

IN THE MISSOURI COURT OF APPEALS  
EASTERN DISTRICT

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Court of Appeals No. ED 91466

**FILED**  
SEP 26 2008

**LAURA ROY**

CLERK, MISSOURI COURT OF APPEALS  
EASTERN DISTRICT

DANIEL J. MARGIOTTA,  
Plaintiff/Appellant,

**90249**

vs.

**FILED**

CHRISTIAN HOSPITAL NORTHEAST NORTHWEST D/B/A <sup>JUL 1 2009</sup>  
CHRISTIAN HOSPITAL AND BJC HEALTH SYSTEM, Thomas F. Simon  
Defendants/Respondents CLERK, SUPREME COURT

BRIEF OF PLAINTIFF/APPELLANT DANIEL J. MARGIOTTA

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D. Eric Sowers, 24970  
es@sowerswolf.com  
Ferne P. Wolf, 29326  
M. Beth Fetterman, 59550  
Sowers & Wolf, LLC  
530 Maryville Centre Dr., Ste 460  
St. Louis, Missouri 63141  
314 744-4010  
314 744-4026

**SCANNED**

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## JURISDICTIONAL STATEMENT

This is an action involving Appellant's common law claim against his former employer under the public policy discharge tort (LF 8). Respondents moved for summary judgment challenging the sufficiency of Appellant's evidence that he was discharged because of his protests and that his protests were protected under the common law (LF 62). Margiotta moved the trial court for additional time to respond to Respondents' motion so he could include testimony from a witness, David Moutria (LF 253). The trial court denied Margiotta's motion (LF 275, A1), granted Respondents' motion, and entered judgment on May 12, 2008 (LF 311, A2 ). Margiotta moved the court to reconsider its entry of summary judgment when the Moutria deposition transcript became available and attached a copy of that transcript to the motion (LF 313); the trial court denied Appellant's Motion for Reconsideration on June 9, 2008 (LF 369, A3). Appellant filed his notice of appeal on June 16, 2008 (LF 371). This court's jurisdiction is based on RS Mo. 512.020(5) in that this is an appeal from a final judgment.

## STATEMENT OF FACTS

### I. Underlying Facts

#### A. Margiotta and other employees involved in case

Daniel Margiotta was a Medical Imaging Technician who worked in the CT Scan Department of Christian Hospital (LF p. 8, ¶ 1; LF 27, ¶1) for less than a year - from April to December of 2005 (LF p. 66, ¶ 1; LF 190, ¶ 1; LF 203, ¶ 95; 282, ¶ 95).

Margiotta worked with fellow Imaging Techs Cindy Rigsby, Kim Darabcsek, and Jamie Harper, and Technician Assistant David Moutria (LF 68-69, ¶¶ 11, 13-14, 16). The Imaging Techs were directly supervised by Tim Cuff; Cuff was supervised by Department Manager, Bill Lundak, and Lundak's direct supervisor, Stuart Schneider (LF 66, ¶ 1; LF 75, ¶ 3). Donna Sorden was a Registered Nurse who worked as a secretary/clinical coordinator (LF 244, p. 8) in the department located next to CT Scan (LF 245, p. 12). Brian Hartwick was the Vice President of Human Resources (LF 68, ¶ 10).

#### B. Margiotta's commendations and complaints

During his brief period of employment, Margiotta received commendations for his work (LF p. 199, ¶ 50; LF 303, ¶ 6) including one from the hospital president acknowledging the "superior skill and compassion" Margiotta brought to the job (LF 199, ¶ 51; LF 278, ¶ 51). Also during this brief period, Margiotta repeatedly complained to Bill Lundak (LF 66, ¶ 1; LF 190, ¶ 1) and another supervisor about practices relating to patient care and safety, including:

- Patients left unattended in the halls of the hospital (LF 197, ¶ 25; LF 276, ¶ 25);
- Hospital staff bringing patients to the CT department without the armbands the CT staff needed to confirm they were performing the right procedure on the right patient (LF 197, ¶¶ 27, 29, 30; LF 276, ¶¶ 27, 29, 30; LF 197, ¶ 28; LF 223, pp. 49-50, 60<sup>1</sup>);
- The practice of having a single member of the hospital staff, without assistance, transfer patients from stretchers to the CT table (LF 197, ¶ 31; LF 225, p. 60; LF 276, ¶ 31), including a discussion with a supervisor about an incident involving a patient whom other staff dropped on the floor, making it impossible to determine whether the patient's injuries were the result of a car accident or hospital staff's conduct (LF 125, pp. 154-58);
- Hospital staff bringing patients with non-functioning or incorrectly-sized IV's to the CT department (LF 197, ¶ 32; LF 71; LF 197, ¶ 33; LF 277, ¶ 33);
- Hospital staff performing a CT scan on a pregnant woman (LF 198, ¶ 37; LF 210, p. 97; LF 119, pp. 96-97<sup>2</sup>) which Margiotta believed resulted in radiation exposure to the fetus. This complaint was to Tim Cuff, Margiotta's direct supervi-

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<sup>1</sup>Where multiple pages of a deposition transcript appear on one cited page of the record, the specific pages are cited as well.

<sup>2</sup>Appellant inadvertently left out the citation to p. 96 in his ¶ 37.

sor, who reported directly to Lundak. (LF 199, ¶ 44; LF 287, ¶ 44; LF 199, ¶ 45; LF 304, ¶¶ 15, 16).

### C. Margiotta's discharge

On December 9, 2005, Lundak, Hartwick, and Schneider decided to discharge Margiotta (LF 70, ¶ 16, first sentence; LF 195, ¶ 16) after, according to Lundak's testimony, interviewing Donna Sorden, Jamie Harper, Kim Darabcsek, and David Moutria about an incident which took place on December 8, 2005 (LF 232, pp. 95-96). Lundak testified the decision was made because of concerns about the safety of patients and staff (LF 233, p. 100), and there had been no concerns of staff or patient safety with respect to Margiotta before the morning of December 9, 2005 (LF 234, p. 101).

Kim Darabcsek testified that on December 8, 2005, Margiotta asked her to start an IV on a patient Margiotta had on the CT scan table (LF 200, ¶ 60; LF 217, pp. 30-31). Margiotta disputed Darabcsek's claim (LF 201, ¶ 65; LF 209, p. 88). Darabcsek testified that while she was starting the IV, she heard an argument in the CT control room (LF 200, ¶ 60, LF 217, pp. 30-31) but could not hear what was being said (LF 200, ¶ 61, LF 218, p. 42). Darabcsek did not know whether the patient heard the argument (LF 201, ¶¶ 63, 64; LF 218, p. 42).

Cindy Rigsby said she observed Margiotta and Moutria in the CT scan room, standing close to a patient, when the two men started arguing (LF 201, ¶¶ 67, 68; LF 239, p. 22; LF 241, p. 30). Rigsby testified she, Margiotta, and Moutria were the only employees in

the area (LF 201, ¶ 69; LF 239, p. 24) and after Margiotta stopped yelling, Kim Darabcsek, Jamie Harper, and Tim Cuff entered the CT scan room (LF 201, ¶ 70; LF 240, pp. 25-26). Rigsby wrote in a statement that as she came into the doorway, Margiotta was throwing a chuck<sup>3</sup> down into (sic) the floor (LF 94).

Donna Sorden testified she witnessed an argument between Margiotta and Moutria as she walked through the CT scan area (LF 201, ¶ 71; LF 245, p. 12). Sorden testified that at the time of the argument, she, Tim Cuff, Margiotta, Cindy Rigsby, and David Moutria were in the CT control room and Kim Darabcsek was in the CT scanning area (LF 201, ¶ 74; LF 246, pp. 14-16). Sorden testified she was standing about “a foot” from Margiotta and Moutria (LF 246, p. 13) and saw Margiotta throw objects on the ground, towards the floor where Moutria was standing (LF 201, ¶ 72; LF 245, p. 12). Margiotta denied throwing objects down on the floor (LF 201, ¶ 73; LF 209, p. 85). Sorden testified when she left the control room, Margiotta, Moutria, Cuff, and Rigsby remained (LF 202, ¶ 75; LF 246, p. 16). In her written statement, Sorden claimed Margiotta threw objects onto the floor (LF 96); and, Bill Lundak testified Tim Cuff told him that Margiotta threw “some chux on the floor” (LF 229, p. 83).

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<sup>3</sup> Chucks, or “chux,” are fabric devices used to support patients on a table or stretcher (LF 345, 346, pp. 116-17). They occasionally become soiled with body fluids, in which case they are deposited in the bio tub/dirty linen bag (LF 345, p. 116; LF 359, pp. 169-71).

Department Manager Bill Lundak testified that the next day, December 9, 2005, he and Human Resources Vice President Brian Hartwick interviewed Sorden, Harper, Darabcsek, Moutria, and Rigsby about the incident (LF 202, ¶ 81; LF 232-33, pp. 93-95). Without questioning Margiotta and without discussing alternative disciplinary measures, Lundak, Hartwick, and Schneider decided to fire Margiotta (LF 202, ¶¶ 81-83; LF 232, p. 96; LF 233, pp. 99-100). Lundak testified he did not consider lesser discipline because of concerns for patient and staff safety (LF 203, ¶ 93; LF 233, p. 100). Margiotta was summoned and notified of his termination at the end of his shift on December 9; he was not scheduled to report to work for another ten days at the time (LF 203, ¶¶ 94, 95; LF 303-04, ¶ 13). When Hartwick questioned Margiotta, the latter denied shouting at another employee or throwing a pillow and stated only he and two others were present at the time in question (LF 202-03, ¶¶ 84-86; LF 210-11, pp. 176-79; LF 303, ¶¶ 9, 10). Lundak testified that when questioned, Margiotta said he “had gotten mad, something to do with the patient,” he was “just, just angry,” and he “was having a bad day” (LF 203, ¶ 87; LF 234, p. 103; LF 235, p. 105).

## II. Facts relating to the testimony of David Moutria

### A. Procedural background

On July 6, 2007, Margiotta served Respondent Christian Hospital with interrogatories requesting last known home addresses and telephone numbers for witnesses (LF 258, ¶¶ 1, 2, 3). Respondent objected to providing the contact information, stating the witnesses

could be contacted only through Respondents' counsel (LF 259, ¶ 4). On March 13, 2008, Margiotta provided Respondents' counsel with the names of six employees, including David Moutria, and asked for deposition dates (LF 248, ¶ 4). On March 27, 2008, Respondents filed their Motion for Summary Judgment (LF 65).

Respondents had fired the witness David Moutria on September 10, 2007 (LF 319, p. 10); they first notified Margiotta's counsel of the change in Moutria's status on April 15, 2008, stating Moutria's last known address was in Illinois (LF 248, ¶¶ 5, 6). Margiotta's attorneys obtained subpoenas from the Circuit Court of Madison County, Illinois, and both Moutria and Tim Cuff were served on April 29, 2008 (LF 249, ¶¶ 7, 8). Both witnesses were deposed on May 7, 2008, and expedited transcripts were requested because the hearing on the Summary Judgment Motion was scheduled for May 9, 2008, at 8:30 a.m. (LF 256, ¶¶ 3, 4, 5).

On May 8, 2008, the court reporter informed Margiotta's counsel that due to the extensive cross-examination in the Moutria deposition, it was impossible to provide a transcript before the hearing (LF 256, 257, ¶¶ 7, 8). Upon receipt of this information, Margiotta's counsel fax-filed appellant's Second Motion for Continuance of Ruling on Defendants (sic) Motion for Summary Judgment (LF 253-55), accompanied by an affidavit from counsel (LF 256-57), and moved to shorten time for the hearing on the Motion for Continuance, so the motion could be heard on May 9, 2008 at 8:30 a.m. (LF 261-62). Margiotta requested a continuance of the hearing and an opportunity to supplement the summary judgment record due to the unavailability of the Moutria deposition

transcript, which included testimony regarding the incident which Respondents claim caused them to discharge Margiotta and that Margiotta would be prejudiced unless allowed to bring this testimony before the trial court (LF 254, ¶¶ 5, 6).

Margiotta's Motion for Continuance was heard on May 9, 2008 and denied (LF 275, A1); the trial court granted summary judgment on May 12, 2008 (LF 311, A2); and, the Moutria transcript was completed on May 13, 2008 (LF 314, ¶ 6). Margiotta moved for reconsideration and to allow supplementation of the record, with the Moutria transcript attached as an exhibit (LF 313-63). The trial court denied the motions on June 9, 2008 (LF 369, A3).

#### **B. Moutria's testimony**

With regard to the events of December 8, 2005, Moutria testified that instead of staggering lunch breaks, everyone left the area except Margiotta and Moutria (LF 324, p. 32; LF 327, p. 41). Cindy Rigsby was working on another patient in a different room and could not assist Margiotta and Moutria because she was unable to leave her patient on the table; Moutria was the only one who could go back and forth (LF 338, pp. 87-88; LF 343, pp. 105-06). When a patient was brought in, Margiotta and Moutria paged for assistance four or five times, but no one came to help transfer the patient from the stretcher to the scanning table (LF 324, p. 32). Margiotta became frustrated because no one was responding to the page and tossed a pillow across the room where it hit a suction cannister and knocked the cannister off the wall (LF 324-25, pp. 32-35; LF 344, pp. 111-12). Margiotta

did not throw the pillow at the suction device, nor did it appear that he was trying to knock it down (LF 325, pp. 34-35; LF 345, pp. 113-14). The suction canister was so loosely attached to the wall it would spontaneously fall off even when no one was around (LF 345, pp. 113-14). Moutria told Margiotta he was just trying to help, and didn't mean to upset Margiotta, who replied, "Dave, you don't understand. It's not you" (LF 326, pp. 38-39).

Moutria further testified that when Harper and Darabcsek returned from lunch, Moutria told them Margiotta was upset about work being backed up and had become frustrated after he and Margiotta unsuccessfully paged for assistance, and that Margiotta had tossed a pillow over to the side where it hit a suction cannister on the wall (LF 333, pp. 66-67). Harper and Darabcsek told Moutria to report the matter to Bill Lundak (LF 333, p. 66).

Moutria testified other CT techs, including Harper and Darabcsek (LF 359, p. 171), pitched chucks into the trash bin; for every twenty patients whose chucks were disposed of in the trash bin, the Techs would pitch the chucks for four or five times (LF 359, pp. 169-71). Moutria observed other CT technicians raise their voices and toss pillows (LF 329, pp. 49-50) and was not aware of anyone being fired for doing so (LF 329, pp. 50-51). Moutria testified that he had never seen Margiotta do anything which caused him to believe Margiotta had a violent temper (LF 327, pp. 44- 45).

A couple of days after Margiotta was fired, Bill Lundak wrote Moutria up for having "antagonized" Margiotta (LF 351, p. 139-41). This was the only written reprimand Moutria had received in 12 ½ years of employment (LF 357, pp. 163-64). Moutria was

later told that the write-up was removed from his file (LF 320, p. 14). Moutria discussed the incident with Bill Lundak once prior to being written up for antagonizing Margiotta (LF 332, p. 61). Moutria did not discuss the matter with Brian Hartwick (LF 336, pp. 79-80).

## POINTS RELIED ON

### POINT I

**The trial court erred in granting Respondents' summary judgment motion because Respondents did not establish their *prima facie* entitlement to summary judgment with respect to causation in that they moved for summary judgment arguing Margiotta did not establish his protests were the exclusive cause of his discharge, where exclusive causation should not be an element of the public policy discharge tort.**

*ITT Commercial Finance Corp. v. Mid-America Marine Supply Corp.*, 854 S.W.2d 371 (Mo. banc 1993).

*Brenneke v. Department of Missouri, Veterans of Foreign Wars of United States of America*, 984 S.W.2d 134 (Mo.App. W.D. 1998).

*Korando v. Mallinckrodt, Inc.*, 239 S.W.3d 647 (Mo.App. E.D. 2007).

RS Mo 213.070

### POINT 2

**The trial court erred in granting Respondents' summary judgment motion because Respondents failed to follow the mandatory provisions of Rule 74.04(c)(1) in that Respondents included multiple facts in individually numbered paragraphs of**

**their Statement of Uncontroverted Material Facts.**

Supreme Court Rule 74.04(c)(1)

*Grattan v. Union Elec. Co.*, 151 S.W.3d 59 (Mo. banc 2004).

*Moss v. City of St. Louis*, 883 S.W.2d 568 (Mo.App. E.D. 1994).

*Murphy v. Middleton*, 256 S.W.3d 159 (Mo.App. S.D. 2008).

**POINT 3**

**The trial court erred in granting Respondents' motion for summary judgment because there were contested issues of material fact as to the element of exclusive causation in that Margiotta contested Respondents' claimed reasons for discharging him as Respondents set forth in their Statement of Uncontroverted Material Facts and because of evidence which would allow a jury to reasonably infer the real reason for Margiotta's discharge was his protests against Respondents' unsafe practices.**

*Kummer v. Royal Gate Dodge, Inc.*, 983 S.W.2d 568, 572 (Mo.App. E.D. 1998).

*Lomax v. DaimlerChrysler Corp.*, 243 S.W.3d 474, 483 (Mo.App. E.D. 2007).

**POINT 4**

**The trial court erred in denying Margiotta's motion for extension of time in which to supplement the summary judgment record because Respondent Christian Hospital had failed to timely update its discovery responses to allow the timely deposition of David Moutria in that the David Moutria deposition testimony raised**

**contested issues of material fact.**

Supreme Court Rule 74.04(f)

*Adams v. City of Manchester*, 242 S.W.3d 418 (Mo.App. E.D. 2007).

*Chouteau Auto Mart, Inc. v. First Bank of Missouri*, 91 S.W.3d 655 (Mo.App. W.D. 2002)

*Binkley v. Palmer*, 10 S.W.3d 166, 173 (Mo.App. E.D. 1999).

**POINT 5**

**The trial court erred in granting Respondents' summary judgment motion because of its finding, to the extent its decision was based on the particular argument raised by Respondents, that Margiotta did not establish that he reported "serious misconduct that constitutes a violation of . . . well established and clearly mandated public policy" in that Margiotta protested practices at Respondents' facility which violated state and federal regulations requiring patient safety.**

*Luethans v. Washington Univ.*, 894 S.W.2d 169 (Mo. banc 1995).

*Porter v. Reardon Machine Co.*, 962 S.W.2d 932 (Mo.App. W.D. 1998).

19 CSR 30-20.021

42 C.F.R. 482.13(c)

## ARGUMENT

### POINT I

**The trial court erred in granting Respondents' summary judgment motion because Respondents did not establish their *prima facie* entitlement to summary judgment with respect to causation in that they moved for summary judgment arguing Margiotta did not establish his protests were the exclusive cause of his discharge, where exclusive causation should not be an element of the public policy discharge tort.**

#### Standard of review

The standard of review applied to a trial court's grant of summary judgment is *de novo*. *Eisenberg v. Redd*, 38 S.W.3d 409, 410 (Mo. banc 2001).

#### Argument

I. Respondents' *prima facie* case for summary judgment was based on Margiotta having to prove the exclusive cause for his firing as an element of his claim.

To prevail on their motion for summary judgment, Respondents were required to show facts negating any one of the elements Margiotta would be required to establish to sustain a verdict at trial. *ITT Commercial Finance Corp. v. Mid-America Marine Supply Corp.*, 854 S.W.2d 371, 381 (Mo. banc 1993)(hereinafter, "ITT"). The elements submitted to a jury under the appropriate verdict directing instruction are the elements the court exam-

ines in ruling on a summary judgment motion. *Daugherty v. City of Maryland Heights*, 231 S.W.3d 814, 820 (Mo. banc 2007)(plaintiff has no higher standard to survive summary judgment than that required to submit claim to jury). Therefore, the elements on which the defending party must file its motion in order to establish its *prima facie* entitlement to summary judgment are those in the verdict director. *ITT*, at 381.

Margiotta filed suit under the common law tort of public policy discharge. LF 8. Since there is no MAI for public policy discharge claims, caselaw provides the elements necessary to sustain a verdict. *Smith v. Kovac*, 927 S.W.2d 493, 497 (Mo.App. E.D. 1996). A plaintiff in a public policy discharge case must prove he reported wrongdoing or violations of the law or public policy by the employer to superiors or outside authorities and that his discharge was attributable to such activity. *Dunn v. Enterprise Rent-A-Car Co.*, 170 S.W.3d 1, 6 (Mo.App. E.D. 2005).

