# Rules of
# Department of Health
## Division 30—Division of Health Standards and Licensure
## Chapter 35—Hospices

## Title 19—DEPARTMENT OF HEALTH
## Division 30—Division of Health Standards and Licensure
## Chapter 35—Hospices

### 19 CSR 30-35.010 Hospice Program Operations

*PURPOSE: This rule defines the minimum requirements for the provision of hospice services by state-certified hospice programs.*

*PUBLISHER'S NOTE: The publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.*

(1) General Provisions.

(A) Definitions Relating to Hospice Care Agencies.

1. Hospice administrator means the employee who organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the interdisciplinary group(s) and the staff; employs qualified personnel; implements an effective budgeting and accounting system; and enforces written policies and procedures. A qualified person is authorized to act in the absence of the hospice administrator.

2. Attending physician means a person who—

A. Is licensed as a doctor of medicine or osteopathy in this state or a bordering state; and

B. Is identified by the patient, at the time s/he elects to receive hospice care, as having the most significant role in the determination and delivery of the patient's medical care.

3. Coordinating provider means any individual or agency which provides services in coordination with the hospice interdisciplinary group.

4. Dietary counselor means a registered dietitian, one who is eligible for registration by the American Dietetics Association (ADA), or one with education and training in relevant areas of food and nutrition.

5. Dying person means a person with a medical prognosis that his/her life expectancy is six (6) months or less if the terminal illness runs its normal course, and for whom the focus of care is on comfort and palliation rather than cure.

6. Employee means a regular employee of the hospice or an individual under contract who is appropriately trained and assigned to the hospice program. Employee also refers to a person volunteering for the hospice program.

7. Family is defined broadly to include not only persons bound by biology or legalities but also those who define themselves as a close other with another person, or those who function for one in a familial way.

8. Freestanding hospice means a hospice that is not part of any other type of provider.

9. Home health aide means a person who meets the training, attitude, and skill requirements specified in the Medicare home health program (42 CFR 484.36).

10. Hospice means a public agency or private organization or subdivision of either of these that—

A. Is primarily engaged in providing care to dying persons and their families; and

B. Meets the standards specified in sections (1)–(5) of this rule and in 19 CSR 30-35.030. If it is a hospice that provides inpatient care directly in a hospice facility, it must also meet the standards of 19 CSR 30-35.020 and 19 CSR 30-35.030.

11. Licensed practical nurse means a person licensed under Chapter 335, RSMo to engage in the practice of practical nursing.

12. Meal preparation means meals planned, offered or served to all patients from prepared menus.

13. Medical director means a person licensed in this state as a doctor of medicine or osteopathy who assumes overall responsibility for the medical component of the hospice's patient care program.

14. Occupational therapist means a person who is registered under Chapter 334, RSMo as an occupational therapist.

15. Occupational therapy assistant means a person who has graduated from an occupational therapy assistant program accredited by the Accreditation Council for Occupational Therapy Education.

16. Registered nurse means a person licensed under Chapter 335, RSMo to engage in the practice of professional nursing.

17. Registered nurse coordinator means a registered nurse, who is a direct employee, designated by the hospice to coordinate the implementation of the hospice services.

18. Pharmacist means a person licensed as a pharmacist under Chapter 338, RSMo.

19. Physician means a physician as defined in subparagraph (1)(A)2.A. of this rule.

20. Physical therapist means a person who is licensed as a physical therapist under Chapter 334, RSMo.

21. Physical therapy assistant means a person who has graduated from at least a two (2)-year college level program accredited by the American Physical Therapy Association.

22. Legal representative means a person who because of the patient's mental or physical incapacity is legally authorized in accordance with state law to act on behalf of the dying person.

23. Satellite office means a location or site from which a hospice provides services within a portion of the total geographic area served by the parent hospice and the area served by the satellite office is contiguous to or part of the area served by the parent hospice.

24. Skilled nursing means those services which are required by law to be provided by registered nurses or licensed practical nurses.

25. Snack means a single meal or item prepared on demand which does not include food items that produce grease-laden vapors.

26. Speech language pathologist means a person who is licensed under Chapter 345, RSMo as a speech therapist.

27. Spiritual counselor means a person who is a pastor, priest, rabbi, minister, or one who has been designated by their faith group as a spiritual leader.

28. Social worker means a person who has at least a bachelor's degree in social work from an accredited school of social work.

(B) Eligibility Requirements. A hospice shall have written admission criteria including the hospice's standards for palliative care (that is treatment modalities such as chemotherapy or radiation).

(C) Certification. The hospice shall obtain the certification that the patient is a dying person in accordance with the following procedures:

1. The hospice shall obtain, no later than ten (10) calendar days after hospice care is initiated, written certification statements signed by—

A. The patient's attending physician; and

B. The medical director of the hospice or the physician member of the hospice interdisciplinary group;

2. The certification shall include:

A. A statement that the patient's medical prognosis is such that his/her life expectancy is six (6) months or less if the terminal illness runs its normal course and that the focus of care is on comfort and palliation rather than cure; and

B. The dated signature(s) of the patient's attending physician(s) and the medical director of the hospice or physician member of the hospice interdisciplinary team; and

3. The hospice shall maintain the certification statements in the patient record.

(D) Consent for Hospice Care.

1. If a patient who meets the eligibility requirements for hospice care wishes to receive that care, s/he shall sign a consent form for hospice services with a particular hospice. A consent may also be signed by a legal representative. The consent statement shall include the elements specified in paragraph (1)(D)2.

2. The consent form shall include the following:

A. Identification of the particular hospice that will provide care to the patient;

B. The patient's or representative's acknowledgment that s/he has been advised and has a full understanding of the palliative rather than curative nature of hospice care, as it relates to the patient's terminal illness;

C. The signature of the patient or legal representative; and

D. The specific type of care and services that may be provided as hospice care during the course of the illness.

3. A hospice shall demonstrate respect for the patient's rights by ensuring that an informed consent form has been obtained for every patient, either from the patient or representative as defined in paragraph (1)(A)22.

(E) Discontinuance of Hospice Care.

1. A patient or legal representative may discontinue the patient's hospice care at any time.

2. To discontinue hospice care, the hospice shall immediately notify the patient or representative and shall include the date that the discontinuance is effective.

3. Patient's/family's continuing care needs, if any, are assessed at discharge, and the patient/family are referred to appropriate resources, including documented notice to the physician.

4. If a patient/family transfers from one (1) hospice program to another or from home care services to inpatient service (or vice versa), the program transferring care shall provide a written summary which includes information about—

A. Services being provided; and

B. Specific medical, psychosocial, spiritual or other problems that require intervention or follow-up.

5. The hospice shall have written policies for hospice patient discharge which identify specific circumstances in which the patient is discharged.

(F) General Provisions.

1. A hospice shall maintain compliance with the conditions in sections (1)–(5) of this rule and 19 CSR 30-35.030. A hospice that operates a facility for hospice care shall also maintain compliance with 19 CSR 30-35.020.

2. A hospice shall be primarily engaged in providing the care and services described in sections (1)–(5) of this rule, and shall—

A. Provide nursing services, physician services and medications on a twenty-four (24)-hour basis;

B. Assure all other services are available on a twenty-four (24)-hour basis to the extent necessary to meet the needs of patients for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions;

C. Provide bereavement counseling; and

D. Assure that services are provided in a manner consistent with accepted standards of practice.

3. Any person convicted of a crime which is reasonably related to the qualifications, functions or duties of any hospice shall not be employed in a position that requires direct contact with patients/families. Before employing an applicant, the hospice shall require the applicant to sign a statement disclosing all crimes, except for minor traffic violations, for which the person has been convicted in any jurisdiction, or a statement indicating that the person has never been convicted of a crime, other than minor traffic violations. The hospice shall make reasonable efforts to assure the accuracy of this statement.

4. The hospice shall have a written statement of patient rights which shall include, but need not be limited to, those specified herein. Each patient of a hospice program shall be informed in writing of his/her rights as recipients of hospice services. The hospice shall document that it has informed patients of their rights in writing and shall protect and promote the exercise of these rights. The patient's family, representative or guardian may exercise the patient's rights when all reasonable efforts to communicate with the patient have failed. These rights shall include:

A. The patient's and family's right for respect of property and person;

B. The right to voice grievances regarding treatment or care that is, or fails to be, furnished or regarding lack of respect of property by anyone who is furnishing services on behalf of the hospice and the patient/family shall not be subjected to discrimination or reprisal for doing so;

C. The right to be informed about his/her care alternatives available from the hospice and payment resources;

D. The right to participate in the development of the plan of care and planning changes in the care;

E. The right to be informed in advance about the care to be furnished;

F. The right to be informed in advance of the disciplines that will furnish care and the frequency of visits proposed to be furnished;

G. The right to be informed in advance of any change in the plan of care before the change is made;

H. The right to confidentiality of the clinical records maintained by the hospice and to be informed of the hospice's policy for disclosure of clinical records;

I. The right to be informed in writing of the extent to which payment may be required from the patient and any changes in liability within thirty (30) days of the hospice becoming aware of the new amount of the liability; and

J. The right to access the Missouri home health and hospice toll-free hotline and to be informed of its telephone number, the hours of operations and its purpose for the receipt of complaints and questions regarding hospice services.

5. A hospice shall develop a written code of ethics required for its practice and have a process for reviewing ethical issues.

6. The hospice shall have written policies and procedures defining access to all services, medications, equipment and supplies during regular business hours, after hours and in emergency situations including a plan for prompt telephone response. Telephone reception is required during normal business hours.

A. Unscheduled nonemergent nursing visits when indicated should normally occur within three (3) hours from the time the need is identified.

B. When clinically indicated, emergent visits shall be made within one (1) hour from the time the need is identified.

7. The hospice shall identify persons responsible for implementing and monitoring an infection control program. The infection control program shall include a system for periodic review and update of infection control policies and procedures, a monitoring of practices and potential exposure to infection and of employee health and compliance with policies and procedures. The infection control policies and procedures shall conform with Centers for Disease Control (CDC), Occupational Safety and Health Administration (OSHA), and Clinical Laboratory

Improvement Amendments (CLIA) patient care and personnel guidelines and, at a minimum, address personal hygiene, aseptic and isolation techniques, waste disposal, and supply and medications storage.

8. The hospice shall have safety and emergency preparedness programs that conform with federal, state and local requirements and which include:

A. A plan for reporting, monitoring and following up on all accidents, injuries and safety hazards;

B. Documentation of all reports monitoring activity and follow-up actions;

C. Education for patient/family, employees and volunteers on the safe use of medical equipment;

D. Evidence that equipment maintenance and safety requirements have been met;

E. Policies and procedures for storing, accessing and distributing supplies and equipment; and

F. A safe and sanitary system for identifying, handling and disposing of hazardous wastes.

9. The standard of care and service intensity shall be the same out of the satellite office as the main office. If the hospice represents to the public that they have a satellite office, there shall be—

A. A designated interdisciplinary group;

B. Regular, documented on-site visits by the hospice administrator or designee and contact with the main office;

C. On-site interdisciplinary group meetings;

D. On-site maintenance of current active patient records; and

E. Telephone reception during normal business hours.

(2) Administration.

