AN ACT

To repeal sections 115.287, 191.656, 192.650, 192.653, 192.655, 197.305, 197.312, 197.314, 197.317, 197.318, 197.367, 198.006, 198.012, 198.014, 198.015, 198.022, 198.030, 198.048, 198.071, 198.073, 198.076, 198.077, 198.087, 198.200, 198.525, 205.375, 208.030, 208.152, 344.010, 344.020, 355.066, 404.830, 404.835, 407.020, 660.050, 660.053, 660.115, and 660.690, RSMo, and to enact in lieu thereof thirty-seven new sections relating to assisted living facilities, with penalty provisions.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

Section A. Sections 115.287, 191.656, 192.650, 192.653, 192.655, 197.305, 197.312, 197.314, 197.317, 197.318, 197.367, 198.006, 198.012, 198.014, 198.015, 198.022, 198.030, 198.048, 198.071, 198.073, 198.076, 198.077, 198.087, 198.200, 198.525, 205.375, 208.030, 208.152, 344.010, 344.020, 355.066, 404.830, 404.835, 407.020, 660.050, 660.053, 660.115, and 660.690, RSMo, are repealed and thirty-seven new sections enacted in lieu thereof, to be known as sections 115.287, 191.656, 192.650, 192.653, 192.655, 197.305, 197.312, 197.314, 197.317, 197.318, 197.367, 198.006, 198.012, 198.015, 198.022, 198.030, 198.048, 198.071, 198.073, 198.076, 198.077, 198.087, 198.200, 198.525, 205.375, 208.030, 208.152, 344.010, 344.020, 355.066, 404.830, 404.835, 407.020, 660.050, 660.053, 660.115, and 660.690, to read as follows:

EXPLANATION-Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted from the law. Matter in boldface type in the above law is new proposed language.

115.287. 1. Upon receipt of a signed application for an absentee ballot and if satisfied the applicant is entitled to vote by absentee ballot, the election authority shall, within three working days after receiving the application, or if absentee ballots are not available at the time the application is received, within five working days after they become available, deliver to the voter an absentee ballot, ballot envelope and such instructions as are necessary for the applicant to vote. Delivery shall be made to the voter personally in the office of the election authority or by bipartisan teams appointed by the election authority, or by first class, registered, or certified mail at the discretion of the election authority. Where the election authority is a county clerk, the members of bipartisan teams representing the political party other than that of county clerk shall be selected from a list of persons submitted to the county clerk by the county chairman of that party. If no list is provided by the time that absentee ballots are to be made available, the county clerk may select a person or persons from lists provided in accordance with section 115.087. If the election authority is not satisfied that any applicant is entitled to vote by absentee ballot, it shall not deliver an absentee ballot to the applicant. Within three working days of receiving such an application, the election authority shall notify the applicant and state the reason he or she is not entitled to vote by absentee ballot. The applicant may appeal

the decision of the election authority to the circuit court in the manner provided in section 115.223.

2. If, after 5:00 p.m. on the Wednesday before an election, any voter from the jurisdiction has become hospitalized, becomes confined due to illness or injury, or is confined in an adult boarding facility, intermediate care facility, **[**residential care**]** assisted living facility, or skilled nursing facility, as defined in section 198.006, RSMo, in the county in which the jurisdiction is located or in the jurisdiction or an adjacent election authority within the same county, the election authority shall appoint a team to deliver, witness the signing of and return the voter's application and deliver, witness the voting of and return the voter's absentee ballot. In counties with a charter form of government and in cities not within a county, and in each city which has over three hundred thousand inhabitants, and is situated in more than one county, if the election authority receives ten or more applications for absentee ballots from the same address it may appoint a team to deliver and witness the voting and return of absentee ballots by voters residing at that address, except when such addresses are for an apartment building or other structure wherein individual living units are located, each of which has its own separate cooking facilities. Each team appointed pursuant to this subsection shall consist of two registered voters, one from each major political party. Both members of any team appointed pursuant to this subsection shall

be present during the delivery, signing or voting and return of any application or absentee ballot signed or voted pursuant to this subsection.

3. On the mailing and ballot envelopes for each applicant in federal service, the election authority shall stamp prominently in black the words "FEDERAL BALLOT, STATE OF MISSOURI" and "U.S. Postage Paid, 39 U.S.C. 3406".

4. No information which encourages a vote for or against a candidate or issue shall be provided to any voter with an absentee ballot.

191.656. 1. (1) All information known to, and records containing any information held or maintained by, any person, or by any agency, department, or political subdivision of the state concerning an individual's HIV infection status or the results of any individual's HIV testing shall be strictly confidential and shall not be disclosed except to:

(a) Public employees within the agency, department, or political subdivision who need to know to perform their public duties;

(b) Public employees of other agencies, departments, or political subdivisions who need to know to perform their public duties;

(c) Peace officers, as defined in section 590.100, RSMo, the attorney general or any assistant attorneys general acting on his or her behalf, as defined in chapter 27, RSMo, and

prosecuting attorneys or circuit attorneys as defined in chapter 56, RSMo, and pursuant to section 191.657;

(d) Prosecuting attorneys or circuit attorneys as defined in chapter 56, RSMo, to prosecute cases pursuant to section 191.677 or 567.020, RSMo. Prosecuting attorneys or circuit attorneys may obtain from the department of health and senior services the contact information and test results of individuals with whom the HIV-infected individual has had sexual intercourse or deviate sexual intercourse. Any prosecuting attorney or circuit attorney who receives information from the department of health and senior services pursuant to the provisions of this section shall use such information only for investigative and prosecutorial purposes and such information shall be considered strictly confidential and shall only be released as authorized by this section;

(e) Persons other than public employees who are entrusted with the regular care of those under the care and custody of a state agency, including but not limited to operators of day care facilities, group homes, **[**residential care**]** <u>assisted living</u> facilities and adoptive or foster parents;

(f) As authorized by subsection 2 of this section;

(g) Victims of any sexual offense defined in chapter 566, RSMo, which includes sexual intercourse or deviate sexual intercourse, as an element of the crime or to a victim of a section 566.135, RSMo, offense, in which the court, for good

cause shown, orders the defendant to be tested for HIV, hepatitis B, hepatitis C, syphilis, gonorrhea, or chlamydia, once the charge is filed. Prosecuting attorneys or circuit attorneys, or the department of health and senior services may release information to such victims;

(h) Any individual who has tested positive or false positive to HIV, hepatitis B, hepatitis C, syphilis, gonorrhea, or chlamydia, may request copies of any and all test results relating to said infections.

(2) Further disclosure by public employees shall be governed by subsections 2 and 3 of this section;

(3) Disclosure by a public employee or any other person in violation of this section may be subject to civil actions brought under subsection 6 of this section, unless otherwise required by chapter 330, 332, 334, or 335, RSMo, pursuant to discipline taken by a state licensing board.

2. (1) Unless the person acted in bad faith or with conscious disregard, no person shall be liable for violating any duty or right of confidentiality established by law for disclosing the results of an individual's HIV testing:

(a) To the department of health and senior services;

(b) To health care personnel working directly with the infected individual who have a reasonable need to know the results for the purpose of providing direct patient health care;

(c) Pursuant to the written authorization of the subject of

the test result or results;

(d) To the spouse of the subject of the test result or results;

(e) To the subject of the test result or results;

(f) To the parent or legal guardian or custodian of the subject of the testing, if he is an unemancipated minor;

(g) To the victim of any sexual offense defined in chapter 566, RSMo, which includes sexual intercourse or deviate sexual intercourse, as an element of the crime or to a victim of a section 566.135, RSMo, offense, in which the court, for good cause shown, orders the defendant to be tested for HIV, B, hepatitis C, syphilis, gonorrhea, or chlamydia, once the charge is filed;

(h) To employees of a state licensing board in the execution of their duties under chapter 330, 332, 334, or 335, RSMo, pursuant to discipline taken by a state licensing board;

The department of health and senior services and its employees shall not be held liable for disclosing an HIV-infected person's HIV status to individuals with whom that person had sexual intercourse or deviate sexual intercourse;

(2) Paragraphs (b) and (d) of subdivision (1) of this subsection shall not be construed in any court to impose any duty on a person to disclose the results of an individual's HIV testing to a spouse or health care professional or other

potentially exposed person, parent or guardian;

(3) No person to whom the results of an individual's HIV testing has been disclosed pursuant to paragraphs (b) and (c) of subdivision (1) of this subsection shall further disclose such results; except that prosecuting attorneys or circuit attorneys may disclose such information to defense attorneys defending actions pursuant to section 191.677 or 567.020, RSMo, under the rules of discovery, or jurors or court personnel hearing cases pursuant to section 191.677 or 567.020, RSMo. Such information shall not be used or disclosed for any other purpose;

(4) When the results of HIV testing, disclosed pursuant to paragraph (b) of subdivision (1) of this subsection, are included in the medical record of the patient who is subject to the test, the inclusion is not a disclosure for purposes of such paragraph so long as such medical record is afforded the same confidentiality protection afforded other medical records.

3. All communications between the subject of HIV testing and a physician, hospital, or other person authorized by the department of health and senior services who performs or conducts HIV sampling shall be privileged communications.

4. The identity of any individual participating in a research project approved by an institutional review board shall not be reported to the department of health and senior services by the physician conducting the research project.

5. The subject of HIV testing who is found to have HIV

infection and is aware of his or her HIV status shall disclose such information to any health care professional from whom such person receives health care services. Said notification shall be made prior to receiving services from such health care professional if the HIV-infected person is medically capable of conveying that information or as soon as he or she becomes capable of conveying that information.

6. Any individual aggrieved by a violation of this section or regulations promulgated by the department of health and senior services may bring a civil action for damages. If it is found in a civil action that:

(1) A person has negligently violated this section, the person is liable, for each violation, for:

(a) The greater of actual damages or liquidated damages of one thousand dollars; and

(b) Court costs and reasonable attorney's fees incurred by the person bringing the action; and

(c) Such other relief, including injunctive relief, as the court may deem appropriate; or

(2) A person has willfully or intentionally or recklessly violated this section, the person is liable, for each violation, for:

(a) The greater of actual damages or liquidated damages of five thousand dollars; and

(b) Exemplary damages; and

(c) Court costs and reasonable attorney's fees incurred by the person bringing the action; and

(d) Such other relief, including injunctive relief, as the court may deem appropriate.