Respondents argued Margiotta was required to prove exclusive causation as an element of his claim, *i.e.*, not only that his protests motivated<sup>4</sup> Respondents to discharge him but

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<sup>4</sup>This element is typically described as the “causation” element. *E.g.*, *Brenneke v. Department of Missouri, Veterans of Foreign Wars of U.S.*, 984 S.W.2d 134, 139 (Mo.App. W.D. 1998). Because causation, in intentional torts, usually refers to a link between a defendant’s conduct and the plaintiff’s damages, *e.g.*, *Nazeri v. Missouri Valley College*, 860 S.W.2d 303, 315 (Mo. banc 1993)(*prima facie* tort; distinguishing between intent to injure and injury), to avoid conflating damage causation with intent,

also that Respondents considered nothing else in reaching their decision (LF 63-64). As set forth below, the exclusive motive element Respondents advanced should not be the measure of the sufficiency of Margiotta's evidence and, if exclusive motive is not an element of a public policy discharge claim, Respondents failed to establish a *prima facie* case for summary judgment as to the one element.

II. Exclusive causation, as an element of the public policy discharge tort, is based on the law applicable to Workers Compensation claims and should not be the causal element of a public policy discharge claim.

A. The Courts of Appeal have described different thresholds a plaintiff should meet to prove his employer's unlawful motive.

This court held a plaintiff must prove his report of wrongdoing was the exclusive cause of his discharge in *Lynch v. Blanke Baer & Bowey Krimko, Inc.*, 901 S.W.2d 147, 150 (Mo.App. E.D. 1995), relying on *Loomstein v. Medicare Pharmacies, Inc.*, 750 S.W.2d 106, 112-13 (Mo.App. E.D. 1988). The *Loomstein* court, in turn, relied on the seminal public policy discharge case, *Boyle v. Vista Eyewear, Inc.*, 700 S.W.2d 859, 878-79 (Mo.App. W.D. 1985), in describing those elements, stating *Loomstein* was required to establish a "causal connection" between his discharge and his alleged refusal to violate the law," with no mention of an exclusive causal connection in the recitation of elements, but using the word "exclusively" later in the decision. *Loomstein*, at 113.

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where practical Margiotta is referring to the element as motive rather than causation.

In reviewing the evidence in *Lynch*, the court cited to the Missouri Supreme Court's discussion of exclusive causation in *Hansome v. Northwestern Cooperage Co.*, 679 S.W.2d 273, 275 (Mo. banc 1984), a case under the Missouri Workers Compensation Act, RS Mo 287.780, prohibiting discrimination against employees who file workers' compensation claims. *See also, Crabtree v. Bugby*, 967 S.W.2d 66 (Mo. banc 1998)(setting forth proper instruction for violation of RS Mo 287.780). Subsequent to *Hansome* and *Crabtree*, the Supreme Court adopted MAI 23.13, incorporating exclusive causation as an element of the verdict director in Workers Compensation claims. The Supreme Court did not mandate the use of MAI 23.13 in common law public policy discharge cases, meaning the public policy discharge tort is not a subset of the Workers Compensation Act.

The Western District highlighted the difference between Workers Compensation and public policy discharge claims in *Brenneke, supra*. Writing for the court, then Court of Appeals Judge Stith observed many of the public policy decisions rely on *Boyle v. Vista Eyewear, Inc., supra*, for the existence of the tort and in *Boyle*, the court "utilized a direct, rather than an exclusive, causation analysis in stating that a person can maintain an action for wrongful discharge under the public policy exception by establishing that the employer discharged the employee . . . because the employee reported to his superiors or to public authorities serious misconduct." *Brenneke*, at 140, *quoting Boyle*, at 878. Judge Stith noted the use of exclusive causation as an element subsequent to *Boyle* appeared to stem from "Missouri Supreme Court cases interpreting *statutory* actions for retaliatory discharge due to filing a workers' compensation claim." *Brenneke*, at 140. Judge Stith

distinguished public policy claims from Workers Compensation claims, surveying other jurisdictions which did not require the discharged employee to prove the employer's sole and exclusive motive was an impermissible one. *Brenneke*, 140, n. 4; *but see, Faust v. Ryder Commercial Leasing & Services*, 954 S.W.2d 383, 391 (Mo.App. W.D. 1997)(applying "exclusive causation").

**B. A conflict exists between two statutes as to the motivation necessary to prove unlawful retaliation.**

Recently, this court held a plaintiff can establish unlawful retaliation under a different anti-retaliation statute, a section of the Missouri Human Rights Act ("MHRA"), RS Mo 213.070, with evidence the employer's retaliatory motive was a "contributing factor" in its decision to take some sort of action against a person who protests discrimination. *Korando v. Mallinckrodt, Inc.*, 239 S.W.3d 647, 650-51 (Mo.App. E.D. 2007).

With conflicting "motivation" elements for proving retaliation under the two statutes - exclusive causation under the Workers Compensation Act and contributing factor for MHRA retaliation cases - which element is more appropriate for proving an employer discharged an employee because of his opposition or his refusal to participate in unlawful activities should be revisited. Because the employee's conduct in a public policy discharge claim is so similar to the type of conduct protected by the MHRA's retaliation section, Margiotta urges this court to adopt the MHRA motivation element for use in public policy discharge cases.

C. Since employees who advance public policy, as protected by common law, are engaging in the same type of conduct as employees who advance the public policy expressed in and protected by the Missouri Human Rights Act, they should be afforded the same level of protection.

Under the MHRA, it is unlawful to retaliate because a person has “opposed” practices made unlawful by the Human Rights Act, which includes various forms of discrimination. RS Mo 213.070. Similarly, the public policy discharge tort protects employees for “reporting wrongdoing or violations of law or public policy . . .” *Dunn*, at 6. Thus, both the MHRA and the public policy discharge tort are designed to protect the individual who sticks his neck out to advance public policy even when not advancing his own cause, in contrast to the injured employee who *must* file a workers compensation claim to get his bills paid and acquires protected status merely by availing himself of the medical and hospital benefits available under the Act. *Hansome*, at 277 (Blackmar, J., concurring), cited in *Wiedower v. ACF Industries, Inc.*, 715 S.W.2d 303, 306 (Mo.App. E.D. 1986).

Here, Margiotta was advancing public policy by protesting multiple unsafe practices, such as abandoning patients in the hallways of the hospital (LF 197, ¶ 25; LF 276, ¶ 25) and performing a CT scan on a pregnant woman (LF 198, ¶ 37; LF 210, p. 97; LF 119, pp. 96-97). In so doing, Margiotta was not unlike the individuals protected by RS Mo 213.070 who oppose or participate in an investigation of discrimination. Both MHRA and public policy plaintiffs are advancing public good by opposing and perhaps preventing unlawful conduct, *e.g.*, *Dunn*, at 9, and the people of the State of Missouri have the same

strong interest in encouraging this behavior by providing the messengers with the same level of protection.

In most other states, courts and legislatures have rejected an “exclusive” causation standard for employees who engage in protected activity. Instead, they require an employee to prove by the preponderance of the evidence a causal connection between the discharge and the protected activity or that the protected activity was a motivating or determining factor in the discharge. *See Brenneke*, at 140 n.4 (citing cases from other jurisdictions); *see also Crabtree*, at 74 (White, J., dissenting)(approving cases in which Missouri courts adopted a “direct” rather than “exclusive” standard for causation); *Riesen v. Irwin Indus. Tool Co.*, 717 N.W.2d 907, 915 (Neb. 2006)(causal link); *Guy v. Mutual of Omaha Ins. Co.*, 79 S.W.3d 528, 535 (Tenn. 2002)(“substantial factor” under common law); *Donofry v. Autotote Systems, Inc.*, 795 A.2d 260 (N.J. Ct. App. 2001); *Teachout v. Forest City Comm. Sch. Dist.*, 584 N.W.2d 296, 302 (Iowa 1998)(determinative factor; “reason that ‘tips the scales decisively one way or the other,’ even if it is not the predominant reason behind the employer's decision.”); *Ryan v. Dan’s Food Stores, Inc.*, 972 P.2d 395, 405 (Utah 1998)(“substantial factor”); *Gardner v. Loomis Armored, Inc.*, 913 P.2d 377 (Wash. 1996) adopting significant factor test from *Wilmot v. Kaiser Alum. and Chem. Corp.*, 821 P.2d 18 (Wash. 1991); *Cardwell v. American Linen Supply*, 843 P.2d 596, 600 (Wyo. 1992)(“significantly motivated by retaliation”); *Buckner v. General Motors Corp.*, 760 P.2d 803, 806-07, 810 (Okla. 1988)(employee’s protected activity must be “significant factor” in discharge decision, finding principles for examining motive under

discrimination statutes were “particularly applicable” to statute); *Anderson v. Meyer Broadcasting Corp.*, 630 N.W.2d 46, 53 (N.D. 2001)(causal connection required under statute or common law claim); *Clemons v. Mechanical Devices Co.*, 704 N.E.2d 403, 406 (Ill. 1998)(applying “traditional tort analysis” to causation); *Shallal v. Catholic Soc. Svcs. of Wayne County*, 566 N.W.2d 571, 574 (Mich. 1997)(causal connection); *Hubbard v. United Press Int’l, Inc.*, 330 N.W.2d 428, 444 (Minn. 1983)(causal connection under statute relating to retaliation for protesting discrimination); *Shovelin v. Central New Mexico Elec. Cooperative, Inc.*, 850 P.2d 996, 1006 and n. 8 (N.M. 1993)(causal connection); *Shockey v. City of Portland*, 837 P.2d 505, 509-10 (Or. 1992)(causal connection).

The “contributing factor” standard, which does not require the plaintiff to eliminate every other factor which could have affected the employer’s decision along with the improper factor, is consistent with federal employment law concerning retaliation, where the statute does not otherwise allocate the burden of proof. *See e.g., Raniola v. Bratton*, 243 F.3d 610, 625 (2nd Cir. 2001)(rejecting sole cause as standard).

Given the similarity between the public policy discharge tort and other statutory and common law protections for employees who oppose unlawful conduct, Margiotta asks this court to revisit the *Lynch* line of cases and hold the requisite state of mind a plaintiff must prove as an element of a public policy discharge claim is that the employee’s protected conduct contributed to the employer’s decision to discharge him. If this court adopts the contributing factor standard, the trial court’s decision should be reversed to the extent it was based on Respondents’ argument that Margiotta was required to and could

not prove his protests were Respondents' exclusive reason for firing him, as Respondents will have failed to establish their *prima facie* entitlement to summary judgment as to that element.

## POINT 2

**The trial court erred in granting Respondents' summary judgment motion because Respondents failed to follow the mandatory provisions of Rule 74.04(c)(1) in that Respondents included multiple facts in individually numbered paragraphs of their Statement of Uncontroverted Material Facts.**

### Standard of Review

The standard of review applied to a trial court's grant of summary judgment is *de novo*. *Eisenberg v. Redd*, at 410.

### Argument

Respondents included multiple facts in the separately numbered paragraphs of their Statement of Uncontroverted Material Facts. *See e.g.*, ¶¶ 2, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 18, 19, and 21 (LF 66-71). For example, in ¶ 2, Respondents included six sentences to state numerous facts ranging from the date of plaintiff's termination, to the motive for his termination, to multiple facts relating to the events of December 8, 2005 and how plaintiff's coworkers felt about plaintiff's alleged conduct.

Supreme Court Rule 74.04(c)(1) requires the moving party in a summary judgment motion to state each fact in a separately numbered paragraph. Margiotta objected to Respondents' violation of this Rule (LF 251). Since adherence to Rule 74.04 is mandatory, *Grattan v. Union Elec. Co.*, 151 S.W.3d 59, 61 (Mo. banc 2004) and Respondents violated the Rule, summary judgment should be reversed. *Moss v. City of St. Louis*, 883 S.W.2d 568, 569 (Mo. App. E.D. 1994); *Murphy v. Middleton*, 256 S.W.3d 159, 162 (Mo. App. S.D. 2008).

### POINT 3

**The trial court erred in granting Respondents' motion for summary judgment because there were contested issues of material fact as to the element of exclusive causation in that Margiotta contested Respondents' claimed reasons for discharging him as Respondents set forth in their Statement of Uncontroverted Material Facts and because of evidence which would allow a jury to reasonably infer the real reason for Margiotta's discharge was his protests against Respondents' unsafe practices.**

### Standard of Review

The standard of review applied to a trial court's grant of summary judgment is *de novo*. *Eisenberg v. Redd*, at 410. Review of the record is in the light most favorable to the party against whom judgment was entered, according the non-moving party the benefit of all reasonable inferences. *ITT*, at 376.

## Argument

I. Since facts Respondents claimed were material to the exclusive causation element were controverted, Respondents' motion should have been denied.

Respondents argued they were entitled to summary judgment because Margiotta could not prove his protests were the exclusive cause of his discharge since Respondents claimed they fired Margiotta because of misconduct (LF 63). In making their argument, Respondents relied on certain paragraphs of their Statement of Uncontroverted Material Facts, specifically, ¶¶ 2, 9-16 (LF 66-70). Margiotta disputed ¶¶ 2, 9, 11, 14, 15, and a portion of ¶ 16 (LF 190, 193-96). Thus, Respondents' argument they were entitled to summary judgment because the material facts in ¶¶ 2 and 9-16 were undisputed, is unfounded. Therefore, summary judgment should have been denied.

II. To the extent this court considers the arguments Respondents made based on the disputed paragraphs, Respondents were still not entitled to summary judgment on the issue of their exclusive motivation because a jury could reasonably conclude Respondents' motive was unlawful.

A. A plaintiff does not have to *prove* the defendant's exclusive motivation at the summary judgment phase.

Respondents' position at the trial court was that to survive summary judgment Margiotta had to prove his whistleblowing was the exclusive cause of his discharge (LF

63, ¶¶ 3, 4; LF 134, 145, 151). To require a plaintiff to *prove* a defendant's exclusive motivation, rather than adduce evidence which would allow a jury to *infer* exclusive motivation, overstates a plaintiff's burden. Under Respondents' argument, an employer would be able to succeed on a summary judgment motion even if it admitted an improper motive for discharging the employee, but simply claimed it had some other factor on its mind as well. The employer could say, "I fired the plaintiff because she protested embezzlement, but I also fired her because she was always wearing blue dresses." If the employee was, indeed, always wearing blue dresses, she could never survive summary judgment because she cannot disprove the additional articulated factor entered into defendant's decision-making at the summary judgment phase. She could establish only a permissible inference. Such a result is contrary to this court's holding in *Kummer v. Royal Gate Dodge, Inc.*, 983 S.W.2d 568, 572 (Mo. App. E.D. 1998), that where there is conflicting evidence as to the real reason for the employee's discharge, summary judgment should be denied. Here, there is conflicting evidence as to the real reason Respondents discharged Margiotta.

**B. Respondents' claimed reasons for firing Margiotta are not credible, which is probative of Respondents' intent and would allow a jury to conclude Respondents' intent was unlawful.**

Respondents' witnesses differed wildly in their accounts of the December 8, 2005 event they claim led to Margiotta's firing, the decision-making process that led to

Margiotta's discharge, and their claimed motivation for that decision. Such evidence, as discussed below, would allow a jury to conclude Respondents' intent was unlawful. *See, Lomax v. DaimlerChrysler Corp.*, 243 S.W.3d 474, 483 (Mo. App. E.D. 2007)(claim under MHRA).

**1. The witnesses' stories are so varied, a jury could conclude they were fabricated.**

There is contradictory evidence as to which of Respondents' employees were present at the time of the claimed incident, meaning a jury could believe the witnesses' could not get the planned stories straight because they witnessed nothing at all.

Kim Darabcsek testified Margiotta asked her to start an IV on a patient he had on the CT scan table (LF 200, ¶ 60; LF 217, pp. 30-31), which Margiotta denied (LF 201, ¶ 65; LF 209, p. 88). Darabcsek claimed she heard an argument in the control room but could not hear what was being said (LF 200, ¶¶ 60, 61; LF 217, pp. 30-31; LF 218, p. 42).

Darabcsek's account is contradicted by the testimony of Cindy Rigsby, who said Margiotta and Moutria were in the CT scan room, not the control room, they were standing close to a patient while arguing (LF 201, ¶¶ 67, 68; LF 239, p. 22; LF 241, p. 30) and that she, Margiotta, and David Moutria were the only employees in the area (LF 201, ¶ 69; LF 239, p. 24). Rigsby also claimed, in further contradiction to Darabcsek, that after Margiotta stopped yelling, Darabcsek, Jamie Harper, and Tim Cuff entered the CT scan room – again, not the control room – and Margiotta and Moutria were still in the

scan room (LF 201, ¶ 70; LF 240, pp. 25-26).

Yet another employee, Donna Sorden, testified *she* witnessed the incident while walking through the CT scan room (LF 201, ¶ 71; LF 245, p. 12). Sorden's version is that when Margiotta and Moutria were arguing, she, Rigsby, Cuff, Margiotta, and Moutria were in the CT control room and Darabcsek was in the CT scanning area (LF 201, ¶ 74; LF 246, pp. 14-16). Sorden claimed she saw Margiotta throw objects on the ground toward Moutria (LF 201, ¶ 72; LF 245, p. 12). Margiotta denied throwing objects down at the floor (LF 201, ¶ 73; LF 209, p. 85). Sorden also claimed that when she left the control room, Cuff, Rigsby, Margiotta, and Moutria stayed behind (LF 202, ¶ 75; LF 246, p. 16).

Sorden also claimed that Margiotta's supervisor, Tim Cuff (LF 75, ¶ 3), witnessed the entire incident and Cuff "sat in a chair *directly next to this and said nothing to stop this*" (LF 96, emphasis added). With evidence Cuff did nothing as the events transpired, a jury could reasonably conclude the incident was a non-event and certainly not Respondents' basis for discharging Margiotta.

## 2. Respondents' claimed decision-making process is suspect because of conflicting evidence.

Lundak claimed he, Brian Hartwick, and Stuart Schneider decided to fire Margiotta (LF 202, ¶ 82; LF 233, pp. 96, 98) and considered no lesser discipline because they believed Margiotta was a threat to the safety of patients and staff (LF 203, ¶ 93; LF 233,

p. 100). Lundak testified that on December 8, 2005, Tim Cuff told Lundak and then Lundak told Hartwick the employees “were frightened” (LF 231, pp. 91-92). A jury could reasonably conclude Lundak was fabricating what Cuff told him in light of the evidence, cited above, that Cuff observed the entire event and chose to do nothing (LF 96).

The next morning, the employees were interviewed (LF 231, p. 90). Lundak testified the decision was made to discharge Margiotta once Sorden, Harper, Darabscek, Moutria, and Rigsby were interviewed (LF 232, p. 96). Lundak also testified that when he met with Hartwick on December 9, he told Hartwick that Margiotta “had become very angry in front of a patient, throwing things, frightening the people in the department” (LF 231, pp. 89-90) and he came to the conclusion that Margiotta might harm someone on December 9, when he, Hartwick and Schneider started taking the witness statements. Since Lundak allowed Margiotta to work the entire day, firing him only at the end of his shift at 4:00 p.m. (LF 303-04, ¶ 13), a jury could reasonably conclude Lundak did not believe Margiotta was dangerous, as claimed.

At a different point in his deposition, Lundak testified the decision to fire Margiotta was not made until after Margiotta was interviewed and “the consensus was . . . that if there is not some positive reasoning coming out of [the Margiotta interview], then that’s what would happen” (LF 235, p. 108). At the interview, Hartwick asked Margiotta if he had yelled at another employee and whether he had thrown a pillow, both of which Margiotta denied. Hartwick told Margiotta there were several witnesses to which Margiotta replied that he, Moutria, and Rigsby were the only ones present when the

incident occurred (LF 303, ¶¶ 9, 10). If a jury believes the version of Lundak's testimony in which he said the decision to fire Margiotta depended on what Margiotta said during his interview, based on Margiotta's responses in the interview, the jury could infer that since Margiotta's responses gave Respondents no basis for firing him, Lundak had to come up with his own story about what Margiotta said in the interview. Thus, Lundak claimed Margiotta stated only that he "had gotten mad, something to do with the patient," he "was just, just angry," and he "was just having a bad day" (LF 203, ¶ 87; LF 234, p. 103; LF 235, p. 105).

