



RULES OF
**Department of Health and Senior
Services**
Division 30—Division of Regulation and Licensure
Chapter 20—Hospitals

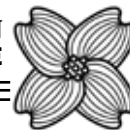
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TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES

**Division 30 – Division of Regulation and Licensure
Chapter 20 – Hospitals**

19 CSR 30-20.001 Anesthesiologist Assistants in Hospitals
(Rescinded November 30, 2019)

AUTHORITY: sections 192.006 and 197.080, RSMo 2000. Original rule filed Jan. 16, 2007, effective Aug. 30, 2007. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.011 Definitions Relating to Hospitals

PURPOSE: This rule defines terminology used throughout this chapter.

(1) Automated Dispensing System—An automated system that is used to dispense medication to patients pursuant to a patient-specific prescription or patient-specific medication order using an electronic verification system. An automated dispensing system does not include an automated system used for compounding medication or an automated filling system governed by 20 CSR 2220-2.950.

(2) Chemical Restraint—A drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.

(3) Chief executive officer—The individual appointed by the governing body to act in its behalf in the overall management of the hospital.

(4) Chief operating officer—The individual appointed by the chief executive officer on behalf of the governing body or the individual who is responsible for the management of one (1) hospital in a multi-hospital organization under the direction of the chief executive officer of the organization.

(5) Compounding—The preparation, incorporation, mixing and packaging, or labeling of a drug or device as the result of a prescriber’s prescription or prescription drug order based on the prescriber/patient/pharmacist relationship in the course of professional practice. Compounding may also be defined as the preparation, incorporation, mixing and packaging, or labeling of a drug or device, for the purpose of, or as an incident to, research, teaching or chemical analysis and not for sale or dispensing purposes.

(6) Defined service area—The geographic area served by a defined group of hospitals and emergency services.

(7) Department—Missouri Department of Health and Senior Services.

(8) Diversion—Temporary closure of a hospital emergency department to ambulance traffic.

(A) Defined service area—The geographic area served by a defined group of hospitals and emergency services. In areas where there is a community-based emergency medical services diversion plan, the service area(s) defined as the catchment area by the plan will be the defined service area(s). In areas where there is not a community-based emergency medical services diversion plan, the defined service area will be a twenty- (20-)

mile radius from a hospital.

(9) Hospital—

(A) A facility that provides inpatient care for medical or surgical patients, or both, and may include pediatric, obstetrical and newborn, psychiatric, or rehabilitation patients; and

(B) A facility that is devoted primarily for the diagnosis, treatment, or care for not less than twenty-four (24) consecutive hours in any week of three (3) or more nonrelated individuals suffering from illness, disease, injury, deformity, or other abnormal physical conditions, or devoted primarily to provide for not less than twenty-four (24) consecutive hours in any week medical or nursing care for three (3) or more nonrelated individuals and includes;

(C) Building(s) —

1. Constructed to hospital standards as outlined in 19 CSR 30-20.030; and

2. Identified on the hospital’s license application as part of the facility; and

(D) The term “hospital” does not include convalescent, nursing, shelter, or boarding homes as defined in Chapter 198, RSMo.

(10) Immediate and serious threat—A situation in which a hospital’s non-compliance with one (1) or more requirements established under the Hospital Licensing Law or section 197.005, RSMo has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident or patient. Unless the language or context clearly indicates otherwise, this definition is intended to have the same meaning, to the extent practicable, as the definition of immediate jeopardy in 42 CFR section 488.1 (2018). The *Code of Federal Regulations* is published by the U.S. Government and is available by calling toll-free (866) 512-1800 or going to <https://bookstore.gpo.gov/>. The address is: U.S. Government Publishing Office, U.S. Superintendent of Documents, Washington, DC 20402-0001. This rule does not incorporate later amendments or additions to 42 CFR section 488.1 (2018).

(11) Infectious waste—Waste capable of producing an infectious disease. Infectious waste shall include the following categories:

(A) Blood and blood products—All human blood and blood products including serum, plasma, and other components known or suspected to be contaminated with a transmissible agent;

(B) Microbiologic cultures and stocks of infectious agents and associated biological agents;

(C) Isolation wastes—Discarded waste contaminated with excretions, exudates, and secretions from patients with highly communicable diseases treated in isolation;

(D) Pathology wastes include human tissues and body parts that are removed during surgery and autopsy;

(E) Contaminated sharps—All discarded sharps including needles, syringes scalpels broken glass or other sharp items that have come in contact with potentially infectious material; and

(F) Animal waste—Discarded material originating from animals inoculated with infectious agents during research, production of biological or pharmaceutical testing.

(12) Inpatient—A person admitted into a hospital by a member of the medical staff for diagnosis, treatment, or care.

(13) Intern Pharmacist—An individual seeking to earn pharmacy practice experience in Missouri.



(14) Licensed practitioner – Any individual who is licensed in Missouri or in another state and is qualified to practice a health care profession.

(15) Long-term care unit – A unit attached to or contained within a hospital that is operated as a skilled nursing unit.

(16) Operator – A person with –
(A) Ultimate responsibility for making and implementing decisions regarding the operation of the hospital; and
(B) Ultimate financial control of the operation of the hospital, including any management consultant or contracted entity who exercises control over the operation of the facility on a day-to-day basis.

(17) Patient – A person who presents to the hospital seeking diagnosis, treatment, or care.

(18) Pharmacist – An individual who is currently licensed under Chapter 338, RSMo, to practice pharmacy in the state of Missouri.

(19) Pharmacy technician – An individual who is currently registered under Chapter 338, RSMo, as a pharmacy technician in the state of Missouri.

(20) Physician – An individual who is currently licensed under Chapter 334, RSMo, to practice medicine in Missouri.

(21) Registered professional nurse – An individual who is licensed under Chapter 335, RSMo, to practice as a registered professional nurse in the State of Missouri.

(22) Repackage – To remove any drug from the original manufacturer's container and place the drug in a dispensing container for other than immediate dispensing to a patient.

(23) Resident – A person who by reason of aging, illness, disease, or physical or mental infirmity requires care and services furnished by a long-term care unit and who resides within the unit for care and treatment.

(24) Respiratory Care Practitioner – An individual who is licensed under Chapter 334, RSMo, to practice respiratory care in the State of Missouri.

(25) Root cause analysis – A process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.

(26) Unit – A functional division or facility of the hospital.

(27) Unlicensed Assistive Personnel (UAP) – unlicensed health care personnel who provide direct patient care twenty-five percent (25%) or more of the time, under the delegation and supervision of a registered professional nurse. Individuals who provide a specific job function such as, but not limited to, phlebotomist, radiology technician, or patient transporter are not included in this definition.

AUTHORITY: sections 192.006, 197.154, and 338.165, RSMo 2016, and sections 197.080 and 197.293, RSMo Supp. 2019.* This rule was previously filed as 13 CSR 50-20.011. Original rule filed June 2, 1982, effective Nov. 11, 1982. Amended: Filed June 2, 1987, effective

Sept. 11, 1987. Amended: Filed Aug. 16, 1988, effective Dec. 29, 1988. Amended: Filed Nov. 21, 1995, effective July 30, 1996. Amended: Filed Oct. 6, 1998, effective April 30, 1999. Amended: Filed June 28, 2001, effective Feb. 28, 2002. Amended: Filed Sept. 20, 2005, effective April 30, 2006. Amended: Filed March 20, 2019, effective Nov. 30, 2019.

*Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995, 2017; 197.154, RSMo 2004; 197.293, RSMo 2000, amended 2004, 2017; and 338.165, RSMo 2014.

19 CSR 30-20.013 Incorporation of Medicare Conditions of Participation

PURPOSE: This rule incorporates the Medicare Conditions of Participation into the hospital regulations.

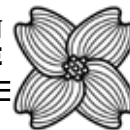
PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency 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) State Licensure Requirements.
(A) This rule incorporates by reference 42 CFR Part 485 (2017), Medicare Conditions of Participation: Critical Access Hospitals, for Missouri licensed critical access hospitals. The Code of Federal Regulations is published by the U.S. Government and is available by calling toll-free (866) 512-1800 or going to https://bookstore.gpo.gov/. The address is: U.S. Government Publishing Office, U.S. Superintendent of Documents, Washington, DC 20402-0001. This rule incorporates later amendments and additions to 42 CFR Part 485 (2017). Missouri licensed critical access hospitals shall strictly meet the Medicare Conditions of Participation, and surveys performed for state licensure will be conducted per Medicare standards.

(B) This rule incorporates by reference 42 CFR Part 482 (2017), Medicare Conditions of Participation: Hospitals, for Missouri licensed hospitals. The Code of Federal Regulations is published by the U.S. Government and is available by calling toll-free (866) 512-1800 or going to https://bookstore.gpo.gov/. The address is: U.S. Government Publishing Office, U.S. Superintendent of Documents, Washington, DC 20402-0001. This rule incorporates later amendments and additions to 42 CFR Part 482 (2017). Missouri licensed hospitals shall strictly meet the Medicare Conditions of Participation and surveys performed for state licensure will be conducted per Medicare standards.

(C) This rule incorporates by reference 42 CFR Part 482 (2017), Medicare Conditions of Participation: Psychiatric Hospitals, for Missouri licensed psychiatric hospitals. The Code of Federal Regulations is published by the U.S. Government and is available by calling toll-free (866) 512-1800 or going to https://bookstore.gpo.gov/. The address is: U.S. Government Publishing Office, U.S. Superintendent of Documents, Washington, DC 20402-0001. This rule incorporates later amendments and additions to 42 CFR Part 482 (2017). Missouri licensed psychiatric hospitals shall strictly meet the Medicare Conditions of Participation and surveys performed for state licensure will be conducted per Medicare standards.

AUTHORITY: sections 197.005 and 197.080, RSMo Supp. 2017, and section 536.031, RSMo Supp. 2018.* Emergency rule filed Feb. 14,



2019, effective Feb. 24, 2019, expired Aug. 22, 2019. Original rule filed Feb. 14, 2019, effective July 30, 2019.

**Original authority: 197.005, RSMo 2017; 197.080, RSMo 1953, amended 1993, 1995, 2013, 2017; and 536.031, RSMo 1975, amended 1976, 1989, 2004, 2016, 2018.*

19 CSR 30-20.015 Administration of the Hospital Licensing Program

PURPOSE: This rule formalizes the hospital licensing policies being carried out by the Department of Health. It prescribes procedures for the review of hospital records, acceptance of plans of deficiency correction and suspension of a hospital license.

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 intending to operate a hospital shall submit information to the Department of Health and Senior Services, as set out in the application form (MO 580-0007(8-18)) which is included herein. Within thirty (30) days after receipt of the application, the applicant will be notified of any omitted information or documents. After sixty (60) days any incomplete application is null. The department may deny a license application in any case which it finds that there has been a substantial failure to comply with the requirements for hospitals in Chapter 197, RSMo, and the regulations promulgated thereunder. Each application for license to operate a hospital shall be accompanied by the appropriate licensing fee, except applications from governmental units, required by section 197.050, RSMo.

(2) Each license shall be issued only for the premises identified on the application for hospital license and entity named in the application. All locations included in the hospital application for hospital license shall meet the definition of "premises" as stated in 19 CSR 30-20.011. No license shall be issued unless the applicant is in substantial compliance with Chapter 197, RSMo and the regulations promulgated thereunder. A license, unless sooner revoked, shall be issued for a period of up to a year. If during the period in which a license is in effect, a licensed operator which is a partnership, limited partnership, or corporation undergoes any of the following changes, whether by one (1) or by more than one (1) action, the operator shall within fifteen (15) working days of such change apply for a new license:

(A) With respect to a partnership, a change in the majority interest of general partners;

(B) With respect to a limited partnership, a change in the general partner or in the majority interest of limited partners;

(C) With respect to a corporation, a change in the persons who own, hold, or have the power to vote the majority of any class of securities issued by the corporation. If the corporation does not have stock, a change of owner occurs when the emerging entity has a new federal tax number; or

(D) The board of directors with management control is an entity other than the licensed operator.

