Rules of
Department of Social Services
Division 15—Division of Aging
Chapter 10—General Licensure Requirements

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 15—Division of Aging
Chapter 10—General Licensure Requirements

13 CSR 15-10.010 General Licensure Requirements

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

(1) Persons wishing to operate a skilled nursing facility, intermediate care facility, residential care facility II or residential care facility I shall submit information to the division as set out in the application for license to operate a long-term care facility form, including all documents listed in that application. The applicant may use one (1) application form, if the operator wishes to license more than one (1) facility on the same premises.

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

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

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

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

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

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

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

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

8. A document disclosing the name, address, title and percentage of ownership of each affiliate of any general partnership, limited partnership, general business corporation, nonprofit corporation, limited liability company or governmental entity which owns or operates the facility or is an affiliate of an entity which owns or operates the facility; and

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

(B) Every facility that provides specialized Alzheimer's or dementia care services, as defined in sections 198.500 to 198.515, RSMo Supp. 1997, by means of an Alzheimer's special care unit or program shall submit to the Division of Aging, as part of the licensure application or renewal, the following:

1. A form entitled "Alzheimer's Special Care Services Disclosure Form" shall be developed by the Division of Aging which provides information, if applicable, of how the care is different from the rest of the facility in the following areas:

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

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

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

D. Staff training and continuing education practices;

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

F. The frequency and types of resident activities;

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

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

I. Safety and security measures; and

2. A document developed by and/or approved by the division which contains, but is not limited to, updated information on selecting an Alzheimer's special care unit or program.

(C) If, after filing an application, the operator identifies an error or if any information changes the issuance of the license, the operator shall—

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

2. Submit the correction or additional information to the division by using MO Form 886-2609, entitled: Corrections for LTC Facility License Application.

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

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

2. Submit the correction or additional information to the division by using MO Form 886-2609, entitled: Corrections for LTC Facility License Application.

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

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

(G) If, during the a license's effective period, an operator which is a partnership, limited partnership or corporation undergoes any of the changes described in section 198.015.3, RSMo, or a new corporation, partnership, limited partnership, limited liability company or other entity assumes facility operation, within ten (10) working days of the effective date of that change, the operator shall submit an application for a new license.

(H) The division shall issue each license only for the premises and operator named in the application. This license shall cover the entire premises unless stipulated otherwise and shall not be transferable. If the licensed operator of a facility is replaced by another operator, the new operator shall apply for a new license before the effective date of the change. A change of operator shall include a change in form of business as well as a change of person. Upon receipt of the application and receipt of confirmation that the

change of operator has taken place, the division shall grant the new operator a temporary operating permit of sufficient duration to allow the division time to evaluate the application, conduct any necessary inspection(s) to determine substantial compliance with the law and the rules, and to either issue or deny a license to the new operator. The new operator shall be subject to all the terms and conditions under which the previous operator's license or temporary operating permit was issued. This includes any existing statement of deficiencies, plans of correction and compliance with any additional requirements imposed by the division as a result of any existing substantial noncompliance. The new operator, however, shall apply to the division for renewal in his/her/its name for any exception to the rules that had been granted the previous operator under the provisions of section (3) of this rule.

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

(J) An operator may apply for licenses for two (2) or more different levels of care located on the same premises either by submitting one (1) application or by submitting a separate application for each level of care. If an operator elects to submit one (1) application for two (2) or more levels of care located on the same premises—

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

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

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

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

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

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

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

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

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

5. The division has verified that the administrator of a residential care facility II, intermediate care facility or skilled nursing facility is currently licensed by the Missouri Board of Nursing Home Administrators under the provisions of Chapter 344, RSMo;

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

7. The applicant meets the definition of operator as defined by 13 CSR 15-11.010(19);

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

9. The division has determined that the operator, owner or any principals in the operation of the facility have ever been convicted of an offense concerning the operation of a long-term care facility or other health care facility or, while acting in a management capacity, ever knowingly acted or knowingly failed to perform any duty which materially and adversely affected the health, safety, welfare or property of a resident;

10. The division has determined that the operator, owner or any principals in the operation of the facility are excluded from participation in the Title XVIII (Medicare) or Title XIX (Medicaid) program or any state or territory;

11. The division has determined that the operator, owner or any principals in the operation of the facility have ever been convicted of a felony in any state or federal court concerning conduct involving either management of a long-term care facility or the provision or receipt of health care services; and

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

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

1. Submit a letter to the division that contains a correction of the application with notification of the effective date of the change and a copy of any new documents. The operator must ensure the letter is accompanied by a notarized statement that the information being submitted is true and correct to the best of the operator's knowledge and belief; or

2. Submit to the division a correction of the application and a copy of any new document by using MO Form 886-2609; entitled: Corrections for LTC Facility License Application.