C. In addition to establishing Respondents' stories about their reason for firing Margiotta were untrue, a jury could infer Respondents' unlawful motivation from the nature and timing of Margiotta's complaints.

Given Margiotta's history of complaints about multiple patient safety concerns, including transferring patients from stretcher to CT table, the very issue at the heart of the December 8, 2005 incident, a jury could reasonably infer Respondents were chafing at the bit to rid themselves of this troublesome employee rather than hear yet another complaint about their dangerous practices.

Respondents argued to the trial court Margiotta could not prove they were motivated to fire him because of his complaints since his complaints were too remote in time to have motivated Respondents' decision, as a matter of law (LF 150-51). First, Respondents conceded that conduct occurring as long as seven months prior to an event could have

motivated their decision where they relied on Margiotta's conduct in May 2005 (LF 136) to argue they were justified in firing Margiotta in December 2005. As Respondents implicitly acknowledged by their inclusion of Margiotta's May 2005 conduct in their Statement of Uncontroverted *Material* Facts (LF 67, ¶ 3), whether an event is too remote in time to have motivated an actor is a question of fact for a jury to decide and not a question of law. Second, when the events of December 8 came to Lundak's attention, a jury could reasonably infer Lundak knew Margiotta's previous complaint about Respondents' transfer procedure was about to rear its head again, meaning Lundak's immediate motivation - the causal connection - was Margiotta's concern about safety issues. Lundak was faced with an administrative choice: fix the problem or eliminate the source of the complaint. The latter option was far simpler and Lundak chose accordingly.

#### POINT 4

**The trial court erred in denying Margiotta's motion for extension of time in which to supplement the summary judgment record because Respondent Christian Hospital had failed to timely update its discovery responses to allow the timely deposition of David Moutria in that the David Moutria deposition testimony raised contested issues of material fact.**

#### Standard of Review

The standard of review is abuse of discretion. *Adams v. City of Manchester*, 242

S.W.3d 418, 427 (Mo. App. E.D. 2007).

## Argument

The rule governing summary judgment, with its strict deadlines for responding to Statements of Uncontroverted Material Facts, contemplates giving the non-moving party additional time to respond to a motion upon a showing that uncompleted discovery is material and important. Supreme Court Rule 74.04(f); *Adams*, at 427. As discussed below, Margiotta made the required showing with regard to the deposition of a witness, David Moutria, which had already been taken but which had not been transcribed. The trial court's refusal to grant Margiotta the opportunity to use the transcript meant the court did not consider material facts when it granted Respondents' summary judgment, thereby depriving Margiotta of the right to have a jury hear his case.

### I. Background to Margiotta's request for extension of time

#### A. Respondents controlled contact with Moutria and then refused to produce him for deposition.

On July 6, 2007, Margiotta served Respondents with interrogatories requesting last known home addresses and telephone numbers for witnesses (LF 258, ¶¶ 1-3). Respondents objected to providing the information, stating the identified individuals were only to be contacted through Respondents' counsel (LF 259, ¶ 4). While Respondents terminated David Moutria on September 10, 2007, they did not amend their interrogatory answers to

information on how to contact him (LF 319, p. 10).

On March 13, 2008, Margiotta's counsel presented Respondents' counsel the names of individuals to depose and requested a date for the deposition of Dave Moutria (LF 248, ¶ 4). Instead of providing agreeable dates and producing Moutria, Respondents moved for summary judgment (LF 65). They waited until April 15, 2008 to disclose the fact that several of the witnesses, including Moutria, were no longer under their control, adding that Moutria's last known address was in Illinois (LF 248, ¶¶ 5, 6). Had Respondents provided this information around March 13, when Margiotta's counsel requested to take Moutria's deposition, Moutria could easily have been deposed with sufficient time to include the testimony in response to a not-yet filed summary judgment motion.

**B. Margiotta asked for sufficient time to include Moutria's testimony in the record.**

Within three days after Respondents notified Margiotta's counsel they could not produce Moutria, Margiotta asked the trial court to extend the date for responding to Respondents' Statement of Uncontroverted Material Facts until ten days after the depositions of Moutria and another former employee, Tim Cuff, who was also an Illinois resident who had to be subpoenaed (LF 167-69). Margiotta's motion was heard on April 22, 2008; the trial court extended the date for Margiotta's response by seven days, to May 7, 2008 (LF 4, 175).

Margiotta sought and obtained subpoenas for both Moutria and Cuff from the Madison

County, Illinois Circuit Court on April 28, 2008 (LF 249, ¶¶ 7, 8). As Margiotta could not know how much time would be needed to obtain service on Moutria and Cuff, or even if the last known addresses Respondents' provided were valid, the subpoena dates of the two depositions were set for May 7, 2008. At that point, Margiotta did not know if either witness would testify in a manner creating a disputed issue of material fact, let alone the specifics of either witness's testimony. Since no date was set date for a hearing on Respondents' summary judgment motion, it appeared that if Moutria or Cuff provided material testimony, Margiotta would be able to expedite any transcript and request an extension of time to include such evidence in the record.

By the afternoon of May 2, 2008, Respondents faxed a notice of hearing for their summary judgment motion, setting the hearing for 8:30 a.m. on Friday, May 9, 2008 (LF 188-89). This setting allowed only one day to obtain the deposition transcripts and identify specific portions to present to the trial court. Margiotta still might have accomplished the supplementation but for the length of the Moutria deposition; due to the length, the court reporter was unable to transcribe the testimony in time for the 8:30 a.m. hearing. Margiotta could not know of this development until the conclusion of the Moutria deposition, late in the day on May 7, 2008 (LF 317, p. 2).

Thus, on May 8, 2008, Margiotta fax-filed his Second Motion for Continuance of Ruling on Defendants' Motion for Summary Judgment (LF 253-55), specifically requesting the trial court to allow sufficient time to obtain the physical transcript and incorporate disputed material facts concerning the incident which Respondents claimed was their

motive for discharging Margiotta (LF 254, ¶¶ 5, 6), clearly facts material to Respondents' motion for summary judgment. Margiotta's motion was supported by an affidavit from counsel explaining the logistical difficulties and advising the court that the testimony in question would establish disputed issues of material fact regarding the December 8, 2005 incident and the true reasons for Margiotta's discharge (LF 256-67, ¶¶ 9,10). Margiotta also filed a Motion to Shorten Time to allow a hearing on his Second Motion for Continuance just prior to the noticed hearing on Respondents' summary judgment motion (LF 261-62).

Margiotta requested this continuance to supplement his response because Moutria testified about the incident Respondents claimed motivated them to discharge Margiotta, and Margiotta would be prejudiced unless allowed to incorporate the testimony into his Statement of Additional Material Facts (LF 254, ¶¶ 5, 6).

Margiotta's Motion for Continuance was heard on Friday, May 9, 2008 and denied (LF 275). The trial court granted summary judgment on Monday, May 12, 2008 (LF 311), one day before the Moutria transcript was completed (LF 314, ¶ 6). Margiotta moved for reconsideration and to allow supplementation of the record, attaching a copy of the Moutria deposition transcript as an exhibit (LF 313-63). The trial court denied Margiotta's motions on June 9, 2008 (LF 369).

II. Moutria's testimony was damaging to Respondents' position and excluding it enabled Respondents to deprive Margiotta of his right to a trial by jury.

As described below, Moutria's testimony was harmful to Respondents and, to the extent the trial court based its summary judgment order on the absence of contested issues of fact as to the reasons Respondents fired Margiotta, Margiotta was prejudiced by the trial court's decision not to extend the time so that Margiotta could include Moutria's testimony in the record.

With respect to the events of December 8, 2005, Bill Lundak actually disciplined Moutria for provoking Margiotta (LF 351, pp. 139-41). This was the only written reprimand that Moutria had received in 12 ½ years of employment with Respondents (LF 357, pp. 163-64). Moutria was told the discipline was removed from his file (LF 320, p. 14). A jury could reasonably infer that if Lundak took the unusual step of reprimanding Moutria for antagonizing Margiotta, Lundak was not motivated to fire Margiotta by the same incident. A jury could also conclude Respondents decided to tidy up their motive behind firing Margiotta by getting rid of the paper showing they believed Moutria had caused a problem.

Moutria's testimony supported Margiotta's and was in general conflict with the other claimed witnesses. Margiotta was accused of two bad behaviors on December 8 that led to his firing for the safety of the patients and staff: throwing objects across a room and yelling and using abusive language toward Moutria (LF 77, ¶ 11). Moutria's deposition testimony undercuts Respondents' claims. According to Moutria, on that day, instead of

staggering lunch breaks, everyone left except for him and Margiotta (LF 324, p. 32; LF 327, p. 41). A patient was brought in; Moutria and Margiotta paged for assistance four or five times but no one came to help them transfer the patient (LF 324, p. 32). Margiotta became frustrated and tossed a pillow across the room which hit a suction cannister, knocking it off the wall (LF 324-25, pp. 32-33). Margiotta did not aim the pillow at the suction device, nor did it appear he was trying to knock it down, he just tossed the pillow (LF 325, pp. 34-35; LF 345, pp. 113-14). Moutria described Margiotta's demeanor as "frustrated" because nobody came to help move the patient (LF 325, p. 35; LF 344, pp. 111-12), a safety issue about which Margiotta had been complaining all along (LF p. 197, ¶ 31; p. 225, p. 60; p. 276, ¶ 31).

With respect to the accusation that Margiotta threw chucks (LF 94, 96, 100), Moutria testified other CT techs pitched chucks into the trash on four or five patients out of twenty (LF 359, pp. 169-71), making it a common practice. Even though these things happened before in the CT scanning department (LF 329, pp. 49-50) apparently without disciplinary repercussions (LF 329, pp. 50-51), Harper and Darabcsek told Moutria to report the matter to Bill Lundak (LF 333, p. 66). Moutria discussed the incident only once with Bill Lundak prior to his own disciplinary meeting (LF 332, p. 61), and he did not discuss the matter at all with Brian Hartwick (LF 336, pp. 79- 80; LF 351, pp. 136-139) in direct contradiction to Lundak's claim in his Affidavit (LF 77, ¶ 11).

III. The trial court abused its discretion in refusing to continue the time for Margiotta to respond to Respondents' Statement of Uncontroverted Material Facts.

The standard of review for the refusal to grant an extension of time to respond to a motion for summary judgment is abuse of discretion. *Adams*, at 427, citing *Chouteau Auto Mart, Inc. v. First Bank of Missouri*, 91 S.W.3d 655, 659 (Mo.App. W.D. 2002). Under *Adams*, "A party seeking a continuance must file an affidavit supporting its motion and 'must specify what additional evidence supporting the existence of a factual dispute the movant would have presented to the court if the court had continued the hearing,'" quoting *Binkley v. Palmer*, 10 S.W.3d 166, 173 (Mo.App. E.D. 1999).

Here, Margiotta initially sought to hold the motion hearing ten days after taking the Moutria and Cuff depositions and then, unlike the defending party in *Binkley*, at 172, Margiotta *did* renew his motion for continuance after filing his response. While the trial of this case was set to commence May 19, 2008 (LF 3), given the quick ruling on Respondents' summary judgment motion (the trial court issued its order the next working day after the hearing (LF 5)), the motion could well have been heard after a brief continuance without compromising the trial date.

Margiotta's affidavit in support of his request for a continuance, unlike the defending party in *Binkley*, was as descriptive as possible given that this was not a requested continuance to obtain an affidavit from a witness where the moving party knows in advance what the witness is going to say and seeks more time to obtain the testimony in

sworn, written form. Instead, the witness was a former employee whom Respondents hid until two weeks before the deadline for responding to their summary judgment motion (LF 264-66, 275).

Had Respondents promptly advised Margiotta, on March 13, 2008, that Moutria and Cuff were no longer under their control, and provided addresses and phone numbers, as requested back in July, Margiotta could have obtained the Illinois subpoenas, deposed the witnesses, and presented Moutria's testimony without any continuance at all. Since Margiotta was able to obtain the Moutria transcript in under a month, logically, if Respondents had acted in a timely manner on March 13, 2008, the transcript would have been available in mid-April, which is before Respondents disclosed they would not produce the witnesses.

The trial court was fully aware of this state of affairs when it ruled and then denied Margiotta of his right to a trial by jury. The court's denial of even three days for Margiotta to supplement his response, when Margiotta did everything possible to put the evidence in the record and Respondents did everything possible to hide it, was a clear abuse of discretion.

## POINT 5

**The trial court erred in granting Respondents' summary judgment motion because Margiotta did not establish he reported serious misconduct that constitutes a violation of well established and clearly mandated public policy in that Margiotta protested practices at Respondents' facility which violated state and federal regulations requiring patient safety.**

### Standard of Review

The standard of review applied to a trial court's grant of summary judgment is *de novo*. *Eisenberg v. Redd*, at 410. Review of the record is in the light most favorable to the party against whom judgment was entered, according the non-moving party the benefit of all reasonable inferences. *ITT*, at 376.

### Argument

Respondents argued Margiotta could not establish the element of his claim which requires that his protest or report involved conduct violating statute, regulation, or other clear mandate of public policy. *Porter v. Reardon Machine Co.*, 962 S.W.2d 932, 938 (Mo.App. W.D. 1998), citing *Luethans v. Washington Univ.*, 894 S.W.2d 169, 171 n.2 (Mo. banc 1995). As discussed below, Margiotta reported conduct which violated both state and federal regulations concerning the safe operation of hospitals which express a

clear mandate of public policy, *i.e.*, that patients at the mercy of hospital staff be treated in a manner which is safe. Therefore, Respondents' motion should have been denied.

Missouri regulations concerning the organization and management of hospitals, then found at 19 CSR 30-20.021, were promulgated to “establish standards for the operations of hospitals” to “provide a high level of care.” 30-20.021(3)(K)(3) specifically required hospitals to “develop a mechanism for the identification and abatement of occupant safety hazards in their facilities” and to correct, “[a]ny safety hazard or threat to the general safety of patients, staff or the public . . .” In the same vein, a federal regulation concerning hospital safety, 42 C.F.R. 482.13(c), requires hospitals to provide care in a safe setting.

Margiotta made multiple complaints about practices he observed at the hospital which compromised the safety of patients. Margiotta reported patients were being abandoned in the hallways (LF 197, ¶ 25; LF 276, ¶ 25). He reported hospital staff were bringing patients to the CT department without identifying armbands (LF 197, ¶¶ 27, 29, 30; LF 276, ¶¶ 27, 29, 30; LF 197, ¶ 28; LF 223, pp. 49-50, 60) leaving CT staff to guess which patient was to be subjected to which procedure. He objected to the procedure the hospital used for transferring patients from stretchers to the CT table (LF 197, ¶ 31; LF 276, ¶ 31), where only one employee was responsible for making sure the patient safely made it from one surface to the other. Margiotta also complained to Cuff about an incident in which a radiology technician in the ER tried to transfer a patient from stretcher to table and dropped the patient, telling Cuff, “Tim, we’ve talked about this before” (LF 125, pp.

154-57). Margiotta objected to hospital staff bringing patients to the CT department without working IV's or without the proper size IV (LF 197, ¶ 32; LF 71; LF. 197, ¶ 33; LF 277, ¶ 33). He reported hospital personnel performed a CT scan on a pregnant woman (LF 198, ¶ 37; LF 210, p. 97; LF 119, pp. 96-97), which he believed resulted in radiation exposure to the fetus.

With state and federal regulations requiring hospitals to operate in a manner ensuring the safety of patients, the mandate of public policy is clear. Since Margiotta reported violations of state and federal regulations which involved clear mandates of significant public policy, Margiotta established the element of his claim and summary judgment should have been denied.

## CONCLUSION

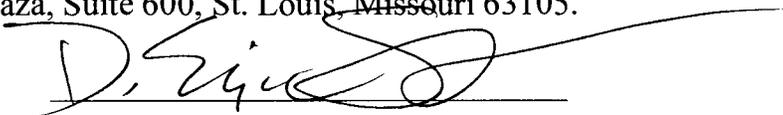
For the reasons stated herein, Appellant Margiotta respectfully requests this court to reverse the case and remand for trial.



D. Eric Sowers, 24970  
es@sowerswolf.com  
Ferne P. Wolf, 29326  
M. Beth Fetterman, 59550  
Sowers & Wolf, LLC  
530 Maryville Centre Dr., Ste 460  
St. Louis, Missouri 63141  
314 744-4010  
314 744-4026

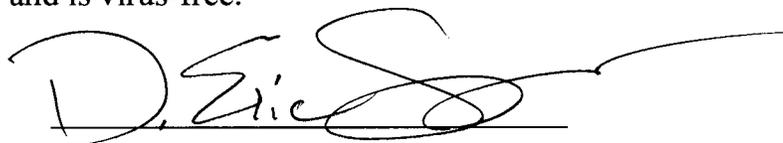
### Certificate of Service

The undersigned certifies that one copy of Brief of Plaintiff/Appellant Daniel J. Margiotta and a diskette containing same were served upon the following counsel of record by U.S. Mail, postage prepaid on the 26<sup>th</sup> day of September, 2008: JoAnn T. Sandifer, Husch Blackwell Sanders, 190 Carondelet Plaza, Suite 600, St. Louis, Missouri 63105.



### Certificates of Compliance

The undersigned certifies this brief contains the information required by Rule 55.03, the original was signed by the attorney, and it complies with the word limits of Rule 84.06(b) in that it contains 10,187 words as set forth in the wordcount of the Wordperfect processing system used to prepare this brief. The undersigned certifies the electronic copy served herewith has been scanned for viruses and is virus-free.



APPENDIX

May 9, 2008 Order ..... A1

May 12, 2008 Order and Judgment ..... A2

June 9, 2008 Order ..... A3

RS Mo 213.070 ..... A4

RS Mo 287.780 ..... A4

RS Mo 512.020(5) ..... A5

MAI 23.13 ..... A6

Rule 74.04(c)(1) ..... A7

Rule 74.04(f) ..... A8

19 CSR 30-20.021 ..... A9

19 CSR 30-20.021(3)(K)(3) ..... A19

42 C.F.R. 482.13(c) ..... A25

In the  
**CIRCUIT COURT**  
of St. Louis County, Missouri



For File Stamp Only

Daniel Margiotta  
Plaintiff(s)

5/9/2008  
Date

vs.  
Christian Hospital N2/NW  
Defendant(s)

07-CC-001441  
Case Number

3  
Division

**FILED**  
MAY 09 2008  
JOAN M. GILMER  
CIRCUIT CLERK, ST. LOUIS COUNTY

Defendant's motion for summary judgment called, heard, and submitted. Taken under advisement.

Plaintiff's motion to extend time for response to allow supplementation of additional facts denied.

Plaintiff's motion to compel is sustained.

**SO ORDERED**

Josh D. King

Judge

ENTERED: \_\_\_\_\_ (Date)

MP Nolan #521646  
Attorney Bar No.

150 Grandview Plaza  
Address

(504) 480-1770 480-1515  
Phone No. Fax No.

D. Eric Sowers 24970  
Attorney Bar No.

530 Maryville Centre #460

A 1 955  
314-744-4010 314-744-4026



In the  
**CIRCUIT COURT**  
St. Louis County, Missouri



For File Stamp Only

**FILED**

JUN 09 2008

JOAN M. GILMER  
CIRCUIT CLERK, ST. LOUIS COUNTY

Daniel J. Murgitta  
Plaintiff(s)

6/9/2008  
Date

vs.  
Christian Hosp. Northeast/  
Northwest, et al.  
Defendant(s)

07 CL 001441  
Case Number

3  
Division

Plaintiff's Motion to Supplement the Record  
and for Reconsideration called, heard,  
and denied.

