Nursing Facility Rule Revisions

Summary

The proposed changes to the Texas Administrative Code, Part 1, Chapter 19 will provide consistency with the CFR by amending, repealing, or adding the selected sections in the following subchapters:

- **Subchapter A, Basis and Scope**
  - Amend §19.1

- **Subchapter B, Definitions**
  - Amend §19.101

- **Subchapter E, Resident Rights**
  - Repeal §19.412, §19.414 and §19.418
  - Add §19.424 (Relating to Environment) and §19.425 (Relating to Communication)

- **Subchapter F, Admission, Transfer and Discharge Rights in Medicaid-Certified Facilities**

- **Subchapter G, Resident Behavior and Facility Practice**
  - Rename Subchapter G to: Freedom from Abuse, Neglect and Exploitation

- **Subchapter H, Quality of Life**
  - Repeal §19.705

- **Subchapter I, Resident Assessment**
  - Amend §79.801, §19.802 and §19.803

- **Subchapter J, Quality of Care**
  - Amend §19.901

- **Subchapter K, Nursing Services**
  - Amend §19.1001 and §19.1010

- **Subchapter L, Dietary Services**
  - Repeal §19.1103
  - Add §19.1116 (Relating to Therapeutic Diets)

- **Subchapter M, Physician Services**

- **Subchapter O, Dental Services**
  - Amend §19.1401

- **Subchapter P, Pharmacy Services**
  - Amend §19.1501

- **Subchapter Q, Infection Control**
Draft Amendments to the Texas Administrative Code, Title 40, Chapter 19

Nursing Facility Requirements for Licensure and Medicaid Certification

TITLE 40    SOCIAL SERVICES AND ASSISTANCE
PART 1    DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 19   NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION
SUBCHAPTER B  BASIS AND SCOPE

§19.1. Basis and Scope.

(a) Basis in legislation. The Nursing Facility Requirements for Licensure and Medicaid Certification implement the [specify] requirements of federal and state laws and regulations governing licensed nursing facilities and nursing facilities participating in the Medicaid program [the Title XIX Nursing Facilities vendor program] administered by HHSC [the Texas Department of Human Services (DHS)] in cooperation with other federal and state agencies. If there is a conflict between material in these requirements and the laws or regulations governing the Medicaid program, the Medicaid laws and regulations [latter] are controlling. It is the intent of the Texas Legislature that rules adopted under Chapter 242 [§242] of the Texas Health and Safety Code may be more stringent than [that] the standards imposed by federal law for certification for participation in the state Medicaid program. The rules and standards may not be less stringent than the Medicaid certification standards imposed under the Omnibus Budget Reconciliation Act of 1987.

(b) Scope. The Nursing Facility Requirements for Licensure and Medicaid Certification contain the requirements that an institution must meet in order to be licensed as a nursing facility and also to qualify to participate in the Medicaid program. The requirements serve as a basis for survey activities for licensure and certification.

(1) Certain requirements are specific to Medicaid-certified facilities and are so designated. The Medicaid-specific requirements apply to all residents, including [but not limited to] private
pay, Medicaid applicants and recipients, Veteran’s Administration [VA] patients, and Medicare recipients, who are admitted to and reside in a Medicaid-certified facility or a Medicaid-certified distinct part of a facility.

(2) Additional requirements [Requirements] for facilities or distinct parts of facilities that are certified for Medicare-only participation are in Title [Chapter] 42, Code of Federal Regulations, §§483.5-483.95 [483.75].

(3) These requirements do not apply to skilled nursing facilities [SNFs] licensed under the Texas Health and Safety Code, Chapter 241, participating only in the Medicare program.

(4) Additional documents that a facility may need for reference include, but are not limited to:

(A) Medication Aide Rules (DHS);

(B) Nurse Aide Training Rules (DHS);

(C) Nurse Aide Training Manual (DHS);

(D) Occupational Safety and Health Administration (OSHA) rules and guidelines;

(E) rules and regulations for the Control of Communicable Diseases (TDH);

(F) Medical Waste Regulation in Texas (Publication RG-1, Texas Natural Resource Conservation Commission);

(G) Nurse Practice Act and Licensed Vocational Nurse Act;

(H) Food Establishment Rules (TDH);

(I) Centers for Disease Control:

(i) Handwashing Guidelines;

(ii) Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health-Care and Public Safety Workers;

(iii) Guidelines for Isolation Precautions in Hospitals and Infection Control in Hospital Personnel;

(iv) Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures; and

(v) Prevention and Control of Tuberculosis in Facilities Providing Long-Term Care to the Elderly;]

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Abuse—Negligent or willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical or emotional harm or pain to a resident; or sexual abuse, including involuntary or nonconsensual sexual conduct that would constitute an offense under Penal Code §21.08 (indecent exposure) or Penal Code Chapter 22 (assaultive offenses), sexual harassment, sexual coercion, or sexual assault.

(2) Act—Chapter 242 of the Texas Health and Safety Code.

(3) Activities assessment—See Comprehensive Assessment and Comprehensive Care Plan.

(4) Activity [Activities] director—The qualified individual appointed by the facility to direct the activities program as described in §19.702 of this chapter (relating to Activities).

(5) Addition—The addition of floor space to an institution.

(6) Administrator—A person currently licensed in accordance with Chapter 18 of this title (relating to Nursing Facility Administrators) [Licensed nursing facility administrator].

(7) Admission MDS assessment—An MDS assessment that determines a recipient’s initial determination of eligibility for medical necessity for admission into the Texas Medicaid Nursing Facility Program.

(8) Advanced practice registered nurse—A person licensed by the Texas Board of Nursing as an advanced practice registered nurse.

(9) Adverse event—An untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk of death or serious injury.
(9) Affiliate—With respect to a:

[(A) partnership, each partner thereof;]

[(B) corporation, each officer, director, principal stockholder, and subsidiary; and each person with a disclosable interest;]

[(C) natural person, which includes each:]

[(i) person’s spouse;]

[(ii) partnership and each partner thereof of which said person or any affiliate of said person is a partner; and]

[(iii) corporation in which said person is an officer, director, principal stockholder, or person with a disclosable interest.]

(10) Agent—An adult to whom authority to make health care decisions is delegated under a durable power of attorney for health care.

(11) Alzheimer’s disease and related disorders—Alzheimer’s disease and any other irreversible dementia described by the Centers for Disease Control and Prevention or the most current edition of the Diagnostic and Statistical Manual of Mental Disorders.

(12) Applicant—A person or governmental unit, as those terms are defined in the Texas Health and Safety Code, Chapter 242, applying for a license under that chapter.


(14) Attending physician—A physician, currently licensed by the Texas Medical Board, who is designated by the resident or responsible party as having primary responsibility for the treatment and care of the resident.

(15) Authorized electronic monitoring—The placement of an electronic monitoring device in a resident’s room and using the device to make tapes or recordings after making a request to the facility to allow electronic monitoring.

(16) Barrier precautions—Precautions including the use of gloves, masks, gowns, resuscitation equipment, eye protectors, aprons, face shields, and protective clothing for purposes of infection control.

(17) Care and treatment—Services required to maximize resident independence, personal choice, participation, health, self-care, psychosocial functioning and reasonable safety, all consistent with the preferences of the resident.

(18) Certification—The determination by DADS that a nursing facility meets all the
requirements of the Medicaid or Medicare programs.

(XX) Certified facility--A facility that meets the requirements of the Medicare program, the Medicaid program, or both.

(19) Change of ownership--An event that occurs when a facility’s license holder has a different federal taxpayer identification number than the prospective license holder’s federal taxpayer identification number, except that the substitution of a personal representative for a deceased license holder is not a change of ownership.

(XX) Chemical restraints--Psychoactive drugs administered for the purpose of discipline or convenience, and not required to treat the resident's medical symptoms.


(21) CMS--Centers for Medicare & Medicaid Services, formerly the Health Care Financing Administration (HCFA).

(22) Complaint--Any allegation received by DADS other than an incident reported by the facility. Such allegations include, but are not limited to, abuse, neglect, exploitation, or violation of state or federal standards.

(23) Completion date--The date an RN assessment coordinator signs an MDS assessment as complete.

(24) Comprehensive assessment--An interdisciplinary description of a resident’s needs and capabilities including daily life functions and significant impairments of functional capacity, as described in §19.801(2) of this chapter (relating to Resident Assessment).

(25) Comprehensive care plan--A plan of care prepared by an interdisciplinary team that includes measurable short-term and long-term objectives and timetables to meet the resident’s needs developed for each resident after admission. The plan addresses at least the following needs: medical, nursing, rehabilitative, psychosocial, dietary, activity, and resident’s rights. The plan includes strategies developed by the team, as described in §19.802(b)(2) of this chapter (relating to Comprehensive Care Plans), consistent with the physician’s prescribed plan of care, to assist the resident in eliminating, managing, or alleviating health or psychosocial problems identified through assessment. Planning includes:

(A) goal setting;

(B) establishing priorities for management of care;

(C) making decisions about specific measures to be used to resolve the resident’s problems; and

(D) assisting in the development of appropriate coping mechanisms.

(27) Controlling person--A person with the ability, acting alone or in concert with others, to directly or indirectly, influence, direct, or cause the direction of the management, expenditure of money, or policies of a nursing facility or other person. A controlling person does not include a person, such as an employee, lender, secured creditor, or landlord, who does not exercise any influence or control, whether formal or actual, over the operation of a facility. A controlling person includes:

(A) a management company, landlord, or other business entity that operates or contracts with others for the operation of a nursing facility;

(B) any person who is a controlling person of a management company or other business entity that operates a nursing facility or that contracts with another person for the operation of a nursing facility;

(C) an officer or director of a publicly traded corporation that is, or that controls, a facility, management company, or other business entity described in subparagraph (A) of this paragraph but does not include a shareholder or lender of the publicly traded corporation; and

(D) any other individual who, because of a personal, familial, or other relationship with the owner, manager, landlord, tenant, or provider of a nursing facility, is in a position of actual control or authority with respect to the nursing facility, without regard to whether the individual is formally named as an owner, manager, director, officer, provider, consultant, contractor, or employee of the facility.

(28) Covert electronic monitoring--The placement and use of an electronic monitoring device that is not open and obvious, and the facility and DADS have not been informed about the device by the resident, by a person who placed the device in the room, or by a person who uses the device.

(29) DADS--The Department of Aging and Disability Services or the Health and Human Services Commission, as its successor agency.

[(30) Dangerous drugs--Any drug as defined in the Texas Health and Safety Code, Chapter 483.]

(31) Dentist--A practitioner licensed to practice dentistry by the Texas State Board of Dental Examiners.

[(32) Department--The Department of Aging and Disability Services or the Health and Human Services Commission, as its successor agency.]
(33) DHS--This term referred to the Texas Department of Human Services; it now refers to HHSC [DADS, unless the context concerns an administrative hearing. Administrative hearings were formerly the responsibility of DHS; they now are the responsibility of the Texas Health and Human Services Commission (HHSC)].

(34) Dietitian--A qualified dietitian is one who is qualified based upon either:

(A) registration by the Commission on Dietetic Registration of the Academy of Nutrition and Dietetics; or

(B) licensure, or provisional licensure as a dietitian under Chapter 701 of the Texas Occupations Code, and [by the Texas State Board of Examiners of Dietitians. These individuals must have] one year of supervisory experience in dietetic service of a health care facility.

(35) Direct care by licensed nurses--Direct care consonant with the physician’s planned regimen of total resident care includes:

[(A) assessment of the resident’s health care status;]

[(B) planning for the resident’s care;]

[(C) assignment of duties to achieve the resident’s care;]

[(D) nursing intervention; and]

[(E) evaluation and change of approaches as necessary.]

(36) Direct ownership interest--Ownership of equity in the capital, stock, or profits of, or a membership interest in, an applicant or license holder.

(37) Disclosable interest--Five percent or more direct or indirect ownership interest in an applicant or license holder.

(38) Distinct part--That portion of a facility certified to participate in the Medicaid Nursing Facility program or as a SNF in the Medicare program.

(39) Drug (also referred to as medication)--Any of the following:

(A) any substance recognized as a drug in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them;

(B) any substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans [man];

(C) any substance (other than food) intended to affect the structure or any function of the
body of a human [man]; and

(D) any substance intended for use as a component of any substance specified in subparagraphs (A) - (C) of this paragraph. It does not include devices or their components, parts, or accessories.

(40) Electronic monitoring device--Video surveillance cameras and audio devices installed in a resident’s room, designed to acquire communications or other sounds that occur in the room. An electronic, mechanical, or other device used specifically for the nonconsensual interception of wire or electronic communication is excluded from this definition.

(41) Emergency--A sudden change in a resident’s condition requiring immediate medical intervention.

(42) Executive Commissioner--The executive commissioner of the Health and Human Services Commission.

(43) Exploitation--The illegal or improper act or process of a caregiver, family member, or other individual who has an ongoing relationship with a resident using the resources of the resident for monetary or personal benefit, profit, or gain without the informed consent of the resident.

[(44) Exposure (infections)--The direct contact of blood or other potentially infectious materials of one person with the skin or mucous membranes of another person. Other potentially infectious materials include the following human body fluids: semen, vaginal secretions, cerebrospinal fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, and body fluid that is visibly contaminated with blood and all body fluids when it is difficult or impossible to differentiate between body fluids.]

(45) Facility--Unless otherwise indicated, a facility is an institution that provides organized and structured nursing care and service and is subject to licensure under Texas Health and Safety Code, Chapter 242.

(A) For Medicaid, a facility is a nursing facility which meets the requirements of §1919(a) - (d) of the Social Security Act. A facility may not include any institution that is for the care and treatment of mental diseases except for services furnished to individuals age 65 and over and who are eligible as defined in Chapter 17 of this title (relating to Preadmission Screening and Resident Review (PASRR)).

(B) For Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the "facility" is always the entity which participates in the program, whether that entity is comprised of all of, or a distinct part of, a larger institution.

(C) "Facility" is also referred to as a nursing home or nursing facility. Depending on context, these terms are used to represent the management, administrator, or other persons or groups involved in the provision of care of the resident; or to represent the physical building,
which may consist of one or more floors or one or more units, or which may be a distinct part of a licensed hospital.

(46) Family council--A group of family members, friends, or legal guardians of residents, who organize and meet privately or openly.

(47) Family representative--An individual appointed by the resident to represent the resident and other family members, by formal or informal arrangement.

(48) Fiduciary agent--An individual who holds in trust another’s monies.

[(49) Free choice--Unrestricted right to choose a qualified provider of services.]

(50) Goals--Long-term: general statements of desired outcomes. Short-term: measurable time-limited, expected results that provide the means to evaluate the resident’s progress toward achieving long-term goals.

(51) Governmental unit--A state or a political subdivision of the state, including a county or municipality.

(52) HCFA--Health Care Financing Administration, now the Centers for Medicare & Medicaid Services (CMS).

(53) Health care provider--An individual, including a physician, or facility licensed, certified, or otherwise authorized to administer health care, in the ordinary course of business or professional practice.

(54) Hearing--A contested case hearing held in accordance with the Administrative Procedure Act, Texas Government Code, Chapter 2001, and the formal hearing procedures in 1 TAC Chapter 357, Subchapter I (relating to Hearings Under the Administrative Procedure Act) and Chapter 91 of this title (relating to Hearings Under the Administrative Procedure Act).

(XX) HHSC--Texas Health and Human Services Commission, or its designee.

(55) HIV--Human Immunodeficiency Virus.

(56) Incident--An abnormal event, including accidents or injury to staff or residents, which is documented in facility reports. An occurrence in which a resident may have been subject to abuse, neglect, or exploitation must also be reported to DADS.

(57) Indirect ownership interest--Any ownership or membership interest in a person that has a direct ownership interest in an applicant or license holder.

(58) Infection control--A program designed to prevent the transmission of disease and infection in order to provide a safe and sanitary environment.
(59) Inspection--Any on-site visit to or survey of an institution by DADS for the purpose of licensing, monitoring, complaint investigation, architectural review, or similar purpose.

[(60) Interdisciplinary care plan--See the definition of "comprehensive care plan."]

(61) Involuntary seclusion--Separation of a resident from others or from the resident’s room or confinement to the resident’s room, against the resident’s will or the will of a person who is legally authorized to act on behalf of the resident. Monitored separation from other residents is not involuntary seclusion if the separation is a therapeutic intervention that uses the least restrictive approach for the minimum amount of time, not exceed to 24 hours, until professional staff can develop a plan of care to meet the resident’s needs.

(62) IV--Intravenous.

(63) Legend drug or prescription drug--Any drug that requires a written or telephonic order of a practitioner before it may be dispensed by a pharmacist, or that may be delivered to a particular resident by a practitioner in the course of the practitioner’s practice.

(64) License holder--A person that holds a license to operate a facility.

(65) Licensed health professional--A physician; physician assistant; advanced practice registered nurse; physical, speech, or occupational therapist; pharmacist; physical or occupational therapy assistant; registered professional nurse; licensed vocational nurse; licensed dietitian; [or] licensed social worker; or certified respiratory care practitioner.

[(66) Licensed nursing home (facility) administrator--A person currently licensed by DADS in accordance with Chapter 18 of this title (relating to Nursing Facility Administrators).]

(67) Licensed vocational nurse (LVN)--A nurse who is currently licensed by the Texas Board of Nursing as a licensed vocational nurse.


(69) Life safety features--Fire safety components required by the Life Safety Code, including, but not limited to, building construction, fire alarm systems, smoke detection systems, interior finishes, sizes and thicknesses of doors, exits, emergency electrical systems, and sprinkler systems.

(70) Life support--Use of any technique, therapy, or device to assist in sustaining life. (See §19.419 of this chapter (relating to Advance Directives)).

(71) Local authorities--Persons, including, but not limited to, local health authority, fire marshal, and building inspector, who may be authorized by state law, county order, or municipal ordinance to perform certain inspections or certifications.
(72) Local health authority--The physician appointed by the governing body of a municipality or the commissioner’s court of the county to administer state and local laws relating to public health in the municipality’s or county’s jurisdiction as defined in Texas Health and Safety Code, §121.021.

(73) Long-term care-regulatory--DADS Regulatory Services Division, which is responsible for surveying nursing facilities to determine compliance with regulations for licensure and certification for Title XIX participation.

(74) Manager--A person, other than a licensed nursing home administrator, having a contractual relationship to provide management services to a facility.

(75) Management services--Services provided under contract between the owner of a facility and a person to provide for the operation of a facility, including administration, staffing, maintenance, or delivery of resident services. Management services do not include contracts solely for maintenance, laundry, or food service.

(76) MDS--Minimum data set. See Resident Assessment Instrument (RAI).

(77) MDS nurse reviewer--A registered nurse employed by HHSC to monitor the accuracy of the MDS assessment submitted by a Medicaid-certified nursing facility.

(78) Medicaid applicant--A person who requests the determination of eligibility to become a Medicaid recipient.

(79) Medicaid nursing facility vendor payment system--Electronic billing and payment system for reimbursement to nursing facilities for services provided to eligible Medicaid recipients.

(80) Medicaid recipient--A person who meets the eligibility requirements of the Title XIX Medicaid program, is eligible for nursing facility services, and resides in a Medicaid-participating facility.

(81) Medical director--A physician licensed by the Texas Medical Board, who is engaged by the nursing home to assist in and advise regarding the provision of nursing and health care.

(82) Medical power of attorney--The legal document that designates an agent to make treatment decisions if the individual designator becomes incapable.

[(83) Medical-social care plan--See Interdisciplinary Care Plan.]

[(84) Medically related condition--An organic, debilitating disease or health disorder that requires services provided in a nursing facility, under the supervision of licensed nurses.]

(85) Medication aide--A person who holds a current permit issued under the Medication Aide Training Program as described in Chapter 95 of this title (relating to Medication Aides--Program
Requirements) and acts under the authority of a person who holds a current license under state law which authorizes the licensee to administer medication.

(86) Misappropriation [of funds]--The taking, secretion, misapplication, deprivation, transfer, or attempted transfer to any person not entitled to receive any property, real or personal, or anything of value belonging to or under the legal control of a resident without the effective consent of the resident or other appropriate legal authority, or the taking of any action contrary to any duty imposed by federal or state law prescribing conduct relating to the custody or disposition of property of a resident.

(87) MN--Medical necessity. A determination, made by physicians and registered nurses who are employed by or contract with the state Medicaid claims administrator, that a recipient requires the services of a licensed nurse in an institutional setting to carry out a physician's planned regimen for total care. A recipient's need for custodial care in a 24-hour institutional setting does not constitute medical necessity.

(88) Neglect--The failure to provide goods or services, including medical services that are necessary to avoid physical or emotional harm, pain, or mental illness.

[(89) NHIC--This term referred to the National Heritage Insurance Corporation. It now refers to the state Medicaid claims administrator.]

[(90) Nonnursing personnel--Persons not assigned to give direct personal care to residents; including administrators, secretaries, activities directors, bookkeepers, cooks, janitors, maids, laundry workers, and yard maintenance workers.]

(91) Nurse aide--An individual who provides nursing or nursing-related services to residents in a facility under the supervision of a licensed nurse. This definition does not include an individual who is a licensed health professional, a registered dietitian, or someone who volunteers such services without pay. A nurse aide is not authorized to provide nursing or nursing-related services for which a license or registration is required under state law. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants.

[(92) Nurse aide trainee--An individual who is attending a program teaching nurse aide skills.]

(93) Nurse practitioner--An advanced practice registered nurse.

[(94) Nursing assessment--See definition of "comprehensive assessment" and "comprehensive care plan."

(95) Nursing care--Services provided by nursing personnel which include, but are not limited to, observation; promotion and maintenance of health; prevention of illness and disability; management of health care during acute and chronic phases of illness; guidance and counseling of individuals and families; and referral to physicians, other health care providers, and
community resources when appropriate.

(96) Nursing facility or nursing home [facility/home]--See definition of “facility.” [An institution that provides organized and structured nursing care and service, and is subject to licensure under Texas Health and Safety Code, Chapter 242. The nursing facility may also be certified to participate in the Medicaid Title XIX program. Depending on context, these terms are used to represent the management, administrator, or other persons or groups involved in the provision of care to the residents; or to represent the physical building, which may consist of one or more floors or one or more units, or which may be a distinct part of a licensed hospital.]

([97] Nursing facility/home administrator--See the definition of "licensed nursing home (facility) administrator."]

(98) Nursing personnel--Persons assigned to give direct personal and nursing services to residents, including registered nurses, licensed vocational nurses, nurse aides, and medication aides. Unlicensed personnel function under the authority of licensed personnel.

(99) Objectives--See definition of "goals."

(100) OBRA--Omnibus Budget Reconciliation Act of 1987, which includes provisions relating to nursing home reform, as amended.

(101) Ombudsman--An advocate who is a certified representative, staff member, or volunteer of the DADS Office of the State Long Term Care Ombudsman.

([102] Optometrist--An individual with the profession of examining the eyes for defects of refraction and prescribing lenses for correction who is licensed by the Texas Optometry Board.]

(103) Paid feeding assistant--An individual who meets the requirements of §19.1113 of this chapter (relating to Paid Feeding Assistants) and who is paid to feed residents by a facility or who is used under an arrangement with another agency or organization.

(104) PASARR or PASRR--Preadmission Screening and Resident Review.

(105) Palliative Plan of Care--Appropriate medical and nursing care for residents with advanced and progressive diseases for whom the focus of care is controlling pain and symptoms while maintaining optimum quality of life.

(106) Patient care-related electrical appliance--An electrical appliance that is intended to be used for diagnostic, therapeutic, or monitoring purposes in a patient care area, as defined in Standard 99 of the National Fire Protection Association.

(107) Person--An individual, firm, partnership, corporation, association, joint stock company, limited partnership, limited liability company, or any other legal entity, including a legal successor of those entities.
(XX) Person-centered care--To focus on the resident as the locus of control, and to support the resident in making his own choices and having control over his daily life.

(108) Pharmacist--An individual, licensed by the Texas State Board of Pharmacy to practice pharmacy, who prepares and dispenses medications prescribed by a practitioner.

(109) Physical restraint--Any manual method, or physical or mechanical device, material or equipment attached, or adjacent to the resident's body, that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The term includes a restraint hold. [See Restraints (physical).]

(110) Physician--A doctor of medicine or osteopathy currently licensed by the Texas Medical Board to practice medicine.

(111) Physician assistant (PA)--

(A) A graduate of a physician assistant training program who is accredited by the Committee on Allied Health Education and Accreditation of the Council on Medical Education of the American Medical Association;

(B) A person who has passed the examination given by the National Commission on Certification of Physician Assistants. According to federal requirements (42 CFR §491.2) a physician assistant is a person who meets the applicable state requirements governing the qualifications for assistant to primary care physicians, and who meets at least one of the following conditions:

(i) is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or

(ii) has satisfactorily completed a program for preparing physician assistants that:

(I) was at least one academic year in length;

(II) consisted of supervised clinical practice and at least four months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and

(III) was accredited by the American Medical Association’s Committee on Allied Health Education and Accreditation; or

(C) A person who has satisfactorily completed a formal educational program for preparing physician assistants who does not meet the requirements of paragraph (d)(2), 42 CFR §491.2, and has been assisting primary care physicians for a total of 12 months during the 18-month period immediately preceding July 14, 1978.