(3) The operator of a licensed hospital shall notify the department in writing within fifteen (15) days of –

(A) A change of ownership of the hospital; or

(B) Any extensive modification, modification, or reconstruction of the licensed premises, as identified in the life safety code standards in 42 CFR Part 482 (2018) and 42 CFR Part 485 (2018), which are incorporated by reference in this rule. The *Code of Federal Regulations* is published by the U.S. Government and is available by calling toll-free (866) 512-1800 or going to <https://bookstore.gpo.gov/>. The address is: U.S. Government Publishing Office, U.S. Superintendent of Documents, Washington, DC 20402-0001. This rule incorporates later amendments and additions to 42 CFR Part 482 (2018) and 42 CFR Part 485 (2018).

(4) An operator of two (2) or more licensed hospitals may submit an initial application to the Department of Health and Senior Services to operate the hospitals as a single licensed hospital. The two (2) or more licensed hospitals may be separated by a distance which can be traveled in no more than one (1) hour by customary ground transportation in normal weather conditions. The operator shall designate a permanent hospital base from which the one- (1-) hour travel distance is determined. If the application is approved, the hospitals may be named on the licensure application and a single license issued. Before the Department of Health and Senior Services approves the application, the applicant shall submit an operational proposal to the director of the Department of Health and Senior Services for approval. At a minimum the proposal shall include:

(A) Approval from the Certificate of Need program if a Certificate of Need is required under sections 197.300–197.367, RSMo;

(B) Assurance that the applicant presented the initial proposal at a public hearing within the community where the currently licensed hospital(s) is located. The proposal shall provide evidence that the entire community was adequately notified at least two (2) weeks in advance, of the public hearings. The written record of the hearings, including the community response to the proposal, shall be submitted to the Department of Health and Senior Services as a part of the applicant's proposal. The Department of Health and Senior Services shall be given two (2) weeks advance notice of the public hearings. The Department of Health and Senior Services may consider the information presented as part of the determination process; and

(C) Assurance that the initial applicant is in compliance with Chapter 197, RSMo, and the regulations promulgated thereunder.

The above criteria is for initial application for single hospital licensure. The annual renewal for the single licensed hospitals will follow the annual licensure process.

(5) The license shall state the maximum licensed bed capacity, the hospital name, issue date, expiration date, and additional information, such as a specialty hospital designation, that the department may require. At least forty-five (45) days prior to the expiration date of an existing license, the department shall notify the operator that the license application is due for renewal. An annual application shall be submitted no more than ninety (90) days and not less than thirty (30) days prior to the expiration date of the existing license. Each application for license, except application from governmental units, shall be accompanied by a licensing fee in accordance with section 197.050, RSMo.



(6) Appointed representatives of the Department of Health and Senior Services, Bureau of Hospital Standards shall be allowed to review patient medical records and hospital employee personnel records in the course of conducting an investigation of allegations against an employee or previous employees of a hospital or allegations of substandard care regarding a patient.

(7) The nursing service administrator shall be a full-time employee and shall have the authority and be accountable for assuring the provision of quality nursing care for those patient areas delineated in the organizational structure.

(8) Survey Process.

(A) The department shall conduct licensure compliance surveys of hospitals as required by section 197.100, RSMo. Initial surveys shall be announced. Complaint investigations shall be unannounced.

(B) Interviews with staff, patients, and visitors shall be conducted in private, unless otherwise requested by the person being interviewed. Staff serving as a witness to an interview or an observation shall only observe and not participate.

(C) Survey findings shall be provided to the hospital in accordance with procedures and time lines designated by Chapter 197, RSMo.

(D) In addition to the powers to deny, suspend, or revoke a license in the case of a substantial failure to comply provided in section 197.070, RSMo, the department shall use the standards for enforcing hospital licensure regulations in section 197.293, RSMo.

(9) Plan of Correction.

(A) If the facility believes that deficiencies are not applicable or are not based upon laws or rules, a request for review may be submitted to the office of the director of the department. If a request for reconsideration is submitted, the request shall contain a rationale or documentation to provide evidence that the deficiency should not have been cited. Failure of the facility to submit a plan of correction or a request for reconsideration of the deficiency acceptable to the director of the department or designee – within the time frame specified – shall be grounds for the department to take disciplinary action against the facility's license if there remains a substantial failure to comply with the requirements for hospitals established under Chapter 197, RSMo and regulations promulgated thereunder. The operator has the right to appeal the department's decision in accordance with section 197.071, RSMo.

(B) Upon receipt of the required plan of correction for achieving licensure compliance, the department shall review the plan to determine the appropriateness of the corrective action. If the plan is acceptable, the department shall notify the chief executive officer or designee, in writing, and indicate that implementation of the plan should proceed. If the plan is not acceptable, the department shall notify the chief executive officer or designee, in writing, and indicate the reasons why the plan is not acceptable. Within ten (10) calendar days from the receipt of the notice, a revised, acceptable plan of correction shall be provided to the department.

(10) Follow-up Surveys.

(A) Upon expiration of the target dates for correction of deficiencies specified in the approved plan of correction, the department may make a follow-up survey to determine whether the required corrective measures have been acceptably accomplished. If the follow-up survey, conducted in accordance with 197.080, RSMo, if applicable, finds the

facility fails to comply with the requirements for hospitals in Chapter 197, RSMo, and regulations promulgated thereunder, the department may deny, suspend, or revoke a license in the case of a substantial failure to comply. The operator has the right to appeal the department's decision in accordance with section 197.071, RSMo.

(B) The powers to deny, suspend, or revoke a license in the case of a substantial failure to comply in section 197.070, RSMo, are in addition to the standards the department shall use for enforcing hospital licensure regulations in section 197.293, RSMo.

(11) If, for a period in excess of fourteen (14) days, a facility ceases to provide patient care or to otherwise operate as a hospital within the definition of section 197.020.2, RSMo, except in the case of a strike, an act of God, manmade disaster or written approval of the department, the facility shall surrender its license to the department. The facility shall not operate again as a hospital until an application for a hospital license is submitted with assurance that the facility complies with the requirements for hospitals in Chapter 197, RSMo, and regulations promulgated thereunder and the Department of Health and Senior Services issues a license.

(12) Requested Suspension of License. If any hospital wishes to cease operation for a period of time but retain its current hospital license, the Department of Health and Senior Services, upon written request from the licensed operator, may grant approval for suspension of the hospital's license for a specified time.

(A) Not less than fourteen (14) days prior to cessation of patient services at the hospital, the licensed operator shall submit to the department a written request for continuance.

(B) The written request for the suspension of the license shall include the reasons for cessation of patient services, the anticipated length of cessation of patient services, what safeguards the hospital will institute to provide security to the institution, the preventive maintenance measures used to assure that all equipment will be kept in good working order and evidence that the hospital is financially solvent to meet the conditions of the request and will remain so throughout the period of cessation of patient services.

(C) Approval may be granted only for the suspension of a hospital's current license if the cessation of patient services is for one (1) of the following reasons:

1. The renovation of the hospital's facility to upgrade to current licensure standards and to correct licensure or federal certification physical plant deficiencies;

2. The transfer of the operation of the hospital to a new operator to allow sufficient time for the new operator to obtain a new license; or

3. Other reasons which will not result in a deterioration of the hospital physical plant or its programs and which will be in the best interest of the citizens it serves.

(D) The suspension of a hospital's current license shall not exceed ninety (90) days beyond the date of cessation of patient services for ownership transfer. The suspension of a hospital's current license shall not exceed one hundred eighty (180) days beyond the date of cessation of patient services for renovation construction. The department may not grant more than one (1) suspension to a hospital's licensed operator within any twelve-(12-) month period and shall grant no suspension for a period of more than one hundred eighty (180) days from the date of cessation of inpatient services.

(E) No inpatients shall be housed within the hospital from



the initial date of cessation of inpatient services until operation of the hospital is restored with Department of Health and Senior Services approval.

(F) No inpatient services shall be provided in the hospital during the period of time that inpatient services are discontinued.

(G) When suspension of the license is requested for a renovation or construction proposal, the licensed operator shall submit plans for the renovation to the department for review and shall have received the department's approval of those plans prior to the date of cessation of inpatient services at the hospital.

(H) The licensed operator shall notify the department no less than fourteen (14) days prior to the resumption of inpatient services that the hospital is ready for review/inspection for approval to reoccupy the hospital with inpatients.

(I) Within ten (10) working days of notification, the department shall respond in writing to the licensed operator with the findings of its review/inspection for the resumption of licensed hospital services at the hospital.

(13) A certificate of live birth shall be prepared for each child born alive and shall be forwarded to the local registrar, or as otherwise directed by the state registrar within five (5) days after the date of delivery. If the physician or other person in attendance does not certify to the facts of birth within five (5) days after the birth, the person in charge of the institution shall complete and sign the certificate.

(14) When a dead fetus is delivered in an institution, the person in charge of the institution or his/her designated representative shall prepare and, within seven (7) days after delivery, file a report of fetal death with the local registrar or as otherwise directed by the state registrar.

(15) Medical records of deceased patients shall contain the date and time of death, autopsy permit, if granted, disposition of the body, by whom received and when.

(16) The State Anatomical Board shall be notified of an unclaimed dead body. A record of this notification shall be maintained.

(17) The patient's medical records shall be maintained to safeguard against loss, defacement, unauthorized access, and tampering and to prevent damage from fire and water. Medical records shall be preserved in a permanent file in the original, on microfilm, or other electronic media. Patients' medical records shall be retained for a minimum of ten (10) years, except that a minor shall have his/her record retained until his/her twentieth birthday, whichever occurs later. Preservation of medical records may be extended by the hospital for clinical, educational, statistical, or administrative purposes.

(18) Requests for variance from the requirements of 19 CSR 30-20 shall be in writing to the Department of Health and Senior Services. Department determinations in response to variance requests shall be in writing and both requests and determinations shall be made a part of the Department of Health and Senior Services permanent records for the facility.

(A) Requests shall contain at a minimum –

1. The section number and text of the rule in question;

2. Specific reasons why compliance with the rule would impose an undue hardship on the operator, including an estimate of any additional cost which might be involved;

3. An explanation of the extenuating factors which may be relevant;

4. A complete description of the individual characteristics of the facility or patients or any other factors which would fulfill the intent of the rule in question to safeguard the health, safety, and the welfare of the patient, staff, or public if the variance from the requirement is granted; and

5. A length of time the variance is being requested.

(19) The department's written determination shall identify a variance expiration date, if approved. The facility may re-apply for a variance up to ninety (90) days prior to the expiration of a department-approved variance.

(20) Any facility granted a variance by the department shall inform the department in writing if the conditions warranting the variance change. This written notification to the department shall be made within thirty (30) days of the change affecting the variance. The department may revoke the granted variance if the changes in conditions detrimentally impact the health, safety, and the welfare of the patient, staff, or public, as determined by the department.