**SO ORDERED**

*Barb DeFay*  
Judge

ENTERED: \_\_\_\_\_  
(Date)

D. Eric Surr 24970  
Attorney Bar No.  
530 Maryville Center Dr. #160  
Address  
314-744-4010 314-744-4026  
Phone No. Fax No.  
MP Warr #54046  
Attorney Bar No.  
190 Grandelot Plaza, Ste 600  
Address  
480 1500 480 1505  
Phone No. Fax No.

Vernon's Annotated Missouri Statutes Currentness  
Title XII. Public Health and Welfare  
Chapter 213. Human Rights (Refs & Annos)

→ 213.070. Additional unlawful discriminatory practices

It shall be an unlawful discriminatory practice:

- (1) To aid, abet, incite, compel, or coerce the commission of acts prohibited under this chapter or to attempt to do so;
- (2) To retaliate or discriminate in any manner against any other person because such person has opposed any practice prohibited by this chapter or because such person has filed a complaint, testified, assisted, or participated in any manner in any investigation, proceeding or hearing conducted pursuant to this chapter;
- (3) For the state or any political subdivision of this state to discriminate on the basis of race, color, religion, national origin, sex, ancestry, age, as it relates to employment, disability, or familial status as it relates to housing; or
- (4) To discriminate in any manner against any other person because of such person's association with any person protected by this chapter.

Vernon's Annotated Missouri Statutes Currentness  
Title XVIII. Labor and Industrial Relations  
Chapter 287. Workers' Compensation Law (Refs & Annos)

→ 287.780. Discrimination because of exercising compensation rights prohibited--civil action for damages

No employer or agent shall discharge or in any way discriminate against any employee for exercising any of his rights under this chapter. Any employee who has been discharged or discriminated against shall have a civil action for damages against his employer.

Vernon's Annotated Missouri Statutes Currentness

Title XXXV. Civil Procedure and Limitations

↳ Chapter 512. Appeals and Appellate Procedure (Refs & Annos)

↳ Appeals to Appellate Courts

→ **512.020. Who may appeal**

Any party to a suit aggrieved by any judgment of any trial court in any civil cause from which an appeal is not prohibited by the constitution, nor clearly limited in special statutory proceedings, may take his or her appeal to a court having appellate jurisdiction from any:

- (1) Order granting a new trial;
- (2) Order refusing to revoke, modify, or change an interlocutory order appointing a receiver or receivers, or dissolving an injunction;
- (3) Order granting or denying class action certification provided that:
  - (a) The court of appeals, in its discretion, permits such an appeal; and
  - (b) An appeal of such an order shall not stay proceedings in the court unless the judge or the court of appeals so orders;
- (4) Interlocutory judgments in actions of partition which determine the rights of the parties; or
- (5) Final judgment in the case or from any special order after final judgment in the cause; but a failure to appeal from any action or decision of the court before final judgment shall not prejudice the right of the party so failing to have the action of the trial court reviewed on an appeal taken from the final judgment in the case.

**23.13 [2000 New] Verdict Directing—Retaliatory Discharge or Discrimination—Workers' Compensation**

Your verdict must be for plaintiff if you believe:

First, plaintiff was employed by defendant, and

Second, plaintiff filed a workers' compensation claim,<sup>1</sup>  
and

Third, defendant discharged<sup>2</sup> plaintiff, and

Fourth, the exclusive cause of such discharge<sup>2</sup> was  
plaintiff's filing of the workers' compensation  
claim<sup>1</sup> and

Fifth, as a direct result of such discharge<sup>2</sup> plaintiff  
sustained damage.

**Notes on Use (2000 New)**

1. Describe the right exercised by the plaintiff under the workers' compensation law if it was other than filing a claim for compensation.

2. If the claim is for discrimination rather than discharge, describe the act of discrimination, such as "reduced plaintiff's rate of pay" or "demoted plaintiff."

**Committee Comment (2000 New)**

This instruction is for use in a retaliatory discharge case under section 287.780, RSMo. See *Crabtree v. Bugby*, 967 S.W.2d 66 (Mo. banc 1998). Section 287.780 also provides a cause of action to employees who are discriminated against by their employer, but not discharged, for exercising rights under the workers' compensation law. This instruction may be modified to submit acts of discrimination other than discharge where appropriate.

**Library References:**

C.J.S. Employer-Employee Relationship § 93.  
West's Key No. Digests, Master and Servant ¶44.

and supported in the manner prescribed by Rule 74.04(c)(1).

Attached to the supplemental statement shall be a copy of any additional discovery, exhibits or affidavits on which the supplemental statement relies.

(4) *Sur-replies in Opposition to Motions for Summary Judgment.* Within 15 days of service, if movant files a statement of additional material facts pursuant to Rule 74.04(c)(3), the adverse party shall file a sur-reply admitting or denying each such factual statement. The sur-reply shall be in the form and shall be supported in the manner prescribed by Rule 74.04(c)(2).

Attached to the sur-reply shall be a copy of any additional discovery, exhibits or affidavits on which the sur-reply relies.

A sur-reply that does not comply with Rule 74.04(c)(2) with respect to any numbered paragraph in movant's statement of additional material facts is an admission of the truth of that numbered paragraph.

If the movant files a statement of additional material facts, the adverse party may file within the same time a sur-reply memorandum of law explaining the legal or factual reasons why summary judgment should not be granted.

(5) *Additional papers.* No other papers with respect to the motion for summary judgment shall be filed without leave of court.

(6) *Rulings on Motions for Summary Judgment.* After the response, reply and any sur-reply have been filed or the deadlines therefor have expired, the court shall decide the motion.

If the motion, the response, the reply and the sur-reply show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law, the court shall enter summary judgment forthwith.

A summary judgment, interlocutory in character, may be entered on any issue, including the issue of liability alone, although there is a genuine issue as to the amount of the damages.

*Text of subd. (c) effective July 1, 2008*

**(c) Motions and Proceedings Thereon.**

(1) *Motions for Summary Judgment.* A motion for summary judgment shall summarily state the legal basis for the motion.

A statement of uncontroverted material facts shall be attached to the motion. The statement shall state with particularity in separately numbered paragraphs each material fact as to which movant claims there is no genuine issue, with specific references to the pleadings, discovery, exhibits or affidavits that demonstrate the lack of a genuine issue as to such facts. An electronic copy of the statement of uncontroverted material facts in a commonly used medium, such as a diskette, CD-ROM or e-mail attachment, in a format

that can be read by most commonly used word processing programs, such as Word for Windows or WordPerfect 5.x or higher, shall be served on the party to whom the motion for summary judgment is directed. In addition to the information normally in a certificate of service, the certificate of service shall also state the format of the electronic copy and the medium used to transmit the electronic copy to the responding party.

Attached to the statement shall be a copy of all discovery, exhibits or affidavits on which the motion relies.

Movant shall file a separate legal memorandum explaining why summary judgment should be granted.

(2) *Responses to Motions for Summary Judgment.* Within 30 days after a motion for summary judgment is served, the adverse party shall serve a response on all parties. The response shall set forth each statement of fact in its original paragraph number and immediately thereunder admit or deny each of movant's factual statements.

A denial may not rest upon the mere allegations or denials of the party's pleading. Rather, the response shall support each denial with specific references to the discovery, exhibits or affidavits that demonstrate specific facts showing that there is a genuine issue for trial.

Attached to the response shall be a copy of all discovery, exhibits or affidavits on which the response relies.

A response that does not comply with this Rule 74.04(c)(2) with respect to any numbered paragraph in movant's statement is an admission of the truth of that numbered paragraph.

The response may also set forth additional material facts that remain in dispute, which shall be presented in consecutively numbered paragraphs and supported in the manner prescribed by Rule 74.04(c)(1).

An electronic copy of the response shall be served as provided in Rule 74.04(c)(1).

The response may include a legal memorandum explaining the legal or factual reasons why summary judgment should not be granted.

(3) *Replies in Support of Motions for Summary Judgment.* Within 15 days after service of the response, the movant may file a reply memorandum of law explaining why summary judgment should be granted.

Within the same time, if the adverse party's response sets forth additional material facts that remain in dispute, movant shall set forth each additional statement of fact in its original paragraph number and immediately thereunder admit or deny each such factual statement. Denials shall be supported in the manner prescribed by Rule 74.04(c)(2).

Within the same time, the movant may file a statement of additional material facts as to which movant

claims there is no genuine issue. The statement shall be presented in consecutively numbered paragraphs and supported in the manner prescribed by Rule 74.04(c)(1).

An electronic copy of the reply shall be served as provided in Rule 74.04(c)(1).

Attached to the supplemental statement shall be a copy of any additional discovery, exhibits or affidavits on which the supplemental statement relies.

(4) *Sur-replies in Opposition to Motions for Summary Judgment.* Within 15 days of service, if movant files a statement of additional material facts pursuant to Rule 74.04(c)(3), the adverse party shall file a sur-reply. The sur-reply shall set forth each additional statement of fact in its original paragraph number and immediately thereunder admit or deny each such factual statement. The sur-reply shall be in the form and shall be supported in the manner prescribed by Rule 74.04(c)(2).

An electronic copy of the sur-reply shall be served as provided in Rule 74.04(c)(1).

Attached to the sur-reply shall be a copy of any additional discovery, exhibits or affidavits on which the sur-reply relies.

A sur-reply that does not comply with Rule 74.04(c)(2) with respect to any numbered paragraph in movant's statement of additional material facts is an admission of the truth of that numbered paragraph.

If the movant files a statement of additional material facts, the adverse party may file within the same time a sur-reply memorandum of law explaining the legal or factual reasons why summary judgment should not be granted.

(d) *Case Not Fully Adjudicated on Motion.* If on motion under this Rule 74.04 judgment is not entered upon the whole case or for all the relief asked and a trial is necessary, the court by examining the pleadings and the evidence before it, by interrogating counsel, and by conducting a hearing, if necessary, shall ascertain, if practicable, what material facts exist without substantial controversy and what material facts are actually and in good faith controverted. The court shall thereupon make an order specifying the facts that appear without substantial controversy, including the extent to which the amount of damages or other relief is not in controversy, and directing such further proceedings in the action as are just. Upon the trial of the action the facts so specified shall be deemed established, and the trial shall be conducted accordingly.

(e) *Form of Affidavit.* Supporting and opposing affidavits shall be made on personal knowledge, shall set forth such facts as would be admissible in evidence, and shall show affirmatively that the affiant is competent to testify to the matters stated therein. Sworn or certified copies of all papers or parts thereof

referred to in an affidavit shall be attached thereto or served therewith.

(f) *When Affidavits Are Unavailable.* Should it appear from the affidavits of a party opposing the motion that for reasons stated in the affidavits facts essential to justify opposition to the motion cannot be presented in the affidavits, the court may refuse the application for judgment or may order a continuance to permit affidavits to be obtained or depositions to be taken or discovery to be had or may make such other order as is just.

(g) *Affidavit Made in Bad Faith.* Should it appear to the satisfaction of the court at any time that any affidavit presented pursuant to this Rule 74.04 is presented in bad faith or solely for the purpose of delay, the court shall forthwith order the party presenting it to pay to the other party the amount of the reasonable expenses that the filing of the affidavit caused the other party to incur, including reasonable attorney's fees, and any offending party or attorney may be adjudged guilty of contempt.

(Adopted May 22, 1987, eff. Jan. 1, 1988. Amended June 1, 1993, eff. Jan. 1, 1994; Sept. 28, 1993, eff. Jan. 1, 1994; Feb. 27, 2002, eff. Jan. 1, 2003; Dec. 18, 2007, eff. July 1, 2008.)

#### Committee Note—1959

This rule is the same as Rule 56 of the Federal Rules of Civil Procedure with the amendments to paragraphs (c) and (e) recommended by the Federal Advisory Committee in 1955; and with the addition of paragraph (h) to make clear that the procedure is not applicable where there is a factual issue to be determined by the court or jury. The reasons for the amendments to paragraphs (c) and (e) are stated by the Federal Advisory Committee as follows:

"Subdivision (c). The specific provision, made by the amendment, allowing summary judgment to be granted against the party who has moved therefore, is in accord with N.Y.C.P. Rule 113 and Wis.Stat. Sec. 270.635(3) (1951), as well as the urging of commentators. McDonald, *Summary Judgments*, 30 *Tex.L.Rev.* 285, 303 (1952); Clark, *The Summary Judgment*, 36 *Minn.L.Rev.* 567, 570-571 (1952); Comment, *Summary Judgment*, 25 *Wash.L.Rev.* 71, 76-77 (1950). It codifies a result already achieved by most federal courts. See 6 *Moore's Federal Practice Par.* 56.12 (2d ed. 1953); 3 *Barron & Holtzoff, Fed.Prac. & Proc.* § 1235 (1950) [See now, Wright, *Federal Practice and Procedure: Civil*].

"Subdivision (e). Some recent cases, particularly in the Third Circuit, have held that a mere allegation in the pleading is sufficient to create a genuine issue as to a material fact, and thus prevent summary judgment, even though the pleader has made no attempt to controvert affidavits and other evidentiary matter presented by his opponent; e. g., *Frederick Hart & Co. v. Recordgraph Corp.*, 169 *F.2d* 580, 581 (3d Cir. 1948); *Reynolds Metals Co. v. Metals Disintegrating Co.*, 8 *F.R.D.* 349 (D.N.J. 1948), *aff'd* 176 *F.2d* 90 (3d Cir. 1949); *Chappell v. Goltsman*, 186 *F.2d* 215, 218 (5th Cir. 1950); and cases cited in 6 *Moore's Federal Practice Par.* 56.11[3], n. 16 (2d ed. 1953). This line of cases is

### 19 CSR 30-20.021 Organization and Management for Hospitals

*PURPOSE: The State Board of Health has the authority to establish standards for the operations of hospitals. This rule establishes standards for the administration, medical staff, nursing staff and supporting departments to provide a high level of care.*

*PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.*

(1) Requests for variance from the requirements of this rule shall be in writing to the Department of Health. Approvals for variance shall be in writing and both requests and approvals shall be made a part of the permanent Department of Health records for the facility. Licensed hospitals participating in innovative demonstration projects may be granted a variance from certain requirements.

(A) This request shall contain—

1. The section number and text of the rule in question;
2. Specific reasons why compliance with the rule would impose an undo hardship on the operator, including an estimate of any additional cost which might be involved;
3. An explanation of the relevant extenuating factors which may be relevant; and
4. A complete description of the individual characteristics of the facility or patients or any other factors which would fulfill the intent of the rule in question to safeguard the health, safety and the welfare of the patient, staff or public if the variance from the requirement is granted.

(2) Governing Body, Administration and Medical Staff.

(A) Governing Body.

1. The governing body is defined as an individual owner(s), partnership, corporate body, association or public agency having legal responsibility for the operation of a hospital subject to provisions of sections 197.020-197.120, RSMo.

2. The governing body shall be the legal authority in the hospital and shall be responsible for the overall planning, directing, control and management of the activities and functions of the hospital.

3. The governing body shall establish and adopt bylaws to provide for the appointment of a qualified chief executive officer and members of the medical staff and of the delegation of authority and responsibility to each. A copy of the governing body bylaws and of all amendments or revisions shall be submitted to the Department of Health for its records.

4. Meetings of the governing body shall be held at regular, stated intervals and at other times necessary for proper operation of the hospital. Minutes of all meetings shall be kept as permanent records, signed and made available to members of the governing body.

5. Bylaws of the governing body shall provide for the election of officers and for the appointment of standing and special committees necessary to effectively carry out its responsibilities. Written minutes of all committee meetings shall be maintained on a confidential basis.

6. Bylaws of the governing body shall establish a direct and effective means of liaison among the governing body, the administration and the medical staff.

7. The governing body shall select and employ a chief executive officer who should be qualified, by education and experience, in the field of hospital or health care administration.

8. Bylaws of the governing body shall describe and convey authority to the chief executive officer for the administration of the hospital in all its activities. The chief executive officer shall be subject to special policies adopted or specific orders issued by the governing body in accordance with its bylaws.

9. The Department of Health shall be notified of any change in the appointment of the chief executive officer.

10. Bylaws of the governing body shall require that the medical staff, hospital personnel and all auxiliary organizations, directly or indirectly, shall be responsible to the governing body through the chief executive officer.

11. Bylaws of the governing body shall require that a qualified individual be designated by the chief executive officer to act in his/her absence.

12. Duly appointed representatives of the Department of Health shall be allowed to inspect the hospital as required in section 197.100, RSMo.

13. Bylaws of the governing body shall provide for the selection and appointment of

medical staff members based upon defined criteria and in accordance with an established procedure for processing and evaluating applications for membership. Applications for appointment and reappointment shall be in writing and shall signify agreement of the applicant to conform with bylaws of both the governing body and medical staff and to abide by professional ethical standards. Initial appointments to the medical staff shall not exceed twelve (12) months. Reappointments, which may be processed and approved at the discretion of the governing body on a monthly or other cyclical pattern, shall not exceed two (2) years.

14. Bylaws of the governing body shall require that the medical staff develop and adopt medical staff bylaws and rules which shall become effective when approved by the governing body.

15. The governing body, acting upon recommendations of the medical staff, shall approve or disapprove appointments and on the basis of established requirements shall determine the privileges extended to each member of the staff.

16. Bylaws of both the governing body and medical staff shall provide for appeal and hearing procedures for the denial of reappointment and for the denial, curtailment, suspension, revocation or other modification of clinical privileges of a member of the medical staff. These bylaws also shall provide that notification of denial of appointment, reappointment, curtailment, suspension, revocation or modification of privileges shall be in writing and shall indicate the reason(s) for this action.

17. The governing body shall establish mechanisms which assure the hospital's compliance with mandatory federal, state and local laws, rules and standards.

18. Although independent licensed practitioners are not authorized membership to the medical staff, the governing body may include provisions within its bylaws to grant licensed practitioners clinical privileges, on an outpatient basis, for diagnostic and therapeutic tests and treatment. The privileges shall be within the scope and authority of each practitioner's current Missouri license and practice act.

A. The provisions shall include a mechanism to assure that independent practitioners who provide services have clinical privileges delineated by the governing body or designee.

B. The mechanism shall include criteria for a review of an independent practitioner's credentials on at least an annual basis the first two (2) years and at least every two (2) years after that. At a minimum, the criteria

shall include documentation of a current license, relevant training and experience, and competency.

19. The governing body shall establish and implement a mechanism which assures compliance with the reporting requirements in section 383.133, RSMo.

(B) Administration, Chief Executive Officer.

1. The chief executive officer shall be the direct representative of the governing body and shall be responsible for management of the hospital commensurate with the authority delegated by the governing body in its bylaws.

2. The chief executive officer shall be responsible for maintaining liaison among the governing body, medical staff and all departments of the hospital.

3. The chief executive officer shall organize the administrative functions of the hospital through appropriate departmentalization and delegation of duties and shall establish a system of authorization, record procedures and internal controls.

4. The chief executive officer shall be responsible for the recruitment and employment of qualified personnel to staff the various departments of the hospital and shall insure that written personnel policies and job descriptions are available to all employees.

5. The chief executive officer shall be responsible for the development and enforcement of written policies and procedures governing visitors to all areas of the hospital.

6. The chief executive officer shall be responsible for establishing effective security measures to protect patients, employees and visitors.

7. The chief executive officer shall maintain policies protecting children admitted to or discharged from the hospital. Policies shall provide for at least the following:

A. A child shall not be released to anyone other than the child's parent(s), legal guardian or custodian;

B. The social work service personnel shall have knowledge of available social services for unmarried mothers and for the placement of children;

C. Adoption placements shall comply with section 453.010, RSMo; and

D. The reporting of suspected incidences of child abuse shall be made to the Division of Family Services as established under section 210.120, RSMo.

8. The chief executive officer shall be responsible for developing a written emergency preparedness plan. The plan shall include procedures which provide for safe and orderly evacuation of patients, visitors and personnel in the event of fire, explosion

or other internal disaster. The plan shall also include procedures for caring for mass casualties resulting from any external disaster in the region.