(112) Podiatrist--A practitioner whose profession encompasses the care and treatment of feet who is licensed to practice podiatry by the Texas State Board of Podiatric Medical Examiners.
(113) Poison--Any substance that federal or state regulations require the manufacturer to label as a poison and is to be used externally by the consumer from the original manufacturer’s container. Drugs to be taken internally that contain the manufacturer’s poison label, but are dispensed by a pharmacist only by or on the prescription order of a practitioner, are not considered a poison, unless regulations specifically require poison labeling by the pharmacist.

(114) Practitioner--A physician, podiatrist, dentist, or an advanced practice registered nurse or physician assistant to whom a physician has delegated authority to sign a prescription order, when relating to pharmacy services.

(115) PRN (pro re nata)--As needed.

(116) Provider--The individual or legal business entity that is contractually responsible for providing Medicaid services under an agreement with DADS.

(117) Psychoactive drugs--Drugs prescribed to control mood, mental status, or behavior.

(XX) QAPI--Quality Assurance and Performance Improvement.

(118) Qualified mental health professional - community services--Has the meaning given in 25 TAC §412.303 (relating to Definitions).

(119) Qualified surveyor--An employee of DADS who has completed state and federal training on the survey process and passed a federal standardized exam.

(120) Quality assessment and assurance committee--A group of health care professionals in a facility who develop and implement appropriate action to identify and rectify substandard care and deficient facility practice.

(121) Quality-of-care monitor--A registered nurse, pharmacist, or dietitian employed by DADS who is trained and experienced in long-term care facility regulation, standards of practice in long-term care, and evaluation of resident care, and functions independently of DADS Regulatory Services Division.

(122) Quality measure report--A report that provides information derived from an MDS that provides a numeric value to quality indicators. This data is available to the public as part of the Nursing Home Quality Initiative (NHQI), and is intended to provide objective measures for consumers to make informed decisions about the quality of care in a nursing facility.

(123) RAI--Resident assessment instrument. An assessment tool used to conduct comprehensive, accurate, standardized, and reproducible assessments of each resident's functional capacity as specified by the Secretary of the U.S. Department of Health and Human Services. At a minimum, this instrument must consist of the MDS core elements specified by CMS, utilization guidelines, and Care Area Assessment process.

(124) Recipient--Any individual residing in a Medicaid certified facility or a Medicaid
certified distinct part of a facility whose daily vendor rate is paid by Medicaid.

(125) Rehabilitative services--Rehabilitative therapies and devices provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition. The term includes physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services.

[(126) Reimbursement methodology--The method by which HHSC determines nursing facility per diem rates.]

(127) Remodeling--The construction, removal, or relocation of walls and partitions, the construction of foundations, floors, or ceiling-roof assemblies, the expanding or altering of safety systems (including, but not limited to, sprinkler, fire alarm, and emergency systems) or the conversion of space in a facility to a different use.

(128) Renovations [Renovation]--The restoration to a former better state by cleaning, repairing, or rebuilding, including, but not limited to, routine maintenance, repairs, equipment replacement, painting.

(129) Representative payee--A person designated by the Social Security Administration to receive and disburse benefits, act in the best interest of the beneficiary, and ensure that benefits will be used according to the beneficiary's needs.

(130) Resident--Any individual residing in a nursing facility.

(131) Resident group--A group or council of residents who meet regularly to:

(A) discuss and offer suggestions about the facility policies and procedures affecting residents' care, treatment, and quality of life;

(B) plan resident activities;

(C) participate in educational activities; or

(D) for any other purpose.

(XX) Resident representative--

(A) Any of the following:

(i) an individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social, or other personal information of the resident; manage financial matters; or receive notifications:

(ii) a person authorized by state or federal law (including agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to
support the resident in decision-making; access medical, social, or other personal information of the resident; manage financial matters; or receive notifications;

(iii) legal representative, as used in Section 712 of the Older Americans Act; or

(iv) the court-appointed guardian or conservator of a resident.

(B) Nothing in this definition is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, state or federal law, or a court of competent jurisdiction.

(132) Responsible party--An individual authorized by the resident to act for him as an official delegate or agent. Responsible party is usually a family member or relative, but may be a legal guardian or other individual. Authorization may be in writing or may be given orally.

(XX) Restraint—A chemical or physical restraint.

(133) Restraint hold--

(A) A manual method, except for physical guidance or prompting of brief duration, used to restrict:

(i) free movement or normal functioning of all or a portion of a resident's body; or

(ii) normal access by a resident to a portion of the resident's body.

(B) Physical guidance or prompting of brief duration becomes a restraint if the resident resists the guidance or prompting.

[(134) Restraints (chemical)–Psychoactive drugs administered for the purposes of discipline, or convenience, and not required to treat the resident's medical symptoms.]

[(135) Restraints (physical)–Any manual method, or physical or mechanical device, material or equipment attached, or adjacent to the resident's body, that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The term includes a restraint hold.]

(136) RN--Registered nurse. An individual currently licensed by the Texas Board of Nursing as a registered nurse.

(137) RN assessment coordinator--A registered nurse who signs and certifies a comprehensive assessment of a resident's needs, using the RAI, including the MDS, as specified by DADS.

(138) RUG--Resource Utilization Group. A categorization method, consisting of 34 categories based on the MDS, that is used to determine a recipient's service and care
requirements and to determine the daily rate DADS pays a nursing facility for services provided to the recipient.

(139) Secretary--Secretary of the U.S. Department of Health and Human Services.

(140) Services required on a regular basis--Services which are provided at fixed or recurring intervals and are needed so frequently that it would be impractical to provide the services in a home or family setting. Services required on a regular basis include continuous or periodic nursing observation, assessment, and intervention in all areas of resident care.

(141) SNF--A skilled nursing facility or distinct part of a facility that participates in the Medicare program. SNF requirements apply when a certified facility is billing Medicare for a resident's per diem rate.

(142) Social Security Administration--Federal agency for administration of social security benefits. Local social security administration offices take applications for Medicare, assist beneficiaries file claims, and provide information about the Medicare program.

(143) Social worker--A qualified social worker is an individual who is licensed, or provisionally licensed, by the Texas State Board of Social Work Examiners as prescribed by the Texas Occupations Code, Chapter 505, and who has at least:

(A) a bachelor's degree in social work; or

(B) similar professional qualifications, which include a minimum educational requirement of a bachelor's degree and one year experience met by employment providing social services in a health care setting.

(144) Standards--The minimum conditions, requirements, and criteria established in this chapter with which an institution must comply to be licensed under this chapter.

(145) State Medicaid claims administrator--The entity under contract with HHSC to process Medicaid claims in Texas.

(146) State plan--A formal plan for the medical assistance program, submitted to CMS, in which the State of Texas agrees to administer the program in accordance with the provisions of the State Plan, the requirements of Titles XVIII and XIX, and all applicable federal regulations and other official issuances of the U.S. Department of Health and Human Services.

[(147) State survey agency--DADS is the agency, which through contractual agreement with CMS is responsible for Title XIX (Medicaid) survey and certification of nursing facilities.]

(148) Stay agreement--An agreement between a license holder and the executive commissioner that sets forth all requirements necessary to lift a stay and rescind a license revocation proposed under §19.2107 of this chapter (relating to Revocation of a License by the Executive Commissioner).
Substandard quality of care violation--One or more violations of §19.601 of this chapter (relating to Resident Behavior and Facility Practices), §19.701 of this chapter (relating to Quality of Life), or §19.901 of this chapter (relating to Quality of Care) that constitute:

(A) an immediate threat to resident health or safety;

(B) a pattern of or actual harm that is not an immediate threat; or

(C) a widespread potential for more than minimal harm, but less than an immediate threat, with no actual harm.

Supervising physician--A physician who assumes responsibility and legal liability for services rendered by a physician assistant (PA) and has been approved by the Texas Medical Board to supervise services rendered by specific PAs. A supervising physician may also be a physician who provides general supervision of an advanced practice registered nurse providing services in a nursing facility.

Supervision--General supervision, unless otherwise identified.

Supervision (direct)--Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his sphere of competence. If the person being supervised does not meet assistant-level qualifications specified in this chapter and in federal regulations, the supervisor must be on the premises and directly supervising.

Supervision (general)--Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his sphere of competence. The person being supervised must have access to the qualified person providing the supervision.

Supervision (intermittent)--Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his sphere of competence, with initial direction and periodic inspection of the actual act of accomplishing the function or activity. The person being supervised must have access to the qualified person providing the supervision.

Survey agency--HHSC is the agency, which through contractual agreement with CMS is responsible for Title XIX (Medicaid) survey and certification of nursing facilities.

Texas Register--A publication of the Texas Register Publications Section of the Office of the Secretary of State that contains emergency, proposed, withdrawn, and adopted rules issued by Texas state agencies. The Texas Register was established by the Administrative Procedure and Texas Register Act of 1975.

Therapeutic diet--A diet ordered by a physician as part of treatment for a disease or clinical condition, in order to eliminate, decrease, or increase certain substances in the diet or to provide food which has been altered to make it easier for the resident to eat.

Therapy week--A seven-day period beginning the first day rehabilitation therapy or
Restorative nursing care is given. All subsequent therapy weeks for a particular individual will begin on that day of the week.

158) Threatened violation--A situation that, unless immediate steps are taken to correct, may cause injury or harm to a resident's health and safety.

159) Title II--Federal Old-Age, Survivors, and Disability Insurance Benefits of the Social Security Act.


161) Title XVIII--Medicare provisions of the Social Security Act.

162) Title XIX--Medicaid provisions of the Social Security Act.

163) Total health status--Includes functional status, medical care, nursing care, nutritional status, rehabilitation and restorative potential, activities potential, cognitive status, oral health status, psychosocial status, and sensory and physical impairments.

164) UAR--HHSC's Utilization and Assessment Review Section.

165) Uniform data set--See RAI (Resident Assessment Instrument).

166) Universal precautions--The use of barrier precautions and other precautions to prevent the spread of blood-borne diseases.

167) Unreasonable confinement--Involuntary seclusion.

168) Vaccine preventable diseases--The diseases included in the most current recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

169) Vendor payment--Payment made by DADS on a daily-rate basis for services delivered to recipients in Medicaid-certified nursing facilities. Vendor payment is based on the nursing facility's approved-to-pay claim processed by the state Medicaid claims administrator. The Nursing Facility Billing Statement, subject to adjustments and corrections, is prepared from information submitted by the nursing facility, which is currently on file in the computer system as of the billing date. Vendor payment is made at periodic intervals, but not less than once per month for services rendered during the previous billing cycle.

170) Widespread--When the problem causing a violation is pervasive in a facility or represents systemic failure that affected or has the potential to affect a large portion or all of a facility's residents.

171) Working day--Any 24-hour period, Monday through Friday, excluding state and federal holidays.
§19.401. Introduction.

(a) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident’s individuality. [The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.] A facility must protect and promote the rights of each resident. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice.

(b) HHSC [The Texas Department of Human Services (DHS)] has developed the following statement of the rights of a resident.

(1) all care necessary for you to have the highest possible level of health;

(2) safe, decent and clean conditions;

(3) be free from abuse, neglect, and exploitation;

(4) be treated with courtesy, consideration, and respect;

(5) be free from discrimination based on age, race, religion, sex, nationality, or disability and to practice your own religious beliefs;
(6) privacy, including privacy during visits and telephone calls;

(7) complain about the facility and to organize or participate in any program that presents residents' concerns to the administrator of the facility;

(8) have facility information about you maintained as confidential;

(9) retain the services of a physician of your choice, at your own expense or through a health care plan, and to have a physician explain to you, in language you understand, your complete medical condition, the recommended treatment, and the expected results of the treatment, including reasonably expected effects, side effects, and risks associated with psychoactive medications;

(10) participate in developing a plan of care, to refuse treatment, and to refuse to participate in experimental research;

(11) a written statement or admission agreement describing the services provided by the facility and the related charges;

(12) manage your own finances or to delegate that responsibility to another person;

(13) access money and property you have deposited with the facility and to an accounting of your money and property that are deposited with the facility and of all financial transactions made with or on behalf of you;

(14) keep and use personal property, secure from theft or loss;

(15) not be relocated within the facility, except in accordance with nursing facility regulations;

(16) receive visitors;

(17) receive unopened mail and to receive assistance in reading or writing correspondence;

(18) participate in activities inside and outside the facility;

(19) wear your own clothes;

(20) discharge yourself from the facility unless you have been adjudicated mentally incompetent;

(21) not be discharged from the facility, except as provided in the nursing facility regulations;

(22) be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat your medical symptoms;
(23) receive information about prescribed psychoactive medication from the person who prescribes the medication or that person's designee, to have any psychoactive medications prescribed and administered in a responsible manner, as mandated by the Health and Safety Code, §242.505, and to refuse to consent to the prescription of psychoactive medications; and

(24) place an electronic monitoring device in your room that is owned and operated by you or provided by your guardian or legal representative.

Your rights may be restricted only to the extent necessary to protect you or another person from danger or harm or to protect a right of another resident, particularly those relating to privacy and confidentiality.

(c) The facility must give a copy of the Statement of Resident Rights to each resident, next of kin or guardian, and facility staff member. The facility must maintain a copy of the statement, signed by the resident or the resident's next of kin or guardian, in the facility records.

(d) The Statement of Resident Rights must be posted in accordance with §19.1921 of this title (relating to General Requirements for a Nursing Facility).


(a) The resident has the right to exercise his or her rights as a resident at the facility and as a citizen or resident of the United States.

(b) The resident has the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising his rights.

(c) In the case of a resident adjudged incompetent under the laws of the State of Texas by a court of competent jurisdiction, the rights of the resident are exercised by the resident representative appointed under Texas law to act on the resident’s behalf. The court-appointed resident representative exercises the resident’s rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.

   (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative’s authority.

   (ii) The resident’s wishes and preferences must be considered in the exercise of rights by the representative.

   (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.
In the case of a resident adjudged incompetent under the laws of the State of Texas by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under Texas law to act on the resident’s behalf.

(d) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.

(e) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.

(f) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns in the manner required under Texas law.

(gd) The facility must comply with all applicable provisions of the Human Resources Code, Title 6, Chapter 102. An individual may not be denied appropriate care on the basis of his race, religion, color, national origin, sex, age, handicap, marital status, or source of payment.

(he) The facility must allow the resident the right to observe his religious beliefs. The facility must respect the religious beliefs of the resident in accordance with 42 United States Code §1396f.

(if) Competent adults may issue directives or durable powers of attorney for health care, subject to the requirements of §19.419 of this title (relating to Directives and Durable Powers of Attorney for Health Care).

(jg) In the case of a resident who has not been adjudged incompetent by a state court, the resident has the right to designate a representative, in accordance with Texas law and any legal surrogate so designated may exercise the resident’s rights to the extent provided by Texas law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.

(i) The resident representative has the right to exercise the resident’s rights to the extent those rights are delegated to the resident representative.

(ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by Texas law.

[In the case of a resident not adjudicated incompetent by a state court, any legal surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law.]

(a) The facility must inform the resident, the resident's next of kin or guardian, both orally and in writing, in a language that the resident understands, of the resident's rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. This notification must be made prior to or upon admission and during the resident's stay if changed.

(b) The facility must also inform the resident, upon admission and during the stay, in a language the resident understands, of the following:

   (1) facility admission policies;
   
   (2) a description of the protection of personal funds as described in §19.404 of this subchapter (relating to Protection of Resident Funds);
   
   (3) the Human Resources Code, Title 6, Chapter 102; or a written list of the rights and responsibilities contained in the Human Resources Code, Title 6, Chapter 102;
   
   (4) a written description of the services available through the [DADS] HHSC Office of the State Long Term Care Ombudsman. This information must be made available to each facility by the ombudsman program. Facilities are responsible for reproducing this information and making it available to residents, their families, and [legal] representatives;
   
   (5) a written statement to the resident, the resident's next of kin, or guardian describing the facility's policy for:

       (A) the drug testing of employees who have direct contact with residents; and
       
       (B) the criminal history checks of employees and applicants for employment; and

   (6) HHSC [DADS] rules and the facility’s policies related to the use of restraint and involuntary seclusion. This information must also be given to the resident's legally authorized representative, if the resident has one.

(c) Upon admission of a resident, a facility must:

   (1) provide written information to the resident's family representative, in a language the representative understands, of the right to form a family council; or
   
   (2) inform the resident's family representative, in writing, if a family council exists, of the council's meeting time, date, location and contact person.

(d) Receipt of information in subsections (a)-(c) of this section, and any amendments to it, must be acknowledged in writing by all parties receiving the information.
(e) The facility must post a copy of the documents specified in subsections (a)-(b) of this section in a conspicuous location.

(f) The resident has the right to access personal and medical records pertaining to him or herself.

(1) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format, including in an electronic form or format when such records are maintained electronically; or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours, excluding weekends and holidays; and

(2) The facility must allow the resident to obtain a copy of the records or any portions thereof, including in an electronic form or format when such records are maintained electronically, upon request and two working days advance notice to the facility. The facility may impose a reasonable, cost based fee on the provision of copies, provided that the fee includes only the cost of:

(A) Labor for copying the records requested by the individual, whether in paper or electronic form;

(B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and

(C) Postage, when the individual has requested the copy be mailed.

(3) With the exception of information described in paragraph (f)(2) of this section and §19.409 of this title (relating to Examination of Survey Results), the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (f)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law.

[The resident or the resident's legal representative has the following rights:

(1) upon an oral or written request to the facility, to access all records pertaining to the resident, including clinical records, within 24 hours (excluding weekends and holidays); and

(2) after receipt of the resident's records for inspection, to purchase photocopies of all or any portion of the records, at a cost not to exceed the community standard, upon request and two workdays advance notice to the facility.]

(g) The resident has the right to be fully informed in language the resident understands of the resident's total health status, including the resident's medical condition.

(h) The resident has the right to refuse treatment, to formulate an advance directive (as specified in §19.419 of this subchapter (relating to Advance Directives), and to refuse to
participate in experimental research.

(1) If the resident refuses treatment, the resident must be informed of the possible consequences.

(2) If the resident chooses to participate in experimental research, the resident must be fully notified of the research and possible effects of the research. The research may be carried on only with the full written consent of the resident's physician, and the resident.

(3) Experimental research must comply with Federal Drug Administration regulations on human research as found in 45 CFR Code of Federal Regulations, Part 4b, Subpart A.

(i) The facility must inform a resident before, or at the time of admission, and periodically during the resident's stay (if there are any changes), of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. [Notice must be in writing, at least 30 days before the effective date of any changes in rates for services not covered by the current charge, or in Medicaid-certified facilities, by Medicaid.]

(1) Where changes in coverage are made to items and services covered by Medicare or Medicaid, the facility must provide notice to residents of the change as soon as is reasonably possible.

(2) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.

(3) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit of charges already paid, less the facility’s per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

(4) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident’s date of discharge from the facility.

(j) The facility must provide a written description of a resident's legal rights, which includes:

(1) a description of the manner of protecting personal funds, described in §19.404 of this subchapter (relating to Protection of Resident Funds);

(2) a posting of names, addresses, and telephone numbers of all pertinent state client advocacy groups such as HHSC [DADS], the state ombudsman program, the protection and advocacy network, and, in Medicaid-certified facilities, the Medicaid fraud control unit; and

(3) a statement that the resident may file a complaint with HHSC [DADS] concerning
any suspected violation of state or federal nursing facility regulations, including resident abuse, neglect, exploitation, and misappropriation of resident property in the facility, non-compliance with the advance directives requirements, and requests for information regarding returning to the community.

(k) The facility must inform a resident of the name, specialty, and way of contacting the physician responsible for the resident's care.

(l) Notification of changes.

(1) A facility must immediately inform the resident; consult with the resident's physician; and [if known,] notify, consistent with his or her authority, the resident['s legal representative [or an interested family member] when there is:

(A) an accident involving the resident that results in injury and has the potential for requiring physician intervention;

(B) a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) a decision to transfer or discharge the resident from the facility.

(2) The facility also must promptly notify the resident and [if known,] the resident['s legal representative, if any, [or interested family member] when there is:

(A) a change in room or roommate assignment with the reason for the change provided in writing [as described in §19.701(4)(B) of this chapter (relating to Quality of Life)]; or

(B) a change in resident rights under federal or state law or regulations as described in subsection (a) of this section.

(3) The facility must record and periodically update the address and phone number of the resident ['s family or legal representative, or a responsible party].

(m) Additional requirements for Medicaid-certified facilities. Medicaid-certified facilities must:

(1) provide the resident with the state-developed notice of rights under §1919(e)(6) of the Social Security Act;

(2) inform a resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of:
(A) the items and services that are included in nursing facility services provided under the State Plan and for which the resident may not be charged;

(B) those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services;

(3) inform each resident when changes are made to the items and services specified in paragraphs (2)(A) and (2)(B) of this subsection;

(4) provide a written description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under §1924(c) of the Social Security Act, which:

(A) is used to determine the extent of a couple's nonexempt resources at the time of institutionalization; and

(B) attributes to the community spouse an equitable share of resources that cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in the process of spending down to Medicaid eligibility levels; and

(5) prominently display in the facility written information, and provide to residents and potential residents oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive funds for previous payments covered by such benefits.

§19.405. Additional Requirements for Trust Funds in Medicaid-certified Facilities.

(a) Deposit of funds. The facility must keep funds received from a resident for holding, safeguarding, and accounting, separate from the facility's funds.

(1) This separate account must be identified "(Name of Facility), Resident's Trust Fund Account," or by a similar title that shows a fiduciary relationship exists between a resident and the facility.

(2) A facility may commingle the trust funds of Medicaid residents and private-pay residents.

(3) If the funds are commingled, the facility must provide, upon request, the following records to the HHSC [Department of Aging and Disability Services], the Texas Office of the Attorney General [attorney general's] Medicaid Fraud Control Unit, and the U.S. Department of Health and Human Services:

(A) copies of release forms signed and dated by each private-pay resident or responsible party whose funds are commingled; and
(B) legible copies of the trust fund records of private-pay residents whose funds are commingled.

(4) The facility must maintain the forms and records described in paragraph (3) of this subsection in the same manner as the financial records of Medicaid residents as specified in this section.

(5) A facility must ensure that a release form described in paragraph (3)(A) of this subsection:

(A) includes permission for the facility to maintain trust fund records of private-pay residents in the same manner as those of Medicaid residents;

(B) is obtained from a private-pay resident upon admission or at the time of request for trust fund services; and

(C) includes a provision allowing inspection of the private-pay resident's trust fund records by the agencies described in paragraph (3) of this subsection.

(b) Funds in excess of $50. The facility must deposit any residents' personal funds in excess of $50 in an interest-bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on the residents' funds to that account. In pooled accounts, there must be a separate accounting for each resident's share.

(c) Funds less than $50. The facility may maintain a resident's personal funds that do not exceed $50 in a noninterest-bearing account, interest-bearing account, or petty cash fund.

(d) Accounting and records.

(1) The facility must:

(A) establish and maintain current, written, individual records of all financial transactions involving a resident's personal funds that the facility is holding, safeguarding, and accounting;

(B) keep these records in accordance with:

(i) the American Institute of Certified Public Accountants' Generally Accepted Accounting Principles; and

(ii) the requirements of law for a fiduciary relationship; and

(C) include at least the following in these records:

(i) resident's name;

(ii) identification of resident's legally authorized representative, representative payee,
or responsible party, if any, and payor source;

(iii) valid letter of guardianship, if any;

(iv) valid power of attorney, if any;

(v) resident's admission and discharge dates;

(vi) resident's trust fund ledger containing the following:

(I) description of each transaction;

(II) the date and amount of each deposit and withdrawal;

(III) the name of the person who accepted any withdrawn funds;

(IV) the balance after each transaction; and

(V) amount of interest earned, posted at least quarterly;

(vii) receipts for purchases and payments, including cash-register tapes or sales statements from a seller;

(viii) written requests for personal funds from the trust fund account; and

(ix) written requests for specific brands, items, or services.

(2) The facility must maintain the following as general trust fund records:

(A) valid trust fund trial balance;

(B) petty cash logs;

(C) bank statements for trust fund and operating accounts;

(D) trust fund checkbook and register;

(E) trust fund account monthly reconciliations;

(F) trust fund bank account agreement form;

(G) applied income ledgers;

(H) applied income payment plans from HHSC [DADS];

(I) proof of surety bond;
(J) written agreements (e.g., bed hold, private room); and

(K) facility census, admission, discharge, and leave records.

(3) A resident must approve a withdrawal from the resident’s personal funds by signing a document that shows the resident’s approval and the date of the approval.

(4) Except as provided in subparagraph (B) of this paragraph, a facility must obtain a receipt for the purchase of an item or service.

(A) The receipt must contain:

(i) the resident’s name;

(ii) the date the receipt was written or created;

(iii) the amount of funds spent;

(iv) the specific item or service purchased;

(v) the name of the business from which the purchase was made; and

(vi) the signature of the resident.

(B) A receipt is not required if:

(i) a purchase is made with funds withdrawn in accordance with paragraph (3) of this subsection;

(ii) a purchase is made by the resident, a legally authorized representative, a responsible party, or an individual (other than facility personnel) authorized in writing by the resident; or

(iii) the item purchased costs one dollar or less.