7. No civil liability shall accrue to any health care provider as a result of making a good faith report to the department of health and senior services about a person reasonably believed to be infected with HIV, or cooperating in good faith with the department in an investigation determining whether a court order directing an individual to undergo HIV testing will be sought, or in participating in good faith in any judicial proceeding resulting from such a report or investigations; and any person making such a report, or cooperating with such an investigation or participating in such a judicial proceeding, shall be immune from civil liability as a result of such actions so long as taken in good faith.

192.650. 1. The department of health and senior services shall establish and maintain a cancer information reporting system to collect data required for the receipt of federal grant funds pursuant to the Cancer Registries Amendment Act of 1992 (42 U.S.C. 280e, et seq.), as amended.

2. The director of the department shall promulgate rules and regulations specifying the malignant neoplasms which shall be reported and accompanying information to be reported in each case. Such rules and regulations shall provide for collection of

the following data:

(1) For inpatient hospital settings, the data items collected by the department of health and senior services as of August 28, 1999, and additional data items required to be collected as a condition of federal funding for state cancer registries pursuant to the Cancer Registries Amendment Act of 1992 (42 U.S.C. 280e, et seq.), as amended; and

(2) For outpatient hospital settings, physician offices, pathology laboratories, ambulatory surgical centers, **[**residential care**]** assisted living facilities I and II, intermediate care facilities, skilled nursing facilities, and free-standing cancer clinics and treatment centers, the data items required to be collected as a condition of federal funding for state cancer registries pursuant to the Cancer Registries Amendment Act of 1992 (42 U.S.C. 280e, et seq.), as amended. Reports of malignant neoplasms, exclusive of nonmelanomatous cutaneous malignancies, shall be filed with the director within six months of the diagnosis or treatment. The department director shall prescribe the form and manner in which the information shall be reported.

192.653. 1. The administrator or designated representative of hospitals, pathology laboratories, physician offices, ambulatory surgical centers, **[**residential care**]** assisted living facilities I or II, intermediate care facilities or skilled nursing facilities, and free-standing cancer clinics and treatment centers shall report to the department of health and

senior services every case of malignant neoplasm as required pursuant to section 192.650. Physicians' offices shall be exempt from reporting cases that are directly referred to or have been previously admitted to any other facility which is required by this subsection to report malignant neoplasms.

2. The attending physician or other health care provider responsible for a patient's diagnosis or treatment for a malignant neoplasm shall provide, in writing, to the administrator or the administrator's designated representative, the information required pursuant to section 192.650.

3. Reports filed with the director may be submitted through a data system designated by the person or organization filing the report.

4. If a facility described in subsection 1 of this section is currently submitting reports of cases to the department of health and senior services through a centralized reporting system, duplicate reporting shall not be required.

192.655. 1. The department of health and senior services shall protect the identity of the patient, physician , health care provider, hospital, pathology laboratory, ambulatory surgical center, **[**residential care**]** assisted living facilities I or II, intermediate care facilities or skilled nursing facilities, and free-standing cancer clinic or treatment center which is involved in the reporting required by section 192.653, and such identity shall not be revealed except that the identity

of the patient may be released only upon written consent of the patient, the identity of the physician or health care provider may be released only upon written consent of the physician or health care provider, and the identity of the hospital, pathology laboratory, ambulatory surgical center, **[**residential care**]** assisted living facilities I or II, intermediate care facilities or skilled nursing facilities, or free-standing cancer clinic or treatment center may be released only upon written consent of the facility.

2. The department shall request consent for release from a patient, physician, health care provider, hospital, pathology laboratory, ambulatory surgical center, **[**residential care**]** assisted living facilities I or II, intermediate care facilities or skilled nursing facilities, or free-standing cancer clinic or treatment center only upon a showing by the applicant for such release that obtaining the identities of certain patients, physicians, health care providers, hospitals, pathology laboratories, ambulatory surgical centers, **[**residential care**]** assisted living facilities I or II, intermediate care facilities or skilled nursing facilities, or free-standing cancer clinics or treatment centers is necessary for his or her cancer research and that his or her cancer research is worthwhile.

3. The department shall use or publish reports based upon materials reported pursuant to sections 192.650 to 192.657 to advance research, education and treatment. The department shall

provide qualified researchers with data from the reported information upon the researcher's compliance with appropriate conditions as provided by rule and upon payment of a fee to cover the cost of processing the data.

4. The department may enter into an exchange of data agreement with other cancer registries maintained by federal, state or local governmental entities. The provisions of subsection 1 of this section shall not apply to such an agreement if the agreement provides that the federal, state or local governmental cancer registry shall protect the identity of the patient, physician, health care provider, hospital, pathology laboratory, ambulatory surgical center, **[**residential care**]** assisted living facilities I or II, intermediate care facilities or skilled nursing facilities, and free-standing cancer clinic or treatment center in all data received from the Missouri department of health and senior services.

197.305. As used in sections 197.300 to 197.366, the following terms mean:

(1) "Affected persons", the person proposing the development of a new institutional health service, the public to be served, and health care facilities within the service area in which the proposed new health care service is to be developed;

(2) "Agency", the certificate of need program of the Missouri department of health and senior services;

(3) "Capital expenditure", an expenditure by or on behalf

of a health care facility which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance;

(4) "Certificate of need", a written certificate issued by the committee setting forth the committee's affirmative finding that a proposed project sufficiently satisfies the criteria prescribed for such projects by sections 197.300 to 197.366;

(5) "Develop", to undertake those activities which on their completion will result in the offering of a new institutional health service or the incurring of a financial obligation in relation to the offering of such a service;

(6) "Expenditure minimum" shall mean:

(a) For beds in existing or proposed health care facilities licensed pursuant to chapter 198, RSMo, and long-term care beds in a hospital as described in subdivision (3) of subsection 1 of section 198.012, RSMo, six hundred thousand dollars in the case of capital expenditures, or four hundred thousand dollars in the case of major medical equipment, provided, however, that prior to January 1, 2003, the expenditure minimum for beds in such a facility and long-term care beds in a hospital described in section 198.012, RSMo, shall be zero, subject to the provisions of subsection 7 of section 197.318;

(b) For beds or equipment in a long-term care hospital meeting the requirements described in 42 CFR, Section 412.23(e), the expenditure minimum shall be zero; and

(c) For health care facilities, new institutional health services or beds not described in paragraph (a) or (b) of this subdivision one million dollars in the case of capital expenditures, excluding major medical equipment, and one million dollars in the case of medical equipment;

(7) "Health care facilities", hospitals, health maintenance organizations, tuberculosis hospitals, psychiatric hospitals, intermediate care facilities, skilled nursing facilities, **[**residential care**]** assisted living facilities I and II, kidney disease treatment centers, including freestanding hemodialysis units, diagnostic imaging centers, radiation therapy centers and ambulatory surgical facilities, but excluding the private offices of physicians, dentists and other practitioners of the healing arts, and Christian Science sanatoriums, also known as Christian Science Nursing facilities listed and certified by the Commission for Accreditation of Christian Science Nursing Organization/Facilities, Inc., and facilities of not-for-profit corporations in existence on October 1, 1980, subject either to the provisions and regulations of Section 302 of the Labor-Management Relations Act, 29 U.S.C. 186 or the Labor-Management Reporting and Disclosure Act, 29 U.S.C. 401-538, and any **[**residential care**]** assisted living facility I or **[**residential care**]** assisted living facility II operated by a religious organization qualified pursuant to Section 501(c)(3) of the federal Internal Revenue Code, as amended, which does not

require the expenditure of public funds for purchase or operation, with a total licensed bed capacity of one hundred beds or fewer;

(8) "Health service area", a geographic region appropriate for the effective planning and development of health services, determined on the basis of factors including population and the availability of resources, consisting of a population of not less than five hundred thousand or more than three million;

(9) "Major medical equipment", medical equipment used for the provision of medical and other health services;

(10) "New institutional health service":

(a) The development of a new health care facility costing in excess of the applicable expenditure minimum;

(b) The acquisition, including acquisition by lease, of any health care facility, or major medical equipment costing in excess of the expenditure minimum;

(c) Any capital expenditure by or on behalf of a health care facility in excess of the expenditure minimum;

(d) Predevelopment activities as defined in subdivision (13) hereof costing in excess of one hundred fifty thousand dollars;

(e) Any change in licensed bed capacity of a health care facility which increases the total number of beds by more than ten or more than ten percent of total bed capacity, whichever is less, over a two-year period;

(f) Health services, excluding home health services, which are offered in a health care facility and which were not offered on a regular basis in such health care facility within the twelve-month period prior to the time such services would be offered;

(g) A reallocation by an existing health care facility of licensed beds among major types of service or reallocation of licensed beds from one physical facility or site to another by more than ten beds or more than ten percent of total licensed bed capacity, whichever is less, over a two-year period;

(11) "Nonsubstantive projects", projects which do not involve the addition, replacement, modernization or conversion of beds or the provision of a new health service but which include a capital expenditure which exceeds the expenditure minimum and are due to an act of God or a normal consequence of maintaining health care services, facility or equipment;

(12) "Person", any individual, trust, estate, partnership, corporation, including associations and joint stock companies, state or political subdivision or instrumentality thereof, including a municipal corporation;

(13) "Predevelopment activities", expenditures for architectural designs, plans, working drawings and specifications, and any arrangement or commitment made for financing; but excluding submission of an application for a certificate of need.

197.312. A certificate of need shall not be required for any institution previously owned and operated for or in behalf of a city not within a county which chooses to be licensed as a facility defined under subdivision (15) or (16) of section 198.006, RSMo, for a facility of ninety beds or less that is owned or operated by a not-for-profit corporation which is exempt from federal income tax as an organization described in section 501(c)(3) of the Internal Revenue Code of 1986, which is controlled directly by a religious organization and which has received approval by the **[**division of aging**]** department of health and senior services of plans for construction of such facility by August 1, 1995, and is licensed by the **[**division of aging**]** department of health and senior services by July 1, 1996, as a facility defined under subdivision (15) or (16) of section 198.006, RSMo, or for a facility, serving exclusively mentally ill, homeless persons, of sixteen beds or less that is owned or operated by a not-for-profit corporation which is exempt from federal income tax which is described in section 501(c)(3) of the Internal Revenue Code of 1986, which is controlled directly by a religious organization and which has received approval by the **[**division of aging**]** department of health and senior services of plans for construction of such facility by May 1, 1996, and is licensed by the **[**division of aging**]** department of health and senior services by July 1, 1996, as a facility defined under subdivision (15) or (16) of section 198.006, RSMo, or **[**a

residential care] an assisted living facility II located in a city not within a county operated by a not for profit corporation which is exempt from federal income tax which is described in section 501(c)(3) of the Internal Revenue Code of 1986, which is controlled directly by a religious organization and which is licensed for one hundred beds or less on or before August 28, 1997.