9. The emergency plan in paragraph (2)(B)8. of this rule shall be readily available to all personnel. The chief executive officer is responsible for ensuring all employees shall be instructed regarding their responsibilities during an emergency. Drills for internal disasters, such as fires, shall be held at least quarterly for each shift and shall include the simulated use of fire alarm signals and simulation of emergency fire conditions. Annual drills for external disasters shall be held in coordination with representatives of local emergency preparedness offices. The movement of hospital patients is not required as a part of the drills.

10. The chief executive officer shall be responsible for carrying out policies of the governing body to ensure that patients are admitted to the hospital only by members of the medical staff and that each patient's general medical condition shall be the primary responsibility of a physician member of the medical staff.

11. The chief executive officer shall bring to the attention of the chief of the medical staff and governing body failure by members of that staff to conform with established hospital policies regarding administrative matters, professional standards or the timely preparation and completion of each patient's clinical record.

12. The chief executive officer shall be responsible for developing and maintaining a hospital environment which provides for efficient care and safety of patients, employees and visitors.

13. The chief executive officer shall be responsible for the development and enforcement of written policies which prohibit smoking throughout the hospital except specific designated areas where smoking may be permitted. Lobbies and dining rooms having an area of at least one thousand (1,000) square feet which are enclosed and separated from the access to exit corridor systems may have a designated smoking area. This designated smoking area may not exceed twenty percent (20%) of the total area of the room and shall be located to minimize the spread of smoke into the nonsmoking areas. Lobbies, dining rooms and other rooms of less than one thousand (1,000) square feet which are enclosed and separated from the access to exit corridor systems may be designated smoking areas provided one hundred percent (100%) of the air supplied to the room is exhausted. Individual patients may be permitted to smoke in their rooms with the consent of any other

patients occupying the room and with the permission of his/her attending physician. If a patient is confined to bed or classified as not being responsible, smoking is permitted only under the direct supervision of an authorized individual. Modification of the patient room ventilation system is not required to permit occasional authorized smoking by a patient.

14. An annual licensing survey for each fiscal year shall be filed with the department on the survey document provided by the Department of Health. The survey shall be due within two (2) months after the hospital's receipt of the survey.

15. The chief executive officer shall be responsible for establishing and implementing a mechanism which will assure that patient services provide care or an appropriate referral that is commensurate with the patient's needs. If services are provided by contract, the contractor shall furnish services that permit the hospital to comply with all applicable hospital licensing requirements.

16. The chief executive officer shall be responsible for establishing and implementing a mechanism to assure that all equipment and physical facilities used by the hospital to provide patient services, including those services provided by a contractor, comply with applicable hospital licensing requirements.

17. The chief executive officer shall be responsible for establishing and implementing a mechanism to assure that patients' rights are protected. At a minimum, the mechanism shall include the following:

A. The patient has the right to be free from abuse or neglect;

B. The patient has the right to be treated with consideration and respect;

C. The patient has the right to protective oversight while a patient in the hospital;

D. The patient or his/her designated representative has the right to be informed regarding the hospital's plan of care for the patient;

E. The patient or his/her designated representative has the right to be informed, upon request, regarding general information pertaining to services received by the patient;

F. The patient or his/her designated representative has the right to review the patient's medical record and to receive copies of the record at a reasonable photocopy fee;

G. The patient or his/her designated representative has the right to participate in the patient's discharge planning, including being informed of service options that are available to the patient and a choice of agencies which provide the service;

H. When a patient has brought personal possessions to the hospital, s/he has the

right to have these possessions reasonably protected;

I. The patient has the right to accept medical care or to refuse it to the extent permitted by law and to be informed of the medical consequences of refusal. The patient has the right to appoint a surrogate to make health care decisions on his/her behalf to the extent permitted by law; and

J. The patient, responsible party or designee has the right to participate in treatment decisions and the care planning process.

(C) Medical Staff.

1. The medical staff shall be organized, shall develop and, with the approval of the governing body, shall adopt bylaws, rules and policies governing their professional activities in the hospital.

2. Medical staff membership shall be limited to physicians, dentists, psychologists and podiatrists. They shall be currently licensed to practice their respective professions in Missouri. The bylaws of the governing body and medical staff shall include the procedure to be used in processing applications for medical staff membership; approving or disapproving appointments; and determining the privileges available to physicians, dentists, psychologists and podiatrists.

3. No application for membership on the medical staff shall be denied based solely upon the applicant's professional degree or the school or health care facility in which the practitioner received medical, dental, psychology or podiatry schooling, postgraduate training or certification, if the schooling or postgraduate training for a physician was accredited by the American Medical Association or the American Osteopathic Association, for a dentist was accredited by the American Dental Association's Commission on Dental Accreditation, for a psychologist was accredited with accordance to Chapter 337, RSMo and for a podiatrist was accredited by the American Podiatric Medical Association. Each application for staff membership shall be considered on an individual basis with objective criteria applied equally to each applicant.

4. Each physician, dentist, psychologist or podiatrist requesting staff membership shall submit a written application to the chief executive officer of the hospital on a form approved by the governing body. Each application shall be accompanied by evidence of education, training, professional qualifications, license and standards of performance.

5. The governing body, acting upon recommendations of the medical staff, shall approve or disapprove appointments. Written criteria shall be developed for privileges extended to each member of the staff. A for-

mal mechanism shall be established for recommending to the governing body delineation of privileges, curtailment, suspension or revocation of privileges and appointments and reappointments to the medical staff. The mechanism shall include an inquiry of the National Practitioner Data Bank.

6. Any applicant for medical staff membership who is denied membership or whose completed application is not acted upon in ninety (90) calendar days or a medical staff member whose membership is terminated, curtailed or diminished in any way shall be given in writing the reasons for the action or lack of action. The reasons shall relate to, but not be limited to, standards of patient care, patient welfare, the objectives of the institution or the conduct or competency of the applicant or staff member.

7. Initial appointments to the medical staff shall not exceed twelve (12) months. Reappointments, which may be processed and approved at the discretion of the governing body on a monthly or other cyclical pattern, shall not exceed two (2) years.

8. The medical staff bylaws shall provide for—an outline of the medical staff organization; designation of officers, their duties and qualifications and methods of selecting the officers; committee functions; and an appeal and hearing process.

9. The medical staff bylaws shall provide for an active staff and other categories as may be designated in the governing body bylaws. The medical staff bylaws shall describe the voting rights, attendance requirements, eligibility for holding offices or committee appointments, and any limitations or restrictions identified with location of residence or office practice for each category.

10. The organized medical staff shall meet at intervals necessary to accomplish its required functions. A mechanism shall be established for monthly decision-making by or on behalf of the medical staff.

11. Written minutes shall be signed and permanently filed on a confidential basis in the hospital.

12. The medical staff as a body or through committee shall review and evaluate the quality of clinical practice of the staff throughout the hospital at least once each quarter. Review and evaluation shall include selected deaths, unimproved cases, tissue, infections, complications, errors in diagnosis and results of treatment.

13. The medical staff shall establish in its bylaws or rules criteria for the content of patients' records provisions for their timely completion and disciplinary action for non-compliance.

14. Bylaws of the medical staff shall require that at all times at least one (1) physician member of the medical staff shall be on duty or available within a reasonable period of time for emergency service.

(3) Required Patient Care Services. Each hospital shall provide the following: central services, dietary services, emergency services, medical records, nursing services, pathology and medical laboratory services, pharmaceutical services, radiology services, social work services and an inpatient care unit.

(A) Central Services.

1. Central services shall be organized and integrated with patient care services in the hospital.

2. The director of central services shall be qualified by education, training and experience in aseptic technique, principles of sterilization and disinfection and distribution of medical/surgical supplies. The director shall be responsible to an administrative officer or a qualified designee.

3. Sufficient supervisory and support staff shall be assigned as related to the scope of services provided.

4. Sufficient space and equipment shall be provided for the safe and efficient operation of the services as determined by the scope of hospital services delivered.

5. Policies and procedures shall define the activities of all services provided. Sterilization and disinfection standards of practice shall be established. The principles of the Association for Practitioners in Infection Control, Association of Operating Room Nurses, Center for Disease Control and Prevention, American Society for Healthcare Central Service Personnel, Association for the Advancement of Medical Instrumentation, and others may be utilized to establish facility standards of practice for central services.

6. Written procedures shall specify how items stored in central services can be obtained when central services is considered closed.

7. Reprocessed packaged item(s) shall be identified as to content, show evidence of sterilization and be labeled indicating the sterilizer used and the load/cycle number. A policy on the shelf life of a packaged sterile item shall be established in accordance with acceptable standards of sterilization and dependent on the quality of the packaging material, storage conditions and the amount of handling of the item.

8. Central services shall maintain documentation from the manufacturer that packaging material utilized for reprocessing is appropriate for this use. Expiration dates shall comply with the packaging material utilized.

9. Sterile medical-surgical packaged items shall be handled only as necessary and stored in vermin-free areas where controlled ventilation, temperature and humidity are maintained. The integrity of sterile items shall be maintained throughout reprocessing, storage, distribution and transportation.

10. Preventive maintenance of equipment shall be done as recommended by the manufacturer or as specified by hospital policy. Records shall be maintained as specified by hospital policy. Records shall include documentation that items processed by steam have undergone sufficient time, temperature and pressure and that items processed by ethylene oxide have undergone sufficient time, temperature, gas concentration and humidity to obtain pathogenic microbial kill.

11. Ethylene oxide sterilized items shall be aerated as specified by hospital policy based on the manufacturer's recommendations to eliminate the hazards of toxic residue for both patient and staff.

12. Principles of sterilization and disinfection as approved by the hospital's infection control committee shall apply throughout the hospital when central services activities are decentralized.

(B) Dietary Services.

1. The hospital shall have a full-time employee designated who—

A. Serves as director of dietary services;

B. Is responsible for the daily management of the dietary services;

C. Is qualified by education, training and experience in food service management and nutrition through an approved course for certification by the Dietary Managers Association or registration by the Commission on Dietetic Registration of the American Dietetic Association, or an associate degree in dietetics or food systems management; and

D. Has documented evidence of annual continuing education.

2. When the director is not a qualified dietitian, a qualified dietitian shall be employed on a part-time or consultant basis. The dietitian shall make visits to the facility to assist in meeting the nutritional needs of the patients and the scope of services offered.

3. The qualified dietitian shall ensure that high quality nutritional care is provided to patients in accordance with recognized dietary practices. When the services of a qualified dietitian are used on a part-time or

consultant basis, the following services shall be provided on the premises on a regularly scheduled basis:

A. Continuing liaison with the administration, medical staff and nursing staff;

B. Approval of planned, written menus, including modified diets; and

C. Evaluation of menus for nutritional adequacy.

4. The consultant or part-time dietitian shall assist the director of dietary services to ensure—

A. Patient and family counseling and diet instructions;

B. Nutritional screening within three (3) days of admission to identify patients at nutritional risk. The hospital shall develop criteria to use in conducting the nutritional screening and staff who conduct the screening shall be trained to use the criteria;

C. Comprehensive nutritional assessments within twenty-four (24) hours after screens on patients at nutritional risk, including height, weight and pertinent laboratory tests;

D. Documentation of pertinent information in patient's records, as appropriate;

E. Participation in committee activities concerned with nutritional care; and

F. Planned, written menus for regular and modified diets.

5. The director of dietary services or his/her designee shall be responsible for—

A. Representing the dietary service in interdepartmental meetings;

B. Recommending the quantity and quality of food purchased;

C. Participating in the selection, orientation, training, scheduling and supervision of dietary personnel;

D. Interviewing the patients for food preferences and tolerances and providing appropriate substitutions;

E. Monitoring adherence to the written planned menu; and

F. Scheduling dietary services meetings.

6. When the qualified dietitian serves as a consultant, written reports shall be submitted to and approved by the chief executive officer or designee concerning the services provided.

7. The director of dietary services shall be responsible for developing and implementing written policies and procedures and for monitoring to assure they are followed. Policies and procedures shall be kept current and approved by the chief executive officer or designee.

8. Dietary services shall be staffed with a sufficient number of qualified personnel.

9. Menus shall be planned, written and followed to meet the nutritional needs of the patients as determined by the recommended dietary allowances (RDA) of the Food and Nutrition Board of the National Research Council, National Academy of Sciences or as modified by physician's order.

10. Diets shall be prescribed in accordance with the diet manual approved by the qualified dietitian and the medical staff. The diet manual shall be available to all medical, nursing and food service personnel.

11. At least three (3) meals or their equivalent shall be served approximately five (5) hours apart with supplementary feedings as necessary. There shall not be more than fourteen (14) hours between a substantial evening meal and breakfast.

12. Dietary records shall be maintained which include: food specifications and purchase orders; meal count; standardized recipes; menu plans; nutritional evaluation of menus; and minutes of departmental and in-service education meetings.

13. The dietary services shall comply with 19 CSR 20-1.010 Sanitation of Food Services Establishments. Foods shall be prepared by methods that conserve nutritive value, flavor and appearance and shall be attractively served at acceptable temperatures. Potentially hazardous foods shall be served at temperatures specified in 19 CSR 20-1.010(4)(I) and (J), (5)(B)1.-3. and (H).

14. When there is a contract to provide dietary services to a hospital, the hospital is responsible for assuring that contractual services comply with rules concerning dietary services in hospitals.

(C) Emergency Services.

1. Each hospital providing general services to the community shall provide an easily accessible emergency area which shall be equipped and staffed to ensure that ill or injured persons can be promptly assessed and treated or transferred to a facility capable of providing needed specialized services. In multiple-hospital communities where written agreements have been developed among the hospitals in accordance with an established community-based hospital emergency plan, individual hospitals may not be required by the Department of Health to provide a fully equipped emergency service.

2. A hospital shall have a written hospital emergency transfer policy and written transfer agreements with one (1) or more hospitals within its service area which provide services not available at the transferring hospital. Transfer agreements shall be established which reflect the usual and customary referral practice of the transferring hospital,

but are not intended to cover all contingencies.

3. Hospital emergency services shall be under the medical direction of a qualified staff physician who is board-certified or board-admissible in emergency medicine and maintains a knowledge of current ACLS and ATLS standards or a physician who is experienced in the care of critically ill and injured patients and maintains current verification in ACLS and ATLS. In pediatric hospitals, PALS shall be substituted for ACLS. With the explicit advanced approval of the Department of Health, a hospital may contract with a qualified consultant physician to meet this requirement.

A. That physician shall be responsible for implementing rules of the medical staff relating to patient safety and privileges and to the quality and scope of emergency services.

B. A qualified registered nurse shall supervise and evaluate the nursing and patient care provided in the emergency area by nursing and ancillary personnel. Supervision may be by direct observation of staff or, at a minimum, the nurse shall be immediately available in the institution.

C. Any person assigned to the emergency services department administering medications shall be a licensed physician, registered nurse, EMT-paramedic or appropriately licensed or certified allied health practitioner and shall administer medications only within his/her scope of practice except for students who are participating in a training program to become physicians, nurses, emergency medical technician-paramedics who may be allowed to administer medication under the supervision of their instructors as a part of their training. Trained individuals from the respiratory therapy department may be allowed to administer aerosol medications when a certified respiratory therapy assistant is not available.

4. Any hospital which provides emergency services and does not maintain a physician in-house twenty-four (24) hours a day for emergency care shall have a call roster which lists the name of the physician who is on call and available for emergency care and the dates and times of coverage. A physician who is on call and available for emergency care shall respond in a manner which is reasonable and appropriate to the patient's condition after being summoned by the hospital.

5. Any hospital with surgical services that also provide emergency surgical services shall have a general surgical call roster which lists the name of the general surgeon who is on call for emergency surgical cases, and the dates and times of coverage. The surgeon

who is on call for emergency surgical cases shall arrive at the hospital within thirty (30) minutes of being summoned. Patients arriving at a hospital that does not provide emergency surgical services and are found upon examination to require emergency surgery shall be immediately transferred to a hospital with the necessary services.

6. All patients admitted to the emergency service shall be assessed prior to discharge by a physician or registered professional nurse.

7. If discharged from the emergency department, other than to the inpatient setting, the patient or responsible person shall be given written instructions for care and an oral explanation of those instructions. Documentation of these instructions shall be entered on the emergency service medical record.

8. There shall be a quality improvement program for the emergency service which includes, but is not limited to, the collection and analysis of data to assist in identification of health service problems, and a mechanism for implementation and monitoring appropriate actions. The quality improvement program shall include the periodic evaluation of at least the following: length of time each patient is in the emergency room, appropriateness of transfers, physician response time, provision for written instructions, timeliness of diagnostic studies, appropriateness of treatment rendered, and mortality.

9. Written policies shall be adopted to assure that notification procedures are implemented concerning the significant exposure of prehospital emergency personnel to communicable diseases as required in 19 CSR 30-40.047.

10. The emergency service medical record shall contain patient identification, time and method of arrival, history, physical findings, treatment and disposition and shall be authenticated by the physician. These records, including an ambulance report when applicable, shall be filed under supervision of the medical records department.

11. There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of emergency services.

12. A hospital shall have a written plan that details the hospital's criteria and process for diversion. The plan must be reviewed and approved by the Missouri Department of Health prior to being implemented by the hospital. A hospital may continue to operate under a plan in existence prior to the effective date of this section while awaiting approval of its plan by the department.

A. The diversion plan shall:

(I) Identify the individuals by title who are authorized by the hospital to implement the diversion plan;

(II) Define the process by which the decision to divert will be made;

(III) Specify that the hospital will not implement the diversion plan until the authorized individual has reviewed and documented the hospital's ability to obtain additional staff, open existing beds that may have been closed or take any other actions that might prevent a diversion from occurring;

(IV) Include that all ambulance services within a defined service area will be notified of the intent to implement the diversion plan upon the actual implementation. Ambulances that have made contact with the hospital before the hospital has declared itself to be on diversion shall not be redirected to other hospitals. In areas served by a real time, electronic reporting system, notification through such system shall meet the requirements of this provision so long as such system is available to all EMS agencies and hospitals in the defined service area;

(V) Include procedures for assessment, stabilization and transportation of patients in the event that services, including but not limited to, ICU beds or surgical suites become unavailable or overburdened. These procedures must also include the evaluation of services and resources of the facility that can still be provided to patients even with the implementation of the diversion plan;

(VI) Include procedures for implementation of a resource diversion in the event that specialized services are overburdened or temporarily unavailable; and

(VII) Include that all other acute care hospitals within a defined service area will be notified upon the actual implementation of the diversion plan. For defined service areas with more than two (2) hospitals, if more than one-half (1/2) of the hospitals implement their diversion plans, no hospital will be considered on diversion. For a defined service area with two (2) hospitals, if both hospitals implement their diversion plans, neither will be considered on diversion. Participation in a real time, electronic reporting system shall meet the notification requirements of this section. If a hospital participates in an approved community wide plan, the community wide plan may set the requirement for the number of hospitals to remain open.

B. Each incident of diversion plan implementation must be reviewed by the hospital's existing quality assurance committee. Minutes of these review meetings must be made available to the Missouri Department of Health and Senior Services upon request.

C. The hospital shall assure compliance with screening, treatment and transfer requirements as required by the Emergency Medical Treatment and Active Labor Act (EMTALA).

D. A hospital or its designee shall report to the department, by phone or electronically, upon actual implementation of the diversion plan. This implementation report shall contain the time the plan will be implemented. The hospital or its designee shall report to the department, by phone or electronically, within eight (8) hours of the termination of the diversion. This termination report shall contain the time the diversion plan was implemented, the reason for the diversion, the name of the individual who made the determination to implement the diversion plan, the time the diversion status was terminated, and the name of the individual who made the determination to terminate the diversion. In areas served by real time, electronic reporting system, reporting through such system shall meet the requirements of this provision so long as such system generates reports as required by the department.

E. Each hospital shall implement a triage system within its emergency department. The triage methodology shall continue to apply during periods when the hospital diversion plan is implemented.

F. Any hospital that has a written approved policy, which states that the hospital will not go on diversion or resource diversion, except as defined in the hospital's disaster plan in the event of a disaster, is exempt from the requirements of 19 CSR 30-20.021(3)(C)12.