(21) All previously approved variances shall be submitted at the time of annual licensure renewal.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF HOSPITAL STANDARDS
APPLICATION FOR HOSPITAL LICENSE

<p>In accordance with the requirements of the Missouri Hospital Licensing Law, application is hereby made for a license to conduct and maintain a hospital.</p>		DO NOT WRITE IN THIS SPACE		
		LICENSE NO.		
		LICENSE DATE		
		CERTIFICATE NO.		
		ISSUE DATE		
NAME OF HOSPITAL (NAME TO APPEAR ON LICENSE)		TELEPHONE NUMBER		
LEGAL NAME OF HOSPITAL				
STREET ADDRESS		CITY AND ZIP CODE	COUNTY	
CHIEF EXECUTIVE OFFICER (FULL NAME)		TITLE	EMAIL	
NEXT IN CHARGE (FULL NAME)		TITLE	EMAIL	
The hospital fiscal year starts on (MONTH/DAY) _____ and ends on (MONTH/DAY) _____				
OWNERSHIP AND MANAGEMENT (CHECK ONLY ONE)				
A. Governmental <input type="checkbox"/> District <input type="checkbox"/> County <input type="checkbox"/> City-County <input type="checkbox"/> City <input type="checkbox"/> Other (specify) _____		B. Non-Governmental Non-Profit Proprietary <input type="checkbox"/> Church Operated <input type="checkbox"/> Individual <input type="checkbox"/> Church Affiliated <input type="checkbox"/> Partnership <input type="checkbox"/> Other Non-Profit <input type="checkbox"/> Corporation <input type="checkbox"/> Other (specify) _____		
LEGAL NAME OF OPERATING ENTITY				
IF OPERATED BY MANAGEMENT CONSULTANT, NAME OF FIRM				
C. Attach an organizational chart which details all executive boards and/or supervisory boards for any entity that maintains management authority over the hospital or an ownership interest in this hospital of more than 50% to include the directors of each required service.				
THE HOSPITAL HAS COMPLETED AND RETURNED THE MOST RECENT ANNUAL SURVEY OF MISSOURI HOSPITALS <input type="checkbox"/> YES <input type="checkbox"/> NO				
ACCREDITATION				
ACCREDITED <input type="checkbox"/> YES <input type="checkbox"/> NO		ACCREDITED BY _____		
DEEMED <input type="checkbox"/> YES <input type="checkbox"/> NO				
BED DESIGNATION BY SERVICES (indicate total beds in each category). If any of the beds have been converted to non-patient use please do not include those beds on the list.				
MEDICAL-SURGICAL	PSYCHIATRIC	OBSTETRICAL	NEONATAL ICU	NURSERY BASSINETS (NOT INCLUDED IN BED COUNT)
REHABILITATION	ICU-CCU	PEDIATRIC	LONG TERM CARE	ALCOHOL/DRUG ABUSE
OTHER (SPECIFY SERVICE)		TOTAL BEDS		CHANGE FROM PREVIOUS TOTAL?
ER BAYS/BEDS (NOT INCLUDED IN BED COUNT)		OR SUITES (NOT INCLUDED IN BED COUNT)		SWING BEDS (NOT INCLUDED IN BED COUNT)
NOTE: ATTACH AN EXPLANATION FOR ANY CHANGES IN TOTAL BED COMPLEMENT SINCE LAST APPLICATION				



OTHER						
<p>Construction/Renovation</p> <ol style="list-style-type: none"> 1. New hospitals - attach Certificate of Need approvals if applicable. 2. Renovations or construction projects during this licensure period should be submitted in accordance with 19 CSR 30-20.030. 3. Provide a copy of all DHSS current, approved variances. <ol style="list-style-type: none"> a. If new variance(s) is requested, please submit in accordance with 19 CSR 30-20.015. 						
<p>Premises</p> <p>For all locations that will be identified as premises, as defined by 19 CSR 30-20.011, please provide a map or drawing of the premises to illustrate the location of each building. Attach a listing of all buildings with each listed by name, address and type of patient service offered.</p>						
<p>Co-location status</p> <p>Is there another provider or licensed entity, or a satellite location of another provider or licensed entity, that occupies space in a building used by the hospital, or in one or more entire buildings located on the hospital's licensed premises?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If answer is yes, then list the name and Medicare identification (i.e. 26xxxx) number of the co-located provider or licensed entity.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 65%; padding: 2px;">NAME OF CO-LOCATION PROVIDER, LICENSED ENTITY OR SATELLITE LOCATION</td> <td style="width: 35%; padding: 2px;">MEDICARE IDENTIFICATION NUMBER</td> </tr> <tr> <td style="height: 30px;"></td> <td></td> </tr> </table>			NAME OF CO-LOCATION PROVIDER, LICENSED ENTITY OR SATELLITE LOCATION	MEDICARE IDENTIFICATION NUMBER		
NAME OF CO-LOCATION PROVIDER, LICENSED ENTITY OR SATELLITE LOCATION	MEDICARE IDENTIFICATION NUMBER					
CERTIFICATION						
<p>We the undersigned hereby certify that we have read the foregoing application and that the statements contained therein are true and correct to the best of our knowledge, and further assure the ability and intention of the _____ to comply with Missouri statutes and regulations pertaining to hospital licensure.</p> <p style="text-align: center; margin-left: 300px;">(NAME OF ENTITY)</p>						
CHAIR OF THE GOVERNING BODY SIGNATURE	PRINT NAME	DATE				
CHIEF EXECUTIVE OFFICER SIGNATURE	PRINT NAME	DATE				



AUTHORITY: sections 192.006, 197.065, and 197.297, RSMo 2016, and section 197.080, RSMo Supp. 2019. This rule was previously filed as 13 CSR 50-20.015. Original rule filed April 9, 1985, effective July 11, 1985. Amended: Filed Nov. 4, 1992, effective June 7, 1993. Amended: Filed Nov. 21, 1995, effective July 30, 1996. Amended: Filed Oct. 6, 1998, effective April 30, 1999. Amended: Filed June 28, 2001, effective Feb. 28, 2002. Amended: Filed April 30, 2004, effective Dec. 30, 2004. Amended: Filed March 20, 2019, effective Nov. 30, 2019. ***

**Original authority: 192.006, RSMo 1993, amended 1995; 197.065, RSMo 2004, amended 2017; 197.080, RSMo 1953, amended 1993, 1995, 2017; and 197.297, RSMo 2000.*

***Pursuant to Executive Order 21-07, 19 CSR 30-20.015, subsection (8)(A) was suspended from April 2, 2020 through August 31, 2021. Pursuant to Executive Order 21-09, 19 CSR 30-20.015, sections (2) and (5) was suspended from March 20, 2020 through December 31, 2021.*

19 CSR 30-20.021 Organization and Management for Hospitals

(Rescinded February 29, 2008)

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2005. This rule was previously filed as 13 CSR 50-20.021 and 19 CSR 10-20.021. Original rule filed June 2, 1982, effective Nov. 11, 1982. Amended: Filed April 9, 1985, effective Sept. 28, 1985. Amended: Filed June 2, 1987, effective Sept. 11, 1987. Amended: Filed Nov. 16, 1987, effective March 26, 1988. Amended: Filed June 14, 1988, effective Oct. 13, 1988. Amended: Filed Aug. 16, 1988, effective Dec. 29, 1988. Amended: Filed Nov. 21, 1995, effective July 30, 1996. Amended: Filed Oct. 6, 1998, effective April 30, 1999. Amended: Filed June 28, 2001, effective Feb. 28, 2002. Amended: Filed April 30, 2004, effective Dec. 30, 2004. Emergency amendment filed Sept. 1, 2005, effective Sept. 11, 2005, expired March 9, 2006. Amended: Filed Feb. 1, 2006, effective July 30, 2006. Rescinded: Filed June 27, 2007, effective Feb. 29, 2008.

19 CSR 30-20.030 Construction Standards for New Hospitals

PURPOSE: This rule establishes up-to-date construction standards for new hospitals to help ensure accessible, functional, fire-safe, and sanitary facilities.

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) New Hospital General Requirements.

(A) A new hospital is one (1) for which plans are submitted to the Department of Health and Senior Services for review and approval after January 1, 2018, for the construction of a new facility, expansion or renovation of an existing hospital, or the conversion of an existing facility not previously and continuously licensed as a hospital under Chapter 197, RSMo. A new hospital shall be designed to provide all of the facilities required by this rule and arranged to accommodate all of the functions required by this rule and to provide comfortable, sanitary, fire-safe, secure, and durable facilities for the patients. In major alteration projects and additions to an existing licensed hospital, only that part of the total hospital affected

by the project is subject to this rule.

(B) These minimum requirements are not intended in any way to restrict innovations and improvements in design, construction or operating techniques. Plans and specifications and operational procedures which contain deviations from these requirements may be approved if it is determined that the purposes of the minimum requirements have been fulfilled. Some facilities may be subject to the requirements of more than one (1) regulatory agency. While every effort has been made to ensure coordination, facilities making requests for changes in services and request for new construction or renovations are cautioned to verify requirements of other agencies involved.

(C) Requests for deviations from the requirements of this rule shall be in writing to the Department of Health and Senior Services. Approvals for deviations shall be in writing and both requests and approvals shall become a part of the permanent Department of Health and Senior Services records for the facility.

(D) Alterations or additions to existing hospitals shall be programmed so construction will minimize disruptions of existing functions. Access to exits and fire protections shall be maintained so the safety of the occupants will not be jeopardized during construction.

(E) The owner of each new facility or the owner of an existing facility being added to or undergoing major alterations shall provide a program scope of services which describes space requirements, staffing patterns, departmental relationships, and other basic information relating to the objectives of the facility. The program may be general but it shall include a description of each function to be performed, approximate space needed for these functions, and the interrelationship of various functions and spaces. The program also shall describe how essential services can be expanded in the future as the demand increases. Appropriate modifications or deletions in space requirements may be made when services are shared or purchased, provided the program indicates where the services are available and how they are to be provided.

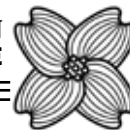
(2) Planning and Construction Procedure.

(A) Plans and specifications shall be prepared for the construction of all new hospitals and additions to and modifications or reconstruction of existing hospitals. The plans and specifications shall be prepared by an architect or a professional engineer licensed to practice in Missouri.

(B) Construction shall be in conformance with plans and specifications approved by the Engineering Consulting Unit of the Department of Health and Senior Services. The Department of Health and Senior Services shall be notified within five (5) days after construction begins. If construction of the project is not started within one (1) year after the date of approval of the plans and specifications, the plans and specifications shall be resubmitted to the Department of Health and Senior Services for its approval and shall be amended, if necessary, to comply with the then current rules before construction work commences.

(3) Design and Construction Requirements.

(A) New hospitals or portions of hospitals constructed or remodeled after the effective date of this amendment shall be maintained so that the building and its various operating systems comply with the life safety code standards in 42 CFR Part 482 (2017) and 42 CFR Part 485 (2017), which are incorporated by reference in this rule. The *Code of Federal Regulations* is published by the U.S. Government and is



available by calling toll-free (866) 512-1800 or going to <http://bookstore.gpo.gov/>. The address is: U.S. Government Publishing Office, U.S. Superintendent of Documents, Washington, DC 20402-0001. This rule incorporates later amendments and additions to 42 CFR Part 482 (2017) and 42 CFR Part 485 (2017). This rule does not incorporate the following chapters of National Fire Protection Association (NFPA) 99, 2012 edition: chapter 7 – Information Technology and Communications Systems for Health Care Facilities; chapter 8 – Plumbing; chapter 12 – Emergency Management; and chapter 13 – Security Management. Existing hospital facilities constructed prior to the effective date of this amendment shall maintain and operate the building in compliance with the design and safety regulations in effect at the time of their construction.