197.314. 1. The provisions of sections 197.300 to 197.366 shall not apply to any sixty-bed stand-alone facility designed and operated exclusively for the care of residents with Alzheimer's disease or dementia and located in a tax increment financing district established prior to 1990 within any county of the first classification with a charter form of government containing a city with a population of over three hundred fifty thousand and which district also has within its boundaries a skilled nursing facility.

2. The provisions of sections 197.300 to 197.366 shall not apply, as hereinafter stated, to a skilled nursing facility that is owned or operated by a not-for-profit corporation which was created by a special act of the Missouri general assembly, is exempt from federal income tax as an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986, is owned by a religious organization and is to be operated as part of a continuing care retirement community offering independent living, [residential care] assisted living and skilled care. This

exemption shall authorize no more than twenty additional skilled nursing beds at each of two facilities which do not have any skilled nursing beds as of January 1, 1999.

197.317. 1. After July 1, 1983, no certificate of need shall be issued for the following:

(1) Additional **[**residential care**]** assisted living facility I, **[**residential care**]** assisted living facility II, intermediate care facility or skilled nursing facility beds above the number then licensed by this state;

(2) Beds in a licensed hospital to be reallocated on a temporary or permanent basis to nursing care or beds in a long-term care hospital meeting the requirements described in 42 CFR, Section 412.23(e), excepting those which are not subject to a certificate of need pursuant to paragraphs (e) and (g) of subdivision (10) of section 197.305; nor

(3) The reallocation of intermediate care facility or skilled nursing facility beds of existing licensed beds by transfer or sale of licensed beds between a hospital licensed pursuant to this chapter or a nursing care facility licensed pursuant to chapter 198, RSMo; except for beds in counties in which there is no existing nursing care facility. No certificate of need shall be issued for the reallocation of existing **[**residential care**]** assisted living facility I or II, or intermediate care facilities operated exclusively for the mentally retarded to intermediate care or skilled nursing

facilities or beds. However, after January 1, 2003, nothing in this section shall prohibit the Missouri health facilities review committee from issuing a certificate of need for additional beds in existing health care facilities or for new beds in new health care facilities or for the reallocation of licensed beds, provided that no construction shall begin prior to January 1, 2004. The provisions of subsections 16 and 17 of section 197.315 shall apply to the provisions of this section.

2. The health facilities review committee shall utilize demographic data from the office of social and economic data analysis, or its successor organization, at the University of Missouri as their source of information in considering applications for new institutional long-term care facilities.

197.318. 1. The provisions of section 197.317 shall not apply to **[**a residential care**]** an assisted living facility I, **[**residential care**]** assisted living facility II, intermediate care facility or skilled nursing facility only where the department of social services has first determined that there presently exists a need for additional beds of that classification because the average occupancy of all licensed and available **[**residential care**]** assisted living facility I, **[**residential care**]** assisted living facility II, intermediate care facility and skilled nursing facility beds exceeds ninety percent for at least four consecutive calendar quarters, in a particular county, and within a fifteen-mile radius of the proposed facility, and the facility

otherwise appears to qualify for a certificate of need. The department's certification that there is no need for additional beds shall serve as the final determination and decision of the committee. In determining ninety percent occupancy, **[**residential care**]** assisted living facility I and II shall be one separate classification and intermediate care and skilled nursing facilities are another separate classification.

2. The Missouri health facilities review committee may, for any facility certified to it by the department, consider the predominant ethnic or religious composition of the residents to be served by that facility in considering whether to grant a certificate of need.

3. There shall be no expenditure minimum for facilities, beds, or services referred to in subdivisions (1), (2) and (3) of section 197.317. The provisions of this subsection shall expire January 1, 2003.

4. As used in this section, the term "licensed and available" means beds which are actually in place and for which a license has been issued.

5. The provisions of section 197.317 shall not apply to any facility where at least ninety-five percent of the patients require diets meeting the dietary standards defined by section 196.165, RSMo.

6. The committee shall review all letters of intent and applications for long-term care hospital beds meeting the

requirements described in 42 CFR, Section 412.23(e) under its criteria and standards for long-term care beds.

7. Sections 197.300 to 197.366 shall not be construed to apply to litigation pending in state court on or before April 1, 1996, in which the Missouri health facilities review committee is a defendant in an action concerning the application of sections 197.300 to 197.366 to long-term care hospital beds meeting the requirements described in 42 CFR, Section 412.23(e).

8. Notwithstanding any other provision of this chapter to the contrary:

(1) A facility licensed pursuant to chapter 198, RSMo, may increase its licensed bed capacity by:

(a) Submitting a letter of intent to expand to the **[**division of aging**]** department of health and senior services and the health facilities review committee;

(b) Certification from the **[**division of aging**]** department of health and senior services that the facility:

a. Has no patient care class I deficiencies within the last eighteen months; and

b. Has maintained a ninety-percent average occupancy rate for the previous six quarters;

(c) Has made an effort to purchase beds for eighteen months following the date the letter of intent to expand is submitted pursuant to paragraph (a) of this subdivision. For purposes of this paragraph, an "effort to purchase" means a copy certified by

the offeror as an offer to purchase beds from another licensed facility in the same licensure category; and

(d) If an agreement is reached by the selling and purchasing entities, the health facilities review committee shall issue a certificate of need for the expansion of the purchaser facility upon surrender of the seller's license; or

(e) If no agreement is reached by the selling and purchasing entities, the health facilities review committee shall permit an expansion for:

a. A facility with more than forty beds may expand its licensed bed capacity within the same licensure category by twenty-five percent or thirty beds, whichever is greater, if that same licensure category in such facility has experienced an average occupancy of ninety-three percent or greater over the previous six quarters;

b. A facility with fewer than forty beds may expand its licensed bed capacity within the same licensure category by twenty-five percent or ten beds, whichever is greater, if that same licensure category in such facility has experienced an average occupancy of ninety-two percent or greater over the previous six quarters;

c. A facility adding beds pursuant to subparagraphs a. or b. of this paragraph shall not expand by more than fifty percent of its then licensed bed capacity in the qualifying licensure category;

(2) Any beds sold shall, for five years from the date of relicensure by the purchaser, remain unlicensed and unused for any long-term care service in the selling facility, whether they do or do not require a license;

(3) The beds purchased shall, for two years from the date of purchase, remain in the bed inventory attributed to the selling facility and be considered by the department of social services as licensed and available for purposes of this section;

(4) Any **[**residential care**]** assisted living facility licensed pursuant to chapter 198, RSMo, may relocate any portion of such facility's current licensed beds to any other facility to be licensed within the same licensure category if both facilities are under the same licensure ownership or control, and are located within six miles of each other;

(5) A facility licensed pursuant to chapter 198, RSMo, may transfer or sell individual long-term care licensed beds to facilities qualifying pursuant to paragraphs (a) and (b) of subdivision (1) of this subsection. Any facility which transfers or sells licensed beds shall not expand its licensed bed capacity in that licensure category for a period of five years from the date the licensure is relinquished.

9. Any existing licensed and operating health care facility offering long-term care services may replace one-half of its licensed beds at the same site or a site not more than thirty miles from its current location if, for at least the most recent

four consecutive calendar quarters, the facility operates only fifty percent of its then licensed capacity with every resident residing in a private room. In such case:

(1) The facility shall report to the [division of aging] department of health and senior services vacant beds as unavailable for occupancy for at least the most recent four consecutive calendar quarters;

(2) The replacement beds shall be built to private room specifications and only used for single occupancy; and

(3) The existing facility and proposed facility shall have the same owner or owners, regardless of corporate or business structure, and such owner or owners shall stipulate in writing that the existing facility beds to be replaced will not later be used to provide long-term care services. If the facility is being operated under a lease, both the lessee and the owner of the existing facility shall stipulate the same in writing.

10. Nothing in this section shall prohibit a health care facility licensed pursuant to chapter 198, RSMo, from being replaced in its entirety within fifteen miles of its existing site so long as the existing facility and proposed or replacement facility have the same owner or owners regardless of corporate or business structure and the health care facility being replaced remains unlicensed and unused for any long-term care services whether they do or do not require a license from the date of licensure of the replacement facility.

197.367. Upon application for renewal by any **[**residential care facility**]** assisted living I or II which on the effective date of this act has been licensed for more than five years, is licensed for more than fifty beds and fails to maintain for any calendar year its occupancy level above thirty percent of its then licensed beds, the **[**division of aging**]** department of health and senior services shall license only fifty beds for such facility.

198.006. 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) "Activities of daily living" or "ADL", one or more of the following activities of daily living: eating, dressing, bathing, toileting, transferring, and walking;

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

[(3)**]** (4) "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;

(5) "Assisted living facility I", any premises, other than an assisted living facility II, intermediate care facility, or skilled nursing facility that is licensed by the state and is utilized by its owner, operator, or manager to provide twenty-four hour care and protective oversight to three or more residents who need or are provided with shelter and board; provided that such care may include storage, distribution, or administration of medications during short-term illness or recuperation; and provided further that it shall not include a facility where all of the residents are related within the fourth degree of consanguinity or affinity to the owner, operator, or manager of the facility, but can no longer live independently;

(6) "Assisted living facility II", any premises, other than an assisted living facility I, intermediate care facility, or skilled nursing facility that is licensed by the state and is utilized by its owner, operator, or manager to provide twenty-four hour care and services and protective oversight to three or more residents who need or may be provided with shelter, board, and assistance with any activities of daily living (ADL), or any instrumental activities of daily living (ADL); provided that such care may include storage, distribution, or administration of medications, or supervision of health care under the direction of

a licensed physician; and provided further that it shall not include a facility where all of the residents are related within the fourth degree of consanguinity or affinity to the owner, operator, or manager of the facility;

(7) "Dementia", a general term for the loss of thinking, remembering, and reasoning so severe that it interferes with an individual's daily functioning, and may cause symptoms which include changes in personality, mood, and behavior;

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

[(5)**]** (9) "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)**]** (10) "Facility", any **[**residential care**]** assisted living facility I, **[**residential care**]** assisted living facility II, immediate care facility, or skilled nursing facility;

[(7)**]** (11) "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;

(12) "Instrumental activities of daily living", or "IADL", one or more of the following activities: preparing meals, shopping for personal items, medication management, managing money, using the telephone, housework, and transportation ability;

[(8)**]** (13) "Intermediate care facility", any premises, other than **[**a residential care**]** an assisted living facility I, **[**residential care**]** assisted living 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)**]** (14) "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)**]** (15) "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)**]** (16) "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)**]** (17) "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)**]** (18) "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)**]** (19) "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)**]** (20) "Skilled nursing facility", any premises, other than **[**a residential care**]** an assisted living facility I, **[**a residential care**]** an assisted living 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)**]** (21) "Vendor", any person selling goods or services to a health care provider;

[(20)**]** (22) "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.

