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Texas Department of Aging and Disability Services

Licensing Standards for Home and Community Support Services Agencies Handbook

Revision: 13-1

Subchapter A – General Provisions

§97.1 Purpose and Scope

- a) Purpose
 - 1) The purpose of this chapter is to implement the Health and Safety Code, Chapter 142, which provides the Department of Aging and Disability Services (DADS) with the authority to adopt minimum standards that a person must meet in order to be licensed as a home and community support services agency (HCSSA) and also to qualify to provide certified home health services. The requirements serve as a basis for licensure and survey activities.
 - 2) Except as provided by the Health and Safety Code, §142.003 (relating to Exemptions from Licensing Requirement), a person, including a health care facility licensed under the Health and Safety Code, may not engage in the business of providing home health, hospice, or personal assistance services (PAS), or represent to the public that the person is a provider of home health, hospice, or PAS for pay without a HCSSA license authorizing the person to perform those services issued by DADS for each place of business from which home health, hospice, or PAS is directed. A certified HCSSA must have a license to provide certified home health services.
- b) Scope. This chapter establishes the minimum standards for acceptable quality of care, and a violation of a minimum standard is a violation of law. These minimum standards are adopted to protect clients of HCSSAs by ensuring that the clients receive quality care, enhancing their quality of life.

- c) **Limitations.** Requirements established by private or public funding sources such as health maintenance organizations or other private third-party insurance, Medicaid (Title XIX of the Social Security Act), Medicare (Title XVIII of the Social Security Act), or state-sponsored funding programs are separate and apart from the requirements in this chapter for agencies. No matter what funding sources or requirements apply to an agency, the agency must still comply with the applicable provisions in the statute and this chapter. The agency is responsible for researching availability of any funding source to cover the service(s) the agency provides.

§97.2 Definitions

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

- (1) **Accessible and flexible services**--Services that are delivered in the least intrusive manner possible and are provided in all settings where individuals live, work, and recreate.
- (2) **Administration of medication**--The direct application of any medication by injection, inhalation, ingestion, or any other means to the body of a client. The preparation of medication is part of the administration of medication and is the act or process of making ready a medication for administration, including the calculation of a client's medication dosage; altering the form of the medication by crushing, dissolving, or any other method; reconstitution of an injectable medication; drawing an injectable medication into a syringe; preparing an intravenous admixture; or any other act required to render the medication ready for administration.
- (3) **Administrative support site**--A facility or site where an agency performs administrative and other support functions but does not provide direct home health, hospice, or personal assistance services. This site does not require an agency license.
- (4) **Administrator**--The person who is responsible for implementing and supervising the administrative policies and operations of a home and community support services agency and for administratively supervising the provision of all services to agency clients on a day-to-day basis.

- (5) Advanced practice nurse--A registered nurse who is approved by the Texas Board of Nursing to practice as an advanced practice nurse and who maintains compliance with the applicable rules of the Texas Board of Nursing. See the Texas Board of Nursing's definition of advanced practice nurse in 22 TAC §221.1.
- (6) Advisory committee--A committee, board, commission, council, conference, panel, task force, or other similar group, or any subcommittee or other subgroup, established for the purpose of obtaining advice or recommendations on issues or policies that are within the scope of a person's responsibility.
- (7) Affiliate--With respect to an applicant or license holder that is:
 - (A) A corporation--means each officer, director, and stockholder with direct ownership of at least 5.0 percent, subsidiary, and parent company;
 - (B) A limited liability company--means each officer, member, and parent company;
 - (C) An individual--means:
 - (i) The individual's spouse;
 - (ii) Each partnership and each partner thereof of which the individual or any affiliate of the individual is a partner; and
 - (iii) Each corporation in which the individual is an officer, director, or stockholder with a direct ownership or disclosable interest of at least 5.0 percent.
 - (D) A partnership--means each partner and any parent company; and
 - (E) A group of co-owners under any other business arrangement--means each officer, director, or the equivalent under the specific business arrangement and each parent company.
- (8) Agency--A home and community support services agency.

- (9) Alternate delivery site (ADS)--A facility or site, including a residential unit or an inpatient unit:
- (A) That is owned or operated by an agency providing hospice services;
 - (B) That is not the hospice's principal place of business, which for the purposes of this definition, means it is not the parent agency;
 - (C) That is located in the geographical area served by the hospice; and
 - (D) From which the hospice provides hospice services.
- (10) Applicant--The owner of an agency that is applying for a license under the statute. This is the person in whose name the license will be issued.
- (11) Assistance with self-administration of medication--Any needed ancillary aid provided to a client in the client's self-administered medication or treatment regimen, such as reminding a client to take a medication at the prescribed time, opening and closing a medication container, pouring a predetermined quantity of liquid to be ingested, returning a medication to the proper storage area, and assisting in reordering medications from a pharmacy. Such ancillary aid includes administration of any medication when the client has the cognitive ability to direct the administration of their medication and would self-administer if not for a functional limitation.
- (12) Association--A partnership, limited liability company, or other business entity that is not a corporation.
- (13) Audiologist--A person who is currently licensed under the Texas Occupations Code, Chapter 401, as an audiologist.
- (14) Bereavement--The process by which a survivor of a deceased person mourns and experiences grief.
- (15) Bereavement services--Support services offered to a family during bereavement. Services may be provided to persons other than family members, including residents of a skilled nursing facility, nursing facility, or intermediate care facility for individuals with an intellectual disability or related conditions, when appropriate and identified in a bereavement plan of care.

- (16) Biologicals--A medicinal preparation made from living organisms and their products, including serums, vaccines, antigens, and antitoxins.
- (17) Boarding home facility--An establishment defined in Texas Health and Safety Code §260.001(2).
- (18) Branch office--A facility or site in the service area of a parent agency from which home health or personal assistance services are delivered or where active client records are maintained. This does not include inactive records that are stored at an unlicensed site.
- (19) Care plan--
 - (A) A written plan prepared by the appropriate health care professional for a client of the home and community support services agency; or
 - (B) For home dialysis designation, a written plan developed by the physician, registered nurse, dietitian, and qualified social worker to personalize the care for the client and enable long- and short-term goals to be met.
- (20) Case conference--A conference among personnel furnishing services to the client to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care or care plan.
- (21) Certified agency--A home and community support services agency, or portion of the agency, that:
 - (A) Provides a home health service; and
 - (B) Is certified by an official of the Department of Health and Human Services as in compliance with conditions of participation in Social Security Act, Title XVIII (42 United States Code (USC) §1395 et seq.).
- (22) Certified home health services--Home health services that are provided by a certified agency.
- (23) CFR--Code of Federal Regulations. The regulations and rules promulgated by agencies of the Federal government that address a broad range of subjects, including hospice care and home health services.

- (24) CHAP--Community Health Accreditation Program, Inc. An independent, nonprofit accrediting body that publicly certifies that an organization has voluntarily met certain standards for home and community-based health care.
- (25) Chief financial officer--An individual who is responsible for supervising and managing all financial activities for a home and community support services agency.
- (26) Client--An individual receiving home health, hospice, or personal assistance services from a licensed home and community support services agency. This term includes each member of the primary client's family if the member is receiving ongoing services. This term does not include the spouse, significant other, or other family member living with the client who receives a one-time service (for example, vaccination) if the spouse, significant other, or other family member receives the service in connection with the care of a client.
- (27) Clinical note--A dated and signed written notation by agency personnel of a contact with a client containing a description of signs and symptoms; treatment and medication given; the client's reaction; other health services provided; and any changes in physical and emotional condition.
- (28) CMS--Centers for Medicare and Medicaid Services. The federal agency that administers the Medicare program and works in partnership with the states to administer Medicaid.
- (29) Complaint--An allegation against an agency regulated by DADS or against an employee of an agency regulated by DADS that involves a violation of this chapter or the statute.
- (30) Community disaster resources--A local, statewide, or nationwide emergency system that provides information and resources during a disaster, including weather information, transportation, evacuation, and shelter information, disaster assistance and recovery efforts, evacuee and disaster victim resources, and resources for locating evacuated friends and relatives.
- (31) Controlling person--A person with the ability, acting alone or with others, to directly or indirectly influence, direct, or cause the direction of the management, expenditure of money, or policies of an agency or other person.

- (A) A controlling person includes:
 - (i) A management company or other business entity that operates or contracts with others for the operation of an agency;
 - (ii) A person who is a controlling person of a management company or other business entity that operates an agency or that contracts with another person for the operation of an agency; and
 - (iii) Any other individual who, because of a personal, familial, or other relationship with the owner, manager, or provider of an agency, is in a position of actual control or authority with respect to the agency, without regard to whether the individual is formally named as an owner, manager, director, officer, provider, consultant, contractor, or employee of the agency.
- (B) A controlling person, as described by subparagraph (A)(iii) of this paragraph, does not include an employee, lender, secured creditor, or other person who does not exercise formal or actual influence or control over the operation of an agency.
- (32) Conviction--An adjudication of guilt based on a finding of guilt, a plea of guilty, or a plea of nolo contendere.
- (33) Counselor--An individual qualified under Medicare standards to provide counseling services, including bereavement, dietary, spiritual, and other counseling services to both the client and the family.
- (34) DADS--Department of Aging and Disability Services.
- (35) Day--Any reference to a day means a calendar day, unless otherwise specified in the text. A calendar day includes weekends and holidays.
- (36) Deficiency--A finding of noncompliance with federal requirements resulting from a survey.
- (37) Designated survey office--A DADS Home and Community Support Services Agencies Program office located in an agency's geographic region.

- (38) Dialysis treatment record--For home dialysis designation, a dated and signed written notation by the person providing dialysis treatment which contains a description of signs and symptoms, machine parameters and pressure settings, type of dialyzer and dialysate, actual pre- and post-treatment weight, medications administered as part of the treatment, and the client's response to treatment.
- (39) Dietitian--A person who is currently licensed under the laws of the State of Texas to use the title of licensed dietitian or provisional licensed dietitian, or who is a registered dietitian.
- (40) Disaster--The occurrence or imminent threat of widespread or severe damage, injury, or loss of life or property resulting from a natural or man-made cause, such as fire, flood, earthquake, wind, storm, wave action, oil spill or other water contamination, epidemic, air contamination, infestation, explosion, riot, hostile military or paramilitary action, or energy emergency. In a hospice inpatient unit, a disaster also includes failure of the heating or cooling system, power outage, explosion, and bomb threat.
- (41) End stage renal disease (ESRD)--For home dialysis designation, the stage of renal impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life.
- (42) Functional need--Needs of the individual that require services without regard to diagnosis or label.
- (43) Health assessment--A determination of a client's physical and mental status through inventory of systems.
- (44) Home and community support services agency--A person who provides home health, hospice, or personal assistance services for pay or other consideration in a client's residence, an independent living environment, or another appropriate location.
- (45) Home health aide--An individual working for an agency who meets at least one of the requirements for home health aides as defined in §97.701 of this chapter (relating to Home Health Aides).
- (46) Home health medication aide--An unlicensed person issued a permit by DADS to administer medication to a client under the Texas Health and Safety Code, Chapter 142, Subchapter B.

- (47) Home health service--The provision of one or more of the following health services required by an individual in a residence or independent living environment:
- (A) Nursing, including blood pressure monitoring and diabetes treatment;
 - (B) Physical, occupational, speech, or respiratory therapy;
 - (C) Medical social service;
 - (D) Intravenous therapy;
 - (E) Dialysis;
 - (F) Service provided by unlicensed personnel under the delegation or supervision of a licensed health professional;
 - (G) The furnishing of medical equipment and supplies, excluding drugs and medicines; or
 - (H) Nutritional counseling.
- (48) Hospice--A person licensed under this chapter to provide hospice services, including a person who owns or operates a residential unit or an inpatient unit.
- (49) Hospice aide--A person working for an agency licensed to provide hospice services who meets the qualifications for a hospice aide as described in §97.843 of this chapter (relating to Hospice Aide Qualifications).
- (50) Hospice homemaker--A person working for an agency licensed to provide hospice services who meets the qualifications described in §97.845 of this chapter (relating to Hospice Homemaker Qualifications).
- (51) Hospice services--Services, including services provided by unlicensed personnel under the delegation of a registered nurse or physical therapist, provided to a client or a client's family as part of a coordinated program consistent with the standards and rules adopted under this chapter. These services include palliative care for terminally ill clients and support services for clients and their families that:
- (A) Are available 24 hours a day, seven days a week, during the last stages of illness, during death, and during bereavement;

- (B) Are provided by a medically directed interdisciplinary team; and
 - (C) May be provided in a home, nursing facility, residential unit, or inpatient unit according to need. These services do not include inpatient care normally provided in a licensed hospital to a terminally ill person who has not elected to be a hospice client. For the purposes of this definition, the word "home" includes a person's "residence" as defined in this section.
- (52) Independent living environment--A client's residence, which may include a group home, foster home, or boarding home facility, or other settings where a client participates in activities, including school, work, or church.
 - (53) Individual and family choice and control--Individuals and families who express preferences and make choices about how their support service needs are met.
 - (54) Individualized service plan--A written plan prepared by the appropriate health care personnel for a client of a home and community support services agency licensed to provide personal assistance services.
 - (55) Inpatient unit--A facility, also referred to as a hospice freestanding inpatient facility, that provides a continuum of medical or nursing care and other hospice services to clients admitted into the unit and that is in compliance with:
 - (A) The conditions of participation for inpatient units adopted under Social Security Act, Title XVIII (42 United States Code §1395 et seq.); and
 - (B) Standards adopted under this chapter.
 - (56) IRoD--Informal review of deficiencies. An informal process that allows an agency to refute a deficiency or violation cited during a survey.
 - (57) JCAHO--Joint Commission on Accreditation of Healthcare Organizations. An independent, nonprofit organization for standard-setting and accrediting in-home care and other areas of health care.

- (58) Joint training--Training provided by DADS at least semi-annually for home and community support services agencies and DADS surveyors on subjects that address the 10 most commonly cited violations of federal or state law by home and community support services agencies as published in DADS annual reports.
- (59) Legally authorized representative (LAR)--A person authorized by law to act on behalf of a client with regard to a matter described in this chapter, and may include a parent of a minor, guardian of an adult or minor, managing conservator of a minor, agent under a medical power of attorney, or surrogate decision-maker under Texas Health and Safety Code, §313.004.
- (60) Licensed vocational nurse--A person who is currently licensed under Texas Occupations Code, Chapter 301, as a licensed vocational nurse.
- (61) Life Safety Code (also referred to as NFPA 101)--The Code for Safety to Life from Fire in Buildings and Structures, Standard 101, of the National Fire Protection Association (NFPA).
- (62) Local emergency management agencies--The local emergency management coordinator, fire, police, and emergency medical services.
- (63) Local emergency management coordinator--The person identified as the emergency management coordinator by the mayor or county judge in an agency's service area.
- (64) Manager--An employee or independent contractor responsible for providing management services to a home and community support services agency for the overall operation of a home and community support services agency including administration, staffing, or delivery of services. Examples of contracts for services that will not be considered contracts for management services include contracts solely for maintenance, laundry, or food services.
- (65) Medication administration record--A record used to document the administration of a client's medications.
- (66) Medication list--A list that includes all prescription and over-the-counter medication that a client is currently taking, including the dosage, the frequency, and the method of administration.