G. If a hospital chooses to participate in a community wide plan, the requirements of number of hospitals to remain open, defined service areas, as well as community notification may be addressed within the community plan. Community plans must be approved by the department. Community plans must include that each hospital has a policy addressing diversion and the criteria used by each hospital to determine the necessity of implementing a diversion plan. Participation in a community plan does not exempt a hospital of the requirement to notify the department of a diversion plan implementation.

(D) Medical Records.

1. The director of the medical record services shall be appointed by the chief executive officer or chief operating officer. This director may be a qualified registered record administrator, an accredited record technician or an individual with demonstrated competence and knowledge of medical record

department activities supervised by a qualified consultant who is a registered record administrator or accredited record technician.

2. Patient care by members of the medical staff, nursing staff and allied health professionals shall be entered in the patient's medical record in a timely manner. Documentation shall be legible, dated, authenticated and recorded in ink, typewritten or recorded electronically.

3. All orders shall be dated and authenticated by the ordering practitioner and shall be kept in the patient's medical record. Verbal orders shall be authenticated by the prescribing practitioner or attending physician within the time frame that is defined by the medical staff in cooperation with nursing and administration. Authentication shall include written signatures, initials, computer-generated signature codes or rubber stamp signatures by the medical members and authorized persons whose signatures the stamp represents. The use of rubber stamps is discouraged, but where authorized, a signed statement shall be maintained in the administrative offices with a copy in the medical records department stating that the medical staff member whose stamp is involved is the only one who has the stamp and is the only one authorized to use it. The duplication of signature stamps and the delegation of their use by others is prohibited.

4. Only abbreviations and symbols approved by the medical staff may be used in the medical records. Each abbreviation or symbol shall have only one (1) meaning and an explanatory legend shall be available for use by all concerned.

5. The medical record of each patient shall be maintained in order to justify admission and continued hospitalization, support the diagnosis, describe the patient's progress and response to medications and services and to facilitate rapid retrieval and utilization by authorized personnel.

6. Medical records are the property of the hospital and shall not be removed from the hospital premises except by court order, subpoena, for the purposes of microfilming or for off-site storage approval by the governing body.

7. Written consent of the patient or the patient's legal representative is required for access to or release of information, copies or excerpts from the medical record to persons not otherwise authorized to receive this information.

8. Patient records shall be considered complete for filing when the required contents are assembled and authenticated. Hospital policy shall define circumstances in which incomplete medical records may be filed per-

manently by order of the medical record committee.

9. An inpatient's medical record shall include: a unique identifying record number; pertinent identifying and personal data; history of present illness or complaint; if injury, how the injury occurred; past history; family history; physical examination; admitting diagnosis; medical staff orders; progress notes; nurses' notes; discharge summary; final diagnosis; and evidence of informed consent. Where applicable, medical records shall contain reports such as clinical laboratory, X-ray, consultation, electrocardiogram, surgical procedures, therapy, anesthesia, pathology, autopsy and any other reports pertinent to the patient's care.

10. Admission forms shall be designed to record pertinent identifying and personal data.

11. A certificate of live birth shall be prepared for each child born alive and shall be forwarded to the local registrar within seven (7) days after the date of delivery. If the physician or other person in attendance does not certify to the facts of birth within five (5) days after the birth, the person in charge of the institution shall complete and sign the certificate.

12. When a dead fetus is delivered in an institution, the person in charge of the institution or his/her designated representative shall prepare and, within seven (7) days after delivery, file a report of fetal death with the local registrar.

13. Medical records of deceased patients shall contain the date and time of death, autopsy permit, if granted, disposition of the body, by whom received and when.

14. The State Anatomical Board shall be notified of an unclaimed dead body. A record of this notification shall be maintained.

15. The patient's medical records shall be maintained to safeguard against loss, defacement and tampering and to prevent damage from fire and water. Medical records shall be preserved in a permanent file in the original, on microfilm or other electronic media. Patients' medical records shall be retained for a minimum of ten (10) years, except that a minor shall have his/her record retained until his/her twenty-third birthday, whichever occurs later. Preservation of medical records may be extended by the hospital for clinical, educational, statistical or administrative purposes.

16. There shall be a mechanism for the review and evaluation on a regular basis of the quality of medical record services.

17. Should the hospital cease to be licensed, arrangements for disposition of the patient medical records shall be made with



nearby hospitals, the patient's physician or a reliable storage company. Notification of the disposition is to be provided to the department.

18. A history and physical examination shall be completed on each inpatient within twenty-four (24) hours of admission, or a history and physical examination shall have been completed within the seven (7) days prior to admission.

19. A patient's records shall be completed within thirty (30) days of discharge.

(E) Nursing Services.

1. The nursing service shall be integrated and identified within the total hospital organizational structure.

2. The nursing service shall have a written organizational structure that indicates lines of authority, accountability and communication.

3. The organization of the nursing service shall conform with the variety of patient care services offered and the range of nursing care activities.

4. Nursing policies and standards of practice describing patient care shall be in writing and be kept current.

5. Policies shall provide for the collaboration of nursing personnel with members of the medical staff and other health care disciplines regarding patient care issues.

6. Nursing service policies shall establish an appropriate committee structure to oversee and assist in the provision of quality nursing care. The purpose and function of each committee shall be defined and a record of its activities shall be maintained.

7. Policies shall make provision for nursing personnel to be participants of hospital committees concerned with patient care activities.

8. The nursing service shall be administered and directed by a qualified registered professional nurse with appropriate education, experience and demonstrated ability in nursing practice and management.

9. The nursing service administrator shall be responsible to the chief executive officer or chief operating officer.

10. The nursing service administrator shall be a full-time employee and shall have the authority and be accountable for assuring the provision of quality nursing care for those patient areas delineated in the organizational structure.

11. The nursing service administrator shall participate in the formulation of hospital policies and the development of long-range plans relating to patient care.

12. The nursing service administrator, or designee, shall represent nursing at all

appropriate meetings of the medical staff and governing board of the hospital.

13. The nursing service administrator shall be accountable for the selection, promotion and termination of all nursing personnel under the authority of nursing service.

14. The nursing service administrator shall have sufficient time to perform the necessary managerial duties and functions of the position.

15. A qualified registered professional nurse shall be designated and authorized to act in the absence of the nursing service administrator.

16. Nursing personnel shall hold a valid and current license in accordance with sections 335.011-335.096, RSMo.

17. There shall be a job description for each classification of nursing personnel which delineates the specific qualifications, licensure, certification, authority, responsibilities, functions and performance standards for that classification. Job descriptions shall be reviewed annually and revised as necessary to reflect current job requirements.

18. There shall be scheduled annual evaluations of job performance for all classifications of nursing personnel.

19. All nursing personnel shall be oriented to the hospital, nursing services and to their position classification. The orientation shall be of sufficient length and content to prepare nursing personnel for their specified duties and responsibilities. Competency shall be validated prior to assuming independent performance in actual patient situation.

20. For specialized nursing units and those units providing specific clinical services, written policies and procedures, including standards of practice, shall be available and current.

21. Nursing personnel meetings shall be conducted at intervals necessary for leadership and to communicate management information. Separate meetings for the various job classifications of personnel may be conducted. Minutes of all meetings shall be maintained and reflect attendance, scope of discussion and action(s) taken. The minutes shall be filed according to hospital policy.

22. Each facility shall develop and utilize a methodology which ensures adequate nurse staffing that will meet the needs of the patients. At a minimum, on duty at all times there shall be a sufficient number of registered professional nurses to provide patient care requiring the judgment and skills of a registered professional nurse and to supervise the activities of all nursing personnel.

23. There shall be sufficient licensed and ancillary nursing personnel on duty on each nursing unit to meet the needs of each

patient in accordance with accepted standards of nursing practice.

24. Patient care assignments shall be consistent with the qualifications of the nursing personnel and the identified patient needs.

25. Documentation in the patient's medical record shall reflect use of the nursing process in the delivery of care throughout the patient's hospitalization.

26. A registered professional nurse shall assess the patient's needs for nursing care in all settings where nursing care is provided. A nursing assessment shall be completed within twenty-four (24) hours of admission as an inpatient. The registered professional nurse may be assisted in the process by other qualified nursing staff members.

27. Patient education and discharge needs shall be addressed and appropriately documented in the medical records.

28. The necessary types and quantities of supplies and equipment shall be available to meet the current needs of each patient. Reference materials pertinent to patient care shall be readily accessible.

(F) Pathology and Medical Laboratory Services.

1. Provision shall be made, either on the premises or by contract with a reference laboratory, for the prompt performance of adequate examinations in the fields of hematology, clinical chemistry, urinalysis, microbiology, immunology, anatomic pathology, cytology and immunohematology.

2. The director of the pathology and medical laboratory services shall be a physician who is a member of the medical staff and appointed by the governing body. If the director is not a pathologist, a pathologist shall be retained on a part-time basis as a consultant on-site. Consultation shall be provided no less than monthly. A written report of the consultant's evaluation and recommendations shall be submitted after each visit.

3. Pathology and medical laboratory services shall be integrated with other hospital services. The pathologist(s) shall have an active role in in-service educational programs and in medical staff functions, the laboratory quality assurance program and shall participate in committees that review tissue, infection control and blood usage.

4. Laboratory technologists shall have graduated from a medical technology program approved by a nationally recognized body or have documented equivalent education, training and experience. There shall be sufficient qualified laboratory technologists and supportive technical staff currently competent in their field to perform the tests

required. Laboratory personnel shall have the opportunity for continuing education.

5. The laboratory shall perform tests and examine specimens from hospital inpatients only on the order of a medical staff member. The laboratory shall perform tests and examine specimens from any other source only on written request. Test requests received by the laboratory shall clearly identify the patient, the source of the request, the tests required and the date. Requests for examinations of surgical specimens shall contain necessary clinical information.

6. The laboratory shall maintain complete written instructions for specimen collection and processing, storage, testing and reporting of results. The instructions shall include, but not be limited to, a step-by-step description of the testing procedure, reagent use and storage, control and calibration procedures and pertinent literature references.

7. Dated reports of all laboratory examinations shall become a part of the patient's medical record. If the original report from a reference laboratory is not part of the patient's record, the original shall be retained and retrievable for a period of not less than two (2) years. Dated reports of tests on outpatients and from referring laboratories shall be sent promptly to the individual or facility ordering the test. Copies of all laboratory tests and examinations shall be retained and retrievable for at least two (2) years.

8. Instruments and equipment shall be evaluated to insure that they function properly at all times. Records shall be maintained for each piece of equipment, showing the date of inspection, calibration, performance evaluation and action taken to correct deficiencies. Temperatures shall be recorded daily for all temperature-controlled instruments.

9. Each section of the pathology and medical laboratory shall have a written quality control program to verify accuracy, measure precision and detect error. Quality control results shall be documented and retained for at least two (2) years.

10. The hospital laboratory shall successfully participate in a proficiency testing program covering all anatomical and clinical specialties in which the laboratory performs tests and in which proficiency testing is available. Records of proficiency testing shall be maintained for at least two (2) years.

11. All specimens, except for teeth and foreign objects, removed during a surgical, diagnostic, or other procedure shall be submitted for pathologic examination, except for specimens that have been previously determined to be exempt. Specimens submitted for pathological examination shall be accompanied by pertinent clinical information. Specimens

exempted from pathologic examination shall be those for which examination does not add to the diagnosis, treatment or prognosis, shall be determined by the medical staff in consultation with the pathologist, and shall be documented in writing. When the specimen is not submitted for pathological examination, a report of the removal must be present in the patient's medical record. Specimens requiring only a gross description and diagnosis shall be determined by the medical staff in consultation with the pathologist and shall be documented in writing.

12. An autopsy service shall be available to meet the needs of the hospital. Each autopsy shall be performed by, or under the supervision of, a pathologist or a physician whose credentials document his/her qualifications in anatomical pathology. All microscopic interpretations shall be made by a pathologist who is qualified in anatomical pathology.

13. At all times there shall be an established procedure for obtaining a supply of blood and blood components. Facilities for the safekeeping and safe administration of blood and blood products shall be provided. Positive patient identification shall be provided through an armband that displays a number or other unique identifying symbol. This armband shall be on the patient before or at the time of drawing the first tube of blood used for transfusion preparation. The refrigerator used for the routine storage of blood for transfusion shall maintain a temperature between one degree and six degrees Celsius (1°-6° C) and this temperature shall be verified by an outside recording thermometer. This refrigerator shall be constantly monitored by an audible and visible alarm that is located in an area that is staffed at all times. The alarm shall be battery-operated or powered by a circuit different from the one supplying the refrigerator. This refrigerator shall be on the power line supplied by the emergency generator.

14. The hospital shall provide safety equipment for laboratory employees that includes, but is not limited to, gloves. No food, drink, tobacco or personal care items shall be in the laboratory testing area.

(G) Pharmacy Services.

1. Pharmacy services shall be identified and integrated within the total hospital organizational plan. Pharmacy services shall be directed by a pharmacist who is currently licensed in Missouri and qualified by education and experience. The director of pharmacy services shall be responsible for the provision of all services required in subsection (4)(G) of this rule and shall be a participant in all decisions made by pharmacy services or committees regarding the use of medications.

With the assistance of medical, nursing and administrative staff, the director of pharmacy services shall develop standards for the selection, distribution and safe and effective use of medications throughout the hospital.

2. Additional professional and supportive personnel shall be available for services provided. Pharmacists shall be currently licensed in Missouri and all personnel shall possess the education and training necessary for their responsibilities.

3. Support pharmacy personnel shall work under the supervision of a pharmacist and shall not be assigned duties that by law must be performed by a pharmacist. Interpreting medication orders, selecting, compounding, packaging, labeling and the dispensing of medications by pharmacy staff shall be performed by or under the supervision of a pharmacist. Interpretation of medication orders by support personnel shall be limited to order processing and shall not be of a clinical nature.

4. Hours shall be established for the provision of pharmacy services. A pharmacist shall be available to provide required pharmacy services during hours appropriate for necessary contact with medical and nursing staff. A pharmacist shall be on call at all other times.

5. Space, equipment and supplies shall be available according to the scope of pharmacy services provided. Office or other work space shall be available for administrative, clerical, clinical and other professional services provided. All areas shall meet standards to maintain the safety of personnel and the security and stability of medications stored, handled and dispensed.

6. The pharmacy and its medication storage areas shall have proper conditions of sanitation, temperature, light, moisture, ventilation and segregation. Refrigerated medication shall be stored separate from food and other substances. The pharmacy and its medication storage area shall be locked and accessible only to authorized pharmacy and supervisory nursing personnel. The director of pharmacy services, in conjunction with nursing and administration, shall be responsible for the authorization of access to the pharmacy by supervisory nursing personnel to obtain doses for administering when pharmacy services are unavailable.

7. Medication storage areas outside of the pharmacy shall have proper conditions of sanitation, temperature, light, moisture, ventilation and segregation. Refrigerated medications shall be stored in a sealed compartment separate from food and laboratory materials. Medication storage areas shall be locked and accessible only to authorized personnel.

8. The evaluation, selection, source of supply and acquisition of medications shall occur according to the hospital's policies and procedures. Medications and supplies needed on an emergency basis and necessary medications not included in the hospital formulary shall be acquired according to the hospital's policies and procedures.

9. Records shall be maintained of medication transactions, including: acquisition, compounding, repackaging, dispensing or other distribution, administration and controlled substance disposal. Persons involved in compounding, repackaging, dispensing, administration and controlled substance disposal shall be identified and the records shall be retrievable. Retention time for records of bulk compounding, repackaging, administration, and all controlled substance transactions shall be a minimum of two (2) years. Retention time for records of dispensing and extemporaneous compounding, including sterile medications, shall be a minimum of six (6) months.

10. Security and recordkeeping procedures in all areas shall ensure the accountability of all controlled substances, shall address accountability for other medications subject to theft and abuse and shall be in compliance with 19 CSR 30-1.030(3). Inventories of Schedule II controlled substances shall be routinely reconciled. Inventories of Schedule III-V controlled substances outside of the pharmacy shall be routinely reconciled. Records shall be maintained so that inventories of Schedule III-V controlled substances in the pharmacy shall be reconcilable.

11. Controlled substance storage areas in the pharmacy shall be separately locked and accessible only to authorized pharmacy staff. Reserve supplies of all controlled substances in the pharmacy shall be locked. Controlled substance storage areas outside the pharmacy shall be separately locked and accessible only to persons authorized to administer them and to authorized pharmacy staff.

12. Authorization of access to controlled substance storage areas outside of the pharmacy shall be established by the director of pharmacy services in conjunction with nursing and administration. The distribution and accountability of keys, magnetic cards, electronic codes or other mechanical and electronic devices shall occur according to the hospital's policies and procedures.

13. All variances involving controlled substances—including inventory, security, recordkeeping, administration and disposal—shall be reported to the director of pharmacy services for review and investigation. Loss, diversion, abuse or misuse of medications

shall be reported to the director of pharmacy services, administration, and local, state and federal authorities as appropriate.

14. The provision of pharmacy services in the event of a disaster, removal from use of medications subject to product recall and reporting of manufacturer drug problems shall occur according to the hospital's policies and procedures.

15. Compounding and repackaging of medications in the pharmacy shall be done by pharmacy personnel under the supervision of a pharmacist. Those medications shall be labeled with the medication name, strength, lot number, expiration date and other pertinent information. Recordkeeping and quality control, including end-product testing when appropriate, shall occur according to the hospital's policies and procedures.

16. Compounding, repackaging or relabeling of medications by nonpharmacy personnel shall occur according to the hospital's policies and procedures. Medications shall be administered routinely by the person who prepared them, and preparation shall occur just prior to administration except in circumstances approved by the director of pharmacy, nursing and administration. Labeling shall include the patient's name, where appropriate, medication name, strength, expiration date, identity of the person preparing and other pertinent information.

17. Compounded sterile medications shall be routinely prepared in a suitably segregated area in a Class 100 environment by pharmacy personnel. Preparation by nonpharmacy personnel shall occur only in specific areas or in situations when immediate preparation is necessary and pharmacy personnel are unavailable and shall occur according to policies and procedures. All compounded cytotoxic/hazardous medications shall be prepared in a suitably segregated area in a Class II biological safety cabinet or vertical airflow hood. The preparation, handling, administration and disposal of sterile or cytotoxic/hazardous medications shall occur according to policies and procedures including: orientation and training of personnel, aseptic technique, equipment, operating requirements, environmental considerations, attire, preparation of parenteral medications, preparation of cytotoxic/hazardous medications, access to emergency spill supplies, special procedures/products, sterilization, extemporaneous preparations and quality control.

18. Radiopharmaceuticals shall be acquired, stored, handled, prepared, packaged, labeled, administered and disposed of according to the hospital's policies and procedures and only by or under the supervision

of personnel who are certified by the Nuclear Regulatory Commission.

19. A medication profile for each patient shall be maintained and reviewed by the pharmacist and shall be reviewed by the pharmacist upon receiving a new medication order prior to dispensing the medication. The pharmacist shall review the prescriber's order or a direct copy prior to the administration of the initial dose, except in an emergency or when the pharmacist is unavailable, in which case the order shall be reviewed within seventy-two (72) hours.

20. Medications shall be dispensed only upon the order of an authorized prescriber and only by or under the supervision of the pharmacist.

21. All medications dispensed for administration to a specific patient shall be labeled with the patient name, drug name, strength, expiration date and, when applicable, the lot number and other pertinent information.

22. The medication distribution system shall provide safety and accountability for all medications, include unit of use and ready to administer packaging, and meet current standards of practice.

23. To prevent unnecessary entry to the pharmacy, a locked supply of routinely used medications shall be available for access by authorized personnel when the pharmacist is unavailable. Removal of medications from the pharmacy by authorized supervisory nursing personnel, documentation of medications removed, restricted and unrestricted medication removal, later review of medication orders by the pharmacist, and documented audits of medications removal shall occur according to the hospital's policies and procedures. The nurse shall remove only amounts necessary for administering until the pharmacist is available.

24. Floorstock medications shall be limited to emergency and nonemergency medications which are authorized by the director of pharmacy services in conjunction with nursing and administration. The criteria, utilization and monitoring of emergency and non-emergency floorstock medications shall occur according to the hospital's policies and procedures. Supplies of emergency medications shall be available in designated areas.