198.012. 1. The provisions of sections 198.003 to 198.136 shall not apply to any of the following entities:

(1) Any hospital, facility or other entity operated by the state or the United States;

(2) Any facility or other entity otherwise licensed by the state and operating exclusively under such license and within the limits of such license, unless the activities and services are or are held out as being activities or services normally provided by a licensed facility under sections 198.003 to 198.186, 198.200, 208.030, and 208.159, RSMo, except hospitals licensed under the provisions of chapter 197, RSMo;

(3) Any hospital licensed under the provisions of chapter 197, RSMo, provided that the **[**residential care**]** <u>assisted living</u> facility II, intermediate care facility or skilled nursing facility are physically attached to the acute care hospital; and provided further that the department of health and senior services in promulgating rules, regulations and standards pursuant to section 197.080, RSMo, with respect to such facilities, shall establish requirements and standards for such hospitals consistent with the intent of this chapter, and

sections 198.067, 198.070, 198.090, 198.093 and 198.139 to 198.180 shall apply to every [residential care] assisted living facility II, intermediate care facility or skilled nursing facility regardless of physical proximity to any other health care facility;

(4) Any facility licensed pursuant to sections 630.705 to 630.760, RSMo, which provides care, treatment, habilitation and rehabilitation exclusively to persons who have a primary diagnosis of mental disorder, mental illness, mental retardation or developmental disabilities, as defined in section 630.005, RSMo;

(5) Any provider of care under a life care contract, except to any portion of the provider's premises on which the provider offers services provided by an intermediate care facility or skilled nursing facility as defined in section 198.006. For the purposes of this section, "provider of care under a life care contract" means any person contracting with any individual to furnish specified care and treatment to the individual for the life of the individual, with significant prepayment for such care and treatment.

2. Nothing in this section shall prohibit any of these entities from applying for a license under sections 198.003 to 198.136.

198.015. 1. No person shall establish, conduct or maintain [a residential care] an assisted living facility I, [residential

care**]** assisted living facility II, intermediate care facility, or skilled nursing facility in this state without a valid license issued by the department. Any person violating this subsection is guilty of a class A misdemeanor. Any person violating this subsection wherein abuse or neglect of a resident of the facility has occurred is guilty of a class D felony. The department of health and senior services shall investigate any complaint concerning operating unlicensed facilities. For complaints alleging abuse or neglect, the department shall initiate an investigation within twenty-four hours. All other complaints regarding unlicensed facilities shall be investigated within forty-five days.

2. If the department determines the unlicensed facility is in violation of sections 198.006 to 198.186, the department shall immediately notify the local prosecuting attorney or attorney general's office.

3. Each license shall be issued only for the premises and persons named in the application. A license, unless sooner revoked, shall be issued for a period of up to two years, in order to coordinate licensure with certification in accordance with section 198.045.

4. If during the period in which a license is in effect, a licensed operator which is a partnership, limited partnership, or corporation undergoes any of the following changes, or a new corporation, partnership, limited partnership or other entity

assumes operation of a facility whether by one or by more than one action, the current operator shall notify the department of the intent to change operators and the succeeding operator shall within ten working days of such change apply for a new license:

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

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

(3) With respect to a corporation, a change in the persons who own, hold or have the power to vote the majority of any class of securities issued by the corporation.

5. Licenses shall be posted in a conspicuous place on the licensed premises.

6. Any license granted shall state the maximum resident capacity for which granted, the person or persons to whom granted, the date, the expiration date, and such additional information and special limitations as the department by rule may require.

7. The department shall notify the operator at least sixty days prior to the expiration of an existing license of the date that the license application is due. Application for a license shall be made to the department at least thirty days prior to the expiration of any existing license.

8. The department shall grant an operator a temporary operating permit in order to allow for state review of the

application and inspection for the purposes of relicensure if the application review and inspection process has not been completed prior to the expiration of a license and the operator is not at fault for the failure to complete the application review and inspection process.

9. The department shall grant an operator a temporary operating permit of sufficient duration to allow the department to evaluate any application for a license submitted as a result of any change of operator.

198.022. 1. Upon receipt of an application for a license to operate a facility, the department shall review the application, investigate the applicant and the statements sworn to in the application for license and conduct any necessary inspections. A license shall be issued if the following requirements are met:

(1) The statements in the application are true and correct;

(2) The facility and the operator are in substantial compliance with the provisions of sections 198.003 to 198.096 and the standards established thereunder;

(3) The applicant has the financial capacity to operate the facility;

(4) The administrator of **[**a residential care**]** an assisted living facility II, a skilled nursing facility, or an intermediate care facility is currently licensed under the provisions of chapter 344, RSMo;

(5) Neither the operator nor any principals in the operation of the facility have ever been convicted of a felony offense concerning the operation of a long-term health care facility or other health care facility or ever knowingly acted or knowingly failed to perform any duty which materially and adversely affected the health, safety, welfare or property of a resident, while acting in a management capacity. The operator of the facility or any principal in the operation of the facility shall not be under exclusion from participation in the Title XVIII (Medicare) or Title XIX (Medicaid) program of any state or territory;

(6) Neither the operator nor any principals involved in the operation of the facility have ever been convicted of a felony in any state or federal court arising out of conduct involving either management of a long-term care facility or the provision or receipt of health care;

(7) All fees due to the state have been paid.

2. Upon denial of any application for a license, the department shall so notify the applicant in writing, setting forth therein the reasons and grounds for denial.

3. The department may inspect any facility and any records and may make copies of records, at the facility, at the department's own expense, required to be maintained by sections 198.003 to 198.096 or by the rules and regulations promulgated thereunder at any time if a license has been issued to or an

application for a license has been filed by the operator of such facility. Copies of any records requested by the department shall be prepared by the staff of such facility within two business days or as determined by the department. The department shall not remove or disassemble any medical record during any inspection of the facility, but may observe the photocopying or may make its own copies if the facility does not have the technology to make the copies. In accordance with the provisions of section 198.525, the department shall make at least two inspections per year, at least one of which shall be unannounced to the operator. The department may make such other inspections, announced or unannounced, as it deems necessary to carry out the provisions of sections 198.003 to 198.136.

4. Whenever the department has reasonable grounds to believe that a facility required to be licensed under sections 198.003 to 198.096 is operating without a license, and the department is not permitted access to inspect the facility, or when a licensed operator refuses to permit access to the department to inspect the facility, the department shall apply to the circuit court of the county in which the premises is located for an order authorizing entry for such inspection, and the court shall issue the order if it finds reasonable grounds for inspection or if it finds that a licensed operator has refused to permit the department access to inspect the facility.

5. Whenever the department is inspecting a facility in

response to an application from an operator located outside of Missouri not previously licensed by the department, the department may request from the applicant the past five years compliance history of all facilities owned by the applicant located outside of this state.

198.030. Every **[**residential care**]** assisted living facility I, **[**residential care**]** assisted living facility II, intermediate care facility, and skilled nursing facility shall post the most recent inspection report of the facility in a conspicuous place. If the operator determines that the inspection report of the facility contains individually identifiable health information, the operator may redact such information prior to posting the inspection report.

198.048. A skilled nursing, intermediate care, **[**residential care**]** assisted living facility II, or **[**residential care**]** assisted living facility I may exist on the same premises under the following circumstances:

(1) The skilled nursing, intermediate care, **[**residential care**]** assisted living facility II or **[**residential care**]** assisted living facility I is an identifiable unit thereof, such as an entire ward or contiguous wards, wing or floor of a building or a separate contiguous building and such identifiable unit is approved in writing by the department;

(2) The identifiable unit meets all the reasonable standards for such facility;

(3) Central services and facilities such as management services, nursing and other patient-care services, building maintenance and laundry which are shared with other units are determined to be sufficient to meet the reasonable standards for such a facility.

198.071. The staff of **[**a residential care**]** an assisted living facility I, **[**a residential care**]** an assisted living facility II, an intermediate care facility, or a skilled nursing facility shall attempt to contact the resident's immediate family or a resident's responsible party, and shall contact the attending physician and notify the local coroner or medical examiner immediately upon the death of any resident of the facility prior to transferring the deceased resident to a funeral home.

198.073. 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)**]** An individual may be accepted for residency in an assisted living facility I or assisted living facility II, or remain in such residence, only if the individual does not require hospitalization or skilled nursing care, and only if the facility:

(1) Provides for or obtains appropriate services to meet the scheduled and unscheduled needs of the resident;

(2) Has twenty-four hour staff appropriate in numbers and

with appropriate skills to provide such services;

(3) Has a written plan for the protection of all residents in the event of a disaster, including keeping residents in place, evacuating residents to areas of refuge, evacuating residents from the building if necessary, or other methods of protection based on the emergency and the individual building design; and

(4) Has written verification signed by the resident or legal representative of the resident, by the resident's physician, and by the facility representative stating how the facility will meet the scheduled and unscheduled needs of the resident.

2. An assisted living facility II may admit or continue to care for individuals with dementia who require assistance to evacuate in the event of a disaster only if all of the following requirements are met:

(1) 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)**]** (2) The facility **[**shall take**]** takes necessary measures

to provide residents with the opportunity to explore the facility and, if appropriate, its grounds;

[(5)**]** (3) The facility **[**shall be**]** is 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)**]** (4) Every resident **[**mentally incapable of negotiating a pathway to safety in the facility shall be**]** with dementia who requires assistance to evacuate in the event of a disaster is 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**]** or by an individual with a bachelor's degree in social work with an assessment tool, determined by the department of health and senior services, for community-based services for persons with dementia:

(a) Upon admission;

(b) At least semiannually; and

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

[(7)**]** (5) Based on the assessment in subdivision **[**(6)**]** (4) 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**]** develops and the facility implements 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**]** to meet the specific needs of each resident with dementia who requires assistance to evacuate in the event of a disaster, and reviews the individualized service plan with the resident or legal representative of the resident at least semiannually; provided that such individualized service plan is modified whenever a significant change occurs in the resident's condition that requires additional services. The individualized service plan shall include an evacuation plan for the resident;

[(8) Every**]** (6) The facility **[**shall use**]** uses 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**]** (7) The facility complies with the training requirements of subsection 8 of section 660.050, RSMo;

(8) The facility **[**shall make**]** makes 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**]** (9) The facility **[**shall develop and implement**]** develops and implements 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 psycho pharmacologic 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.**]** 3. Notwithstanding the provisions of subsections 1 and

2 of this section, those persons previously qualified for residence who may have a temporary period of incapacity due to illness, surgery, or injury for a period of not more than forty-five days may be allowed to remain in an assisted living facility I or II if approved by a physician.