(B) New hospitals or portions of hospitals constructed or remodeled after the effective date of this amendment must be constructed so that the building and its various operating systems comply with the standards contained in *The Facility Guidelines Institute (FGI) Guidelines for the Design and Construction of Health Care Facilities* (2010 edition) or the *FGI Guidelines for Design and Construction of Hospitals and Outpatient Facilities* (2014 edition), which are incorporated by reference in this rule and are published by the FGI at 350 N. Saint Paul Street, Ste. 100, Dallas TX 75201, or so that the building and its various operating systems comply with other standards and guidelines that provide equivalent design criteria. Prior to the department granting approval of the construction plans and specifications required in this rule, the architect or professional engineer submitting the plans shall identify the equivalent design criteria used. This rule does not incorporate any subsequent amendments or additions. This rule does not incorporate the following chapter of FGI, 2010 edition: 1.2-8 – Commissioning. This rule does not incorporate the following chapter of FGI, 2014 edition: 1.2-7 – Commissioning. Existing hospital facilities constructed prior to the effective date of this amendment shall maintain and operate the building in compliance with the design and construction regulations in effect at the time of their construction.

(4) Additional Requirements.

(A) The facility shall have at least two (2) pressure sterilizers located in the Central Sterile Processing designed to maintain two hundred fifty degrees Fahrenheit (250 °F) or one hundred twenty-one degrees Celsius (121 °C) at fifteen pounds (15 lbs.) pressure.

(B) If a facility is located outside of a service area or range of a public fire department, arrangements shall be made to have the nearest fire department respond in the case of fire. A copy of the agreement shall be kept on file in the facility and a copy shall be forwarded to the Department of Health and Senior Services. If the agreement is changed, a copy shall be forwarded to the Department of Health and Senior Services.

(C) Manual fire alarm initiating devices shall be installed at each nurses' station or other patient care control station and at the telephone switchboard.

AUTHORITY: sections 192.006 and 197.065, RSMo 2016, and sections 197.080 and 197.100, RSMo Supp. 2019. This rule was previously filed as 13 CSR 50-20.031 and 19 CSR 10-20.031. Original rule filed June 2, 1982, effective Nov. 11, 1982. Amended: Filed June 14, 1988, effective Oct. 13, 1988. Rescinded and readopted: Filed March 20, 2019, effective Nov. 30, 2019. ***

**Original authority: 192.006, RSMo 1993, amended 1995; 197.065, RSMo 2004, amended 2017; 197.080, RSMo 1953, amended 1993, 1995, 2017; and 197.100, RSMo 1953, amended 1988, 2013, 2017.*

***Pursuant to Executive Order 21-09, 19 CSR 30-20.030 was suspended from March 20, 2020 through December 31, 2021.*

19 CSR 30-20.040 Definitions Relating to Long-Term Care Units in Hospitals

(Rescinded November 30, 2019)

AUTHORITY: sections 192.005.2 and 197.080, RSMo 1986. This rule was previously filed as 13 CSR 50-20.040 and 19 CSR 10-20.040. Original rule filed Nov. 29, 1982, effective March 11, 1983. Amended: Filed May 31, 1989, effective Aug. 24, 1989. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.050 Standards for the Operation of Long-Term Care Units

PURPOSE: This rule establishes standards for the administration, nursing staff, and overall operation of long-term care units in hospitals to provide a high level of care.

(1) Swing beds located in the hospital which may be used intermittently for long-term care are exempt from the requirements of this rule.

(2) Administration.

(A) A long-term care unit shall be licensed as part of the hospital in which it is located or attached. The hospital governing body shall be the legal authority for the long-term care unit and shall be responsible for the overall planning, directing, control, and management of the activities and functions of the long-term care unit.

(B) The administration of the long-term care unit shall be the responsibility of the chief executive officer of the hospital. This authority may be delegated to a qualified assistant in accordance with the governing body bylaws of the hospital.

(C) Visiting Hours.

1. Regular daily visiting hours shall be established.

2. Relatives or guardians and clergy, if requested by the resident or family, shall be allowed to see critically-ill residents at any time in keeping with the orders of the physician.

(D) Medical records shall comply with 19 CSR 30-20.015. All medical orders shall be renewed at least monthly.

(E) All residents shall have a comprehensive, accurate, standardized assessment completed within fourteen (14) days of admission utilizing the resident assessment instrument developed by the Centers for Medicare and Medicaid Services (CMS) for use in long-term care facilities. The assessment shall be documented and become the basis for the care and treatment to be provided.

(3) The hospital shall assure that individuals who are employed as nursing assistants in the long-term care unit are trained and tested, including successful completion of a final examination, pursuant to the provisions of 19 CSR 30-84.010.

(4) Orientation In-Service Training and Continuing Education.

(A) The chief executive officer of the hospital shall assure the development of an in-service orientation and continuing education program offered by qualified instructors for the development of all personnel in the long-term care unit that is appropriate to their job functions. Orientation for all new personnel shall begin the first day of employment in the long-term care unit and shall cover, at a minimum, prevention



and control of infection and hospital policies and procedures, including emergency protocol, job responsibilities, lines of authority, confidentiality of patient information, resident's rights, and preservation of patient dignity.

(B) The continuing education program for nursing assistants shall focus on basic nursing skills, personal care skills, mental health and social service needs, and basic restorative services.

(5) Training Record. Written records of the employee's training and testing shall be maintained in the employee's personnel file.

(6) Medical Care.

(A) Medical care in long-term care units shall be under the direction of a physician member of the medical staff and appointed by the governing body.

(B) Each resident shall have the privilege of selecting his/her own physician consistent with hospital medical staff bylaws.

(C) Each resident shall be visited by the attending physician as often as medically necessary but no less than every thirty (30) days for the first ninety (90) days and every sixty (60) days thereafter.

(D) There shall be a process for the review and evaluation on a regular basis of the quality and appropriateness of medical care in the long-term care unit.

(7) Long-Term Care Unit.

(A) A long-term care unit as defined in 19 CSR 30-20.011 shall have a registered professional nurse on duty eight (8) hours a day and seven (7) days a week.

(B) The nursing service administrator shall be responsible for the quality of nursing care supervision of personnel providing nursing care and for a program of in-service education for nursing personnel.

(C) Skilled nursing units shall employ nursing personnel in sufficient numbers and sufficiently qualified to meet the needs of the residents. Exclusive of supervisory staff, the minimum ratio of nursing staff engaged in direct patient care and treatment to residents shall be as follows:

<u>Time</u>	<u>Ratio of Staff to Residents*</u>
7 a.m. to 3 p.m. (day)	1 staff person for each 10 residents plus 1 additional staff person for any remainder of 6 or more residents
3 p.m. to 11 p.m. (evening)	1 staff person for each 15 residents plus 1 additional staff person for any remainder of 8 or more residents
11 p.m. to 7 a.m. (night)	1 staff person for each 20 residents plus 1 additional staff person for any remainder of 11 or more residents.

*The number of residents is based on occupied beds.

(D) On every shift there shall be a registered professional nurse or a licensed practical nurse on duty.

(E) A registered professional nurse shall be available in the hospital to assist during the time a licensed practical nurse is in charge.

(F) In a multi-story long-term care unit, at least one (1) direct-care staff person shall be on duty at all times for each occupied floor.

(G) All medications shall be administered in accordance with state law and the provisions of 42 CFR 482.23 (2017),

Condition of Participation for Nursing Services. The *Code of Federal Regulations* is published by the U.S. Government and is available by calling toll-free (866) 512-1800 or going to <https://bookstore.gpo.gov/>. The address is: U.S. Government Publishing Office, U.S. Superintendent of Documents, Washington, DC 20402-0001. This rule incorporates later amendments and additions to 42 CFR Part 482.23 (2017).

(H) A physical examination by a licensed physician shall be completed and recorded on the clinical record of each resident, preferably before admission, but not later than seven (7) days after admission, unless the resident is accompanied on admission from a hospital or long-term care unit by a record of a physical examination completed within the past six (6) months. Physical examinations shall be performed at least annually.

(I) The unit shall not knowingly admit or continue to care for residents whose needs cannot be met by the unit directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts.

(J) Provision shall be made for the care of residents with a communicable disease either in the hospital or in a suitable room in the unit. Infection control policies and procedures shall be followed.

(8) Resident's Rights and Grievance Procedures for Long-Term Care Units.

(A) A complete copy of each official notification from the Department of Health and Senior Services of violations, deficiencies, licensure approvals, disapprovals, and responses shall be retained and made available at the unit for inspection when requested by staff, residents, families or legal representatives of the residents, and the public.

(B) Each resident shall be informed of his/her rights and responsibilities as a resident and of all rules governing resident conduct and responsibilities. A copy of all the information shall be posted in a conspicuous location in the facility and copies shall be available to anyone requesting the information. Prior to or at the time of admission, a copy of the information shall be provided to each resident or his/her designee, next of kin, or legal guardian.

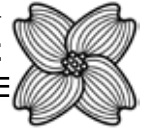
(C) Each resident shall be informed in writing, prior to or at the time of admission and during his/her stay, of services available in the unit and of related charges, including any charges for services not covered under the federal or state programs or not covered by the facility's per-diem rate.

(D) Each resident shall be informed by a physician of his/her health and medical condition unless medically contraindicated (as documented by a physician in the resident's record); shall be given the opportunity to participate in the planning of his/her total care and medical treatment and to refuse treatment; and shall participate in experimental research only upon his/her informed written consent.

(E) Each resident shall be transferred or discharged only for medical reasons, for his/her welfare or that of other residents, or for nonpayment for his/her stay.

(F) Each resident shall be encouraged and assisted, throughout his/her period of stay, to exercise his/her rights as a resident and as a citizen and to this end may voice grievances and recommend changes in policies and services to facility staff or to outside representatives of his/her choice and shall be free from restraint, interference, coercion, discrimination, or reprisal.

(G) Each resident may manage his/her personal financial affairs and, to the extent that the facility assists in the management, may have his/her personal financial affairs



managed in accordance with section (9) of this rule.

(H) No resident shall be mentally or physically abused. Each resident shall be free from chemical and physical restraints except when the restraints are authorized in writing by a physician for a specific period of time or when the restraints are necessary in an emergency to protect the resident from injury to him/herself or others. In an emergency, physical restraints may be authorized by a registered professional nurse. This action shall be reported immediately to a physician to obtain an order.

(I) Each resident shall be assured confidential treatment of all information contained in his/her records, including information contained in an automatic data bank; his/her written consent shall be required for the release of information to persons not otherwise authorized under law to receive it.

(J) Each resident shall be treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment and in care for his/her personal needs.

(K) No resident shall be required to perform services for the unit that are not included for therapeutic purposes in the plan of care.

(L) Each resident may communicate, associate, and meet privately with persons of his/her choice, unless to do so would infringe upon the rights of other residents. Each resident may send and receive his/her personal mail unopened.

(M) Each resident may participate in activities of social, religious, and community groups at his/her discretion, unless contraindicated for reasons documented by a physician in the resident's medical record.

(N) Each resident may retain and use his/her personal clothing and possessions as space permits.

(O) If married, a resident shall be insured privacy for visits by his/her other spouse; if both are residents in the facility, they shall be permitted to share a room unless medically contraindicated.

(P) Each resident shall be allowed to purchase or rent any goods or services not included in the per-diem or monthly rate as long as the quality and delivery of those goods or services conform with policies and procedures of the hospital.

(9) Personal Funds and Property of Residents.

(A) No hospital shall be required to hold any personal funds or money in trust unless some other governmental agency placing residents in the facility imposes this requirement.

(B) Authorizations by the resident, his/her designee, or legal guardian for the hospital to use the personal funds of the resident shall be in writing and kept with the resident's record or with the personal funds account.

