MISSOURI DEPARTMENT OF
HEALTH &
SENIOR SERVICES

SLCR Update

MALA October 2026

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STATE WORKLOAD

LICENSURE:

269 Residential Care Facilities

332 Assisted Living Facilities

18 Licensed only ICF/SNF Facilities

SLCR staff completed 99% of RCF and ALF inspection in state FY26

COMPLAINTS:

- State Fiscal Year 2020: **8,970**
- State Fiscal Year 2026: **11,707**
  - RCF/ALF and **state licensed** SNF/ICF complaints-**2,233**
  - **97% IJ intakes investigated within required timeframes**

Average number of health deficiencies per survey/complaint investigation

- 2020: **7.8** citations per recertification; **2,080** complaint investigation onsite (**0.3** citations per survey)
- 2026: **8.38** citations per recertification; **1,159** complaint investigation onsite (**0.4** citations per survey)

LEVEL ONE MEDICATION AIDE

Current Challenges

- Two Departments
- Differing Regulations
- Two separate LIMA registries
- Outdated curriculum and testing platforms
- Inefficient for providers and nurse aides

Vision

- Single registry for providers to check L1MA status
- Improved curriculum and testing
- Better-trained workforce=fewer medication errors

STATE REGULATORY UPDATES

Regulation change: DHSS proposed changes to RCF/ALF regulations eliminating a requirement for written statement from a physician for employees to work in those settings.

19 CSR 30-86.047

- April 30, 2026- The amended regulation was published in the Missouri Code of State Regulations.
- May 30, 2026 - The amendment made to 19 CSR 30-86.047 will become effective.

19 CSR 30-86.042

- June 30, 2026- The amended regulation was published in the Missouri Code of State Regulations.
- July 30, 2026- the proposed amendment became effective

SUBCUTANEOUS INJECTIONS AND EPINEPHRINE- H.B. 2372 AND S.B. 1233

- **335.081.** Medication aides, nurse aides, and similar trained staff in LTC may administer certain injectable medications. Permitted injectable medications include:
- (a) Insulin
- (b) Prescribed subcutaneous diabetes medications;
- (c) Physician-prescribed subcutaneous medications; and
- (d) Epinephrine delivery systems (with training) in accordance with section 196.990

- **Next Steps**:
  - DHSS is developing emergency rules.
  - Implementation guidance will be forthcoming.

LOOKING AHEAD

State licensed only providers transitioning to iQIES system

- **Anticipated roll out 11/2026**
- **May experience some delays in statement of deficiencies during transition**

Electronic Plans of Correction (ePOC)

- **Anticipated roll out 01/01/2027.**
- **Watch for instructions on the listserv and via email.**

MEDICATION ADMINISTRATION

Medication Administration Errors

- Not administered as ordered by physician
- Not documenting administration
- Failure to order or reorder medications
- Storage of medications

Significant Medication Errors: seizure medications, narcotic pain medications

MEDICATION SAFETY

- Objectives:
  - Identify common points where medication systems break down.
  - Recognize risks involving orders, transitions of care, staff roles, and resident changes.
  - Describe immediate priorities after a medication error or suspected adverse reaction.
  - Use practical checks to strengthen medication safety in the facility.

MEDICATION SAFETY IS A SYSTEM

- THE ORDER
  - Is it current, complete, clear, and consistent with the pharmacy label?
- THE PERSON
  - Is the staff member qualified, authorized, trained, and competent for the task?
- THE RESIDENT
  - Is the resident's condition consistent with baseline? Are there new symptoms or risks?

When any answer is unclear: pause, protect the resident, clarify, and document.

TRANSITIONS OF CARE

- Reconcile medications after hospital, ER visits, or doctor appointments.
- Compare current orders, discharge paperwork, and pharmacy labels.
- Clarify incomplete, conflicting, or changed **orders-do not guess or assume**.
- Track discontinued medications and changes in dose, timing, or route.
- Document contacts, instructions, and actions taken.

STAFF ROLES, AUTHORIZATION, AND COMPETENCY

- Confirm authorization and competency for the specific task-not just general experience.
- Provide training, supervision, and reassessment when duties or risks change.
- A resident's need does not authorize an unqualified employee to perform a task.

HIGH-RISK MEDICATIONS AND CHANGING CONDITIONS

- **EXAMPLES OF HIGHER-RISK MEDICATIONS**
  - Insulin and other glucose-lowering medications
  - Anticoagulants
  - Opioids and sedatives
  - Medications that may lower blood pressure
- **WATCH FOR**
  - Low blood sugar
  - Bleeding or unusual bruising
  - New confusion or unusual sleepiness
  - Dizziness, falls, or weakness
- **WHEN CONCERNED**
  - Follow emergency procedures
  - Report recent medication changes
  - Document findings

MEDICATION ERRORS: RESPOND, REPORT, LEARN

- **PROTECT**
  - **Assess the resident and address immediate safety needs.**
- **ESCALATE**
  - **Get appropriate clinical guidance; use emergency response when indicated.**
- **DOCUMENT**
  - **Record what actually happened, observations, contacts, and actions.**
- **PREVENT**
  - **Review contributing factors and reduce recurrence.**

CASE STUDY 1-HOSPITAL DISCHARGE

- A resident returns from the hospital. The discharge list shows a different dose from the pharmacy label, and the facility has not yet received clarification.