4. 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] 5. The department of health and senior services 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] 2004, shall be invalid and void.

198.076. The department shall promulgate reasonable standards and regulations for all [residential care] assisted living facilities I and all [residential care] assisted living facilities II. The standards and regulations shall take into account the level of care provided and the number and type of residents served by the facility to insure maximum flexibility. These standards and regulations shall relate to:

(1) The number and qualifications of employed and contract personnel having responsibility for any of the services provided for residents;

(2) The equipment, facilities, services and supplies essential to the health and welfare of the residents;

(3) Fire safety and sanitation in the facility;

(4) Diet, which shall be based on good nutritional practice;

(5) Personal funds and property of residents;

(6) Resident rights and resident grievance procedures appropriate to the levels of care, size and type of facility;

(7) Record keeping appropriate to the levels of care, size and type of facility;

(8) Construction of the facility;

(9) Care of residents.

198.077. For any [residential care] assisted living

facility I, [residential care] assisted living facility II, intermediate care facility or skilled nursing facility, if the department of [social] health and senior services maintains records of site inspections and violations of statutes, rules, or the terms or conditions of any license issued to such facility, the department shall also maintain records of compliance with such statutes, rules, or terms or conditions of any license, and shall specifically record in such records any actions taken by the facility that are above and beyond what is minimally required for compliance.

198.087. To ensure uniformity of application of regulation standards in long-term care facilities throughout the state, the department of [social] health and senior services shall:

(1) Evaluate the requirements for inspectors or surveyors of facilities, including the eligibility, training and testing requirements for the position.

Based on the evaluation, the department shall develop and implement additional training and knowledge standards for inspectors and surveyors;

(2) Periodically evaluate the performance of the inspectors or surveyors regionally and statewide to identify any deviations or inconsistencies in regulation application. At a minimum, the Missouri on-site surveyor evaluation process, and the number and type of actions overturned by the informal dispute resolution process and formal appeal shall be used in the evaluation. Based

on such evaluation, the department shall develop standards and a retraining process for the region, state, or individual inspector or surveyor, as needed;

(3) In addition to the provisions of subdivisions (1) and (2) of this section, the department shall develop a single uniform comprehensive and mandatory course of instruction for inspectors/surveyors on the practical application of enforcement of statutes, rules and regulations. Such course shall also be open to attendance by administrators and staff of facilities licensed pursuant to this chapter;

(4) With the full cooperation of and in conjunction with the department of **[**health and senior**]** social services, Evaluate the implementation and compliance of the provisions of subdivision (3) of subsection 1 of section 198.012 in which rules, requirements, regulations and standards pursuant to section 197.080, RSMo, for **[**residential care**]** assisted living facilities II, intermediate care facilities and skilled nursing facilities attached to an acute care hospital are consistent with the intent of this chapter**[**. A report of the differences found in the evaluation conducted pursuant to this subdivision shall be made jointly by the departments of social services and health to the governor and members of the general assembly by January 1, 2000**]**; and

(5) With the full cooperation and in conjunction with the department of **[**health and senior**]** social services, develop rules

and regulations requiring the exchange of information, including regulatory violations, between the departments to ensure the protection of individuals who are served by health care providers regulated by either the department of health and senior services or the department of social services.

198.200. 1. A nursing home district may be created, incorporated and managed as provided in sections 198.200 to 198.350 and may exercise the powers herein granted or necessarily implied. A nursing home district may include municipalities or territory not in municipalities or both or territory in one or more counties; except, that the provisions of sections 198.200 to 198.350 are not effective in counties having a population of more than four hundred thousand inhabitants. The territory contained within the corporate limits of an existing nursing home district shall not be incorporated in another nursing home district.

2. When a nursing home district is organized it shall be a body corporate and political subdivision of the state and shall be known as "..... Nursing Home District", and in that name may sue and be sued, levy and collect taxes within the limitations of sections 198.200 to 198.350 and the constitution and issue bonds as herein provided.

3. For the purposes of sections 198.200 to 198.360, "nursing home" shall mean **[**a residential care**]** an assisted living facility I, **[**a residential care**]** an assisted living facility II, an intermediate care facility, or a skilled nursing facility as

defined in section 198.006.

198.525. Except as otherwise provided pursuant to section 198.526, in order to comply with sections 198.012 and 198.022, the department of health and senior services shall inspect **[**residential care**]** assisted living facilities I, **[**residential care**]** assisted living facilities II, intermediate care facilities, and skilled nursing, including those facilities attached to acute care hospitals at least twice a year.

205.375. 1. For the purposes of this section "nursing home" means **[**a residential care**]** an assisted living facility I, **[**a residential care**]** an assisted living facility II, an intermediate care facility, or a skilled nursing facility as defined in section 198.006, RSMo:

(1) Which is operated in connection with a hospital, or

(2) In which such nursing care and medical services are prescribed by, or are performed under the general direction of, persons licensed to practice medicine or surgery in the state.

2. The county commission of any county or the township board of any township may acquire land to be used as sites for, construct and equip nursing homes and may contract for materials, supplies, and services necessary to carry out such purposes.

3. For the purpose of providing funds for the construction and equipment of nursing homes the county commissions or township boards may issue bonds as authorized by the general law governing the incurring of indebtedness by counties; provided, however,

that no such tax shall be levied upon property which is within a nursing home district as provided in chapter 198, RSMo, and is taxed for nursing home purposes under the provisions of that chapter, or may provide for the issuance and payment of revenue bonds in the manner provided by and in all respects subject to chapter 176, RSMo, which provides for the issuance of revenue bonds of state educational institutions.

4. The county commissions or township boards may provide for the leasing and renting of the nursing homes and equipment on the terms and conditions that are necessary and proper to any person, firm, corporation or to any nonprofit organizations for the purpose of operation in the manner provided in subsection 1 of this section.

208.030. 1. The division of family services shall make monthly payments to each person who was a recipient of old age assistance, aid to the permanently and totally disabled, and aid to the blind and who:

(1) Received such assistance payments from the state of Missouri for the month of December, 1973, to which they were legally entitled; and

(2) Is a resident of Missouri.

2. The amount of supplemental payment made to persons who meet the eligibility requirements for and receive federal supplemental security income payments shall be in an amount, as established by rule and regulation of the division of family

services, sufficient to, when added to all other income, equal the amount of cash income received in December, 1973; except, in establishing the amount of the supplemental payments, there shall be disregarded cost-of-living increases provided for in Titles II and XVI of the federal Social Security Act and any benefits or income required to be disregarded by an act of Congress of the United States or any regulation duly promulgated thereunder. As long as the recipient continues to receive a supplemental security income payment, the supplemental payment shall not be reduced. The minimum supplemental payment for those persons who continue to meet the December, 1973, eligibility standards for aid to the blind shall be in an amount which, when added to the federal supplemental security income payment, equals the amount of the blind pension grant as provided for in chapter 209, RSMo.

3. The amount of supplemental payment made to persons who do not meet the eligibility requirements for federal supplemental security income benefits, but who do meet the December, 1973, eligibility standards for old age assistance, permanent and total disability and aid to the blind or less restrictive requirements as established by rule or regulation of the division of family services, shall be in an amount established by rule and regulation of the division of family services sufficient to, when added to all other income, equal the amount of cash income received in December, 1973; except, in establishing the amount of the supplemental payment, there shall be disregarded

cost-of-living increases provided for in Titles II and XVI of the federal Social Security Act and any other benefits or income required to be disregarded by an act of Congress of the United States or any regulation duly promulgated thereunder. The minimum supplemental payments for those persons who continue to meet the December, 1973, eligibility standards for aid to the blind shall be a blind pension payment as prescribed in chapter 209, RSMo.

4. The division of family services shall make monthly payments to persons meeting the eligibility standards for the aid to the blind program in effect December 31, 1973, who are bona fide residents of the state of Missouri. The payment shall be in the amount prescribed in subsection 1 of section 209.040, RSMo, less any federal supplemental security income payment.

5. The division of family services shall make monthly payments to persons age twenty-one or over who meet the eligibility requirements in effect on December 31, 1973, or less restrictive requirements as established by rule or regulation of the division of family services, who were receiving old age assistance, permanent and total disability assistance, general relief assistance, or aid to the blind assistance lawfully, who are not eligible for nursing home care under the Title XIX program, and who reside in a licensed **[**residential care**]** <u>assisted living</u> facility I, a licensed **[**residential care**]** <u>assisted living</u> facility II, a licensed intermediate care facility or a licensed

skilled nursing facility in Missouri and whose total cash income is not sufficient to pay the amount charged by the facility; and to all applicants age twenty-one or over who are not eligible for nursing home care under the Title XIX program who are residing in a licensed **[**residential care**]** assisted living facility I, a licensed **[**residential care**]** assisted living facility II, a licensed intermediate care facility or a licensed skilled nursing facility in Missouri, who make application after December 31, 1973, provided they meet the eligibility standards for old age assistance, permanent and total disability assistance, general relief assistance, or aid to the blind assistance in effect on December 31, 1973, or less restrictive requirements as established by rule or regulation of the division of family services, who are bona fide residents of the state of Missouri, and whose total cash income is not sufficient to pay the amount charged by the facility. Until July 1, 1983, the amount of the total state payment for home care in licensed **[**residential care**]** assisted living facilities I shall not exceed one hundred twenty dollars monthly, for care in licensed intermediate care facilities or licensed skilled nursing facilities shall not exceed three hundred dollars monthly, and for care in licensed **[**residential care**]** assisted living facilities II shall not exceed two hundred twenty-five dollars monthly. Beginning July 1, 1983, for fiscal year 1983-1984 and each year thereafter, the amount of the total state payment for home care in licensed **[**residential

care] assisted living facilities I shall not exceed one hundred fifty-six dollars monthly, for care in licensed intermediate care facilities or licensed skilled nursing facilities shall not exceed three hundred ninety dollars monthly, and for care in licensed [residential care] assisted living facilities II shall not exceed two hundred ninety-two dollars and fifty cents monthly. No intermediate care or skilled nursing payment shall be made to a person residing in a licensed intermediate care facility or in a licensed skilled nursing facility unless such person has been determined, by his own physician or doctor, to medically need such services subject to review and approval by the department. Residential care payments may be made to persons residing in licensed intermediate care facilities or licensed skilled nursing facilities. Any person eligible to receive a monthly payment pursuant to this subsection shall receive an additional monthly payment of not more than twenty-five dollars. The exact amount of the additional payment shall be determined by rule of the department. This additional payment shall not be used to pay for any supplies or services, or for any other items that would have been paid for by the division of family services if that person would have been receiving medical assistance benefits under Title XIX of the federal Social Security Act for nursing home services pursuant to the provisions of section 208.159. Notwithstanding the previous part of this subsection, the person eligible shall not receive this additional payment if such

eligible person is receiving funds for personal expenses from some other state or federal program.