(C) When a resident is admitted, s/he and his/her next of kin or legal guardian shall be provided with a statement explaining the resident's rights regarding personal funds.

(D) Resident's personal funds that are held in trust shall be kept separate from the hospital funds.

(E) There shall be a written account for each resident showing receipts to and disbursements from the personal funds of each resident.

(F) A written statement of all receipts and disbursements showing the current balance shall be given on a quarterly basis to the resident, his/her designee, or legal guardian.

(G) When personal funds and possessions held in trust by the hospital are returned to the resident or his/her designee or guardian before or after the resident's discharge, the resident or his/her designee or guardian shall give the hospital a receipt for the funds and possessions returned.

(H) There is no duty on the part of the hospital to invest a resident's funds held in trust or to increase the principal.

(I) Any owner, manager, employee, or affiliate of an owner who receives any personal property or anything else with a value of ten dollars (\$10) or more from a resident shall give the resident a written statement giving the date it was received, from whom it was received, and its estimated value.

(J) No owner, manager, employee, or affiliate of an owner, in one (1) calendar year, shall receive any personal property or anything else with a total value exceeding one hundred dollars (\$100) from a resident of any facility. This does not apply to bequests.

(K) The recordkeeping and other requirements of section (9) of this rule apply only to those personal possessions and funds which the facility accepts to hold in trust for the resident and does not apply to other possessions residents have in their rooms or bring into the facility.

AUTHORITY: sections 192.006 and 197.297, RSMo 2016, and section 197.080, RSMo Supp. 2019. This rule was previously filed as 13 CSR 50-20.050 and 19 CSR 10-20.050. Original rule filed Nov. 29, 1982, effective March 11, 1983. Amended: Filed May 31, 1989, effective Aug. 24, 1989. Amended: Filed July 12, 1991, effective Feb. 6, 1992. Amended: Filed March 20, 2019, effective Nov. 30, 2019. ***

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995, 2017; and 197.297, RSMo 2000.*

***Pursuant to Executive Order 21-09, 19 CSR 30-20.050, subsection (2)(C) was suspended from March 19, 2020 through December 31, 2021 and 19 CSR 30-20.050 was suspended from March 20, 2020 through December 31, 2021.*

19 CSR 30-20.060 Construction Standards for New Long-Term Care Units in Hospitals
(Rescinded November 30, 2019)

AUTHORITY: sections 192.005.2 and 197.080, RSMo 1986. This rule was previously filed as 13 CSR 50-20.060 and 19 CSR 10-20.060. Original rule filed Nov. 29, 1982, effective March 11, 1983. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.070 Registration as a Hospital Infectious Waste Generator

PURPOSE: This rule establishes standards and procedures for the registration of hospitals to ensure a high level of public safety in the handling and disposal of infectious waste.

(1) Application for Registration as a Hospital Infectious Waste Generator.

(A) Annually every hospital shall submit to the Department of Health and Senior Services an application for registration as an infectious waste generator. The application shall be furnished by the Department of Health and Senior Services and is included herein.

(B) Each application shall include:

1. An operational plan for the handling and treatment of infectious waste as specified in 19 CSR 30-20.114(1)(C);

2. A statement that the applicant understands and complies with sections 260.200–260.345, RSMo; 19 CSR 30-20.011; 19 CSR 30-20.114(1)(C); 10 CSR 80-2.010; and 10 CSR 80-7.010; and

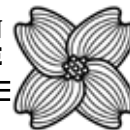
3. The signature of the hospital's chief executive officer and the director of the infectious waste management program.

(C) The application shall be submitted annually. It shall be



reviewed and denial or acceptance given within thirty (30) days after the Department of Health and Senior Services receives the application. If denied, specific reasons, with references, shall be given for the denial.

(D) The date of annual registration of a licensed hospital as an infectious waste generator shall be the hospital license renewal date and a nonlicensed hospital shall be assigned an annual registration date.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 BUREAU OF HOSPITAL STANDARDS
**INFECTIOUS WASTE GENERATOR REGISTRATION
 APPLICATION FOR MISSOURI HOSPITALS**

P.O. BOX 570
 JEFFERSON CITY, MO 65102

Pursuant to the requirements of 260.203 RSMo., application is hereby made for registration as an infectious waste generator.

NAME OF HOSPITAL (NAME TO APPEAR ON REGISTRATION)		DATE OF APPLICATION
ADDRESS (STREET AND NUMBER, CITY, ZIP CODE)		TELEPHONE NUMBER
CHIEF EXECUTIVE OFFICER (FULL NAME)	TITLE	
NEXT IN CHARGE (FULL NAME)	TITLE	
OWNERSHIP AND MANAGEMENT (CHECK ONLY ONE)		
A. GOVERNMENTAL <input type="checkbox"/> DISTRICT <input type="checkbox"/> STATE <input type="checkbox"/> COUNTY <input type="checkbox"/> FEDERAL <input type="checkbox"/> CITY-COUNTY <input type="checkbox"/> OTHER (EXPLAIN) <input type="checkbox"/> CITY		B. NON-GOVERNMENTAL NON-PROFIT PROPRIETARY <input type="checkbox"/> CHURCH OPERATED <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> CHURCH AFFILIATED <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> OTHER NON-PROFIT <input type="checkbox"/> CORPORATION
NAME OF GOVERNING BODY		
CHIEF OFFICER OF GOVERNING BODY (FULL NAME)		
LEGAL NAME OF OPERATING CORPORATION		
IF OPERATED BY MANAGEMENT CONSULTANT, NAME OF FIRM		
FISCAL YEAR	TOTAL CAPACITY OF HOSPITAL (INCLUDE STAFFED AND NON-STAFFED NURSING UNITS) BEDS	
CERTIFICATION		
Having read and understood 19 CSR 30 Chapter 20, 260.200 - 260.245 RSMo. and 10 CSR 80. _____ I/WE further certify that the _____ HOSPITAL NAME will comply with these sections and all required corrections and/or improvements deemed necessary following reviews and inspections by the Missouri Department of Health and Senior Services		
SIGNATURES		
HOSPITAL CHIEF EXECUTIVE OFFICER	DIRECTOR, INFECTIOUS WASTE MANAGEMENT PROGRAM	
▶	▶	



AUTHORITY: section 197.080, RSMo Supp. 2013, and section 260.203, RSMo 2000. Original rule filed Aug. 15, 1988, effective Dec. 29, 1988. Amended: Filed Dec. 31, 2013, effective Aug. 30, 2014.*

**Original authority: 197.080, RSMo 1953 and 260.203, RSMo 1986, amended 1988, 1992.*

19 CSR 30-20.080 Governing Body of Hospitals
(Rescinded November 30, 2019)

AUTHORITY: sections 192.006 and 197.080, RSMo 2000. This rule previously filed as 19 CSR 30-20.021(2)(A). Original rule filed June 27, 2007, effective Feb. 29, 2008. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.082 Chief Executive Officer in Hospitals
(Rescinded November 30, 2019)

AUTHORITY: sections 192.006 and 197.080, RSMo 2000. This rule previously filed as 19 CSR 30-20.021(2)(B). Original rule filed June 27, 2007, effective Feb. 29, 2008. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.084 Patients' Rights in Hospitals
(Rescinded November 30, 2019)

AUTHORITY: sections 192.006 and 197.080, RSMo 2000. This rule previously filed as 19 CSR 30-20.021(2)(B)17. Original rule filed June 27, 2007, effective Feb. 29, 2008. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.086 Medical Staff in Hospitals
(Rescinded November 30, 2019)

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(2)(C). Original rule filed June 27, 2007, effective Feb. 29, 2008. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.088 Central Services
(Rescinded November 30, 2019)

AUTHORITY: section 192.006, RSMo 2000, and sections 197.080 and 197.154, RSMo Supp. 2013. This rule previously filed as 19 CSR 30-20.021(3)(A). Original rule filed June 27, 2007, effective Feb. 29, 2008. Amended: Filed Dec. 31, 2013, effective Aug. 30, 2014. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.090 Food and Nutrition Services
(Rescinded November 30, 2019)

AUTHORITY: section 192.006, RSMo 2000, and sections 197.080 and 197.154, RSMo Supp. 2013. This rule previously filed as 19 CSR 30-20.021(3)(B). Original rule filed June 27, 2007, effective Feb. 29, 2008. Amended: Filed Dec. 31, 2013, effective Aug. 30, 2014. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.092 Diversion

PURPOSE: This rule establishes the requirements for emergency services in a hospital.

(1) A hospital shall have a written plan that details the hospital's criteria and process for diversion. Diversion may be due to the emergency department being overwhelmed with significantly critically ill or injured patients, or an overwhelming number of minor emergency patients, to the extent that the hospital is unable to provide quality care or protect the health or welfare of the patients it serves. A diversion also may be implemented if the hospital has resource limitations, such as, no available beds in specialty care units or general acute care, no surgical suites or shortages of equipment or personnel. The plan must be reviewed and approved by the Missouri Department of Health and Senior Services prior to being implemented by the hospital. A hospital may continue to operate under a plan in existence prior to the effective date of this section while awaiting approval of its plan by the department.

(A) The diversion plan shall:

1. Identify the individuals by title who are authorized by the hospital to implement the diversion plan;

2. Define the process by which the decision to divert will be made;

3. Specify that the hospital will not implement the diversion plan until the authorized individual has reviewed and documented the hospital's ability to obtain additional staff, open existing beds that may have been closed, or take any other actions that might prevent a diversion from occurring;

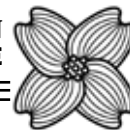
4. Include that all ambulance services within a defined service area will be notified of the intent to implement the diversion plan upon the actual implementation. Ambulances that have made contact with the hospital before the hospital has declared itself to be on diversion shall not be redirected to other hospitals. In areas served by a real time, electronic reporting system, notification through such system shall meet the requirements of this provision so long as such system is available to all EMS agencies and hospitals in the defined service area;

5. Include procedures for assessment, stabilization, and transportation of patients in the event that services, including but not limited to, ICU beds or surgical suites become unavailable or overburdened. These procedures must also include the evaluation of services and resources of the facility that can still be provided to patients even with the implementation of the diversion plan;

6. Include procedures for implementation of a resource diversion in the event that specialized services are overburdened or temporarily unavailable; and

7. Include that all other acute care hospitals within a defined service area will be notified upon the actual implementation of the diversion plan. For defined service areas with more than two (2) hospitals, if more than one-half (1/2) of the hospitals implement their diversion plans, no hospital will be considered on diversion. For a defined service area with two (2) hospitals, if both hospitals implement their diversion plans, neither will be considered on diversion. Participation in a real time, electronic reporting system shall meet the notification requirements of this section. If a hospital participates in an approved community-wide plan, the community-wide plan may set the requirement for the number of hospitals to remain open.

(B) Each incident of diversion plan implementation must be reviewed by the hospital's existing quality assurance



committee. Minutes of these review meetings must be made available to the Missouri Department of Health and Senior Services upon request.

(C) The hospital shall assure compliance with screening, treatment, and transfer requirements as required by the Emergency Medical Treatment and Active Labor Act (EMTALA).

(D) A hospital or its designee shall report to the department, by phone or electronically, upon actual implementation of the diversion plan. This implementation report shall contain the time the plan will be implemented. The hospital or its designee shall report to the department, by phone or electronically, within eight (8) hours of the termination of the diversion. This termination report shall contain the time the diversion plan was implemented, the reason for the diversion, the name of the individual who made the determination to implement the diversion plan, the time the diversion status was terminated, and the name of the individual who made the determination to terminate the diversion. In areas served by real time, electronic reporting system, reporting through such system shall meet the requirements of this provision so long as such system generates reports as required by the department.