- (67) Mitigation--An action taken to eliminate or reduce the probability of a disaster, or reduce a disaster's severity or consequences.
- (68) Multiple location--A Medicare-approved alternate delivery site that meets the definition in 42 CFR §418.3.
- (69) Notarized copy--A sworn affidavit stating that attached copies are true and correct copies of the original documents.
- (70) Nursing facility--An institution licensed as a nursing home under the Texas Health and Safety Code, Chapter 242.
- (71) Nutritional counseling--Advising and assisting individuals or families on appropriate nutritional intake by integrating information from the nutrition assessment with information on food and other sources of nutrients and meal preparation consistent with cultural background and socioeconomic status, with the goal being health promotion, disease prevention, and nutrition education. Nutritional counseling may include the following:
 - (A) Dialogue with the client to discuss current eating habits, exercise habits, food budget, and problems with food preparation;
 - (B) Discussion of dietary needs to help the client understand why certain foods should be included or excluded from the client's diet and to help with adjustment to the new or revised or existing diet plan;
 - (C) A personalized written diet plan as ordered by the client's physician or practitioner, to include instructions for implementation;
 - (D) Providing the client with motivation to help the client understand and appreciate the importance of the diet plan in getting and staying healthy; or
 - (E) Working with the client or the client's family members by recommending ideas for meal planning, food budget planning, and appropriate food gifts.
- (72) Occupational therapist--A person who is currently licensed under the Occupational Therapy Practice Act, Texas Occupations Code, Chapter 454, as an occupational therapist.

- (73) Operating hours--The days of the week and the hours of day an agency's place of business is open as identified in an agency's written policy as required by §97.210 of this chapter (relating to Agency Operating Hours).
- (74) Original active client record--A record composed first-hand for a client currently receiving services.
- (75) Palliative care--Intervention services that focus primarily on the reduction or abatement of physical, psychosocial, and spiritual symptoms of a terminal illness. It is client and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitating client autonomy, access to information, and choice.
- (76) Parent agency--An agency that develops and maintains administrative controls and provides supervision of branch offices and alternate delivery sites.
- (77) Parent company--A person, other than an individual, who has a direct 100 percent ownership interest in the owner of an agency.
- (78) Person--An individual, corporation, or association.
- (79) Person with a disclosable interest--Any person who owns at least a 5.0 percent interest in any corporation, partnership, or other business entity that is required to be licensed under Texas Health and Safety Code, Chapter 142. A person with a disclosable interest does not include a bank, savings and loan, savings bank, trust company, building and loan association, credit union, individual loan and thrift company, investment banking firm, or insurance company, unless these entities participate in the management of the agency.
- (80) Personal assistance services--Routine ongoing care or services required by an individual in a residence or independent living environment that enable the individual to engage in the activities of daily living or to perform the physical functions required for independent living, including respite services. The term includes:
 - (A) Personal care;

- (B) Health-related services performed under circumstances that are defined as not constituting the practice of professional nursing by the Texas Board of Nursing through a memorandum of understanding with DADS in accordance with Texas Health and Safety Code, §142.016; and
 - (C) Health-related tasks provided by unlicensed personnel under the delegation of a registered nurse or that a registered nurse determines do not require delegation.
- (81) Personal care--The provision of one or more of the following services required by an individual in a residence or independent living environment:
- (A) Bathing;
 - (B) Dressing;
 - (C) Grooming;
 - (D) Feeding;
 - (E) Exercising;
 - (F) Toileting;
 - (G) Positioning;
 - (H) Assisting with self-administered medications;
 - (I) Routine hair and skin care; and
 - (J) Transfer or ambulation.
- (82) Pharmacist--A person who is licensed to practice pharmacy under the Texas Pharmacy Act, Texas Occupations Code, Chapter 558.
- (83) Pharmacy--A facility defined in the Texas Occupations Code, §551.003(31), at which a prescription drug or medication order is received, processed, or dispensed.
- (84) Physical therapist--A person who is currently licensed under Texas Occupations Code, Chapter 453, as a physical therapist.
- (85) Physician--This term includes a person who is:

- (A) Licensed in Texas to practice medicine or osteopathy in accordance with Texas Occupations Code, Chapter 155;
 - (B) Licensed in Arkansas, Louisiana, New Mexico, or Oklahoma to practice medicine, who is the treating physician of a client and orders home health or hospice services for the client, in accordance with the Texas Occupations Code, §151.056(b)(4); or
 - (C) A commissioned or contract physician or surgeon who serves in the United States uniformed services or Public Health Service if the person is not engaged in private practice, in accordance with the Texas Occupations Code, §151.052(a)(8).
- (86) Physician assistant--A person who is licensed under the Physician Assistant Licensing Act, Texas Occupations Code, Chapter 204, as a physician assistant.
 - (87) Physician-delegated task--A task performed in accordance with the Texas Occupations Code, Chapter 157, including orders signed by a physician that specify the delegated task, the individual to whom the task is delegated, and the client's name.
 - (88) Place of business--An office of a home and community support services agency that maintains client records or directs home health, hospice, or personal assistance services. This term includes a parent agency, a branch office, and an alternate delivery site. The term does not include an administrative support site.
 - (89) Plan of care--The written orders of a practitioner for a client who requires skilled services.
 - (90) Practitioner--A person who is currently licensed in a state in which the person practices as a physician, dentist, podiatrist, or a physician assistant, or a person who is a registered nurse registered with the Texas Board of Nursing as an advanced practice nurse.
 - (91) Preparedness--Actions taken in anticipation of a disaster.
 - (92) Presurvey conference--A conference held with DADS staff and the applicant or the applicant's representatives to review licensure standards and survey documents, and to provide consultation before the survey.

- (93) Progress note--A dated and signed written notation by agency personnel summarizing facts about care and the client's response during a given period of time.
- (94) Psychoactive treatment--The provision of a skilled nursing visit to a client with a psychiatric diagnosis under the direction of a physician that includes one or more of the following:
 - (A) Assessment of alterations in mental status or evidence of suicide ideation or tendencies;
 - (B) Teaching coping mechanisms or skills;
 - (C) Counseling activities; or
 - (D) Evaluation of the plan of care.
- (95) Recovery--Activities implemented during and after a disaster response designed to return an agency to its normal operations as quickly as possible.
- (96) Registered nurse (RN)--A person who is currently licensed under the Nursing Practice Act, Texas Occupations Code, Chapter 301, as a registered nurse.
- (97) Registered nurse delegation--Delegation by a registered nurse in accordance with:
 - (A) 22 TAC Chapter 224 (concerning Delegation of Nursing Tasks by Registered Professional Nurses to Unlicensed Personnel for Clients with Acute Conditions or in Acute Care Environments); and
 - (B) 22 TAC Chapter 225 (relating to RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions).
- (98) Residence--A place where a person resides, including a home, a nursing facility, a convalescent home, or a residential unit.
- (99) Residential unit--A facility that provides living quarters and hospice services to clients admitted into the unit and that is in compliance with standards adopted under the Texas Health and Safety Code, Chapter 142.

- (100) Respiratory therapist--A person who is currently licensed under Texas Occupations Code, Chapter 604, as a respiratory care practitioner.
- (101) Respite services--Support options that are provided temporarily for the purpose of relief for a primary caregiver in providing care to individuals of all ages with disabilities or at risk of abuse or neglect.
- (102) Response--Actions taken immediately before an impending disaster or during and after a disaster to address the immediate and short-term effects of the disaster.
- (103) Restraint--A restraint is:
 - (A) A manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a client in a hospice inpatient unit to move his or her arms, legs, body, or head freely, but does not include a device, such as an orthopedically prescribed device, a surgical dressing or bandage, a protective helmet, or other method that involves the physical holding of the client for the purpose of:
 - (i) Conducting a routine physical examination or test;
 - (ii) Protecting the client from falling out of bed; or
 - (iii) Permitting the client to participate in activities without the risk of physical harm, not including a physical escort; or
 - (B) A drug or medication when used as a restriction to manage a client's behavior or restrict the client's freedom of movement in a hospice inpatient unit, but not as a standard treatment or medication dosage for the client's condition.
- (104) Seclusion--The involuntary confinement of a client alone in a room or an area in a hospice inpatient unit from which the client is physically prevented from leaving.
- (105) Section--A reference to a specific rule in this chapter.
- (106) Service area--A geographic area established by an agency in which all or some of the agency's services are available.

- (107) Skilled services--Services in accordance with a plan of care that require the skills of:
- (A) A registered nurse;
 - (B) A licensed vocational nurse;
 - (C) A physical therapist;
 - (D) An occupational therapist;
 - (E) A respiratory therapist;
 - (F) A speech-language pathologist;
 - (G) An audiologist;
 - (H) A social worker; or
 - (I) A dietitian.
- (108) Social worker--A person who is currently licensed as a social worker under Texas Occupations Code, Chapter 505.
- (109) Speech-language pathologist--A person who is currently licensed as a speech-language pathologist under Texas Occupations Code, Chapter 401.
- (110) Statute--The Texas Health and Safety Code, Chapter 142.
- (111) Substantial compliance--A finding in which an agency receives no recommendation for enforcement action after a survey.
- (112) Supervised practical training--Hospice aide training that is conducted in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual. The training is supervised by a registered nurse or by a licensed vocational nurse who works under the direction of a registered nurse.
- (113) Supervising nurse--The person responsible for supervising skilled services provided by an agency and who has the qualifications described in §97.244(c) of this chapter (relating to Administrator Qualifications and Conditions and Supervising Nurse Qualifications). This person may also be known as the director of nursing or similar title.
- (114) Supervision--Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity with initial direction and periodic inspection of the actual act of accomplishing the function or activity.

- (115) Support services--Social, spiritual, and emotional care provided to a client and a client's family by a hospice.
- (116) Survey--An on-site inspection or complaint investigation conducted by a DADS representative to determine if an agency is in compliance with the statute and this chapter or in compliance with applicable federal requirements or both.
- (117) Terminal illness--An illness for which there is a limited prognosis if the illness runs its usual course.
- (118) Unlicensed person--A person not licensed as a health care provider. The term includes home health aides, hospice aides, hospice homemakers, medication aides permitted by DADS, and other unlicensed individuals providing personal care or assistance in health services.
- (119) Unsatisfied judgments--A failure to fully carry out the terms or meet the obligation of a court's final disposition on the matters before it in a suit regarding the operation of an agency.
- (120) Violation--A finding of noncompliance with this chapter or the statute resulting from a survey.
- (121) Volunteer--An individual who provides assistance to a home and community support services agency without compensation other than reimbursement for actual expenses.
- (122) Working day--Any day except Saturday, Sunday, a state holiday, or a federal holiday.

§97.3 License Fees

- a) The schedule of fees for licensure of an agency authorized to provide one or more services is as follows:
 - 1) Initial (includes change of ownership) license fee — \$1,750;
 - 2) Renewal license fee — \$1,750;
 - 3) Initial (includes change of ownership) branch office license fee — \$1,750;
 - 4) Renewal branch office license fee — \$1,750;
 - 5) Initial (includes change of ownership) alternate delivery site license fee — \$1,000; and

- 6) Renewal alternate delivery site license fee — \$600.
- b) The late fee established in §97.17 of this chapter (relating to Application Procedures for a Renewal License) is one-half the amount of the required renewal license fee established in subsection (a) of this section plus the required renewal fee.
- c) If an applicant for an initial license based on a change of ownership submits a late application for a license to DADS, as described in §97.25 of this chapter (relating to Application Procedures and Requirements for Change of Ownership), the applicant must pay the required initial license fee as set out in subsection (a) of this section plus a late fee of \$250.
- d) DADS does not consider an application as officially submitted until the applicant pays the required license fee. The fee must accompany the application.
- e) A fee paid to DADS is not refundable, except as provided by §97.31 of this chapter (relating to Time Frames for Processing and Issuing a License).
- f) DADS accepts a certified check, money order, company check or personal check made out to the Department of Aging and Disability Services in payment for a required fee.

Subchapter B - Application and Issuance of a License

§97.11 Criteria and Eligibility for Licensing

- a) An applicant for a license must not admit a client or initiate services until the applicant completes the application process and receives an initial license.
- b) A first-time application for a license is an application for an initial license.
- c) An application for a license when there is a change of ownership is an application for an initial license.
- d) A separate license is required for each place of business as defined in §97.2 of this chapter (relating to Definitions).
- e) An agency's place of business must be located in and have an address in Texas. An agency located in another state must receive a license as a parent agency in Texas to operate as an agency in Texas.
- f) An applicant must be at least 18 years of age.

- g) Before issuing a license, DADS considers the background and qualifications of:
- 1) The applicant;
 - 2) A controlling person of the applicant;
 - 3) A person with a disclosable interest;
 - 4) An affiliate of the applicant;
 - 5) The administrator;
 - 6) The alternate administrator; and
 - 7) The chief financial officer.
- h) DADS may deny an application for an initial license or for renewal of a license if any person described in subsection (g) of this section:
- 1) On the date of the application:
 - A. Is subject to denial or refusal as described in Chapter 99 of this title (relating to Denial or Refusal of License) during the time frames described in that chapter;
 - B. Has an unsatisfied final judgment in any state or other jurisdiction;
 - C. Is in default on a guaranteed student loan (Education Code, §57.491); or
 - D. Is delinquent on child support obligations (Family Code, Chapter 232);
 - 2) For two years preceding the date of the application, has a history in any state or other jurisdiction of any of the following:
 - A. An unresolved federal or state tax lien;
 - B. An eviction involving any property or space used as an inpatient hospice agency; or
 - C. An unresolved final Medicare or Medicaid audit exception; or
 - 3) for twelve months preceding the date of the application, has a history in any state or other jurisdiction of any of the following:

- A. Denial, suspension or revocation of an agency license or a license for a health care facility;
- B. Surrendering a license before expiration or allowing a license to expire instead of the licensing authority proceeding with enforcement action;
- C. A Medicaid or Medicare sanction or penalty relating to the operation of an agency or a health care facility;
- D. Operating an agency that has been decertified in any state under Medicare or Medicaid; or
- E. Debarment, exclusion or involuntary contract cancellation in any state from Medicare or Medicaid.