208.152. 1. Benefit payments for medical assistance shall be made on behalf of those eligible needy persons who are unable to provide for it in whole or in part, with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the division of medical services, unless otherwise hereinafter provided, for the following:

(1) Inpatient hospital services, except to persons in an institution for mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the division of medical services shall provide through rule and regulation an exception process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional activities study (PAS) or the Medicaid children's diagnosis length-of-stay schedule; and provided further that the division of medical services shall take into account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients;

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth

in Title XVIII A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301, et seq.), but the division of medical services may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the division of medical services not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for recipients, except to persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the **[**division of aging**]** department of health and senior services or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX, of the federal Social Security Act (42 U.S.C. 301, et seq.), as amended, for nursing facilities. The division of medical services may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of Medicaid patients. The division of medical services when determining the amount of the benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a

classification separate from other nursing facilities;

(5) Nursing home costs for recipients of benefit payments under subdivision (4) of this section for those days, which shall not exceed twelve per any period of six consecutive months, during which the recipient is on a temporary leave of absence from the hospital or nursing home, provided that no such recipient shall be allowed a temporary leave of absence unless it is specifically provided for in his or her plan of care. As used in this subdivision, the term "temporary leave of absence" shall include all periods of time during which a recipient is away from the hospital or nursing home overnight because he is visiting a friend or relative;

(6) Physicians' services, whether furnished in the office, home, hospital, nursing home, or elsewhere;

(7) Dental services;

(8) Services of podiatrists as defined in section 330.010, RSMo;

(9) Drugs and medicines when prescribed by a licensed physician, dentist, or podiatrist;

(10) Emergency ambulance services and, effective January 1, 1990, medically necessary transportation to scheduled, physician-prescribed nonelective treatments. The department of social services may conduct demonstration projects related to the provision of medically necessary transportation to recipients of medical assistance under this chapter. Such demonstration

projects shall be funded only by appropriations made for the purpose of such demonstration projects. If funds are appropriated for such demonstration projects, the department shall submit to the general assembly a report on the significant aspects and results of such demonstration projects;

(11) Early and periodic screening and diagnosis of individuals who are under the age of twenty-one to ascertain their physical or mental defects, and health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Such services shall be provided in accordance with the provisions of section 6403 of P.L.53 101-239 and federal regulations promulgated thereunder;

(12) Home health care services;

(13) Optometric services as defined in section 336.010, RSMo;

(14) Family planning as defined by federal rules and regulations; provided, however, that such family planning services shall not include abortions unless such abortions are certified in writing by a physician to the Medicaid agency that, in his or her professional judgment, the life of the mother would be endangered if the fetus were carried to term;

(15) Orthopedic devices or other prosthetics, including eye glasses, dentures, hearing aids, and wheelchairs;

(16) Inpatient psychiatric hospital services for individuals under age twenty-one as defined in Title XIX of the

federal Social Security Act (42 U.S.C. 1396d, et seq.);

(17) Outpatient surgical procedures, including presurgical diagnostic services performed in ambulatory surgical facilities which are licensed by the department of health and senior services of the state of Missouri; except, that such outpatient surgical services shall not include persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended, if exclusion of such persons is permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended;

(18) Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his <u>or her</u> physician on an outpatient, rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be rendered by an individual not a member of the recipient's family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for

any one recipient one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time;

(19) Mental health services. The state plan for providing medical assistance under Title XIX of the Social Security Act, 42 U.S.C. 301, as amended, shall include the following mental health services when such services are provided by community mental health facilities operated by the department of mental health or designated by the department of mental health as a community mental health facility or as an alcohol and drug abuse facility. The department of mental health shall establish by administrative rule the definition and criteria for designation as a community mental health facility and for designation as an alcohol and drug abuse facility. Such mental health services shall include:

(a) Outpatient mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(b) Clinic mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan

of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(c) Rehabilitative mental health and alcohol and drug abuse services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management. As used in this section, "mental health professional" and "alcohol and drug abuse professional" shall be defined by the department of mental health pursuant to duly promulgated rules. With respect to services established by this subdivision, the department of social services, division of medical services, shall enter into an agreement with the department of mental health. Matching funds for outpatient mental health services, clinic mental health services, and rehabilitation services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the division of medical services. The agreement shall establish a mechanism for the joint implementation of the provisions of this subdivision. In addition, the agreement shall establish a mechanism by which rates for services may be jointly developed;

(20) Comprehensive day rehabilitation services beginning

early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive and behavioral function. The division of medical services shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism;

(21) Hospice care. As used in this subsection, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. Beginning July 1, 1990, the rate of reimbursement paid by the division of medical services to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of

reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(22) Such additional services as defined by the division of medical services to be furnished under waivers of federal statutory requirements as provided for and authorized by the federal Social Security Act (42 U.S.C. 301, et seq.) subject to appropriation by the general assembly;

(23) Beginning July 1, 1990, the services of a certified pediatric or family nursing practitioner to the extent that such services are provided in accordance with chapter 335, RSMo, and regulations promulgated thereunder, regardless of whether the nurse practitioner is supervised by or in association with a physician or other health care provider;

(24) Subject to appropriations, the department of social services shall conduct demonstration projects for nonemergency, physician-prescribed transportation for pregnant women who are recipients of medical assistance under this chapter in counties selected by the director of the division of medical services. The funds appropriated pursuant to this subdivision shall be used for the purposes of this subdivision and for no other purpose. The department shall not fund such demonstration projects with revenues received for any other purpose. This subdivision shall not authorize transportation of a pregnant woman in active labor.

The division of medical services shall notify recipients of nonemergency transportation services under this subdivision of such other transportation services which may be appropriate during active labor or other medical emergency;

(25) Nursing home costs for recipients of benefit payments under subdivision (4) of this subsection to reserve a bed for the recipient in the nursing home during the time that the recipient is absent due to admission to a hospital for services which cannot be performed on an outpatient basis, subject to the provisions of this subdivision:

(a) The provisions of this subdivision shall apply only if:

a. The occupancy rate of the nursing home is at or above ninety-seven percent of Medicaid certified licensed beds, according to the most recent quarterly census provided to the **[**division of aging**]** department of health and senior services which was taken prior to when the recipient is admitted to the hospital; and

b. The patient is admitted to a hospital for a medical condition with an anticipated stay of three days or less;

(b) The payment to be made under this subdivision shall be provided for a maximum of three days per hospital stay;

(c) For each day that nursing home costs are paid on behalf of a recipient pursuant to this subdivision during any period of six consecutive months such recipient shall, during the same period of six consecutive months, be ineligible for payment of

nursing home costs of two otherwise available temporary leave of absence days provided under subdivision (5) of this subsection; and

(d) The provisions of this subdivision shall not apply unless the nursing home receives notice from the recipient or the recipient's responsible party that the recipient intends to return to the nursing home following the hospital stay. If the nursing home receives such notification and all other provisions of this subsection have been satisfied, the nursing home shall provide notice to the recipient or the recipient's responsible party prior to release of the reserved bed.

2. Benefit payments for medical assistance for surgery as defined by rule duly promulgated by the division of medical services, and any costs related directly thereto, shall be made only when a second medical opinion by a licensed physician as to the need for the surgery is obtained prior to the surgery being performed.

3. The division of medical services may require any recipient of medical assistance to pay part of the charge or cost, as defined by rule duly promulgated by the division of medical services, for dental services, drugs and medicines, optometric services, eye glasses, dentures, hearing aids, and other services, to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.) and regulations thereunder. When substitution of a generic

drug is permitted by the prescriber according to section 338.056, RSMo, and a generic drug is substituted for a name brand drug, the division of medical services may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section must collect from all recipients the partial payment that may be required by the division of medical services under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by recipients under this section shall be in addition to, and not in lieu of, any payments made by the state for goods or services described herein.

4. The division of medical services shall have the right to collect medication samples from recipients in order to maintain program integrity.

5. Reimbursement for obstetrical and pediatric services under subdivision (6) of subsection 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and services are available under the state plan for medical assistance at least to the extent that such care and services are available to the general population in the geographic area, as required under subparagraph (a)(30)(A) of 42 U.S.C. 1396a and federal regulations promulgated thereunder.

6. Beginning July 1, 1990, reimbursement for services rendered in federally funded health centers shall be in

accordance with the provisions of subsection 6402(c) and section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations promulgated thereunder.

7. Beginning July 1, 1990, the department of social services shall provide notification and referral of children below age five, and pregnant, breast-feeding, or postpartum women who are determined to be eligible for medical assistance under section 208.151 to the special supplemental food programs for women, infants and children administered by the department of health and senior services. Such notification and referral shall conform to the requirements of section 6406 of P.L. 101-239 and regulations promulgated thereunder.

8. Providers of long-term care services shall be reimbursed for their costs in accordance with the provisions of section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. 1396a, as amended, and regulations promulgated thereunder.

9. Reimbursement rates to long-term care providers with respect to a total change in ownership, at arm's length, for any facility previously licensed and certified for participation in the Medicaid program shall not increase payments in excess of the increase that would result from the application of section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. 1396a (a)(13)(C).

10. The department of social services, division of medical services, may enroll qualified **[**residential care**]** <u>assisted living</u>

facilities, as defined in chapter 198, RSMo, as Medicaid personal care providers.

344.010. As used in this chapter the following words or phrases mean:

(1) "Board", the Missouri board of nursing home administrators;

(2) "Long-term care facility", any **[**residential care**]** assisted living facility I, **[**residential care**]** assisted living facility II, intermediate care facility or skilled nursing facility, as defined in section 198.006, RSMo, or similar facility licensed by states other than Missouri;

(3) "Nursing home", any institution or facility defined as **[**a residential care**]** an assisted living facility II, intermediate care facility, or skilled nursing facility for licensing purposes by section 198.006, RSMo, whether proprietary or nonprofit;

(4) "Nursing home administrator", a person who administers, manages, supervises, or is in general administrative charge of a nursing home, whether such individual has an ownership interest in the home, and whether his or her functions and duties are shared with one or more individuals.