(A) Governing Body. A hospice shall have a governing body that assumes full legal responsibility for determining, implementing and monitoring policies governing the hospice's total operation. The governing body shall designate an individual who is responsible for the day-to-day management of the hospice program. The governing body shall also ensure that all services provided are consistent with accepted standards of practice.

(B) The medical director shall be a hospice employee who is a licensed doctor of medicine or osteopathy and shall offer consultation for the medical component of the hospice patient's care program. The medical director's or designee's services and responsibilities include:

1. Consulting with attending physicians regarding pain and symptom control;

2. Reviewing patient eligibility for hospice services;

3. Acting as medical resource for the interdisciplinary group;

4. Acting as liaison to physicians in the community;

5. Developing and coordinating procedures for the provision of emergency care; and

6. Routinely attending the interdisciplinary group meetings.

(C) Services Under Arrangement. A hospice may arrange for another individual or entity to furnish services to the hospice's patients except as otherwise provided in these regulations. If services are provided under arrangement, the hospice shall meet the following standards:

1. Assure the continuity of patient/family care in home, outpatient and inpatient settings;

2. Have a written agreement for the provision of arranged services. The agreement shall include the following:

A. Identification of the services to be provided in accordance with the plan of care;

B. The manner in which services are coordinated by the hospice to maintain hospice professional management responsibility;

C. Delineation of the role(s) of the hospice and the coordinating provider;

D. Assurance that the coordinating provider shall be appropriately licensed;

E. Provision for transfer and updating the plan of care on inpatient admission; and

F. Such arrangement shall not relieve the hospice for the primary responsibility of ensuring patient care or otherwise complying with these regulations;

3. Whenever a hospice program manages, delivers, or both, care to a patient who is a resident of a facility, other than a hospice facility—

A. There shall be an agreed upon plan of care that reflects coordination and input from both the hospice and the facility which reflects the hospice philosophy and an appropriate standard of care, and is based on an assessment of the individual's needs and unique living situation in the facility;

B. The hospice designates a registered nurse from the hospice to coordinate the implementation of the plan of care;

C. There shall be a coordinated single plan of care, which may be multiple documents, and shall identify the care and services which the facility and hospice will provide in order to be responsive to the unique needs of the patient/resident and his/her expressed desire for hospice care;

D. The coordinated single plan of care shall include directives for managing pain and other symptoms and shall be revised and updated as necessary to reflect the individual's current status;

E. The facility and the hospice shall both be responsible for the content of the single plan of care and for ensuring that it is implemented according to accepted professional standards of practice;

F. The services usually identified as hospice services shall remain the responsibility of the hospice, and are provided or arranged by the hospice to meet the needs of the patient at the same level that the hospice normally furnishes to patients in their homes; and

G. Documentation shall reflect communication between the facility and the hospice when any changes are made to the plan of care and each provider shall be aware of the other's responsibilities in implementing the plan of care; and

4. The coordinating provider shall maintain documentation to show that the provider is appropriately licensed.

(D) Plan of Care. A written plan of care shall be established and maintained for each patient admitted to a hospice program and the care provided to a patient shall be in accordance with the plan.

1. Documentation identifies that, prior to initiating care, the initial plan is to be established by two (2) members of the interdisciplinary group on the day of admission. Within two (2) working days of the initiation of care, the comprehensive plan of care shall be developed by the interdisciplinary group.

2. The plan shall be reviewed and updated by the interdisciplinary group at intervals specified in the plan but at a minimum of every two (2) weeks. These reviews shall be documented in the patient record.

3. The plan shall include assessment of the patient's/family's problems and needs and identification of the services including the management of discomfort and symptom relief. It shall state in detail the scope and frequency of services needed to meet the patient's and family's needs and by whom the services will be provided. The plan of care shall include: realistic and achievable goals and objectives, prescribed and required medical equipment, supplies, medications and level of care.

4. The ongoing plan of care shall reflect the changing needs of the patient/family and the services required.

(E) In-Service Training and Orientation.

1. Each hospice shall provide an ongoing program for the orientation and training of its employees and hospice in-service train-

ing to coordinating providers. The hospice shall maintain documentation of its orientation and in-service activities. The orientation program shall include:

A. The purpose and focus of hospice care;

B. Hospice policies and procedures as appropriate to the position;

C. Group function and responsibility;

D. Communication skills;

E. The introduction of physical, psychosocial and spiritual assessment and symptom management;

F. Review of universal precautions;

G. Patient/family safety issues; and

H. Patient/family rights.

2. The ongoing in-service training shall include a broad range of topics which reflect identified education needs.

(F) Quality Improvement.

1. The hospice shall follow a written plan for continually assessing and improving all aspects of operations which includes:

A. Goals and objectives;

B. The identity of the person responsible for the program;

C. A system to ensure systematic, objective regular reports are prepared and distributed to appropriate personnel;

D. The method for evaluating the quality and appropriateness of care;

E. A method for resolving identified problems; and

F. Application of the plan to improving the quality of patient care.

2. The plan shall be reviewed at least annually by the interdisciplinary group and the governing body and revised as appropriate.

3. Quality assessment and improvement activities shall be based on the systematic collection, review and evaluation of data which may include:

A. Services provided by professional and volunteer staffs, including pain and symptom management;

B. Outcome audits of patient charts;

C. Reports from staff and volunteers about services;

D. Concerns or suggestions for improvement in services;

E. Organizational review of the hospice program;

F. Patient/family evaluations of care;

G. High-risk, high-volume and problem-prone activities;

H. Stress management;

I. Continuity of care; and

J. Inpatient services.

4. When problems are identified in the provision of hospice services, the hospice shall document any evidence of corrective actions taken, including ongoing monitoring, revisions of policies and procedures, educational intervention, and changes in the provision of services.

5. The effectiveness of actions taken to improve services or correct identified problems shall be evaluated.

6. The interdisciplinary group and the governing body shall review and document the quality improvement activities and monitor corrective actions.

(G) Interdisciplinary Group. The hospice shall designate an interdisciplinary group or groups composed of qualified individuals who provide or supervise the care and services offered by the hospice.

1. The interdisciplinary group shall include at least the following individuals who are employees of the hospice:

A. A doctor of medicine or osteopathy;

B. A registered nurse;

C. A social worker; and

D. A pastoral or other counselor.

2. The interdisciplinary group shall be responsible for—

A. Participation in the establishment of the plan of care;

B. Provision or coordination of hospice care and services;

C. Review and updating of the plan of care at least every two (2) weeks for each patient receiving hospice care;

D. Monitor and make recommendations to policies governing the day-to-day provision of hospice care and services; and

E. Oversight of the Quality Improvement program.

3. If a hospice has more than one (1) interdisciplinary group, it shall designate in advance the group it chooses to execute the functions described in subparagraphs (2)(G)2.D. and E. of this rule.

4. The hospice shall designate a registered nurse who is a direct employee of the hospice to coordinate the implementation of the hospice services.

(H) Volunteers.

1. The hospice shall provide task-appropriate orientation and training that is consistent with acceptable standards of hospice practice on the following topics:

A. An introduction to hospice;

B. The volunteer role in hospice care;

C. Concepts of death and dying;

D. Communication skills;

E. Care and comfort measures;

F. Diseases and medical conditions;

G. Psychosocial and spiritual issues related to death and dying;

H. The concepts of the hospice patient and family as a unit of care;

I. Bereavement;

J. Infection control;

K. Safety;

L. Confidentiality;

M. Patient rights; and

N. Additional training such as hospice and the nursing home.

2. Volunteers may be used in administrative or direct patient care roles. Volunteers functioning in accordance with professional practice acts must show evidence of current professional standing and licensure, if applicable.

3. The hospice shall document initial screening, active and ongoing efforts to recruit and retain volunteers.

4. Each hospice shall document and maintain a volunteer staff sufficient to provide administrative or direct patient care in an amount that, at a minimum, equals five percent (5%) of the total patient care hours of all paid hospice employees and contract staff. The hospice shall document a continuing level of volunteer activity. Expansion of care and services achieved through the use of volunteers, including the type of services and the time worked, shall be recorded.

5. The hospice shall document orientation and training activities.

(I) Central Clinical Records. In accordance with accepted principles of practice, the hospice shall establish and maintain a clinical record for every patient receiving care and services. The record shall be complete, legible, readily accessible and systematically organized to facilitate retrieval. Documentation shall be prompt and accurate.

1. Each clinical record shall be a comprehensive compilation of information. Entries shall be made for all services provided. Entries shall be made and signed by the person providing the services. The record shall include all services whether furnished directly or through coordinating providers. Each clinical record shall contain:

A. Initial and subsequent assessments which address, at a minimum, physical, psychosocial and spiritual issues;

B. Complete documentation of all services and events (evaluations, treatments, progress notes, and the like) including:

(I) The physical condition of the patient, including a current history and physical;

(II) The psychosocial status of the patient/family;

(III) The spiritual status of the patient/family; and

(IV) Potential bereavement complications;

C. The plan of care;

D. Identification data;

E. Consent forms;

F. Pertinent medical history;

G. Certification of terminal illness; and

H. Documentation of coordination with coordinating providers.

2. The hospice shall safeguard the clinical record against loss, destruction and unauthorized use.

(3) Core Services. The hospice shall directly provide and shall not arrange for agreement for the core services of nursing, medical social services, physician services and counseling.

(A) Nursing Services.

1. Nursing services shall be directed and staffed to assure that the nursing needs of patients are met.

2. Patient care responsibilities of nursing personnel and coordinating providers shall be specified.

3. Services shall be provided in accordance with recognized standards of practice.

4. The assessment, planning and provision of nursing services shall be the responsibility of the registered nurse.

5. Nursing services delegated to the licensed practical nurse shall be supervised by a registered nurse who is available to the licensed practical nurse at least by phone during the hours that the licensed practical nurse is providing services or is on call. When the licensed practical nurse is providing service to a patient, the registered nurse shall be responsible for the implementation of the plan of care through monthly on-site visits. Written documentation shall show that the licensed practical nurse is routinely providing nursing services in accordance with the plan of care and acceptable standards of practice.

6. When home health aide services are provided, the registered nurse shall develop a written aide assignment based upon the patient's/family's needs.

(B) Medical Social Services. Medical social services shall be provided by a qualified social worker under the direction of the hospice interdisciplinary group.