§97.13 Application Procedures for an Initial License

- a) The following staff must complete a presurvey conference seminar before submitting an application for a license:
 - 1) The administrator and alternate administrator (all license categories); and
 - 2) The supervising nurse and alternate supervising nurse (licensed home health services with or without home dialysis designation, licensed and certified home health services with or without home dialysis designation, and hospice services license categories).
- b) When applying for a license, an applicant must not:
 - 1) Provide incorrect or false information; or
 - 2) Withhold information.
- c) Upon request, DADS furnishes a person with an application packet for a license.
- d) An applicant may request to be licensed in one or more of the following categories:
 - 1) Licensed and certified home health services;
 - 2) Licensed and certified home health services with home dialysis designation;

- 3) Licensed home health services;
 - 4) Licensed home health services with home dialysis designation;
 - 5) Hospice services; or
 - 6) Personal assistance services.
- e) DADS does not require an agency to be licensed in more than one category if the category for which the agency is licensed covers the services the agency provides.
- f) An applicant must complete and furnish all documents and information that DADS requests in accordance with instructions provided with the application packet. All submitted documents must be notarized copies or originals.
- g) Upon receipt of an application packet and license fee, DADS reviews the material to determine whether it is complete and correct. A complete and correct application packet includes all documents and information that DADS requests as part of the application process. If DADS receives a partial fee, the application packet and monies are returned to the applicant.
- 1) DADS processes the application packet in accordance with time frames established in §97.31 of this chapter (relating to Time Frames for Processing and Issuing a License).
 - 2) If an applicant decides not to continue the application process for an initial license after submitting the application packet and license fee, the applicant must submit to DADS a written request to withdraw the application. DADS does not refund the license fee.
 - 3) If an applicant receives a notice from DADS that some or all of the information required by this section is missing or incomplete, the applicant must submit the required information no later than 30 days after the date of the notice. If an applicant fails to submit the required information within 30 days after the notice date, DADS considers the application packet incomplete and denies the application. If DADS denies the application, DADS does not refund the license fee.

- h) An applicant who has requested the category of licensed and certified home health services on the initial license application must also make an application for certification by CMS as a Medicare-certified agency under the Social Security Act, Title XVIII.
 - 1) Pending approval by CMS, the applicant:
 - A. Receives an initial license reflecting the category of licensed home health services if the applicant meets the criteria for a license; and
 - B. Complies with the Medicare conditions of participation for home health agencies in 42 Code of Federal Regulations, Part 484, as if the applicant were dually certified.
 - 2) If CMS certifies an agency to participate in the Medicare program during the initial license period, DADS sends a notice to the agency that the category of licensed and certified home health services has been added to the license. If the agency wants to delete the licensed home health services category once the category of licensed and certified home health services has been added, the agency must submit a written request for deletion of that category.
 - 3) If CMS denies certification to an applicant or if the applicant withdraws the application for participation in the Medicare program, the agency may retain the category of licensed home health services.

§97.15 Issuance of an Initial License

- a) DADS issues an initial license when DADS determines:
 - 1) The application and license fee are complete and correct; and
 - 2) The applicant meets the criteria for the license as described in §97.11 of this subchapter (relating to Criteria and Eligibility for Licensing).
- b) An initial license is valid for two years from the date of issuance.
- c) DADS may deny an application to renew an initial license, or revoke or suspend an initial license, if an agency fails to:
 - 1) Meet the requirements for an initial survey as specified in Subchapter E of this chapter (relating to Licensure Surveys); or

- 2) Maintain substantial compliance with the statute and this chapter for the services authorized under the license.
- d) DADS may deny an application for an initial license for any of the reasons specified in §97.21 of this chapter (relating to Denial of an Application or a License).
- e) A license designates an agency's place of business from which services are to be provided and designates an agency's authorized category or categories of service.

§97.17 Application Procedures for a Renewal License

- a) An agency license is valid for two years. In order to continue providing services to clients, an agency must renew its license.
- b) When applying for a renewal license, an agency must not provide inaccurate or false statements or withhold information from the renewal application and attachments to the application. If an agency provides inaccurate or false statements or withholds information from a renewal application or an attachment to the application, DADS may assess the same range of penalties against the agency that apply in §97.13 of this chapter (relating to Application Procedures for an Initial License) for providing inaccurate or false statements or withholding information from an initial application for a license.
- c) For each license period, an agency must provide services to at least one client.
- d) DADS does not require an agency to admit a client under each category of service authorized under the license as a condition for renewal of the license.
- e) An agency must document the provision of services and keep documentation readily available for review by a DADS surveyor.
- f) With each renewal application, an accredited agency must submit documentation of its accreditation that the agency receives from the accreditation organization.
- g) DADS sends written notice of expiration of a license to an agency at least 120 days before the expiration date of the license. The written notice includes an application to renew the license and instructions for completing the application.
 - 1) If an agency does not receive notice of expiration from DADS at least 90 days before the expiration date of a license, the agency must notify DADS and submit a written request for a renewal application.

- 2) An agency must submit to DADS a complete and correct renewal application and the required license fee specified in §97.3 of this chapter (relating to License Fees), postmarked no later than the 45th day before the expiration date of the license.
 - 3) If an agency submits a renewal application that is postmarked later than the 45th day before the expiration date of a license, but no later than the expiration date of the license, DADS assesses the late fee set out in §97.3(b) of this chapter for failure to comply with paragraph (2) of this subsection.
 - 4) All documents submitted with the renewal application must be notarized copies or originals.
- h) Upon receipt of a renewal application and the renewal license fee, DADS reviews the application to determine whether it is complete and correct. A complete and correct renewal application includes all documents, information, and the required fee that DADS requests as part of the application process.
- 1) DADS processes the renewal application according to the time frames in §97.31 of this chapter (relating to Time Frames for Processing and Issuing a License).
 - 2) If an agency decides to discontinue the application process for a renewal license after submitting the renewal application and the renewal license fee, the agency must submit to DADS a notarized statement requesting to withdraw the renewal application. DADS does not refund the renewal license fee.
 - 3) DADS notifies an agency, in writing, if an application does not include all documents, information, or the license fee required by this section. An agency must submit the missing documents, information, or fee to DADS postmarked no later than 30 days after the date of the notice or DADS considers the renewal application incomplete and denies the application. If DADS denies the renewal application, DADS does not refund the renewal license fee.

- 4) If an agency receives a written notice from DADS that a late fee is assessed in accordance with subsection (g) of this section, the agency's late fee must be postmarked no later than 30 days after the date of the notice or DADS considers the renewal application incomplete and denies the application. If DADS denies the renewal application, DADS does not refund the renewal license fee.
- i) If an agency submits a renewal application to DADS that is postmarked after the expiration date of the license, DADS denies the renewal application and does not refund the renewal license fee. The agency is not eligible to renew the license and must cease operation on the date the license expires. An agency whose license expires must apply for an initial license in accordance with §97.13 of this subchapter (relating to Application Procedures for an Initial License).
- j) If an agency submits a timely renewal application in accordance with this section, and an action to revoke, suspend, or deny renewal of the license is pending, the agency may continue to operate, and the license is valid until the agency has had an opportunity for a formal hearing as described in §97.601 of this chapter (relating to Enforcement Actions). Until the action to revoke, suspend, or deny renewal of the license is completed, the agency must continue to submit a renewal application in accordance with this section. DADS issues a renewal license only if DADS determines the reason for the proposed action no longer exists.
- k) If a license holder fails to submit a timely renewal application in accordance with this section because the license holder is or was on active duty with the armed forces of the United States of America outside the state of Texas, the license holder may renew the license pursuant to this subsection.
- 1) An individual having power of attorney from the license holder or other authority to act on behalf of the license holder may request renewal of the license. The renewal application must include a current address and telephone number for the individual requesting the renewal.
- 2) An agency may request a renewal application before or after the expiration of the license.

- 3) A copy of the official orders or other official military documentation showing that the license holder is or was on active military duty serving outside the state of Texas must be filed with DADS along with the renewal application.
- 4) A copy of the power of attorney from the license holder or other authority to act on behalf of the license holder must be filed with DADS along with the renewal application.
- 5) A license holder renewing under this subsection must pay the applicable renewal fee.
- 6) A license holder is not authorized to operate the agency for which the license was obtained after the expiration of the license unless and until the license holder actually renews the license.
- 7) This subsection applies to a license holder who is an individual or a partnership comprised of individuals, all of whom are or were on active duty with the armed forces of the United States of America serving outside the state of Texas.

§97.19 Issuance of a Renewal License

- a) A renewal license is valid for two years. The new licensure period begins the day after the previous license expires.
- b) Except as specified in §97.503 of this chapter (relating to Exemption from a Survey), DADS may not renew an initial license unless DADS conducts an initial survey of the agency. For renewal of an initial license, an agency must:
 - 1) Meet the requirements for an initial survey as specified in Subchapter E of this chapter (relating to Licensure Surveys);
 - 2) Demonstrate substantial compliance with the statute and this chapter for the services authorized under the license as confirmed by an initial survey; and
 - 3) Apply for renewal of the license in accordance with §97.17 of this subchapter (relating to Application Procedures for a Renewal License).
- c) For renewal of a license other than an initial license, an agency must:

- 1) Maintain substantial compliance with the statute and this chapter for the services authorized under the license; and
 - 2) Apply for renewal of the license in accordance with §97.17 of this subchapter.
- d) DADS may deny a renewal application:
- 1) If an agency fails to meet the eligibility criteria in §97.11 of this subchapter (relating to Criteria and Eligibility for Licensing);
 - 2) If the agency fails to meet the requirements for renewal of a license as specified in this section; or
 - 3) For any of the reasons specified in §97.21 of this subchapter (relating to Denial of an Application or a License).
- e) A renewal license designates an agency's place of business from which services are to be provided and designates an agency's authorized category or categories of service.

§97.21 Denial of an Application or a License

- a) DADS may deny an application for an initial license or for renewal of a license if any person described in §97.11(g) of this subchapter (relating to Criteria and Eligibility for Licensing):
- 1) Fails to comply with the statute;
 - 2) Fails to comply with this chapter;
 - 3) Knowingly aids, abets, or permits another person to violate the statute or this chapter; or
 - 4) Fails to meet the criteria for a license established in §97.11 of this subchapter; or
 - 5) Violates Texas Occupations Code, §102.001 (relating to Soliciting Patients; Offense) or §102.006, (relating to Failure to Disclose; Offense).
- b) If DADS denies an application for an initial license or for renewal of a license, the applicant or agency may request an administrative hearing in accordance with §97.601 of this chapter, (relating to Enforcement Actions).

§97.23 Change of Ownership

- a) A license issued under this chapter may not be sold or assigned to another person.

- b) A change of ownership occurs when there is:
 - 1) A change of 50% or more in the ownership of the business organization or sole proprietorship that is licensed to operate the agency; or
 - 2) A change in the federal taxpayer identification number.
- c) A change of ownership for a parent agency is a change of ownership for the parent agency's branch office or alternate delivery site and requires the submittal of an initial application and license fee for the branch office or alternate delivery site.
- d) A change of ownership does not apply if an agency is a business entity and is simply amending its official documents to revise its name.
- e) For agencies licensed to provide licensed and certified home health services and licensed and certified hospice services, applicable federal laws and regulations relating to change of ownership or control apply in addition to the requirements of this section.

§97.25 Application Procedures and Requirements for Change of Ownership

- a) An application for an initial license resulting from a change of ownership must be requested at least 60 days before the effective date of the change of ownership.
 - 1) To avoid a gap in the license period, a prospective new owner must submit a complete and correct application packet for a license and the appropriate license fee to DADS at least 30 days before the anticipated date of sale or other transfer of ownership, and before expiration date of the license.
 - 2) An applicant must submit a complete and correct application packet to DADS in accordance with the instructions provided with the application packet.
 - 3) An applicant must meet the criteria for a license as described in §97.11 of this subchapter (relating to Criteria and Eligibility for Licensing).

- 4) If an applicant submits a timely and sufficient application packet and license fee and meets all criteria for a license, DADS issues the applicant a license effective on the date of the transfer of ownership. DADS considers an applicant to have filed a timely and sufficient application for a license if the applicant submits:
- A. A complete and correct application packet and license fee to DADS that is postmarked at least 30 days before the anticipated date of sale or other transfer of ownership, and before the expiration date of the license;
 - B. An incomplete application packet and license fee to DADS with a letter explaining the circumstances that prevented its completion that is postmarked at least 30 days before the anticipated date of sale or other transfer of ownership, and before the expiration date of the license; and DADS accepts the explanation. The applicant must submit the missing information to DADS within 30 days after the date of the letter;
 - C. A complete and correct application packet and license fee to DADS that is postmarked less than 30 days before the anticipated date of sale or other transfer of ownership, and before the expiration date of the license; and the applicant pays the late fee set out in §97.3(d) of this chapter (relating to License Fees); or
 - D. A complete and correct application packet and license fee to DADS that is received by the date of sale or other transfer of ownership, and before the expiration date of the license; and the applicant proves to DADS' satisfaction that the health and safety of the agency's clients required an emergency change of ownership.
- 5) If an applicant files a timely application packet and license fee, but DADS determines that the application packet is incomplete and a letter explaining the circumstances that prevented its completion was not filed with the application, DADS considers the application timely filed but incomplete.

- A. DADS provides the applicant with written notification of the missing information required to complete the application and may assess the late fee set out in 97.3(d) of this chapter for failure to comply with paragraph (1) of this subsection.
 - B. An applicant must submit the required information and late fee, if assessed, no later than 30 days after the date of the notice. If an applicant fails to submit the required information within 30 days after the notice date, DADS considers the application incomplete and DADS denies the license. If DADS denies the license, DADS does not refund the license fee.
- 6) The initial license issued to the new owner is valid for two years from the date of issuance.
 - 7) The previous owner's license is void on the effective date of the new owner's initial license. The previous owner's license must be surrendered to DADS within five working days after the effective date of the change of ownership.
 - 8) DADS may deny issuance of a license for any of the reasons specified in §97.21 of this subchapter (relating to Denial of an Application or a License).
- b) For agencies licensed to provide licensed and certified home health services and licensed and certified hospice services, applicable federal laws and regulations relating to change of ownership or control apply in addition to the requirements of this section.

§97.27 Application and Issuance of a Branch Office License

- a) An agency with a current license to provide licensed home health services, licensed and certified home health services, or personal assistance services may qualify for a branch office license if the parent agency:
 - 1) Is found to be in substantial compliance with the statute and this chapter; and
 - 2) Has no enforcement action pending against the license.
- b) Upon request, DADS furnishes a parent agency with an application packet for a branch office license.

- c) An agency must submit to DADS a complete and correct application packet and the required license fee for a branch office license in accordance with the instructions provided with the application packet. A complete and correct application packet includes all documents and information that DADS requests as part of the application process.
- d) DADS reviews an application packet for a branch office license to determine whether it is complete and correct.
 - 1) DADS processes an application packet for a branch office license according to the time frames in §97.31 of this chapter (relating to Time Frames for Processing and Issuing a License).
 - 2) If an agency receives a notice from DADS that some or all of the information required by this section is missing or incomplete, the agency must submit the required information no later than 30 days after the date of the notice. If an agency fails to submit the required information within 30 days after the notice date, DADS considers the application for a branch office license incomplete and denies the application. If DADS denies the application, DADS does not refund the license fee.
- e) A designated survey office conducts a review of an agency's request to establish a branch office. The survey office makes a recommendation to approve or disapprove the branch office request.
- f) DADS approves or denies the application for a branch office license after considering the designated survey office's recommendation. If DADS denies the application, DADS sends the agency a written notice:
 - 1) Informing the agency of its decision; and
 - 2) Providing the agency with an opportunity to appeal its decision through a formal hearing process as described in §97.601 of this chapter (relating to Enforcement Actions).
- g) CMS approves or denies the branch location if an agency is licensed to provide licensed and certified home health services.
- h) A branch office license expires on the same expiration date as the parent agency's license, and the agency may renew it with the parent agency's license.