344.020. No person shall act or serve in the capacity of a nursing home administrator without first procuring a license from the Missouri board of nursing home administrators as provided in sections 344.010 to 344.100. The board may issue a separate license to administrators of **[**residential care**]** assisted living

facilities II, as defined in section 198.006, RSMo. Any individual who receives a license to operate [a residential care] an assisted living facility II is not thereby authorized to operate any intermediate care facility or skilled nursing facility as those terms are defined in section 198.006, RSMo.

355.066. Unless the context otherwise requires or unless otherwise indicated, as used in this chapter the following terms mean:

(1) "Approved by or approval by the members", approved or ratified by the affirmative vote of a majority of the voters represented and voting at a duly held meeting at which a quorum is present, which affirmative votes also constitute a majority of the required quorum, or by a written ballot or written consent in conformity with this chapter, or by the affirmative vote, written ballot or written consent of such greater proportion, including the votes of all the members of any class, unit or grouping as may be provided in the articles, bylaws or this chapter for any specified member action;

(2) "Articles of incorporation" or "articles", amended and restated articles of incorporation and articles of merger;

(3) "Board" or "board of directors", the board of directors except that no person or group of persons is the board of directors because of powers delegated to that person or group pursuant to section 355.316;

(4) "Bylaws", the code or codes of rules, other than the

articles, adopted pursuant to this chapter for the regulation or management of the affairs of the corporation, irrespective of the name or names by which such rules are designated. Bylaws shall not include legally enforceable covenants, declarations, indentures or restrictions imposed upon members by validly recorded indentures, declarations, covenants, restrictions or other recorded instruments, as they apply to real property;

(5) "Class", a group of memberships which have the same rights with respect to voting, dissolution, redemption and transfer. For the purpose of this section, "rights" shall be considered the same if they are determined by a formula applied uniformly;

(6) "Corporation", public benefit and mutual benefit corporations;

(7) "Delegates", those persons elected or appointed to vote in a representative assembly for the election of a director or directors or on other matters;

(8) "Deliver" includes mail;

(9) "Directors", individuals, designated in the articles or bylaws or elected by the incorporator or incorporators, and their successors and individuals elected or appointed by any other name or title to act as members of the board;

(10) "Distribution", the payment of a dividend or any part of the income or profit of a corporation to its members, directors or officers;

(11) "Domestic corporation", a Missouri corporation;

(12) "Effective date of notice" is defined in section 355.071;

(13) "Employee" does not include an officer or director who is not otherwise employed by the corporation;

(14) "Entity", domestic corporations and foreign corporations, business corporations and foreign business corporations, for-profit and nonprofit unincorporated associations, business trusts, estates, partnerships, trusts, and two or more persons having a joint or common economic interest, and a state, the United States, and foreign governments;

(15) "File", "filed" or "filing", filed in the office of the secretary of state;

(16) "Foreign corporation", a corporation organized under a law other than the laws of this state which would be a nonprofit corporation if formed under the laws of this state;

(17) "Governmental subdivision" includes authority, county, district, and municipality;

(18) "Includes" denotes a partial definition;

(19) "Individual", a natural person;

(20) "Means" denotes a complete definition;

(21) "Member", without regard to what a person is called in the articles or bylaws, any person or persons who on more than one occasion, pursuant to a provision of a corporation's articles or bylaws, have the right to vote for the election of a director

or directors; but a person is not a member by virtue of any of the following:

(a) Any rights such person has as a delegate;

(b) Any rights such person has to designate a director or directors; or

(c) Any rights such person has as a director;

(22) "Membership", the rights and obligations a member or members have pursuant to a corporation's articles, bylaws and this chapter;

(23) "Mutual benefit corporation", a domestic corporation which is formed as a mutual benefit corporation pursuant to sections 355.096 to 355.121 or is required to be a mutual benefit corporation pursuant to section 355.881;

(24) "Notice" is defined in section 355.071;

(25) "Person" includes any individual or entity;

(26) "Principal office", the office, in or out of this state, so designated in the annual report filed pursuant to section 355.856 where the principal offices of a domestic or foreign corporation are located;

(27) "Proceeding" includes civil suits and criminal, administrative, and investigatory actions;

(28) "Public benefit corporation", a domestic corporation which is formed as a public benefit corporation pursuant to sections 355.096 to 355.121, or is required to be a public benefit corporation pursuant to section 355.881;

(29) "Record date", the date established pursuant to sections 355.181 to 355.311 on which a corporation determines the identity of its members for the purposes of this chapter;

(30) "Resident", a full-time resident of a long-term care facility or **[**residential care**]** assisted living facility;

(31) "Secretary", the corporate officer to whom the board of directors has delegated responsibility pursuant to subsection 2 of section 355.431 for custody of the minutes of the directors' and members' meetings and for authenticating the records of the corporation;

(32) "State", when referring to a part of the United States, includes a state or commonwealth, and its agencies and governmental subdivisions, and any territory or insular possession, and its agencies and governmental subdivisions, of the United States;

(33) "United States" includes any agency of the United States;

(34) "Vote" includes authorization by written ballot and written consent; and

(35) "Voting power", the total number of votes entitled to be cast for the election of directors at the time the determination of voting power is made, excluding a vote which is contingent upon the happening of a condition or event that has not occurred at the time. Where a class is entitled to vote as a class for directors, the determination of voting power of the

class shall be based on the percentage of the number of directors the class is entitled to elect out of the total number of authorized directors.

404.830. 1. No physician, nurse, or other individual who is a health care provider or an employee of a health care facility shall be required to honor a health care decision of an attorney in fact if that decision is contrary to the individual's religious beliefs, or sincerely held moral convictions.

2. No hospital, nursing facility, **[**residential care**]** assisted living facility, or other health care facility shall be required to honor a health care decision of an attorney in fact if that decision is contrary to the hospital's or facility's institutional policy based on religious beliefs or sincerely held moral convictions unless the hospital or facility received a copy of the durable power of attorney for health care prior to commencing the current series of treatments or current confinement.

3. Any health care provider or facility which, pursuant to subsection 1 or 2 of this section, refuses to honor a health care decision of an attorney in fact shall not impede the attorney in fact from transferring the patient to another health care provider or facility.

404.835. 1. It shall be unlawful for a physician, nurse or other individual who is a health care provider or an employee of a health care facility, hospital, nursing facility, **[**residential

care] assisted living facility or other health care facility to require an individual to execute a durable power of attorney for health care as a condition for the provision of health care services or admission to a health care facility.

2. It shall be unlawful for an insurance company authorized to transact health insurance business in this state, nonprofit health care service plan, health maintenance organization, or other similar person or entity who contracts or agrees to the provision of health care benefits to require an individual to execute a durable power of attorney for health care as a condition to being insured or to receive benefits for health care services.

407.020. 1. The act, use or employment by any person of any deception, fraud, false pretense, false promise, misrepresentation, unfair practice or the concealment, suppression, or omission of any material fact in connection with the sale or advertisement of any merchandise in trade or commerce or the solicitation of any funds for any charitable purpose, as defined in section 407.453, in or from the state of Missouri, is declared to be an unlawful practice. The use by any person, in connection with the sale or advertisement of any merchandise in trade or commerce or the solicitation of any funds for any charitable purpose, as defined in section 407.453, in or from the state of Missouri of the fact that the attorney general has approved any filing required by this chapter as the approval,

sanction or endorsement of any activity, project or action of such person, is declared to be an unlawful practice. Any act, use or employment declared unlawful by this subsection violates this subsection whether committed before, during or after the sale, advertisement or solicitation.

2. Nothing contained in this section shall apply to:

(1) The owner or publisher of any newspaper, magazine, publication or printed matter wherein such advertisement appears, or the owner or operator of a radio or television station which disseminates such advertisement when the owner, publisher or operator has no knowledge of the intent, design or purpose of the advertiser; or

(2) Any institution or company that is under the direction and supervision of the director of the department of insurance, director of the division of credit unions, or director of the division of finance, unless the directors of such divisions specifically authorize the attorney general to implement the powers of this chapter or such powers are provided to either the attorney general or a private citizen by statute.

3. Any person who willfully and knowingly engages in any act, use, employment or practice declared to be unlawful by this section with the intent to defraud shall be guilty of a class D felony.

4. It shall be the duty of each prosecuting attorney and circuit attorney in their respective jurisdictions to commence

any criminal actions under this section, and the attorney general shall have concurrent original jurisdiction to commence such criminal actions throughout the state where such violations have occurred.

5. It shall be an unlawful practice for any long-term care facility, as defined in section 660.600, RSMo, except a facility which is **[**a residential care**]** an assisted living facility I or **[**a residential care**]** an assisted living facility II, as defined in section 198.006, RSMo, which makes, either orally or in writing, representation to residents, prospective residents, their families or representatives regarding the quality of care provided, or systems or methods utilized for assurance or maintenance of standards of care to refuse to provide copies of documents which reflect the facility's evaluation of the quality of care, except that the facility may remove information that would allow identification of any resident. If the facility is requested to provide any copies, a reasonable amount, as established by departmental rule, may be charged.

6. Any long-term care facility, as defined in section 660.600, RSMo, which commits an unlawful practice under this section shall be liable for damages in a civil action of up to one thousand dollars for each violation, and attorney's fees and costs incurred by a prevailing plaintiff, as allowed by the circuit court.

660.050. 1. The "Division of Aging" is hereby transferred

from the department of social services to the department of health and senior services by a type I transfer as defined in the Omnibus State Reorganization Act of 1974. The division shall aid and assist the elderly and low-income handicapped adults living in the state of Missouri to secure and maintain maximum economic and personal independence and dignity. The division shall regulate adult long-term care facilities pursuant to the laws of this state and rules and regulations of federal and state agencies, to safeguard the lives and rights of residents in these facilities.