25. All medication storage areas in the hospital shall be inspected at least monthly by a pharmacist or designee according to the hospital's policies and procedures.

26. The pharmacist shall be responsible for the acquisition, inventory control, dispensing, distribution and related documentation requirements of investigational medications according to the hospital's policies and

procedures. A copy of the investigational protocol shall be available in the pharmacy to all health care providers who prescribe or administer investigational medications. The identity of all recipients of investigational medications shall be readily retrievable.

27. Sample medications shall be received and distributed by the pharmacy according to the hospital's policies and procedures.

28. Dispensing of medications by the pharmacist to patients who are discharged from the hospital or who are outpatients shall be in compliance with 4 CSR 220.

29. Persons other than the pharmacist may provide medications to patients leaving the hospital only when prescription services from a pharmacy are not reasonably available. Medications shall be provided according to the hospital's policies and procedures, including: circumstances when medications may be provided, practitioners authorized to order, specific medications and limited quantities, prepackaging and labeling by the pharmacist, final labeling to facilitate correct administration, delivery, counseling and a transaction record. Final labeling, delivery and counseling shall be performed by the prescriber or a registered nurse.

30. Current medication information resources shall be maintained in the pharmacy and patient care areas. The pharmacist shall provide medication information to the hospital staff as requested.

31. The director of pharmacy services shall be an active member of the pharmacy and therapeutics committee or its equivalent, which shall advise the medical staff on all medication matters. A formulary shall be established which includes medications based on an objective evaluation of their relative therapeutic merits, safety and cost and shall be reviewed and revised on a continual basis. A medication use evaluation program shall be established which evaluates the use of selected medications to ensure that they are used appropriately, safely and effectively. Follow-up educational information shall be provided in response to evaluation findings.

32. The pharmacist shall be available to participate with medical and nursing staff regarding decisions about medication use for individual patients, including: not to use medication therapy; medication selection, dosages, routes and methods of administration; medication therapy monitoring; provision of medication-related information; and counseling to individual patients. The pharmacist or designee shall personally offer to provide medication counseling when discharge or outpatient prescriptions are filled.

The pharmacist shall provide requested counseling.

33. Medication orders shall be initiated or modified only by practitioners who have independent statutory authority to prescribe or who are legally given authority to order medications. That authority may be given through an arrangement with a practitioner who has independent statutory authority to prescribe and who is a medical staff member. The authority may include collaborative practice agreements, protocols or standing orders and shall not exceed the practitioner's scope of practice. Practitioners given this authority who are not hospital employees shall be approved through the hospital credentialing process. When hospital-based agreements, protocols or standing orders are used, they shall be approved by the pharmacy and therapeutics or equivalent committee.

34. All medication orders shall be written in the medical record and signed by the ordering practitioner. When medication therapy is based on a protocol or standing order and a specific medication order is not written, a signed copy of the protocol or of an abbreviated protocol containing the medication order parameters or of the standing order shall be placed in the medical record. Telephone or verbal orders shall be accepted only by authorized staff, immediately written and identified as such in the medical record and signed by the ordering practitioner within a time frame defined by the medical staff.

35. Medication orders shall be written according to policies and procedures and those written by persons who do not have independent statutory authority to prescribe shall be included in the quality improvement program.

36. Automatic stop orders for all medications shall be established and shall include a procedure to notify the prescriber of an impending stop order. A maximum stop order shall be effective for all medications which do not have a shorter stop order. Automatic stop orders are not required when the pharmacist continuously monitors medications to ensure that they are not inappropriately continued.

37. Medications shall be administered only by persons who have statutory authority to administer or who have been trained in each pharmacological category of medication they administer, and administration shall be limited to the scope of their practice. Persons who do not have statutory authority to administer shall not administer parenteral medications, controlled substances or medications that require professional assessment at the time of administration. A person who has statutory authority to administer shall be

readily available at the time of administration. Training for persons who do not have statutory authority to administer shall be documented and administration by those persons shall be included in the quality improvement program. Medications shall be administered only upon the order of a person authorized to prescribe or order medications. Administration by all persons shall occur according to the hospital's policies and procedures.

38. Medications brought to the hospital by patients shall be handled according to policies and procedures. They shall not be administered unless so ordered by the prescriber and identified by the pharmacist or the prescriber.

39. Medications shall be self-administered or administered by a responsible party only upon the order of the prescriber and according to policies and procedures.

40. Medication incidents, including medication errors shall be reported to the prescriber and the appropriate manager. Medication incidents shall be reported to the appropriate committee. Adverse medication reactions shall be reported to the prescriber and the director of the pharmacy services. The medication administered and medication reaction shall be recorded in the patient's medical record. Adverse medication reactions shall be reviewed by the pharmacy and therapeutics committee and other medical or administrative committees when appropriate.

(H) Radiology Services.

1. Radiographic and fluoroscopic diagnostic services shall be provided in each hospital.

2. The director of radiology services shall be a qualified physician member of the medical staff and appointed by the governing body. This physician shall be responsible for implementing the rules of the medical staff governing the quality and scope of radiology services and safety precautions to protect patients and personnel.

3. Radiotherapy services shall be administered only under the supervision of a physician appropriately qualified by special training and experience.

4. Requests for radiology services shall be authenticated in the patient's medical record by the attending physician, licensed house staff or other medical staff member authorized to request radiologic services.

5. A written interpretation, authenticated by a radiologist or other medical staff member appropriately trained and qualified through the medical staff credentialing process, shall be made for all radiological diagnostic services.



6. Documentation of each radiotherapy treatment shall be authenticated and become a part of the patient's medical record.

7. A qualified radiologic technologist shall be on duty or on call at all times. Emergency radiologic services shall be available at all times.

8. Protection from radiation to patients and personnel shall comply with 19 CSR 20-10.010-19 CSR 20-10.190.

9. There shall be periodic inspection of equipment by a medical physicist qualified to furnish complete evaluation. Documentation shall be maintained and available for two (2) years.

(I) Social Work Services.

1. The program shall include: a method of screening to determine the social service needs of the patient; a method of providing appropriate social work interventions, including discharge planning and counseling; and a mechanism for referrals to community agencies when appropriate.

2. The social service program shall be identified and integrated in the total hospital organizational plan. Social work services shall be provided under the direction of a qualified social services worker. When the individual is not a qualified social worker, a qualified social worker shall be employed on a part-time or consultant basis.

3. Social work services including discharge planning shall be integrated with other direct patient-care services of the hospitals. The social work assessment and plan of action shall be implemented for each patient who has need for social services.

4. Written policies and procedures relating to the quality and scope of social work services shall be kept current.

(J) Inpatient Care Unit.

1. A facility to be classified as a general hospital shall provide inpatient care for medical or surgical patients, or both, and may include pediatric, obstetrical and newborn, psychiatric or rehabilitation patients. To be classified a specialized pediatric, psychiatric or rehabilitation hospital, a facility shall provide inpatient care in an exclusive specialty such as pediatrics, psychiatry or rehabilitation and shall have a medical staff and other professional or technical personnel especially qualified in the particular specialty for which the hospital is operated.

(K) Fire Safety, General Safety and Operating Features.

1. Each hospital shall comply with the "Operating Features" requirements of Chapter 31 of NFPA 101, 1994. New hospitals or portions of hospitals constructed or remodeled after the effective date of this amendment shall be maintained so that the building and

its various operating systems comply with NFPA 99, 1993 and NFPA 101, 1994. Existing hospital facilities constructed prior to the effective date of this amendment shall maintain and operate the building in compliance with the design and safety regulations in effect at the time of their construction.

2. Each hospital shall be maintained in good repair to facilitate the maintenance of an appropriate health care delivery environment and to minimize hazards.

3. Each hospital shall develop a mechanism for the identification and abatement of occupant safety hazards in their facilities. Any safety hazard or threat to the general safety of patients, staff or the public shall be corrected.

4. Each hospital shall develop and maintain current a disaster plan which is specified to its facility for response to man-made or natural disasters. Annex 1 of NFPA 99, 1993 shall be used as a guide in the preparation and revision of the hospital's health care disaster plan.

(L) Orientation and Continuing Education.

1. There shall be an orientation and continuing education program for the development and improvement of necessary skills and knowledge of the facility personnel.

2. The orientation program shall be of the scope and duration necessary to effectively prepare personnel new to a unit for their assigned duties and responsibilities based on job descriptions. Temporary personnel shall participate in an orientation prior to providing direct patient care.

3. Educational programs shall be conducted using internal or external resources and shall be planned and documented. Documentation on the topic, presenter, date/time of presentation and the program attendance shall be available.

4. Teaching material and suitable references shall be identified and supplied as needed for the staff of each department or unit that treats patients.

5. The orientation and continuing education program shall participate in the performance improvement process and shall provide evaluation opportunities appropriate to its goals and objectives.

6. The continuing education program shall include, as appropriate for the job, but not be limited to:

A. Problems and needs of specific age groups, chronically ill, acutely ill and disabled patients;

B. Prevention and control of infections including universal precautions;

C. Interpersonal relationships and communication skills;

D. Fire prevention, safety and accident prevention;

E. Patient rights, dignity and privacy issues;

F. Licensed nursing personnel training on basic cardiac life support and choking prevention and intervention; and

G. Any other educational need identified through the quality improvement activities and those generated by advances made in health care science and technology.

7. Competency of all employees shall be evaluated annually based on job description and necessary job skills and knowledge.

(M) Quality Improvement Program.

1. The governing body shall ensure the development and implementation of an effective, ongoing, systematic hospital-wide, patient-oriented performance improvement plan.

2. This plan shall be designed to measure, assess and improve the quality of patient care as evidenced by patient health outcomes or improvement in processes, or both.

3. The performance improvement plan shall be written and shall include:

A. Description of the plan purpose, objectives, organizations, scope, authority, responsibility, and mechanisms of a planned systematic, organization-wide approach to designing, measuring, assessing and improving performance;

B. Assurance of collaborative participation from appropriate departments and services, both clinical and nonclinical, including those services provided directly and under contract;

C. Provision for assessment and coordination of quality improvement activities through an established oversight team that meets on an established periodic basis;

D. Assurance of ongoing communication, reporting and documentation of patient-care issues and quality improvement activities and their effectiveness to the governing body and medical staff at least quarterly; and

E. Development of an annual assessment of the effectiveness of the plan.

4. At a minimum, the plan shall include:

A. Organization-wide design, measurement, assessment and improvement of patient care and organizational functions;

B. Review of care that includes outcomes of care provided by the medical and nursing staff and by other health care practitioners employed or contracted by the hospital;

C. Measurements of quality of care which are outcome- or process-based, specific to the hospital, and to identified needs and expectations of the patients and staff;

D. Review on a continuing basis of the processes that affect a large percentage of patients, that place patients at risk or that have caused or are likely to cause quality problems; and

E. Review of all hospital specific data and state normative data provided by the Department of Health (DOH). The CEO or his/her designee shall respond to the DOH with a corrective plan when the hospital is directed to do so by the Bureau of Hospital Licensing and Certification.

5. The performance improvement plan shall be designed to review activity, actions initiated and reassessments. Documentation shall be maintained on these activities.

(4) Optional Ancillary Services.

(A) Ambulatory Care Services.

1. Ambulatory care services, if provided through an organized department of the hospital, shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body. This physician shall be responsible for implementing rules of the medical staff governing the quality and scope of ambulatory care services provided.

2. Ambulatory care services shall be integrated with other hospital services as required to meet the needs of the patient.

3. Nursing personnel assigned to the ambulatory care services shall be under the supervision of a qualified registered professional nurse with relevant education, experience and demonstrated current competency.

4. Approved written policies and procedures shall describe the scope of ambulatory care provided. Policies and procedures shall be reviewed at least annually and revised as necessary.

5. Ambulatory care services shall be staffed by personnel qualified by education, training and experience to provide safe patient care.

6. Patient's medical records shall reflect ambulatory care and treatment provided. These records shall be filed and maintained under supervision of the medical records department.

7. There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of ambulatory care services provided.

(B) Anesthesia Services.

1. Anesthesia services, if provided, shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body. This physician shall be responsible for implementing the rules of the medical staff governing the

quality and scope of anesthesia care provided.

2. Approved written policies and procedures shall include: patient and employee safety, pre- and post-anesthesia evaluation, care of equipment, storage of anesthesia agents and the administration of anesthesia.

3. Anesthesia shall be administered only by qualified anesthesiologists, physicians or dentists trained in anesthesia, certified nurse anesthetists or supervised students in an approved educational program.

4. An anesthesia record documenting the care given shall be a permanent part of the patient's medical record.

5. The pre-anesthesia patient evaluation shall be accomplished by a physician and documented within forty-eight (48) hours before surgery and shall include the history and physical examination; anesthetic, drug and allergy history; essential laboratory data; and other diagnostic test results to establish potential anesthetic risks. These procedures may be waived in the event of a life threatening emergency, provided the surgeon so certifies on the patient medical record.

6. A post-anesthesia evaluation shall be documented in the patient's medical record within twenty-four (24) hours after surgery.

7. The use of flammable anesthetic agents shall be limited to those areas of the hospital which comply with all applicable requirements of the *Standard for Inhalation Anesthetics 1980* published by the National Fire Protection Association.

8. Prior to surgery, the patient's medical record shall contain evidence that the patient has been advised regarding the surgical procedure(s) contemplated, the type of anesthesia to be administered and the risks involved with each. Evidence that informed consent has been given shall become a part of the patient's medical record.

9. There shall be a mechanism for the review and evaluation on a regular basis of the quality and scope of anesthesia services.

(C) Home-Care Services.

1. Home-care services, if provided, shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body. This physician shall be responsible for implementing rules of the medical staff governing the quality and scope of home-care services.

2. The objectives and description of home-care services shall be related to identifiable needs and shall include those services the hospital provides or those provided through participating community agencies.

3. There shall be written policies and procedures delineating administrative control, scope of services offered and the manner

in which they are provided. These policies and procedures shall be reviewed annually and revised as necessary.

4. A medical record shall be maintained on every patient receiving home-care services. These records shall contain the overall care plan, physician's orders, services provided, progress notes and disposition of the patient. Records shall be filed under supervision of the medical records department.

5. There shall be a mechanism for the review and evaluation on a regular basis of the quality and scope of home-care services provided.

(D) Medical Services.

1. Medical services, if provided, shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body as chief of the medical services. This director shall be responsible for implementing the rules of the medical staff governing medical privileges and the quality of medical care provided.

2. Medical services shall be responsible for the medical care of all patients except those under the care of physicians or other services as defined in the medical staff or governing body bylaws.

3. The activities of medical services shall be integrated with other services in the hospital.

4. There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of medical services provided.

(E) Obstetrical and Newborn Services.

1. Obstetrical services, if provided, shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body. This physician shall be responsible for implementing the rules of the medical staff governing obstetrical privileges, quality of obstetrical care and patient safety.

2. Obstetrical services shall be supervised by a qualified registered professional nurse with relevant education, experience and demonstrated current competency.

3. The obstetrical nursing supervisor shall have the authority to implement and enforce hospital policies and procedures governing obstetrical services and shall have the responsibility for evaluating the competency of nursing personnel assigned to obstetrical services.

4. Facilities for obstetrical services shall be designed to prevent unauthorized traffic.

5. Undelivered patients receiving intravenous oxytocin shall be under continuous observation by trained personnel. Induction or augmentation of labor with oxytocin may be initiated only after a qualified physician



has evaluated the patient, determined that induction or augmentation is beneficial to the mother, fetus, or both, recorded the indication and established the plan of management. The physician initiating these procedures shall be readily accessible to manage complications that arise during infusion and a physician who has privileges to perform Caesarean deliveries shall be in consultation and readily accessible in order to manage any complications that require surgical intervention.

6. There shall be provision for isolation of infants with known or suspected infections or communicable diseases. Policies and procedures regarding isolation shall be integrated with the hospital infection control program.

7. Each newborn shall be identified by an acceptable method which includes the name, date and time of birth, the infant's sex and the mother's hospital number.

8. A delivery room record shall be maintained.

9. A nursery shall be provided for care of the newborn.

10. Hospitals with an obstetrical service shall have at least one (1) premature-care incubator by an independent testing laboratory.

11. All cases of acute infectious conjunctivitis (*Ophthalmia neonatorum*) shall be reported immediately to the individual(s) responsible for the infection control program and to the local or district health department in accordance with section 210.080, RSMo.

12. All cases of epidemic diarrhea of the newborn shall be reported immediately to the individual(s) responsible for the infection control program and the local or district health department.

13. Resuscitation, suction, oxygen, monitoring and newborn temperature control equipment shall be available for the care of newborn. Supplies for the proper care of newborn shall be available.

14. An incubator or bassinet with controlled temperature shall be available for each delivery room and for transport to the nursery.

15. Space shall be provided for the preparation or the handling and storage of formula. Separate refrigeration shall be provided for formula.

16. Eye care of newborn shall be in accordance with section 210.070, RSMo.

17. Written policies and procedures shall be established to provide safe transport of infants within the hospital or to another health-care facility.

18. Written policies and procedures governing special care programs shall be

approved by the medical staff and governing body.

19. There shall be a mechanism for the review and evaluation on a regular basis of the quality of obstetrical and newborn services provided.

(F) Pediatric Services.

1. The pediatric unit, if provided, shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body. This physician shall be responsible for implementing the rules of the medical staff governing the quality and scope of pediatric services.

2. The pediatric unit shall be supervised by a qualified registered professional nurse with relevant education, experience and demonstrated current competency.

3. The pediatric supervisor shall have the authority to implement and enforce hospital policies and procedures governing pediatric services and shall have the responsibility for evaluating the competency of nursing personnel assigned to pediatric services.

4. The pediatric unit shall be designed for specific needs of children and located apart from adult patients and the newborn.

5. The pediatric unit shall have at least one (1) room suitable for isolation.

6. Supplies and equipment required for emergencies shall be readily available in the pediatric unit.

7. There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of pediatric services provided.

(G) Post-Anesthesia Recovery Services.

1. Post-anesthesia recovery services, if provided, shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body. This director shall be responsible for implementing the rules of the medical staff governing post-anesthesia recovery services.

2. A qualified registered professional nurse shall direct and evaluate the nursing care provided by post-anesthesia recovery services.

3. A post-anesthesia recovery record documenting patient care shall be a permanent part of the patient's medical record.

4. Patients receiving post-anesthesia recovery care shall be closely observed by qualified personnel until each patient is stabilized for safe transfer. Written procedures for discharge from the post-anesthesia recovery service shall be approved by the medical staff.

5. There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of post-anesthesia recovery services provided.

(H) Psychiatric Services—Emergency and Acute.

1. Emergency psychiatric care.

A. If the hospital does not have a psychiatric unit, written policies and procedures shall be developed to provide for the safe management of patients requiring psychiatric services until they can be safely transferred to an appropriate facility.

B. Written policies shall be established regarding the use of restraints or seclusion. These restraints or seclusion shall be used only on the order of a physician. In the absence of a physician, a registered professional nurse shall make the decision that the use of a physical restraint or seclusion is the least restrictive procedure appropriate at the time of the emergency situation. The physician shall be notified immediately and a physician's order obtained as soon as possible after the occurrence of an emergency. Physicians' orders for use of physical restraints or seclusion shall be rewritten every twenty-four (24) hours. A full record of any restriction of activity for any patient shall be recorded on the nurses' notes and shall include the reason for restriction, the type of restriction used, the time of starting and ending the restriction and regular observations of the patient while restricted.