1. Medical social services shall provide counseling and linkage to community service for the patient/family to assist them in—

A. Developing optimal coping strategies;

B. Assessing community resources;

C. Preparing for death; and

D. Making the most effective use of the health care system.

2. The initial social work assessment visit shall be done within seven (7) calendar days of admission or sooner if indicated.

(C) Physician Services. In addition to palliation and management of terminal illness and related conditions, physician employees of the hospice, including the physician member(s) of the interdisciplinary group, shall coordinate with the attending physician to meet the general medical needs of the patients to the extent that these needs are not met by the attending physician or designee.

(D) Counseling services shall be available to both the patient and the family. Counseling includes dietary, spiritual and any other counseling services for the patient and family which are provided while the patient is enrolled in the hospice and bereavement counseling following the patient's death.

1. Dietary counseling, when required, shall be provided by a qualified individual.

2. Spiritual counseling shall be based on an initial, ongoing and documented assessment of the spiritual needs of the patient/family that includes a history of any religious affiliation and the nature and scope of the spiritual concerns or needs. A visit by the spiritual counselor shall be offered to each patient.

3. Counseling may be provided by other members of the interdisciplinary group as well as by other qualified professionals as determined by the hospice.

4. There shall be an organized program for the provision of bereavement services under the supervision of a qualified professional who is a person with training or experience related to death, dying and bereavement. Following patient's death, the bereavement plan shall be updated based upon an assessment visit to evaluate the needs of the bereaved family and to recognize their social, religious, and cultural variables and values. It shall include an assessment of risk factors, goals, the scope, type and frequency of follow-up services for one (1) year following the death of the patient, and the family's acceptance of bereavement services. At least one (1) bereavement visit shall be planned to occur within three (3) months after the death of the patient.

(4) Other Services. The hospice shall attempt to ensure that the services described in section (5) of this rule are provided directly by hospice employees or through a coordinating provider.

(A) Physical Therapy, Occupational Therapy, and Speech Language Pathology. Physical therapy services, occupational therapy services, and speech language pathology services shall be offered in a manner consistent with accepted standards of practice.

1. The assessment, planning and provision of these services shall be the responsibility of the licensed or registered professional.

2. Therapy services delegated to the physical therapy assistant or the occupational therapy assistant shall be supervised by a licensed physical therapist or registered occupational therapist as appropriate who is available to the physical therapy assistant or occupational therapy assistant at least by phone during the hours that s/he is providing services. When the assistant is providing services to a patient, the licensed or registered therapist shall make a supervisory visit to the residence of the patient at least every sixty-two (62) days. Written documentation shall show that the assistant is providing therapy services in accordance with the plan of care and acceptable standards of practice.

3. This requirement shall be waived by the Department of Health for areas of the state in which no licensed therapists are available provided a good faith effort to provide the service is being made. A hospice seeking this waiver shall submit a written request to the department along with evidence of efforts made by the hospice to provide the service. If approved, a request for waiver shall be resubmitted annually for review.

(B) Home Health Aide and Homemaker Services. Home health aide and homemaker services shall be available to meet the needs of the patients. Effective as to services furnished after August 14, 1990, the home health aide must be a person who has successfully completed a state-established or other training program that meets the requirements of 42 CFR 484.36(a) and a competency evaluation program or state licensure program that meets the requirements of 42 CFR 484.36(b) or (e). An individual is not considered to have completed a training and competency evaluation program, or a competency evaluation program if, since the individual's most recent completion of such program(s), there has been a continuous period of twenty-four (24) consecutive months during none of which the individual furnished services described in 42 CFR 409.40 for compensation.

1. When aide services are being provided, a hospice-registered nurse shall visit the home at least every two (2) weeks. The visit shall include an assessment of the aide services. Written documentation shall show that the aide is providing services in accordance with the plan of care and acceptable standards of practice.

2. The home health aide shall follow written instructions for patient care which are prepared by a registered nurse. Duties include, but shall not be limited to, the duties specified in the regulations pertaining to the

Medicare home health aide (42 CFR 484.36), but shall be in accordance with accepted standards of practice.

3. Twelve (12) hours of in-service per aide per twelve (12)-month period shall be provided or assured by the hospice. The hospice shall maintain a record of in-service provided.

(C) Medical Services. The provision of medical supplies and appliances including medications shall be coordinated as needed for the palliation and management of the terminal illness and related conditions. Hospices shall make every effort to assure that patient needs for medical supplies and appliances are met.

(D) Medications.

1. The hospice shall develop policies and procedures for the safe and effective use of medications, in accordance with accepted professional standards and applicable laws and regulations, including at least the following: ordering, acquiring, storing, controlling, administering, evaluating usage and the disposing of medications.

2. Medications shall be provided on a timely basis and medication services shall be available on a twenty-four (24)-hour basis for emergencies.

A. Prescription medications shall be obtained from pharmacies as patient prescriptions or the patient's own medications may be used.

B. When controlled substance medications are delivered to the patient's residence by hospice staff, the date, patient name, medication name and strength, quantity indicated on the prescription container, and signatures of the hospice staff member and the receiver shall be documented.

3. The hospice shall have written policies and procedures to identify any misuse or patterns of misuse of controlled substances and shall notify the prescriber of abnormalities.

4. Only hospice staff authorized to administer medications shall inventory or handle individual dosage units.

5. Medications shall be ordered only by persons lawfully authorized to prescribe. Medication orders shall include the medication name, dose, frequency and route of administration.

A. *Pro re nata* (PRN) orders shall include frequency parameters and the reason for administration. Oral orders shall be received only by a nurse, pharmacist or physician, immediately reduced to writing, signed by the person receiving the order and signed by the prescriber within twenty-one (21) days.

B. Medication profiles shall be maintained for each patient. Periodic review and monitoring for appropriate medications and use shall be documented and recommendations made to the physician when appropriate. Medication use shall be reviewed with the patient, family, or both, and medication information, counseling and education shall be provided when appropriate.

C. Current medication reference material shall be available to professional staff for all medications used.

6. Medications shall be administered on the order of an authorized prescriber in accordance with accepted standards of practice.

A. Medications shall be administered by persons who have statutory authorization, the patient**,** or a family member. Administration by the patient or by a family member shall be evaluated for appropriateness and ability and this evaluation documented by the nurse.

B. Medication incidents, including medication errors and adverse medication reactions, shall be reported to the prescriber and the registered nurse coordinator, and shall be reviewed through the quality improvement plan. Adverse medication reactions shall also be reported to the pharmacist for documentation on the pharmacist's patient medication profile.

7. Upon the death of the patient, controlled substances at the patient's residence shall be destroyed by the nurse with the consent of the family and in the presence of a witness. A written record of destruction shall be maintained which includes the date, patient name, prescription number, medication name and strength, quantity, method of destruction and signatures of the nurse and witness.

A. The nurse shall recommend the destruction of all noncontrolled substance medications and shall document the destruction.

B. When the nurse is not available, other hospice staff shall recommend that all medications be destroyed by the family.

8. Medications shall not be transferred to other patients and shall not be removed from the residence by hospice staff.

(5) Coordinating Provider. When the hospice patient resides in or is a patient of an acute health care, skilled care or residential care facility which is not providing services under arrangement with the hospice, or if the hospice has an agreement with a coordinating provider, the hospice collaborates with the other organizations and individuals providing care to the patient/family to ensure coordination of services. Collaboration activities shall include the following:

(A) A current copy of the hospice plan of care is placed in the facility patient record;

(B) Written information is provided to the facility regarding the hospice philosophy and services available;

(C) A registered nurse from the hospice is identified to coordinate the hospice services and respond to questions and concerns from the facility or other coordinating provider; and

(D) The hospice patient record is documented to reflect communication between the facility or other coordinating provider and the hospice when any changes are made to the plan of care.

(6) This rule will expire October 15, 2001.

*AUTHORITY: section 197.250, RSMo 1994.* Original rule filed March 8, 1996, effective Oct. 30, 1996.*

**Original authority 1992.*

**19 CSR 30-35.020 Hospices Providing Direct Care in a Hospice Facility**

*PURPOSE: This rule defines the minimum requirements necessary for the construction and operation of hospice inpatient facilities in order to be certified as part of the hospice program.*

*PUBLISHER'S NOTE: The publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.*

(1) A hospice that delivers care in a facility operated by the hospice and not otherwise licensed shall comply with this rule in addition to 19 CSR 30-35.010 Hospice Program Operations. The hospice governing board members shall meet, tour, or both, the inpatient facility at a minimum of once a year.

(2) Organization and Management of Hospice Facilities.

(A) Twenty-Four (24)-Hour Staffing.

1. The hospice shall provide twenty-four (24)-hour staffing which is sufficient to meet the patients' total needs in accordance with

the patient plan of care. Each patient shall receive treatment, medications and diet as prescribed and shall be kept comfortable, clean, well-groomed and protected from accident, injury and infection.

2. All hospices shall employ qualified staff at the ratio of one for every ten (1:10) patients per shift, per patient unit, twenty-four (24) hours a day. Staffing personnel shall be on duty at all times on each patient-occupied floor, with no less than two (2) staff personnel in a facility at all times. Minimum staff personnel shall be no less qualified than one (1) home health aide or companion/volunteer and one (1) licensed practical nurse.

3. Staff shall be supervised by the hospice interdisciplinary group. A registered nurse shall be available for telephone consultation or on-site visit as needed, twenty-four (24) hours a day. The hospice medical director shall make an on-site visit to the hospice facility a minimum of once a month and as needed.

4. Facility personnel shall have telephone access to administrative staff, twenty-four (24) hours a day.

5. The level of licensed nursing staff shall be adjusted to meet the needs of the hospice residents residing in the hospice facility based upon established indicators of patient acuity and ability to perform activities of daily living as established by the hospice and approved by the Department of Health.

(B) Disaster Preparedness. The hospice shall have a written plan, annually rehearsed with staff, which includes procedures to be followed in the event of an internal or external disaster and for the care of casualties (patients and personnel) arising from disasters. Each facility shall conduct quarterly fire drills so that each shift participates at least annually.

