MISSOURI

Licensure Terms

Assisted Living Facilities and Residential Care Facilities

General Approach

The Missouri Department of Health and Senior Services, Division of Regulation and Licensure, Section for Long-Term Care Regulation, licenses assisted living and residential care facilities (RCFs) with one set of rules; however, some provisions differ for the two facility types. The primary difference between assisted living and RCFs is that assisted living facilities (ALFs) may admit and retain individuals who require a higher level of assistance to evacuate the building than can RCFs, whose residents must be able to evacuate without assistance. In addition, ALFs must adhere to social model of care principles and have a physician available to supervise care.

Under 2006 revised statutes, facilities previously licensed as RCF I are now licensed as RCFs, and facilities previously licensed as RCF II are now licensed as ALFs. However, facilities licensed on or before August 27, 2006, that continue to meet the licensure standards in effect on that date may maintain this designation on behalf of residents receiving supplemental welfare assistance payments allocated immediately prior to August 28, 2006.

The state has no licensure category for adult foster care.

This profile includes summaries of selected regulatory provisions for ALFs and RCFs. Because the rules do not permit construction of RCFs II after 2006, this profile does not include the regulations for this category. The complete regulations are online at the links provided at the end.

Definitions

Assisted living facility means any residence, other than a RCF, intermediate care facility, or skilled nursing facility, that provides 24-hour care and services and protective oversight to three or more adults who need assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs); storage, distribution, or administration of medications; and/or supervision of health care under the direction of a licensed physician.

The rules describe assisted living as a social model of care that emphasizes the abilities, desires, and functional needs of the individual, with services delivered in a setting that is more home-like than institutional and which promote the residents' dignity, individuality, privacy, independence, and autonomy.

Residential care facility means any residence, other than an ALF, intermediate care facility, or skilled nursing facility, that provides 24-hour care to three or more adults 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.

Resident Agreements

At the time of admission, both facility types are required to provide information about the services they provide or coordinate; service costs; resident's rights; policies related to resident conduct and responsibilities; and community-based services available in the state.

Disclosure Provisions

Both licensure categories require facilities to disclose to prospective residents, and/or their representative, information regarding the services that will be provided or coordinated, their cost, and discharge policies.

Admission and Retention Policy

Assisted Living Facilities. Facilities may not admit or retain persons who are bedbound; or who: (1) have behaviors that present a reasonable likelihood of serious harm to self and/or others; (2) require the use of physical or chemical restraints; (3) require skilled nursing services, which the facility is not able to provide; or (4) require more than one person to provide physical assistance (excluding bathing and transferring). Facilities may discharge residents who have needs that cannot be met; who no longer need assisted living services; and/or who endanger the health and/or safety of others. Facilities must be able to accommodate residents who require minimal or more than minimal assistance to evacuate the building during an emergency.

Facilities may admit and retain individuals who are receiving hospice care, including those who are bedbound, require skilled nursing care, and need more than one person to provide physical assistance, provided the resident, his or her legally authorized representative or designee, or both, and the facility, physician, and licensed hospice provider all agree that such program of care is appropriate for the resident.

Residents experiencing short periods of incapacity due to illness or injury or who are recuperating from surgery may be allowed to remain or be readmitted from a hospital if the period of incapacity does not exceed 45 days and a physician provides written approval.

Facilities may accept or retain residents with an impairment (physical, cognitive, or other type) that prevents their safe evacuation with minimal assistance only if provisions are met regarding staffing requirements to assist in evacuations, and each resident has an individualized evacuation plan.

Residential Care Facilities. To be admitted and retained, individuals must be able to independently get to an area of refuge inside or outside the building during an emergency within 5 minutes of being alerted. Facilities may discharge residents who have needs that cannot be met; who no longer need services; and/or who endanger the health and/or safety of others. Residents who have short periods of incapacity due to illness, injury, or recuperation from surgery may be allowed to remain or be readmitted from a hospital if the period of incapacity does not exceed 45 days and a physician provides written approval.

Services

Assisted Living Facilities. Facilities must provide 24-hour care and protective oversight; nursing services; assistance with ADLs and IADLs; assistance with storage, distribution, and/or administration of medications; and recreational activities.

Residential Care Facilities. Facilities must provide 24-hour care and protective oversight; storage, distribution or administration of medications, and care during short-term illness or recuperation. Staff must encourage residents to be active and participate in activities.