(5) If a facility cannot obtain the signature of a resident as required by paragraph (3) or (4)(A)(vi) of this subsection, the facility must obtain the signature of a witness. The witness may not be the person responsible for accounting for the resident’s trust funds, that person’s supervisor, or the person who accepts the withdrawn funds or who sells the item being purchased. The facility and HHSC [DADS] staff must be able to identify the witness’s name, address, and relationship to the resident or facility.

(e) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits:

(1) if the amount in the resident's account reaches $200 less than SSI resource limit for one
person, specified in §1611(a)(3)(B) of the Social Security Act; and

(2) that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

(f) Conveyance of funds [upon death].

1) Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility [If a resident with personal funds managed by a facility dies], the facility must convey, within 30 days after the date of the event [resident's death], the resident's funds and a final accounting of those funds to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, or make a bona fide effort to locate the responsible party or heir to the estate [(see also §19.416 of this title (relating to Personal Property))].

2) If a facility is not able to convey funds in accordance with paragraph (1) of this subsection, the facility must, within 30 days after the resident's death;

(A) hold the funds by depositing them in a separate account or maintaining them in an existing account, designating on the account records that the resident is deceased; or

(B) submit funds to [HHSC DADS] in accordance with paragraph (4) of this subsection.

3) If the facility holds funds in accordance with paragraph (2)(A) of this subsection:

(A) the facility must provide [HHSC DADS] with a notarized affidavit that contains:

(i) the resident's name;

(ii) the amount of funds being held;

(iii) a description of the facility's efforts to locate a responsible party or heir;

(iv) a statement acknowledging that the funds are not the property of the facility, but the property of the deceased resident's estate; and

(v) a statement that the facility will hold the funds until they are conveyed to a responsible party or heir or submitted to [HHSC DADS] in accordance with paragraph (4) of this section;

(B) the facility must submit the funds to [HHSC DADS] in accordance with paragraph (4) of this subsection within 180 days after the resident's death; and

(C) funds held by a facility in accordance with this paragraph may be monitored or reviewed by [HHSC DADS] or the [Health and Human Services Commission,] Office of
Inspector General.

(4) A facility must submit unclaimed funds to HHSC [DADS], Accounts Receivable [Mail Code E-411, P.O. Box 149030, Austin Texas 78714-9030].

(A) The funds must be identified as money that will escheat to the state.

(B) If the facility held the funds in accordance with paragraph (3) of this subsection, the facility must include the notarized affidavit described in paragraph (3)(A) of this subsection.

(g) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary of Health and Human Services to ensure the security of all personal funds of residents deposited with the facility.

(1) The amount of a surety bond must equal the average monthly balance of all the facility’s resident trust fund accounts for the 12-month period preceding the bond issuance or renewal date.

(2) Resident trust fund accounts are specific only to the single facility purchasing a resident trust fund surety bond.

(3) If a facility employee is responsible for the loss of funds in a resident’s trust fund account, the resident, the resident’s family, and the resident’s legal representative are not obligated to make any payments to the facility that would have been made out of the trust fund had the loss not occurred.

(h) Items and services that may not be charged to a resident's personal funds.

(1) The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare.

(2) Items or services included in Medicare or Medicaid payment that may not be billed to the resident's personal funds by the facility include:

(A) nursing services as required in §19.1001 of this title (relating to Nursing Services);

(B) dietary services as required in §19.1101 of this title (relating to Dietary Services);

(C) an activities program as required in §19.702 of this title (relating to Activities);

(D) room and bed maintenance services;

(E) routine personal hygiene items and services as required to meet the needs of the resident, including, but not limited to:

(i) hair hygiene supplies, including shampoo, comb, and brush;
(ii) bath soaps, disinfecting soaps, or specialized cleansing agents when indicated to treat special skin problems or to fight infection;

(iii) razor and shaving cream;

(iv) toothbrush, toothpaste, and dental floss;

(v) denture adhesive and denture cleanser;

(vi) moisturizing lotion;

(vii) tissues, cotton balls, and cotton swabs;

(viii) deodorant;

(ix) incontinent care and supplies, to include, but not limited to, cloth or disposable incontinent briefs;

(x) sanitary napkins and related supplies;

(xi) towels and washcloths;

(xii) hospital gowns;

(xiii) over-the-counter drugs;

(xiv) hair and nail hygiene services; and

(xv) personal laundry; [and]

(F) medically-related social services as required in §19.703 of this title (relating to Social Services General Requirements); and

(G) hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan.

(3) A facility must base necessity for and type of incontinent brief described in paragraph (2)(E)(ix) of this subsection on an assessment of the resident's medical and psychosocial condition and resulting determination.

(i) Items and services that may be charged to a resident's personal funds. The facility may charge a resident for requested services that are more expensive than or in excess of covered services in accordance with §19.2601 of this title (relating to Vendor Payment (Items and Services Included)). The following list contains general categories and examples of items and services that the facility may charge to a resident's personal funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident’s care plan, if the facility informs
the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:

(1) telephone, including a cellular phone;

(2) television, radio, personal computer, or other electronic device for personal use;

(3) personal comfort items, including smoking materials, notions and novelties, and confections;

(4) cosmetics and grooming items and services in excess of those for which payment is made under Medicare or Medicaid;

(5) personal clothing;

(6) personal reading material;

(7) gifts purchased on behalf of a resident;

(8) flowers and plants;

(9) social events and entertainment offered outside the scope of the activities program, provided under §19.702 of this title (relating to Activities);

(10) noncovered special care services, such as privately hired nurses and aides;

(11) private room, except when therapeutically required, such as isolation for infection control;

(12) specially-prepared or alternative food requested instead of the food generally prepared by the facility, as required in §19.1101 of this title (relating to Food and Nutrition Services), except that the facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident’s physician, physician assistant, or advanced practice registered nurse, as these are included in accordance with §19.1911(b) of this title (relating to Contents of the Clinical Record); and

(13) incontinent briefs if the resident's legally authorized representative or responsible party submits a written request to the facility and the attending physician and director of nurses (DON) determine and document in the clinical record that there is no medical or psychosocial need for supplies.

(j) Request for items or services that may be charged to a resident's personal funds. The facility must:

(1) not charge a resident, nor his representative, for any item or service not requested by the resident;
(2) not require a resident, or his representative, to request any item or service as a condition of admission or continued stay; and

(3) inform the resident or his representative, when he requests an item or service for which a charge will be made, that there will be a charge for the item or service and the amount of the charge.

(k) Access to financial record. The individual financial record must be available on request to the resident, responsible party, representative payee or legal representative.

(l) Quarterly statement.

(1) The individual financial record must be available, through quarterly statements and on request, to the resident, legally authorized representative, representative payee, or responsible party.

(2) The statement must reflect any resident's funds that the facility has deposited in an account as well as any resident's funds held by the facility in a petty cash account.

(3) The statement must include at least the following:

(A) balance at the beginning of the statement period;

(B) total deposits and withdrawals;

(C) interest earned, if any;

(D) bank name and location of any account in which the resident's personal funds have been deposited; and

(E) ending balance.

(m) Banking charges.

(1) Charges for checks, deposit slips, and services for pooled checking accounts are the responsibility of the facility and may not be charged to the resident, legally authorized representative, or responsible party.

(2) Bank service charges and charges for checks and deposit slips may be deducted from the individual checking accounts if it is the resident's written, individual choice to have this type of account.

(3) Bank fees on individual accounts established solely for the convenience of the facility are the responsibility of the facility and may not be charged to the resident, legally authorized representative, or responsible party.
(4) The facility may not charge the resident, legally authorized representative, or responsible party for the administrative handling of either type of account.

(5) If the facility places any part of the resident's funds in savings accounts, certificates of deposit, or any other plan whereby interest or other benefits are accrued, the facility must distribute the interest or benefit to participating residents on an equitable basis. If pooled accounts are used, interest must be prorated on the basis of actual earnings or end-of-quarter balances.

(n) Access to funds.

(1) Disbursements from the trust fund.

   (A) A request for funds from the trust fund or trust fund petty cash box may be made, either orally or in writing, by the resident, the resident's legally authorized representative, representative payee, or responsible party to cover a resident's expenses.

   (B) The facility must respond to a request received during normal business hours at the time of the request.

   (C) The facility must respond to a request received during hours other than normal business hours immediately at the beginning of the next normal business hours.

(2) Discontinuing trust fund participation.

   (A) If a resident, legally authorized representative, or responsible party requests that the facility discontinue managing the resident's personal funds the facility must return to the resident, legally authorized representative, or responsible party all of the resident's personal funds held by the facility, including any interest accrued.

   (B) If the request is made during normal business hours, the facility must immediately return the funds.

   (C) If the request is made during hours other than normal business hours, the facility must return the funds immediately during the next normal business hours.

(3) Transfer or discharge. If a resident is transferred or discharged from a facility, the facility must, within five working days after the transfer or discharge, return to the resident, legally authorized representative, or responsible party all of the resident's personal funds held by the facility, including any interest accrued.

(4) For purposes of this subsection, normal business hours are 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding national holidays.

(o) Handling of monthly benefits. If the Social Security Administration has determined that a Title II and Title XVI Supplemental Security Income (SSI) benefit to which the resident is

(p) Change of ownership. If the ownership of a facility changes, the former owner must transfer the bank balances or trust funds to the new owner with a list of the residents and their balances. The former owner must get a receipt from the new owner for the transfer of these funds. The former owner must keep this receipt for monitoring or audit purposes.

(q) Alternate forms of documentation. Without HHSC’s [DADS] prior written approval, a facility may not submit alternate forms of documentation, including affidavits, to verify a resident's personal fund expenditures or as proof of compliance with any requirements specified in these requirements for the resident's personal funds.

(r) Limitation on certain charges. A nursing facility may not impose charges for certain Medicaid-eligible individuals, for nursing facility services that exceed the per diem amount established by HHSC [DADS] for such services. "Certain Medicaid-eligible individuals" means an individual who is entitled to medical assistance for nursing facility services, but for whom such benefits are not being paid because, in determining the individual's income to be applied monthly to the payment for the costs of nursing facility services, the amount of such income exceeds the payment amounts established by HHSC [DADS].

(s) Trust fund monitoring and audits.

(1) HHSC [DADS] may periodically monitor all trust fund accounts to assure compliance with this section. HHSC [DADS] notifies a facility of monitoring plans and gives a report of the findings to the facility.

(2) HHSC [DADS] may, as a result of monitoring, refer a facility to the Office of Inspector General (OIG) for an audit.

(3) The facility must provide all records and other documents required by subsection (d) of this section to HHSC [DADS] upon request.

(4) HHSC [DADS] provides the facility with a report of the findings, which may include corrective actions that the facility must take and internal control recommendations that the facility may follow.

(5) The facility may request an informal review in accordance with subsection (t) of this section or a formal hearing in accordance with subsection (u) of this section to dispute the report of findings.

(6) If the facility does not request an informal review or a formal hearing and the report of findings requires corrective actions, the facility must complete corrective actions within 60 days after receiving the report of findings.
(7) If the facility does not complete corrective actions required by HHSC [DADS] within 60 days after receiving the report of findings, HHSC [DADS] may impose a vendor hold on payments due to the facility under the provider agreement until the facility completes corrective actions.

(8) If HHSC [DADS] imposes a vendor hold in accordance with paragraph (7) of this subsection, the facility may request a formal hearing in accordance with subsection (u)(5) of this section. If the failure to correct is upheld, HHSC [DADS] continues the vendor hold until the facility completes the corrective actions.

(t) Informal review.

(1) A facility that disputes the report of findings described in subsection (s)(4) of this section may request an informal review under this section. The purpose of an informal review is to provide for the informal and efficient resolution of the matters in dispute and is conducted according to the following procedures:

(A) HHSC [DADS] must receive a written request for an informal review by United States (U.S.) mail, hand delivery, special mail delivery, or fax no later than 15 days after the date on the written notification of the report of findings described in subsection (s)(4) of this section. If the 15th day is a Saturday, Sunday, national holiday, or state holiday, then the first day following the 15th day is the final day the written request will be accepted. A request for an informal review that is not received by the stated deadline is not granted.

(B) A facility must submit a written request for an informal review [:(i) by U.S. mail] to the HHSC [DADS] Trust Fund Monitoring Unit, [Attn: Manager, P.O. Box 149030, Mail Code W-340, Austin, Texas 78714-9030;]

[(ii) hand delivery or special mail delivery to 701 West 51st Street, Austin, Texas 78751-2321; or]

[(iii) by fax to (512) 438-3639.]

(C) A facility must, with its request for an informal review:

(i) submit a concise statement of the specific findings it disputes;

(ii) specify the procedures or rules that were not followed;

(iii) identify the affected cases;

(iv) describe the reason the findings are being disputed; and

(v) include supporting information and documentation that directly demonstrates that each disputed finding is not correct.
(D) HHSC [DADS] does not grant a request for an informal review that does not meet the requirements of this subsection.

(2) Informal review process. Upon receipt of a request for an informal review, the Trust Fund Monitoring Unit Manager coordinates the review of the information submitted.

(A) Additional information may be requested by HHSC [DADS], and must be received in writing by U.S. mail, hand delivery, special mail, or fax in accordance with paragraph (1)(B)(i)-(iii) of this subsection no later than 15 days after the date the facility receives the written request for additional information. If the 15th day is a Saturday, Sunday, national holiday, or state holiday, then the first day following the 15th day is the final day the additional information will be accepted.

(B) HHSC [DADS] sends its written decision to the facility by certified mail, return receipt requested.

(i) If the original findings are upheld, HHSC [DADS] continues the schedule of deficiencies and requirement for corrective action.

(ii) If the original findings are reversed, HHSC [DADS] issues a corrected schedule of deficiencies with the written decision.

(iii) If the original findings are revised, HHSC [DADS] issues a revised schedule of deficiencies including any revised corrective action.

(iv) If the original findings are upheld or revised, the facility may request a formal hearing in accordance with subsection (u) of this section.

(v) If the original findings are upheld or revised and the facility does not request a formal hearing, the facility has 60 days from the date of receipt of the written decision to complete the corrective actions. If the facility does not complete the corrective actions by that date, HHSC [DADS] may impose a vendor hold. If HHSC [DADS] imposes a vendor hold, the facility may request a formal hearing in accordance with subsection (u)(5) of this section. If the failure to correct is upheld, HHSC [DADS] continues the vendor hold until the facility completes the corrective action.

(u) Formal hearing.

(1) The facility must submit a written request for a formal hearing under this section to [.: the HHSC Appeals Division [Mail Code W-613, P.O. Box 149030, Austin, Texas 78714-9030].

(2) The written request for a formal hearing must be received within 15 days after:

(A) the date on the written notification of the report of findings described in subsection (s)(4) of this section; or
(B) the facility receives the written decision sent as described in subsection (t)(2)(B) of this section.

(3) A formal hearing is conducted in accordance with Texas Administrative Code, Title 1, Chapter 357, Subchapter I (relating to Hearings Under the Administrative Procedure Act).

(4) No later than 60 days after a final determination is issued as a result of a formal hearing requested by a facility under subsection (s)(8) or (t)(2)(B)(iv) of this section, the facility must complete any corrective action required by HHSC [DADS] or be subject to a vendor hold on payments due to the facility under the provider agreement until the facility completes corrective action. If HHSC [DADS] imposes a vendor hold, the facility may request a formal hearing in accordance with paragraph (5) of this subsection. If the failure to correct is upheld, HHSC [DADS] continues the vendor hold until the facility completes the corrective action.

(5) If HHSC [DADS] imposes a vendor hold under subsections (s)(7), (t)(2)(B)(v), or (u)(4) of this section, the facility may request a formal hearing within 15 days after receiving notice of the correction failure and the vendor hold. The formal hearing is limited to the issue of whether the facility completed the corrective action.


(a) The resident has the right to choose and retain a personal attending physician.

(1) The physician must be licensed to practice, and

(2) If the physician chosen by the resident refuses to or does not meet requirements specified in this title, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment.

(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.

(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident’s preferences, if any, among options.

(5) If the resident subsequently selects another attending physician who meets the requirements specified in this title, the facility must honor that choice.

(b) The resident has the right to be informed of, and participate in, his or her treatment, including:
(1) the right to be fully informed in language that he or she can understand of his or her total health status, including his or her medical condition;

(2) the right to participate in the development and implementation of his or her person-centered plan of care, including:

   (i) the right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care;

   (ii) the right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care;

   (iii) the right to be informed, in advance, of changes to the plan of care;

   (iv) the right to receive the services and items included in the plan of care; and

   (v) the right to see the care plan, including the right to sign after significant changes to the plan of care;

(3) the facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must:

   (i) facilitate the inclusion of the resident and the resident representative;

   (ii) include an assessment of the resident’s strengths and needs;

   (iii) incorporate the resident’s personal and cultural preferences in developing goals of care;

(4) the right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care;

(5) the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers;

(6) the right to request, refuse, or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive;

(7) the right to self-administer medications if the interdisciplinary team, as defined by §19.802(c)(2) of this title (relating to Comprehensive Care Plans), has determined that this practice is clinically appropriate; and

(8) nothing in this paragraph should be construed as the right of the resident to receive the
provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

(c) The resident has the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.

(d) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care.

(e) The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.

(f) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

(g) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(a) Resident rights. The resident has the right to:

(1) choose and retain a personal attending physician, subject to that physician's compliance with the facility's standard operating procedures for physician practices in the facility;

(2) be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and

(h) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State of Texas, the resident has the right to participate in planning care and treatment or changes in care and treatment. [See §19.419 of this title (relating to Directives and Durable Powers of Attorney).]

(i) Licensed-only facilities. The resident must be allowed complete freedom of choice to obtain pharmacy services from any pharmacy that is qualified to perform the services. A facility must not require residents to purchase pharmaceutical supplies or services from the facility itself or from any particular vendor. The resident has the right to be informed of prices before purchasing any pharmaceutical item or service from the facility, except in an emergency.

(i) Additional requirements regarding freedom of choice for Medicaid recipients. The recipient must be allowed complete freedom of choice to obtain any Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, unless the provider causes the facility to be out of compliance with the requirements specified in this chapter.

(1) A facility must not require recipients to purchase supplies or services, including
pharmaceutical supplies or services, from the facility itself or from any particular vendor. The recipient has the right to be informed of prices before purchasing any item or services from the facility, except in an emergency [(see §19.1502(b)(3) of this title (relating to Choice of Pharmacy Provider)).]

(2) The facility must furnish Medicaid recipients with complete information about available Medicaid services, how to obtain these services, their rights to freely choose service providers as specified in this subsection and the right to request a hearing before the HHSC [Texas Department of Human Services (DHS)] if the right to freely choose providers has been abridged without due process.


The resident has the right to personal privacy and confidentiality of his personal and clinical records. [(See also §19.1910(e) of this title (relating to Clinical Records) and §19.403(e) of this title (relating to Notice of Rights and Services).)]

(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

(2) Except as provided in paragraph (4) [(3)(B)] of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside of the facility.

(3) The facility must respect the resident’s right to personal privacy, including the right to privacy in his or her oral, written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

(4) [(3)] The resident's right to refuse release of personal and clinical records does not apply [when]:

(A) when the resident is transferred to another health care institution;

(B) when the record release is required by law; or

(C) during surveys.

(5) [(4)] The facility must ensure the resident's right to privacy in the following areas:

(A) accommodations as described in §19.1701 of this title (relating to General Requirements);

(B) medical treatment. The facility must provide privacy to each resident during
examinations, treatment, case discussions, and consultations. Staff must treat these matters confidentially;

(C) personal care;

(D) access and visitation as described in §19.413 of this title (relating to Access and Visitation Rights);

(E) governmental searches are permitted only if there exists probable cause to believe an illegal substance or activity is being concealed. Administrative searches by the appropriate entity, such as the fire inspector, are allowed only for limited purposes, but such searches would not ordinarily extend to the resident's personal belongings. HHSC [The Texas Department of Human Services (DHS)] and the nursing facility must provide for and allow residents their individual freedoms. State statutes authorize inspections of the nursing facility but do not authorize inspection of those areas in which an individual has a reasonable expectation of privacy. Any direct participation by HHSC [DHS] personnel in an inspection of "the contents of residents' personal drawers and possessions," is in violation of federal and state law; and

(F) the resident has the right to privacy for meetings with family and resident groups.

(6) [(5)] All information that contains personal identification or descriptions which would uniquely identify an individual resident or a provider of health care is considered to be personal and private and will be kept confidential. Personal identifying information (except for PCN numbers) will be deleted from all records, reports, or [and/or] minutes from formal studies which are forwarded to HHSC [DHS], or anyone else. These records, reports, and/or minutes, which have been de-identified, will still be treated as confidential. All such material mailed to HHSC [DHS] or anyone else must be in a sealed envelope marked "Confidential."

§19.408. Grievances.

(a) A resident has the right to:

(1) voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. These grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns regarding their nursing facility stay;

(2) prompt efforts by the facility to resolve grievances the resident may have [including those with respect to the behavior of other residents]; and

(3) notify state agencies of complaints against a facility. Complaints will be acknowledged by the staff of the agency that receives the complaint. All complaints will be investigated, whether oral or written.
(b) The facility must make prompt efforts to resolve grievances the resident may have relating to subsection (a)(1) of this section.

(c) The facility must make information on how to file a grievance or complaint available to the resident.

(d) The facility must establish a written grievance policy to ensure the prompt resolution of all grievances regarding the residents’ rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:

   (1) notifying resident individually or through postings in prominent locations throughout the facility of:

      (A) the right to file grievances orally (meaning spoken) or in writing;

      (B) the right to file grievances anonymously;

      (C) the contact information of the grievance official with whom a grievance can be filed, including, his or her name, business address, email address, and business phone number;

      (D) a reasonable expected time frame for completing the review of the grievance;

      (E) the right to obtain a written decision regarding his or her grievance; and

      (F) the contact information of independent entities with whom grievances may be filed, including HHSC, the Quality Improvement Organization, and the State Long-Term Care Ombudsman program;

   (2) identifying a grievance official who is responsible for:

      (A) overseeing the grievance process,

      (B) receiving and tracking grievances through to the conclusion;

      (C) leading any necessary investigations by the facility;

      (D) maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously;

      (E) issuing written grievance decisions to the resident; and

      (F) coordinating with state and federal agencies as necessary in light of specific allegations;

   (3) taking immediate action to prevent further potential violations of any resident right while
the alleged violation is being investigated;

(4) reporting immediately all alleged violations involving neglect, abuse, including injuries of unknown source, or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider, consistent with §19.602 of this title (relating to Incidents of Abuse, Neglect, and Exploitation Reportable to the Texas Health and Human Services Commission and Law Enforcement Agencies by Facilities) and as required by State law;

(5) ensuring that all written grievance decisions include:

(A) the date the grievance was received;

(B) a summary statement of the resident’s grievance;

(C) the steps taken to investigate the grievance;

(D) a summary of the pertinent findings or conclusions regarding the resident’s concerns;

(E) a statement as to whether the grievance was confirmed or not confirmed;

(F) any corrective action taken or to be taken by the facility as a result of the grievance, and

(G) the date the written decision was issued;

(6) taking appropriate corrective action in accordance with Texas law if the alleged violation of the residents’ rights is confirmed by the facility or if an outside entity having jurisdiction, such as HHSC, Quality Improvement Organization, or local law enforcement agency confirms a violation of any of these residents’ rights within its area of responsibility; and

(7) maintaining evidence demonstrating the results of all grievances for a period of no less than three years from the issuance of the grievance decision.

(e) A nursing facility may not retaliate or discriminate against a resident, a family member or guardian of the resident, or a volunteer because the resident, the resident's family member or guardian, a volunteer, or any other person:

(1) makes a complaint or files a grievance concerning the facility;

(2) reports a violation of law, including a violation of laws or regulations regarding nursing facilities; or

(3) initiates or cooperates in an investigation or proceeding of a governmental entity relating to care, services, or conditions at the nursing facility.
§19.409. Examination of Survey Results.

(a) The resident has the right to:

(1) examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility [. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability]; and

(2) receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

(b) The facility must:

(1) post in a place readily accessible to the residents, resident representatives, family members, and legal representatives of residents, the results of the most recent survey of the facility;

(2) have reports with respect to any survey, certifications, and complaint investigations made respecting the facility during the three preceding years, and a plan of correction in effect with respect to the facility, available for any individual to review upon request;

(3) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public; and

(4) not make available identifying information about complainants or residents.


(a) The nursing facility must refund private funds paid to the facility for periods covered by Medicaid, including retroactive periods of Medicaid coverage, when:
(1) the Medicaid vendor payment has been accepted by the nursing facility; or

(2) the nursing facility has been notified by HHSC [the Texas Department of Human Services (DHS)] about an individual's eligibility for Medicaid.

(b) The nursing facility must make the refund within 30 days of:

(1) notification of eligibility for nursing home coverage;

(2) notification of correction of applied income [(see also §19.2316(f) of this title (relating to Collection of Applied Income) which specifies procedures concerning applied income refunds at the time of discharge)]; or

(3) receipt of any vendor payment from HHSC [DHS] for any covered period.