(C) Meals Service Menu Planning and Supervision. The hospice shall—

1. Make available a practical freedom of choice diet offering at least three (3) meals and snacks, or their equivalent, that accommodate patient's needs and preferences each day at regular times, with not more than fourteen (14) hours between a substantial evening meal and breakfast. At least two (2) meals shall be hot;

2. Prepare and serve foods using methods that conserve nutritive value, flavor and appearance;

3. Give special attention to the texture of food served to patients who have chewing difficulty;

4. Provide assurance that hot food is served hot and cold food is served cold;

5. Give a minimum of thirty (30) minutes for eating meals. Patients who eat slowly or who need assistance shall be given as much time to eat as necessary;

6. Make tray service and dining room service attractive for patients and ensure that each patient receives appropriate table service;

7. Provide each patient who is served meals in bed or in a chair not within the dining area with either a table, an overbed table or an overbed tray of sturdy construction which is positioned so that the patient can eat comfortably;

8. Provide assistance upon tray delivery to all patients requiring assistance at mealtimes, whether it be preparation of the food items or actual feeding. Dining room supervision shall be provided during meals;

9. Establish an identification system to assure that each patient receives the diet as ordered;

10. Provide sufficient equipment and personnel trained in their duties to assure adequate preparation and serving of food if meals are prepared on-site;

11. Review menus for special prescribed diets and approve in writing by either a qualified dietitian, a registered nurse, or a physician;

12. Keep a current record of purchased food to show the kind and amount of food purchased each month, if meals are prepared on-site;

13. Plan menus for all diets at least two (2) weeks in advance if meals are prepared on-site. If cycle menus are used, the cycle shall cover a minimum of three (3) weeks and shall be different each day of the week;

14. Make fresh water readily accessible to all patients at all times;

15. Procure, store, prepare, distribute and serve all food under sanitary conditions;

16. Permit family to bring, prepare and serve food to their loved one; and

17. Permit staff to prepare a single patient snack upon request.

(D) Patient Areas.

1. The hospice shall design and equip areas for the comfort and privacy of each patient and family member.

2. The hospice shall have accommodations for family privacy after a patient's death that do not infringe on other patients' rights and decor which is homelike in design and function;

3. Patients shall be permitted to receive visitors, including small children, at any hour;

4. Each patient shall receive twenty-four (24)-hour protective oversight and supervision;

5. The facility shall have a policy regarding pets; and

6. Smoking may be permitted in the hospice consistent with the smoking policy of the facility. Smoking may be permitted in the patient's room and in designated smoking areas. Individual patients may be permitted to smoke in their rooms with the consent of any other patients occupying the room and with the permission of his/her attending physician. If a patient is confined to bed or classified as not being responsible, smoking is permitted only under the direct supervision of an authorized individual.

(E) Infection Control.

1. The hospice shall make disease-specific provision for isolating patients with infectious diseases.

2. Infectious waste management control.

A. Every inpatient hospice facility 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 the least the following: administrator's endorsement letter; introduction and purpose; objectives; phone number of responsible individuals; definition of those wastes handled by the facility; identification of responsible individuals; procedures for waste identification, segregation, containment, transport, treatment and disposal; emergency and contingency procedures and training and educational procedures.

B. 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.

C. Containers for infectious waste shall be identified with the universal biological waste symbol. All packaging shall maintain its integrity during storage and transport. Infectious waste shall not be placed in a gravity disposal chute.

D. Pending disposal, infectious waste shall be stored separately from other wastes in a room limited to staff access.

E. When transported off the premises of the hospice, all infectious waste shall be packaged and transported as provided in sections 260.200–260.245, RSMo.

3. Approved written policies and procedures shall define and describe the scope and conduct of laundry and linen services. There shall be a mechanism for the review and evaluation on a regular basis of the quality of linen sanitizing services.

4. Approved written policies and procedures shall define and describe the scope and conduct of on-site cleaning of dietary ware.

There shall be a mechanism for the review and evaluation on a regular basis of the quality of dietary-ware sanitizing services provided.

(F) Pharmacy Services. The hospice shall comply with all provisions of 19 CSR 30-35.010 regarding medications.

1. The hospice shall employ or contract with a pharmacist on a full-time, part-time or consultant basis. The pharmacist shall assist in the development of policies and procedures for medication use, shall advise the hospice on all other matters pertaining to the use of medications, shall serve as a member of, or consultant to, the interdisciplinary team and shall provide medication information to professional staff as required. A pharmacist shall be available on a twenty-four (24)-hour basis for emergencies.

2. Medication acquisition and labeling.

A. No stock supply of prescription medications shall be maintained except that each facility shall maintain an emergency medication kit and controlled substances may be maintained as stock.

B. When the emergency medication kit contains controlled substances, the facility shall be registered with the Missouri Bureau of Narcotics and Dangerous Drugs. When controlled substances are maintained in stock, the facility shall be registered with the Missouri Bureau of Narcotics and Dangerous Drugs and the Drug Enforcement Administration.

C. Patient prescription medications shall be labeled with at least the patient name, medication name, strength and date dispensed. They shall also contain accessory information and the expiration date when applicable.

D. Prescription medication labels shall not be altered by hospice staff and medications shall not be repackaged by hospice staff.

E. When the patient's own medications are used, they shall be examined prior to use for suitability and positively identified by a pharmacist or nurse in writing.

F. Nonprescription medications may be obtained as stock or individual patient supplies. They shall not be repackaged and supplies for individual patients shall be labeled with the patient's name.

3. Medication storage and control.

A. All medications shall be stored in locked compartments under proper temperature controls, separate from food and other substances, and accessible only to persons authorized to administer them.

B. Controlled substances shall be stored in locked compartments separate from other medications.

C. The pharmacist shall inspect medication storage areas and the emergency medication kit monthly and shall document this inspection.

D. Records of receipt and disposition of all controlled substances shall be maintained separate from other records.

(I) Inventories of Schedule II controlled substances shall be reconciled each shift.

(II) Inventories of Schedule III–V controlled substances shall be reconciled daily.

(III) Receipt records shall include the date, source of supply, patient name and prescription number when applicable, medication name and strength, quantity and signatures of the supplier and receiver.

(IV) Administration records shall include the date, time, patient name, medication name, dose administered and signature of the person administering.

(V) Documentation of waste at the time of administration shall also include the reason for the waste and the signature of an authorized witness.

E. The pharmacist shall review controlled substance recordkeeping monthly as part of the quality improvement plan.

F. All variances of controlled substance records shall be reported to the registered nurse coordinator and the pharmacist for review and investigation. All losses of controlled substances shall be reported to the Missouri Bureau of Narcotics and Dangerous Drugs and to other federal, state and local authorities when required.

G. All controlled substance records shall be maintained for two (2) years.

4. Medication administration.

A. Medication administration by the patient or a family member shall be ordered by the physician. Instructions for administration shall be provided.

B. Noncontrolled substances may be stored in a locked compartment in the patient's room.

C. Single doses of controlled substances may be placed in the locked compartment or provided directly to the patient or family member prior to the time of administration.

D. Administration of the patient's own medications brought to the facility shall be ordered by the authorized prescriber.

E. Medications for administration when a patient temporarily leaves the facility shall be labeled by the pharmacy with instructions for administration, except that single doses of each medication may be provided by the nurse in containers labeled with the patient's name, medication name and strength, instructions for administration, and other necessary information.

F. Medication administration shall be documented on a separate record. Administration by the patient or a family member shall be monitored by nursing staff and documented.

G. Medication incidents shall be reported as required in 19 CSR 30-35.010 and shall be reported to the pharmacist when appropriate.

5. Other medication disposition.

A. Medications may be sent with a patient at the time of discharge only if they have been labeled by the dispensing pharmacy with instructions for administration and ordered by the authorized prescriber.

B. Records of this disposition shall include the date, patient name, prescription number, drug name and strength, quantity and signatures of the persons releasing and receiving the medications.

C. Patient prescription medications which have been discontinued shall be destroyed within sixty (60) days if they are controlled substances or if they are not in unit-dose packaging.

D. Patient prescription medications of expired patients shall be destroyed within five (5) days if they are controlled substances or if they are not in unit-dose packaging or if they were brought from home.

E. Other expired or nonusable medications shall be destroyed within five (5) days.

F. Medications shall be destroyed by a pharmacist and a nurse or two (2) nurses, and a record of destruction shall be maintained which includes the date, patient name, prescription number, medication name and strength, quantity, method of destruction and signatures of the persons destroying the medications.

G. Unit-dose packaged medications returnable to the pharmacy shall be returned within ten (10) days.

H. Medications shall not be transferred to other patients and shall not be removed from the facility by hospice staff, except those being returned to the pharmacy.

(3) General Design and Construction Standards for New Inpatient Hospice Facilities.

(A) Health and Safety Laws. The hospice shall meet all federal, state and local laws, ordinances, regulations and codes pertaining to health and safety, including but not limited to, provisions regulating construction, maintenance and equipment.

1. General requirements.

A. After October 30, 1996, a new hospice facility shall submit plans for

approval to the Department of Health for the construction of a new facility, expansion or renovation of an existing state certified hospice or the conversion of an existing facility not previously and continuously state certified and operated as a hospice facility under section 197.250, RSMo.

B. New hospice facilities shall be designed and constructed in conformance with this rule.

C. This rule is not intended to restrict innovations and improvements in design or construction techniques. Accordingly, the Department of Health may approve plans and specifications which contain deviations from this rule. Requests for deviations from requirements on physical facilities shall be in writing to the Department of Health and shall contain information which determines that the respective intent or objectives of this rule have been met. Approvals for deviations shall be in writing and both requests and approvals shall be made a part of the permanent Department of Health records for the hospice.

D. Where renovation or replacement work is done within an existing licensed facility, all new work, additions, or both, shall comply with the applicable sections of this rule. Where existing major structural elements make total compliance impractical or impossible, alternative proposals which result in an equivalency may be considered by the department.

E. In renovation projects and additions to existing state certified hospice facilities, only that portion of the total facility affected by the project shall comply with the applicable sections of this rule. However, upon construction completion, the facility shall satisfy all functional requirements for state certified hospices.

F. Those existing portions of the facility which are not included in the renovation but which are essential to the functioning of the complete facility as well as existing state certified building areas that receive less than substantial amounts of new work shall, at a minimum, comply with the state certification requirements which were in effect at the time that the existing portion of the building was state certified.

G. All required fire exits shall be maintained throughout the construction and the work shall be phased as necessary to minimize disruption of the existing hospice operation.

2. Planning and construction procedures.

A. Any hospice facility constructed or renovated after October 30, 1996, shall have plans and specifications prepared in conformance with Chapter 327, RSMo by an architect or engineer duly registered in Missouri. The owner of each new facility or the owner of an existing licensed inpatient hospice 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 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. This program shall be submitted to the Department of Health for review along with the plans developed for the project. Schematic and preliminary plans showing the basic layout of the building and the general types of construction, mechanical and electrical systems and details may be submitted to the department before the larger and more complicated working drawings and specifications so that necessary corrections can be easily made before final plans are completed. Working drawings and specifications, complete in all respects, shall be prepared and submitted to the Department of Health for approval. These plans shall cover all phases of the construction project, including site preparation: paving; general construction; mechanical work, including plumbing, heating, ventilating and air conditioning; electrical work; and all built-in equipment, including elevators, kitchen equipment, cabinet work, and the like.

B. The Department of Health shall be notified in writing within five (5) days after construction begins. Construction shall be in conformance with plans and specifications approved by the Department of Health. The department may elect to inspect the construction of hospice projects at any time during the development of the project. If construction of the project is not started within one (1) year or completed within a period of three (3) years after the date of the approval of the plans and specifications, the plans and specifications shall be resubmitted to the Department of Health for its approval and shall be amended, if necessary, to comply with the then current rules before construction work is started or continued.

