MISSOURI HOUSE OF REPRESENTATIVES

REPORT OF THE INTERIM COMMITTEE ON ASSISTED LIVING FACILITIES

Representative Mike Sutherland, Chair
District 99

Representative J.C. Kuessner
District 152

Representative Kate Meiners
District 46

Representative Vicki Schneider
District 17

Representative Kevin Wilson
District 130

Prepared by:
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February 14, 2005

February 14, 2005

The Honorable Rod Jetton
Speaker of the House
State Capitol, Room 308
Jefferson City, Missouri 65101

Dear Mr. Speaker:

The Interim Committee on Assisted Living Facilities, acting pursuant to the request of Speaker Catherine Hanaway, has met, taken testimony, deliberated, and concluded its study on assisted living and in-home services for seniors. The undersigned members of the Committee are pleased to submit the attached report.

Representative Mike Sutherland
Chair

Representative J. C. Kuessner

Representative Kate Meiners

Representative Vicki Schneider

Representative Kevin Wilson

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INTRODUCTION

The House Interim Committee on Assisted Living was formed at the authorization of House Speaker Catherine Hanaway. The committee was charged with studying the role of assisted living facilities in providing care for the elderly, examining how assisted living facilities fit in with the current regulatory scheme for long-term care facilities, determining whether the current regulatory framework for long-term care facilities should encompass assisted living facilities, and engaging stakeholders in a policy discussion about the future of assisted living facilities in Missouri. The Committee was also charged with examining the role of in-home services in providing care for seniors. The members of the committee included Representatives Mike Sutherland (chair), J. C. Kuessner, Kate Meiners, Vicki Schneider, and Kevin Wilson.

The Committee held meetings on October 20, 2004 in Columbia, Missouri; November 22, 2004 in Jefferson City, Missouri, and December 16, 2004 in Jefferson City, Missouri. During its October 20, 2004 meeting in Columbia, the Committee visited and toured Tiger Place, an Aging in Place project affiliated with the University of Missouri-Columbia – Sinclair School of Nursing; NBA Lenoir Retirement Community, a campus that includes several types of facilities in one location; and The Arbors, a specialized Alzheimer's care facility.

The committee heard testimony from stakeholders and other interested parties about the current regulatory framework for long-term care and how assisted living fits into that framework, in-home services for seniors, and the Assisted Living Stakeholders Taskforce Report to the Interim Committee on Assisted Living. A complete list of witnesses appears in Appendix A. Appendix B includes Missouri law relating to the regulation of long-term care facilities.

SUMMARY OF ISSUES AND FINDINGS

For nearly 60 years, the children of World War II veterans have had a profound impact on public policy and culture in America. These baby boomers number over 76 million and represent 27 % of the country's population[1]. The first baby boomers will begin turning 65 in 2010 and as they age, they will continue to have an impact on public policy. As baby boomers age and their health care needs change, they will play an even more significant role in re-shaping long-term care.

The emergence of Assisted Living as a popular long-term care option for seniors in recent years is one sign of the impact that baby boomers will have on the long-term care industry in years to come. Nationwide, there are nearly 1 million beds in over 35, 000 licensed assisted living facilities, and the number of beds increased 15% between 2000 and 2003.[2] The rapid emergence of Assisted Living as a care option has caused state legislatures and state aging agencies around the country to struggle with issues of licensure, regulation, and integrating these facilities into their existing regulatory structure for long-term care facilities. Missouri is no exception to these struggles. Missouri is one of 16 states that do not refer to assisted living facilities in state statutes or regulations. The committee heard testimony from several individuals indicating that there is some confusion among long-term care consumers about what assisted living is, and what types of facilities must be licensed in Missouri. Defining assisted living and determining how assisted living fits in with the current regulatory scheme for long-term care were two issues that garnered significant attention from the committee.

Long Term Care Regulation in Missouri

Missouri adopted its first long-term care facility statutes in 1957. The regulatory scheme included regulations for three types of facilities: Residential Care Facilities, Intermediate Care Facilities, and Skilled Nursing Facilities. The next major change to long-term care facility regulation came in 1979 with the adoption of the Omnibus Nursing Home Act. A fourth type of facility, Residential Care Facility II, was added and the four categories of facilities remain in law today.