(c) When the facility becomes aware of the need for a refund as indicated in subsection (a) of this section, facility staff must write to the resident or his responsible party, notifying him about his right to a refund and the amount due.


(a) The facility must not require a resident to perform services for the facility.

(b) The resident has the right to:

(1) refuse to perform services for the facility; and

(2) perform services for the facility, if he chooses, when:

(A) the facility has documented the need or desire for work in the plan of care;

(B) the plan specifies the nature of the services performed and whether the services are voluntary or paid;

(C) compensation for paid services is at or above prevailing rates; and

(D) the resident agrees to the work arrangement described in the plan of care.


[The resident has the right to privacy in written communications, including the right to:]

51
[(1) send and receive mail promptly that is unopened;]

[(2) request facility staff to help open and read incoming mail and help address and post outgoing mail;]

[(3) have access to stationery, postage, and writing implements at the resident's own expense.]


(a) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident’s rights to deny visitation when applicable, and in a manner that does not impose on the rights of another resident.

(b) The resident has the right to have access to, and the facility must provide immediate access to a resident to, the following:

(1) in Medicaid-certified facilities, any representative of the Secretary of Health and Human Services;

(2) any representative of the State of Texas;

(3) the resident's individual physician;

(4) any representative of the Office of the State Long Term Care Ombudsman [(the Office), as described in §85.401(r) of this title (relating to Long-Term Care Ombudsman Program)];

(5) any representative of Advocacy, Incorporated, which is responsible for the protection and advocacy system for individuals with intellectual or developmental disabilities [developmentally disabled individuals] established under the Developmental Disabilities Assistance and Bill of Rights Act, 42 USC Chapter 144, Subchapter I, Part C [part C];

(6) any representative of Advocacy, Incorporated, which is responsible for the protection and advocacy system for individuals with mental illness [mentally ill individuals] established under the Protection and Advocacy for Mentally Ill Individuals Act, 42 USC Chapter 114, Subchapter I;

(7) the resident representative;

(8) subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; [and]

(9) subject to reasonable clinical and safety restrictions and the resident's right to deny
or withdraw consent at any time, others who are visiting with the consent of the resident; and [·]

(10) subject to the resident's right to deny or withdraw consent at any time, by any entity or individual that provides health, social, legal, or other services to the resident.

(b) A facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(c) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this section, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation.

(c) A facility must allow a certified ombudsman, as defined in §85.2 of this title (relating to Definitions), and a staff person of the Office access:

(1) to the medical and social records of a resident, including an incident report involving the resident, if the certified ombudsman or staff person of the Office has the consent of the resident or the legally authorized representative of the resident;

(2) to the medical and social records of a resident 60 years of age or older, including an incident report involving the resident, in accordance with the Older Americans Act, §712(b); and

(3) to the administrative records, policies, and documents of the facility to which the facility residents or general public have access.

(d) A facility must meet the following requirements:

(1) inform each resident or resident representative, where appropriate, of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this section, the reasons for the restriction or limitation, and to whom the restrictions apply, when the resident is informed of his or her other rights under this section.

(2) inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates, including a spouse, a same-sex spouse, a domestic partner, a same-sex domestic partner, another family member or a friend, and the right to withdraw or deny such consent at any time;

(3) not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability; and

(4) ensure that all visitors enjoy full and equal visitation privileges consistent with resident
preferences.

§19.414. Telephone.

(a) The resident has the right to have reasonable access to the use of a telephone (other than a pay phone), where calls can be made without being overheard, and which can also be used for making calls to summon help in case of emergency.

(b) The facility must permit residents to contract for private telephones at their own expense. The facility must not require private telephones to be connected to a central switchboard.


The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Reasons for any limitations are documented in the resident's clinical record. [See §19.1921(i) of this title (relating to General Requirements for a Nursing Facility).]

(1) If the resident dies, personal property must be transferred to the estate or the person designated by the resident.

(2) If it is donated or sold to the facility by the resident or estate, the transaction must be documented.

(3) If the resident dies and there is no responsible party, family, or legal guardian and no arrangements have been made for the disposition of property, the facility must dispose of property according to the Texas Property Code, Title 6, Chapter 71 (concerning Escheat of Property) and according to the Texas Estates Code, Chapter 551 (concerning Payment of Certain Estates to State) [Probate Code, Chapter 10 (concerning Payment of Estates into State Treasury)].

§19.417. Living Arrangements [Married Couples].

(a) The resident has the right to share a room with a roommate of choice, when practicable, and both residents consent to the arrangement.

(b) The resident must be ensured privacy for visits with a [his] spouse. The resident has the right to share a room with a [his] spouse when married residents live in the same facility and both spouses consent to the arrangement.
(c) Accommodations for children. Pediatric residents should be matched with roommates of similar age and developmental levels.

§19.418. Self-administration of Drugs.

[An individual may self-administer drugs if the interdisciplinary team, as defined in §19.802(b)(2) of this title (relating to Comprehensive Care Plans), has determined that this practice is safe.]


(a) An individual has the right to refuse a transfer to another room within the facility, if the purpose of the transfer is to relocate:

(1) a resident of a skilled nursing facility (SNF) from the distinct part of the facility that is an SNF to a part of the facility that is not an SNF; or

(2) a resident of a nursing facility from the distinct part of the facility that is a nursing facility to a distinct part of the facility that is an SNF; or

(3) solely for the convenience of the staff.

(b) A resident's exercise of the right to refuse transfer under this section does not affect the individual's eligibility or entitlement to Medicaid benefits.

(c) Room changes in a facility that is a composite distinct part, as defined in 42 CFR §483.5, must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's location.


The facility must provide:

(1) a safe, clean, comfortable, and homelike environment, allowing the resident to use his personal belongings to the extent possible;

(2) housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior;

(3) clean bed and bath linen that are in good condition:
(4) private closet space in each resident room;

(5) adequate and comfortable lighting levels in all areas;

(6) comfortable and safe temperature levels. Facilities initially licensed or certified after
October 1, 1990, must maintain temperature ranges of 71-81 degrees Fahrenheit; and

(7) for the maintenance of comfortable sound levels.

§19.425 Communication

(a) The resident has the right to have reasonable access to the use of a telephone (other than a
pay phone), including TTY and TDD services, and a place in the facility where calls can be
made without being overheard and which can also be used for making calls to summon help in
case of emergency. This includes the right to retain and use a cellular phone at the resident’s own
expense.

(b) The facility must permit residents to contract for private telephones at their own expense. The
facility must not require a private telephone to be connected to a central switchboard.

(c) The facility must protect and facilitate the resident’s right to communicate with individuals
and entities within and external to the facility, including reasonable access to:

(1) a telephone, including TTY and TDD services;

(2) the internet, to the extent available to the facility; and

(3) stationery, postage, writing implements and the ability to send mail.

(d) The resident has the right to send and receive mail, and to receive letters, packages and other
materials delivered to the facility for the resident through a means other than a postal service,
including the right to:

(1) privacy of such communications consistent with this section;

(2) access to stationery, postage, and writing implements at the resident’s own expense; and

(3) request facility staff to help open and read incoming mail and help address and post
outgoing mail.

(e) The resident has the right to have reasonable access to and privacy in the use of electronic
communications, such as email and video communications and for Internet research.

(1) If the access is available to the facility
(2) At the resident’s expense, if any additional expense is incurred by the facility to provide such access to the resident.

(3) Such use must comply with state and federal law.


(a) The facility must not require:

(1) residents or potential residents to waive their rights to Medicare or Medicaid; [and]

(2) oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits; and [1]

(3) residents or potential residents to waive potential facility liability for losses of personal property.

(b) The facility must not require a third-party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(c) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State Plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission, or continued stay in the facility. However, a nursing facility may:

(1) charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State Plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of these additional services; and

(2) solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid-eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or
continued stay in the facility for a Medicaid-eligible resident.

(d) A nursing facility must disclose and provide a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility.

(e) A nursing facility that is a composite distinct part, as defined by 42 CFR §483.5, must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations.

§19.502. Transfer and Discharge in Medicaid-certified Facilities.

(a) Examples. [Definition.] Transfer and discharge includes movement of a resident to a bed outside the certified facility, whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement within the same certified facility.

(b) Transfer and discharge requirements. The facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless:

(1) the transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the facility;

(2) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(3) the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;

(4) the health of other individuals in the facility would otherwise be endangered;

(5) the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;

(6) the resident, responsible party, or family or legal representative requests a voluntary transfer or discharge; or

(7) the facility ceases to operate as a nursing facility and no longer provides resident care.

(c) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in subsection (a)(1)-(7) or this section, the resident’s clinical record must
be documented. Documentation must include:

(1) the basis for the transfer per subsection (a)(1)-(7) of this section;

(2) In the case of subsection (a)(1) of this section the specific resident need(s) that cannot be
met, facility attempts to meet the resident needs, and the service available at the receiving facility
to meet the needs.

(3) The documentation required by subsection (a)(1)-(7) of this section, must be made by:

(A) the resident’s physician when transfer or discharge is necessary under subsection
(b)(1) or (b)(2) of this section; or

(B) a physician when transfer or discharge is necessary under subsection (b)(3) or (b)(4)
of this section.

(4) Information provided to the receiving provider must include a minimum of the following:

(A) contact information of the practitioner responsible for the care of the resident;

(B) resident representative information including contact information;

(C) advance directive information;

(D) all special instructions or precautions for ongoing care, as appropriate;

(E) comprehensive care plan goals; and

(F) all other necessary information, including a copy of the resident’s discharge
summary, consistent with §19.803 of this title (relating to Discharge Summary (Discharge Plan
of Care)), as applicable, to ensure a safe and effective transition of care.

[When the facility transfers or discharges a resident under any of the circumstances specified in
subsection (b)(1)-(5) of this section, the resident’s clinical record must be documented. The
documentation must be made by:]

(1) the resident’s physician when transfer or discharge is necessary under subsection (b)(1) or
(2) of this section; and]

(2) a physician when transfer or discharge is necessary under subsection (b)(4) of this
section.]

(d) Notice before transfer or discharge. Before a facility transfers or discharges a resident, the
facility must:

(1) notify the resident and the resident’s [if known, a responsible party or family or legal]
representative of the resident about the transfer or discharge and the reasons for the move in writing and in a language and manner the resident understands. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman;

(2) record the reasons in the resident's clinical record;

(3) include in the notice the items described in subsection (f) of this section; and

(4) comply with §19.2310 of this chapter (relating to Nursing Facility Ceases to Participate) when the facility voluntarily withdraws from Medicaid or Medicare or is terminated from Medicaid or Medicare participation by HHSC [DADS] or the secretary.

(e) Timing of the notice.

(1) Except when specified in paragraph (3) of this subsection or in §19.2310 of this chapter, the notice of transfer or discharge required under subsection (d) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(2) The requirements described in paragraph (1) of this subsection and subsection (g) of this section do not have to be met if the resident, responsible party, or family or legal representative requests the transfer or discharge.

(3) Notice may be made as soon as practicable before transfer or discharge when:

(A) the safety of individuals in the facility would be endangered, as specified in subsection (b)(3) of this section;

(B) the health of individuals in the facility would be endangered, as specified in subsection (b)(4) of this section;

(C) the resident's health improves sufficiently to allow a more immediate transfer or discharge, as specified in subsection (b)(2) of this section;

(D) the transfer and discharge is necessary for the resident's welfare because the resident's needs cannot be met in the facility, as specified in subsection (b)(1) of this section, and the resident's urgent medical needs require an immediate transfer or discharge; or

(E) a resident has not resided in the facility for 30 days.

(4) When an immediate involuntary transfer or discharge as specified in subsection (b)(3) or (4) of this section, is contemplated, unless the discharge is to a hospital, the facility must:

(A) immediately call the staff of the state office Consumer Rights and Services section of HHSC [DADS] to report its intention to discharge; and

(B) submit to HHSC [DADS] the required physician documentation regarding the
discharge.

(f) Contents of the notice. For nursing facilities, the written notice specified in subsection (d) of this section must include the following:

(1) the reason for transfer or discharge;

(2) the effective date of transfer or discharge;

(3) the location to which the resident is transferred or discharged;

(4) a statement of the resident’s appeal rights, including [that]:

(A) the resident has the right to appeal the action as outlined in HHSC’s Fair and Fraud Hearings [Fraud, and Civil Rights] Handbook by requesting a hearing through the Medicaid eligibility worker at the local HHSC [DADS] office within 90 [40] days of the date of the notice;

(B) if the resident requests the hearing before the discharge date, the resident has the right to remain in the facility, except in the circumstances described in subsections (b)(5) and (e)(3) of this section, until the hearing officer makes a final determination; and

(C) information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;

(5) the name, address, and telephone number of the regional representative of the Office of the State Long Term Care Ombudsman, HHSC [DADS], and of the toll-free number of the Texas Long Term Care Ombudsman [1-800-252-2412]; and

(6) in the case of a resident with mental illness, the address and phone number of the state mental health authority, which is HHSC [Texas Department of State Health Services, P. O. Box 149347, Austin, Texas 78712-9347, 1-800-252-8154]; or in the case of a resident with an intellectual or developmental disability, the authority for persons with intellectual and developmental disabilities [which is DADS Access and Intake Division, P.O. Box 14930, Austin, Texas 78714-9030, 1-800-458-9858.] and the phone number of the agency responsible for the protection and advocacy of persons with intellectual and developmental disabilities [which is: Disability Rights Texas, 2222 West Braker Lane, Austin, Texas 78758, 1-800-252-9108].

(g) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

(h) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.
(i) [44] Notice of relocation to another room. Except in an emergency, the facility must notify the resident and either the responsible party or the family or legal representative at least five days before relocation of the resident to another room within the facility. The facility must prepare a written notice which contains:

(1) the reasons for the relocation;

(2) the effective date of the relocation; and

(3) the room to which the facility is relocating the resident.

(j) [45] Fair hearings.

(1) Individuals who receive a discharge notice from a facility have 90 days to appeal. If the recipient appeals before the discharge date, the facility must allow the resident to remain in the facility, except in the circumstances described in subsections (b)(5) and (e)(3) of this section, until the hearing officer makes a final determination. Vendor payments and eligibility will continue until the hearing officer makes a final determination. If the recipient has left the facility, Medicaid eligibility will remain in effect until the hearing officer makes a final determination.

(2) When the hearing officer determines that the discharge was inappropriate, the facility, upon written notification by the hearing officer, must readmit the resident immediately, or to the next available bed. If the discharge has not yet taken place, and the hearing officer finds that the discharge will be inappropriate, the facility, upon written notification by the hearing officer, must allow the resident to remain in the facility. The hearing officer will also report the findings to HHSC [DADS] Regulatory Services Division for investigation of possible noncompliance.

(3) When the hearing officer determines that the discharge is appropriate, the resident is notified in writing of this decision. Any payments made on behalf of the recipient past the date of discharge or decision, whichever is later, must be recouped.

(k) [46] Discharge of married residents. If two residents in a facility are married and the facility proposes to discharge one spouse to another facility, the facility must give the other spouse notice of his right to be discharged to the same facility. If the spouse notifies a facility, in writing, that he wishes to be discharged to another facility, the facility must discharge both spouses on the same day, pending availability of accommodations.


(a) Notice before transfer. Before a nursing facility transfers a resident to a hospital or a resident goes [allows a resident to go] on therapeutic leave, the nursing facility must provide written information to the resident [and a family member] or resident [legal] representative that specifies:
(1) the duration of the bed-hold policy under the Medicaid State Plan, [see §19.2603 of this title (relating to Therapeutic Home Visits Away from the Facility] if any, during which the resident is permitted to return and resume residence in the facility; [and]

(2) the reserved bed payment policy, in the State plan;

(3) the facility's policies regarding bed-hold periods, which must be consistent with subsection (c) of this section, permitting a resident to return; and

(4) the information specified in §19.502 of this title (relating to Transfer and Discharge in Medicaid-certified Facilities).

(b) Bed-hold notice upon transfer. At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility must provide to the resident and resident [a family member or legal] representative, written notice which specifies the duration of the bed-hold policy described in subsection (a) of this section.

(c) Permitting resident to return to facility. A nursing facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on [under which a resident whose hospitalization or] therapeutic leave. The policy must provide for the following:

(1) a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State Plan, returns to the facility to their previous room if available or [is readmitted to the facility] immediately upon the first availability of a bed in a semi-private room if the resident:

(A) requires the services provided by the facility; and

(B) is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.

(2) If the facility that determines that a resident who was transferred with an expectation of returning to the facility cannot return to the facility, the facility must comply with the requirements of §19.502 of this title (relating to Transfer and Discharge in Medicaid-certified Facilities).

(d) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part, as defined by 42 CFR §483.5, the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If the bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.

(e) Bed-hold charges. The facility may enter into a written agreement with the recipient or responsible party to reserve a bed.

(1) The facility may charge the recipient an amount not to exceed the HHSC [DHS] daily
vendor rate according to the recipient's classification at the time the individual leaves the facility.

(2) The facility must document all bed-hold charges in the recipient's financial record at the time the bed-hold reservation services were provided.

(3) The facility may not charge a bed-hold fee if HHSC [the Texas Department of Human Services (DHS)] is paying for the same period of time, as in a three-day therapeutic home visit.

§19.504. Equal Access to Quality Care in Medicaid-certified Facilities.

(a) A facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the Medicaid State Plan for all individuals regardless of source of payment.

(b) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in §19.403(h) and (i) of this title (relating to Notice of Rights and Services).

(c) HHSC [The Texas Department of Human Services] is not required to offer additional services on behalf of a recipient other than services provided in the State Plan.

TITLE 40 SOCIAL SERVICES AND ASSISTANCE
PART 1 DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION
SUBCHAPTER G FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION
[RESIDENT BEHAVIOR AND FACILITY PRACTICE]

§19.601. Freedom from Abuse, Neglect and Exploitation. [Resident Behavior and Facility Practice.]

(a) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in §19.101 of this title (relating to Definitions). This includes freedom from any physical or chemical restraint not required to treat the resident’s medical symptoms.

(b) Abuse. The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion.

(c) The facility must develop and implement written policies and procedures that prohibit and prevent mistreatment, neglect, exploitation and abuse of residents, and misappropriation of
residents' property.

(1) The facility must:

   (A) not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary
       seclusion; and

   (B) not employ or otherwise engage an individual individuals who has have:

       (i) been found guilty of abusing, neglecting, exploiting or mistreating residents by a
           court of law, or

       (ii) had a finding entered into the state nurse aide registry concerning abuse, neglect,
            exploitation or mistreatment of residents, or misappropriation of their property; or

       (iii) been convicted of any crime contained in §250.006, Health and Safety Code; or

   and

       (iv) a disciplinary action in effect against his or her professional license by a state
            licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or
            misappropriation of resident property; and

   (C) report any knowledge it has of actions by a court of law against an employee, which
       would indicate unfitness for service as a nurse aide or other staff to the state nurse aide registry
       or licensing authority.

(2) The written policies and procedures must:

   (A) establish protocols to investigate any such allegations;

   (B) include training as required by §19.1929 of this title (relating to Staff Development); and

   (C) effective November 28, 2019, establish coordination with the QAPI program as
       required by §19.1927 of this title (relating to Quality Assurance and Performance Improvement
       Program).

(d) Restraints. The facility must ensure that the resident is free from physical or chemical
    restraints imposed for purposes of discipline or convenience and that are not required to treat the
    resident's medical symptoms. If the use of restraints is indicated, the facility must use the least
    restrictive alternative for the least amount of time and document ongoing re-evaluation of the
    need for restraints. [The resident has the right to be free from any physical or chemical restraints
    imposed for purposes of discipline or convenience, and not required to treat the resident's
    medical symptoms.]

   (1) If physical restraints are used because they are required to treat the resident's medical

   65
condition, the restraints must be released and the resident repositioned as needed to prevent deterioration in the resident's condition. Residents must be monitored hourly and, at a minimum, restraints must be released every two hours for a minimum of ten minutes, and the resident repositioned.

(2) A facility must not administer to a resident a restraint that:

   (A) obstructs the resident’s airway, including a procedure that places anything in, on, or over the resident’s mouth or nose;

   (B) impairs the resident’s breathing by putting pressure on the resident’s torso;

   (C) interferes with the resident’s ability to communicate; or

   (D) places the resident in a prone or supine hold.

(3) A behavioral emergency is a situation in which severely aggressive, destructive, violent, or self-injurious behavior exhibited by a resident:

   (A) poses a substantial risk of imminent probable death of, or substantial bodily harm to, the resident or others;

   (B) has not abated in response to attempted preventive de-escalatory or redirection techniques;

   (C) could not reasonably have been anticipated; and

   (D) is not addressed in the resident’s comprehensive care plan.

(4) If restraint is used in a behavioral emergency, the facility must use only an acceptable restraint hold. An acceptable restraint hold is a hold in which the resident’s limbs are held close to the body to limit or prevent movement and that does not violate the provisions of paragraph (2) of this subsection.

(5) A staff person may use a restraint hold only for the shortest period of time necessary to ensure the protection of the resident or others in a behavioral emergency.

(6) A facility may adopt policies that allow less use of restraint than allowed by the rules of this chapter.

(7) Use of restraints and their release must be documented in the clinical record.

[(b) Abuse. The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion.]
(c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, and misappropriation of residents’ property.

(1) The facility must:

(A) not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; and

(B) not employ individuals who have:

(i) been found guilty of abusing, neglecting, or mistreating residents by a court of law; or

(ii) had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents, or misappropriation of their property; or

(iii) been convicted of any crime contained in §250.006, Health and Safety Code; and

(C) report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other staff to the state nurse aide registry or licensing authority.

(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, are reported immediately to the administrator of the facility and to other officials in accordance with Texas law through established procedures (see §19.602 of this title (relating to Incidents of Abuse and Neglect Reportable to the Texas Department of Human Services and Law Enforcement Agencies by Facilities)).

(3) The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with Texas law (including to the state survey and certification agency) within five workdays of the incident, and if the alleged violation is verified, appropriate corrective action must be taken.

§19.602. Incidents of Abuse, [and] Neglect, and Exploitation Reportable to the Texas Health and Human Services Commission [Department of Aging and Disability Services (DADS)] and Law Enforcement Agencies by Facilities.

(a) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:
(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse, or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to HHSC;

(2) conduct an investigation of the reported act(s) and have evidence that all alleged violations are thoroughly investigated;

(3) prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress; and

(4) report the results of all investigations to the administrator or the administrator’s designee and to HHSC within five working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

(b) [(a)] A facility owner or employee who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect, or exploitation caused by another person must report the abuse, neglect, or exploitation.

(c) [(b)] Reports described in subsections (a)(1) and (b) [(subsection (a))] of this section must be made to HHSC Consumer Rights and Services. [DADS at 1-800-458-9858 and]

(d) Written investigation [written] reports described in paragraph (a)(4) of this section must be sent to: HHSC [DADS] Consumer Rights and Services no later than the fifth working day after the initial report [. P. O. Box 14930, Austin, Texas 78714-9030].

[(1) The person reporting must make the telephone report immediately on learning of the alleged abuse, neglect, exploitation, conduct, or conditions. The person must send a written report to DADS Consumer Rights and Services within five days after the telephone report.]

[(2) The facility must conduct an investigation of the reported act(s). The facility must send a written report of the investigation to DADS no later than the fifth working day after the oral report.]

(e) [(c)] As a condition of employment an employee of a facility must sign a statement that states:

(1) the employee may be criminally liable for failure to report abuses; and

(2) under the Texas Health and Safety Code, Title 4, §260A.014 [§260A.14], the employee has a cause of action against a facility, its owner(s) or employee(s) if he is suspended, terminated, disciplined, or discriminated or retaliated against as a result of:

(A) reporting to the employee's supervisor, the administrator, HHSC [DADS], or a law
enforcement agency a violation of law, including a violation of laws or regulations regarding nursing facilities; or

(B) for initiating or cooperating in any investigation or proceeding of a governmental entity relating to care, services, or conditions at the nursing facility.

(f) [44] The statements described in subsection (d) [(e)] of this section must be available for inspection by HHSC [DADS].

(g) [(e)] A local or state law enforcement agency must be notified of reports described in subsection (a) of this section that allege that:

(1) a resident's health or safety is in imminent danger;

(2) a resident has recently died because of conduct alleged in the report of abuse or neglect or other complaint;

(3) a resident has been hospitalized or treated in an emergency room because of conduct alleged in the report of abuse or neglect or other complaint;

(4) a resident has been a victim of any act or attempted act described in the Penal Code, §§21.02, 21.11, 22.011, or 22.021; or

(5) a resident has suffered bodily injury, as that term is defined in the Penal Code, §1.07, because of conduct alleged in the report of abuse or neglect or other complaint.

§19.606. Reporting of Resident Death Information.

(a) All licensed facilities must submit to HHSC [the Texas Department of Human Services (DHS)] a report of deaths of any persons residing in the facility and those persons transferred from the facility to a hospital who expire within 24 hours after transfer.

(b) The facility must submit to HHSC [DHS] a standard HHSC [DHS] form within ten workdays after the last day of the month in which a resident death occurs. The form must include:

(1) name of deceased;

(2) social security number of the deceased;

(3) date of death; and

(4) name and address of the institution.