C. References in this rule to National Fire Protection Association (NFPA) publications are those contained in the twelve (12)-volume *1994 Compilation of NFPA Codes, Standards, Recommended Practices and Guides*. Where there are discrepancies between referenced NFPA publication requirements and this rule, the requirements of this rule shall apply.

D. The design and construction of hospices shall conform to the most stringent requirements of this rule and the local governing building code and zoning ordinances.

3. Site.

A. Adequate paved pedestrian access shall be provided within the lot lines to the main entrance. Loading and unloading space for delivery vehicles shall be paved.

B. Adequate paved parking shall be provided. Parking space needs shall be determined by the local zoning requirement and the operational program but shall not be less than one (1) space for each of the maximum number of staff persons on duty at any given time plus one (1) parking space for each licensed inpatient bed in the facility.

C. Fire lanes shall be provided as required by local authority and kept clear to provide immediate access for fire fighting equipment.

D. The site shall provide reasonable access for those individuals to be served by the facility. The facility shall be on an all-weather road for easy access by vehicular traffic. Consideration should be given to locating the hospice to provide easy access to public transportation services which may be available in the community.

E. The site shall be located within the service area of a public fire department.

4. Roads, parking facilities, walks, ramps and entrances shall be accessible and usable by persons with various physical handicaps. At least one (1) toilet, telephone and drinking fountain shall be provided on each floor of a hospice which is accessible for use by handicapped public and staff. Elevator controls and alarms shall be accessible to wheelchair occupants and shall be provided with tactile signage for the visually impaired. Design details for handicapped accessible facilities should be consistent with the *Guidebook to: The Minimum Federal Guidelines of Requirements for Accessible Design* published January 6, 1981, by the U.S. Architectural and Transportation Barriers Compliance Board. At least ten percent (10%) of the patient beds shall be located in handicapped-accessible rooms with accessible toilet rooms which open directly into the patient room. All other clinical areas to which patients have common access shall be handicapped-accessible.

5. Administrative and public areas shall be provided.

A. All hospices shall provide adequate work areas to support the administrative personnel and governing body. The facilities shall allow business to be conducted in a setting which provides confidentiality and privacy as required. The administrative offices may be located remotely from a hospice inpatient unit or may be housed within the inpatient facility. Where administration is included within the inpatient facility, the following shall be provided:

(I) Administrator's office;

(II) Business office including a work area for quality assurance;

(III) Storage and work area for archived medical records;

(IV) Conference room for governing board meetings and personnel in-service training; and

(V) Office for director of patient care services.

B. Each inpatient hospice facility shall provide the following public areas in a location separated from the clinical and service areas of the facility:

(I) Lobby/waiting room with reception;

(II) Wheelchair accessible public toilet;

(III) Wheelchair accessible public drinking fountain; and

(IV) Wheelchair accessible public phone.

6. Design of patient-care units.

A. One (1) or more patient-care units shall be provided. Each unit shall not exceed a maximum of twenty (20) beds. Each patient-care unit shall be a continuous area which does not require patient-care traffic to traverse other areas and shall be restricted to only one (1) floor level. If justified by the program submitted under subparagraph (2)(A)2.A. of this rule, the department may consider approval of designs which provide for larger capacity patient-care units.

B. The bed area in a patient room, exclusive of toilet rooms, closets, alcoves or vestibules, shall be not less than one hundred twenty (120) square feet in a private room and not less than two hundred (200) square feet in a semiprivate room. Heating units and lavatories may protrude into this space. No dimension for the bed area in any patient room shall be less than ten feet (10'). No patient room shall house more than two (2) patients. Each patient-care unit shall have not greater than fifty percent (50%) of its beds housed in semiprivate rooms and the remaining rooms shall be limited to occupancy by one (1) patient. If justified by the program submitted under subparagraph (2)(A)2.A. of this rule, the department may consider approval of designs which provide other ratios of semiprivate to private patient rooms.

C. Each patient shall have access to a toilet room without entering the general corridor area. One (1) toilet may serve not more than two (2) adjacent rooms. The toilet room shall contain a lavatory and water closet and shall be sized to permit access for the patient and an assisting member of the staff. The lavatory may be omitted from the toilet room if a lavatory is provided in the patient room.

D. At least one (1) patient room per patient-care unit shall be provided to be used for isolation. This unit shall have a toilet room equipped with a bathing facility which serves this room exclusively.

E. Mirrors shall be provided in each patient room or adjoining toilet room. Mirrors shall be at least three feet (3') high located with the bottom edge no more than three feet four inches (3' 4") above the floor.

F. Patients shall have separate wardrobes, lockers or closets located within their respective patient rooms. A clothes rod and shelf shall be provided.

G. One (1) or more windows shall be provided, with the sash not more than three feet (3') above the floor and with a gross area of not less than ten percent (10%) of the floor area of the room. In each patient room at least one (1) window to the outside shall be operable. Patient room windows shall be exposed to an outside area not less than thirty feet (30') horizontally opposite the window which contains no construction or grading which would further diminish the view and the exposure of the window to natural light.

H. Social spaces (dining, recreation, meditation) shall be provided throughout the facility with a cumulative area of not less than thirty (30) square feet per patient bed. One (1) social space may serve more than one (1) patient-care unit provided it is directly accessible from each unit and is sized proportionate to the total number of patient beds it serves. No social space shall be smaller than one hundred fifty (150) square feet in area.

I. Unless bathing facilities are included in the toilets serving each patient room, central bathing facilities shall be provided in each patient-care unit at a ratio of not fewer than one for each ten (1:10) beds. Each bathing facility shall be located in its own room and shall be directly accessible from the general corridor. The bathing facility may be either a tub, shower or tub/shower combination. However, at least one (1) handicapped-accessible shower shall be provided on each patient unit. A locked cabinet for the storage of cleaning supplies shall be available in or near each bathroom.

7. The following staff support and service areas shall be located directly accessible to each patient-care unit:

A. Clean work and storage facilities shall be equipped with counter and sink and storage space provided for clean linen and supplies;

B. A separate soiled/decontamination utility room shall be equipped with a clinic sink (this fixture is not required where bedpan-flushing devices have been installed at each patient toilet), counter and sink and sufficient floor space shall be provided to accommodate storage containers for soiled linen, trash and infectious waste;

C. Space shall be provided for secure storage of staff personal items;

D. A staff station shall be located to provide visual supervision of the patient-care unit corridors. The station shall consist of a work counter and secure storage space for charts;

E. A medication storage and preparation station which has a means of locked storage for all medications shall be equipped with a work counter, sink and refrigerator. Separate locked storage facilities shall be provided in the station for controlled substances. If medications are held in each patient room, the room shall include separate locked storage facilities for each patient's medications;

F. A nourishment station shall be equipped with a work counter, sink and refrigerator shall be provided physically remote from the medication preparation station;

G. Storage space shall be provided for mobile equipment used on the unit;

H. A janitor's closet shall be provided which is equipped with a mop sink and has sufficient space for the cleaning equipment and open supplies used to maintain the patient-care unit; and

I. All clean support functions may be located in one (1) clean work room provided the room is carefully designed to provide adequate storage and function separations.

8. Food service facilities shall be designed and equipped to meet the requirements of the scope of services outlined as follows:

A. Dietary facilities shall comply with 19 CSR 20-1.010;

B. In hospice facilities where food is prepared on-site, the dietary facilities shall, as a minimum, have—a storage space including cold storage for four (4) day's supply, space and equipment for food preparation to facilitate efficient food preparation and to provide for a safe and sanitary environment, conveniently located handwashing facilities, space for preparing food for distribution to

patients, warewashing facilities which are isolated from the food preparation and serving area, and storage facilities for waste which is inaccessible to insects and rodents and accessible to the outside for pickup or disposal. The warewashing processes shall produce dietary ware which is free of pathogenic organisms; and

C. In hospice facilities where the food service is provided through a vendor contract, dietary facilities shall, as a minimum, include space for receiving and holding the food transport equipment, utility connections for food transport equipment to maintain appropriate serving temperatures, and a holding area for soiled dietary ware transport equipment which is out of the patient area and located near the service entrance for pick-up.

(B) Service facilities shall meet the following standards:

1. Services including linen service.

A. Service facilities shall be provided in each inpatient hospice facility and located to be out of the normal public and clinical traffic flow.

B. A weather-protected service entrance shall be provided separate from entrances used by public and patients.

C. Space and facilities shall be provided for the sanitary storage and disposal of waste. Exterior dumpsters will suffice provided they can be accessed under the protection provided at the service entrance.

D. A general storage room shall be provided with an area not less than ten (10) square feet per bed for the first fifty (50) beds, plus eight (8) square feet per bed for the next twenty-five (25) beds, plus five (5) square feet per bed for any additional beds over seventy-five (75). No storage room shall be less than one hundred (100) square feet of floor space. Off-site storage is acceptable, however, one-half (1/2) of the required storage space shall be located in the inpatient hospice facility. General storage shall be concentrated in one (1) area.

E. Space shall be provided to house mechanical equipment. The space shall be adequate for initial installation and on-going maintenance access for each component of the systems housed in it. Mechanical equipment shall not be installed in rooms designated to house other functions.

F. A housekeeping room shall be provided with a janitor's sink and space to store opened containers of cleaning supplies and housekeeping equipment used to maintain the facility. This room is not required if the hospice is maintained by a contract cleaning service which transports the necessary cleaning supplies and equipment to the facility on a daily basis.

G. An oxygen storage room shall be provided. This room shall be enclosed with one (1)-hour rated construction and shall have a powered or gravity vent to the outside. Permanent racks or fasteners shall be provided and used in the oxygen storage room to prevent accidental damage or dislocation of oxygen cylinders. In facilities storing quantities of oxygen less than fifteen hundred (1500) cubic feet in total, a power ventilated storage cabinet will comply. No ventilated gas storage facilities are required in hospices which store no medical gases within the building.

H. Laundry services may be provided by the hospice operator or may be obtained through contract with a linen service vendor. If laundry for the facility is done commercially, either entirely or in part, space shall be provided for the sorting, processing and storing of both soiled and clean linen. Storage space shall be located to facilitate convenient pickup and delivery by commercial laundry personnel. Hospices with only one (1) patient-care unit may accommodate these functions within the utility facilities provided in the unit's staff support area.

I. Hospice-operated laundry facilities shall be designed and procedures instituted to prevent cross-contamination of clean and dirty linen. The laundry room shall be in a separate room from the kitchen, patients' rooms, the dining room and the bathrooms or the nursing utility room. Adequate space shall be provided in the laundry room for the storing, sorting and processing of soiled linen. The processes of the laundry operation shall be appropriate to the production of patient linens which are free of pathogenic organisms. Space shall be provided for the storage of clean linen in a separate room from the laundry.