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

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

2. Submit the financial information to the division by using MO Form 886-2609.

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

1. To designated employees of the division;

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

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

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

5. To appropriate committees of the general assembly or their representatives as designated in writing;

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

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

(P) To obtain a license for an additional level of care on the premises, the licensed operator shall submit a written request to the division for the issuance of a license for the desired level of care. The request shall indicate the level of care, the number of beds desired, the name and address of the facility, the name and address of the operator, and shall include the notarized signature of the operator. The licensure fee shall accompany this request. Requests are subject to division approval. The operator shall submit this request no less than sixty (60) days prior to the initiation date of the new level of care. The division shall coordinate this license's expiration date with that of the original license and the division shall prorate the license fee accordingly.

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

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

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

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

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

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

B. Fifty dollars ($50); and

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

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

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

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

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

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

(A) If a facility changes from a skilled nursing or intermediate care facility to any other level, or if the facility changes from a residential care facility II to a residential care facility I, the facility shall comply with construction, fire safety and physical plant rules applicable to an existing or existing licensed facility as defined in 13 CSR 15-11.010(8).

(B) If the facility changes from a residential care facility I to any other level or if a residential care facility II changes to an intermediate care or skilled nursing facility, the facility shall comply with construction, fire safety and physical plant rules applicable to a new or newly licensed facility as defined in 13 CSR 15-11.010(17).

(C) The facility shall comply with the rules applicable to a new or newly licensed facility if an application for relicensure has not been filed with the Division of Aging within one (1) year of the license denial, license revocation or voluntary closure.

(3) If a licensed facility discontinues operation as evidenced by the fact that no residents are in care or at any time the division is unable to freely gain entry into the facility to conduct an inspection, unless the facility operator has made special arrangements with the division for temporary closure, the facility shall be considered closed. The division shall notify the operator in writing requesting the voluntary surrender of the license. If the division does not receive the license within thirty (30) days, it shall be void. Later, if operation is to resume, the operator shall file a new application and fee and the provisions of section (1) shall apply.

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

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

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

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

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

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

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

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

(C) The division shall only grant exceptions to licensure requirements set out in rules imposed by the division and cannot grant exceptions to requirements established by state statute or federal regulations. Operators wishing to obtain waivers of regulations under Title XVIII or Title XIX of the Social Security Act shall follow procedures established by the Health Care Financing Administration (HCFA).

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

(A) Make every reasonable effort to provide residents of the facility or their responsible parties, if any—

1. A written notice of the noncompliance;

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

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

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

(6) A licensed facility shall comply with the provisions of Title VI of the Civil Rights Act 1964, as amended; Section 504 of the Rehabilitation Act of 1973; Title IX of the Education Amendment of 1972; the Age Discrimination Act of 1975; the Omnibus Budget and Reconciliation Act of 1982; the Americans with Disabilities Act of 1990; and the Keyes Amendment to the Social Security Act. No person shall be denied admission to, be denied benefits of, or be subjected to discrimination under any program, activity or service provided by the facility based on his/her race, color, national origin, sex, religion, age or disability, including Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS). Every licensed facility shall complete and sign an Assurance of Compliance (MO Form 886-3131) and file it with the Division of Aging. The facility shall submit the signed assurance form with the application for license or with the first application for relicensure submitted after December 31, 1998.

