilities may also submit to the department proposals describing implementation of a quality improvement program, in lieu of the QIPMO Program. Such proposals shall address areas of noncompliance that have been cited in the notice of noncompliance issued in the past twelve (12) months. Upon approval of the proposal by the department, the department may use funds in the NFQC Fund that have been collected from state civil money penalties to fund the qualified facility's proposal. In the absence of extraordinary circumstances, a qualified facility shall receive no more than one thousand dollars (\$1,000) per proposal. A qualified facility which wishes to receive more than one thousand dollars (\$1,000) per proposal must separately justify reimbursement in excess of one thousand dollars (\$1,000) by setting forth the extraordinary circumstances justifying reimbursement in excess of one thousand dollars (\$1,000). The department may, in its sole discretion, approve reimbursement in excess of one thousand dollars (\$1,000).

(C) The department may impose upon a qualified facility a directed plan of correction, as set forth in section 198.066, RSMo, which includes QIPMO consultation. Funding for the QIPMO consultation may be taken from the NFQC Fund, not to exceed one thousand dollars (\$1,000), unless the department, in its sole discretion, determines reimbursement in excess of one thousand dollars (\$1,000) is justified by extraordinary circumstances.

(3) The qualified facility will submit to the department the paid invoice(s) for the QIPMO consultation or other quality improvement program. The department will reimburse the qualified facility for the amount granted.

AUTHORITY: section 198.067.6, RSMo Supp. 2003. Emergency rule filed Sept. 12, 2003, effective Sept. 22, 2003, expired March 19, 2004. Original rule filed Sept. 12, 2003, effective Feb. 29, 2004.*

**Original authority: 198.067, RSMo 1979, amended 1989, 1996, 1999, 2003.*