(c) These reports are confidential under the Health and Safety Code, §260A.016 [§242.134];
however, licensed facilities must make available historical statistics provided to them by HHSC [DHS] and must provide the statistics, if requested, to the applicants for admission or their representative.

(d) HHSC [DHS] produces statistical information of official causes of death to determine patterns and trends of incidents of death among the elderly and in specific facilities and makes this information available to the public upon request.

TITLE 40    SOCIAL SERVICES AND ASSISTANCE
PART 1    DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 19    NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION
SUBCHAPTER H  QUALITY OF LIFE

§19.701. Quality of Life.

(a) Each resident must receive, and the facility must provide, the necessary care and services to attain or maintain the highest practicable, physical, mental, and psychosocial well-being, consistent with the resident’s comprehensive assessment and plan of care.

(1) Based on the comprehensive assessment of a resident and consistent with the resident’s needs and choices, the facility must provide the necessary care and services to ensure that a resident’s abilities in activities of daily living do not diminish unless circumstances of the individual’s clinical condition demonstrate that such diminution was unavoidable.

(2) This includes the facility ensuring that:

(A) A resident is given the appropriate treatment and services to maintain or improve the ability to carry out the activities of daily living including those specified in paragraph (b) of this subsection.

(B) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and

(C) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident’s advance directives.

(b) Activities of daily living. The facility must provide care and services in accordance with subsection (a) of this section for the following activities of daily living:

(1) hygiene – bathing, dressing grooming, and oral care;

(2) mobility – transfer and ambulation, including walking;
(3) elimination – toileting;

(4) dining – eating including meals and snacks; and

(5) communication – Speech, language, and other functional communication systems.

c) If children are admitted to a facility, care must be provided to meet their unique medical and developmental needs.

[§19.701. Quality of Life.]

[A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. If children are admitted to a facility, care must be provided to meet their unique medical and developmental needs.]

[(1) Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of the resident's individuality.]

[(2) Self-determination and participation. The resident has the right to:]

[(A) choose activities, schedules, and health care consistent with the resident's interests, assessments, and plans of care;]

[(B) interact with members of the community both inside and outside of the facility; and]

[(C) make choices about aspects of the resident's life in the facility that are significant to the resident.]

[(3) Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.]

[(4) Accommodation of needs. A resident has the right to:]

[(A) reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and]

[(B) receive notice before the resident's room or roommate in the facility is changed.]

[(5) Accommodations for children. Pediatric residents should be matched with roommates of similar age and developmental levels.]
§19.702. Activities.

(a) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program of activities, both facility sponsored group and individual activities and independent activities, designed to meet the interest of and support, in accordance with the comprehensive assessment, the interest and the physical, mental, and psychosocial well-being of each resident encouraging both independence and interaction in the community.

(b) The activities program must be directed by a qualified professional who:

1. is a qualified therapeutic recreation specialist or an activities professional who is:

   A. licensed or registered, if applicable, by the state in which practicing; and

   B. eligible for certification as a therapeutic recreation specialist, therapeutic recreation assistant, or an activities professional by a recognized accrediting body, such as the National Council for Therapeutic Recreation Certification; or

   2. has two years of experience in a social or recreational program within the last five years, one of which was full-time in a patient activities program in a health care setting; or

   3. is a qualified occupational therapist or occupational therapy assistant; or

   4. has completed an activity director training course approved by a recognized credentialing body, any state. The Texas Department of Human Services (DHS) does not review or approve any courses. DHS accepts training courses approved by a recognized credentialing body, such as the National Certification Council for Activity Professionals, the National Therapeutic Recreation Society, or the Consortium for Therapeutic Recreation/Activities Certification, Inc.

(c) Activity directors must complete eight hours of approved continuing education or equivalent continuing education units each year. Approval bodies include organizations or associations recognized as such by certified therapeutic recreation specialists or certified activity professionals or registered occupational therapists.

(d) The facility must ensure that activities assessment and care planning are completed and reviewed or updated as provided in §19.801 and §19.802 of this title (relating to Resident Assessment and Comprehensive Person-Centered Care Planning Plans). If indicated by the Resident Assessment Instrument (RAI) and/or the resident's need, an in-depth activities assessment is required.

(e) Toys and recreational equipment for pediatric residents must be appropriate for the size, age, and developmental level of the residents.
§19.703. Social Services General Requirements.

(a) The facility must provide medically-related social services to attain the highest practicable physical, mental, or psychosocial well-being of each resident. [See also §19.901 of this title (relating to Quality of Care) for information concerning psychosocial functioning.]

(1) A facility with more than 120 beds must employ a qualified social worker on a full-time basis.

(2) A facility of 120 beds or less must employ or contract with a qualified social worker (or in lieu thereof, a social worker who is licensed by the Texas State Board of Social Work Examiners, and who meets the requirements of subsection (b)(2) of this section) to provide social services a sufficient amount of time to meet the needs of the residents.

(b) A qualified social worker is an individual who is licensed, including a temporary or provisional license, by the Texas State Board of Social Work Examiners as prescribed by Chapter 50 of the Human Resources Code, and who has at least:

(1) a bachelor's degree in social work, or a bachelor's degree in a human services field, including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and

(2) one year of supervised social work experience in a health care setting working directly with individuals.

[§19.705. Environment.]

[The facility must provide:

[(1) a safe, clean, comfortable, and homelike environment, allowing the resident to use his personal belongings to the extent possible;]

[(2) housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior;]

[(3) clean bed and bath linen that are in good condition;]

[(4) private closet space in each resident room;]

[(5) adequate and comfortable lighting levels in all areas (see §19.1721 of this title (relating to Lighting and Illumination));]

[(6) comfortable and safe temperature levels. Facilities initially licensed or certified after October 1, 1990, must maintain temperature ranges of 71-81 degrees Fahrenheit; and]

(a) A resident has the right to organize and participate in resident groups in a facility.

(b) A facility must assist residents who require assistance to attend resident group meetings.

(c) A resident's family has the right to meet in the facility with the families of other residents in the facility and organize a family council. A family council may:

   (1) make recommendations to the facility proposing policy and operational decisions affecting resident care and quality of life; and

   (2) promote educational programs and projects intended to promote the health and happiness of residents.

(d) If a resident group or family council exists, a facility must:

   (1) listen to and consider the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility;

   (2) provide a resident group or family council with private space and to take reasonable steps with the approval of the group, to make residents and family member aware of upcoming meetings in a timely manner;

   (3) provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from resident group and family council meetings; and

   (4) allow staff or visitors to attend meetings at the resident group's or family council’s invitation.

(e) If a family council exists, a facility must:

   (1) upon written request, allow the family council to meet in a common meeting room of the facility at least once a month during hours mutually agreed upon by the family council and the facility;

   (2) provide the family council with adequate space on a prominent bulletin board to post notices and other information;

   (3) designate a staff person to act as the family council's liaison to the facility;
(4) respond in writing to written requests by the family council within five working days;

(5) demonstrate responses to the grievances and recommendations of the family council and the rationale for such responses;

(6) include information about the existence of the family council in a mailing that occurs at least semiannually; and

(7) permit a representative of the family council to discuss concerns with an individual conducting an inspection or survey of the facility.

(f) Unless the resident objects, a family council member may authorize, in writing, another member to visit and observe a resident represented by the authorizing member.

(g) A facility must not limit the rights of a resident, a resident's family member, or a family council member to meet with an outside person, including:

(1) an employee of the facility during the employee's nonworking hours if the employee agrees; or

(2) a member of a nonprofit or government organization.

(h) A facility must not:

(1) terminate an existing family council;

(2) prevent or interfere with the family council from receiving outside correspondence addressed to the family council or open family council mail; or

(3) willfully interfere with the formation, maintenance, or operation of a family council, including interfering by:

(A) denying a family council the opportunity to accept help from an outside person;

(B) discriminating or retaliating against a family council participant; or

(C) willfully scheduling events in conflict with previously scheduled family council meetings, if the facility has other scheduling options.
§19.801. Resident Assessment.

A facility must conduct, initially and periodically, a comprehensive, accurate, standardized, reproducible assessment of a resident's functional capacity. The facility must electronically transmit to CMS resident-entry-and-death-in-facility tracking records required by the RAI; and OBRA assessments, including admission, annual, quarterly, significant change, significant correction, and discharge assessments.

(1) Admission orders. At the time a resident is admitted, the facility must have physician orders for the resident's immediate care.

(2) Comprehensive assessments.

(A) A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences using the current RAI process, including the MDS, Care Area Assessment process, and the Utilization Guidelines specified by HHSC [DADS] and approved by CMS. The current RAI process is found in the MDS 3.0 manual posted by CMS on http://www.cms.gov.

(B) A facility must conduct an additional assessment and document the summary information if the MDS indicates an additional assessment on a care area is required.

(C) A facility must conduct a comprehensive assessment of a resident as follows:

(i) within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.

(ii) within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.

(iii) not less often than once every 12 months.

(3) Quarterly review assessment. A facility must assess a resident using the quarterly review instrument specified by HHSC [DADS] and approved by CMS not less frequently than once every three months.

(4) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care as specified in §19.802 of this subchapter.
(relating to Comprehensive Care Plans).

(5) PASRR. A Medicaid-certified facility must:

(A) coordinate assessments with the PASRR [PASRR] process in 42 CFR, Part 483, Subpart C to the maximum extent practicable to avoid duplicative testing and effort, including:

   (i) incorporating the recommendations from the PASRR level II determination and the PASRR evaluation report into a resident’s assessment, care planning, and transitions of care; and

   (ii) referring all level II residents and all residents suspected of having mental illness, an intellectual disability, or a developmental disability for level II resident review upon a significant change in status assessment; and

(B) promptly report a significant change in the mental or physical condition of a resident by submitting a Minimum Data Set (MDS) Significant Change in Status Assessment Form in the LTC Online Portal, in accordance with §19.2704(i)(9) of this title.

(6) Automated data processing requirement.

(A) A facility must complete an MDS for a resident. The facility must enter MDS data into the facility's assessment software within 7 days after completing the MDS and electronically transmit the MDS data to CMS within 14 days after completing the MDS.

(B) A facility must complete the Long Term Care Medicaid Information form on an OBRA assessment that is submitted to the state Medicaid claims system for a Medicaid recipient or Medicaid applicant according to HHSC [DADS] instructions located on the Texas Medicaid Healthcare Partnership Long Term Care Portal at http://www.tmhp.com.

(C) Data format. The facility must transmit MDS data to CMS in the format specified by CMS and HHSC [DADS].

(D) Information concerning a resident is confidential and a facility must not release information concerning a resident except as allowed by this chapter, including §19.407 of this chapter (relating to Privacy and Confidentiality) and §19.1910(d) of this chapter (relating to Clinical Records).

(7) Accuracy of assessments. The assessment must accurately reflect the resident's status.

(8) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

(9) Certification.

(A) A registered nurse must sign and certify that the assessment is completed.
(B) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(10) Penalty for falsification under Medicare and Medicaid.

(A) An individual who willfully and knowingly:

(i) certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

(B) Clinical disagreement does not constitute a material and false statement.

(11) Use of independent assessors in Medicaid-certified facilities and dually certified facilities. If HHSC [DADS] determines, under a certification survey or otherwise, that there has been a knowing and willful certification of false statements under paragraph (10) of this section, HHSC [DADS] may require (for a period specified by HHSC [DADS]) individuals who are independent of the facility and who are approved by HHSC [DADS] to conduct and certify the resident assessments under this section.

(12) Pediatric resident assessment.

(A) A facility must ensure that a pediatric assessment:

(i) is performed by a licensed health professional experienced in the care and assessment of children;

(ii) includes parents or guardians in the assessment process; and

(iii) includes a discussion with a parent or guardian about the potential for community transition.

(B) The clinical record of a child must include a record of immunizations, blood screening for lead, and developmental assessment. The local school district's developmental assessment may be used if available. [See §19.1934 of this chapter (relating to Educational Requirements for Persons Under Age 22).]

(C) A licensed health professional must assess a child's functional status in relation to pediatric developmental levels, rather than adult developmental levels.

(D) A facility must ensure pediatric residents receive services in accordance with the guidelines established by the Department of State Health Services' Texas Health Steps (THSteps). For Medicaid-eligible pediatric residents between the ages of six months and six years, blood screening for lead must be done in accordance with THSteps guidelines.
§19.802. Comprehensive Person-Centered Care Planning [Plans].

(a) Baseline care plans.

(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must:

(A) be developed within 48 hours of a resident’s admission;

(B) include the minimum healthcare information necessary to properly care for a resident including:

(i) initial goals based on admission orders;

(ii) physician orders;

(iii) dietary orders;

(iv) therapy services;

(v) social services; and

(vi) PASRR recommendation, if applicable;

(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan:

(A) is developed within 48 hours of the resident’s admission; and

(B) meets the requirements set forth in subsections (b) – (g) of this section, excepting subsection (c)(1) of this section; and

(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes:

(A) the initial goals of the resident;

(B) a summary of the resident’s medications and dietary instructions;

(C) any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and

(D) any updated information based on the details of the comprehensive care plan, as
(b) [(a)] A facility must develop a comprehensive person-centered care plan for each resident that includes measurable short-term and long-term objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. If a child is admitted to the facility, the comprehensive care plan must be based on the child's individual needs. The comprehensive person-centered care plan must describe the following:

1. the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §19.701 of this title (relating to Quality of Life) and §19.901 of this title (relating to Quality of Care); and

2. any services that would otherwise be required under §19.701 of this title, (relating to Quality of Life) and §19.901 of this title (relating to Administration) but are not provided due to the resident’s exercise of rights, including the right to refuse treatment under §19.402(g) of this title (relating to Exercise of Rights).

3. any nursing facility specialized services or nursing facility PASRR support activities the nursing facility will provide as a result of PASRR recommendations, in accordance with Subchapter BB of this chapter. If a facility disagrees with the findings of the PASRR, it must indicate its rationale in the resident’s medical record.

4. In consultation with the resident and resident’s representative:
   (A) the resident’s goals for admission and desired outcomes;
   (B) the resident’s preference and potential for future discharge. The facility must document whether the resident’s desire to return to the community was assessed and any referrals to local contact agencies or other appropriate entities, for this purpose.
   (C) discharge plans in the comprehensive care plan as appropriate, in accordance with paragraph (g) of this section.

(c) [(b)] The comprehensive care plan must be:

1. developed within seven days after completion of the comprehensive assessment;

2. prepared by an interdisciplinary team that includes:
   (A) the attending physician;
   (B) a registered nurse with responsibility for the resident;
   (C) a nurse aide with responsibility for the resident;
(D) the qualified dietitian or director of food and nutrition services;

(E) other appropriate staff in disciplines as determined by the resident’s needs or as requested by the resident; and

(F) to the extent practicable, the participation of the resident and the resident’s legal representative;

(3) periodically reviewed and revised by a team of qualified persons after each assessment including both the comprehensive and quarterly review assessments; and

(4) for a resident under 22 years of age, annually reviewed at a comprehensive care plan meeting between the facility and the resident’s LAR as defined in §19.805(a)(5) of this title (relating to Permanency Planning for a Resident Under 22 Years of Age), which includes a review of:

(A) the LAR’s contact information as required by §19.805(b)(4)(F) of this title;

(B) the resident’s comprehensive assessment;

(C) the resident’s educational status; and

(D) the resident’s permanency plan.

(d) Regarding subsection (c)(2)(F) of this section, an explanation must be included in a resident’s medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident’s care plan.

(e) A comprehensive care plan must include:

(1) for a resident under 18 years of age, the activities, supports, and services that, when provided or facilitated by the facility, will enable the resident to live with a family; or

(2) for a resident 18-22 years of age, the activities, supports, and services that, when provided or facilitated by the facility, will result in the resident having a consistent and nurturing environment in the least restrictive setting, as defined by the resident and LAR as defined in §19.805(a)(5) of this title.

(f) A comprehensive care plan may include a palliative plan of care. This plan may be developed only at the request of the resident, surrogate decision maker or legal representative for residents with terminal conditions, end stage diseases or other conditions for which curative medical interventions are not appropriate. The plan of care must have goals that focus on maintaining a safe, comfortable and supportive environment in providing care to a resident at the end of life.
For a resident under 22 years of age, the facility must provide written notice to the LAR, as defined in §19.805(a)(5) of this title, of a meeting to conduct an annual review of the resident’s comprehensive care plan no later than 21 days before the meeting date and request a response from the LAR.

The services provided or arranged by the facility must:

1. meet professional standards of quality; and

2. be provided by qualified persons in accordance with each resident's written plan of care; and

(3) effective November 28, 2019, be culturally-competent and trauma-informed.

The comprehensive care plan must be made available to all direct care staff.

§19.803. Discharge Summary (Discharge Plan of Care).

(a) Discharge planning. The facility must develop and implement an effective discharge planning process. The facility’s discharge planning process must:

1. ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident;

2. include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes;

3. involve the interdisciplinary team in the ongoing process of developing the discharge plan;

4. consider caregiver or support person availability and the resident’s or caregiver’s or support person’s capacity and capability to perform required care, as part of the identification of discharge needs;

5. involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan;

6. address the resident’s goals of care and treatment preferences; and

7. document that a resident has been asked about their interest in receiving information regarding returning to the community:

   (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this...
(B) Facilities must update a resident’s comprehensive care plan and discharge plan as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.

(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.

(8) The evaluation of the resident’s discharge needs and discharge plan must be completed on a timely basis and documented in the resident’s clinical record.

(9) The results of the evaluation of the resident’s discharge needs and discharge plan must be discussed with the resident or the resident’s representative.

(b) When a facility anticipates [Before or at the time of] a resident’s discharge, the facility must develop [give the resident] a discharge summary that includes:

(1) a recapitulation of the overall course of the resident's stay that includes diagnoses, course of illness, treatment, or therapy and pertinent lab, radiology, and consultation results, a final summary of the resident’s status;

(2) reconciliation or all pre-discharge medications with the resident’s post-discharge medications both prescribed and over-the-counter;

(3) a statement notifying a resident granted permanent medical necessity (PMN) under the Medicaid program that:

   (A) PMN status continues after discharge, unless the resident is discharged to home;

   (B) PMN status expires 30 consecutive days after the resident is discharged to home; and

   (C) a new medical necessity determination is required if the resident applies to be admitted to a nursing facility under the Medicaid program more than 30 consecutive days after the resident moves home from a nursing facility; and

(4) a post-discharge plan of care, developed with the participation of the resident, and a resident [family] representative that: [responsible party or legal guardian, that will, after discharge,]

   (A) will assist the resident to adjust to the [his] new living environment; and

   (B) indicates where the resident plans to reside and arrangements that have been made for follow-up care and any post discharge medical and non-medical services.

(c) The facility discharge summary must be available for release to authorized persons,
facilities or agencies with the consent of the resident or resident’s representative [as required by subsection (a) of this section when a resident is being discharged home; to another nursing facility; a Medicare skilled nursing facility; or another residential facility, such as a board and care home, an intermediate care facility for individuals with an intellectual disability or related conditions, or an assisted living facility].

TITLE 40 SOCIAL SERVICES AND ASSISTANCE
PART 1 DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION
SUBCHAPTER J QUALITY OF CARE

§19.901. Quality of Care.

Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident’s choices, including the following:

[Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, as defined by and in accordance with the comprehensive assessment and plan of care. If children are admitted to the facility, care and services must be provided to meet their unique medical and developmental needs.]

[—(1) Activities of daily living. Based on the comprehensive assessment of the resident, the facility must ensure that:]

[——(A) a resident’s abilities in activities of daily living do not diminish unless the circumstances of the individual’s clinical condition demonstrate that diminution is unavoidable. This includes the resident’s abilities to:]

[—— (i) bathe, dress, and groom;]

[—— (ii) transfer and ambulate;]

[—— (iii) toilet;]

[—— (iv) eat; and]

[—— (v) use speech, language, or other functional communication systems;]

[—— (B) the resident is given the appropriate treatment and services to maintain or improve his abilities specified in paragraph (1) of this section;]
(C) a resident who is unable to carry out activities of daily living receives the necessary
services to maintain good nutrition, grooming, and personal and oral hygiene.

(1) [(2)] Vision and hearing. To ensure that residents receive proper treatment and assistive
devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident:

(A) in making appointments; and

(B) by arranging for transportation to and from the office of a practitioner specializing in
the treatment of vision or hearing impairment or the office of a professional specializing in the
provision of vision or hearing assistive devices.

(2) [(3)] Skin Integrity.

(A) Pressure ulcers [sores]. Based on the comprehensive assessment of the resident, the
facility must ensure that:

(i) [(A)] a resident receives care, consistent with professional standards of practice, to
prevent [who enters the facility without] pressure ulcers [sores] and does not develop pressure
ulcers [sores] unless his clinical condition demonstrates that they are unavoidable; and

(ii) [(B)] a resident with [having] pressure ulcers [sores] receives necessary treatment
and services, consistent with professional standards of practice, to promote healing, prevent
infection, and prevent new ulcers [sores] from developing.

(B) Foot Care. To ensure that residents receive proper treatment and care to maintain
mobility and good foot health, the facility must:

(i) provide foot care and treatment, in accordance with professional standards of
practice, including to prevent complications from the resident’s medical condition; and

(ii) if necessary, assist the resident in making appointments with a qualified person,
and arranging for transportation to and from such appointments.

(3) [(4)] Incontinence [Urinary incontinence].

(A) The facility must ensure that a resident who is continent of bladder and bowel on
admission receives services and assistance to maintain continence unless his or her clinical
condition is or becomes such that continence is not possible to maintain

(B) For a resident with urinary incontinence, based [Based] on the comprehensive
assessment of the resident, the facility must ensure that:

(i) [(A)] a resident who enters the facility without an indwelling catheter is not
catheterized unless his clinical condition demonstrates that catheterization is necessary; [and]
(ii) a resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident’s clinical condition demonstrates that catheterization is necessary; and

(iii) a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

[(B) a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.]

(C) For a resident with fecal incontinence, based on the resident’s comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.

(4) Colostomy, urostomy, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents’ goals and preferences.

(5) Mobility. The facility must ensure that:

(A) a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; [and]

(B) a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion; and [−]

(C) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is unavoidable.

(6) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident’s comprehensive assessment, the facility must ensure that a resident:

(A) maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident’s clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

(B) is offered sufficient fluid intake to maintain proper hydration and health;

(C) is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet;
(D) who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident’s clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and

(E) who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

[(6) Mental and psychosocial functioning. Based on the comprehensive assessment of the resident, the facility must ensure that:

[(A) a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem; and]

[(B) a resident whose assessment does not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless his clinical condition demonstrates that such a pattern is unavoidable.]

[(7) Naso-gastric tube. Based on the comprehensive assessment of the resident, the facility must ensure that:

[(A) a resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless his clinical condition demonstrates that use of a naso-gastric tube is unavoidable; and]

[(B) a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers, and to restore, if possible, normal eating skills.]

(7) (8) Accidents. The facility must ensure that:

(A) the resident environment remains as free of accident hazards as possible; and

(B) each resident receives adequate supervision and assistive devices to prevent accidents.

(8) Parenteral fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident’s goals and preferences.

(9) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the
comprehensive person-centered care plan, the resident’s goals and preferences, and §19.802 of this title, relating to Comprehensive Person-Centered Care Plannings.

(10) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident’s goals and preferences, to wear and be able to use the prosthetic device.

(11) Pain management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents’ goals and preferences.

(12) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents’ goals and preferences.

(13) Trauma-informed care. Effective November 28, 2019, the facility must ensure that a resident who are trauma survivors receive culturally-competent, trauma-informed care in accordance with professional standards of practice and accounting for residents’ experiences and preferences in order to eliminate or mitigate triggers that my cause re-traumatization of the resident.

(14) Bed rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use and maintenance of bed rails, including but not limited to the following elements:

(A) assess the resident for risk of entrapment from bed rails prior to installation.

(B) review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(C) ensure the bed’s dimensions are appropriate for the resident’s size and weight; and

(D) follow the manufactures’ recommendations and specifications for installing and maintaining bed rails.

(9) Nutrition. Based on the comprehensive assessment of the resident, the facility must ensure that a resident:

(A) maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless his clinical condition demonstrates that this is not possible; and

(B) receives a therapeutic diet when there is a nutritional problem.

(10) Hydration. The facility must ensure that the resident is provided with sufficient fluid intake to maintain proper hydration and health.
(11) Special needs. The facility must ensure that residents receive proper treatment and care for the following special services:

(A) injections;

(B) parenteral or enteral fluids;

(C) colostomy, ureterostomy, or ileostomy care;

(D) tracheostomy care;

(E) tracheal suctioning;

(F) respiratory care;

(G) foot care; and

(H) prostheses.

(12) Unnecessary drugs.

(A) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

(i) in excessive dose (including duplicate drug therapy); or

(ii) for excessive duration; or

(iii) without adequate monitoring; or

(iv) without adequate indications for its use; or

(v) in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(vi) any combination of the circumstances in clauses (i)-(v) of this subparagraph.