(7) The division's central office in Jefferson City shall make available to interested individuals without charge a single copy of—

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

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

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

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

(8) Every skilled nursing facility, intermediate care facility and residential care facility issued a license or temporary operating permit by the division shall submit the required certificate of need quarterly surveys to the division on or before the fifteenth day of the first month following the previous Social Security quarter. (For example, for the Social Security quarter ending December 31, the due date is by January 15; for the Social Security quarter ending March 31, the due date is by April 15; for the Social Security quarter ending June 30, the due date is by July 15; and for the Social Security quarter ending September 30, the due date is by October 15). The information shall be submitted on the ICF/SNF Certificate of Need Quarterly Survey form or the RCF Certificate of Need Quarterly Survey form (MO Form 886-9001).

AUTHORITY: Executive Order 77-9 of the Governor filed Jan. 31, 1979, effective Sept. 28, 1979, Chapter 198, sections 207.020, 208.152, 251.070 and 536.023, RSMo 1994 and Supp. 1997. Emergency rule filed Aug. 13, 1979, effective Oct. 1, 1979, expired Jan. 25, 1980. Original rule filed Aug. 13, 1979, effective Dec. 13, 1979. Emergency amendment filed Oct. 15, 1980, effective Oct. 25, 1980, expired Feb. 26, 1981. Amended: Filed Dec. 10, 1980, effective May 11, 1981. Amended: Filed Dec. 7, 1981, effective May 11, 1982. Amended: Filed March 15, 1983, effective July 11, 1983. Amended: Filed July 13, 1983, effective Oct. 11, 1983. Amended: Filed Sept. 12, 1984, effective Dec. 11, 1984. Amended: Filed June 17, 1986, effective Oct. 24, 1986. Amended: Filed Aug. 1, 1988, effective Nov. 10, 1988. Emergency amendment filed Aug. 14, 1992, effective Aug. 28, 1992, expired Dec. 25, 1992. Rescinded and readopted: Filed April 14, 1993, effective Oct. 10, 1993. Amended: Filed Feb. 13, 1998, effective Sept. 30, 1998.*

Original authority see* ***Missouri Revised Statutes* *1994 and Supp. 1997.*

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF AGING

CORRECTIONS FOR LTC FACILITY LICENSE APPLICATION

NAME OF FACILITY

FACILITY ADDRESS

LEVEL OF CARE

☐ SNF ☐ ICF ☐ RCF II ☐ RCF I

REASON FOR CORRECTION

☐ TO CORRECT ERROR ON PENDING APPLICATION

☐ NOTIFICATION OF CHANGE EFFECTIVE THE _____ DAY OF _____, 19____.

In order to comply with Section 198.018.4 RSMo, I hereby request that my application for license to operate a long term care facility be corrected as follows:

APPL. QUEST. NO.	CORRECTION
1.	
2.	
2a.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

MO 886-2609 (4-90)

10. ADMINISTRATOR
11.
12.
13a.
13b.
14.
15.
16.
17.
18.
19.
20.
21.

IN ADDITION, THE FOLLOWING DOCUMENTS ARE ATTACHED:

These corrections and attached documents are true and correct to the best of my knowledge and belief.

DATE	APPLICANT (OPERATOR OF FACILITY)
	▶

NOTARY INFORMATION

NOTARY PUBLIC EMBOSSER SEAL	STATE OF		COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF 19		**USE RUBBER STAMP IN CLEAR AREA BELOW.**
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		

MO 886-2609 (4-90)

13 CSR 15-10.020 Classification of Rules

PURPOSE: This rule adds to the classification of the standards for long-term care facilities as cited in chapters 13 CSR 15-12, 13 CSR 15-14, 13 CSR 15-15 and 13 CSR 15-16 and as required in section 198.085.1, RSMo.

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

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

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

(4) A violation of a class II standard is one which has a direct or immediate relationship to the health, safety or welfare of any resident, but which does not create any imminent danger. When a violation is noted, the operator shall either correct the violation immediately or prior to the time of the reinspection or shall be correcting it in accordance with the time schedules set out in the operator's approved plan of correction, as provided for under section 198.026.2, RSMo. If not, or the plan of correction is not approved and the violation not corrected, the violation will constitute substantial noncompliance under the Omnibus Nursing Home Act. After review by the division director or his/her designee, the division may initiate any action authorized by law, including those provided for in sections 198.026, 198.036, 198.067, 198.070.6, 198.103, 198.105 and 198.108, RSMo. Where specific standards are set out in sections 198.003–198.186, RSMo and are not otherwise classified, those standards will be treated as class II standards.