(E) Each hospital shall implement a triage system within its emergency department. The triage methodology shall continue to apply during periods when the hospital diversion plan is implemented.

(F) Any hospital that has a written approved policy, which states that the hospital will not go on diversion or resource diversion, except as defined in the hospital's disaster plan in the event of a disaster, is exempt from the requirements of this section.

(G) If a hospital chooses to participate in a community-wide plan, the requirement of the number of hospitals to remain open, defined service areas, as well as community notification may be addressed within the community plan. Community plans must be approved by the department. Community plans must include that each hospital has a policy addressing diversion and the criteria used by each hospital to determine the necessity of implementing a diversion plan. Participation in a community plan does not exempt a hospital of the requirement to notify the department of a diversion plan implementation.

AUTHORITY: sections 192.006 and 197.154, RSMo 2016, and section 197.080, RSMo Supp. 2019. This rule previously filed as 19 CSR 30-20.021(3)(C). Original rule filed June 27, 2007, effective Feb. 29, 2008. Amended: Filed March 20, 2019, effective Nov. 30, 2019. ***

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995, 2017; and 197.154, RSMo 2004.*

***Pursuant to Executive Order 21-09, 19 CSR 30-20.092 was suspended from March 19, 2020 through December 31, 2021.*

19 CSR 30-20.094 Medical Records
(Rescinded November 30, 2019)

AUTHORITY: section 192.006, RSMo 2000, and sections 197.080 and 197.154, RSMo Supp. 2013. This rule previously filed as 19 CSR 30-20.021(3)(D). Original rule filed June 27, 2007, effective Feb. 29, 2008. Amended: Filed Dec. 31, 2013, effective Aug. 30, 2014. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.096 Nursing Services
(Rescinded November 30, 2019)

AUTHORITY: section 192.006, RSMo 2000, and sections 197.080 and 197.154, RSMo Supp. 2013. This rule previously filed as 19 CSR 30-20.021(3)(E). Original rule filed June 27, 2007, effective Feb. 29, 2008. Amended: Filed Oct. 22, 2008, effective June 30, 2009. Amended: Filed Dec. 31, 2013, effective Aug. 30, 2014. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.097 Safe Patient Handling and Movement in Hospitals
(Rescinded November 30, 2019)

AUTHORITY: section 197.080, RSMo 2000. Original rule filed April 29, 2011, effective Nov. 30, 2011. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.098 Pathology and Medical Laboratory Services
(Rescinded November 30, 2019)

AUTHORITY: section 192.006, RSMo 2000, and sections 197.080 and 197.154, RSMo Supp. 2013. This rule previously filed as 19 CSR 30-20.021(3)(F). Original rule filed June 27, 2007, effective Feb. 29, 2008. Amended: Filed June 6, 2013, effective Jan. 30, 2014. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.100 Pharmacy Services and Medication Management

PURPOSE: This rule establishes the requirements for pharmacy services and medication management in a hospital to ensure optimal selection, safe use, and security of medications.

(1) There shall be evidence of the education, training, experience, and demonstrated competency for all duties assigned in the pharmacy technicians' personnel records.

(2) In addition to other authorized duties, a pharmacy technician may perform the following duties:

(A) Authenticate medication selected by another pharmacy technician when a pharmacist is present for purposes of distribution within the hospital for subsequent administration by hospital staff authorized to administer medication, provided the final product is verified by authorized hospital staff prior to administration. A pharmacy technician shall not be authorized to authenticate compounded medications or the repackaging activities of another pharmacy technician. In order to authenticate medication as described in this section, the pharmacy technician must –

1. Hold an active pharmacy technician certification issued by a certification entity accredited by the National Commission for Certifying Agencies;

2. Have an initial and annual documented assessment of competency; and

3. Have assisted in the practice of pharmacy as a registered or licensed pharmacy technician in the state of Missouri or another U.S. state or territory for a minimum of one (1) year; and

(B) Perform assigned duties under visual and auditory supervision of a pharmacist at a different site, including, technology assisted medication authentication. Documentation of electronic authentication shall be maintained at the dispensing site.

1. The pharmacy technician shall have a current certificate



issued by a certification entity accredited by the National Commission for Certifying Agencies.

2. The pharmacy technician shall have completed training and documented competency in the assigned responsibilities being performed remotely as attested by the director of pharmacy.

3. The director of pharmacy is responsible for developing and implementing standards to ensure adequate supervision of electronically supervised technicians.

(3) An intern pharmacist licensed by the Board of Pharmacy may also perform any activity authorized for pharmacy technicians pursuant to this rule.

(4) Persons involved in compounding, repackaging, dispensing, administration, and controlled substance disposal shall be identified and the records shall be retrievable. Retention time for records of bulk compounding, repackaging, administration, and all controlled substance transactions shall be a minimum of two (2) years. Retention time for records of dispensing and extemporaneous compounding, including sterile medications, shall be a minimum of six (6) months.

(5) All variances, discrepancies, inconsistencies, or non-compliance involving controlled substances—including inventory, audits, security, record keeping, administration, and disposal—shall be reported to the director of pharmacy services for review and investigation.

(6) Patient medications may be received from an authorized provider. The medications shall—

(A) Be delivered directly to the pharmacy and not to a patient care area unless the pharmacist is not available;

(B) When a pharmacist is present, be identified, determined suitable for use and documented by the pharmacist. When a pharmacist is not present, be identified and documented by an authorized practitioner. Unused doses of medication shall be identified by the pharmacist when the pharmacist is present; and

(C) The pharmacy may compound, repackage, or re-label medications received from an outside provider, including prescriptions dispensed by a pharmacy, as necessary for proper distribution and administration. Records of compounding, repackaging, or relabeling of prescriptions dispensed by a pharmacy shall allow identification of the original prescription.

(7) Sample medications, if allowed, shall be received and distributed only by the pharmacy.

(8) Medications may be provided to patients for use outside the hospital, by persons other than the pharmacist.

(A) When the patient is a registered patient of the emergency department or is being discharged from the hospital—

1. Medications shall be provided according to the hospital's policies and procedures, including:

- A. Circumstances when medications may be provided;
- B. Practitioners authorized to order;
- C. Specific medications;
- D. Limited quantities;
- E. Prepackaging and labeling by the pharmacist;
- F. Final labeling to facilitate correct administration;
- G. Delivery;
- H. Counseling; and
- I. A transaction record;

2. Medications shall be labeled with the date, patient's

name, prescriber's name, name and address of the hospital, exact medication name and strength, instructions for use, and other pertinent information;

3. Medications may be provided only when prescription services from a pharmacy are not reasonably available. Reasonably available includes a pharmacist on duty in the hospital or a community pharmacy that is reasonably accessible to the patient;

4. The medication provided shall be limited to urgently needed treatment;

5. The quantity of medication provided shall be limited to the amount necessary until pharmacy services are available;

6. The provisions of paragraph (A)3. and paragraph (A)5. of this subsection shall not apply when the patient is being treated for an acute condition and it is believed that the immediate health and welfare of the patient and/or the community are in jeopardy. The quantity limit may be extended to provide single-course therapy; and

7. Final labeling, delivery, and counseling shall be performed by a pharmacist, the prescriber or a registered nurse, except that final labeling and delivery may be performed by an automated dispensing system.

(B) Automated dispensing systems may be used in accordance with all requirements of this section—

1. When the automated dispensing system is controlled by the prescriber it may be used only during times when no pharmacy services are reasonably available, except as allowed in paragraph (A)6. of this section; and

2. When the automated dispensing system is controlled by a pharmacy according to regulations of the Missouri Board of Pharmacy, including, but not limited to 20 CSR 2220-2.900.

(C) Medications in multidose containers that were administered to or used for the patient during the patient's hospital stay may be sent with the patient at discharge when so ordered by an authorized practitioner.

1. Examples of multidose medication containers include, but are not limited to, inhalers, ointments, creams, medications requiring the original container for dispensing, insulin pens, eye drops, ear drops, and infusions that are currently connected to the patient's infusion device.

2. Written instructions for use shall be provided by a pharmacist, prescriber, or registered nurse at the time of discharge.

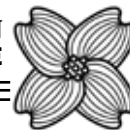
3. Controlled substances shall not be sent with the patient, except that controlled substance infusions or continuous delivery systems currently connected to the patient may be sent as follows:

A. The medication is necessary for administration during transport of the patient; and

B. The quantity of controlled substance sent is documented in the patient's medical record by the person sending the medication.

(9) The director of pharmacy services or his/her pharmacist designee shall be an active member of the pharmacy and therapeutics committee or its equivalent, which shall advise the medical staff on all medication matters.

(10) Medications shall be ordered only by practitioners who have independent statutory authority to prescribe or who are authorized to order medications by their professional licensing agency as provided by state law. Authority to order medications may be granted to a non-physician licensed practitioner in accordance with state law.



(11) Medications in the possession of the patient at time of admission shall be given to the patient's representative unless there is an identified need to retain them.

(A) Medications that are not given to the patient's representative and that are not to be administered shall be documented, sealed, and stored in a locked area accessible only to individuals authorized to access medications.

(B) Controlled substances shall be security sealed and stored in a locked area accessible only to individuals authorized to administer controlled substances or to authorized pharmacy personnel.

AUTHORITY: sections 192.006 and 338.165, RSMo 2016, and section 197.080, RSMo Supp. 2021. This rule previously filed as 19 CSR 30-20.021(3)(G). Original rule filed June 27, 2007, effective Feb. 29, 2008. Rescinded and readopted: Filed March 20, 2019, effective Nov. 30, 2019. Amended: Filed June 25, 2021, effective Dec. 30, 2021.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995, 2013, 2017; and 338.165, RSMo 2014.*

19 CSR 30-20.102 Radiology Services in Hospitals
(Rescinded November 30, 2019)

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(3)(H). Original rule filed June 27, 2007, effective Feb. 29, 2008. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.104 Social Services
(Rescinded November 30, 2019)

AUTHORITY: section 192.006, RSMo 2000, and section 197.080, RSMo Supp. 2013. This rule previously filed as 19 CSR 30-20.021(3)(I). Original rule filed June 27, 2007, effective Feb. 29, 2008. Amended: Filed Dec. 31, 2013, effective Aug. 30, 2014. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.106 Inpatient Care Units in Hospitals
(Rescinded November 30, 2019)

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(3)(J)1. Original rule filed June 27, 2007, effective Feb. 29, 2008. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.108 Fire Safety, General Safety and Operating Features
(Rescinded November 30, 2019)

AUTHORITY: section 192.006, RSMo 2000, and section 197.080, RSMo Supp. 2013. This rule previously filed as 19 CSR 30-20.021(3)(K). Original rule filed June 27, 2007, effective Feb. 29, 2008. Amended: Filed Dec. 31, 2013, effective Aug. 30, 2014. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.110 Orientation and Continuing Education
(Rescinded November 30, 2019)

AUTHORITY: section 192.006, RSMo 2000, and section 197.080, RSMo Supp. 2013. This rule previously filed as 19 CSR 30-20.021(3)(L). Original rule filed June 27, 2007, effective Feb. 29, 2008. Amended: Filed June 6, 2013, effective Jan. 30, 2014. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.112 Quality Assessment and Performance Improvement Program
(Rescinded November 30, 2019)

AUTHORITY: section 192.006, RSMo 2000, and sections 197.080 and 197.154, RSMo Supp. 2013. This rule previously filed as 19 CSR 30-20.021(3)(M). Original rule filed June 27, 2007, effective Feb. 29, 2008. Amended: Filed June 6, 2013, effective Jan. 30, 2014. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.114 Environmental Waste Management and Support Services

PURPOSE: This rule specifies the requirements for environmental and support services provided by a hospital.