(B) Antipsychotic drugs. Based on the comprehensive assessment of the resident, the facility must ensure that:

(i) residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and

(ii) residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue use of these
[(13) Medication errors. The facility must ensure that:]

[(A) it is free of medication error rates of 5.0% or greater; and]

[(B) residents are free of significant medication errors.]

(15) [(14)] Pediatric care.

(A) Licensed nursing care of children. A facility caring for children must have 24 hour a day on-site licensed nursing staff in numbers sufficient to provide safe care. For any facility with five or more children under 26 pounds, at least one nurse must be assigned solely to the care of those children.

(B) Fewer than five pediatric residents. Facilities with fewer than five pediatric residents must assure that the children's rooms are in close proximity to the nurses' station.

(C) Respiratory care of children.

(i) To facilitate the care of ventilator-dependent children or children with tracheostomies, a facility must group those children in rooms contiguous or in close proximity to each other. An exception to this rule is children who are able to be schooled off-site.

(ii) Facilities must assure that alarms on ventilators, apnea monitors, and any other such equipment uniquely identify the child or the child's room.

(iii) A facility caring for children with tracheostomies requiring daily care (including ventilator-dependent children with tracheostomies) must have 24 hour a day on-site respiratory therapy staff in numbers sufficient to provide a safe ratio of respiratory therapist per these residents. For the purposes of this rule, respiratory therapy staff is defined as a registered respiratory therapist (RRT), a certified respiratory therapy technician (CRT), or a licensed nurse whose primary function is respiratory care.

(I) If the facility cares for nine or more children with tracheostomies requiring daily care (including ventilator-dependent children with tracheostomies), the facility must maintain a ratio of no less than one respiratory therapy staff per nine tracheostomy residents 24 hours a day.

(II) If the facility cares for six or more ventilator dependent children, the facility must:

(-a-) designate a respiratory therapy supervisor, either on staff or contracted who must be credentialed by the National Board for Respiratory Care (either CRT or RRT).

(-b-) provide and document that all respiratory therapy staff is trained in the
care of children who are ventilator dependent. This training must be reviewed annually.

(-c-) assure that appropriate care, maintenance, and disinfection of all ventilator equipment and accessories occurs.


Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

(1) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility’s resident population in accordance with §19.1931 of this title (relating to Facility Assessment). These competencies and skills sets include knowledge of and appropriate training and supervision for:

(A) caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §19.1931 of this title (relating to Facility Assessment); and

(B) implementing non-pharmacological interventions.

(2) Based on the comprehensive assessment of a resident, the facility must ensure that—

(A) a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma or posttraumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;

(B) A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma or post-traumatic stress disorder does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident’s clinical condition demonstrates that development of such a pattern was unavoidable; and

(C) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.

(3) If rehabilitative services such as physical therapy, speech-language pathology, occupational therapy, and rehabilitative services for mental disorders and intellectual disability,
are required in the resident’s comprehensive plan of care, the facility must—

(A) provide the required services, including specialized rehabilitation services as required in §19.802 of this title (relating to Comprehensive Person-Centered Care Planning).

(B) obtain the required services from an outside resource in accordance with §19.1906 of this title (relating to Use of Outside Resources), from a Medicare or Medicaid provider of specialized rehabilitative services.

(4) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.


(a) The facility must have sufficient staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility’s resident population in accordance with the facility assessment required at §19.1931 of this title (relating to Facility Assessment). Nursing services to children must be provided by staff who have been instructed and have demonstrated competence in the care of children. Care and services are to be provided as specified in §19.901 of this chapter (relating to Quality of Care).

(1) Sufficient staff.

(A) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) licensed nurses, except when waived under paragraph (3) of this subsection; and

(ii) other nursing personnel, including nurse aides.

(B) The facility must designate a licensed nurse to serve as a charge nurse on each shift, except when waived under paragraph (3) of this subsection.
(C) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents’ needs, as identified through resident assessments, and described in the plan of care.

(D) Providing care includes assessing, evaluating, planning and implementing resident care plans and responding to residents’ needs.

(2) Registered nurse.

(A) The facility must use the services of a registered nurse for at least eight consecutive hours a day, seven days a week, except when waived under paragraph (3) or (4) of this subsection.

(B) The facility must designate a registered nurse to serve as the director of nursing on a full-time basis, 40 hours per week, except when waived under paragraph (4) of this subsection.

(C) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

(3) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in their plans of care.

(4) Requirements for facility hiring and use of nursing aides.

(A) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless:

(i) That individual is competent to provide nursing and nursing related services; and

(ii) that individual:

(I) has completed a training and competency evaluation program, or a competency evaluation program approved by the state as meeting the requirements of 42 CFR §§483.151-493.154; or

(II) has been deemed or determined competent as provided in 42 CFR §483.150(a) and (b).

(B) Nonpermanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (2)(A) and (B) of this section.

(C) Competency. A facility must not use any individual who has worked less than four months as a nurse aide in that facility unless the individual:
(i) is a full-time employee in a state-approved training and competency evaluation program;

(ii) has demonstrated competence through satisfactory participation in a state-approved nurse aide training and competency evaluation program, or competency evaluation program; or

(iii) has been deemed or determined competent as provided in 42 CFR §483.150(a) and (b).

(D) Registry Verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements and is not designated in the registry as having a finding concerning abuse, neglect or mistreatment of a resident, or misappropriation of a resident's property, unless:

(i) the individual is a full-time employee in a training and competency evaluation program approved by the state; or

(ii) the individual can prove that he has recently successfully completed a training and competency evaluation program, or competency evaluation program approved by the state and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.

(E) Multi-state registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every state registry, established under §1819(e)(2)(A) or §1919(e)(2)(A) of the Social Security Act, that the facility believes will include information about the individual.

(F) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.

(G) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must:

(i) be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year;

(ii) address areas of weakness as determined in nurse aides' performance reviews and facility assessment at §19.1931 (relating to Facility Assessment), and may address the special needs of residents as determined by the facility staff;

(iii) for nurse aides providing services to individuals with cognitive impairments, also
address the care of the cognitively impaired; and

(iv) include dementia management training and resident abuse prevention training.

(H) The facility must comply with the nurse aide training and registry rules found in Chapter 94 of this title (relating to Nurse Aides).

(5) [(4)] Waiver of requirement to provide licensed nurses on a 24-hour basis.

(A) To the extent that a facility is unable to meet the requirements of paragraphs (1)(B) and (2)(A) of this subsection, the state may waive these requirements with respect to the facility, if:

(i) the facility demonstrates to the satisfaction of HHSC [the Texas Department of Aging and Disability Services (DADS)] that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel;

(ii) HHSC [DADS] determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility;

(iii) the state finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility; and

(iv) the waivered facility has a full-time registered or licensed vocational nurse on the day shift seven days a week. For purposes of this requirement, the starting time for the day shift must be between 6 a.m. and 9 a.m. The facility must specify in writing the schedule that it follows.

(B) A waiver granted under the conditions listed in this paragraph is subject to annual state review.

(C) In granting or renewing a waiver, a facility may be required by the state to use other qualified, licensed personnel.

(D) The state agency granting a waiver of these requirements provides notice of the waiver to the state long term care ombudsman (established under §712 [(§307(a)(12)] of the Older Americans Act of 1965) and the protection and advocacy systems [system] in the state for individuals with intellectual disabilities established under the Developmental Disabilities Assistance and Bill of Rights Act (42 USC Chapter 144, Subchapter I, Part C) and individuals with mental illness established under the Protection and Advocacy for Mentally Ill Individuals Act (42 USC Chapter 114, Subchapter I) [the mentally ill and mentally retarded].

(E) The nursing facility that is granted a waiver by the state notifies residents of the facility and their resident representatives [(or, when appropriate, the guardians or legal

95
Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week in a Medicare skilled nursing facility (SNF).

(A) The secretary of the U.S. Department of Health and Human Services (secretary) may waive the requirement that a Medicare SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (2) of this subsection, if the secretary finds that:

(i) the facility is located in a rural area and the supply of Medicare SNF services in the area is not sufficient to meet the needs of individuals residing in the area;

(ii) the facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and

(iii) the facility either has:

(I) only residents whose physicians have indicated (through physician's orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hour period; or

(II) made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty.

(B) The secretary provides notice of the waiver to the state long term care ombudsman (established under §712 [§307(a)(12)] of the Older Americans Act of 1965) and the protection and advocacy systems [system] in the state for individuals with intellectual disabilities established under the Developmental Disabilities Assistance and Bill of Rights Act (42 USC Chapter 144, Subchapter I, Part C) and individuals with mental illness established under the Protection and Advocacy for Mentally Ill Individuals Act (42 USC Chapter 114, Subchapter I) [the mentally ill and mentally retarded].

(C) The SNF that is granted a waiver [by the state] notifies residents of the facility (or, when appropriate, the guardians or legal representatives of the residents) and members of their immediate families of the waiver.

(D) A waiver of the registered nurse requirement under subparagraph (A) of this paragraph is subject to annual renewal by the secretary.

(7) [(5)] Request for waiver concerning staffing levels. The facility must request a waiver through the local HHSC [DADS] Regulatory Services Division, in writing, at any time the administrator determines that staffing will fall, or has fallen, below that required in paragraphs (1) and (2) of this subsection for a period of 30 days or more out of any 45 days.
(A) The following information must be included in the request/notification:

(i) beginning date when facility was/is unable to meet staffing requirements;

(ii) type waiver requested (24-hour licensed nurse or seven-day-per-week RN);

(iii) projected number of hours per month staffing reduced for 24-hour licensed nurse waiver or seven-day-per-week RN waiver; and

(iv) staffing adjustments made due to inability to meet staffing requirements.

(B) Waivers for licensed-only or certified facilities will be granted by HHSC [DADS] Regulatory Services Division staff. Waivers for a Medicare SNF receive final approval from the Centers for Medicare and Medicaid Services.

(C) If a facility, after requesting a waiver, is later able to meet the staffing requirements of paragraphs (1) and (2) of this subsection, HHSC [DADS] Regulatory Services Division staff must be notified, in writing, of the effective date that staffing meets requirements.

(D) Verification that the facility appropriately made a request and notification will be done at the time of survey.

(E) Amounts paid to Medicaid-certified facilities in the per diem payment to meet the staffing requirements of paragraphs (1) and (2) of this subsection may be adjusted if staffing requirements are not met.

(8) [(6)] Duration of waiver. Approved waivers are valid throughout the facility licensure or certification period, unless approval is withdrawn. During the relicensure or recertification survey, the determination is made for approval or denial for the next facility licensure or certification period if a waiver continues to be necessary. The facility requests a redetermination for a waiver from HHSC [DADS] Regulatory Services Division staff at the time the survey is scheduled. At other times if a request is made, HHSC [DADS] staff may schedule a visit for waiver determination.

(9) [(7)] Requirements for waiver approval. To be approved for a waiver, the nursing facility must meet all of the requirements stated in this subchapter and the requirements specified throughout this chapter. In some instances, the survey agency may require additional conditions or arrangements such as:

(A) an additional licensed vocational nurse on day-shift duty when the registered nurse is absent;

(B) modification of nursing services operations; and

(C) modification of the physical environment relating to nursing services.
Denial or withdrawal of a waiver. Denial or withdrawal of a waiver may be made at any time if any of the following conditions exist:

(A) requirements for a waiver are not met on a continuing basis;

(B) the quality of resident care is not acceptable; or

(C) justified complaints are found in areas affecting resident care.

Requirement that SNFs be in a rural area. A SNF (Medicare) must be in a rural area for waiver consideration, as specified in paragraph (4) of this subsection. A rural area is any area outside the boundaries of a standard metropolitan statistical area. Rural areas are defined and designated by the federal Office of Management and Budget; are determined by population, economic, and social requirements; and are subject to revisions.

(b) Nurse staffing information.

(1) Data requirements. The facility must post the following information:

(A) on a daily basis:

   (i) the facility name;

   (ii) the current date;

   (iii) the resident census; and

   (iv) the specific shifts for the day; and

(B) at the beginning of each shift, the total number of hours and actual time of day to be worked by the following licensed and unlicensed nursing staff, including relief personnel directly responsible for resident care:

   (i) RNs;

   (ii) LVNs; and

   (iii) CNAs.

(2) Posting requirements. The nursing facility must post the data described in paragraph (1) of this subsection:

(A) in a clear and readable format; and

(B) in a prominent place readily accessible to residents and visitors.
(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make copies of nurse staffing data available to the public for review at a cost not to exceed the community standard rate.

(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for the period of time specified by written facility policy or for at least two years following the last day in the schedule, whichever is longer.


(a) Licensed nurses must practice within the constraints of applicable state laws and regulations governing their practice, including the Nurse Practice Act, and must follow the guidelines contained in the facility's written policies and procedures.

(b) Nurses must enter, or approve and sign, nurses' notes in the following instances:

(1) at least monthly; and

(2) at the time of any physical complaints, accidents, incidents, and change in condition or diagnosis, and progress. All of these situations must be promptly recorded as exceptions and included in the clinical record.

(c) If permitted by written policies of the nursing facility, an RN or a physician's assistant may determine and pronounce a resident dead unless a resident is being supported by artificial means that preclude a determination that the resident's spontaneous respiratory and circulatory functions have ceased. The facility's nursing staff and the medical staff or consultant must have jointly developed and approved the policies. The policies must include the following requirements:

(1) The apparent death of a resident must be reported immediately to the attending physician, relatives, and any guardian or legal representatives.

(2) The body of a deceased resident must not be removed from the facility without a physician's or registered nurse's authorization. Telephone authorization is acceptable, if not in conflict with local regulations. Authorization by a justice of the peace, acting as a coroner, is sufficient when the attending or consulting physician or registered nurse is not available.

(3) A death that involves trauma, or unusual or suspicious circumstances, must be reported immediately, in accordance with local regulations, and to HHSC [DADS], in accordance with §19.602(g)(2) [§19.602(e)(2)] of this chapter (relating to Incidents of Abuse, [and] Neglect, and Exploitation Reportable to the Texas Health and Human Service Commission [Department of Aging and Disability (DADS)] and Law Enforcement Agencies by Facilities). Deaths must also be reported to HHSC [DADS] monthly, in accordance with §19.606 of this chapter (relating to Reporting of Resident Death Information).
§19.1101. Food and Nutrition Services [Dietary Service].

The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets daily nutritional and special dietary needs of each resident, taking into consideration the preferences of each resident.

§19.1102. Staffing.

The facility must employ sufficient staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition services, taking into consideration resident assessments, individual plans of care, and the number, acuity, and diagnoses of the facility’s resident population in accordance with the facility assessment required at §19.1931 of this title (relating to Facility Assessment). This includes:

(1) a qualified dietitian either full-time, part-time, or on a consultant basis. A qualified dietitian is one who:

   (A) holds a bachelors’ or higher degree granted by a regionally accredited college or university in the United States, or an equivalent foreign degree, with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose;

   (B) has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional; and

   (C) is licensed as a dietitian by the state of Texas;

(2) A dietitian hired or contracted with prior to November 28, 2016 that does not meet the requirements in (1)(A-C) must:

   (A) be either:

       (i) registered by the Commission on Dietetic Registration or;

       (ii) licensed, or provisionally licensed, by the Texas Department of Licensing and Regulation with at least one year of supervisory experience in dietetic service of a health care facility; and
(B) meet the requirements in (1)(A-C) by November 28, 2021.

(3) If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who receives frequent scheduled consultations from a qualified dietitian and who:

(A) is a certified dietary manager; or

(B) is a certified food service manager; or

(C) has similar national certification for food service management and safety from a national certifying body; or

(D) has an associate’s or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning.

(4) A director of food and nutrition services who is not a qualified dietitian and who does not meet the requirements in (3)(A-D), who was designated prior to November 28, 2016 must:

(A) be at least:

(i) an associate-in-arts graduate in nutrition and food service management; or

(ii) a graduate of a dietetic technician or dietetic assistant training program approved by the Academy of Nutrition and Dietetics or the Association of Nutrition & Foodservice Professionals; and

(B) meet one of the requirements in (3)(A-D) by November 28, 2021.

(5) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.

[§19.1102. Staffing.]

[The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis.]

[(1) A qualified dietitian is one who is qualified based upon either:]

[(A) registration by the Commission on Dietetic Registration of the American Dietetic Association; or]

[(B) licensure, or provisional licensure, by the Texas State Board of Examiners of]
Dietitians. These individuals must have one year of supervisory experience in dietetic service of a health care facility.]

[(2) If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian.]

[(3) The designated director of food service is responsible for the overall operation of the dietary service. If the director is not a qualified dietitian, he must receive consultation from a qualified dietitian. The director of food service must participate in regular conferences with the administrator and with the registered nurse who has responsibility for the resident and the resident's plan of care. In conferences concerning the resident's plan of care, the director of food service must provide information about approaches to identified nutritional problems. The director of food service should make recommendations and assist in developing personnel policies.]

[(4) The director of food service must be at least:]

[(A) a qualified dietitian;]

[(B) an associate-in-arts graduate in nutrition and food management (such as Dietetics, Home Economics, or Restaurant Management);]

[(C) a graduate of a dietetic technician or dietetic assistant training program approved by the American Dietetic Association, or the Dietary Manager's Association, whether conducted by correspondence or in a classroom;]

[(D) a person who has completed a state agency approved 90-hour course in food service supervision; or]

[(E) a person who has training and experience in food service supervision and management in a military service equivalent in content to the programs in subparagraphs (A) (D) of this paragraph and has had his training credentials evaluated and approved by the nutrition program specialist of the Texas Department of Human Services' Long Term Care Regulatory.]


[The facility must employ sufficient dietary support personnel who are competent to carry out the functions of the dietary service.]

§19.1104. Dietary Consultant Requirements.
(a) The facility must ensure a qualified dietitian is available as frequently and for such time as is necessary to assure each resident a diet that meets the daily nutritional and special dietary needs of each resident, based upon the acuity and clinical needs of the resident. The facility must ensure that monthly dietary consultant hours are provided, at a minimum, as follows:

1. facility population: 60 residents or under - eight hours;
2. facility population: each additional 30 residents or fraction thereof - additional four hours.

(b) To meet the consultant-hour requirement, time is accrued and counted exactly as rendered.

(c) The qualified dietitian must be a part of the interdisciplinary team conducting assessment and care planning where indicated by the individual resident's needs.

(d) The facility must outline consultant services in a signed contract. This requirement does not apply to facilities which employ a qualified dietitian on their staff.


(a) Menus must:

1. meet the nutritional needs of residents in accordance with established national guidelines [the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences];
2. be prepared at least one week in advance;
3. be written for each type of diet ordered in the facility, in accordance with the facility's diet manual;
4. be written or completely evaluated by the facility's qualified dietitian [dietitian or consultant dietitian];
5. vary from week to week, taking the general age-group of residents into consideration;
6. be followed unless [any] substitutions are [must be] documented as required in subsection (d) of this section; and [ ]
7. reflect, based on a facility’s reasonable effort, the religious, cultural, and ethnic needs of the resident population, as well as input received from residents and resident groups.

(b) A qualified dietitian may accept diet orders and changes from the physician.

(c) The facility must ensure that a current diet manual, approved by the qualified dietitian
(facility dietitian or the consultant dietitian], is readily available to dietary service personnel and the supervisor of nursing service. To be current, the diet manual must be no more than five years old.

(d) The facility must retain records of menus served, including substitutions, and food purchased for 30 days. A list of residents receiving special diets and a record of their diets must be kept in the dietary area for at least 30 days.

(e) The facility must post the current week's menu:

(1) in the dietary department, including therapeutic diet menus, so employees responsible for purchasing, preparing, and serving foods can use it; and

(2) in a convenient location so the residents may see it.

(f) The dietary department must keep a seven-day supply of staple foods and a two-day supply of perishable foods at all times. The facility is allowed the flexibility to use food on hand to make substitutions at any interval as long as comparable nutritional value is maintained. Any substitution of menu items must be recorded on the day of use. [See also §19.1719(o)(1) of this title (relating to Other Rooms and Areas) for information concerning storage areas.]

(g) Accommodation of resident needs. The facility must provide:

(1) table service for all who can and will eat at the table, including wheelchair residents;

(2) firm supports, such as over-bed tables, for serving trays to bedfast residents;

(3) sturdy tray stands of proper height to residents able to be out of bed for their meals;

(4) special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks; and

(5) prompt assistance for residents who need help eating.

(h) An identification system, such as tray cards, must be available to ensure that all diets are served in accordance with physician's orders.

(i) Nothing in this section limits a resident’s right to make personal dietary choices.

§19.1108. Food and Drink.

Each resident must receive and the facility must provide:
(1) food prepared in accordance with established professional food preparation practices and by methods that conserve nutritive value, flavor, and appearance;

(2) adequate amounts of food and drink that is palatable, attractive, and at the proper temperature;

(3) food prepared in a form designed to meet individual needs;

(4) substitutes of similar nutritive value to residents who refuse food served; [and]

(5) food that is prepared and served on schedule; [and]

(6) food that accommodates resident allergies, intolerances and preferences; and

(7) drinks, including water and other liquids, consistent with resident needs and preferences and sufficient to maintain resident hydration.

§19.1109. Food Intake.

Food intake of residents must be monitored and recorded as follows.

(1) Deviations from normal food and fluid intake must be recorded in the clinical records in accordance with §19.1911(b)(16)(E) [See also §19.1911(12)(B)(vi)] of this title (relating to Contents of the Clinical Record) for information concerning dietary intake and clinical records.

(2) In-between meals and bedtime snacks, and supplementary feedings, either as a part of the overall care plan or as ordered by a physician, including caloric-restricted diets, must be documented using the point, percentage, or other system consistently facility-wide. [See also §19.1911(12)(B)(vi) of this title (relating to Contents of the Clinical Record) for information concerning dietary intake and clinical records.]

§19.1110. Frequency of Meals.

(a) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests and plan of care.

(b) There must be not more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in subsection (d) of this section.

(c) The facility must offer snacks at bedtime daily. Routine snacks that are not ordered by the physician and are not part of the plan of care do not need to be documented as accepted or
(c) [(d)] When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day, if a resident group agrees to this meal span [and a nourishing snack is served].

(d) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the residents’ plans of care.


(a) The facility must:

(1) procure food from sources approved or considered satisfactory by federal, state, and local authorities; 

(A) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.

(B) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food handling practices.

(C) This provision does not preclude residents from consuming foods not procured by the facility.

(2) store, prepare, and serve food under sanitary conditions, as required by the Texas Department of State Health Services food service sanitation requirements; [and]

(3) dispose of garbage and refuse properly [See also §19.318(j)-(l) of this title (relating to Other Rooms and Areas) for information concerning dietary physical plant.]; and

(4) have a written policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling and consumption.

(b) Dietary service personnel must be in good health and practice hygienic food-handling techniques. Persons with symptoms of communicable diseases or open, infected wounds may not work.

(c) Dietary service personnel must wear clean, washable garments, wear hair coverings or clean caps, and have clean hands and fingernails.

(d) The facility and all food service personnel must meet the standards imposed by local, state, and federal codes regarding food and food handling. [Routine health examinations must meet all
§19.1113. Paid Feeding Assistants.

(a) State-approved training course. The facility may use a paid feeding assistant, if the paid feeding assistant has successfully completed a state-approved training course that meets the requirements of §19.1115 of this subchapter [chapter] (relating to Requirements for Training of Paid Feeding Assistants) before feeding residents. [The facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed the state-approved training course for paid feeding assistants.]

(b) Supervision. A paid feeding assistant must work under the supervision of an RN or an LVN [a registered nurse or a licensed vocational nurse]. In an emergency, a paid feeding assistant must call a supervisory nurse for help. A paid feeding assistant can only feed residents in the dining room.

(c) Resident selection criteria.

(1) The facility must ensure that a paid feeding assistant only feed residents who have no complicated feeding problems, which include difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.

(2) The facility must base resident selection on the IDT’s [charge nurse’s] assessment and the resident’s latest assessment and plan of care. A resident’s comprehensive care plan must reflect the resident’s appropriateness for a paid feeding assistant.

§19.1116. Therapeutic Diets.

If a resident requires a therapeutic diet, the attending physician must prescribe the therapeutic diet, unless the physician delegates this task to a qualified dietitian.

TITLE 40    SOCIAL SERVICES AND ASSISTANCE
PART 1    DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 19    NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION
SUBCHAPTER M    PHYSICIAN SERVICES

A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, or advanced practice registered nurse must provide orders for the resident's immediate care and needs.

The facility must ensure that:

(1) the medical care and other health care of each resident is supervised by an attending physician. Any consultations must be ordered by the attending physician;

(2) another physician supervises the medical care and other health care of residents when their attending physician is unavailable; and

(3) if children are admitted to the facility:

   (A) appropriate pediatric consultative services are utilized, in accordance with the comprehensive assessment and plan of care; and

   (B) a pediatrician or other physician with training or expertise in the clinical care of children with complex medical needs participates in all aspects of the medical care.