- i) DADS mails the branch office license to the parent agency. The branch office must post the license in a conspicuous place on the licensed branch office premises.
- j) A branch office must comply with §97.321 of this title (relating to Standards for Branch Offices) and the additional standards that relate to the agency's authorized categories under the license.
- k) DADS may conduct a survey of a branch office after issuance of the license to verify compliance with the statute and this chapter.

§97.29 Application and Issuance of an Alternate Delivery Site License

- (a) An agency with a license to provide hospice services may qualify for an alternate delivery site license if the parent agency:
 - (1) Is in substantial compliance with the statute and this chapter; and
 - (2) Has no enforcement action pending against its license.
- (b) An agency may obtain an application for an ADS license on DADS website. If needed, an applicant can use information provided on DADS website to call DADS to obtain an application by mail. On the application, an agency may request to operate an inpatient unit at the alternate delivery site location.
- (c) An agency must submit to DADS a complete and correct application and the required license fee specified in §97.3 of this chapter (relating to License Fees) for an ADS in accordance with instructions provided with the application. A complete and correct application includes all documents and information that DADS requests as part of the application process.
- (d) After an agency submits an application for an ADS with an inpatient unit, the agency must contact the DADS Architectural Unit to request a Life Safety Code survey. Before DADS considers whether the application is complete, DADS must determine an agency's compliance with the Life Safety Code requirements in Subchapter H, Division 7 of this chapter (relating to Hospice Inpatient Units).
- (e) DADS reviews an application for an ADS license to determine whether it is complete and correct.
 - (1) DADS processes an application for an ADS license according to the time frames in §97.31 of this subchapter (relating to Time Frames for Processing and Issuing a License).

- (2) If an agency receives a written notice from DADS that some or all of the documents, information, or the license fee required by this section is missing or incomplete, the agency must submit the required information to DADS postmarked within 30 days after the date of the notice. If an agency fails to submit the required information postmarked within 30 days after the notice date, DADS considers the application for an ADS license incomplete and denies the application. If DADS denies the application, DADS does not refund the license fee.
- (f) A designated survey office reviews an agency's application for an ADS license and makes a recommendation to DADS Home and Community Support Services Agencies licensing unit whether to approve or deny the application. The DADS licensing unit approves or denies the agency's application.
- (g) If DADS denies an agency's application, DADS sends the agency a written notice:
 - (1) Informing the agency of its decision; and
 - (2) Providing the agency with an opportunity to appeal its decision through a formal hearing process as described in §97.601 of this chapter (relating to Enforcement Actions).
- (h) After DADS issues a license for an ADS with an inpatient unit, the agency must, after providing inpatient services to a client, submit the Notification of Readiness for a Health Survey of a Hospice Inpatient Unit (DADS Form 2020-A), to the designated survey office. DADS conducts an initial licensure health survey to review the standards specified in Subchapter H, Division 7 of this chapter that a DADS Life Safety Code surveyor did not review during the initial Life Safety Code survey.
- (i) An agency is not required to request an initial licensure health survey of an ADS with an inpatient unit if the agency is exempt from the health survey as specified in §97.503 of this chapter (relating to Exemption From a Survey). To demonstrate that it is exempt, the agency must send the accreditation documentation from JCAHO or CHAP to the DADS designated survey office within seven days after the agency receives the accreditation documentation.

- (j) If an agency receives accreditation documentation from JCAHO or CHAP after the agency submits a written request to DADS for an initial licensure health survey, the agency may demonstrate that it is exempt from the survey by sending the accreditation documentation to the DADS designated survey office before DADS arrives at the agency to conduct an initial health survey.
- (k) A Medicare-certified hospice agency must also submit a request to CMS for approval of an ADS, including an ADS with an inpatient unit. CMS approves or denies the request.
- (l) An ADS license expires on the same date the parent agency's license expires. The agency may renew its ADS license with the parent agency's license.
- (m) DADS mails an ADS license to the parent agency. The agency must post the ADS license in a conspicuous place on the licensed ADS premises.
- (n) An ADS must comply with the statute and this chapter, including the applicable additional standards for hospice agencies in Subchapter H of this chapter (relating to Standards Specific to Agencies Licensed to Provide Hospice Services) and §97.322 of this chapter (relating to Standards for Alternate Delivery Sites). A Medicare-certified hospice agency's ADS must also comply with the applicable federal rules and regulations for hospice agencies in 42 CFR Part 418, Hospice Care.

§97.31 Time Frames for Processing and Issuing a License

- a) General.
 - 1) In this section, the date of an application is the date the DADS' Home and Community Support Services Agencies (HCSSA) Licensing Unit receives the application.
 - 2) DADS considers an application for an initial license complete when DADS receives, reviews, and accepts the information described in §97.13 of this subchapter (relating to Application Procedures for an Initial License).
 - 3) DADS considers an application for a renewal license complete when DADS receives, reviews, and accepts the information described in §97.17 of this subchapter (relating to Application Procedures for a Renewal License). An agency may continue to operate in accordance with §97.17(j) of this subchapter.

- 4) DADS considers an application for a change of ownership license complete when DADS receives, reviews, and accepts the information described in §97.25 of this subchapter (relating to Change of Ownership).
 - 5) DADS considers an application for a branch office license complete when DADS receives, reviews, and accepts the information described in §97.27 of this subchapter (relating to Application and Issuance of a Branch Office License).
 - 6) DADS considers an application for an alternate delivery site license complete when DADS receives, reviews, and accepts the information described in §97.29 of this subchapter (relating to Application and Issuance of an Alternate Delivery Site License).
- b) Time frames. An application from an agency for an initial, renewal, change of ownership, branch office, or alternate delivery site license is processed in accordance with the following time frames:
- 1) The first time frame begins on the date DADS' HCSSA Licensing Unit receives an application and ends on the date a license is issued. If DADS' HCSSA Licensing Unit receives an incomplete application, the first time frame ends on the date DADS' HCSSA Licensing Unit sends a written notice to the agency that the application is incomplete. The written notice describes the specific information that the applicant must submit to complete the application. The first time frame is no longer than 45 days.
 - 2) The second time frame begins on the date DADS' HCSSA Licensing Unit receives the last item necessary to complete the application and ends on the date the license is issued. The second time frame is no longer than 45 days.
 - 3) If an agency is subject to a proposed or pending enforcement action on its license on or within 45 days before the expiration date of the license, DADS may suspend issuance of a renewal license until a formal hearing as described in §97.601 of this chapter (relating to Enforcement Actions) is complete.

- c) Reimbursement of fees.
 - 1) If DADS does not process the application in the time frames stated in subsection (b) of this section, the applicant has the right to request that DADS reimburse the license fee. If DADS does not agree that the established time frames have been violated or finds that good cause existed for exceeding the established time frames, DADS denies the request.
 - 2) DADS considers that good cause for exceeding the established time frames exists if:
 - A. The number of applications to be processed exceeds by 15% or more the number of applications processed in the same quarter for the preceding year;
 - B. Another public or private entity used in the application process caused the delay; or
 - C. Other conditions existed giving good cause for exceeding the established time frames.
- d) Appeal. If DADS denies the request for reimbursement of the license fee as authorized by subsection (c) of this section, the applicant may appeal the denial. In order to appeal, the applicant must send a written request for reimbursement of the license fee to the DADS commissioner. The request must include that the application was not processed within the established time frame. DADS' HCSSA Licensing Unit provides the DADS commissioner with a written report of the facts related to the processing of the application and good cause for exceeding the established time frame. The DADS commissioner makes the final decision and provides written notification of the decision to the applicant and DADS' HCSSA Licensing Unit.

Subchapter C, Minimum Standards for All HCSS Agencies

Division 1, General Provisions

§97.201 Applicability

- (a) This subchapter applies to a home and community support services agency providing licensed home health services or licensed and certified home health services with and without home dialysis designation, hospice services, or personal assistance services.

- (b) In addition to the minimum standards in this subchapter, an agency must also comply with applicable standards in Subchapter D of this chapter (relating to Additional Standards Specific to License Category and Specific to Special Services) and Subchapter H of this chapter (relating to Standards Specific to Agencies Licensed to Provide Hospice Services).

Division 2, Condition of License

§97.208 Reporting Changes in Application Information and Fees

- a) If certain information provided on an initial or renewal application changes after DADS issues the license, an agency must report the change to DADS. The agency must use the Home and Community Support Services Agency License Application, (DADS Form 2021), to report the change. To avoid a late fee, a change must be reported within the time frame specified for the type of change.
 - 1) For requirements on reporting a change in the agency's location, see §97.213 of this subchapter (relating to Agency Relocation);
 - 2) For requirements on reporting a change in the agency's contact information and operating hours, see §97.214 of this subchapter (relating to Notification Procedures for a Change in Agency Contact Information and Operating Hours);
 - 3) For requirements on reporting a change to the agency's name, see §97.215 of this subchapter (relating to Notification Procedures for an Agency Name Change);
 - 4) For requirements on reporting a change in the agency's organizational management personnel, see §97.218 of this subchapter (relating to Agency Organizational Changes);
 - 5) For requirements on adding or deleting a category of service to the license, see §97.219 of this subchapter (relating to Procedures for Adding or Deleting a Category to the License); and
 - 6) For requirements on expanding or reducing the agency's service area, see §97.220 of this subchapter (relating to Service Areas).

- b) The schedule of fees an agency must pay when the agency timely submits DADS Form 2021 to report changes in application information is as follows.
- 1) An agency is not required to pay a fee if the agency reports changes to contact information and operating hours, within the required time frame, as specified in §97.214 of this subchapter.
 - 2) An agency is not required to pay a fee if the agency reports a change in the alternate administrator, within the required time frame, as specified in §97.218 of this subchapter.
 - 3) An agency must pay a fee of \$30 if the agency, within the required time frame, reports one or more of the following changes:
 - A. A change in physical location, as specified in §97.213 of this subchapter;
 - B. A change in name (legal entity or doing business as), as specified in §97.215 of this subchapter;
 - C. A change in administrator, chief financial officer or controlling person, as specified in §97.218 of this subchapter;
 - D. A change in category of service designated on a license, as specified in §97.219 of this subchapter; or
 - E. A change in service area, as specified in §97.220 of this subchapter.
- c) If an agency untimely submits DADS Form 2021 to report one or more changes referenced in subsection (a) of this section, the agency must pay a late fee of \$100. If an agency must pay a fee of \$30 for reporting a change referenced in subsection (b)(3) of this section, the \$100 late fee is in addition to the \$30 fee.
- d) If DADS determines, based on review of an agency's renewal application, that an agency did not report a change in application information as required by this section, DADS notifies the agency in writing of the fee amount due for payment.

- e) If DADS determines, based on a survey, that an agency did not report a change in application information as required by this section, DADS notifies the agency in writing of the fee amount due for payment. Reporting the change and paying the required fee does not preclude DADS from taking other enforcement action against the agency as specified in §97.601 of this chapter (relating to Enforcement Actions).
- f) If an agency pays a fee to DADS to report a change in application information, the fee is not refundable. DADS accepts payment for a required fee as described in §97.3(f) of this chapter (relating to License Fees).
- g) DADS may suspend or revoke a license or deny an application for a renewal license if an agency does not pay a fee as required by this section within 30 days after DADS provides written notice of a fee amount due for payment. Within 10 days after receipt of DADS written notice of a fee amount due for payment, an agency may submit proof to DADS that the agency:
 - 1) Submitted DADS Form 2021 to timely report a change in application information as specified in each rule referenced in subsection (a) of this section; or
 - 2) Paid the fee amount required by this section when the agency submitted DADS Form 2021.

§97.210 Agency Operating Hours

- a) An agency must adopt and enforce a written policy identifying the agency's operating hours.
- b) For the purposes of this section, the person in charge means the administrator, the designated alternate administrator, the supervising nurse, or the alternate supervising nurse.
- c) If an agency is closed during the agency's operating hours or between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday, the person in charge must:
 - 1) Post a notice in a visible location outside the agency that will provide information regarding how to contact the person in charge; and
 - 2) Leave a message on an answering machine or similar electronic mechanism that will provide information regarding how to contact the person in charge.

§97.211 Display of License

The license must be displayed in a conspicuous place in the designated place of business. If the information on the license is officially amended during the licensure period, a notice must be posted beside the license to provide public notice of the change.

§97.212 License Alteration Prohibited

A license may not be altered.

§97.213 Agency Relocation

- a) An agency must not transfer a license from one location to another without prior notice to DADS. If an agency is considering relocation, the agency must submit written notice to DADS to report a change in physical location at least 30 days before the intended relocation unless DADS grants the agency an exemption from the 30-day time frame as specified in subsection (b) of this section. A change in physical location for a hospice inpatient unit requires DADS to conduct a survey to approve the new location.
- b) An agency must notify DADS immediately if an unexpected situation beyond the agency's control makes it impossible for the agency to submit written notice to DADS no later than 30 days before the agency relocates. DADS grants or denies the exemption.
 - 1) If DADS grants the exemption, the agency must submit written notice to DADS as described in subsection (c) of this section within 30 days after the date DADS grants the exemption.
 - 2) If DADS denies the exemption, the agency may not relocate until at least 30 days after the agency submits the written notice to DADS as described in subsection (c) of this section.
- c) An agency must use the Home and Community Support Services Agency License Application, (DADS Form 2021), to submit the written notice and follow the instructions on the DADS website for reporting a change in physical location.
- d) If an agency reports a change in physical location, the agency must pay a fee and may be subject to a late fee, as described in §97.208 of this subchapter (relating to Reporting Changes in Application Information and Fees).

- e) DADS sends the agency a Notification of Change reflecting the new location. The agency must post the Notification of Change beside its license in accordance with §97.211 of this subchapter (relating to Display of License).
- f) A Medicare certified home health and hospice agency must comply with applicable federal laws and regulations and the requirements of this section for reporting an agency relocation. A change in physical location for a Medicare-certified agency requires DADS review.
- g) An agency is exempt from the requirements in subsections (a)–(d) of this section when reporting a temporary relocation that results from the effects of an emergency or disaster, as specified in §97.256(o) of this subchapter (relating to Emergency Preparedness Planning and Implementation).

§97.214 Notification Procedures for a Change in Telephone Number and Agency Operating Hours

- a) An agency must submit written notice to DADS no later than seven days after a change in the agency's:
 - 1) Telephone number; or
 - 2) Mailing address, if different than the physical location.
- b) An agency must notify DADS within seven days after a change in the agency's operating hours.
- c) An agency must use the Home and Community Support Services Agency License Application, (DADS Form 2021), to submit the written notice and follow the instructions on DADS website for reporting the changes described in subsections (a) and (b) of this section.
- d) If an agency reports the information after the timeframes required by this section, the agency must pay a late fee as described in §97.208 of this subchapter (relating to Reporting Changes in Application Information and Fees).

§97.215 Notification Procedures for an Agency Name Change

- a) If an agency intends to change its name (legal entity or doing business as), but does not undergo a change of ownership as defined in §97.23(b) of this chapter (relating to Change of Ownership), the agency must report the name change to DADS no later than seven days after the effective date of the name change.