A Residential Care Facility I (RCF I) provides 24-hour care to three or more residents who are in need of or who are provided with protective oversight. Protective oversight may include the storage, distribution, or administration of medication and care during short-term illnesses or periods of recuperation. A Residential Care Facility II (RCF II) provides a higher level of care, which includes 24-hour accommodation, board and care to three or more residents. The residents of an RCF II are provided with supervision of diets; assistance in personal care; storage, distribution, and administration of medications; supervision of health care under the direction of a licensed physician; and protective oversight including care during short-term illnesses or recuperation. Intermediate Care Facilities provide 24-hour accommodation, board, personal care, and basic health and nursing care services under the daily supervision of a licensed nurse and under the direction of a licensed physician. Residents are dependent on the facility for

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[1] *Baby Boomers Envision their Retirement: An AARP Segmentation Analysis,* http://research.aarp.org/econ/boomer_seg_1.html, Accessed January 13, 2005.

[2] Assisted Living, Wendy Fox-Grage and Robert Mollica, National Conference of State Legislatures, *Legisbrief*, Volume 11, No. 24, April/May 2003. http://www.ncsl.org/legis/lbriefs/assistedliving.pdf

care and supervision. Skilled Nursing Facilities (SNF) provide 24- hour accommodations, board, and skilled nursing care and treatment services. Skilled nursing care and treatment includes services commonly performed by or under the supervision of a registered professional nurse.[3]

Missouri law specifies that Residential Care Facilities I and Residential Care Facilities II may only admit or retain persons who are mentally and physically capable of negotiating a path to safety using assistive devices or aids when necessary. This requirement is known as the "pathway to safety" requirement, and it refers to the ability of residents to find a safe exit or safe haven in the event of an emergency. Residents of these facilities may need assisted personal care that can be provided within the limits of the facility, and may not require hospitalization or skilled nursing care.[4] Individuals who are qualified for residence in an RCF I or RCF II and who have a temporary period of incapacity due to illness, surgery or injury can remain in the facility for a period of 45 days if approved by the person's physician, even though they may not be able to negotiate a path to safety during the period of recovery..

Residential Care Facilities I and II may continue to provide care for individuals who are physically capable but not mentally capable of negotiating a path to safety due to a diagnosis of Alzheimer's disease or Alzheimer's-related dementia if the facility meets the requirements outlined in section 198.073, RSMo. These requirements include 24-hour staffing, special monitoring devices, training for staff on the care of dementia patients, activity programs, and regularly scheduled assessments of residents. [5] The complete list of requirements is included in Appendix B[6]. Residential Care facilities have the option of becoming one of these special Alzheimer's care units but according to the Department of Health and Senior Services, only 17 facilities have met the statutory requirements to become an Alzheimer's care unit. As a result, the pathway to safety requirement remains an obstacle to individuals who wish to remain in a Residential Care Facility but who are in need of assistance in the event of an emergency, and these individuals are forced to move to a skilled nursing facility to meet this need.

According to the Department of Health and Senior Services, there are currently 1,249 long-term care facilities in Missouri. 538 of these facilities are Medicaid and/or Medicare Certified, 639 are Residential Care Facilities I or II, and 62 are Intermediate Care Facilities. The average size of a nursing home in Missouri is 102.9 beds, which is slightly lower than the national average of 104 beds. There are 57,408 residents of long-term care facilities in Missouri. Over 41,000, or about 73% of these residents are age 75 and older, and 43% or over 24,000 are age 85 and older. Medicaid pays for 53% of patient days, while Medicare pays for 7% and 40% of patient days are private-pay.

Funding for Long-Term Care

One of the issues frequently mentioned when discussing the long-term care system in Missouri is the issue of cost. Medicaid is the only source of publicly-assisted funding that pays for long-

[3] Section 198.006, RSMo.
[4] Section 198.073, RSMo.
[5] Section 198.073, RSMo.
[6] *See* Section 198.073, RSMo.

term care, and is the only option for many elderly individuals who do not have private long-term care insurance or savings to pay for long-term care.

Individuals must meet both categorical guidelines[7] and financial guidelines to qualify for Medicaid. Most long-term care consumers meet the categorical guidelines to qualify for Medicaid because they are over the age of 65. These individuals also qualify for the federal Medicare program, which covers some of their health care needs, but does not cover long-term care. These individuals are often referred to as "dual eligibles." To qualify for Medicaid in Missouri, an individual must also meet two financial guidelines, an income test and an asset test. For most dual eligibles, the income limit for a single person is $674 per month and $909 per month for a couple. The asset limit is $999.99 for a single person and $2,000 for a couple.

Seniors access services that are paid for by Medicaid in one of three ways. First, seniors who meet the income and asset limits and who do not need long term care have access to routine medical care and pharmaceutical coverage through Medicaid. Second, some seniors who are in need of long term care choose to stay in their own homes or move to a residential care facility and obtain care from an in-home service provider for assistance with activities of daily living and medical care. These in-home service providers are covered by Medicaid. Finally, seniors who are not able to stay in their own homes and take care of themselves access care through skilled nursing facilities that provide round-the-clock care for patients. These individuals are not subject to an absolute income limit; rather their monthly income goes first to pay for the cost of care, and then Medicaid pays the balance.