J. As may be required by the program, laundry facilities provided for cleaning patients' clothing exclusively shall be located in the patient-care unit but in a room separate from other functions. A residential-style laundry equipment installation is acceptable.

K. As required by the program, living and sleeping quarters, separate from patients' facilities, shall be provided for the employees and their families who may reside in the facility;

2. Elevators.

A. All inpatient hospice facilities having patient-care facilities located on any floor other than the main entrance floor shall have at least one (1) electric or electrohydraulic elevator. Hospice facilities with more than thirty (30) beds located on any floor other than the main entrance floor shall have at least two (2) elevators. Hospice facilities with more than two hundred (200) beds located on any floor other than the main entrance floor shall provide passenger and service elevators in numbers and at locations determined by a professionally conducted study of the hospice operation and its estimated vertical transportation needs.

B. Inside dimensions of patient-use elevators shall be not less than five feet four inches by eight feet (5' 4" × 8') with a capacity of three thousand five hundred pounds (3500 lbs.). Cab and hoistway doors shall be not less than three feet ten inches (3' 10") clear opening.

C. Elevators shall be equipped with an automatic leveling device of the two (2)-way automatic maintaining type with an accuracy of plus or minus one-half inch (±1/2").

D. Elevator call buttons, controls and door safety stops shall be of a type that will not be activated by heat or smoke.

E. Elevator controls, alarm buttons and telephones shall be accessible to wheelchair occupants and usable by others with various physical disabilities.

F. Elevator hoistway doors shall be fire rated to maintain the integrity of the fire-rated shaft enclosure;

3. Chutes and dumbwaiters.

A. Chutes and dumbwaiters may be installed in hospice facilities as required by the operational program.

B. Linen and trash chutes shall be of fire-resistant material and shall be installed with flushing ring, vent to atmosphere and floor drain at the floor of the chute discharge. An automatic sprinkler shall be provided at the top of each linen and trash chute.

C. Service openings to chutes shall not be located in corridors or passageways but shall be located in a room having a fire-resistant construction of not less than one (1) hour. Doors to the rooms shall be not less than three-fourths (3/4)-hour labeled doors equipped with an automatic closing device.

D. Service openings to chutes and other vertical openings shall have an approved self-closing labeled fire door rating not less than the fire-resistant rating of the shaft in which the chute is installed.

E. Chutes shall discharge directly into collection rooms separate from the incinerator, laundry or other services. Separate collection rooms shall be provided for trash and for linen. These rooms shall have a fire-resistant construction of not less than one (1) hour. Doors to these rooms shall be not less than three-fourths (3/4)-hour labeled doors equipped with an automatic closing device.

F. Dumbwaiters, conveyors and material-handling systems shall not open directly into a corridor or exitway but shall open into a room enclosed by construction having a fire resistance of not less than one (1) hour and provided with a three-fourths (3/4)-hour labeled fire door with a self-closing device.

G. Where horizontal conveyors and material-handling systems penetrate fire-rated walls or smoke walls, the penetrations shall be protected to maintain the integrity of the wall;

4. General design, finish and life safety requirements.

A. A continuous system of unobstructed corridors, referred to as required corridors, shall extend through the enclosed portion of each story of the building, connecting all rooms and spaces with each other and with all entrances, exitways and elevators, with the following exceptions: work suites such as the administrative suite and dietary area, which are occupied primarily by employed personnel, may have within them corridors or aisles as considered advisable, but are not subject to the regulations applicable to required corridors. Areas may be open to the required corridor system as permitted by NFPA 101 (1994), *The Life Safety Code*.

B. The arrangement of the physical plant shall provide for separation of the administrative/business, service and public areas from patient service areas.

C. Ceilings shall be at a height of at least eight feet (8'). Ceilings in corridors, storage rooms, toilet rooms and other minor rooms shall not be less than seven feet six inches (7' 6"). Suspended fixtures located in the path of normal traffic shall not be less than six feet eight inches (6' 8") above the floor.

D. Handrails may be provided on both sides of all corridors and aisles used by patients and, if provided, corridor handrails shall have ends return to the wall.

E. New inpatient hospice facilities shall be designed and constructed in compliance with chapters five through seven and chapter twelve of NFPA 101 (1994) *Life Safety Code* and NFPA 99 (1993) *Standard for Health Care Facilities*, NFPA 13 (1994) *Standard for Installation of Sprinkler Systems* and NFPA 90A (1993) *Standard for the Installation of Air Conditioning and Ventilation Systems*. Section 12-6 of NFPA 101 shall not apply to these facilities.

F. Hardware on toilet room doors shall be operable from both the inside and the outside. All toilet room doors shall provide a net clear opening of not less than thirty-two inches (32").

G. The corridor doors from all patient-use areas as well as all doors through which patients may need to pass for emergency exit shall be not less than thirty-six inches (36") wide.

H. Every window in patient-use areas shall be provided with shades, curtains or drapes. Curtains and drapes shall be made of fabric which is treated to be or is inherently flame-retardant.

I. The floors of toilets, baths, utility rooms and janitor's closets shall have smooth, waterproof surfaces which are wear-resistant. The floors of kitchens and food preparation areas shall be waterproof, grease-proof, smooth and resistant to heavy wear.

J. The walls of all rooms where food and drink are prepared, served or stored shall have a smooth surface with painted or equally washable finish. At the base they shall be waterproof and free from spaces which may harbor insects. The walls of kitchens, utility rooms, baths, warewashing rooms, janitor's closets and spaces with sinks shall have waterproof, painted, glazed, or similar finishes to a point above the splash and spray line.

K. The ceilings of all kitchens, sculleries and other rooms where food and drink are prepared shall be painted with washable paint.

L. All casework in the facility shall be finished with at least a sealer on all interior surfaces. Casework with sinks installed in the counter shall be caulked to provide a watertight joint between the backsplash and the wall.

M. All floor covering used in inpatient hospice facilities shall have either Class A or B fire ratings as required by chapter twelve of NFPA 101 (1994) *The Life Safety Code*.

N. Stairways, ramps, elevator hoistways, light or ventilation shafts, chutes and other vertical openings between stories shall be enclosed with construction which is equal to or greater than the required floor assembly rating of the building's construction type.

O. The number of stories in a building housing a hospice facility shall be determined by counting the number of occupiable levels in the building regardless of their location at, above or below grade.

P. Each room or patient-use area shall be conspicuously and unmistakably identifiable at its entrance by patients, visitors and staff.

Q. All signage within six feet (6') of the floor shall be tactile to be usable by visually impaired persons.

R. Fire-resistant ratings—

(I) Definitions—

(a) Fire separation distance is the distance in feet measured from the building face to the closest interior lot line, to the centerline of a street or public way or to an imaginary line between two (2) buildings on the same property.

(b) Fire-protection rating is the time in hours, or fractions of an hour, that an opening protective assembly will resist fire exposure as determined in accordance with the test procedures set forth in ASTM E119.

(II) Exterior walls with a fire-separation distance less than five feet (5') shall have a fire-resistant rating of one (1) hour.

(III) In exterior walls with a fire-separation distance of three feet (3') or less, no openings will be allowed, from three feet to five feet (3'–5') no unprotected openings will be allowed, and protected openings will be allowed with a total aggregate area of fifteen percent (15%) of the wall surface.

(IV) Approved fire protective assemblies shall be fixed, self-closing or equipped with approved automatic-closing devices, a fire-resistant rating of not less than three quarters (3/4) of an hour shall be required.

(V) Fire protective assemblies are not required where outside automatic sprinklers are installed for the protection of the exterior openings. The sprinklers shall be installed in accordance with NFPA 13;

5. Structural design.

A. All new facilities and additions to all areas of existing licensed facilities which undergo major remodeling, in all their parts, shall be of sufficient strength to resist all stresses imposed by dead loads, live loads and lateral or uplift forces such as wind, without exceeding, in any of the structural materials, the allowable working stress established for these materials by generally accepted good engineering practice.

B. Foundations shall rest on solid ground or properly compacted fill and shall be carried to a depth of not less than one foot (1') below the estimated frost line or shall rest on leveled rock or load-bearing piles when solid ground is not encountered. When engineered fill is used, site preparation and placement of fill shall be done under the direct full-time supervision of the soils engineer. The soils engineer shall issue a final report on the compacted fill operation and certify its compliance with the job specifications. Reasonable care shall be taken to establish proper soil-bearing values for soil at the building site. If the bearing capacity of a soil is in question, a recognized load test may be used to determine the safe bearing value. Footings, piers and foundation walls shall be

adequately protected against deterioration from the action of groundwater;

6. Electrical systems.

A. The entire electrical system shall be designed, installed and tested in compliance with NFPA 70 (1993) *The National Electrical Code* and NFPA 99 (1993) *Standard for Health Care Facilities*.

B. Emergency lighting shall be provided for exits, stairs and exit access corridors which shall be supplied by an emergency service and automatic electric generator or battery lighting system. This emergency lighting system shall be equipped with an automatic transfer switch. If battery lights are used, they shall be wet cell units or other rechargeable-type batteries equipped with automatic trickle charger. These units shall be rated at four (4) hours.

C. Patient rooms shall have a minimum general illumination of ten (10) footcandles, a nightlight and a patient's reading light. The general illumination fixtures and the nightlight shall be switched at the patient room door.

D. Ceiling lighting fixtures, if used, shall be of a type which are shaded or globed to minimize glare.

E. Each patient room shall have not less than one (1) duplex receptacle on each wall in the room. The spacing of receptacles around the perimeter of the room shall not be greater than twelve feet (12').

F. All occupied areas shall be adequately lighted as required by the duties performed in the space.

G. Nightlights shall be provided in corridor, stairways and patient rooms. Toilets adjacent to patient rooms are not required to have nightlights.

H. An electrically powered communication system shall be provided which allows staff to respond to patient calls regardless of patient location.

I. An electrically powered fire alarm system shall be provided as required by NFPA 101 (1994) *The Life Safety Code*. The fire alarm system shall have an emergency backup source of electrical power and a direct connection for notifying the fire department or fire department dispatch service. Fire alarm manual pull stations shall be provided at each exit and at each staff work station in the patient-care units. Smoke detectors shall be installed in social space rooms which open directly to the corridor, in the vicinity of any smoke or fire door which is permitted to be held open by a magnetic hold-open device, and in the corridors at intervals not exceeding thirty feet (30').