- b) An agency must use the Home and Community Support Services Agency License Application, (DADS Form 2021), to submit the written notice and follow the instructions on DADS website for reporting a name change.
- c) If an agency reports a name change, the agency must pay a fee and may be subject to a late fee, as described in §97.208 of this subchapter (relating to Reporting Changes in Application Information and Fees).
- d) After DADS receives and verifies the required documents and information, DADS sends the agency a Notification of Change reflecting the agency's new name. The agency must post the Notification of Change beside its license in accordance with §97.211 of this subchapter (relating to Display of License).

§97.216 Change in Agency Certification or Accreditation Status

- a) An agency must notify DADS in writing no later than five days after the agency decides to voluntarily withdraw from the Medicare Program. If an agency's voluntary withdrawal from the Medicare Program is based on the permanent closure of the agency, the agency must also comply with §97.217 of this subchapter (relating to Agency Closure Procedures and Voluntary Suspension of Operations).
- b) If an agency chooses to voluntarily withdraw from the Medicare Program, or if CMS involuntarily terminates or denies its certification, the license will be affected as follows:
 - 1) If an agency licensed to provide licensed and certified home health services has no other license categories remaining on the license after losing its Medicare certification, its license is void and the agency must cease operation. If the agency wants to resume providing services, it must apply for an initial license.
 - 2) If a Medicare-certified agency has another license category remaining on the current license and the agency wants to continue providing services under the remaining license category, DADS surveys the agency under the remaining license category.

- c) As specified in §97.601(c)(2) of this chapter (relating to Enforcement Actions), DADS may take enforcement action against an agency licensed to provide licensed and certified home health services if the agency fails to maintain its Medicare certification. The agency may request an administrative hearing in accordance with §97.601 of this chapter to contest the enforcement action taken by DADS against the agency.

§97.217 Agency Closure Procedures and Voluntary Suspension of Operations

- a) Permanent closure. An agency must notify DADS in writing within five days before the permanent closure of the agency, branch office, or alternate delivery site.
 - 1) The agency must include in the written notice the reason for closing, the location of the client records (active and inactive), and the name and address of the client record custodian.
 - 2) If the agency closes with an active client roster, the agency must transfer a copy of the active client record with the client to the receiving agency in order to ensure continuity of care and services to the client.
 - 3) The agency must mail or return the initial license or renewal license to DADS at the end of the day that services ceased.
 - 4) If an agency continues to operate after the closure date specified in the notice, DADS may take enforcement action against the agency.
- b) Applicability. This subsection applies to an agency licensed to provide licensed home health services, personal assistance services, and licensed-only hospice services.
 - 1) Voluntary suspension of operations occurs when an agency voluntarily suspends its normal business operations for 10 or more consecutive days. A voluntary suspension of operations may not last longer than the licensure renewal period. If an agency voluntarily suspends operations, the agency must:
 - A. Discharge or arrange for backup services for active clients;

- B. Provide written notification to the designated survey office at least five days before the voluntary suspension of operations or within two working days before the voluntary suspension of operations if an emergency occurs that is beyond the agency's control; and
 - C. Post a notice of voluntary suspension of operations on the entry door of the agency and leave a message on an answering machine or with an answering service that informs callers of the voluntary suspension of operations.
- 2) An agency must notify the Home and Community Support Services Agencies Licensing Unit in writing no later than seven days after resuming operations.

§97.218 Agency Organizational Changes

- a) If a change occurs in the following management personnel, an agency must submit written notice to DADS no later than seven days after the date of a change in:
 - 1) Administrator;
 - 2) Alternate administrator;
 - 3) Chief financial officer; or
 - 4) Controlling person, as defined in §97.2 of this chapter (relating to Definitions).
- b) An agency must use the Home and Community Support Services Agency License Application, (DADS Form 2021), to submit the written notice and follow the instructions on DADS website for reporting a change in the management personnel listed in subsection (a) of this section.
- c) If an agency reports a change in the administrator, chief financial officer or controlling person, the agency must pay a fee and may be subject to a late fee, as described in §97.208 of this subchapter (relating to Reporting Changes in Application Information and Fees).
- d) An agency is not required to pay a fee to report a change in alternate administrator, but the agency must pay a late fee, as described in §97.208 of this subchapter, if the agency does not report the change within the time frame required in this section.

- e) A change in the management personnel listed in subsection (a) of this section requires DADS evaluation and approval. DADS reviews the required documents and information submitted. DADS notifies an agency if the information the agency provides does not reflect that a person listed in subsection (a)(1)-(4) of this section meets the required qualifications.

§97.219 Procedures for Adding or Deleting a Category to the License

- a) To add or delete a category of service to a license, an agency must submit written notice to DADS at least 30 days before the addition or deletion of the category.
- b) DADS either approves or denies the addition of a category of service no later than 30 days after DADS receives the written notice. An agency must not provide the services under the category the agency is adding until the agency receives written notice of approval from DADS.
 - 1) To add a category of service to a license, an agency must:
 - A. Be in substantial compliance with the statute and this chapter; and
 - B. Have no enforcement action pending against the license.
 - 2) If DADS denies the addition of a category of service, DADS informs the agency of the reason for denial.
 - 3) DADS may conduct a survey after the approval of a category.
- c) DADS receipt of a request to delete a category from a license does not preclude DADS from taking enforcement action as appropriate in accordance with Subchapter F of this chapter (relating to Enforcement).
- d) An agency must use the Home and Community Support Services Agency License Application, (DADS Form 2021), to submit the written notice and follow the instructions on DADS website for requesting to add or delete a category of service.
- e) If an agency reports a change in a category of service, the agency must pay a fee and may be subject to a late fee, as described in §97.208 of this subchapter (relating to Reporting Changes in Application Information and Fees).

- f) When DADS adds or deletes a category of service, DADS sends the agency a Notification of Change reflecting the change in the category of service. The agency must post the Notification of Change beside its license in accordance with §97.211 of this subchapter (relating to Display of License).

§97.220 Service Areas

- (a) An agency must identify its licensed service area. A branch office or alternate delivery site must be located within the parent agency's licensed service area. An agency must not provide services outside its licensed service area, except as provided in subsections (i) and (j) of this section.
- (b) An agency must maintain adequate staff to provide services and to supervise the provision of services.
- (c) An agency may expand its service area at any time during the licensure period. An agency must submit written notice to DADS to expand the agency's service area at least 30 days before the expansion unless DADS grants the agency an exemption from the 30-day time frame as specified in subsection (d) of this section.
- (d) An agency is exempt from the requirement to submit written notice to DADS no later than 30 days before the agency expands its service area if DADS determines an emergency situation exists that would affect client health and safety.
- (1) An agency must notify DADS immediately of a possible emergency situation that would affect client health and safety.
- (2) DADS grants or denies an exemption from the 30-day written notice requirement.
- (A) If DADS grants an exemption, the agency must submit written notice to DADS, as described in subsection (e) of this section, no later than 30 days after the date DADS grants the exemption.
- (B) If DADS denies an exemption, the agency may not expand agency's service area until at least 30 days after the agency submits the written notice to DADS as described in subsection (e) of this section.

- (e) If an agency intends to expand or reduce the agency's service area, the agency must submit written notice to DADS by using the Home and Community Support Services Agency License Application, (DADS Form 2021), following the instructions on the DADS website for requesting to expand or reduce the agency's service area.
- (f) If an agency reports a change in service area, the agency must pay a fee and may be subject to a late fee, as described in §97.208 of this subchapter (relating to Reporting Changes in Application Information and Fees).
- (g) An agency may reduce its service area at any time during the licensure period. An agency must submit written notice to DADS informing DADS that the agency reduced its service area no later than 10 days after the reduction.
- (h) DADS sends the agency a Notification of Change reflecting the change in service area. An agency is not required to post the Notification of Change in service area beside its license.
- (i) An agency is exempt from the requirements described in subsections (c) - (f) of this section if a temporary expansion results from an emergency or disaster, as specified in §97.256(o) of this subchapter (relating to Emergency Preparedness Planning and Implementation).
- (j) An agency may provide services to a client outside the agency's licensed service area but within the state of Texas in accordance with this subsection and, for an agency licensed to provide hospice services, the additional standards in §97.830 of this chapter (relating to Provision of Hospice Core Services).
 - (1) The agency may provide the services for no more than 60 consecutive days unless the agency expands its service area as described in subsections (e) and (f) of this section, except the written notice to DADS must be postmarked no later than the 60th day to comply with this subsection and avoid a late fee.
 - (2) The client must reside in the agency's service area and be receiving services from the agency at the time the client leaves the agency's service area.
 - (3) The agency must maintain compliance with the statute and this chapter and, if applicable, federal home health and hospice regulations.

- (4) The agency must document in the client record the start and end dates for the services.
 - (5) An agency's ability to provide services to a client outside its service area may depend on regulations or requirements established by the client's private or public funding source, including a health maintenance organization or other private third-party insurance, Medicaid (Title XIX of the Social Security Act), Medicare (Title XVIII of the Social Security Act), or a state-funded program. The agency is responsible for knowing these requirements.
- (k) If a client notifies an agency that the client is leaving the agency's service area and the agency does not provide services in accordance with subsection (j), the agency must inform the client that leaving its service area will require the agency to:
- (1) Place the client's services on hold in accordance with the agency's written policy required by §97.281 of this subchapter (relating to Client Care Policies) until the client returns to the agency's service area;
 - (2) Transfer and discharge the client in accordance with §97.295 of this subchapter (relating to Client Transfer or Discharge Notification Requirements) and the agency's written policy required by §97.281 of this subchapter; or
 - (3) Discharge the client in accordance with §97.295 of this subchapter and the agency's written policy required by §97.281 of this subchapter.

§97.222 Compliance

An agency must maintain satisfactory compliance with all the provisions of the statute and this chapter to maintain licensure.

Division 3, Agency Administration

§97.241 Management

- a) Agency policies. The license holder is responsible for the conduct of the agency and for adoption, implementation, enforcement and monitoring of adherence to the written policies required throughout this chapter. The license holder is also responsible for ensuring that these policies comply with the statute and the applicable provisions of this chapter and are administered to provide safe, professional, quality health care.

- b) Criminal conviction. The persons described in §97.11(g) of this chapter (relating to Criteria and Eligibility for Licensing) must not have been convicted of an offense described in Chapter 99 of this title (relating to Criminal Convictions Barring Facility Licensure), during the time frames described in that chapter.
- c) Documentation. The license holder must ensure that all documents submitted to DADS or maintained by the agency pursuant to this chapter are accurate and do not misrepresent or conceal a material fact.
- d) Compliance with enforcement orders. The license holder must comply with an order of the DADS commissioner or other enforcement orders that may be imposed on the agency in accordance with the statute and this chapter.

§97.242 Organizational Structure and Lines of Authority

- a) An agency must prepare and maintain a current written description of the agency's organizational structure. The document may be either in the form of a chart or a narrative.
- b) The description must include:
 - 1) All services provided by the agency;
 - 2) The governing body, the administrator, the supervising nurse, advisory committee, interdisciplinary team, and staff, as appropriate, based on services provided by the agency; and
 - 3) The lines of authority and the delegation of responsibility down to and including the client care level.

§97.243 Administrative and Supervisory Responsibilities

- a) Administrative responsibilities.
 - 1) A license holder or the license holder's designee must designate an individual who meets the qualifications and conditions set out in §97.244 of this chapter (relating to Administrator Qualifications and Conditions and Supervising Nurse Qualifications) to serve as the administrator of the agency.
 - 2) A license holder or the license holder's designee must designate in writing an alternate administrator who meets the qualifications and conditions of an administrator to act in the absence of the administrator.

b) Administrator responsibilities.

- 1) An administrator must be responsible for implementing and supervising the administrative policies and operations of the agency and for administratively supervising the provision of all services to agency clients on a day-to-day basis. An administrator must:
 - A. Manage the daily operations of the agency;
 - B. Organize and direct the agency's ongoing functions;
 - C. Administratively supervise the provision of quality care to agency clients;
 - D. Supervise to ensure implementation of agency policy and procedures;
 - E. Ensure that the documentation of services provided is accurate and timely;
 - F. Employ or contract with qualified personnel;
 - G. Ensure adequate staff education and evaluations according to requirements in §97.245(b) of this chapter (relating to Staffing Policies);
 - H. Ensure the accuracy of public information materials and activities;
 - I. Implement an effective budgeting and accounting system that promotes the health and safety of the agency's clients; and
 - J. Supervise and evaluate client satisfaction survey reports on all clients served.
- 2) An administrator or alternate administrator must be available to agency personnel in person or by telephone during the agency's operating hours and in accordance with the rules in this chapter, including §97.210 of this subchapter (relating to Agency Operating Hours), §97.404(h)(2) of this chapter (relating to Standards Specific to Agencies Licensed to Provide Personal Assistance Services), §97.523 of this chapter (relating to Personnel Requirements for a Survey), and §97.527 of this chapter (relating to Post-Survey Procedures).

- 3) An administrator must designate in writing an agency employee who must provide DADS surveyors entry to the agency in accordance with §97.523(e) of this chapter (relating to Personnel Requirements for a Survey) if the administrator and alternate administrator are not available.
- c) Supervision of services.
- 1) Except as provided in paragraph (3) of this subsection, an agency licensed to provide licensed home health services, licensed and certified home health services, or hospice services must directly employ or contract with an individual who meets the qualifications in §97.244 of this chapter to serve as the supervising nurse.
 - 2) An agency must designate in writing a similarly qualified alternate to serve as supervising nurse in the absence of the supervising nurse.
 - A. The supervising nurse or alternate supervising nurse must:
 - i. Be available to the agency at all times in person or by telephone;
 - ii. Participate in activities relevant to services furnished, including the development of qualifications and assignment of agency personnel;
 - iii. Ensure that a client's plan of care or care plan is executed as written; and
 - iv. Ensure that an appropriate health care professional performs a reassessment of a client's needs:
 - I. When there is a significant health status change in the client's condition;
 - II. At the physician's request; or
 - III. After hospital discharge
 - B. A supervising nurse may also be the administrator of the agency if the supervising nurse meets the qualifications and conditions of an administrator described in §97.244(a) and (b) of this chapter.

- 3) An agency that provides only physical, occupational, speech or respiratory therapy, medical social services, or nutritional counseling is not required to employ or contract with a supervising nurse. A qualified licensed professional must supervise these services, as applicable.
- d) Supervision of branch offices and alternate delivery sites. An agency must adopt and enforce a written policy relating to the supervision of branch offices or alternate delivery sites, if established. This policy must be consistent with the following:
 - 1) For a branch office, §97.27 of this chapter (relating to Application and Issuance of a Branch Office License) and §97.321 of this chapter (relating to Standards for Branch Offices);
 - 2) For an alternate delivery site, §97.29 of this chapter (relating to Application and Issuance of an Alternate Delivery Site License) and §97.322 of this chapter (relating to Standards for Alternate Delivery Sites).