(1) Each hospital shall have an organized service which maintains a clean and safe environment.

(A) Housekeeping Services.

1. The housekeeping services shall have a director who is qualified by education, training, and experience in the principles of hospital housekeeping. This individual shall report to a designated administrative officer or his or her designee.

2. Approved written policies and procedures shall define and describe the scope of housekeeping services. These shall be reviewed in cooperation with the infection prevention control program, kept current per hospital policy, and be readily available to staff.

3. Adequate space for housekeeping services shall be provided.

4. There shall be sufficient trained personnel to meet the needs of housekeeping services.

5. All solid waste generated within the hospital shall be collected in appropriate containers for disposal.

6. There shall be a process for the review and evaluation on a regular basis of the quality of housekeeping services provided.

(B) Laundry and Linen Services.

1. The hospital shall have organized services which ensure that adequate supplies of clean linens are available. There shall be specific written procedures for the processing, distribution, and storage of linen. These shall be reviewed in cooperation with the infection control committee and kept current.

2. Soiled linen processing functions shall be physically separated from both clean linen storage and soiled linen holding areas. Only commercial laundry equipment shall be used to process hospital linen.

3. Clean linen shall be stored and distributed to the point of use in a way that minimizes microbial contamination from surface contact or airborne particles.

4. Soiled linen shall be collected at the point of use and transported to the soiled linen holding room in a manner that minimizes microbial dissemination into the environment.

5. If a commercial laundry service is used, verification shall be provided to assure the hospital that the processing and handling of linen complies with paragraphs (1)(B)1.-4. of this rule and by following manufacturer recommendations.



6. There shall be a process for the review and evaluation on a regular basis of the quality of laundry and linen services provided.

(C) Infectious Waste Management

1. The director of this program shall be qualified by education, training, and experience in the principles of infectious waste management.

2. Every hospital shall write an infectious waste management plan with an annual review identifying infectious waste generated on-site, the scope of the infectious waste program, and policies and procedures to implement the infectious waste program. The plan shall include at least the following:

A. Contact information for responsible individuals; organizational chart; schematic(s) of waste disposal routes; definition of those wastes handled by the system; department and individual responsibilities; hospital policies and procedures for waste identification, segregation, containment, transport, treatment, and disposal; emergency and contingency procedures; training and educational procedures; and appendices (rules and other applicable institutional policy statements).

B. Any hospital exempt from infectious waste processing facility permit requirements of 10 CSR 80-7.010 and that accepts infectious waste from off-site shall include in its plan requirements for storage, processing, and record keeping of this waste and the cleanup of potential spills in the unloading area.

C. Manufacturers' specifications for temperature, residence time, and control devices for any infectious waste processing devices shall be included in the plan.

3. A trained operator shall operate the equipment during any infectious waste treatment procedures.

4. Infectious waste shall be segregated from other wastes at the point of generation and shall be placed in distinctive, clearly marked, leakproof containers or plastic bags appropriate for the characteristics of the infectious waste. Containers for infectious waste shall be identified with the universal biological hazard symbol. All packaging shall maintain its integrity during storage and transport. Infectious waste shall not be placed in a gravity waste disposal chute.

5. Pending disposal, infectious waste shall be stored, separated from other wastes, in a limited-access enclosure posted with the biological hazard symbol. This enclosure shall afford protection from vermin, be a dry area, and be provided with an impervious floor with a perimeter curb. The floor shall slope to a drain connected to the sanitary sewage system or collection device. If infectious waste is compacted, the mechanical device shall contain the fluids and aerosols and shall not release aerosols or fluids when opened and the container is removed. Provisions for waste stored seventy-two (72) hours or more shall be separately addressed in the infectious waste management plan to include proper storage, handling, and disposal by commercial vendors when utilized.

6. Hospital infectious waste treated on site shall be rendered innocuous, using one (1) of the following methods:

A. Sterilization of the waste in an autoclave is permitted, provided that the unit is operated in accordance with the manufacturer's recommendations and that the autoclave's effectiveness is verified at least weekly with a biological spore assay containing *Bacillus Stearothermophilus*. If the autoclave is used for other functions, the infectious waste management plan will develop specific guidelines for its use;

B. Decontamination of the infectious waste by other technologies in a manner acceptable to the Department of Health and Senior Services shall be permitted;

C. Bulk blood, suctioned fluids, excretions, and secretions may be carefully poured down a drain connected to a sanitary sewer; or

D. Infectious waste rendered innocuous by the methods in subparagraphs (1)(C)6.A. or B. of this rule shall be disposed of in accordance with the requirements of 10 CSR 80-7.010.

7. An infectious waste treatment program shall include records of biological spore assay tests if required by treatment methods and the approximate amount of waste disinfected per hour measured by weight per load. The program director shall maintain records demonstrating the proper operation of the disinfection equipment.

8. All infectious waste when transported off the premises of the hospital shall be packaged and transported as provided in sections 260.200–260.207, RSMo.

9. Any hospital which accepts infectious waste from small quantity generators as defined by 10 CSR 80-7.010 or from other Missouri hospitals – in quantities exceeding fifty percent (50%) of the total poundage of infectious waste generated on-site at the hospital – shall notify the Department of Natural Resources and comply with permitting requirements of sections 260.200–260.207, RSMo. The weight of infectious waste generated on-site shall be calculated by multiplying one and five-tenths (1.5) pounds per day times the number of beds complying with Department of Health and Senior Services standards for hospital licensure. Infectious waste generated off-site may be accepted by a hospital only if packaged according to 10 CSR 80-7.010(2)(A)–(D).

(D) Medication Waste Management.

1. Disposal of unwanted medications and medication waste shall be identified in the following categories: general, controlled substances, radiologic, infectious, and hazardous. Medication waste shall include materials contaminated with such medications.

A. Specific waste streams shall be identified for each category including storage container type, storage prior to disposal, and final disposition.

B. Medications shall be returned to the pharmacy for disposal except –

(I) Single doses that may be disposed of by medication staff at the time of administration;

(II) Doses that are an infectious hazard; and

(III) Radiopharmaceuticals.

C. Medications shall be disposed of according to the Missouri Department of Natural Resources, the United States Food and Drug Administration, and the United States Environmental Protection Agency.

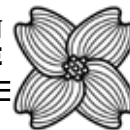
D. Disposal of controlled substances shall be according to 19 CSR 30-1.078.

E. Unused radiopharmaceuticals shall be returned to the supplier or held and disposed of according to Nuclear Regulatory Commission guidelines.

F. Disposal of hazardous medications including, but not limited to, antineoplastic medications shall be handled as follows:

(I) Personnel who handle hazardous medications and/or medication waste shall be trained regarding collection, transportation, containment, segregation, manifest, and disposal; and

(II) Waste shall be contained and segregated from other waste in leak proof containers clearly labeled with a statement such as CAUTION: HAZARDOUS CHEMICAL WASTE and held in a secure place until disposed.



AUTHORITY: section 192.006, RSMo 2000, and sections 197.080 and 197.154, RSMo Supp. 2013. This rule previously filed as 19 CSR 30-20.021(5)(A), (C), and (D). Original rule filed June 27, 2007, effective Feb. 29, 2008. Amended: Filed June 6, 2013, effective Jan. 30, 2014.*

**Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995, 2013; and 197.154, RSMo 2004.*

19 CSR 30-20.116 Infection Prevention and Control
(Rescinded November 30, 2019)

AUTHORITY: section 192.006, RSMo 2000, and sections 197.080, 197.150, and 197.154, RSMo Supp. 2013. This rule previously filed as 19 CSR 30-20.021(5)(B). Original rule filed June 27, 2007, effective Feb. 29, 2008. Amended: Filed Dec. 31, 2013, effective Aug. 30, 2014. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.118 Outpatient Services in Hospitals
(Rescinded November 30, 2019)

AUTHORITY: section 192.006, RSMo 2000, and sections 197.080 and 197.154, RSMo Supp. 2013. This rule previously filed as 19 CSR 30-20.021(4)(A). Original rule filed June 27, 2007, effective Feb. 29, 2008. Amended: Filed June 6, 2013, effective Jan. 30, 2014. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.120 Anesthesia Services in Hospitals
(Rescinded November 30, 2019)

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(4)(B). Original rule filed June 27, 2007, effective Feb. 29, 2008. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.122 Home-Care Services in Hospitals
(Rescinded January 30, 2014)

AUTHORITY: sections 192.006 and 197.080, RSMo 2000, and section 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(4)(C). Original rule filed June 27, 2007, effective Feb. 29, 2008. Rescinded: Filed June 6, 2013, effective Jan. 30, 2014.

19 CSR 30-20.124 Medical Services
(Rescinded November 30, 2019)

AUTHORITY: section 192.006, RSMo 2000, and sections 197.080 and 197.154, RSMo Supp. 2013. This rule previously filed as 19 CSR 30-20.021(4)(D). Original rule filed June 27, 2007, effective Feb. 29, 2008. Amended: Filed June 6, 2013, effective Jan. 30, 2014. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.125 Unlicensed Assistive Personnel Training Program

PURPOSE: This rule requires hospitals to have a personnel training policy that requires unlicensed health care personnel who provide direct patient care under the delegation and supervision of a registered nurse to complete the Unlicensed Assistive Personnel

(UAP) Training Program, which shall be used to prepare individuals for employment in hospitals. This program shall be designed to teach the knowledge and skills that will qualify students to perform uncomplicated nursing procedures and assist in direct patient care.

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) Hospitals may only employ or contract with a staffing agency for unlicensed assistive personnel (UAP) in accordance with this rule.

(2) The hospital training policy for UAPs shall include the following minimum standards:

(A) The curriculum of the UAP Program shall consist of a standard plan of instruction to include:

1. A minimum of seventy-five (75) hours of classroom instruction;

2. Computer or paper-based learning modules that provide documentation of completion may be substituted for up to sixty (60) hours of classroom time;

3. Comparable certified medical assistant training from an accredited medical assistant program may be substituted for up to fifty (50) hours of classroom time of comparable subject matter;

4. A minimum of one hundred (100) hours of clinical practicum; and

5. Curriculum content of the program shall include procedures and instructions on basic patient care skills including, but not limited to, the areas of:

A. The Role of the UAP (ethics, law, team member communication, observation, reporting, documentation, medical terminology);

B. Patient/Client Rights (Health Insurance Portability and Accountability Act (HIPAA), privacy, confidentiality, advanced directives, abuse and neglect, age specific care, cultural diversity, pain management, restraint-free care, end-of-life care, death and dying, do not resuscitate (DNR) orders, post-mortem care);

C. Vital Signs;

D. Basic Human Needs (age specific cognitive/psychological/social needs, activities of daily living, ambulation, positioning, personal care, elimination and toileting, nutrition, hydration, feeding, bed making);

E. Infection Control (universal precautions, blood-borne pathogens, safe needle devices, aseptic technique, hand washing, gloving, isolation);

F. Skin Care (wound care, pressure ulcers and prevention); and

G. Safety (cardiopulmonary resuscitation (CPR), allergies, fall prevention, environmental safety issues, fire/electrical, hazardous materials transportation safety information (HAZMAT), emergency procedures, body mechanics).

(B) The clinical practicum of one hundred (100) hours shall start after the student has enrolled and started the course curriculum.

(C) Skill validation and knowledge verification is to be used to determine student competence.