The physician must:

(1) review and/or revise and sign orders relating to the resident's total program of care, including medications and treatments, according to the visit schedule required by §19.1203(2) of this title (relating to Frequency of Physician Visits);

(2) write, sign, and date progress notes at each visit;

(3) sign and date all orders, with the exception of influenza and pneumococcal vaccines, which may be administered per physician standing order after an assessment for contraindications;

(4) write, sign, and date a physician's discharge summary within 20 workdays of being notified by the facility of the discharge, except as specified in §19.1912(e) of this title (relating to Additional Clinical Record Service Requirements), if the resident has been temporarily discharged for 30 days or less, and readmitted to the same facility; and

(5) provide documentation in the clinical record as specified in §19.1911 and §19.1912 of this title (relating to Contents of the Clinical Record, and Additional Clinical Record Service Requirements).

Physician visits must conform to the following schedule:

(1) Licensed-only facility. Each resident must have a medical examination at least annually by his physician and as necessary to meet the needs of the resident. Physician orders must be reviewed and revised as necessary at least once every 60 days, unless the resident's physician specifies, in writing in the resident's clinical record, a different schedule for each review and revision.

(2) Medicaid-certified facilities and Medicare skilled nursing facilities.

   (A) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

   (B) A physician visit is considered timely if it occurs not later than ten days after the date the visit was required.

   (C) Except as provided in paragraph (3) of this section and §19.1205(c) of this title (relating to Physician Delegation of Tasks), all required visits must be made by the physician personally.

(3) Medicare skilled nursing facilities. At the option of the physician, required visits in Medicare skilled nursing facilities after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or an advanced practice registered nurse [nurse practitioner, or clinical nurse specialist] in accordance with §19.1205 of this title (relating to Physician Delegation of Tasks).


(a) In a Medicare skilled nursing facility (SNF), except as specified in subsection (b) of this section, a physician may delegate tasks to a physician assistant, or an advanced practice registered nurse [nurse practitioner, or clinical nurse specialist] who:

   (1) meets the applicable definition in [42 Code of Federal Regulations, §491.2 (see] §19.101 of this title (relating to Definitions) [or in the case of a clinical nurse specialist, is licensed as such by the state];

   (2) is acting within the scope of practice as defined by state law; and

   (3) is under the supervision of the physician.
(b) In a Medicare SNF, a physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under state law or by the facility's own policies.

(c) In a Medicaid nursing facility, any required physician task may also be satisfied when performed by an advanced practice registered nurse [a nurse practitioner, clinical nurse specialist], or physician assistant who is not an employee of the facility but who is working in collaboration with a physician. Services must be provided in the context of applicable state laws, rules, and regulations governing the practice of an advanced practice registered nurse [nurse practitioners, clinical nurse specialists,] and physician assistants.

(d) A physician may delegate the task of writing dietary orders to a qualified dietitian who:

   (1) is acting within the scope of practice; and
   (2) is under the supervision of the physician.

(e) A physician may delegate the task of writing therapy orders to a qualified therapist who:

   (1) is acting within the scope of practice; and
   (2) is under the supervision of the physician.

(f) The physician extender providing care to a pediatric resident must have training and expertise in the care of children with complex medical needs.

TITLE 40 SOCIAL SERVICES AND ASSISTANCE
PART 1 DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION
SUBCHAPTER O DENTAL SERVICES


(a) The facility must assist residents in obtaining routine and 24-hour emergency dental care.

   (1) At the time of admission, the facility must obtain the name of the resident's preferred dentist and record the name in the clinical record.

   (2) At least annually, the facility must ask each resident and/or responsible party if they desire a dental examination at the resident's expense.

   (3) The facility must make all reasonable efforts to arrange for a dental examination for each
resident who desires one.

(4) The facility is not liable for the cost of the resident's dental care.

(5) Licensed-only facilities must maintain a list of local dentists for residents who require one.

(b) Medicaid-certified facilities also must provide or obtain from an outside resource, in accordance with §19.1906 of this title (relating to Use of Outside Resources), the following dental services to meet the needs of each resident:

(1) emergency dental services, which are limited to procedures necessary to control bleeding, relieve pain, and eliminate acute infection; operative procedures which are required to prevent the imminent loss of teeth; treatment of injuries to the teeth or supporting structures.

(A) Covered emergency dental procedures include [but are not limited to]:

   (i) alleviation of extreme pain in oral cavity associated with serious infection or swelling;

   (ii) repair of damage from loss of tooth due to trauma (acute care only, no restoration);

   (iii) open or closed reduction of fracture of the maxilla or mandible;

   (iv) repair of laceration in or around oral cavity;

   (v) excision of neoplasms, including benign, malignant and premalignant lesions, tumors and cysts;

   (vi) incision and drainage of cellulitis;

   (vii) root canal therapy. Payment is subject to dental necessity review and pre- and post-operative x-rays are required; and

   (viii) extractions: single tooth, permanent; single tooth, primary; supernumerary teeth; soft tissue impaction; partial bony impaction; complete bony impaction; surgical extraction of erupted tooth or residual root tip.

(B) Routine restorative procedures are not considered emergency procedures. Dental services not covered include [but are not limited to]:

   (i) cleaning;

   (ii) filling teeth with amalgam composite, glass ionomer, or any other restorative material;
(iii) cast or preformed crowns (capping);

(iv) restoration of carious or noncarious permanent or primary teeth, including those requiring root canal therapy;

(v) replacement or repositioning of teeth;

(vi) services to the alveolar ridges or periodontium of the maxilla and the mandible, except for procedures covered under subparagraph (A) of this paragraph; and

(vii) complete or partial dentures.

(2) assistance to the resident, if necessary:

(A) in making appointments; and

(B) by arranging for transportation to and from the dentist's office.

(3) prompt referral, within three days, of residents with lost or damaged dentures for dental services. If a referral does not occur within three days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay to a dentist.

(4) coordination of dental services for pediatric residents age 12 months to 21 years, in accordance with Texas Health Steps [Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)] guidelines.

(c) The facility must have a written policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and

(d) Medicaid-certified facilities are not required to provide routine dental services.

(e) Payment for services provided on the teeth, gums, alveolar ridges, and supporting structures are not a benefit of the Texas Medicaid Program; however, recipients with applied income may use incurred medical expenses to pay for routine dental services and appliances.

A licensed-only facility must assist the resident in obtaining routine drugs and biologicals and make emergency drugs readily available, or obtain them under an agreement described in §19.1906 of this title (relating to Use of Outside Resources). A Medicaid-certified facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §19.1906 of this title (relating to Use of Outside Resources). [See also §19.901(12) and (13) of this title (relating to Quality of Care) for information concerning drug therapy and medication errors.]

(1) Methods and procedures. The facility may permit unlicensed personnel to administer drugs, but only under the general supervision of a licensed nurse. The unlicensed individual must be a nursing student, a medication aide student, or a medication aide with a current permit issued by the HHSC [Texas Department of Human Services].

(2) Accuracy in service delivery. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(3) Service consultation. The facility must employ or obtain the services of a pharmacist, currently licensed by the Texas State Board of Pharmacy and in good standing, who:

   (A) provides consultation on all aspects of the provision of pharmacy services in the facility;

   (B) establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation;

   (C) determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled; and

   (D) adheres to requirements in §19.1503 of this title (relating to Additional Supervision and Consultation Requirements).

(4) Drug regimen review.

   (A) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The consultant pharmacist’s drug regimen review must be maintained in the resident’s clinical record. This review must include a review of the resident’s medical chart.

   (B) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs includes psychoactive medications as defined in §19.1207 of this title (relating to Prescription of Psychoactive Medication). These drugs include, but are not limited to, drugs in the following categories:

          (i) Anti-psychotic;
(ii) Anti-depressant;

(iii) Anti-anxiety; and

(iv) Hypnotic

The pharmacist must report any irregularities to the attending physician and the director of nursing, and these reports must be acted upon.

(i) Irregularities include any drug that meets the criteria set forth in paragraph (5) of this subsection;

(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility’s medical director and director of nursing and lists, at a minimum, the resident’s name, the relevant drug, and the irregularity the pharmacist identified;

(iii) The attending physician must document in the resident’s clinical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it, if there is to be no change in the medication, the attending physician must document his or her rationale in the resident’s medical record.

(D) The facility must develop and maintain written policies and procedures for the monthly drug regiment review that include time frames for the different steps in the process and steps the pharmacist must take when he identifies an irregularity that requires urgent action to protect the resident.

(5) Unnecessary Drugs. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

(A) in excessive dose (including duplicate drug therapy); or

(B) for excessive duration; or

(C) without adequate monitoring; or

(D) without adequate indications for its use; or

(E) in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(F) any combination of reason stated in paragraph (5)(A) through (E) of the subsection.

(6) Psychotropic drugs. Based on a comprehensive assessment of a resident, the facility must ensure that:
(A) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

(B) Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

(C) Residents do not receive psychotropic drugs pursuant to an PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

(D) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in paragraph (6)(E) of this subsection, if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she must document the rationale in the resident’s clinical record and indicate the duration for the PRN order;

(E) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of the medication.

(7) Medication errors. The facility must ensure that its:

(A) medication error rates are not 5 percent or greater; and

(B) residents are free of any significant medication errors.

(8) [§5] Labeling of drugs and biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principals and in compliance with the state laws and regulations [Texas State Board of Pharmacy Laws and Regulations, §291], including the appropriate accessory and cautionary instructions and the expiration date when applicable.

(9) [§6] Storage of drugs and biologicals.

(A) In accordance with state and federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.

(B) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs, listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976, and of other drugs subject to abuse, except when the facility uses single-unit-package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected [(see §19.1509 of this title (relating to Controlled Substances))].
§19.1601. Infection Control.

(a) Infection Control Program. The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections. Under the program, the facility must:

1. investigate, control, and prevent infections in the facility;
2. decide what procedures, such as isolation, should be applied to an individual resident; and
3. maintain a record of incidents and corrective actions related to infections.

(b) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

1. a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §19.1931 of this title (relating to Facility Assessment), and following accepted national standards;
2. written standards, policies, and procedures for the program, which must include:
   A. a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
   B. when and to whom possible incidents of communicable disease or infections should be reported;
   C. standard and transmission-based precautions to be followed to prevent spread of infections;
   D. when and how isolation should be used for a resident; including:
      i. the type and duration of the isolation, depending upon the infectious agent or
organism involved; and

(ii) a requirement that the isolation should be the least restrictive possible for the resident under the circumstances; and

(E) the circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(F) the hand hygiene procedures to be followed by staff involved in direct resident contact.

(3) an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use;

(4) a system for recording incidents identified under the facility’s IPCP and the corrective actions taken by the facility; and

(5) residents with communicable disease must be provided acceptable accommodations according to current practices and policies for infection control.

(6) Annual review. Effective November 28, 2019, the facility will conduct an annual review of its IPCP and update their program, as necessary.

(7) The Quality Assessment and Assurance Committee as described in §19.1917 of this title (relating to Quality Assessment and Assurance), will monitor the Infection Prevention and Control Program.

[b) Preventing spread of infection.]

[(1) If the facility determines in accordance with its infection control program, that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. Residents with communicable disease must be provided acceptable accommodations according to current practices and policies for infection control. See §19.1(b)(4)(I) of this title (relating to Basis and Scope) for information concerning the Centers for Disease Control and Prevention (CDC) guidelines.]

[(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.]

[(3) The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.]

[(4) The name of any resident with a reportable disease as specified in Title 25, Chapter 97, Subchapter A (relating to Control of Communicable Diseases) must be reported immediately to
the city health officer, county health officer, or health unit director having jurisdiction, and appropriate infection control procedures must be implemented as directed by the local health authority.

(c) Infection preventionist. Effective November 28, 2019, the facility must designate one or more individuals as the infection preventionist (IP) who are responsible for the facility’s IPCP. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility’s quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. The IP must:

   (1) have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;

   (2) be qualified by education, training, experience or certification;

   (3) work at least part-time at the facility; and

   (4) have completed specialized training in infection prevention and control.

(d) [49] Communicable Diseases.

   (1) The facility must have and implement written policies for the control of communicable diseases in employees and residents and must maintain evidence of compliance with local and state health codes and ordinances regarding employee and resident health status.

   (2) The name of any resident with a reportable disease as specified in Title 25, Chapter 97, Subchapter A (relating to Control of Communicable Diseases), must be reported immediately to the city health officer, county health officer, or health unit director having jurisdiction, and appropriate infection control procedures must be implemented as directed by the local health authority.

   (3) [(d)] Tuberculosis.

      (A) The facility must conduct and document an annual review that assesses the facility's current risk classification according to the current CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Settings.

      (B) The facility must screen all employees before providing services in the facility, according to CDC guidelines. The facility must require all persons providing services under an outside resource contract to provide evidence of a current tuberculosis screening prior to providing services in the facility. The facility must document or keep a copy of the evidence provided.

      (C) If the facility determines or suspects that an employee or person providing services under an outside resource contract has been exposed to or has a positive screening for a communicable disease, the facility must respond according to the current CDC guidelines and
keep documentation of the action taken.

(D) If the facility determines that an employee or a person providing services under an outside resource contract has been exposed to a communicable disease, the facility must conduct and document a reassessment of the risk classification. The facility must conduct and document subsequent screening based upon the reassessed risk classification.

(E) The facility must screen all residents at admission in accordance with the attending physician's recommendations and current CDC guidelines. If the facility determines or suspects that a resident has been exposed to a communicable disease or has a positive screening, the facility must respond according to the current CDC guidelines and attending physician's recommendations, and keep documentation of the response.

(e) Vaccinations.

(1) A facility must develop and implement a written policy to protect a resident from vaccine preventable diseases in accordance with Texas Health and Safety Code, Chapter 224.

(A) The policy must:

(i) require an employee, contractor, or other individual with privileges providing direct care to a resident to receive vaccines for the vaccine preventable diseases specified by the facility based on the level of risk the employee, contractor, or other individual presents to residents by the employee's, contractor's, or other individual's routine and direct exposure to residents;

(ii) specify the vaccines an employee, contractor, or other individual with privileges to provide direct resident care is required to receive in accordance with clause (i) of this subparagraph;

(iii) include procedures for the facility to verify that an employee, contractor, or other individual with privileges to provide direct resident care has complied with the policy;

(iv) include procedures for the facility to exempt an employee, contractor, or other individual with privileges to provide direct resident care from the required vaccines for the medical conditions identified as contraindications or precautions by the CDC;

(v) for an employee, contractor, or other individual with privileges to provide direct resident care who is exempt from the required vaccines, include procedures the employee, contractor, or other individual must follow to protect residents from exposure to vaccine preventable diseases, such as the use of protective equipment, such as gloves and masks, based on the level of risk the employee, contractor, or other individual presents to residents by the employee's, contractor's, or other individual's routine and direct exposure to residents;

(vi) prohibit discrimination or retaliatory action against an employee, contractor, or
other individual with privileges to provide direct resident care who is exempt from the required vaccines for the medical conditions identified as contraindications or precautions by the CDC, except that required use of protective medical equipment, such as gloves and masks, may not be considered retaliatory action;

(vii) require the facility to maintain a written or electronic record of each employee's, contractor's, or other individual's compliance with or exemption from the policy; and

(viii) include disciplinary actions the facility may take against an employee, contractor, or other individual with privileges to provide direct resident care who fails to comply with the policy.

(B) The policy may:

(i) include procedures for an employee, contractor, or other individual with privileges to provide direct resident care to be exempt from the required vaccines based on reasons of conscience, including a religious beliefs; and

(ii) prohibit an employee, contractor, or other individual with privileges to provide direct resident care who is exempt from the required vaccines from having contact with residents during a public health disaster, as defined in Texas Health and Safety Code, §81.003 (relating to Definitions).

(2) A facility must offer vaccinations to residents in accordance with an immunization schedule adopted by the Advisory Committee on Immunization Practices of the CDC.

(A) Pneumococcal vaccinations for residents. The facility must offer pneumococcal vaccination to a resident 65 years of age or older who has not received the vaccination and to a resident younger than 65 years of age, who has not received the vaccination but is a candidate for it because of chronic illness. A pneumococcal vaccination must be offered to a current resident of a facility and to a new resident at the time of admission. A vaccination must be completed unless a physician has indicated that the vaccination is medically contraindicated or the resident refuses the vaccination. The facility must develop and implement policies and procedures to ensure that:

(i) before offering the pneumococcal immunization, each resident or resident’s representative receives education regarding the benefits and potential side effects of the pneumococcal vaccination;

(ii) each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

(iii) the resident or the resident’s representative has the opportunity to refuse immunization; and

(iv) the resident’s clinical record includes documentation that indicates:
(I) the resident or the resident’s representative was provided education regarding the benefits and potential side effects of pneumococcal immunization;

(II) that the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal; and

(III) the date of the receipt or refusal of the pneumococcal vaccination.

[(i) The facility must develop and implement policies and procedures to ensure that the resident or resident’s legal representative receives education regarding the benefits and potential side effects of the pneumococcal vaccination. When a pneumococcal vaccination is offered, the facility must show in the resident medical record that this was provided.]

(v) [[ii]] Based on an assessment and practitioner recommendation, a second pneumococcal vaccination may be given five years after the first pneumococcal vaccination, unless medically contraindicated or the resident or the resident’s [legal] representative refuses the second vaccination.

(B) Influenza vaccinations for residents and employees. The facility must offer influenza vaccinations to residents and employees in contact with residents, unless the vaccination is medically contraindicated by a physician or the employee or resident has refused the vaccination.

(i) Influenza vaccinations for all residents and employees in contact with residents must be completed by November 30 of each year. Employees hired or residents admitted after this date and during the influenza season (through March of each year) must receive influenza vaccinations, unless medically contraindicated by a physician or the employee, the resident, or the resident’s legal representative refuses the vaccination.

(ii) The facility must develop and implement policies and procedures that ensure that;

(I) before offering the influenza immunization, each [the] resident or resident's [legal] representative receives education regarding the benefits and potential side effects of the influenza vaccination; and [.]

(II) the resident’s medical record includes documentation that indicates:

(-a-) that the resident or the resident’s representative was provided education regarding the benefits and potential side effects of influenza immunization;

(-b-) that the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal; and

(-c-) the date of the receipt or refusal of the annual influenza vaccination.

[When an influenza vaccination is offered, the facility must show in the resident medical record that this education was provided.]
(3) [(C)] Hepatitis B vaccinations for employees. The facility must develop a method to identify employees at risk of directly contacting blood or potentially infectious materials. The facility must offer an employee identified as being at risk of directly contacting blood or potentially infectious materials a hepatitis B vaccine within 10 days of employment. If the employee initially declines the hepatitis B vaccination but at a later date, while still at risk of directly contacting blood or potentially infectious materials, decides to accept the vaccination, the facility must make the vaccination available within 10 days after the employee decides to accept that vaccination.

[(D) Documentation of receipt, refusal, or contraindication of vaccination.]

[(i) Except as provided in clause (ii) of this subparagraph, the medical record for each resident must show the date of the receipt or refusal of the annual influenza vaccination and the pneumococcal vaccination.]

[(ii) If a resident does not receive or refuse a vaccination, the resident's medical record must show the resident did not receive the annual influenza vaccination or the pneumococcal vaccination due to a medical contraindication.]

(f) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection and in accordance with §19.325 of this chapter (relating to Linen).

[(g) The Quality Assessment and Assurance Committee as described in §19.1917 of this chapter (relating to Quality Assessment and Assurance) will monitor the infection control program.]

TITLE 40    SOCIAL SERVICES AND ASSISTANCE
PART 1     DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 19  NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION
SUBCHAPTER T  ADMINISTRATION

§19.1901. Administration.

A nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

(1) Licensure. A nursing facility (NF) must be licensed by HHSC [the Texas Department of Human Services (DHS)] as described in §19.201 of this title (relating to Criteria for Licensing).

(2) Compliance with federal, state, and local laws and professional standards. The facility must operate and provide services in compliance with all applicable federal, state, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.
(3) Medicaid-certified facilities' relationship to other Health and Human Services regulations. In addition to compliance with the regulations set forth in these Nursing Facility Requirements for Licensure and Certification, as Medicaid providers, facilities are obliged to meet the applicable provisions of other federal regulations, including [but not limited to] those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR [Code of Federal Regulations], Part 80), nondiscrimination on the basis of handicap (45 CFR [Code of Federal Regulations], Part 84), nondiscrimination on the basis of age (45 CFR [Code of Federal Regulations], Part 91), nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR, part 92), protection of human subjects of research (45 CFR [Code of Federal Regulations], Part 46), and fraud and abuse (42 CFR [Code of Federal Regulations], Part 455); and protection of individually identifiable health information (45 CFR, parts 160 and 164). Although these regulations are not in themselves considered requirements under 42 CFR, [Code of Federal Regulations] part 483, their violation may result in the termination or suspension of payment with federal funds, or the refusal to grant or continue payment with federal funds.


(a) The facility must have a governing body, or designated persons functioning as a governing body that is legally responsible for establishing and implementing policies regarding the management and operation of the facility. The governing body must have periodically updated written policies and procedures that are formally adopted and dated, specifying and governing all services. The policies and procedures must be available to all of the facility's governing body's members, staff, residents, family or [legal] representatives of residents, and the public. The governing body must:

(1) designate a person to exercise the administrator's authority when the facility does not have an administrator. The facility must secure a licensed nursing home administrator within 30 days; [and]

(2) ensure that a person designated as being in authority notifies HHSC [the Texas Department of Human Services] immediately when the facility does not have an administrator; [and]

(3) effective November 28, 2019, be responsible and accountable for the QAPI program, as required by §19.1927 of this title (relating to Quality Assurance and Performance Improvement Program).

(b) The governing board appoints the [The] facility must operate under the supervision of a nursing facility administrator who is:

(1) licensed by the Texas Board of Nursing Facility Administrators;

(2) responsible for management of the facility; [and]

123
required to work at least 40 hours per week on administrative duties; and [ ]

accountable to and who reports to the governing body for the overall management of the nursing facility.

The administrator must be accountable to the governing body for overall management of the nursing facility.

§19.1903. Required Training of Nurse Aides.

See also §19.1929 of this title (relating to Staff Development).

(1) Definitions. The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise.

(A) Licensed health professional—A physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; physical or occupational therapy assistant; registered professional nurse; licensed practical nurse; or licensed or certified social worker.

(B) Nurse aide—An individual providing nursing or nursing-related services to residents in a facility under the supervision of a licensed nurse. This definition does not include an individual who is a licensed health professional or a registered dietitian or someone who volunteers such services without monetary compensation.

(2) General rule. A facility must not use any individual working in the facility as a nurse aide for more than four months, on a full-time basis, unless:

(A) that individual is competent to provide nursing and nursing related services, and

(B) that individual:

(i) has completed a training and competency evaluation program, or a competency evaluation program approved by the state as meeting the requirements of 42 Code of Federal Regulations §§483.151-493.154; or

(ii) has been deemed or determined competent as provided in 42 Code of Federal Regulations §483.150(a) and (b).

(3) Nonpermanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (2)(A) and (B) of this section.

(4) Competency. A facility must not use any individual who has worked less than four months as a nurse aide in that facility unless the individual:}
[(A) is a full-time employee in a state-approved training and competency evaluation program;]

[(B) has demonstrated competence through satisfactory participation in a state-approved nurse aide training and competency evaluation program, or competency evaluation program; or]

[(C) has been deemed or determined competent as provided in 42 Code of Federal Regulations §483.150(a) and (b).]

[(5) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements and is not designated in the registry as having a finding concerning abuse, neglect or mistreatment of a resident, or misappropriation of a resident's property, unless:]

[(A) the individual is a full-time employee in a training and competency evaluation program approved by the state; or]

[(B) the individual can prove that he has recently successfully completed a training and competency evaluation program, or competency evaluation program approved by the state and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.]

[(6) Multi-state registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every state registry, established under §1819(e)(2)(A) or §1919(e)(2)(A) of the Social Security Act, that the facility believes will include information about the individual.]

[(7) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.]

[(8) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must:]

[(A) be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year;]

[(B) address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and]

[(C) for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.]
The facility must comply with the nurse aide training and registry rules found in Chapter 94 of this title (relating to Nurse Aides).

[The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§19.1908. Laboratory Services.
(a) The facility must provide or obtain clinical laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

(1) If the facility provides its own laboratory services, the services must meet the applicable requirements [conditions] for [coverage of the services furnished by] laboratories specified in 42 CFR [Code of Federal Regulations], Part 493.

(2) If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in 42 CFR [Code of Federal Regulations], Part 493.

(3) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified [approved or licensed to test specimens] in the appropriate specialties and/or subspecialties of services in accordance with 42 CFR [Code of Federal Regulations], Part 493.

(4) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services only from a laboratory that meets the applicable requirements of 42 CFR [Code of Federal Regulations], Part 493, or from a physician's office.

(b) The facility must:

(1) provide or obtain laboratory services only when ordered by a physician, physician assistant, or advanced practice registered nurse in accordance with state law, including scope of practice laws [the attending physician];

(2) promptly notify the ordering [attending] physician, physician assistant, or advanced practice registered nurse of the results that fall outside of clinical reference ranges in accordance with written facility policies and procedures for notification of a practitioner or per the ordering physician’s orders [findings];

(3) assist the resident in making transportation arrangements to and from the source of

(a) The nursing facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

(1) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in 42 CFR, [Code of Federal Regulations] §482.26.

(2) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.