§97.244 Administrator Qualifications and Conditions and Supervising Nurse Qualifications

- (a) Administrator qualifications.
 - (1) For an agency licensed to provide licensed home health services, licensed and certified home health services, or hospice services, the administrator and the alternate administrator must:
 - (C) Be a licensed physician, registered nurse, licensed social worker, licensed therapist, or licensed nursing home administrator with at least one year of management or supervisory experience in a health-related setting, such as:
 - (i) A home and community support services agency;
 - (ii) A hospital;
 - (iii) A nursing facility;
 - (iv) A hospice;
 - (v) An outpatient rehabilitation center;
 - (vi) A psychiatric facility;

- (vii) An intermediate care facility for individuals with an intellectual disability or related conditions; or
 - (viii) A licensed health care delivery setting providing services for individuals with functional disabilities; or
- (D) Have a high school diploma or a general equivalency degree (GED) with at least two years of management or supervisory experience in a health-related setting, such as:
 - (i) A home and community support services agency;
 - (ii) A hospital;
 - (iii) A nursing facility;
 - (iv) A hospice;
 - (v) An outpatient rehabilitation center;
 - (vi) A psychiatric facility;
 - (vii) An intermediate care facility for individuals with an intellectual disability or related conditions; or
 - (viii) A licensed health care delivery setting providing services for individuals with functional disabilities.
- (2) For an agency licensed to provide hospice services, in addition to the qualifications listed in paragraph (1)(A) or (B) of this subsection, the administrator and the alternate administrator must:
 - (A) Be a hospice employee; and
 - (B) Have any additional education and experience required by the hospice's governing body as specified in the agency's job description.
- (3) For an agency licensed to provide only personal assistance services, the administrator and the alternate administrator must meet at least one of the following qualifications:

- (A) Have a high school diploma or a GED with at least one year experience or training in caring for individuals with functional disabilities;
- (B) Have completed two years of full-time study at an accredited college or university in a health-related field; or
- (C) Meet the qualifications listed in paragraph (1)(A) or (B) of this subsection.

(b) Administrator conditions.

- (1) An administrator and alternate administrator must be able to read, write, and comprehend English.
- (2) An administrator and alternate administrator designated as an administrator or alternate administrator for the first time on or after December 1, 2006, must meet the initial educational training requirements specified in §97.259 of this subchapter (relating to Initial Educational Training in Administration of Agencies).
- (3) An administrator and alternate administrator designated as an administrator or alternate administrator before December 1, 2006, must meet the continuing education requirements specified in §97.260 of this subchapter (relating to Continuing Education in Administration of Agencies).
- (4) A person is not eligible to be the administrator or alternate administrator of any agency if the person was the administrator of an agency cited with a violation that resulted in DADS taking enforcement action against the agency while the person was the administrator of the cited agency.
 - (A) This paragraph applies for 12 months after the date of the enforcement action.
 - (B) For purposes of this paragraph, enforcement action means license revocation, suspension, emergency suspension of a license, denial of an application for a license, or the imposition of an injunction but does not include administrative or civil penalties.

- (C) If DADS prevails in one enforcement action against the agency and also proceeds with, but does not prevail in, another enforcement action based on some or all of the same violations, this paragraph does not apply.
 - (5) An administrator and alternate administrator must not be convicted of an offense described in Chapter 99 of this title (relating to Denial or Refusal of License) during the time frames described in that chapter.
- (c) Supervising nurse qualifications.
- (1) For an agency without a home dialysis designation, a supervising nurse and alternate supervising nurse must each:
 - (A) Be a registered nurse (RN) licensed in Texas or in accordance with the Texas Board of Nursing rules for Nurse Licensure Compact (NLC); and
 - (B) Have at least one year experience as an RN within the last 36 months.
 - (2) For an agency with home dialysis designation, a supervising nurse and alternate supervising nurse must each:
 - (A) Be an RN licensed in Texas or in accordance with the Texas Board of Nursing rules for NLC, and:
 - (i) Have at least three years of current experience in hemodialysis; or
 - (ii) Have at least two years of experience as an rn and hold a current certification from a nationally recognized board in nephrology nursing or hemodialysis; or
 - (B) Be a nephrologist or physician with training or demonstrated experience in the care of ESRD clients.

§97.245 Staffing Policies

- a) An agency must adopt and enforce staffing policies that govern all personnel used by the agency, including employees, volunteers and contractors.
- b) An agency's written staffing policies must:
 - 1) Include requirements for orientation to the policies, procedures, and objectives of the agency;
 - 2) Include requirements for participation by all personnel in job-specific training. Agency training program policies must:
 - A. Ensure personnel are properly oriented to tasks performed;
 - B. Ensure demonstration of competency for tasks when competency cannot be determined through education, license, certification or experience;
 - C. Ensure a continuing systematic program for the training of all personnel; and
 - D. Ensure personnel are informed of changes in techniques, philosophies, goals, client's rights, and products relating to client's care;
 - 3) Address participation by all personnel in appropriate employee development programs;
 - 4) Include a written job description (statement of those functions and responsibilities which constitute job requirements) and job qualifications (specific education and training necessary to perform the job) for each position within the agency;
 - 5) Include procedures for processing criminal history checks and searches of the nurse aide registry and the employee misconduct registry for unlicensed personnel in accordance with §97.247 of this subchapter (relating to Employability and Use of Unlicensed Persons);
 - 6) Ensure annual evaluation of employee and volunteer performance;
 - 7) Address employee and volunteer disciplinary action and procedures;

- 8) If volunteers are used by the agency, address the use of volunteers. The policy must be in compliance with §97.248 of this subchapter (relating to Volunteers);
- 9) Address requirements for providing and supervising services to pediatric clients. Services provided to pediatric clients must be provided by staff who have been instructed and have demonstrated competency in the care of pediatric clients; and
- 10) Include a requirement that all personnel who are direct care staff and who have direct contact with clients (employed by or under contract with the agency) sign a statement that they have read, understand, and will comply with all applicable agency policies.

§97.246 Personnel Records

- a) An agency must maintain a personnel record for an employee and volunteer. A personnel record may be maintained electronically if it meets the same requirements as a paper record. All information must be kept current. A personnel record must include the following:
 - 1) A signed job description and qualifications for each position accepted or a signed statement that the person read the job description and qualifications for each position accepted;
 - 2) An application for employment or volunteer agreement;
 - 3) Verification of license, permits, references, job experience, and educational requirements as conducted by the agency to verify qualifications for each position accepted;
 - 4) Performance evaluations and disciplinary actions;
 - 5) The signed statement about compliance with agency policies required by §97.245(b)(10) of this subchapter (relating to Staffing Policies), if applicable; and
 - 6) For an unlicensed employee and unlicensed volunteer whose duties would or do include face-to-face contact with a client:
 - A. A printed copy of the results of the initial and annual searches of the nurse aide registry (NAR) and employee misconduct registry (EMR) obtained from the DADS Internet website; and

- B. Documentation that the employee, in accordance with §97.247(a)(4) of this subchapter (relating to Verification of Employability and Use of Unlicensed Persons), or volunteer, in accordance with §97.247(b)(4), received written information about the EMR.
- b) An agency may keep a complete and accurate personnel record for an employee and volunteer in any location as determined by the agency. An agency must provide personnel records not stored at the site of a survey upon request by a DADS' surveyor as specified in §97.507(c) of this chapter (relating to Agency Cooperation with a Survey).

§97.247 Verification of Employability and Use of Unlicensed Volunteers

- a) The provisions in this subsection apply to an unlicensed applicant for employment and an unlicensed employee, if the person's duties would or do include face-to-face contact with a client.
 - 1) An agency must conduct a criminal history check authorized by, and in compliance with, Texas Health and Safety Code (THSC), Chapter 250 (relating to Nurse Aide Registry and Criminal History Checks of Employees and Applicants for Employment in Certain Facilities Serving the Elderly or Persons with Disabilities) for an unlicensed applicant for employment and an unlicensed employee.
 - 2) The agency must not employ an unlicensed applicant whose criminal history check includes a conviction listed in THSC §250.006 that bars employment or a conviction the agency has determined is a contraindication to employment. If an applicant's or employee's criminal history check includes a conviction of an offense that is not listed in THSC §250.006, the agency must document its review of the conviction and its determination of whether the conviction is a contraindication to employment.

- 3) Before the agency hires an unlicensed applicant, or before an unlicensed employee's first face-to-face contact with a client, the agency must search the nurse aide registry (NAR) and the employee misconduct registry (EMR) using the DADS Internet website to determine if the applicant or employee is listed in either registry as unemployable. The agency must not employ an unlicensed applicant who is listed as unemployable in either registry.
 - 4) The agency must provide written information about the EMR to an unlicensed employee in compliance with the requirements of §93.3(c) of this title (relating to Employment and Registry Information).
 - 5) In addition to the initial verification of employability, the agency must search the NAR and the EMR to determine if the employee is listed as unemployable in either registry as follows:
 - A. For an employee most recently hired before September 1, 2009, by August 31, 2011, and at least every twelve months thereafter; and
 - B. For an employee most recently hired on or after September 1, 2009, at least every 12 months.
 - 6) The agency must immediately discharge an unlicensed employee whose duties would or do include face-to-face contact with a client when the agency becomes aware:
 - A. That the employee is designated in the NAR or the EMR as unemployable; or
 - B. That the employee's criminal history check reveals conviction of a crime that bars employment or that the agency has determined is a contraindication to employment.
- b) The provisions in this subsection apply to an unlicensed volunteer, if the person's duties would or do include face-to-face contact with a client.
- 1) An agency must conduct a criminal history check before an unlicensed volunteer's first face-to-face contact with a client of the agency.

- 2) The agency must not use the services of an unlicensed volunteer for duties that would or do include face-to-face contact with a client whose criminal history information includes a conviction that bars employment under THSC §250.006 or a conviction the agency has determined is a contraindication to employment. If an unlicensed volunteer's criminal history check includes a conviction of an offense not listed in THSC §250.006, the agency must document its review of the conviction and its determination of whether the conviction is a contraindication to employment.
- 3) Before an unlicensed volunteer's first face-to-face contact with a client, the agency must conduct a search of the NAR and the EMR using the DADS Internet website to determine if an unlicensed volunteer is listed in either registry as unemployable. The agency must not use the services of an unlicensed volunteer who is listed as unemployable in either registry.
- 4) The agency must provide written information about the EMR that complies with the requirements of §93.3(c) of this title to an unlicensed volunteer within five working days from the date of the person's first face-to-face contact with a client.
- 5) In addition to the initial verification of employability, the agency must search the NAR and the EMR to determine if a volunteer is designated in either registry as unemployable, as follows:
 - A. For a volunteer with face-to-face contact with a client for the first time before September 1, 2009, by August 31, 2011, and at least every twelve months thereafter; and
 - B. For a volunteer with face-to-face contact with a client for the first time on or after September 1, 2009, at least every twelve months.
- 6) The agency must immediately stop using the services of an unlicensed volunteer for duties that would or do include face-to-face contact with a client when the agency becomes aware:

- A. That the unlicensed volunteer is designated in the NAR or the EMR as unemployable; or
 - B. That the unlicensed volunteer's criminal history check reveals conviction of a crime that bars employment or that the agency has determined is a contraindication to employment.
- c) Upon request by DADS, an agency must provide documentation to demonstrate compliance with subsections (a) and (b) of this section.
- d) An agency that contracts with another agency or organization for an unlicensed person to provide home health services, hospice services, or personal assistance services under arrangement must also comply with the requirements in §97.289(c)-(d) of this subchapter (relating to Independent Contractors and Arranged Services).

§97.248 Volunteers

- a) This section applies to all licensed agencies. However, agencies licensed and certified to provide hospice services also must comply with 42 Code of Federal Regulations, §418.70, Conditions of Participation — Volunteers.
- b) If an agency uses volunteers, the agency must use volunteers in defined roles under the supervision of a designated agency employee.
 - 1) A volunteer must meet the same requirements and standards in this chapter that apply to agency employees performing the same activities.
 - 2) An agency may use volunteers in administrative and direct client care roles.
 - 3) Volunteers must document services provided to a client and, if applicable, services provided to the client's family.

§97.249 Self-Reported Incidents of Abuse, Neglect, and Exploitation

- a) The following words and terms, when used in this section, have the following meanings, unless the context clearly indicates otherwise.
 - 1) Abuse, neglect, and exploitation of a client 18 years of age and older have the meanings assigned by the Texas Human Resources Code, §48.002.

- 2) Abuse, neglect, and exploitation of a child have the meanings assigned by the Texas Family Code, §261.401.
 - 3) Employee means an individual directly employed by an agency, a contractor, or a volunteer.
 - 4) Cause to believe means that an agency knows, suspects, or receives an allegation regarding abuse, neglect, or exploitation.
- b) An agency must adopt and enforce a written policy relating to the agency's procedures for reporting alleged acts of abuse, neglect, and exploitation of a client by an employee of the agency.
 - c) If an agency has cause to believe that a client served by the agency has been abused, neglected, or exploited by an agency employee, the agency must report the information immediately, meaning within 24 hours, to:
 - 1) The Department of Family and Protective Services (DFPS) at 1-800-252-5400, or through the DFPS secure website at www.txabusehotline.org; and
 - 2) DADS at 1-800-458-9858.

§97.250 Agency Investigations

- a) Written policy.
 - 1) An agency must adopt and enforce a written policy relating to the agency's procedures for investigating complaints and reports of abuse, neglect, and exploitation.
 - 2) The policy must meet the requirements of this section.
- b) Reports of abuse, neglect, and exploitation (ANE).
 - 1) Immediately upon witnessing the act or upon receipt of the allegation, an agency must initiate an investigation of known and alleged acts of ANE by agency employees, including volunteers and contractors.
 - 2) An agency must complete DADS' Provider Investigation Report form and include the following information:
 - A. Incident date;
 - B. The alleged victim;
 - C. The alleged perpetrator;

- D. Any witnesses;
 - E. The allegation;
 - F. Any injury or adverse affect;
 - G. Any assessments made;
 - H. Any treatment required;
 - I. The investigation summary; and
 - J. Any action taken.
- 3) An agency must send the completed DADS' Provider Investigation Report form to DADS' Complaint Intake Unit no later than the 10th day after reporting the act to the Department of Family and Protective Services and DADS.
- c) Agency complaint investigations.
- 1) An agency must investigate complaints made by a client, a client's family or guardian, or a client's health care provider, in accordance with this subsection, regarding:
 - A. Treatment or care that was furnished by the agency;
 - B. Treatment or care that the agency failed to furnish; or
 - C. A lack of respect for the client's property by anyone furnishing services on behalf of the agency.
 - 2) An agency must:
 - A. Document receipt of the complaint and initiate a complaint investigation within 10 days after the agency's receipt of the complaint; and
 - B. Document all components of the investigation.
- d) Completing agency investigations. An agency must complete the investigation and documentation within 30 days after the agency receives a complaint or report of abuse, neglect, and exploitation, unless the agency has and documents reasonable cause for a delay.
- e) Retaliation.

- 1) An agency may not retaliate against a person for filing a complaint, presenting a grievance, or providing, in good faith, information relating to home health, hospice, or personal assistance services provided by the agency.
- 2) An agency is not prohibited from terminating an employee for a reason other than retaliation.

§97.251 Peer Review

An agency must adopt and enforce a written policy to ensure that all professional disciplines comply with their respective professional practice acts or title acts relating to reporting and peer review.

§97.252 Financial Solvency and Business Records

An agency must have the financial ability to carry out its functions.