(D) Annual in-service training also shall occur as required by 19 CSR 30-20.110.

(3) Hospitals shall not be required to meet the UAP training requirements if an employee demonstrates competency in the content areas required by this rule; in the duties specific to their job and the patient population assigned and –

(A) Is enrolled in a professional or practical nursing education program and has or will complete within ninety (90) days a fundamentals of nursing course; or

(B) Was a professional nursing or practical nursing licensure candidate who failed to pass the state licensure examinations in the past three (3) years; or

(C) Is certified as a nursing assistant as defined in section 198.082, RSMo; or

(D) Has documentation of current registration as a certified nursing assistant in another state that meets the requirements listed in 42 CFR 483.151 and 483.152 (April 2012) which are incorporated by reference in this rule and are published by the U.S. Government Printing Office, 710 North Capitol Street, NW, Washington, DC 20401. This rule does not incorporate any subsequent amendments or additions; or

(E) Has documented experience as a nurse assistant, emergency medical technician, or surgical technician in the past three (3) years; or

(F) Has proof of completion of UAP training program in Missouri or another state which meets the requirements of this rule within the last three (3) years; or

(G) Has completed a professional or licensed practical nursing program outside the United States and is awaiting the licensure examination in this country.

(4) The hospital training policy for UAPs shall meet the following faculty qualifications and responsibilities:

(A) A registered professional nurse shall be designated as the course coordinator and shall be responsible for all aspects of the course, and must supervise all classroom and clinical instruction;

(B) Instructors shall hold a current license or temporary permit to practice as a registered professional nurse in Missouri or in another Nurse Licensure Compact state and have a minimum of two (2) years of nursing experience in an acute care, long-term care, or ambulatory surgery facility within the prior five (5) years, or an experience as a clinical faculty member in a nursing program within the prior five (5) years. An instructor's nursing license shall not be under current disciplinary action;

(C) A clinical supervisor's or preceptor's nursing license shall not be under current disciplinary action; and

(D) UAPs who have satisfied the training requirements of this rule and Licensed Practical Nurses may assist with the clinical practicum under the direction of the course coordinator.

(5) A hospital or ambulatory surgical center that provides training for UAPs shall meet the following training site requirements:

(A) Provide designated space sufficient to accommodate the classroom teaching portion of the course or have a written agreement with another acute care hospital, an area vocational-technical school, a high school offering a health service occupation program, a community college, or a provider agency to provide the classroom portion of the course;

(B) Provide on-the-job clinical practicum or have a written agreement with one (1) or more hospitals or ambulatory surgical centers in their vicinity to do so;

(C) Assess and review the program and outcomes of any training provided by another facility to ensure that all of the requirements of this rule have been met;

(D) Maintain, either electronically or on paper records of course completion and competency for a minimum of three (3) years. Records shall be signed and dated by the course coordinator and each of the instructors and clinical supervisors verifying classroom time, clinical time, and competency for each student; and

(E) Provide a signed copy of the course completion and competency record to the student, that includes the elements in subsection (5)(D) of this rule.

(6) The UAP training shall be completed within ninety (90) days of employment for any individual who is hired as a UAP. A UAP shall not work in direct patient care, except as part of their supervised practicum, until the entire UAP training requirements have been met.

*AUTHORITY: section 197.287, RSMo Supp. 2013. * Original rule filed Jan. 31, 2008, effective Sept. 30, 2008. Amended: Filed Dec. 31, 2013, effective Aug. 30, 2014. ***

**Original authority: 197.287, RSMo 2000.*

***Pursuant to Executive Order 21-07, 19 CSR 30-20.125, section (6) was suspended from April 2, 2020 through May 1, 2021. Pursuant to Executive Order 21-09, 19 CSR 30-20.125, section 197.287, RSMo was suspended from April 2, 2020 through December 31, 2021 and section (6) was suspended from October 13, 2021 through December 31, 2021.*

19 CSR 30-20.126 Obstetrical and Newborn Services in Hospitals

(Rescinded November 30, 2019)

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(4)(E). Original rule filed June 27, 2007, effective Feb. 29, 2008. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.128 Pediatric Services in Hospitals

(Rescinded November 30, 2019)

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(4)(F). Original rule filed June 27, 2007, effective Feb. 29, 2008. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.130 Post-Anesthesia Recovery Services in Hospitals

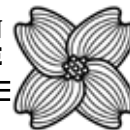
(Rescinded November 30, 2019)

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule was previously filed as 19 CSR 30-20.021(4)(G). Original rule filed June 27, 2007, effective Feb. 29, 2008. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.132 Psychiatric Services in Hospitals

(Rescinded November 30, 2019)

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(4)(H). Original rule filed June 27, 2007, effective Feb. 29, 2008. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.



19 CSR 30-20.134 Rehabilitation Services in Hospitals
(Rescinded November 30, 2019)

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2007. This rule previously filed as 19 CSR 30-20.021(4)(I). Original rule filed June 27, 2007, effective Feb. 29, 2008. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.136 Respiratory Care Services
(Rescinded November 30, 2019)

AUTHORITY: section 192.006, RSMo 2000, and sections 197.080 and 197.154, RSMo Supp. 2013. This rule previously filed as 19 CSR 30-20.021(4)(J). Original rule filed June 27, 2007, effective Feb. 29, 2008. Amended: Filed Dec. 31, 2013, effective Aug. 30, 2014. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.138 Specialized Inpatient Care Services
(Rescinded November 30, 2019)

AUTHORITY: section 192.006, RSMo 2000, and sections 197.080 and 197.154, RSMo Supp. 2013. This rule previously filed as 19 CSR 30-20.021(4)(K). Original rule filed June 27, 2007, effective Feb. 29, 2008. Amended: Filed Dec. 31, 2013, effective Aug. 30, 2014. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.140 Surgical Services
(Rescinded November 30, 2019)

AUTHORITY: section 192.006, RSMo 2000, and sections 197.080 and 197.154, RSMo Supp. 2013. This rule previously filed as 19 CSR 30-20.021(4)(L). Original rule filed June 27, 2007, effective Feb. 29, 2008. Amended: Filed Dec. 31, 2013, effective Aug. 30, 2014. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.142 Variance Requests
(Rescinded November 30, 2019)

AUTHORITY: section 192.006, RSMo 2000, and sections 197.080 and 197.154, RSMo Supp. 2013. This rule previously filed as 19 CSR 30-20.021(1) and (1)(A). Original rule filed on June 27, 2007, effective Feb. 29, 2008. Amended: Filed June 6, 2013, effective Jan. 30, 2014. Rescinded: Filed March 20, 2019, effective Nov. 30, 2019.

19 CSR 30-20.144 Standards and Guidelines for Essential Caregiver Program

PURPOSE: This rule establishes the standards and guidelines regarding the essential caregiver program established under section 191.2290, RSMo.

(1) As used in this rule, the following terms and phrases shall mean –

(A) Department shall mean the Department of Health and Senior Services;

(B) Essential caregiver shall mean a family member, friend, guardian, or other individual selected by a hospital patient who has not been adjudged incapacitated under Chapter 475, RSMo, or the guardian or legal representative of the patient; and

(C) Hospital shall have the same meaning assigned to it in 19 CSR 30-20.011(9).

(2) Every hospital within Missouri shall develop an essential caregiver program which shall allow a patient who has not been adjudged incapacitated under Chapter 475, RSMo, a patient's guardian, or a patient's legally authorized representative to designate an essential caregiver for in-person contact with the patient in accordance with the provisions of section 191.2290, RSMo, and the standards and guidelines developed by the department under this rule.

(3) The essential caregiver program shall be operable during a state of emergency declared pursuant to Chapter 44, RSMo, relating to infectious, contagious, communicable, or dangerous diseases.

(4) The essential caregiver program established by the hospital shall –

(A) Allow at least two (2) individuals per patient to be designated as essential caregivers, although the hospital may limit the in-person contact to one (1) caregiver at a time. The caregiver shall not be required to have previously served in a caregiver capacity prior to the declared state of emergency;

(B) Include a reasonable in-person contact schedule to allow the essential caregiver to provide care to the patient for at least four (4) hours each day, including evenings, weekends, and holidays, but shall allow for twenty-four- (24-) hour in-person care as necessary and appropriate for the well-being of the patient. The essential caregiver shall be permitted to leave and return during the scheduled hours or be replaced by another essential caregiver;

(C) Include procedures to enable physical contact between the patient and the essential caregiver. The hospital may not require the essential caregiver to undergo more stringent screening, testing, hygiene, personal protective equipment, and other infection control and prevention protocols than required of hospital employees; and

(D) Specify in its protocols the criteria that the hospital will use to determine that in-person contact by a particular essential caregiver is inconsistent with the patient's therapeutic care and treatment or is a safety risk to other patients or staff at the facility. Any limitations placed upon a particular essential caregiver shall be reviewed and documented every seven (7) days to determine if the limitations remain appropriate.

(5) A hospital shall inform, in writing, patients who have not been adjudged incapacitated under Chapter 475, RSMo, or guardians or legal representatives of patients, of the essential caregiver program and the process for designating an essential caregiver. Consistent with 42 CFR 482.12(h), a hospital shall inform each patient, or such patient's guardian or legal representative, where appropriate, of his or her visitation rights and right to access an essential caregiver in accordance with this rule.

(6) A hospital may restrict or revoke in-person contact by an essential caregiver who fails to follow required protocols and procedures established under section (4) of this rule.

(7) A hospital may request from the department a suspension of in-person contact by essential caregivers for a period not to exceed seven (7) days. A hospital may request from the department an extension of a suspension for more than seven (7) days, but such extension period shall not be for a period



longer than seven (7) days at a time. Under the provisions of this section, a hospital shall not suspend in-person caregiver contact for more than fourteen (14) consecutive days in a twelve- (12-) month period or for more than forty-five (45) total days in a twelve- (12-) month period. Requests for a suspension of in-person contact of essential caregivers or an extension of a suspension under this section shall be submitted in writing to the department. Department determinations in response to suspension requests shall be in writing and both requests and determinations shall be made a part of the department's permanent records for the hospital.

(A) Requests for a suspension of in-person contact by essential caregivers shall contain at a minimum the following:

1. The specific reason or reasons why allowing in-person contact by essential caregivers poses a serious community health risk;
2. An explanation of the extenuating factors which may be relevant to granting a suspension to the particular requesting hospital; and
3. The length of time, not to exceed seven (7) days, the suspension is being requested.

(8) The department's written determination shall identify a suspension expiration date, if approved. The hospital may reapply for an extension of the suspension up to one (1) day prior to the expiration of the department's originally approved suspension. The department may deny a hospital's request to suspend in-person contact with essential caregivers if the department determines that such in-person contact does not pose a serious community health risk.

(9) The department shall suspend in-person contact by essential caregivers under this rule if it determines that doing so is required under federal law, including a determination that federal law requires a suspension of in-person contact by members of the patient's care team.

(10) The provisions of this rule shall not apply to those patients whose particular plan of therapeutic care and treatment necessitates restricted or otherwise limited visitation for reasons unrelated to the stated reasons for the declared state of emergency.

(11) The provisions of this rule shall not be construed to require an essential caregiver to provide necessary care to a patient and a hospital shall not require an essential caregiver to provide necessary care.

AUTHORITY: sections 191.2290 and 197.080, RSMo Supp. 2022.
Emergency rule filed Sept. 15, 2022, effective Sept. 29, 2022, expired
March 27, 2023. Original rule filed Sept. 15, 2022, effective March
30, 2023.*

**Original authority: 191.2290, RSMo 2022, and 197.080, RSMo 1953, amended 1993,
1995, 2013, 2017.*