In the 1988, Congress recognized that the rules for qualifying for Medicaid sometimes adversely affected married couples. In order to qualify a spouse for nursing home care, the couple would have to spend down their assets to a level that made it difficult for the other spouse to remain in home. In response, Congress enacted provisions allowing couples to divide their assets to qualify one spouse for nursing home care and to prevent the impoverishment of the other spouse. The division of assets process requires all exempt assets to be transferred to the community spouse, including a car, home, and an irrevocable prepaid burial plan. The non-exempt resources are then divided in half and the community spouse is entitled to one-half of the non-exempt assets, or up to the annual maximum Community Spouse Resource Allowance (CSRA). The SCRA was originally set by federal law and is adjusted annually based on the Consumer Price Index. For 2005, the maximum CSRA is $95,100, and the minimum is $19,020. If one-half of the assets do not equal at least $19,020 for the community spouse, assets from the institutionalized spouse are deemed to be available to the community spouse to reach that level. The community spouse's share may also be adjusted to meet the Community Spouse's Monthly Income Allowance (CSMIA), the Minimum Monthly Maintenance Needs Allowance (MMMNA), and excess shelter expenses. The community spouse can also request additional assets in hardship circumstances. After all of the adjustments are made, the institutional spouse must spend down any assets that remain in his or her share to $1,000. Medicaid covers medical care, plus the cost of the nursing home for the institutionalized spouse.

[7] "Categorical guideline" refers to determining whether an individual falls into one of the groups that is eligible to receive Medicaid. Examples of these groups or categories include children , persons receiving Temporary Assistance for Needy Families, disabled individuals, and the elderly.

Individuals who are receiving home and community-based services paid for by Medicaid have a monthly income limit of $1012. This income limit is only applicable to the individual needing the services. Home and community based service recipients also go through the division of assets described above, and then the asset limit is $1,000 for the person needing services. The Home and Community-Based services waiver was implemented in January, 1994. The waiver limits the number of people that can participate, and these individuals receive services that allow them to stay in their homes, including homemaker chore services and respite care services.[8] According to the Department of Social Services, the number of Medicaid-eligible individuals in nursing homes has remained relatively stable.

Medicaid rules prohibit the use of Medicaid funds to pay for room and board costs. As a result Medicaid beneficiaries who reside in Assisted Living or Residential Care facilities must pay for the room and board component of the facility's cost, while Medicaid can pay for personal care services to provide for medical care, pharmaceuticals, and assistance with the activities of daily living. Medicaid pays for such personal care services through Nursing Care Grants. These grants are available to individuals who are elderly, blind, or disabled, have less than $1,000 in assets for a single person or less than $2,000 in assets for a married couple, and who have an income that is below the basic charge of the facility. The grant covers the difference between the individual's monthly income and the facility's basic charge, up to a pre-set maximum amount. There are three levels of grants that are available. The maximum grant for an RCF I is $156 per month; the maximum for an RCF II is $292 per month, and the maximum for a SNF is $390 per month.

Federal law requires Medicaid recipients seeking either home and community based service or admission to a skilled nursing facility to be evaluated to determine the individual's level of care and whether the care is medically necessary. The Department of Health and Senior Services conducts the level of care assessments. Level of care is an assessment of an individual's ability to perform activities of daily living. Points are assessed in nine categories: monitoring, medications, treatments, restorative, rehabilitative, personal care, behavior and mental condition, mobility, and dietary. Generally, the more assistance an individual needs in each of these nine categories, the more points are assessed to the individual In Missouri, an individual must have a level of care of 18 in order to receive Medicaid funded home and community based services or skilled nursing facility services. Federal law requires the level of care point total to be the same whether the individual is receiving care in a skilled nursing facility or home and community based care.

Defining Assisted Living

Many individuals who provided testimony to the committee discussed the issue of defining assisted living. As noted, Missouri statutes do not define an assisted living facility or residence, but there are facilities in the state that hold themselves out as being assisted living facilities, or offering assisted living to consumers. Some of these facilities are actually licensed as residential care facilities or intermediate care facilities under the existing regulatory framework in Missouri, but other facilities have chosen not to be licensed. Some say that the current regulatory framework adequately describes assisted living facilities, but others argue that the terms used by

[8] 13 CSR 40-2.030

the industry still cause confusion among consumers. Missouri is one of 16 states that do not use the term "Assisted Living" in their licensing statutes or regulations.[9] Stakeholders say that many facilities that are called "assisted living" are private pay facilities. Surveys indicate that consumers prefer assisted living facilities or residences to nursing homes, but consumers are also confused about what the term "assisted living" really means. Most individuals agree that any changes to the statutory definitions of long-term care in Missouri should be consistent and aid consumers in making long-term care choices that are appropriate for themselves and their families.