(b) The facility must:

(1) provide or obtain radiology and other diagnostic services only when ordered by a physician, physician assistant; or advanced practice registered nurse in accordance with state law, including scope of practice laws [the attending physician];

(2) promptly notify the ordering [attending] physician, physician assistant, or advanced practice registered nurse of the results that fall outside of clinical reference ranges in accordance with written facility policies and procedures for notification of a practitioner or per the ordering physician’s orders [findings];

(3) assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and

(4) file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services.


(a) The facility must maintain clinical records on each resident, in accordance with accepted professional health information management standards and practices that are:

(1) complete;
(2) accurately documented;
(3) readily accessible;
(4) systematically organized; and
(5) protected from unauthorized release.

(b) Clinical records must be retained for:

(1) five years after medical services end; or

(2) for a minor, three years after a resident reaches legal age under Texas law.

(c) The facility must safeguard clinical record information against loss, destruction, or unauthorized use;

(d) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is:

____(1) required by:

____ (A) [ ] transfer to another health care institution;

____ (B) [ ] law or this chapter;

____ (C) [ ] third party payment contract; or

____ (D) [ ] the resident or his or her resident representative where permitted by applicable law; or

____(2) permitted by and in compliance with applicable law.

§19.1911. Contents of the Clinical Record.

(a) A resident's clinical record must meet all documentation requirements in the HHSC [Texas Health and Human Services Commission] rule at Texas Administrative Code, Title 1, Part 15, Chapter 371, Subchapter C (relating to Utilization Review) [1 TAC §371.214 (relating to Resource Utilization Group Classification System)].

(b) The clinical record of each resident must contain:

(1) a face sheet that contains the attending physician's current mailing address and telephone numbers;
(2) sufficient information to identify and care for the resident, to include at a minimum:

(A) full name of resident;

(B) full home or mailing address, or both;

(C) social security number;

(D) health insurance claim numbers, if applicable;

(E) date of birth; and

(F) clinical record number, if applicable;

(3) a record of the resident's assessments, including 15 months of MDS records;

(4) the comprehensive care plan and services provided [(see also §19.802 of this chapter (relating to Comprehensive Care Plans))];

(5) a permanency plan, for residents younger than 22 years of age;

(6) the results of any Preadmission Screening and Resident Review conducted by HHSC;

(7) signed and dated clinical documentation from all health care practitioners involved in the resident's care, with each page identifying the name of the resident for whom the clinical care is intended;

(8) any directives or medical powers of attorney as described in §19.419 of this chapter (relating to Advance Directives);

(9) discharge information and a discharge summary in accordance with §19.803 of this chapter (relating to Discharge Summary (Discharge Plan of Care)) [and a physician discharge summary, to include, at least, dates of admission and discharge, admitting and discharge diagnoses, condition on discharge, and prognosis, if applicable];

(10) at admission or within 14 days after admission, documentation of an initial medical evaluation, including history, physical examination, diagnoses and an estimate of discharge potential and rehabilitation potential, and documentation of a previous annual medical examination;

(11) authentication of a hospital diagnosis, which may be in the form of a signed hospital discharge summary, a signed report from the resident's hospital or attending physician, or a transfer form signed by the physician;

(12) the physician's signed and dated orders, including medication, treatment, diet, restorative and special medical procedures, and routine care to maintain or improve the resident's functional
abilities (required for the safety and well-being of the resident), which must not be changed either on a handwritten or computerized physician's order sheet after the orders have been signed by the physician unless space allows for additional orders below the physician's signature, including space for the physician to sign and date again;

(13) arrangements for the emergency care of the resident in accordance with §19.1204 of this chapter (relating to Availability of Physician for Emergency Care);

(14) observations made by nursing personnel according to the time frames specified in §19.1010 of this chapter (relating to Nursing Practices);

(15) items as specified on the MDS assessment;

(16) current information, including:

(A) PRN medications and results;

(B) treatments and any notable results;

(C) physical complaints, changes in clinical signs and behavior, mental and behavioral status, and all incidents or accidents;

(D) flow sheets, which may include bathing, restraint observation or release documentation, elimination, fluid intake, vital signs, ambulation status, positioning, continence status and care, and weight;

(E) a record of dietary intake, including deviations from normal diet, rejection of substitutions, and physician's ordered snacks or supplemental feedings;

(F) a record of the date and hour a drug or treatment is administered; and

(G) documentation of a special procedure performed for the safety and well-being of the resident; and

(17) laboratory, radiology and other diagnostic services reports, as required by §19.1908 of this title (relating to Laboratory Services) and §19.1909 of this title (relating to Radiology and Other Diagnostic Services).

[(17) a copy of the most recent court order and letters of guardianship appointing a guardian of the resident or the resident's estate received by the facility.]

§19.1912. Additional Clinical Record Service Requirements.

(a) Index of admissions and discharges. The facility must maintain a permanent, master index of
all residents admitted to and discharged from the facility. This index must contain at least the following information concerning each resident:

(1) name of resident (first, middle, and last);

(2) date of birth;

(3) date of admission;

(4) date of discharge; and

(5) social security, Medicare, or Medicaid number.

(b) Facility closure. In the event of closure of a facility, change of ownership or change of administrative authority:

(1) the facility must have in place written policies and procedures to ensure that the administrator’s duties and responsibilities involve providing the appropriate notices, as required by §19.2310 of this title (relating to Nursing Facility Ceases to Participate); and

(2) the new management must maintain documented proof of the medical information required for the continuity of care of all residents. This documentation may be in the form of copies of the resident's clinical record or the original clinical record. In a change of ownership, the two parties will agree and designate in writing who will be responsible for the retention and protection of the inactive and closed clinical records.

(c) Method of recording/correcting information. All resident care information must be recorded in ink or permanent print except for the medication, treatment, or diet section of the care plan. Correction of errors will be in accordance with accepted health information management standards.

(1) Erasures are not allowed on any part of the clinical record, with the exception of the medication, treatment, or diet section of the resident care plan.

(2) Correction of errors will be in accordance with accepted health information management standards.

(d) Required record retention. Periodic thinning of active clinical records is permitted; however, the following items must remain in the active clinical record:

(1) current history and physical;

(2) current physician's orders and progress notes;

(3) current resident assessment instrument (RAI) and subsequent quarterly reviews; in Medicaid-certified facilities, all RAIs and Quarterly Reviews for the prior 15-month period;
(4) current care plan;

(5) most recent hospital discharge summary or transfer form;

(6) current nursing and therapy notes;

(7) current medication and treatment records;

(8) current lab and x-ray reports;

(9) the admission record; and

(10) the current permanency plan.

e) Readmissions.

(1) If a resident is discharged for 30 days or less and readmitted to the same facility, upon readmission, to update the clinical record, staff must:

   (A) obtain current, signed physician's orders;

   (B) record a descriptive nurse note, giving a complete assessment of the resident's condition;

   (C) include any changes in diagnoses, etc.;

   (D) obtain signed copies of the hospital or transferring facility history and physical and discharge summary. A transfer summary containing this information is acceptable;

   (E) complete a new RAI and update the comprehensive care plan if evaluation of the resident indicates a significant change, which appears to be permanent. If no such change has occurred, then update only the resident comprehensive care plan; and

   (F) comply with §19.805 of this title (regarding Permanency Planning for Pediatric Residents).

(2) A new clinical record must be initiated if the resident is a new admission or has been discharged for over 30 days.

f) Signatures.

(1) The use of faxing [electronic data transmission of facsimiles (faxing)] is acceptable for sending and receiving health care documents, including the transmission of physicians' orders. Long term care facilities may utilize electronic transmission if they adhere to the following requirements:
(A) The facility must implement safeguards to assure that faxed documents are directed to the correct location to protect confidential health information.

(B) All faxed documents must be signed by the author before transmission.

(2) Stamped signatures are acceptable for all health care documents requiring a physician's signature, if the person using the stamp sends a letter of intent which specifies that he will be the only one using the stamp, and then signs the letter with the same signature as the stamp.

(3) The facility must maintain all letters of intent on file and make them available to representatives of the HHSC [Texas Department of Human Services (DHS)] upon request.

(4) Use of a master signature legend in lieu of the legend on each form for nursing staff signatures of medication, treatment, or flow sheet entries is acceptable under the following circumstances.

(A) Each nursing employee documenting on medication, treatment, or flow sheets signs his full name, title, and initials on the legend.

(B) The original master legend is kept in the clinical records office or director of nurses' office.

(C) A current copy of the legend is filed at each nurses' station.

(D) When a nursing employee leaves employment with the facility, his name is deleted from the list by lining through it and writing the current date by the name.

(E) The facility updates the master legend as needed for newly hired and terminated employees.

(F) The master signature legend must be retained permanently as a reference to entries made in clinical records.

(g) Destruction of Records. When resident records are destroyed after the retention period is complete, the facility must shred or incinerate the records in a manner which protects confidentiality. At the time of destruction, the facility must document the following for each record destroyed:

(1) resident name;

(2) medical record number, if used;

(3) social security number, Medicare/Medicaid number, or the date of birth; and

(4) date and signature of person carrying out disposal.
(h) Confidentiality. The facility must develop and implement written policies and procedures to safeguard the confidentiality of medical record information from unauthorized access.

(1) Except as provided in paragraph (2) of this subsection, the facility must not allow access to a resident's clinical record unless a physician's order exists for supplies, equipment, or services provided by the entity seeking access to the record.

(2) The facility must allow access and/or release confidential medical information under court order or by written authorization of the resident or his or her resident [legal] representative, as in [(see] §19.407 of this title (relating to Privacy and Confidentiality) [3].

§19.1915. Transfer Agreement.

(a) The facility must have in effect a written transfer agreement with one or more hospitals that reasonably assures that:

(1) Residents will be transferred from the facility to the hospital and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, another practitioner in accordance with written facility policy.

(2) Providers will exchange medical [Medical] and other information, including information required under §19.502(b)(4) of this title (relating to Transfer and Discharge in Medicaid-certified Facilities), needed for care and treatment of residents and when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services, receive services [be adequately cared for] in a less restrictive [expensive] setting than either the facility or the hospital or reintegrate into the community [, will be exchanged between the institutions].

(3) For Medicaid-certified facilities, the hospitals must be approved for participation under the Medicare and Medicaid programs.

(b) In addition, to ensure continuity of care, the transfer agreement must [should]:

(1) provide for prompt diagnostic and other medical services;

(2) ensure accountability for a resident's personal effects at the time of transfer;

(3) specify the steps needed to transfer a resident in a prompt, safe and efficient manner; and

(4) provide for supplying, at the time of transfer, a summary of administrative, social, medical, and nursing information to the facility to which the resident is transferred.

(c) If the board and/or governing body for a long-term care facility and a hospital are the same,
the controlling entity must have written procedures outlining how transfers will occur.

(d) The facility is considered to have a transfer agreement in effect if HHSC [DHS] determines that the facility attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible but could not, and it is in the public interest not to enforce this requirement. The facility must document in writing its good faith effort to enter into an agreement.


(a) The facility must maintain a Quality Assessment and Assurance Committee consisting of:

(1) the director of nursing services;

(2) the medical director or his or her designee; [a physician designated by the facility; and]

(3) at least three other members of the facility's staff, at least one of who must be the administrator, a board member or other individual in a leadership role; and

(4) effective November 28, 2019, the infection control and prevention officer.

(b) The Quality Assessment and Assurance Committee reports to the facility’s governing body, regarding its activities, including implementation of the quality assurance and performance improvement (QAPI) program, defined in §19.1927 of this title (relating to Quality Assurance and Performance Improvement Program). The committee must:

(1) meet [meets] at least quarterly and as needed to coordinate and evaluate activities under the QAPI program to identify issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary; [and]

(2) develop [develops] and implement [implements] appropriate plans of action to correct identified quality deficiencies; and [ ]

(3) regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.

(c) Texas or the Secretary of Health and Human Services may not require disclosure of the records of the Quality Assessment and Assurance Committee except insofar as such disclosure is related to the compliance of the committee with the requirements of subsection (b) of this section.

(d) Good faith attempts by the committee to identify and correct quality deficiencies may not be used as a basis for sanctions.
(e) The Quality Assessment and Assurance Committee must adopt and ensure implementation of a written policy to identify, assess, and develop strategies to control risk of injury to residents and nurses associated with the lifting, transferring, repositioning, or moving of a resident. The policy must establish a process that includes:

1. Analysis of the risk of injury to both residents and nurses posed by the resident handling needs of the resident populations served by the nursing facility and the physical environment in which resident handling and moving occurs;

2. Annual in-service education of nurses in the identification, assessment, and control of risk of injury to residents and nurses during resident handling;

3. Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment;

4. Restriction, to the extent feasible with existing equipment and aids, of manual resident handling or moving of all or most of a resident’s weight to emergency, life-threatening, or otherwise exceptional circumstances;

5. Collaboration with and an annual report to the nurse staffing committee;

6. Specific procedures for nurses to refuse to perform or be involved in resident handling or moving that the nurse believes in good faith will expose a resident or a nurse to an unacceptable risk of injury;

7. Submission of an annual report by the nursing staff to the Quality Assessment and Assurance Committee on activities related to the identification, assessment, and development of strategies to control risk of injury to residents and nurses associated with the lifting, transferring, repositioning, or moving of a resident; and

8. In developing architectural plans for constructing or remodeling a nursing facility or a unit of a nursing facility in which resident handling and moving occurs, consideration of the feasibility of incorporating resident handling equipment or the physical space and construction design needed to incorporate that equipment at a later date.


(a) QAPI program. Effective November 28, 2019, each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:

1. Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include systems and reports demonstrating
systematic identification, reporting, investigation, analysis, and prevention of adverse events; and
documentation demonstrating the development, implementation, and evaluation of corrective
actions or performance improvement activities;

(2) present its QAPI plan to a state agency or federal surveyor at each annual recertification
survey and upon request during any other survey and to CMS upon request; and

(3) present documentation and evidence of its ongoing QAPI program’s implementation and
the facility’s compliance with requirements to a State Agency, Federal surveyor or CMS upon
request.

(b) Program design and scope. A facility must design its QAPI program to be ongoing,
comprehensive, and to address the full range of care and services provided by the facility. It
must:

(1) address all systems of care and management practices;

(2) include clinical care, quality of life, and resident choice;

(3) utilize the best available evidence to define and measure indicators of quality and facility
goals that reflect processes of care and facility operations that have been shown to be predictive
of desired outcomes for residents of a SNF or NF; and

(4) reflect the complexities, unique care, and services that the facility provides.

(c) Program feedback, data systems and monitoring. A facility must establish and implement
written policies and procedures for feedback, data collections systems, and monitoring, including
adverse event monitoring. The policies and procedures must include the following:

(1) facility maintenance of effective systems to obtain and use of feedback and input from
direct care staff, other staff, residents, and resident representatives, including how such
information will be used to identify problems that are high risk, high volume, or problem-prone,
and opportunities for improvement;

(2) facility maintenance of effective systems to identify, collect, and use data from all
departments, including the facility assessment required by §19.1931 of this title (relating to
Facility Assessment) and including how such information will be used to develop and monitor
performance indicators;

(3) facility development, monitoring, and evaluation of performance indicators, including the
methodology and frequency for such development, monitoring, and evaluation; and

(4) facility adverse event monitoring, including the methods by which the facility will
systematically identify, report, track, investigate, analyze and use data and information relating
to adverse events in the facility, including how the facility will use the data to develop activities
to prevent adverse events.
(d) Program systematic analysis and systemic action.

(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

(2) The facility will develop and implement policies addressing:

(A) how they will use a systematic approach, such as root cause analysis, reverse tracer methodology, or health care failure and effects analysis, to determine underlying causes of problems impacting larger systems;

(B) how they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and

(C) how the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

(e) Program activities.

(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

(3) The facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility’s services and available resources, as reflected in the facility assessment required by §19.1931 of this title (relating to Facility Assessment). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

(f) Governance and leadership. The governing body and executive leadership or organized group or individual who assumes full legal authority and responsibility for operation of the facility is responsible and accountable for ensuring that:

(1) an ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities;

(2) the QAPI program is sustained during transitions in leadership and staffing;
(3) the QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;

(4) the QAPI program identifies and prioritizes problems and opportunities based on performance indicator data; and resident and staff input that reflects organizational processes, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information;

(5) corrective actions address gaps in systems, and are evaluated for effectiveness; and

(6) clear expectations are set around safety, quality, rights, choice, and respect.

§19.1929. Staff Development.

Each facility must develop, implement and maintain effective training programs of orientation, training, and continuing in-service education to develop the skills of its staff, including all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. Effective November 28, 2019, a facility must determine the amount and types of training necessary based on a facility assessment as specified at §19.1931 of this title (relating to Facility Assessment) and as described in §19.1001 [§19.903] of this title (relating to Nursing Services) [(relating to Required Training of Nurse Aides)].

(1) As part of orientation and annually, each employee must receive instruction regarding:

   (A) Human Immunodeficiency Virus (HIV), as outlined in the educational information provided by the Texas Department of Health Model Workplace Guidelines. At a minimum the HIV curriculum must include:

      (i) modes of transmission;

      (ii) methods of prevention;

      (iii) behaviors related to substance abuse;

      (iv) occupational precautions;

      (v) current laws and regulations concerning the rights of an acquired immune deficiency syndrome/HIV-infected individual; and

      (vi) behaviors associated with HIV transmission which are in violation of Texas law; and

   (B) restraint reduction and the prevention of falls through competency-based training. Facilities also may choose to train on behavior management, including prevention of aggressive
behavior and de-escalation techniques; [-]

(C) activities that constitute abuse, neglect, exploitation, or misappropriation of resident property as set forth at §19.601 of this title (relating to Freedom from Abuse, Neglect and Exploitation);

(D) procedures for reporting incidents of abuse, neglect, exploitation, or misappropriation of resident property; and

(E) dementia management and resident abuse prevention.

(2) Each registered nurse, licensed vocational nurse, and nurse aide (nurse assistant) who provides nursing services must receive at least one hour of training each year in caring for people who have dementia.

(3) Nursing staff, licensed nurses, and nurse aides must receive annual in-service training which includes components, appropriate to their job responsibilities, from one or more of the following categories:

(A) communication techniques and skills useful when providing geriatric care, such as skills for communicating with the hearing impaired, visually impaired and cognitively impaired; therapeutic touch; and recognizing communication that indicates psychological abuse;

(B) assessment and nursing interventions related to the common physical and psychological changes of aging for each body system;

(C) geriatric pharmacology, including treatment for pain management and sleep disorders;

(D) common emergencies of geriatric residents and how to prevent them, for example, falls, choking on food or medicines, injuries from restraint use; recognizing sudden changes in physical condition, such as stroke, heart attack, acute abdomen, and acute glaucoma; and obtaining emergency treatment;

(E) common mental disorders with related nursing implications; and

(F) ethical and legal issues regarding advance directives, abuse and neglect, guardianship, and confidentiality.

(4) Facilities with pediatric residents must comply with the following:

(A) Facility staff must be trained in the use of pediatric equipment and supplies, including emergency equipment and supplies.

(B) Facility staff must [should] receive annual continuing education dealing with pediatric issues, including child growth and development and pediatric assessment.
(5) Minimum continuing in-service education requirements are listed in subparagraphs (A)-(B) of this paragraph. Attendance at relevant outside training may be used to satisfy the in-service education requirement. The facility must keep in-service records for each employee listed. The minimum requirements are:

(A) licensed personnel--two hours per quarter; and

(B) nurse aides--12 hours annually. For the purpose of this paragraph, a medication aide is considered a nurse aide and must receive the same continuing in-service education. This in-service education does not qualify as continuing education units required for renewal of a medication aide permit.

(6) A rural hospital participating in the Medicaid Swing Bed Program as specified in §19.2326 of this title (relating to Medicaid Swing Bed Program for Rural Hospitals) is not required to meet the requirements of this section, if the swing beds are used for no more than one 30-day length of stay per year, per resident.

(7) Effective November 28, 2019, the facility must also include as part of its mandatory training the following topics:

(A) effective communications for direct care staff;

(B) rights of the resident and the responsibilities of a facility to properly care for its residents as set forth in this chapter, Subchapter E, Resident Rights;

(C) elements and goals for the facility’s QAPI program, as set forth in §19.1927 of this title (relating to Quality Assurance and Performance Improvement Program);

(D) standards, policies and procedures for the facility’s IPCP, as set forth in §19.1601 of this title (relating to Infection Control); and

(E) behavioral health training, as set forth in §19.904 of this title (relating to Behavioral Health Services).


The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility must address or include:

(1) the facility’s resident population, including:
(A) both the number of residents and the facility’s resident capacity;

(B) the care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;

(C) the staff competencies that are necessary to provide the level and types of care needed for the resident population;

(D) the physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and

(E) any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

(2) the facility’s resources, including:

(A) all buildings and/or other physical structures and vehicles;

(B) equipment (medical and non-medical);

(C) services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;

(D) all personnel, including managers, employees, contractors, and volunteers, as well as their education, training and any competencies related to resident care;

(E) contracts, memorandums of understanding, or other agreements with their parties to provide services or equipment to the facility during both normal operations and emergencies; and

(F) health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

(3) a facility-based and community-based risk assessment, utilizing an all-hazards approach.

§19.2704. Nursing Facility Responsibilities Related to PASRR.
(a) If an individual seeks admission to a nursing facility, the nursing facility:

(1) must coordinate with the referring entity to ensure the referring entity conducts a PL1; and

(2) may provide assistance in completing the PL1, if the referring entity is a family member, LAR, other personal representative selected by the individual, or a representative from an emergency placement source and requests assistance in completing the PL1.

(b) A nursing facility must not admit an individual who has not had a PL1 conducted before the individual is admitted to the facility.

(c) If an individual's PL1 indicates the individual is not suspected of having MI, ID, or DD, a nursing facility must enter the PL1 from the referring entity into the LTC Online Portal. The nursing facility may admit the individual into the facility through the routine admission process.

(d) For an individual whose PL1 indicates the individual is suspected of having MI, ID, or DD, a nursing facility:

(1) must enter the PL1 into the LTC Online Portal if the individual's admission category is:

   (A) expedited admission; or

   (B) exempted hospital discharge; and

(2) must not enter the PL1 into the LTC Online Portal if the individual's admission category is pre-admission.

(e) Except as provided by subsection (f) of this section, a nursing facility must not admit an individual whose PL1 indicates a suspicion of MI, ID, or DD without a complete PE and PASRR determination.

(f) A nursing facility may admit an individual whose PL1 indicates a suspicion of MI, ID, or DD without a complete PE and PASRR determination only if the individual:

(1) is admitted as an expedited admission;

(2) is admitted as an exempted hospital discharge; or

(3) has not had an interruption in continuous nursing facility residence other than for acute care lasting fewer than 30 days and is returning to the same nursing facility.

(g) A nursing facility must check the LTC Online Portal daily for messages related to admissions and directives related to the PASRR process.

(h) Within seven calendar days after the LIDDA or LMHA has entered a PE or resident review
into the LTC Online Portal for an individual or resident who has MI, ID, or DD, a nursing facility must:

(1) review the recommended list of nursing facility specialized services, LIDDA specialized services, and LMHA specialized services; and

(2) certify in the LTC Online Portal whether the individual's or resident's needs can be met in the nursing facility.

(i) After an individual or resident who has MI, ID, or DD has been admitted to a nursing facility, the facility must:

(1) contact the LIDDA or LMHA within two calendar days after the individual's admission or, for a resident, within two calendar days after the LTC Online Portal generated an automated notification to the LIDDA or LMHA, to schedule an IDT meeting to discuss nursing facility specialized services, LIDDA specialized services, and LMHA specialized services;

(2) convene the IDT meeting within 14 calendar days after admission or, for a resident review, within 14 calendar days after the LTC Online Portal generated an automated notification to the LIDDA or LMHA;

(3) participate in the IDT meeting to:

   (A) identify which of the nursing facility specialized services, LIDDA specialized services, and LMHA specialized services recommended for the resident that the resident, or LAR on the resident's behalf, wants to receive; and

   (B) determine whether the resident is best served in a facility or community setting.

(4) provide staff from the LIDDA and LMHA access to the resident and the resident's clinical facility records upon request from the LIDDA or LMHA;

(5) enter into the LTC Online Portal within 3 business days after the IDT meeting for a resident:

   (A) the date of the IDT meeting;

   (B) the name of the persons who participated in the IDT meeting;

   (C) the nursing facility specialized services, LIDDA specialized services, and LMHA specialized services that were agreed to in the IDT meeting; and

   (D) the determination of whether the resident is best served in a facility or community setting;

(6) include in the comprehensive care plan:
(A) the nursing facility specialized services agreed to by the resident or LAR; and

(B) the nursing facility PASRR support activities;

(7) if Medicaid or other funding is available:

(A) initiate nursing facility specialized services within 30 days after the date that the
services are agreed to in the IDT meeting; and

(B) provide nursing facility specialized services agreed to in the IDT meeting to the
resident; [and]

(8) for a resident who is a Medicaid recipient, annually document in the LTC Online Portal
all nursing facility specialized services, LIDDA specialized services, and LMHA specialized
services currently being provided to a resident; and [.] [and]

(9) promptly report a significant change in the mental or physical condition of a resident by
submitting a Minimum Data Set (MDS) Significant Change in Status Assessment Form in the
LTC Online Portal.