2. In addition to its duties and responsibilities enumerated pursuant to other provisions of law, the division shall:

(1) Serve as advocate for the elderly by promoting a comprehensive, coordinated service program through administration of Older Americans Act (OAA) programs (Title III) P.L. 89-73, (42 U.S.C. 3001, et seq.), as amended;

(2) Assure that an information and referral system is developed and operated for the elderly, including information on the Missouri care options program;

(3) Provide technical assistance, planning and training to local area agencies on aging;

(4) Contract with the federal government to conduct surveys of long-term care facilities certified for participation in the Title XVIII program;

(5) Serve as liaison between the department of health and senior services and the Federal Health Standards and Quality Bureau, as well as the Medicare and Medicaid portions of the United States Department of Health and Human Services;

(6) Conduct medical review (inspections of care) activities such as utilization reviews, independent professional reviews, and periodic medical reviews to determine medical and social needs for the purpose of eligibility for Title XIX, and for level of care determination;

(7) Certify long-term care facilities for participation in the Title XIX program;

(8) Conduct a survey and review of compliance with P.L. 96-566 Sec. 505(d) for Supplemental Security Income recipients in long-term care facilities and serve as the liaison between the Social Security Administration and the department of health and senior services concerning Supplemental Security Income beneficiaries;

(9) Review plans of proposed long-term care facilities before they are constructed to determine if they meet applicable state and federal construction standards;

(10) Provide consultation to long-term care facilities in all areas governed by state and federal regulations;

(11) Serve as the central state agency with primary responsibility for the planning, coordination, development, and evaluation of policy, programs, and services for elderly persons

in Missouri consistent with the provisions of subsection 1 of this section and serve as the designated state unit on aging, as defined in the Older Americans Act of 1965;

(12) With the advice of the governor's advisory council on aging, develop long-range state plans for programs, services, and activities for elderly and handicapped persons. State plans should be revised annually and should be based on area agency on aging plans, statewide priorities, and state and federal requirements;

(13) Receive and disburse all federal and state funds allocated to the division and solicit, accept, and administer grants, including federal grants, or gifts made to the division or to the state for the benefit of elderly persons in this state;

(14) Serve, within government and in the state at large, as an advocate for elderly persons by holding hearings and conducting studies or investigations concerning matters affecting the health, safety, and welfare of elderly persons and by assisting elderly persons to assure their rights to apply for and receive services and to be given fair hearings when such services are denied;

(15) Provide information and technical assistance to the governor's advisory council on aging and keep the council continually informed of the activities of the division;

(16) After consultation with the governor's advisory council on aging, make recommendations for legislative action to

the governor and to the general assembly;

(17) Conduct research and other appropriate activities to determine the needs of elderly persons in this state, including, but not limited to, their needs for social and health services, and to determine what existing services and facilities, private and public, are available to elderly persons to meet those needs;

(18) Maintain and serve as a clearinghouse for up-to-date information and technical assistance related to the needs and interests of elderly persons and persons with Alzheimer's disease or related dementias, including information on the Missouri care options program, dementia-specific training materials and dementia-specific trainers. Such dementia-specific information and technical assistance shall be maintained and provided in consultation with agencies, organizations and/or institutions of higher learning with expertise in dementia care;

(19) Provide area agencies on aging with assistance in applying for federal, state, and private grants and identifying new funding sources;

(20) Determine area agencies on aging annual allocations for Title XX and Title III of the Older Americans Act expenditures;

(21) Provide transportation services, home-delivered and congregate meals, in-home services, counseling and other services to the elderly and low-income handicapped adults as designated in the Social Services Block Grant Report, through contract with

other agencies, and shall monitor such agencies to ensure that services contracted for are delivered and meet standards of quality set by the division;

(22) Monitor the process pursuant to the federal Patient Self-determination Act, 42 U.S.C. 1396a (w), in long-term care facilities by which information is provided to patients concerning durable powers of attorney and living wills.

3. The division director, subject to the supervision of the director of the department of health and senior services, shall be the chief administrative officer of the division and shall exercise for the division the powers and duties of an appointing authority pursuant to chapter 36, RSMo, to employ such administrative, technical and other personnel as may be necessary for the performance of the duties and responsibilities of the division.

4. The division may withdraw designation of an area agency on aging only when it can be shown the federal or state laws or rules have not been complied with, state or federal funds are not being expended for the purposes for which they were intended, or the elderly are not receiving appropriate services within available resources, and after consultation with the director of the area agency on aging and the area agency board. Withdrawal of any particular program of services may be appealed to the director of the department of health and senior services and the governor. In the event that the division withdraws the area

agency on aging designation in accordance with the Older Americans Act, the division shall administer the services to clients previously performed by the area agency on aging until a new area agency on aging is designated.

5. Any person hired by the department of health and senior services after August 13, 1988, to conduct or supervise inspections, surveys or investigations pursuant to chapter 198, RSMo, shall complete at least one hundred hours of basic orientation regarding the inspection process and applicable rules and statutes during the first six months of employment. Any such person shall annually, on the anniversary date of employment, present to the department evidence of having completed at least twenty hours of continuing education in at least two of the following categories: communication techniques, skills development, resident care, or policy update. The department of health and senior services shall by rule describe the curriculum and structure of such continuing education.

6. The division may issue and promulgate rules to enforce, implement and effectuate the powers and duties established in this section and sections 198.070 and 198.090, RSMo, and sections 660.250 and 660.300 to 660.320. 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, 2001, shall be invalid and void.

7. Missouri care options is a program, operated and coordinated by the division of aging, which informs individuals of the variety of care options available to them when they may need long-term care.

8. The division shall, by January 1, 2002, establish minimum dementia-specific training requirements for employees involved in the delivery of care to persons with Alzheimer's disease or related dementias who are employed by skilled nursing facilities, intermediate care facilities, **[**residential care**]** assisted living facilities, agencies providing in-home care services authorized by the division **[**of aging**]**, adult day-care programs, independent contractors providing direct care to persons with Alzheimer's disease or related dementias and the division **[**of aging**]**. Such training shall be incorporated into new employee orientation and ongoing in-service curricula for all employees involved in the care of persons with dementia. The department of health and senior services shall, by January 1, 2002, establish minimum dementia-specific training requirements

for employees involved in the delivery of care to persons with Alzheimer's disease or related dementias who are employed by home health and hospice agencies licensed by chapter 197, RSMo. Such training shall be incorporated into the home health and hospice agency's new employee orientation and ongoing in-service curricula for all employees involved in the care of persons with dementia. The dementia training need not require additional hours of orientation or ongoing in-service. Training shall include at a minimum, the following:

(1) For employees providing direct care to persons with Alzheimer's disease or related dementias, the training shall include an overview of Alzheimer's disease and related dementias, communicating with persons with dementia, behavior management, promoting independence in activities of daily living, and understanding and dealing with family issues;

(2) For other employees who do not provide direct care for, but may have daily contact with, persons with Alzheimer's disease or related dementias, the training shall include an overview of dementias and communicating with persons with dementia.

As used in this subsection, the term "employee" includes persons hired as independent contractors. The training requirements of this subsection shall not be construed as superceding any other laws or rules regarding dementia-specific training.

660.053. As used in section 199.025, RSMo, and sections

660.050 to 660.057 and 660.400 to 660.420, the following terms mean:

(1) "Area agency on aging", the agency designated by the division in a planning and service area to develop and administer a plan and administer available funds for a comprehensive and coordinated system of services for the elderly and persons with disabilities who require similar services;

(2) "Area agency board", the local policy-making board which directs the actions of the area agency on aging under state and federal laws and regulations;

(3) "Director", the director of the division of aging of the Missouri department of **[**social**]** health and senior services;

(4) "Division", the division of aging of the Missouri department of **[**social**]** health and senior services;

(5) "Elderly" or "elderly persons", persons who are sixty years of age or older;

(6) "Disability", a mental or physical impairment that substantially limits one or more major life activities, whether the impairment is congenital or acquired by accident, injury or disease, where such impairment is verified by medical findings;

(7) "Local government", a political subdivision of the state whose authority is general or a combination of units of general purpose local governments;

(8) "Major life activities", functions such as caring for one's self, performing manual tasks, walking, seeing, hearing,

speaking, breathing, learning, and working;

(9) "Medicaid", medical assistance provided 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;

(10) "Protective services", a service provided by the Missouri division of aging in response to the need for protection from harm or neglect to eligible adults under sections 660.250 to 660.295;

(11) "Registered caregiver", a person who provides primary long-term care for an elderly person and wishes to receive information, services or support from the shared care program;

(12) "Shared care", a program administered by the division of aging in which Missouri families who provide primary long-term care for an elderly person and register as a shared care member with the division of aging shall receive access to certain supportive services and may receive a state tax credit;

(13) "Shared care community project", a project in a community that offers to help support shared care participation through development of programs;

(14) "Shared care member", a registered caregiver or shared care provider who registers with the division of aging in order to participate in the shared care program;

(15) "Shared care provider", any state authorized long-term care provider in the state, including, but not limited to,

in-home, home health, hospice, adult day care, [residential care] assisted living facility I or II, or nursing home, who voluntarily registers with the division of aging to be available as a resource for the shared care program;

(16) "Shared care tax credit", a tax credit to registered caregivers who meet the requirements of section 660.055.

660.115. 1. For each eligible household, an amount not exceeding six hundred dollars for each fiscal year may be paid from the utilicare stabilization fund to the primary or secondary heating source supplier, or both, including suppliers of heating fuels, such as gas, electricity, wood, coal, propane and heating oil. For each eligible household, an amount not exceeding six hundred dollars for each fiscal year may be paid from the utilicare stabilization fund to the primary or secondary cooling source supplier, or both; provided that the respective shares of overall funding previously received by primary and secondary heating and cooling source suppliers on behalf of their customers shall be substantially maintained.

2. For an eligible household, other than a household located in publicly owned or subsidized housing, an adult boarding facility, an intermediate care facility, [a residential care] an assisted living facility or a skilled nursing facility, whose members rent their dwelling and do not pay a supplier directly for the household's primary or secondary heating or cooling source, utilicare payments shall be paid directly to the

head of the household, except that total payments shall not exceed eight percent of the household's annual rent or one hundred dollars, whichever is less.

660.690. In order to protect the community spouse of an individual living in **[**a residential care**]** an assisted living facility I or **[**residential care**]** assisted living facility II, as defined in section 198.006, RSMo, from impoverishment and to prevent premature placement in a more expensive, more restrictive environment, the division of family services shall comply with the provisions of subsection 6 of section 208.010, RSMo, when determining the eligibility for benefits pursuant to section 208.030, RSMo.

[198.014. The department of health and senior services, with the full cooperation of and in conjunction with the department of social services, shall evaluate the implementation and compliance of the provisions of subdivision (3) of subsection 1 of section 198.012 in which rules, requirements, regulations and standards pursuant to section 197.080, RSMo, for residential care facilities II, intermediate care facilities and skilled nursing facilities attached to an acute care hospital are consistent with the intent of chapter 198. A report of the differences found in the evaluation conducted pursuant to this section shall be made jointly by the departments of health and senior services and social services to the governor and members of the general assembly by January 1, 2000.**]**