One consumer testified about his experiences selecting a long-term care facility for his mother, who suffers from Alzheimer's disease. He wanted to find an assisted living facility for his mother, and it was important to find a facility where his mother could live for as long as possible. He described the confusion he felt when confronted by an array of choices, and described his difficulty determining the differences between skilled nursing facilities, residential care facilities, and intermediate care facilities. He urged the committee to consider the needs of consumers in crafting legislation to govern assisted living facilities.

Most stakeholders agreed that assisted living generally involves a different philosophy than other types of long term care. While most types of long-term care are based on a medical model, assisted living is based on a social model. A social model of care is an approach to the delivery of long-term care services that focuses on the abilities, desires, and functional needs of the individual. Services are provided in a setting that is more like a home than an institution. The assessment of residents in an assisted living facility also differs from the assessments currently used for residents of residential care facilities. Currently, the assessment tool used in nursing facilities is a medically oriented assessment and does not cover instrumental activities of daily living. Instrumental activities of daily living are activities such as preparing meals, shopping for personal items, medication management, managing money, using the telephone, housework, and transportation. Activities of daily living include dressing, bathing, toileting, transferring, and walking. A community based assessment is a systematic gathering and analysis of information describing an individual's abilities and needs in areas of functioning as activities of daily living, instrumental activities of daily living, vision and hearing, nutrition, social participation and support, and cognitive functioning.

Report of the Stakeholders Taskforce on Assisted Living

A group of stakeholders formed the Assisted Living Stakeholders Taskforce in August 2004 to discuss the role of assisted living in providing long term care and make recommendations for future state action. The Stakeholders Taskforce presented its findings and recommendations to the Interim Committee at its November 22, 2004 meeting.

One of the issues the taskforce addressed was the definition of assisted living. Members of the taskforce indicated that this was one of the most difficult parts of their deliberations, and was not an issue that received unanimous approval from the taskforce. The definition is in two parts, and while it was not unanimously approved, it was supported by a majority of the members of the task force:

[9] State Assisted Living Policy: 2002, Robert Mollica, National Academy for State Health Policy, November 2002.

Assisted living is a state regulated and monitored residential long-term care option. Assisted living provides or coordinates oversight and services to meet residents' individualized scheduled needs, based on the residents' assessments and service plans, and their unscheduled needs as they arise.

Services that are required by state law and regulation to be provided or coordinated must include, but are not limited to:

- 24-hour staff to provide oversight and meet scheduled and unscheduled needs.
- Provision and oversight of personal and supportive services (assistance with activities of daily living and instrumental activities of daily living)
- Health related services (e.g. medication management services)
- Social services
- Recreational activities
- Meals
- Housekeeping and laundry

A resident has the right to make choices and receive services in a way that will promote the resident's dignity, autonomy, independence, and quality of life. These services are disclosed and agreed to in the contract between the provider and resident. Assisted living may provide occasional skilled nursing on a short-term basis only.

The state must establish at least two assisted living licensure categories, based on types and severity of the physical and mental conditions of residents that the assisted living residence is prepared to accommodate. The licensure category shall determine licensure requirements relating to important concerns such as staffing levels and qualifications, special care or services, participation by health care professionals, and fire safety. [10]

Stakeholders told the committee that this definition incorporates the philosophy of assisted living: to promote residents' dignity, autonomy, independence, and quality of life. The definition of assisted living is one issue addressed by the taskforce that will likely require statutory changes.

Another issue that will likely require statutory changes is the issue of licensure of assisted living. The taskforce's recommendation on this issue was approved unanimously:

> The state shall require assisted living licensing for any entity that meets the state's definition or does the following:
> 1. Holds itself out as an Assisted Living Residence, OR

[10] Report to the Missouri House of Representatives Interim Committee on Assisted Living, Assisted Living Stakeholders Taskforce, November 2004.
http://www.alzstl.org/Advocacy/AL%20Final%20Report%20with%20cover.pdf

2. Offers to provide assisted living services unless licensed under another related category; OR
3. Uses the phrase "assisted living" in its name or marketing materials.[11]

The taskforce's recommendation about licensing addresses the issue of consumer confusion about what assisted living is and what consumers can expect from an assisted living facility or residence. The recommendation also addresses the issue of unlicensed facilities that hold themselves out as assisted living. Several individuals told the committee about their particular concern for consumers who are not familiar with the licensing requirements in Missouri, but who are interested in finding an assisted living facility for their loved ones.