What should staff do before the next dose is due?

A. Choose the dose shown on the pharmacy label.

B. Give the usual dose and clarify it later.

C. Promptly clarify the discrepancy and follow the directions from the physician.

CASE STUDY 2- MISSED MEDICATION

A staff member discovers that a scheduled medication was not administered during a busy pass. The staff member considers documenting it as given to avoid trouble.

What are the immediate priorities?

A. Assess the resident and seek medication-specific clinical guidance.

B. Accurately document the omission and follow notification/reporting procedures.

C. Review why the omission occurred and how to prevent recurrence.

CASE STUDY 3- REQUESTED INJECTION

A resident has a new injectable medication. An administrator asks an experienced LIMA to administer it because a nurse is not available.

What must be verified before assigning the task?

A. The exact rules/regulations for the medication.

B. The employee's authorization, training, and competency for the specific task.

C. A safe plan to obtain appropriate care if the task cannot be assigned.

CASE STUDY 4- CHANGE IN CONDITION

After a medication change, a resident who is usually alert becomes unusually sleepy, unsteady, and confused. Staff attribute it to dementia.

What should staff consider?

A. An acute change from baseline that needs prompt assessment.

B. A possible medication effect or other medical problem.

C. Escalation based on symptoms, appropriate documentation, and communication of recent medication changes.

EVERYDAY CONTROLS TO PREVENT ERRORS

- Secure storage, correct labeling, appropriate temperature, and expiration checks.
- Reliable processes for PRN medications, refusals, omissions, and follow-up.
- Controlled-medication accountability where applicable.
- Reduce interruptions during medication preparation and administration.
- Clear handoffs when staff, orders, or resident needs change.

MEDICATION SAFETY SELF-ASSESSMENT

- Orders and pharmacy labels are reconciled after transitions of care.
- Staff authorization and competency are verified for assigned tasks.
- Storage, security, labeling, and expiration dates are checked.
- Missed doses, refusals, PRN use, and follow-up are documented accurately.
- Staff know how to respond to errors and suspected adverse reactions.
- Changes in resident condition are communicated and evaluated.
- Incidents and recurring trends are reviewed for system improvements.

TAKEAWAYS

1. **Clarify-** **Never guess when an order is unclear of conflicting.**
2. **Verify-** **Confirm authorization and competency for the specific task.**
3. **Notice-** **Treat sudden changes from baseline as meaningful.**
4. **Respond-** **Protect the resident, escalate, document accurately, and report as required.**
5. **Improve-** **Use incidents and near misses to strengthen the system.**

WEATHER CONDITIONS PLANNING

- Facilities must have an emergency preparedness plan and be ready to act in an emergency to ensure they are adequately prepared to meet the needs of clients, residents, and participants during disasters and emergency situations.
- **If your facility experiences a loss of a necessary service (electricity, water, gas, phone, etc.), contact SLCR via the Regional Office emergency phone line and keep SLCR informed of the facility's status**.
- If, for some reason, the facility cannot contact SLCR staff through the regional office phone number, you should contact the hotline.
- The emergency protocol is available at this link: SLCR Emergency Protocol
- Facilities should call their local emergency operation center in order to obtain the necessary resources to either stay at the facility or to evacuate, if appropriate

SLCR EMERGENCY PROTOCOL

Each SLCR regional office has designated a cellular phone number for facilities to call in case of a disaster that results in loss of a necessary service (electricity, water, gas, phone, etc.) This phone number will be answered twenty-four hours a day, seven days a week. The regional office main phone number should be used during normal business hours.

Region	Main Office Number	Emergency Cell Number
Region 1 (Springfield)	417-895-6435	417-425-8780
Region 2 (Poplar Bluff)	573-840-9580	573-778-6495
Region 3 (Kansas City)	816-889-2818	816-719-0089
Region 4 (Cameron)	816-632-6541	816-632-9371
Region 5 (Macon)	660-385-5763	660-621-2326
Region 6 (Jefferson City)	573-751-2270	573-619-3338
Region 7 (St. Louis)	314-340-7360	314-623-2852

*******THIS PROTOCOL IS NOT TO BE USED TO SELF REPORT INCIDENTS NORMALLY REPORTED TO THE ELDERLY ABUSE AND NEGLECT HOTLINE*******

THANK YOU

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