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

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

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

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

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

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

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

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

AUTHORITY: sections 198.009 and 198.085.1, RSMo 1986. Original rule filed Dec. 10, 1981, effective May 13, 1982. Amended: Filed July 13, 1983, effective Oct. 13, 1983.*

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

13 CSR 15-10.030 Assessment of Availability of Beds

PURPOSE: This rule sets forth the procedures followed by the Division of Aging in determining for the Missouri Health Facilities Review Committee whether or not a need exists in a particular locale for additional Medicaid certified beds.

(1) The Department of Social Services/Division of Aging will determine whether there presently exists a need for additional beds in a particular county or locality after the Department of Social Services/Division of Aging is notified by the State Health Planning and Development Agency that a Certificate of Need letter of intent has been filed for a project in that particular county or locality. The Department of Social Services/Division of

Aging will obtain from the State Health Planning and Development Agency information concerning the project's projected completion date, the number of beds to be licensed for each level of care and the number of beds for which Medicaid certification will be sought.

(2) The Department of Social Services/Division of Aging will consider the need for intermediate care facility and skilled nursing facility licensed beds and will evaluate separately the need for licensed beds certified to participate in Missouri's Title XIX (Medicaid) program.

(3) Once per quarter, the Department of Social Services/Division of Aging will determine the total number of licensed only beds and the total number of beds certified to participate in the Medicaid program in every county or locality in the state and the percentage of those beds which are occupied.

(4) If the Department of Social Services/Division of Aging is notified by the State Health Planning and Development Agency that a Certificate of Need letter of intent has been filed for a project, the Department of Social Services/Division of Aging will determine if a present need actually exists for additional licensed beds in the county or locality and the minimum number of additional beds needed, taking into account, one (1) or more of the following factors:

(A) Legal or administrative actions to which the Department of Social Services/Division of Aging may or may not be a party, which may affect availability of licensed intermediate care facility or skilled nursing facility beds in the county or locality;

(B) The number of beds under actual construction for which a certificate of need has been issued in that county or locality; and

(C) Whether ninety percent (90%) or more of the existing licensed long-term care beds in the county or locality are occupied.

(5) If the Department of Social Services/Division of Aging is notified by the State Health Planning and Developing Agency that a Certificate of Need letter of intent has been filed for a project for any county or locality where fifteen percent (15%) or less of the total Medicaid-certified beds in that county or locality are available, or if that county or locality has no certified beds, the Department of Social Services/Division of Aging will determine if a present need actually exists for additional Medicaid-certified beds in that county or locality and the minimum number of additional Medicaid-certified beds needed, taking into account, one (1) or more of the following factors:

(A) The number of certifiable and potentially certifiable beds in existence in the county or locality;

(B) The number of potentially certifiable beds under construction in that county or locality for which a Certificate of Need has been issued which are scheduled for completion on or before the date scheduled for completion for beds proposed in the application in question; and

(C) Legal or administrative action to which the Department of Social Services/Division of Aging may or may not be a party, which may affect availability of licensed and Medicaid-certified intermediate care facility and skilled nursing facility beds in the county or locality.

(6) Available Medicaid-certified beds are—

(A) Those which are certified to participate in the Medicaid program, currently staffed and capable of being occupied by a resident and not occupied by either a Medicaid or private pay resident; or

(B) Those, if occupied by a private pay resident in a distinct part facility, where the facility has verified in writing to the Department of Social Services/Division of Aging that the private pay resident will be transferred to a noncertified bed in the same facility if a Medicaid recipient or Medicaid-eligible individual requests placement.