In-home Services for Seniors

The committee's charge was expanded to include a discussion of in-home services for seniors. The committee heard testimony from a variety of in-home care providers and learned about different types of services that are offered to individuals to provide care in their homes. In home services are generally funded by Medicaid and to qualify for Medicaid coverage, the client must be assessed and meet the level of care requirement that would qualify the individual for placement in a nursing home. In-home services are generally long-term arrangements and providers offer a variety of services including homemaker or chore services, personal care, respite care, adult day care, and limited nursing care. Last year, the average point count for in-home services clients was 30, and the clients typically received services three times each week.

Home health and hospice services are generally for a shorter duration than in-home services, and typically provide assistance to clients who have been recently hospitalized or to clients who have terminal diseases. Home health services include nursing services, physical therapy, occupational therapy, speech therapy, and social work services. Medicare is the primary source of funding for home health and hospice services.

In-home services are provided by a variety of service providers throughout the state who go into seniors' homes and provide a variety of services. Medicaid covers in-home services for individuals who are qualified for nursing home care. In order to receive Medicaid coverage, an in-home services client must be evaluated and have a point count of at least 18. There are approximately 44,000 in-home services clients in Missouri, and by one estimate it costs $3,700 per year to care for an in-home services client, while it costs $37,000 per year to provide care to that same person in a nursing home. The committee heard testimony indicating in the last four years, the in-home services industry has received a $.49 increase in its reimbursement rate, while its costs have increased by $6 over the same time period.

The committee heard testimony from a variety of in-home service providers who discussed some of the barriers that currently exist that prevent more seniors from taking advantage of the services offered. The first barrier identified by some advocates is the Medicaid asset limit,

[11] Report to the Missouri House of Representatives Interim Committee on Assisted Living, Assisted Living Stakeholders Taskforce, November 2004.
http://www.alzstl.org/Advocacy/AL%20Final%20Report%20with%20cover.pdf

which is currently $999.99 for a single person and $2000 for a couple. Some indicated that this asset limit makes it difficult for a senior who wants to stay in their home to do so because it limits the amount of money available to make repairs to the home when necessary.

The second barrier identified by advocates is the issue of division of assets for those under the age of 63. Current law allows couples to divide their assets when one partner needs to enter a nursing home. This allows the "institutional spouse" to qualify for Medicaid upon entering the nursing home but prevents the "community spouse" from becoming impoverished. Advocates say that Missouri should revise its rules regarding division of assets to allow a division to occur for individuals under the age of 63 who wish to receive in-home services.

A third barrier identified by numerous witnesses is access to in-home services in all areas of the state. One witness testified that in some rural areas of the state, there are very few in-home service providers available and many times these providers are unable to serve all of the needs of their clients. Finally, some providers indicated that there is some disparity across the state in the assessment tool that is used to determine the level of services needed for each client. These providers expressed frustration over the lack of consistency in the assessment tool used to evaluate clients, which impacts the number of units of care the client is authorized to receive.

The Department of Health and Senior Services uses an assessment tool to determine the needs of an in-home services client. The tool documents the met and unmet needs of the client. It is completed by a social service worker who meets face-to-face with the prospective client upon receipt of the referral for services. The assessment is also completed each year after the initial assessment, and any time there is a significant change in the client's condition during the year. The information gained in the assessment is used as documentation to support the need for a specific in-home service that is offered to the client.

The committee also heard testimony suggesting the need for licensure of in-home providers to insure the consistent and safe delivery of care.

The committee heard testimony from a variety of stakeholders and interested parties during its examination of long term care regulations and services provided to seniors. The committee's recommendations are outlined on the following page of this report.

RECOMMENDATIONS

- **The Committee recommends that the Department of Health and Senior Services continue to explore the idea of implementing a social model of care in facilities regulated by the department. Such a model would include community-based assessments, and would ensure that skilled care is available for individuals who require that level of care.**

- **The Committee recommends that the General Assembly, in conjunction with the Department of Health and Senior Services continue to study and explore alternatives to ensure the safety of seniors in the least restrictive environment.** Such study and exploration should include a thorough examination of the pathway to safety requirement and the implementation of a social model of care in long-term care facilities.

- **The Committee recommends that the General Assembly increase the per-unit reimbursement rate for in-home care providers by $2.** In his Fiscal Year 2006 Budget Governor Matt Blunt proposed funding to improve the quality of in-home care service by increasing reimbursement rates paid by the state to providers.