Service Planning

Assisted Living Facilities. Facilities must complete screening prior to admission to determine whether an applicant is eligible to be admitted. Within 5 days of admission, a community-based assessment--using a Department-approved assessment tool--must be completed by an authorized staff person and a physician must conduct a physical exam to document the individual's current medical status and write any special orders regarding care and needed procedures. The community-based assessment must be repeated whenever the resident has a significant change in condition and at least semi-annually. An individualized service plan must be developed that describes the services to be provided to meet the resident's goals, needs, and expectations. An individualized evacuation plan must be developed for residents who require more than minimal assistance to evacuate.

Residential Care Facilities. Individuals must be examined by a licensed physician in order to document their current medical status and the need for any special orders or procedures. Documentation should be obtained prior to admission but not later than 10 days after admission. The facility must review, on a monthly basis, each resident's general medical condition and needs; medications; weight; referrals for third-party services; and any accidents that potentially could have or did result in injury to the resident.

Third-Party Providers

Both facility types may obtain services from third-party providers, if needed to meet residents' needs.

Medication Provisions

In both facility types, residents may self-administer prescription and non-prescription medications if a licensed health provider approves. A physician, pharmacist, or registered nurse (RN) must review the medication regimen of each resident every other month. At a minimum, staff who administer medications must be certified as level I medication aides or certified medication technicians unless they are a licensed physician, nurse, or pharmacist. Injections may be administered only by a physician or licensed nurse, except that insulin injections may be administered by a certified medication technician or Level I medication aide who has successfully completed the state-approved course for insulin administration.

Food Service and Dietary Provisions

Both licensure categories require at least three meals a day. Modified diets prescribed by a physician can be provided if the resident is monitored by the physician and the diet is reviewed at least quarterly by a consulting nutritionist, dietitian, RN, or physician.

Staffing Requirements

Assisted Living Facility

Type of Staff. Facilities must employ a licensed *administrator* (or manager) to oversee daily operations and supervise staff, a *licensed nurse*, and *direct care staff*. A *Level I medication aide* and/or *certified medication technicians* may be employed to administer medications. Each facility must be under the supervision of a *physician* who has been informed of the facility's emergency medical procedures and is kept informed of treatments or medications prescribed by any other professional authorized to prescribe medications. The facility must hire an adequate number and type of personnel

to ensure the proper care of residents, the residents' social well-being, protective oversight of residents, and the facility's upkeep.

Staff Ratios. Minimum staff-to-resident ratios are 1:15 during the day shift; 1:20 during the evening shift; and 1:25 during the night shift. The required staff must be in the facility awake, dressed, and prepared to assist residents in case of emergency. The administrator may count toward staffing when physically present in the facility. A licensed nurse must be employed a minimum number of hours per week based on the number of residents: 8 hours a week for 3-30 residents; 16 hours a week for 31-60 residents; 24 hours a week for 61-90 residents; and 40 hours a week for more than 90 residents.

Facilities that provide services to residents with a physical, cognitive, or other impairment that prevents them from safely evacuating the facility with minimal assistance must meet the following minimum staff-to-resident ratios: 1:15 during the day and evening shifts, and 1:20 during the night shift.

Residential Care Facility

Type of Staff. Facilities must employ an *administrator* (or manager) to oversee daily operations and supervise staff and *direct care staff* to provide personal care. A *Level I medication aide* and/or *certified medication technicians* may be employed to administer medications. Facilities are required to provide an adequate number and type of personnel on duty at all times for the proper care of residents and the facility's upkeep.

Staff Ratios. At minimum, there must be one staff person for every 40 residents. Facilities operated in conjunction with and contiguous to another licensed facility may not be required to have staff on-site 24 hours daily based on specified exceptions (e.g., a call system or the number of staff in the other building). Facilities with fewer than 12 residents are not required to have overnight awake staff unless any of those residents are blind or use mobility aides, in which case awake staff are required.

Training Requirements

In both facility types, all staff must receive at least 1 hour of fire safety training and orientation appropriate to job function and responsibilities, including information about preservation of resident dignity, abuse/neglect, and working with residents with mental illness.

Any facility that provides care to any resident having Alzheimer's disease or other dementia must provide orientation to all staff. For employees providing direct care to such residents, the orientation training must include at least 3 hours of training, including at a minimum an overview of mentally confused residents; communicating with persons with dementia; behavior management; promoting independence in ADLs;

techniques for creating a safe, secure, and socially oriented environment; provision of structure, stability, and a sense of routine for residents based on their needs; and understanding and dealing with family issues.