- 1) An agency must not intentionally or knowingly pay employees or contracted staff with checks from accounts with insufficient funds.
- 2) An agency must have sufficient funds to meet its payroll.
- 3) An agency must make available to DADS upon request business records relating to its ability to carry out its functions. If there is a question relating to the accuracy of the records or the agency's financial ability to carry out its functions, DADS or its designee may conduct a more extensive review of the records.
- 4) An agency must maintain business records in their original state. Each entry must be accurate and dated with the date of entry. Correction fluid or tape may not be used in the record. Corrections must be made in accordance with standard accounting practices.

§97.253 Disclosure of Drug Testing Policy

- a) An agency must have a written policy describing whether it will conduct drug testing of its employees who have direct contact with clients.
- b) If an agency conducts drug testing, the written policy must describe the method by which drug testing is conducted.
- c) If an agency does not practice drug testing of its employees, the written policy must state that the agency does not conduct drug testing of its employees.

- d) An agency must provide a copy of the policy to anyone applying for services from the agency and any person who requests it.

§97.254 Billing and Insurance Claims

The agency must adopt and enforce a written policy to ensure that the agency submits accurate billings and insurance claims.

§97.255 Prohibition of Solicitation of Patients

- a) An agency must adopt and enforce a written policy to ensure compliance of the agency and its employees and contractors with the Texas Occupations Code, Chapter 102 (relating to Solicitation of Patients). For the purpose of this section a patient is considered to be a client.
- b) DADS may take enforcement action against an agency in accordance with §97.601 of this chapter (relating to Enforcement Actions) and §97.602 of this chapter (relating to Administrative Penalties), if the agency violates Texas Occupations Code, §102.001 (relating to Soliciting Patients; Offense) or §102.006 (relating to Failure to Disclose; Offense).

§97.256 Emergency Preparedness Planning and Implementation

- a) An agency must have a written emergency preparedness and response plan that comprehensively describes its approach to a disaster that could affect the need for its services or its ability to provide those services. The written plan must be based on a risk assessment that identifies the disasters from natural and man-made causes that are likely to occur in the agency's service area. With the exception of a freestanding hospice inpatient unit, DADS does not require an agency to physically evacuate or transport a client.
- b) Agency personnel that must be involved with developing, maintaining, and implementing an agency's emergency preparedness and response plan include:
 - 1) The administrator;
 - 2) The supervising nurse, if the agency is required to employ or contract with a supervising nurse as required by §97.243 of this subchapter (relating to Administrative and Supervisory Responsibilities);
 - 3) The agency disaster coordinator; and
 - 4) The alternate disaster coordinator.

- c) An agency's written emergency preparedness and response plan must:
- 1) Designate, by title, an employee, and at least one alternate employee to act as the agency's disaster coordinator;
 - 2) Include a continuity of operations business plan that addresses emergency financial needs, essential functions for client services, critical personnel, and how to return to normal operations as quickly as possible;
 - 3) Include how the agency will monitor disaster-related news and information, including after hours, weekends, and holidays, to receive warnings of imminent and occurring disasters;
 - 4) Include procedures to release client information in the event of a disaster, in accordance with the agency's written policy required by §97.301(a)(2) of this subchapter (relating to Client Records); and
 - 5) Describe the actions and responsibilities of agency staff in each phase of emergency planning, including mitigation, preparedness, response, and recovery.
- d) The response and recovery phases of the plan must describe:
- 1) The actions and responsibilities of agency staff when warning of an emergency is not provided;
 - 2) Who at the agency will initiate each phase;
 - 3) A primary mode of communication and alternate communication or alert systems in the event of telephone or power failure; and
 - 4) Procedures for communicating with:
 - A. Staff;
 - B. Clients or persons responsible for a client's emergency response plan;
 - C. Local, state, and federal emergency management agencies; and
 - D. Other entities including DADS and other healthcare providers and suppliers.

- e) An agency's emergency preparedness and response plan must include procedures to triage clients that allow the agency to:
 - 1) Readily access recorded information about an active client's triage category in the event of an emergency to implement the agency's response and recovery phases, as described in subsection (d) of this section; and
 - 2) Categorize clients into groups based on:
 - A. The services the agency provides to a client;
 - B. The client's need for continuity of the services the agency provides; and
 - C. The availability of someone to assume responsibility for a client's emergency response plan if needed by the client.
- f) The agency's emergency preparedness and response plan must include procedures to identify a client who may need evacuation assistance from local or state jurisdictions because the client:
 - 1) Cannot provide or arrange for his or her transportation; or
 - 2) Has special health care needs requiring special transportation assistance.
- g) If the agency identifies a client who may need evacuation assistance, as described in subsection (f) of this section, agency personnel must provide the client with the amount of assistance the client requests to complete the registration process for evacuation assistance if the client:
 - 1) Wants to register with the Transportation Assistance Registry, accessed by dialing 2-1-1; and
 - 2) Is not already registered, as reported by the client or legally authorized representative.
- h) An agency must provide and discuss the following information about emergency preparedness with each client:
 - 1) The actions and responsibilities of agency staff during and immediately following an emergency;
 - 2) The client's responsibilities in the agency's emergency preparedness and response plan;

- 3) Materials that describe survival tips and plans for evacuation and sheltering in place; and
 - 4) A list of community disaster resources that may assist a client during a disaster, including the Transportation Assistance Registry available through 2-1-1 Texas, and other community disaster resources provided by local, state, and federal emergency management agencies. An agency's list of community disaster resources must include information on how to contact the resources directly or instructions to call 2-1-1 for more information about community disaster resources.
- i) An agency must orient and train employees, volunteers, and contractors about their responsibilities in the agency's emergency preparedness and response plan.
 - j) An agency must complete an internal review of the plan at least annually, and after each actual emergency response, to evaluate its effectiveness and to update the plan as needed.
 - k) As part of the annual internal review, an agency must test the response phase of its emergency preparedness and response plan in a planned drill if not tested during an actual emergency response. Except for a freestanding hospice inpatient unit, a planned drill can be limited to the agency's procedures for communicating with staff.
 - l) An agency must make a good faith effort to comply with the requirements of this section during a disaster. If the agency is unable to comply with any of the requirements of this section, it must document in the agency's records attempts of staff to follow procedures outlined in the agency's emergency preparedness and response plan.
 - m) An agency is not required to continue to provide care to clients in emergency situations that are beyond the agency's control and that make it impossible to provide services, such as when roads are impassable or when a client relocates to a place unknown to the agency. An agency may establish links to local emergency operations centers to determine a mechanism by which to approach specific areas within a disaster area in order for the agency to reach its clients.

- n) If written records are damaged during a disaster, the agency must not reproduce or recreate client records except from existing electronic records. Records reproduced from existing electronic records must include:
- 1) The date the record was reproduced;
 - 2) The agency staff member who reproduced the record; and
 - 3) How the original record was damaged.
- o) Notwithstanding the provisions specified in Division 2 of this subchapter (relating to Conditions of a License), no later than five working days after an agency temporarily relocates a place of business, or temporarily expands its service area resulting from the effects of an emergency or disaster, an agency must notify and provide the following information to the DADS Home and Community Support Services Agencies licensing unit:
- 1) If temporarily relocating a place of business:
 - A. The license number for the place of business and the date of relocation;
 - B. The physical address and phone number of the location; and
 - C. The date the agency returns to a place of business after the relocation; or
 - 2) If temporarily expanding the service area to provide services during a disaster:
 - A. The license number and revised boundaries of the service area;
 - B. The date the expansion begins; and
 - C. The date the expansion ends.
- p) An agency must provide the notice and information described in subsection (o) of this section by fax or email. If fax and email are unavailable, the agency may notify the DADS licensing unit by telephone, but must provide the notice and information in writing as soon as possible. If communication with the DADS licensing unit is not possible, the agency must provide the notice and information by fax, e-mail, or telephone to the designated survey office.

§97.257 Medicare Certification Optional

- a) An agency that applies for the category of licensed and certified home health services must comply with the regulations in the Medicare Conditions of Participation for Home Health Agencies, 42 CFR, Part 484, pending approval of certification granted by CMS. After DADS receives written approval from CMS, DADS amends the licensing status of the agency to include the licensed and certified home health services category.
- b) An agency providing hospice services and applying for participation in the Medicare program must comply with the Medicare Conditions of Participation for Hospice Care, 42 CFR Part 418, pending approval of certification granted by CMS. After DADS receives written approval from CMS, DADS enters the hospice provider number issued by CMS into its Home and Community Support Services Agencies database but does not amend the hospice services category on the license.

§97.259 Initial Educational Training in Administration of Agencies

- a) This section applies only to an administrator and alternate administrator designated as an administrator or alternate administrator for the first time on or after December 1, 2006.
- b) In addition to the qualifications and conditions described in §97.244 of this division (relating to Administrator Qualifications and Conditions and Supervising Nurse Qualifications), a first-time administrator and alternate administrator of an agency must each complete a total of 24 clock hours of educational training in the administration of an agency before the end of the first 12 months after designation to the position.
- c) Prior to designation, a first-time administrator or alternate administrator must complete eight clock hours of educational training in the administration of an agency. The initial eight clock hours must be completed during the 12 months immediately preceding the date of designation to the position. The initial eight clock hours must include:
 - 1) Information on the licensing standards for an agency; and
 - 2) Information on the state and federal laws applicable to an agency, including:

- A. The Texas Health and Safety Code, Chapter 142, Home and Community Support Services, and Chapter 250, Nurse Aide Registry and Criminal History Checks of Employees and Applicants for Employment in Certain Facilities Serving the Elderly or Persons with Disabilities;
 - B. The Texas Human Resources Code, Chapter 102, Rights of the Elderly;
 - C. The Americans with Disabilities Act;
 - D. The Civil Rights Act of 1991;
 - E. The Rehabilitation Act of 1993;
 - F. The Family and Medical Leave Act of 1993; and
 - G. The Occupational Safety and Health Administration requirements.
- d) A first-time administrator and alternate administrator must complete an additional 16 clock hours of educational training before the end of the first 12 months after designation to the position. Any of the additional 16 clock hours may be completed prior to designation if completed during the 12 months immediately preceding the date of designation to the position. The additional 16 clock hours must include the following subjects and may include other topics related to the duties of an administrator:
- 1) Information regarding fraud and abuse detection and prevention;
 - 2) Legal issues regarding advance directives;
 - 3) Client rights, including the right to confidentiality;
 - 4) Agency responsibilities;
 - 5) Complaint investigation and resolution;
 - 6) Emergency preparedness planning and implementation;
 - 7) Abuse, neglect, and exploitation;
 - 8) Infection control;
 - 9) Nutrition (for agencies licensed to provide inpatient hospice services); and
 - 10) The Outcome and Assessment Information Set (OASIS) (for agencies licensed to provide licensed and certified home health services).

- e) The 24-hour educational training requirement described in subsection (b) of this section must be met through structured, formalized classes, correspondence courses, competency-based computer courses, training videos, distance learning programs, or off-site training courses. Subject matter that deals with the internal affairs of an organization does not qualify for credit.
 - 1) The training must be provided or produced by:
 - A. An academic institution;
 - B. A recognized state or national organization or association;
 - C. An independent contractor who consults with agencies; or
 - D. An agency.
 - 2) If an agency or independent contractor provides or produces the training, the training must be approved by DADS or recognized by a state or national organization or association. The agency must maintain documentation of this approval or recognition for review by DADS surveyors.
 - 3) A first-time administrator and alternate administrator may apply joint training provided by DADS toward the 24 hours of educational training required by this section if the joint training meets the educational training requirements described in subsections (c) and (d) of this section.
- f) Documentation of administrator and alternate administrator training must:
 - 1) Be on file at the agency; and
 - 2) Contain the name of the class or workshop, the course content (such as the curriculum), the hours and dates of the training, and the name and contact information of the entity and trainer who provided the training.
- g) A first-time administrator and alternate administrator must not apply a pre-survey conference toward the 24 hours of educational training required in this section.

- h) After completing the 24 hours of initial educational training prior to or during the first 12 months after designation as a first-time administrator and alternate administrator, an administrator and alternate administrator must then complete the continuing education requirements as specified in §97.260 of this division (relating to Continuing Education in Administration of Agencies) in each subsequent 12-month period after designation.

§97.260 Continuing Education in Administration of Agencies

- a) In addition to the qualifications and conditions described in §97.244 of this division (relating to Administrator Qualifications and Conditions and Supervising Nurse Qualifications), an administrator and alternate administrator must complete 12 clock hours of continuing education within each 12-month period beginning with the date of designation. The 12 clock hours of continuing education must include at least two of the following topics and may include other topics related to the duties of an administrator:
- 1) Any one of the educational training subjects listed in §97.259(d) of this division (relating to Initial Educational Training in Administration of Agencies);
 - 2) Development and interpretation of agency policies;
 - 3) Basic principles of management in a licensed health-related setting;
 - 4) Ethics;
 - 5) Quality improvement;
 - 6) Risk assessment and management;
 - 7) Financial management;
 - 8) Skills for working with clients, families, and other professional service providers;
 - 9) Community resources; or
 - 10) Marketing.

- b) This subsection applies only to an agency administrator or alternate administrator designated as an agency administrator or alternate administrator before December 1, 2006, who has not served as an administrator or alternate administrator for 180 days or more immediately preceding the date of designation. Within the first 12 months after the date of designation, at least eight of the 12 clock hours of continuing education must include the topics listed in §97.259(c) of this division. The remaining four hours of continuing education must include topics related to the duties of an administrator and may include the topics listed in subsection (a) of this section.
- c) Documentation of administrator and alternate administrator continuing education must:
 - 1) Be on file at the agency; and
 - 2) Contain the name of the class or workshop, the topics covered, and the hours and dates of the training.
- d) An administrator or alternate administrator must not apply the pre-survey conference toward the continuing education requirements in this section.

Division 4, Provision and Coordination of Treatment and Services

§97.281 Client Care Policies

An agency must adopt and enforce a written policy that specifies the agency's client care practices. The written policy must include the following elements if covered under the scope of services provided by the agency:

- 1) Initial assessment, reassessment;
- 2) Start of care, transfer, and discharge;
- 3) Intravenous services;
- 4) Care of the pediatric client;
- 5) Triage of clients in the event of disaster;
- 6) How to handle emergencies in the home;
- 7) Safety of staff;
- 8) Procedures the staff will perform for clients, such as dressing changes, Foley catheter changes, wound irrigation, administration of medication;
- 9) Psychiatric nursing procedures;

- 10) Patient and caregiver teaching relating to disease process/procedures;
- 11) Care planning;
- 12) Care of the dying patient/client;
- 13) Receiving physician orders;
- 14) Performing waived testing;
- 15) Medication monitoring; and
- 16) Anything else pertaining to client care.