- **The Committee recommends that the Department of Health and Senior services develop and adopt a uniform assessment tool for statewide application when assessing Medicaid recipients receiving personal care services.** Such assessment tool should delineate the amount of time a provider should reasonably dedicate to each of the activities of daily living tasks reimbursed under the personal care program, and the number of times per week that each task should be performed. The development and adoption of such a tool would provide consistency in the evaluation of recipients and the reimbursement for such services.

- **The Committee recommends amending the residential care facility definition to include assisted living facilities or residences.**

- **The Committee recommends that the General Assembly enact legislation that would require a facility that holds itself out as a facility providing care for the elderly to disclose to prospective residents and their families whether the facility is licensed.** Several witnesses told the committee that consumers are often confused about the variety of long-term care options that are available and the services they provide. Providing information to consumers about whether a facility is licensed could help ensure that consumers are fully informed about the available options.

- **The Committee recommends that the General Assembly work with the Department of Health and Senior Services to increase public awareness of information concerning home and community based services for seniors, and long-term care for seniors that is available on the Department's web site.** The Department of Health and Senior Services should ensure that its Guide for Seniors and web site are user-friendly and updated on a timely basis.

APPENDIX A

Witness List

October 20, 2004

Marilyn Rantz, University of Missouri-Columbia, School of Nursing
Darrell Hendrickson, Department of Health and Senior Services
Roberta Whitlock, Missouri Kidney Program
Barbara Miltenberger, Missouri Healthcare Association
Denise Clemonds, Missouri Association of Homes for the Aging
Kathryn Miller, Missouri Assisted Living Association
Peter Koukola, Mid-Missouri Chapter, Alzheimer's Association
Carroll Rodriguez, Missouri Coalition of Alzheimer's Association Chapters
Norma J. Collins, American Association of Retired Persons

November 22, 2004

Charles Bentley, Department of Social Services, Family Support Division
Terry Walkenhorst, Department of Health and Senior Services
Barbara Miltenberger, Missouri Healthcare Association
Carol Scott, Department of Health and Senior Services, Long Term Care Ombudsman Program
Denise Clemonds, Missouri Association of Homes for the Aging
Joe Kunkemueller, Lutheran Senior Services
Jamie Seifert, Missouri Association of Nursing Home Administrators
Carroll Rodriguez, Missouri Coalition of Alzheimer's Association Chapters
Deborah Shockley, Division of Medical Services

December 16, 2004

Scott Andrew, Homemaker Health Care and Missouri Council for In-Home Services
Mary Schantz, Missouri Alliance for Home Care
Stephen Bradford, Pyramid Home Care
Kent Stalder, Department of Mental Health, Division of Mental Retardation and Developmental Disabilities
Denise Clemonds, Missouri Association of Homes for the Aging
Brenda Campbell, Department of Health and Senior Services
Carroll Rodriguez, Missouri Coalition of Alzheimer's Association Chapters
Steve Vaughn, Independent Living (PAS Program)
Jorgen Schlemeier, Missouri Assisted Living Association
Kevin Edmonds, Missouri Assisted Living Association
Verda Barnes, Nursing Home Administrator
Kelly Flaugher, Department of Elementary and Secondary Education, Vocational Rehabilitation
Jeanne Lloyd, Department of Elementary and Secondary Education, Vocational Rehabilitation

APPENDIX B

Relevant Statutes

198.006. Definitions.--

As used in sections 198.003 to 198.186, unless the context clearly indicates otherwise, the following terms mean:

(1) "**Abuse**", the infliction of physical, sexual, or emotional injury or harm;

(2) "**Administrator**", the person who is in general administrative charge of a facility;

(3) "**Affiliate**":

(a) With respect to a partnership, each partner thereof;

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

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

(d) With respect to a natural person, any parent, child, sibling, or spouse of that person;

(4) "**Department**", the Missouri department of health and senior services;

(5) "**Emergency**", a situation, physical condition or one or more practices, methods or operations which presents imminent danger of death or serious physical or mental harm to residents of a facility;

(6) "**Facility**", any residential care facility I, residential care facility II, immediate care facility, or skilled nursing facility;

(7) "**Health care provider**", any person providing health care services or goods to residents and who receives funds in payment for such goods or services under Medicaid;

(8) "**Intermediate care facility**", any premises, other than a residential care facility I, residential care facility II, or skilled nursing facility, which is utilized by its owner, operator, or manager to provide twenty-four hour accommodation, board, personal care, and basic health and nursing care services under the daily supervision of a licensed nurse and under the direction of a licensed physician to three or more residents dependent for care and supervision and who are not related within the fourth degree of consanguinity or affinity to the owner, operator or manager of the facility;