(7) The Department of Social Services/Division of Aging finds a present need exists for additional beds of the classification proposed in a particular Certificate of Need letter of intent, the Department of Social Services/Division of Aging will certify the proposed facility to the Missouri Health Facilities Review Committee for whatever action it deems appropriate on that proposed facility including action pursuant to section 197.330, RSMo. If a Certificate of Need letter of intent has been filed for more than one (1) project in a county or locality in which the Department of Social Services/Division of Aging has found existence of a need for additional beds of the classification(s) proposed in the letters of intent, the Department of Social Services/Division of Aging will certify all such proposed facilities to the Missouri Health Facilities Review Committee to determine which, if any, of the proposed facilities will be issued a Certificate of Need to meet the present need for additional beds determined by the Department of Social Services/Division of Aging. Where the Department of Social Services/Division of Aging finds a present need for additional beds in a particular county or locality, the report to the Missouri Health Facilities Review Committee will specify whether licensed long-term care beds are needed or whether the need is for long-term care beds which are also certified to participate in the Medicaid program and what minimum number of beds is needed for each classification.

AUTHORITY: sections 197.318, RSMo Supp. 1992 and 198.009, RSMo 1986. Emergency rule filed June 17, 1986, effective June 27, 1986, expired Oct. 24, 1986. Original rule filed June 17, 1986, effective Oct. 24, 1986.*

**Original authority: 197.318, RSMo 1986, amended 1992 and 198.009, RSMo 1979.*

13 CSR 15-10.050 Transfer and Discharge Procedures

PURPOSE: This rule provides instructions for persons who are discharged from a licensed long-term care facility under involuntary circumstances. When this proposed rule becomes effective it will replace 13 CSR 15-9.010(17) which will be rescinded by subsequent rulemaking. This rule also includes the provisions of section 198.088, RSMo applicable to transfer or discharge and the notice and due process required of all licensed facilities.

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

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

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

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

1. The resident or a legally authorized representative of the resident has consented

to, agreed with, or requested the discharge; or

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

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

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

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

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

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

(C) The safety of individuals in the facility is endangered;

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

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

(F) The facility ceases to operate.

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

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

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

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

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

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

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

1. The reason for the transfer or discharge;

2. The effective date of transfer or discharge;

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

4. The address to which the request for a hearing should be sent: Administrative Hearings Unit, Division of Legal Services, P.O. Box 1527, Jefferson City, MO 65102-1527;

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

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

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

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

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

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

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

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

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

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

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

(6) Any resident of a facility who receives notice of discharge from the facility in which he/she resides may file an appeal of the notice with the Administrative Hearings Section, Division of Legal Services, P.O. Box 1527, Jefferson City, MO 65102-1527 within thirty (30) days of the date the resident received the discharge notice from the facility. The resident's legal guardian, the resident's attorney-in-fact appointed under sections 404.700–404.725, RSMo (Durable Power of Attorney Law of Missouri) or pursuant to sections 404.800–404.865, RSMo (Durable Power of Attorney for Health Care Act) or any other individual may file an appeal on the resident's behalf. A Nursing Facility Transfer or Discharge Hearing Request form (MO Form 886-3245) to request a hearing may be obtained from the Division of Aging or the regional ombudsman. However, the use of a form is not required in order to file a request for a hearing. The request for a hearing shall be verified in writing by the resident, his/her legal guardian, attorney-in-fact, or any other party requesting a hearing on the resident's behalf by attesting to the truth of the resident's request for a hearing.

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

(A) The designated hearing official shall notify the resident, the state long-term care ombudsman and the facility that the request

for a hearing has been received and that a hearing has been scheduled.

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

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

(A) The facility may show good cause for discharging the resident prior to a hearing decision being issued by the designated hearing official by filing a written Motion to Set Aside the Stay with the Administrative Hearings Unit at the address in paragraph (4)(B)4. The facility must provide a copy of the Motion to Set Aside the Stay to the resident, or to the resident's legally authorized representative and to at least one (1) family member, if one is known. In the event that a resident has no legally authorized representative and no known family members, then a copy of the Motion to Set Aside the Stay must be provided to the Missouri State Long-Term Care Ombudsman's Office.

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

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

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

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

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

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

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

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

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

AUTHORITY: section 198.088, RSMo 1994 and 660.050, RSMo Supp. 1997. Original rule filed Feb. 13, 1998, effective Sept. 30, 1998.*

Original authority: 198.088, RSMo 1997, amended 1988, 1989, 1994 and 660.050, RSMo 1984, amended 1988, 1992, 1993, 1994, 1995.