J. Portable fire extinguishers shall be provided as required by NFPA 101 (1994) *The Life Safety Code* and the local authority;

7. Mechanical systems.

A. The heating, ventilation and air conditioning systems shall be capable of providing temperature ranges between seventy-two degrees Fahrenheit (72°F) and eighty degrees Fahrenheit (80°F) in all patient care areas. The heating system shall be capable of maintaining a winter indoor temperature of not less than seventy-two degrees Fahrenheit (72°F) in all nonpatient areas. The air conditioning system shall be capable of maintaining a summer indoor temperature of not more than eighty degrees Fahrenheit (80°F) in all nonpatient areas.

B. The heating system shall have automatic controls adequate to provide comfortable conditions in all portions of the building at all times.

C. Heating, ventilation and air conditioning systems installed in inpatient hospice facilities shall be designed, installed and balanced in compliance with NFPA 90A (1993) *Standard for the Installation of Air Conditioning and Ventilation Systems*, and shall provide the pressure relationships and at least the minimum air change rates indicated in Table 1.

**TABLE 1—VENTILATION REQUIREMENTS**

| Area Designation | Pressure Relationship to Adjacent Areas | Minimum Air Changes of Outdoor Air Per Hour Supplied to Room | Minimum Total Air Changes Per Hour Supplied to Room | All Air Exhausted Directly to Outdoors | Air Returned From This Room |
|---|---|---|---|---|---|
| Patient Room | E | 2 | 2 | Optional | Optional |
| Patient Area Corridor and Patient Living Room | P | 2 | 2 | Optional | Optional |
| Soiled Work Room and Soiled Linen Holding | N | Optional | 6 | Yes | No |
| Clean Staff Work Area | P | 2 | 6 | Optional | Optional |
| Toilet Room | N | Optional | 6 | Yes | No |
| Clean Linen Storage | P | Optional | 2 | Optional | Optional |
| Designated Smoking Area | N | Optional | 10 | Yes | No |
| Food Preparation Area | E | 2 | 6 | Yes | No |
| Warewashing | N | Optional | 6 | Yes | No |
| Dietary and General Storage | V | Optional | 2 | Optional | Optional |
| Linen and Trash Chute Room | N | Optional | 6 | Yes | No |
| Medical Gas Storage and Manifold Rooms | N | Optional | 6 | Yes | No |
| Administrative and Public Areas | E | 2 | 2 | Optional | Optional |

P=Positive
N=Negative
V=Variable
E=Equal

D. All air-moving, heating, ventilation and air-conditioning equipment shall be equipped with at least one (1) filter located upstream of the conditioning equipment. If a pre-filter is employed, the pre-filter shall be upstream of the conditioning equipment and the main filter shall be located farther downstream. All filters shall be easily accessible for maintenance. Filter frames shall be durable and carefully dimensioned and shall provide an airtight fit with the enclosing ductwork. All joints between the filter segments and the enclosing ductwork shall be sealed to preclude air leakage.

E. Outside air intakes shall be located no less than twenty-five feet (25') from exhaust outlets of ventilation systems, combustion equipment stacks, clinical suction discharges and plumbing vent stacks or from areas which may collect vehicular exhaust and other noxious fumes.

F. Corridors shall not be used to supply air to or exhaust air from any room, except that air from corridors may be used to ventilate bathrooms, toilet rooms, janitor's closets and small electrical or telephone closets opening directly onto corridors provided that ventilation can be accomplished by the undercutting of doors. The installation of louvers in corridor doors is prohibited. The space above the finished ceiling may be used as a plenum for return air only.

G. Exhaust hoods in meal preparation areas shall comply with the requirements of NFPA 96 (1994). All hoods and cooktop surfaces in meal preparation areas shall be equipped with automatic fire suppression systems, automatic fan controls and fuel shutoff;

8. Plumbing systems.

A. The entire plumbing system, its design, operation and maintenance shall comply with the requirements of all applicable local and state codes including the requirements set forth in this rule.

B. Plumbing fixtures.

(I) All plumbing fixtures shall be of nonabsorptive acid-resistant material.

(II) Clinical sinks shall have a bedpan-flushing device and shall have an integral trap in which the upper portion of a visible trap seal provides a water surface.

(III) Showers and tubs shall be provided with nonslip surfaces.

(IV) Water closets in patient areas shall be quiet operating types.

(V) Stools in patient toilet facilities shall be the elongated bowl type with nonreturn stops, backflow preventers and silencers. Seats shall be the split type and white in color.

(VI) Grab bars or handrails shall be provided adjacent to all bathtubs.

(VII) All lavatories shall be trimmed with valving operable without the use of hands.

C. Water supply systems.

(I) A reliable source of potable water shall be provided at the site to supply water in sufficient quantities to meet the various use demands of the hospice. The source of water shall have been tested and approved by the Missouri Department of Natural Resources.

(II) The water supply systems shall be designed to supply water at sufficient pressure to operate all fixtures and equipment during maximum demand periods.

(III) Each water service main, branch main, riser and branch to a group of fixtures shall be valved. Stop valves shall be provided at each fixture.

(IV) Reduced pressure backflow preventers shall be installed on water service entrance, hose bibbs, janitors' sinks, bedpan flushing attachments, and on all other fixtures to which hoses or tubing can be attached. The installation of backflow preventors shall provide safeguards against waterline expansion.

(V) The water supply system shall be designed to provide hot water at each hot water outlet at all times. The water-heating equipment shall have sufficient capacity to supply five (5) gallons of water at one hundred twenty degrees Fahrenheit (120°F) per hour per bed for hospice fixtures and eight (8) gallons per hour per bed for kitchen and laundry. Lesser capacities may be accepted upon submission of the calculation for the anticipated demand of all fixtures and equipment in the building. Hot water at showers and bathing facilities shall not exceed one hundred ten degrees Fahrenheit (110°F). Hot water at handwashing facilities shall not exceed one hundred twenty degrees Fahrenheit (120°F). Hot water circulating mains and risers shall be run from the hot storage tank to a point directly below the highest fixture at the end of each branch main.

D. Drainage Systems.

(I) All fixtures and equipment shall be connected through traps to soil and waste piping and to the sewer and they shall all be properly vented to the outside.

(II) Courts, yards and drives which do not have natural drainage from the building shall have catch basins and drains to low ground, storm-water drainage system or dry wells.

(III) The building sanitary drain system shall be piped in cast iron, steel, copper or plastic.

(IV) Building sewers shall discharge into a community sewerage system when available. If such a system is not available, a facility providing sewage treatment shall conform to the rules of the Department of Natural Resources.

(V) Drainage piping shall not be installed within the ceiling or exposed in food preparation centers, food service facilities, food storage areas and clean linen storage rooms; special precautions shall be taken to protect any of these areas from possible leakage or condensation from necessary overhead drainage piping systems. These special precautions include requiring noncorrosive drip troughs with a minimum four-inch (4")-outside diameter to be installed under the drainage pipe in the direction of slope to a point where the pipe leaves the protected space and terminates at that point, usually at a wall. The trough shall be supported with noncorrosive strap hangers and screws from the pipe above. Trough joints and hanging screw penetrations shall be sealed to maintain watertight integrity throughout.

E. Natural or liquefied petroleum (LP) gas systems.

(I) Where gas-fire equipment is used, all gas piping, fittings, tanks and specialties shall be provided and installed in compliance with NFPA 54 (1992), NFPA 58 (1992), and the instructions of the gas supplier, except where more strict requirements are stated. Where liquefied petroleum gas (LPG) is used, compliance with the rules of the Missouri Department of Agriculture is also required.

(II) Where gas piping enters the building below grade, it shall have an outside vent as follows: a concrete box shall be made eighteen inches by eighteen inches (18" H 18") with three-inch (3") thick walls, of a height to rest on top of the entering gas pipe, and the top of the box to coming within six inches (6") of top grade. The box shall be filled with course gravel. A one-inch (1") upright vent line shall be to one-half (1/2) the depth of box and extend twelve inches (12") above grade with a screened U-vent looking down. The vent line shall be anchored securely to the building wall.

(III) Gas outlets and gas-fired equipment shall not be installed in any patients' bedrooms.

F. Where a piped central medical gas distribution system is installed, the oxygen piping, outlets, manifold rooms, and storage rooms shall be installed in accordance with the requirements of Chapter 4 of NFPA 99 (1993); and

9. Fire prevention and general operating requirements.

A. The hospice facility shall be maintained in a manner which provides a clean

safe environment for the delivery of patient care and shall, until remodeled or renovated with the approval of the Department of Health, remain compliant with the codes and regulations under which the facility was constructed.

B. Exitways shall always be maintained free of obstructions.

C. Curtains, drapes and cubicle curtains shall be maintained in a manner which does not compromise their fire-resistant properties.

D. Smoking may be permitted in the patient's room by the patient only, and designated smoking areas by others. Designated smoking areas shall be ventilated as required by Table 1 of this rule. Modification of the patient room ventilation system is not required to permit occasional authorized smoking by a patient.

E. All waste containers shall be of noncombustible construction.

F. Electrical systems and medical gas systems shall be tested according to the provisions of NFPA 99 (1993) and shall be modified as necessary to comply with the operational requirements of that standard.

(4) General Design and Construction Standards for Existing Inpatient Hospital Facilities. Any inpatient hospice facility existing and in continuous operation prior to the date of October 30, 1996, will, upon receipt of application for licensure, be inspected by the Department of Health to determine compliance with this rule. Where existing physical conditions cause strict compliance to be difficult to achieve, the department may determine that the intent of the new construction rules has been satisfied through the establishment of acceptable equivalency conditions. The provision of fire alarm and detection systems, automatic extinguishment systems, building compartmentation and the presence of staff trained consistent with the facility's disaster preparedness plan are factors which will be considered in determining fire safety compliance equivalency. The ability of the existing facility to meet the programmatic needs of the patients, their family, staff and public in an accessible and sanitary environment will be considered in determining functional equivalency. Existing inpatient hospice facilities shall provide the department evidence of compliance with all local regulations and codes as well as evidence that the existing operation is in good standing with the health facility licensure programs administered by Department of Social Services/Division of Aging. Existing inpatient hospice facilities shall be operated and licensed exclusively under the provisions of section 197.250, RSMo.

(5) This rule will expire October 15, 2001.

*AUTHORITY: section 197.250, RSMo 1994.* Original rule filed March 8, 1996, effective Oct. 30, 1996.*

**Original authority 1992.*

**19 CSR 30-35.030 State Certification Management**

*PURPOSE: This rule defines the state activities related to the inspection, complaint investigation, and issuance of the certificate for state-certified hospice programs.*

(1) Initial Certification. After *(the effective date of this rule)*, those hospice programs that are currently Medicare-certified hospice programs and submit an application (MO 580-2071) shall be issued a state hospice certificate for a period not to exceed twelve (12) months. No certificate to serve the entire state shall be issued. The amount of the certification fee shall correspond at a prorated amount to the number of months for which the certificate is issued. The issuance of these initial certificates shall take into consideration the need to distribute the dates for the annual survey over a twelve (12)-month period. At the expiration of the initial certificate, an annual survey inspection shall be conducted for continued state certification.