(9) "**Manager**", any person other than the administrator of a facility who contracts or otherwise agrees with an owner or operator to supervise the general operation of a facility, providing such services as hiring and training personnel, purchasing supplies, keeping financial records, and making reports;

(10) "**Medicaid**", medical assistance under section 208.151, RSMo, et seq., in compliance with Title XIX, Public Law 89-97, 1965 amendments to the Social Security Act (42 U.S.C. 301 et seq.), as amended;

(11) "**Neglect**", the failure to provide, by those responsible for the care, custody, and control of a resident in a facility, the services which are reasonable and necessary to maintain the physical and mental health of the resident, when such failure presents either an imminent danger to the health, safety or welfare of the resident or a substantial probability that death or serious physical harm would result;

(12) "**Operator**", any person licensed or required to be licensed under the provisions of sections 198.003 to 198.096 in order to establish, conduct or maintain a facility;

(13) "**Owner**", any person who owns an interest of five percent or more in:

(a) The land on which any facility is located;

(b) The structure or structures in which any facility is located;

(c) Any mortgage, contract for deed, or other obligation secured in whole or in part by the land or structure in or on which a facility is located; or

(d) Any lease or sublease of the land or structure in or on which a facility is located.

"Owner" does not include a holder of a debenture or bond purchased at public issue nor does it include any regulated lender unless the entity or person directly or through a subsidiary operates a facility;

(14) **"Protective oversight"**, an awareness twenty-four hours a day of the location of a resident, the ability to intervene on behalf of the resident, the supervision of nutrition, medication, or actual provisions of care, and the responsibility for the welfare of the resident, except where the resident is on voluntary leave;

(15) **"Resident"**, a person who by reason of aging, illness, disease, or physical or mental infirmity receives or requires care and services furnished by a facility and who resides or boards in or is otherwise kept, cared for, treated or accommodated in such facility for a period exceeding twenty-four consecutive hours;

(16) **"Residential care facility I"**, any premises, other than a residential care facility II, intermediate care facility, or skilled nursing facility, which is utilized by its owner, operator or manager to provide twenty-four hour care to three or more residents, who are not related within the fourth degree of consanguinity or affinity to the owner, operator, or manager of the facility and who need or are provided with shelter, board, and with protective oversight, which may include storage and distribution or administration of medications and care during short-term illness or recuperation;

(17) **"Residential care facility II"**, any premises, other than a residential care facility I, an intermediate care facility, or a skilled nursing facility, which is utilized by its owner, operator or manager to provide twenty-four hour accommodation, board, and care to three or more residents who are not related within the fourth degree of consanguinity or affinity to the owner, operator, or manager of the facility, and who need or are provided with supervision of diets, assistance in personal care, storage and distribution or administration of medications, supervision of health care under the direction of a licensed physician, and protective oversight, including care during short-term illness or recuperation;

(18) **"Skilled nursing facility"**, any premises, other than a residential care facility I, a residential care facility II, or an intermediate care facility, which is utilized by its owner, operator or manager to provide for twenty-four hour accommodation, board and skilled nursing care and treatment services to at least three residents who are not related within the fourth degree of consanguinity or affinity to the owner, operator or manager of the facility. Skilled nursing care and treatment services are those services commonly performed by or under the supervision of a registered professional nurse for individuals requiring twenty-four hours a day care by licensed nursing personnel including acts of observation, care and counsel of the aged, ill, injured or infirm, the administration of medications and treatments as prescribed by a licensed physician or dentist, and other nursing functions requiring substantial specialized judgment and skill;

(19) **"Vendor"**, any person selling goods or services to a health care provider;

(20) **"Voluntary leave"**, an off-premise leave initiated by:

(a) A resident that has not been declared mentally incompetent or incapacitated by a court; or

(b) A legal guardian of a resident that has been declared mentally incompetent or incapacitated by a court.

198.073. Persons eligible for care in residential care facility I or residential care facility II--facility requirements for care of Alzheimer's patients.--

1. Except as provided in subsection 3 of this section, a residential care facility II or residential care facility I shall admit or retain only those persons who are capable mentally and physically of negotiating a normal path to safety using assistive devices or aids when necessary, and who may need assisted personal care within the limitations of such facilities, and who do not require hospitalization or skilled nursing care.

2. Notwithstanding the provisions of subsection 3 of this section, those persons previously qualified for residence who may have a temporary period of incapacity due to illness, surgery, or injury, which period does not exceed forty-five days, may be allowed to remain in a residential care facility II or residential care facility I if approved by a physician.