For other employees who do not provide direct care but may have daily contact with such residents, the orientation training must include at least 1 hour of training, including at a minimum an overview of mentally confused residents, such as those having dementias, as well as communicating with persons with dementia.

Dementia-specific training must be incorporated into ongoing in-service curricula. Orientation and training must be conducted, presented, or provided by an individual who is qualified by education, experience, or knowledge in the care of individuals with Alzheimer's disease or other dementia.

In addition to the requirements listed above, all staff in an ALF must receive a minimum of 2 hours of initial training on transfer assistance (e.g., wheelchair to bed, bed to dining room chair); instruction regarding person-centered care and the social model of care; and techniques that are effective in enhancing residents' choice and control over their environment; and 24 hours of additional training, approved by the Department, consisting of definition and assessment of ADLs; assessment of cognitive ability; service planning; and interview skills.

Provisions for Apartments and Private Units

Apartment-style units are not required. Both facility types may offer either single or multiple-occupancy rooms, with a maximum of four residents to a room. One tub or shower must be provided for every 20 residents and one toilet and sink for every six residents.

For ALFs, the rules emphasize that facilities must be "home-like," which is defined as "a self-contained long-term care setting that integrates the environmental, psychosocial, and organizational qualities that are associated with being at home." Home-like may include, but is not limited, to the following: (1) a living room and common-use areas for social interactions and activities; (2) a kitchen and family-style eating area for use by the residents; (3) a laundry area for use by residents; (4) a toilet room that contains a toilet, sink, and bathing unit in each resident's room; (5) meeting preferences for residents who wish to share a room and for residents who wish to have private bedrooms; (6) an outdoor area for outdoor activities and recreation; and (7) a place where residents can enjoy privacy, security, familiarity, and a sense of belonging; exercise control over their environment; give and receive affection; explore their interests; and engage in interactions with others.

Provisions for Serving Persons with Dementia

No provisions identified for either type of facility apart from general training described above.

Background Checks

Prior to hiring staff or allowing volunteers to work, both facility types must conduct a criminal background check and an employee disqualification list check (maintained by the Department of Health and Senior Services). Individuals who have been convicted of, pled guilty or no contest to, or who have been found guilty of a crime (Class A or B felony violation), cannot have contact with residents unless the facility obtains verification from the Department that a good cause waiver has been granted. Professional services staff (e.g., plumbing or air conditioning repair personnel) who will have contact with any resident must either have a criminal background check or be monitored by staff while in the facility.

Inspection and Monitoring

Facilities in both licensure categories must be inspected prior to being licensed and then annually.

Public Financing

The state pays for the provision of personal care services in assisted living and RCFs under the Medicaid State Plan Personal Care authority. The program provides support to residents whose personal care needs exceed those that the facility is typically able to provide. The state does not cover services in either facility type under a Medicaid waiver program.

Room and Board Policy

The state provides an optional state supplement (OSS) to eligible residents in specified living arrangements. In 2015, the maximum OSS was $156 per month for RCF residents and $292 per month for ALF residents, less a personal needs allowance of $45, which is retained by the resident.

In 2009, family supplementation was allowed.[1]

[1] Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association. http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf. Current information about family supplementation policy was not available online or from other sources.

Location of Licensing, Certification, or Other Requirements

Code of State Regulations, Title 19, Division 30, Chapter 86: Licensure and Regulation of Residential Care Facilities and Assisted Living Facilities. [September 30, 2012]
http://www.sos.mo.gov/adrules/csr/current/19csr/19c30-86.pdf

Missouri Revised Statutes, Title XL, Chapter 660.050: Division of Aging created–dementia-specific training requirements established. [2009]
http://law.justia.com/codes/missouri/2009/t40/c660/660_050.html

Information Sources

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Missouri Assisted Living Association

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Regulation Unit Manager
Division of Regulation and Licensure
Section for Long-Term Care Regulation
Missouri Department of Health and Senior Services

COMPENDIUM OF RESIDENTIAL CARE AND ASSISTED LIVING REGULATIONS AND POLICY: 2015 EDITION

Files Available for This Report

FULL REPORT

Executive Summary	http://aspe.hhs.gov/execsum/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-executive-summary
HTML	http://aspe.hhs.gov/basic-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition
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SEPARATE STATE PROFILES

[***NOTE***: These profiles are available in the full HTML and PDF versions, as well as each state available as a separate PDF listed below.]

Alabama	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-alabama-profile
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