2. Acute psychiatric services. If a psychiatric unit is designed within the hospital, it shall comply with the following requirements as a minimum:

A. Psychiatric services shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body. The director shall be responsible for implementing rules of the medical staff governing psychiatric privileges, quality and scope of care and patient safety;

B. Psychiatric services shall be supervised by a qualified registered professional nurse with relevant education, experience and demonstrated current competency;

C. The psychiatric nursing supervisor shall have the authority to implement and enforce hospital policies and procedures governing psychiatric care and shall have the responsibility for evaluating the competency of all nursing personnel assigned to psychiatric services;

D. Appropriate registered nurse staffing patterns shall be developed to meet the care needs and activity demands of each patient in the psychiatric unit;

E. New employees shall attend appropriate orientation, in-service and staff development programs prior to being considered part of the staff required to meet the minimum standards of patient care;

F. Written policies shall be established regarding the use of restraints or seclusion. These restraints or seclusion shall be used only on the order of a physician. In the absence of a physician, a registered professional nurse shall make the decision that the use of a physical restraint or seclusion is the least restrictive procedure appropriate at the time of the emergency situation. The physician shall be notified immediately and a physician's order obtained as soon as possible after the occurrence of an emergency. Physician's orders for use of physical restraints or seclusion shall be rewritten every twenty-four (24) hours. A full record of any restriction of activity for any patient shall be recorded on the nurses' notes and shall include the reason for restriction, the type of restriction used, the time of starting and ending the restriction and regular observations of the patient while restricted;

G. The social work services staff shall be available to participate as members of the treatment team, exchanging information and evaluations with the attending physician and other professional disciplines in order to insure a comprehensive treatment program for patients;

H. Activity therapy services shall be available with the services provided under the direction of a qualified therapist. All therapy shall be given on the written order of a physician and documented in the patients' clinical records; and

I. There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of psychiatric services provided.

(I) Rehabilitation Services.

1. The rehabilitation services, if provided, shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body. The director shall be responsible for implementing rules of the medical staff governing the quality and scope of rehabilitation services.

2. Rehabilitation services shall be supervised by a qualified physician or a qualified therapist with relevant education and experience.

3. Rehabilitation services shall be integrated within the total organizational plan and the director shall assist in the formulation of policies and development of long-range planning affecting patient care.

4. Therapy shall be administered in accordance with a physician's written orders and shall be documented in the patient's medical record.

5. Rehabilitation services shall be provided by qualified personnel. In-service shall be ongoing and documented.

6. Approved written policies and procedures which define and describe the scope and conduct of rehabilitative care shall be reviewed annually and revised as necessary.

7. The qualified therapist shall evaluate and reevaluate the therapy administered and this shall be documented in the patient's medical record.

8. Space and equipment shall be provided to meet the needs of rehabilitation services. Space, supplies and equipment shall be maintained to ensure patient safety.

9. There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of rehabilitation services provided.

(J) Respiratory Care Services.

1. Respiratory care services, if provided, shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body. The director shall be responsible for implementing rules of the medical staff governing the quality and scope of respiratory care services.

2. Respiratory care services shall be integrated within the total hospital organizational plan.

3. Respiratory care services shall be administered under the direction of a qualified registered or certified respiratory therapist or a registered professional nurse with relevant education and experience.

4. Therapy shall be administered in accordance with a physician's written orders and shall be documented in the patient's medical record.

5. Respiratory care services shall be provided by qualified personnel. In-service shall be ongoing and documented.

6. Approved written policies and procedures which define and describe the scope and conduct of respiratory care shall be reviewed annually and revised as necessary.

7. A qualified registered or certified respiratory therapist or a registered professional nurse shall evaluate and reevaluate the therapy administered and this shall be documented in the patient's medical record.

8. Space and equipment shall be provided to meet the needs of respiratory care services. Space, supplies and equipment shall be maintained to ensure patient safety.

9. There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of respiratory care services provided.

(K) Special Patient Care Services.

1. Special care units, if provided, shall be under the medical direction of a qualified physician, member of the medical staff and appointed by the governing body.

2. Patient care in each special care unit shall be integrated with the other nursing services and supervised by a qualified registered professional nurse with relevant education, experience and demonstrated current competency.

3. Approved written policies and procedures shall define and describe the scope and conduct of each special patient-care service. These shall be reviewed annually and revised as necessary.

4. Qualifications of personnel for assignment to each special care unit shall be delineated in writing. Orientation, in-service training and continuing education shall be provided and documented.

5. Registered nurse staffing patterns shall be developed to meet the needs of each patient in special care units.

6. A multi-disciplinary committee, chaired by the director, shall develop protocols for the conduct of patient care in each special care unit. This committee shall meet at least quarterly and minutes shall be kept and filed on a confidential basis.

7. There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of care provided in each special care area.

(L) Surgical Services.

1. Surgical services, if provided, shall be under the medical direction of a qualified physician member of the medical staff and appointed by the governing body. This physician shall be responsible for implementing rules of the medical staff governing the quality and scope of surgical services.

2. Approved written policies and procedures shall define and describe the scope and conduct of surgical services. These shall be reviewed annually and revised as necessary.

3. The surgical suite shall be supervised by a qualified registered professional nurse with relevant education, experience and demonstrated current competency. This supervisor shall have the authority to implement hospital policies and procedures for the surgical suite and shall have the responsibility for evaluating all nursing personnel assigned to the surgical suite.

4. A qualified registered professional nurse shall be assigned circulating duties for surgical procedures performed.

5. Accepted standards of patient care, sterility and aseptic techniques shall be maintained.



6. Prior to surgery, the patient's medical record shall contain evidence that the patient has been advised as to the surgical procedure(s) contemplated, the type of anesthesia to be administered and the risks involved with each. Evidence that informed consent has been given shall become a part of the patient's medical record.

7. An operating room record documenting the patient care provided shall become a part of the patient's medical record. The record shall contain at least the name of the patient, the patient's hospital number, the name of the surgeon, name of surgical procedure(s), the date, time surgery began and ended, names and titles of persons assisting with the procedure and the verification of countable materials.

8. There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of surgical services.

(5) Environmental and Support Services. Each hospital shall have an organized service which maintains a clean and safe environment.

(A) Housekeeping Services.

1. The housekeeping services shall have a director who is qualified by education, training and experience in the principles of hospital housekeeping. This individual shall report to a designated administrative officer.

2. Approved written policies and procedures shall define and describe the scope and conduct of housekeeping services. These shall be reviewed in cooperation with the infection control program and kept current.

3. Space for housekeeping services shall provide for office(s), the storage of supplies and equipment and for equipment maintenance.

4. There shall be sufficient trained personnel to meet the needs of housekeeping services. Housekeeping personnel shall be given the opportunity to participate in-service training or other relevant continuing educational programs.

5. All noninfectious wastes generated within the hospital shall be collected in appropriate containers for disposal.

6. There shall be a mechanism for the review and evaluation on a regular basis of the quality of housekeeping services provided.

(B) Infection Control.

1. There shall be an active multidisciplinary infection control committee responsible for implementing and monitoring the infection control program. The committee shall include, but not be limited to, a member of the medical staff, registered profes-

sional nursing staff and administration. This program shall include measures for preventing, identifying, investigating, reporting and controlling infections throughout the hospital, including the employee health program.

2. The infection control committee or its designated infection control practitioner shall conduct an ongoing review and analysis of nosocomial infection data and risk factors. The infection control practitioner shall be a physician, registered nurse, have a bachelor's degree in laboratory science or have similar qualifications and have additional training or education preparation in infection control, infectious diseases, epidemiology and principles of quality improvement.

3. Written policies and procedures outlining infection control measures, aseptic techniques, cleaning, disinfection and sterilization and a mechanism for reporting and monitoring patient and employee infections shall be developed for all patient care and support departments in the hospital.

4. Orientation and ongoing education shall be provided to all patient care and patient-care support personnel on the cause, effect, transmission, prevention and elimination of infections. Records of employee attendance shall be retained and available for inspection. A mechanism for monitoring compliance with infection control policies and procedures shall be coordinated with administrative staff, personnel staff and the quality improvement program.

5. Infection control committee meetings shall be held quarterly. Minutes shall be retained.

6. There shall be an annual review and evaluation of the quality of the infection control program.

(C) Laundry and Linen Services.

1. The hospital shall have organized services which ensure that adequate supplies of clean linens are available. There shall be specific written procedures for the processing, distribution and storage of linen. These shall be reviewed in cooperation with the infection control committee and kept current.

2. Soiled linen processing functions shall be physically separated from both clean linen storage and soiled linen holding areas. Only commercial laundry equipment shall be used to process hospital linen.

3. Clean linen shall be stored and distributed to the point of use in a way that minimizes microbial contamination from surface contact or airborne particles.

4. Soiled linen shall be collected at the point of use and transported to the soiled linen holding room in a manner that minimizes microbial dissemination into the environment.

5. If a commercial laundry service is used, verification shall be provided to assure the hospital that the processing and handling of linen complies with paragraphs (5)(C)1.-4. of this rule.

6. There shall be a mechanism for the review and evaluation on a regular basis of the quality of laundry and linen services provided.

(D) Infectious Waste Management.

1. Every hospital shall write an infectious waste management plan with an annual review identifying infectious waste generated on-site, the scope of the infectious waste program, and policies and procedures to implement the infectious waste program. The director of this program shall be qualified by education, training and experience in the principles of infectious waste management. The plan shall include at least the following: chief executive officer's endorsement letter; introduction and purpose; objectives; phone number of responsible individuals; organizational chart; schematic(s) of waste disposal routes; definition of those wastes handled by the system; department and individual responsibilities; procedures for waste identification, segregation, containment, transport, treatment and disposal; emergency and contingency procedures; training and educational procedures; and appendices (rules and other applicable institutional policy statements). Any hospital exempt from infectious waste processing facility permit requirements of 10 CSR 80-7.010 and that accepts infectious waste from off-site shall include in its plan requirements for storage, processing and recordkeeping of this waste and the cleanup of potential spills in the unloading area. Manufacturers' specifications for temperature, residence time and control devices for any infectious waste processing devices shall be included in the plan. A trained operator shall operate the equipment during any infectious waste treatment procedures.

2. Infectious waste shall be segregated from other wastes at the point of generation and shall be placed in distinctive, clearly marked, leakproof containers or plastic bags appropriate for the characteristics of the infectious waste. Containers for infectious waste shall be identified with the universal biological hazard symbol. All packaging shall maintain its integrity during storage and transport. Infectious waste shall not be placed in a gravity waste disposal chute.

3. Pending disposal, infectious waste shall be stored, separated from other wastes, in a limited-access enclosure posted with the biological hazard symbol. This enclosure shall afford protection from vermin, be a dry area and be provided with an impervious

floor with a perimeter curb. The floor shall slope to a drain connected to the sanitary sewage system or collection device. If infectious waste is compacted, the mechanical device shall contain the fluids and aerosols and shall not release aerosols or fluids when opened and the container is removed. Provisions for waste stored seventy-two (72) hours or more shall be separately addressed in the infectious waste management plan.

4. Hospital infectious waste treated on site shall be rendered innocuous, using one (1) of the following methods:

A. Sterilization of the waste in an autoclave is permitted, provided that the unit is operated in accordance with the manufacturer's recommendations and that the autoclave's effectiveness is verified at least weekly with a biological spore assay containing *Bacillus Stearothermophilus*. If the autoclave is used for other functions, the infectious waste management plan will develop specific guidelines for its use;

B. Incineration in a multi-chamber incinerator designed to provide complete combustion of the type of waste introduced into the incinerator is permitted. The incinerator shall be operated in accordance with the manufacturer's recommendations and shall comply with air pollution control laws and regulations. The incinerator shall achieve a minimum temperature of eighteen hundred degrees Fahrenheit (1,800°F) in the secondary chamber with a minimum retention time of one-half (1/2) second in the secondary chamber. The incinerator shall be equipped with continuous temperature recording charts for the secondary chamber and utilized during any infectious waste treatment process. Pathological wastes mixed with or contained in plastic materials shall be incinerated in a multi-chamber incinerator achieving a minimum temperature of eighteen hundred degrees Fahrenheit (1,800°F) in the secondary combustion chamber with one-half (1/2) second retention time;

C. Decontamination of the infectious waste by other technologies in a manner acceptable to the Department of Health shall be permitted;

D. Bulk blood, suctioned fluids, excretions and secretions may be carefully poured down a drain connected to a sanitary sewer; or

E. Infectious waste rendered innocuous by the methods in subparagraphs (5)(D)4.A. or C. of this rule shall be disposed of in accordance with the requirements of 10 CSR 80-7.010.

5. An infectious waste treatment program shall include records of biological spore assay tests if required by treatment methods

and the approximate amount of waste disinfected or incinerated per hour measured by weight per load. The program director shall maintain records demonstrating the proper operation of the disinfection or incineration equipment.

6. All infectious waste when transported off the premises of the hospital shall be packaged and transported as provided in sections 260.200-260.207, RSMo.

7. Any hospital which accepts infectious waste from small quantity generators as defined by 10 CSR 80-7.010 or from other Missouri hospitals—in quantities exceeding fifty percent (50%) of the total poundage of infectious waste generated on-site at the hospital—shall notify the Department of Natural Resources and comply with permitting requirements of sections 260.200-260.207, RSMo. The weight of infectious waste generated on-site shall be calculated by multiplying one and five-tenths (1.5) pounds per day times the number of beds complying with Department of Health standards for hospital licensure. Infectious waste generated off-site may be accepted by a hospital only if packaged according to 10 CSR 80-7.010(2)(A)-(D).

*AUTHORITY: sections 192.006 and 197.080, RSMo 2000.\* This rule was previously filed as 13 CSR 50-20.021 and 19 CSR 10-20.021. Original rule filed June 2, 1982, effective Nov. 11, 1982. Amended: Filed April 9, 1985, effective Sept. 28, 1985. Amended: Filed June 2, 1987, effective Sept. 11, 1987. Amended: Filed Nov. 16, 1987, effective March 26, 1988. Amended: Filed June 14, 1988, effective Oct. 13, 1988. Amended: Filed Aug. 16, 1988, effective Dec. 29, 1988. Amended: Filed Nov. 21, 1995, effective July 30, 1996. Amended: Filed Oct. 6, 1998, effective April 30, 1999. Amended: Filed June 28, 2001, effective Feb. 28, 2002.*

*\*Original authority: 192.006, RSMo 1993 amended 1995 and 197.080, RSMo 1953, amended 1993, 1995.*

#### 19 CSR 30-20.030 Construction Standards for New Hospitals

*PURPOSE: This rule establishes up-to-date construction standards for new hospitals to help ensure accessible, functional, fire-safe and sanitary facilities.*

*PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this*

*rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.*

#### (1) New Hospital General Requirements.

(A) A new hospital is one for which plans are submitted to the Department of Health for review and approval after November 11, 1982 for the construction of a new facility, expansion or renovation of an existing hospital or the conversion of an existing facility not previously and continuously licensed as a hospital under Chapter 197, RSMo. A new hospital shall be designed to provide all of the facilities required by this rule and arranged to accommodate all of the functions required by this rule and to provide comfortable, sanitary, fire-safe, secure and durable facilities for the patients. In major alteration projects and additions to an existing licensed hospital, only that part of the total hospital affected by the project is subject to this rule.

(B) These minimum requirements are not intended in any way to restrict innovations and improvements in design, construction or operating techniques. Plans and specifications and operational procedures which contain deviations from these requirements may be approved if it is determined that the purposes of the minimum requirements have been fulfilled. Some facilities may be subject to the requirements of more than one (1) regulating agency. While every effort has been made to ensure coordination, facilities making requests for changes in services and request for new construction or renovations are cautioned to verify requirements of other agencies involved.

(C) Requests for deviations from the requirements of this rule shall be in writing to the Department of Health. Approvals for deviations shall be in writing and both requests and approvals shall become a part of the permanent Department of Health records for the facility.

(D) Alterations or additions to existing hospitals shall be programmed so construction will minimize disruptions of existing functions. Access to exits and fire protections shall be maintained so the safety of the occupants will not be jeopardized during construction.

(E) The owner of each new facility or the owner of an existing facility being added to or undergoing major alterations shall provide a program—scope of services—which de-

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TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF  
HEALTH AND HUMAN SERVICES (CONTINUED)

PART 482\_CONDITIONS OF PARTICIPATION FOR HOSPITALS--Table of Contents

Subpart B\_Administration

Sec. 482.13 Condition of participation: Patient's rights.

A hospital must protect and promote each patient's rights.

-(a) Standard: Notice of rights. (1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.

(2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. At a minimum:

(i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital.

(ii) The grievance process must specify time frames for review of the grievance and the provision of a response.

(iii) In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.

-(b) Standard: Exercise of rights. (1) The patient has the right to participate in the development and implementation of his or her plan of care.

(2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

(3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with Sec. 489.100 of this part (Definition), Sec. 489.102 of this part (Requirements for providers), and Sec. 489.104 of this part (Effective dates).

(4) The patient has the right to have a family member or

representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital.

— (c) Standard: Privacy and safety. (1) The patient has the right to personal privacy.

(2) The patient has the right to receive care in a safe setting.

(3) The patient has the right to be free from all forms of abuse or harassment.

(d) Standard: Confidentiality of patient records. (1) The patient has the right to the confidentiality of his or her clinical records.

(2) The patient has the right to access information contained in his or her clinical records within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.

(e) Standard: Restraint or seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

(1) Definitions. (i) A restraint is--

(A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or

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(B) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

(ii) Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

(2) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient a staff member or others from harm.

(3) The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.

(4) The use of restraint or seclusion must be--

(i) In accordance with a written modification to the patient's plan of care; and

(ii) Implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.

(5) The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under Sec. 482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.

(6) Orders for the use of restraint or seclusion must never be

written as a standing order or on an as needed basis (PRN).

(7) The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.

(8) Unless superseded by State law that is more restrictive--

(i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:

(A) 4 hours for adults 18 years of age or older;

(B) 2 hours for children and adolescents 9 to 17 years of age; or

(C) 1 hour for children under 9 years of age; and

(ii) After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under Sec. 482.12(c) of this part and authorized to order restraint or seclusion by hospital policy in accordance with State law must see and assess the patient.

(iii) Each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by hospital policy.

(9) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

(10) The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy.

(11) Physician and other licensed independent practitioner training requirements must be specified in hospital policy. At a minimum, physicians and other licensed independent practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or seclusion.

(12) When restraint or seclusion is used for the management of violent or

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self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention--

(i) By a--

(A) Physician or other licensed independent practitioner; or

(B) Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section.

(ii) To evaluate--

(A) The patient's immediate situation;

(B) The patient's reaction to the intervention;

(C) The patient's medical and behavioral condition; and

(D) The need to continue or terminate the restraint or seclusion.

(13) States are free to have requirements by statute or regulation that are more restrictive than those contained in paragraph (e)(12)(i) of this section.

(14) If the face-to-face evaluation specified in paragraph (e)(12) of this section is conducted by a trained registered nurse or physician assistant, the trained registered nurse or physician assistant must consult the attending physician or other licensed independent

practitioner who is responsible for the care of the patient as specified under Sec. 482.12(c) as soon as possible after the completion of the 1-hour face-to-face evaluation.

(15) All requirements specified under this paragraph are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored--

(i) Face-to-face by an assigned, trained staff member; or

(ii) By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.

(16) When restraint or seclusion is used, there must be documentation in the patient's medical record of the following:

(i) The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior;

(ii) A description of the patient's behavior and the intervention used;

(iii) Alternatives or other less restrictive interventions attempted (as applicable);

(iv) The patient's condition or symptom(s) that warranted the use of the restraint or seclusion; and

(v) The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.

(f) Standard: Restraint or seclusion: Staff training requirements. The patient has the right to safe implementation of restraint or seclusion by trained staff.

(1) Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion--

(i) Before performing any of the actions specified in this paragraph;

(ii) As part of orientation; and

(iii) Subsequently on a periodic basis consistent with hospital policy.

(2) Training content. The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:

(i) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.

(ii) The use of nonphysical intervention skills.

(iii) Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.

(iv) The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia);

(v) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.

(vi) Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including

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but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation.

(vii) The use of first aid techniques and certification in the use

of cardiopulmonary resuscitation, including required periodic recertification.

(3) Trainer requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors.

(4) Training documentation. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.

(g) Standard: Death reporting requirements: Hospitals must report deaths associated with the use of seclusion or restraint.

(1) The hospital must report the following information to CMS:

(i) Each death that occurs while a patient is in restraint or seclusion.

(ii) Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.

(iii) Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. ``Reasonable to assume'' in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

(2) Each death referenced in this paragraph must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.

(3) Staff must document in the patient's medical record the date and time the death was reported to CMS.

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