3. A residential care facility II may admit or continue to care for those persons who are physically capable of negotiating a normal path to safety using assistive devices or aids when necessary but are mentally incapable of negotiating such a path to safety that have been diagnosed with Alzheimer's disease or Alzheimer's related dementia, if the following requirements are met:

(1) A family member or legal representative of the resident, in consultation with the resident's primary physician and the facility, determines that the facility can meet the needs of the resident. The facility shall document the decision regarding continued placement in the facility through written verification by the family member, physician and the facility representative;

(2) The facility is equipped with an automatic sprinkler system, in compliance with National Fire Protection Association Code 13 or National Fire Protection Association Code 13R, and an automated fire door system and smoke alarms in compliance with 13-3.4 of the 1997 Life Safety Codes for Existing Health Care Occupancy;

(3) In a multilevel facility, residents who are mentally incapable of negotiating a pathway to safety are housed only on the ground floor;

(4) The facility shall take necessary measures to provide residents with the opportunity to explore the facility and, if appropriate, its grounds;

(5) The facility shall be staffed twenty-four hours a day by the appropriate number and type of personnel necessary for the proper care of residents and upkeep of the facility. In meeting such staffing requirements, every resident who is mentally incapable of negotiating a pathway to safety shall count as three residents. All on-duty staff of the facility shall, at all times, be awake, dressed and prepared to assist residents in case of emergency;

(6) Every resident mentally incapable of negotiating a pathway to safety in the facility shall be assessed by a licensed professional, as defined in sections 334.010 to 334.265, RSMo, chapter 335, RSMo, or chapter 337, RSMo, with an assessment instrument utilized by the division of aging known as the minimum data set used for assessing residents of skilled nursing facilities:

(a) Upon admission;

(b) At least semiannually; and

(c) When a significant change has occurred in the resident's condition which may require additional services;

(7) Based on the assessment in subdivision (6) of this subsection, a licensed professional, as defined in sections 334.010 to 334.265, RSMo, chapter 335, RSMo, or chapter 337, RSMo, shall develop an individualized service plan for every resident who is mentally incapable of

negotiating a pathway to safety. Such individualized service plan shall be implemented by the facility's staff to meet the specific needs of the resident;

(8) Every facility shall use a personal electronic monitoring device for any resident whose physician recommends the use of such device;

(9) All facility personnel who will provide direct care to residents who are mentally incapable of negotiating a pathway to safety shall receive at least twenty-four hours of training within the first thirty days of employment. At least twelve hours of such training shall be classroom instruction, with six classroom instruction hours and two on-the-job training hours related to the special needs, care and safety of residents with dementia;

(10) All personnel of the facility, regardless of whether such personnel provides direct care to residents who cannot negotiate a pathway to safety, shall receive on a quarterly basis at least four hours of in- service training, with at least two such hours relating to the care and safety of residents who are mentally incapable of negotiating a pathway to safety;

(11) Every facility shall make available and implement self-care, productive and leisure activity programs for persons with dementia which maximize and encourage the resident's optimal functional ability;

(12) Every facility shall develop and implement a plan to protect the rights, privacy and safety of all residents and to prevent the financial exploitation of all residents; and

(13) A licensee of any licensed residential care facility or any residential care facility shall ensure that its facility does not accept or retain a resident who is mentally incapable of negotiating a normal pathway to safety using assistive devices and aids that:

(a) Has exhibited behaviors which indicate such resident is a danger to self or others;

(b) Is at constant risk of elopement;

(c) Requires physical restraint;

(d) Requires chemical restraint. As used in this subdivision, the following terms mean:

a. "Chemical restraint", a psychopharmacologic drug that is used for discipline or convenience and not required to treat medical symptoms;

b. "Convenience", any action taken by the facility to control resident behavior or maintain residents with a lesser amount of effort by the facility and not in the resident's best interests;

c. "Discipline", any action taken by the facility for the purpose of punishing or penalizing residents;

(e) Requires skilled nursing services as defined in subdivision (17) of section 198.003 for which the facility is not licensed or able to provide;

(f) Requires more than one person to simultaneously physically assist the resident with any activity of daily living, with the exception of bathing;

(g) Is bed-bound or chair-bound due to a debilitating or chronic condition.

4. The facility shall not care for any person unless such facility is able to provide appropriate services for and meet the needs of such person.

5. Nothing in this chapter shall prevent a facility from discharging a resident who is a danger to himself or herself, or to others.

6. The training requirements established in subdivisions (9) and (10) of subsection 3 of this section shall fully satisfy the training requirements for the program described in subdivision (18) of subsection 1 of section 208.152, RSMo.

7. The division of aging shall promulgate rules to ensure compliance with this section and to sanction facilities that fail to comply with this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section

shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 1999, shall be invalid and void.