(2) The Annual Survey Inspection. The hospice management shall allow representatives of the Department of Health to survey the hospice to determine continued eligibility for hospice state certification. A renewal application must be submitted by every hospice prior to the expiration of the previous certificate.

(A) The survey may include visits to the place of residence of any appropriate patient or family. After completion of the Department of Health (DOH) survey, a written survey shall be prepared reporting the findings with respect to compliance or noncompliance with the provisions and the standards established in this chapter as well as a list of deficiencies found. A copy of the report and the list of deficiencies found shall be served upon the hospice within fifteen (15) business days following the survey process. The list of deficiencies shall specifically state the statute or rule which the hospice is alleged to have violated. The hospice shall inform the Department of Health of the time necessary for compliance not to exceed sixty (60) days from date of survey and within ten (10) business days shall file a plan of correction with the Department of Health. A follow-up by the Department of Health to assure implementation of the plan of correction shall occur within sixty (60) days of the hospice's prior approved plan of correction date.

(B) In addition to the survey inspection required for certification or certification renewal, the Department of Health may make other survey inspections during normal business hours. Each hospice shall allow the DOH or its authorized representatives to enter upon its premises as needed for the purpose of conducting the survey inspection.

(C) Any person wishing to make a complaint against a hospice certified under the provisions of sections 197.250–197.280, RSMo may register the complaint in writing or verbally with the DOH setting forth the details and facts supporting the complaint. Any complaint related to abuse, neglect or exploitation as described in section 197.266, RSMo shall be reported according to the requirements of that section.

(3) Initial Application. When an initial application and fee for state hospice certification is received, the applicant shall provide the DOH with sufficient evidence that the hospice has established appropriate policies and procedures for providing hospice services according to these rules. After review of these policies and procedures, and verification that the hospice has the capability of providing hospice services by qualified persons, the DOH shall issue a temporary operating permit not to exceed ninety (90) days. After the hospice has been in operation for ninety (90) days, or sooner if possible, the DOH shall survey the hospice for compliance with these rules. The hospice shall have provided care to at least three (3) patients for a period of at least three (3) weeks for the purpose of the initial survey review. The DOH shall conduct the unannounced initial review after the applicant indicates a readiness for that survey. The DOH may extend the temporary approved certificate if the hospice can show good intent to accomplish the preparations for initial survey.

(4) Change of Ownership. The hospice certification shall not be transferable or assignable. If during the period in which a certificate is in effect, an 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 apply for a new approved certificate not less than thirty (30) days before any change:

(A) With respect to a limited 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; or

(C) With respect to a for-profit corporation, a change in the persons who own, hold or have the power to vote the majority of any class of stocks issued by the corporation.

(5) Multiple Offices/Counties. When the hospice consistently manages and supervises multiple offices, serving contiguous geographic areas as evidenced by indicators such as consistent meetings, chart review and other methods, and evidences the provision of patient care services on a consistent basis throughout its geographic area of services, only one (1) certificate shall be required. When the hospice has multiple offices or county areas and it is evident that consistent management and supervision or consistent provision of patient care services throughout its service area is lacking, a separate certificate shall be required for one (1) or more of the multiple offices or through the new development of a separate certified office as determined by the DOH. State wide certification will not be granted. Inpatient facilities shall be located within boundaries of the state of Missouri.

(6) Satellite Offices and Reciprocal Agreements with Bordering States. All agencies providing hospice services in Missouri shall have a valid Missouri Hospice Certification and shall pay the annual fee. The DOH shall not be required to survey a hospice providing service to Missouri residents through an office located in a state bordering Missouri if the area served in Missouri by the agency is contiguous to the area served in the bordering state and the state in which the agency is located has a reciprocal agreement with Missouri on Hospice Certification. If the agency is in a state which does not have a reciprocal agreement with Missouri on Hospice Certification, that agency shall maintain a satellite office in Missouri. The satellite office shall make available all records required for the survey which shall be conducted by the DOH.

(7) Certificate Not Issued. A certificate shall not be issued or renewed if the operator, owner or any principle in the operation of the hospice has ever been convicted of any offense concerning the operation of hospice or of any offense which is reasonably related to the qualification, functions, or duties of a hospice. Notwithstanding any other provisions of law, the DOH shall have access to records involving an owner or manager of a hospice applying for or renewing a certificate as provided in this chapter, where the applicant has been adjudicated and found guilty or entered a plea of guilty or *nolo contendere* in a prosecution under the laws of any state or of the United States for any offense reasonably related to the qualification, functions or duties of any person who manages or owns a hospice certified under sections 197.2500–197.280, RSMo. The DOH may deny, suspend, or revoke the certificate of any company whose owners or managers have been convicted of such an offense.

(8) Revocation. The DOH may refuse to issue, may suspend or may revoke or refuse to renew the certificate of any hospice for failure to comply with any provision of sections 197.250–197.280, RSMo, or with any of these rules or standards adopted under the provisions of sections 197.250–197.280, RSMo, or for obtaining a certificate by means of fraud, misrepresentation or concealment of any material facts. Any hospice which has been refused a certificate or which has had its certificate revoked or suspended by the DOH may seek a review of the Department of Health's action by the Administrative Hearing Commission. There shall be a six (6)-month waiting period for reapplication from final Department of Health action.

(9) Intermediate Sanctions. If the department determines on the basis of an inspection, or otherwise, that a state-certified hospice program is no longer in compliance with the requirements specified in these rules, and determines that the deficiencies jeopardize the health and safety of the patients of the hospice, the department shall take action to remedy the specific deficiencies through intermediate sanctions or the termination of the certification. Any action taken under this section shall be immediately effective notwithstanding any provisions of law to the contrary. Intermediate sanctions may include:

(A) Suspension of all or part of the services provided by the hospice;

(B) Restrictions on the admission of new patients to the hospice's program;

(C) DOH approval of the appointment of temporary management at hospice expense to oversee the operation of the hospice to protect and assure the health and safety of the individuals under the care of the hospice while improvements are made in order to bring the hospice into compliance with the requirements of these rules; and

(D) These intermediate sanctions shall be designed so as to minimize the time between identification of deficiencies and imposition of these sanctions, and shall provide for the imposition of incrementally more severe sanctions for repeated or uncorrected deficiencies.

(10) This rule will expire October 15, 2001.

*AUTHORITY: section 197.250, RSMo 1994.* Original rule filed March 8, 1996, effective Oct. 30, 1996.*

**Original authority 1992.*

MISSOURI DEPARTMENT OF HEALTH
BUREAU OF HOME HEALTH LICENSING AND CERTIFICATION

# APPLICATION FOR HOSPICE CERTIFICATION

In accordance with the requirements of the Missouri Hospice Certification Law (Chapter 197, RSMo. Cumulative Supp. 1992) Regulations and Codes, application is hereby made for a certificate to conduct and maintain a Hospice (See Missouri Hospice Certification Law "Definitions", Section 197.250.)

**THIS INFORMATION, WITHOUT FURTHER VERIFICATION, WILL BE USED TO UPDATE THE STATE HOME HEALTH AND HOSPICE DIRECTORY.**

NAME OF HOSPICE | TELEPHONE NO.

ADDRESS (STREET, CITY, STATE, ZIP) | COUNTY

HOSPICE ADMINISTRATOR

**TYPE OF HOSPICE (CHECK ONLY ONE)**

1. ☐ Hospital Based
2. ☐ Skilled Nursing Facility
3. ☐ Intermediate Care Facility
4. ☐ Home Health Agency
5. ☐ Freestanding Hospice
6. ☐ Other

A. ☐ JCAH Accredited
B. ☐ Non-Accredited
C. ☐ Other Accreditation

**TYPE OF CONTROL (CHECK ONLY ONE)**

*Non-Profit*
1. ☐ Church
2. ☐ Private
3. ☐ Other

*Proprietary*
4. ☐ Individual
5. ☐ Partnership
6. ☐ Corporation
7. ☐ Other

*Government*
8. ☐ State
9. ☐ County
10. ☐ City
11. ☐ City-County
12. ☐ Combination Government and Nonprofit
13. ☐ Other

CHIEF OFFICER OF GOVERNING BODY

LEGAL NAME OF OPERATING CORPORATION

IF OPERATED BY MANAGEMENT CONSULTANT, NAME OF FIRM

**GEOGRAPHIC AREA COVERED BY HOSPICE OPERATION**

LIST COUNTY(IES).

ADDING COUNTY(IES)? LIST.
EFFECTIVE DATE

DELETING COUNTY(IES)? LIST.
EFFECTIVE DATE

**SERVICES PROVIDED BY STAFF** (By staff, place a "1" in the block(s). If under arrangement, place a "2" in the block(s).

*CORE SERVICES*
1. ☐ Physician Services No. of FTE's
2. ☐ Nursing Services No. of FTE's
3. ☐ Medical Social Services No. of FTE's
4. ☐ Bereavement Counseling No. of FTE's
5. ☐ Spiritual Counseling No. of FTE's
6. ☐ Dietary No. of FTE's
7. ☐ Home Health Aide/Homemaker No. of FTE's
8. ☐ Physical Therapy
9. ☐ Occupational Therapy
10. ☐ Speech-Language Pathology
11. ☐ Pharmacy
12. ☐ Medical Supplies
13. ☐ Short Term Inpatient Care
14. ☐ Other (Specify)

☐ Acute
☐ Respite

Total Number of Volunteers

**INPATIENT FACILITY**

Total Number of Beds

**SATELLITE/INPATIENT LOCATIONS** (Identify each location and continue listing on back if necessary)

| *Address:* | *Address:* | *Address:* | *Address:* |
|---|---|---|---|
| Telephone No. | Telephone No. | Telephone No. | Telephone No. |

MO 580-2071 (6-96) HHA-26

**CERTIFICATION**

_____ and _____
PRESIDENT OF BOARD OF TRUSTEES, OWNER OR ONE PARTNER OF PARTNERSHIP — HOSPICE ADMINISTRATOR

being duly sworn by me on their oath, deposes and says that they have read the foregoing application and that the statements contained therein are correct and true and of their knowledge; and further gives assurance of the ability

and intention of the _____ Hospice to comply with the
EXACT LEGAL NAME

regulations promulgated under the Missouri Hospice Certification Law (Chapter 197, RsMo. Cumulative 1992).

It is further certified that the _____ will comply with all recommendations
NAME OF HOSPICE

for correction and/or improvements as contained in the most recent Licensing Survey Report prepared by the Department of Health and submitted to said Hospice.

**SIGNATURES**

PRESIDENT OF BOARD OF TRUSTEES, OWNER OR ONE PARTNER OF PARTNERSHIP

HOSPICE ADMINISTRATOR

MO 580-2071 (6-96)