§97.282 Client Conduct and Responsibility and Client Rights

- a) An agency must adopt and enforce a written policy governing client conduct and responsibility and client rights in accordance with this section. The written policy must include a grievance mechanism under which a client can participate without fear of reprisal.
- b) An agency must protect and promote the rights of all clients.
- c) An agency must comply with the provisions of the Texas Human Resources Code, Chapter 102, Rights of the Elderly, which applies to a client 60 years of age or older.
- d) At the time of admission, an agency must provide a client who receives licensed home health services, licensed and certified home health services, hospice services, or personal assistance services with a written statement that informs the client that a complaint against the agency may be directed to the Department of Aging and Disability Services, DADS' Consumer Rights and Services Division, P.O. Box 149030, Austin, Texas 78714-9030, toll free 1-800-458-9858. The statement also may inform the client that a complaint against the agency may be directed to the administrator of the agency. The statement about complaints directed to the administrator also must include the time frame in which the agency will review and resolve the complaint.
- e) In advance of furnishing care to a client or during the initial evaluation visit before the initiation of treatment, an agency must provide the client or their legal representative with a written notice of all policies governing client conduct and responsibility and client rights.
- f) A client has the following rights:

- 1) A client has the right to be informed in advance about the care to be furnished, the plan of care, expected outcomes, barriers to treatment, and any changes in the care to be furnished. The agency must ensure that written informed consent specifying the type of care and services that may be provided by the agency has been obtained for every client, either from the client or their legal representative. The client or the legal representative must sign or mark the consent form.
- 2) A client has the right to participate in planning the care or treatment and in planning a change in the care or treatment.
 - A. An agency must advise or consult with the client or legal representative in advance of any change in the care or treatment.
 - B. A client has the right to refuse care and services.
 - C. A client has the right to be informed, before care is initiated, of the extent to which payment may be expected from the client, a third-party payer, and any other source of funding known to the agency.
- 3) A client has the right to have assistance in understanding and exercising the client's rights. The agency must maintain documentation showing that it has complied with the requirements of this paragraph and that the client demonstrates understanding of the client's rights.
- 4) A client has the right to exercise rights as a client of the agency.
- 5) A client has the right to have the client's person and property treated with consideration, respect, and full recognition of the client's individuality and personal needs.
- 6) A client has the right to be free from abuse, neglect, and exploitation by an agency employee, volunteer, or contractor.
- 7) A client has the right to confidential treatment of the client's personal and medical records.

- 8) A client has the right to voice grievances regarding treatment or care that is or fails to be furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the agency and must not be subjected to discrimination or reprisal for doing so.
- g) In the case of a client adjudged incompetent, the rights of the client are exercised by the person appointed by law to act on the client's behalf.
- h) In the case of a client who has not been adjudged incompetent, any legal representative may exercise the client's rights to the extent permitted by law.

§97.283 Advance Directives

- a) An agency must maintain a written policy regarding implementation of advance directives. The policy must be in compliance with the Advance Directives Act, Health and Safety Code, Chapter 166. The policy must include a clear and precise statement of any procedure the agency is unwilling or unable to provide or withhold in accordance with an advance directive.
- b) The agency must provide written notice to a client of the written policy required by subsection (a) of this section. The notice must be provided at the earlier of:
 - 1) The time the client is admitted to receive services from the agency; or
 - 2) The time the agency begins providing care to the client.
- c) If, at the time notice must be provided under subsection (b) of this section, the client is incompetent or otherwise incapacitated and unable to receive the notice, the agency must provide the required written notice, in the following order of preference, to:
 - 1) The client's legal guardian;
 - 2) A person responsible for the health care decisions of the client;
 - 3) The client's spouse;
 - 4) The client's adult child;
 - 5) The client's parent; or
 - 6) The person admitting the client.

- d) If subsection (c) of this section applies, except as provided by subsection (e) of this section, if an agency is unable, after a diligent search, to locate an individual listed by subsection (c) of this section, the agency is not required to provide the notice.
- e) If a client who was incompetent or otherwise incapacitated and unable to receive the notice required by this section at the time notice was to be provided under subsection (b) of this section later becomes able to receive the notice, the agency must provide the written notice at the time the client becomes able to receive the notice.
- f) DADS assesses an administrative penalty of \$500 without an opportunity to correct against an agency that violates this section.

§97.284 Laboratory Services

An agency that provides laboratory services must adopt and enforce a written policy to ensure that the agency meets the Clinical Laboratory Improvement Act, 42 United States Code Annotated, §263a, (CLIA 1988). CLIA 1988 applies to all agencies with laboratories that examine human specimens for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings.

§97.285 Infection Control

An agency must adopt and enforce written policies addressing infection control including the prevention of the spread of infectious and communicable disease. The policies must:

- 1) Ensure compliance by the agency, its employees, and its contractors with:
 - A. The Communicable Disease Prevention and Control Act, Health and Safety Code, Chapter 81;
 - B. The Occupational Safety and Health Administration (OSHA), 29 CFR Part 1910.1030 and Appendix A relating to Bloodborne Pathogens; and
 - C. The Health and Safety Code, Chapter 85, Subchapter I, concerning the prevention of the transmission of human immunodeficiency virus and hepatitis B virus; and
- 2) Require documentation of infections that the client acquires while receiving services from the agency.

- A. If an agency is licensed to provide only personal assistance services, documentation must include the date that the infection was disclosed to the agency employee, the client's name, and treatment.
- B. If an agency is licensed to provide services other than personal assistance services, documentation must include the date that the infection was detected, the client's name, primary diagnosis, signs and symptoms, type of infection, pathogens identified, and treatment as disclosed by the client.

§97.286 Disposal of Special or Medical Waste

- a) An agency must adopt and enforce a written policy for the safe handling and disposal of biohazardous waste and materials, if applicable
- b) An agency that generates special or medical waste while providing home health services must dispose of the waste according to the requirements in 25 TAC, §§1.131-1.137 (relating to Definition, Treatment, and Disposition of Special Waste from Health Care-Related Facilities). An agency must provide both verbal and written instructions to the agency's clients regarding the proper procedure for disposing of sharps. For purposes of this subsection, sharps include hypodermic needles, hypodermic syringes with attached needles, scalpel blades, razor blades, disposable razors, disposable scissors used in medical procedures, and intravenous stylets and rigid introducers.

§97.287 Quality Assessment and Performance Improvement

- a) Quality Assessment and Performance Improvement (QAPI) Program.
 - 1) An agency must maintain a QAPI Program that is implemented by a QAPI Committee. The QAPI Program must be ongoing, focused on client outcomes that are measurable, and have a written plan of implementation. The QAPI Committee must review and update or revise the plan of implementation at least once within a calendar year, or more often if needed. The QAPI Program must include:

- A. A system that measures significant outcomes for optimal care. The QAPI Committee must use the measures in the care planning and coordination of services and events. The measures must include the following as appropriate for the scope of services provided by the agency:
 - i. An analysis of a representative sample of services furnished to clients contained in both active and closed records;
 - ii. A review of:
 - I. Negative client care outcomes;
 - II. Complaints and incidents of unprofessional conduct by licensed staff and misconduct by unlicensed staff;
 - III. Infection control activities;
 - IV. Medication administration and errors; and
 - V. Effectiveness and safety of all services provided, including:
 - a. The competency of the agency's clinical staff;
 - b. The promptness of service delivery; and
 - c. The appropriateness of the agency's responses to client complaints and incidents;
 - iii. A determination that services have been performed as outlined in the individualized service plan, care plan, or plan of care; and
 - iv. An analysis of client complaint and satisfaction survey data; and
- B. An annual evaluation of the total operation, including services provided under contract or arrangement.

- i. An agency must use the evaluation to correct identified problems and, if necessary, to revise policies.
 - ii. An agency must document corrective action to ensure that improvements are sustained over time.
- 2) An agency must immediately correct identified problems that directly or potentially threaten the client care and safety.
- 3) QAPI documents must be kept confidential and be made available to DADS staff upon request.
- b) QAPI Committee membership. At a minimum, the QAPI Committee must consist of:
 - 1) The administrator;
 - 2) The supervising nurse or therapist, or the supervisor of an agency licensed to provide personal assistance services; and
 - 3) An individual representing the scope of services provided by the agency.
- c) Frequency of QAPI Committee meeting. The QAPI Committee must meet twice a year or more often if needed.

§97.288 Coordination of Services

- (a) An agency must adopt and enforce a written policy regarding coordination of services to ensure the effective exchange of information, reporting, and coordination of client services among:
 - (1) All agency personnel providing care and services, whether the care and services are provided directly or under arrangement;
 - (2) The agency and other providers of health care services involved in the care of a client, if known by the agency; and
 - (3) The agency and a licensed facility, group home, foster home, or boarding home facility in which a client resides.

- (b) The agency must include documentation in the client record of coordination of services as specified in subsection (a) of this section.
- (c) In this section, other providers of health care services involved in the care of a client may include:
 - (1) A physician;
 - (2) Another agency;
 - (3) An adult day care center;
 - (4) An outpatient facility; and
 - (5) A managed care organization.

§97.289 Independent Contractors and Arranged Services

- a) Independent contractors. If an agency uses independent contractors, there must be a contract between each independent contractor that performs services and the agency. The contract must be enforced by the agency and clearly designate:
 - 1) That clients are accepted for care only by the agency;
 - 2) The services to be provided by the contractor and how they will be provided (i.e. per visit, per hours, etc.);
 - 3) The necessity of the contractor to conform to all applicable agency policies, including personnel qualifications;
 - 4) The contractor's responsibility for participating in developing the plan of care, care plan or individualized service plan;
 - 5) The manner in which services will be coordinated and evaluated by the agency in accordance with §97.288 of this subchapter (relating to Coordination of Services);
 - 6) The procedures for:
 - A. Submitting information and documentation by the contractor in accordance with the agency's client record policies;
 - B. Scheduling of visits by the contractor or the agency;
 - C. Periodic client evaluation by the contractor; and
 - D. Determining charges and reimbursement payable by the agency for the contractor's services under the contract.

- b) Arranged services. Home health services, hospice services, or personal assistance services provided by an agency under arrangement with another agency or organization must be provided under a written contract conforming to the requirements specified in subsection (a) of this section.
- c) If an agency contracts with another agency or organization for an unlicensed person to provide home health services, hospice services, or personal assistance services under arrangement, the agency must ensure that either it or the contracting agency or organization:
 - 1) Searches the nurse aide registry (NAR) and the employee misconduct registry (EMR) before the unlicensed person's first face-to-face contact with a client of the agency using the DADS Internet website to confirm that the unlicensed person is not listed in either registry as unemployable;
 - 2) Provides written information to the unlicensed person about the EMR that complies with the requirements of §93.3(c) of this title (relating to Employment and Registry Information); and
 - 3) Searches the NAR and the EMR at least every twelve months using the DADS Internet website to confirm that the person is not listed in either registry as unemployable.
- d) If an agency contracts with another agency or organization for an unlicensed person to provide home health services, hospice services, or personal assistance services under arrangement, the agency must ensure that the contracting agency or organization:
 - 1) Conducts a criminal history check before the unlicensed person's first face-to-face contact with a client of the agency; and
 - 2) Verifies that the unlicensed person's criminal history information does not include a conviction that bars employment under the Texas Health and Safety Code §250.006.
- e) Documentation for contract staff. An agency is not required to maintain a personnel record for independent contractors or staff who provide services under arrangement with another agency or organization. Upon request by DADS, an agency must provide documentation at the site of a survey within eight working hours of the request to demonstrate:

- 1) That independent contractors or staff under arrangement meet the agency's written job qualifications for the position and duties performed;
- 2) The agency ensures compliance with subsection (c) of this section for unlicensed staff providing services to the agency's clients under arrangement; and
- 3) The agency complies with subsection (d) of this section for unlicensed staff providing services to the agency's clients under arrangement by providing a written statement, signed by a person authorized to make decisions on personnel matters for the contracting agency or organization, attesting that a criminal history check was conducted before an unlicensed person's first face-to-face contact with a client and did not include a conviction barring employment under THSC §250.006.

§97.290 Backup Services and After Hours Care

- a) Backup services. An agency must adopt and enforce a written policy to ensure that backup services are available when an agency employee or contractor is not available to deliver the services.
 - 1) Backup services may be provided by an agency employee, a contractor, or the client's designee who is willing and able to provide the necessary services.
 - 2) If the client's designee has agreed to provide backup services required by this section, the agency must have the designee sign a written agreement to be the backup service provider. The agency must keep the agreement in the client's file.
 - 3) An agency must not coerce a client to accept backup services.
- b) After hours care. An agency must adopt and enforce a written policy to ensure that clients are educated in how to access care from the agency or another health care provider after regular business hours.

§97.291 Agency Dissolution

An agency must adopt and enforce a written policy that describes the agency's written contingency plan.

- 1) The plan must be implemented in the event of dissolution to assure continuity of client care.

- 2) The plan must:
 - A. Be consistent with §97.295 of this title (relating to Client Transfer or Discharge Notification Requirements);
 - B. Include procedures for:
 - i. Notifying the client of the agency's dissolution;
 - ii. Documenting the notification;
 - iii. Carrying out the notification; and
 - C. Comply with §97.217(a)(2) of this chapter (relating to Agency Closure Procedures and Voluntary Suspension of Operations).

§97.292 Agency and Client Agreement and Disclosure

- a) The agency must provide the client or the client's family with a written agreement for services. The agency must comply with the terms of the agreement. The agreement must include at a minimum the following:
 - 1) Notification of client rights;
 - 2) Documentation concerning notification to the client of the availability of medical power of attorney for health care, advance directive or "Do Not Resuscitate" orders in accordance with the applicable law;
 - 3) Services to be provided;
 - 4) Supervision by the agency of services provided;
 - 5) Agency charges for services rendered if the charges will be paid in full or in part by the client or the client's family, or on request;
 - 6) A written statement containing procedures for filing a complaint in accordance with §97.282(d) of this chapter (relating to Client Conduct and Responsibility and Client Rights); and
 - 7) A client agreement to and acknowledgement of services by home health medication aides, if home health medication aides are used.
- b) The agency must obtain an acknowledgment of receipt from the client or his family of the items listed under subsection (a) of this section. This acknowledgment of receipt must be kept in the client's record.

§97.293 Client List and Services

An agency must maintain a current list of clients for each category of service licensed.

- 1) The list must include all services being delivered by the agency and services being delivered under contract.
- 2) The client list must include the client's name, identification or clinical record number, start of care date or admission date, certification period (if applicable), diagnosis(es) or functional assessment (as appropriate), and the disciplines that are providing services.

§97.294 Time Frame(s) for the Initiation of Care or Services

An agency must adopt and enforce a written policy establishing time frame(s) for the initiation of care or services.

§97.295 Client Transfer or Discharge Notification Requirements

- a) Except as provided in subsection (e) of this section, an agency intending to transfer or discharge a client must:
 - 1) Provide written notification to the client or the client's parent, family, spouse, significant other or legal representative; and
 - 2) Notify the client's attending physician or practitioner if he is involved in the agency's care of the client.
- b) An agency must ensure delivery of the written notification no later than five days before the date on which the client will be transferred or discharged.
- c) The agency must deliver the required notice by hand or by mail.
- d) If the agency delivers the written notice by mail:
 - 1) The notice must be mailed at least eight working days before the date of discharge or transfer; and
 - 2) The agency must speak with the client by telephone or in person to ensure the client's knowledge of the transfer or discharge at least five days before the date of discharge or transfer.
- e) An agency may transfer or discharge a client without prior notice required by subsection (b) of this section:
 - 1) Upon the client's request;

- 2) If the client's medical needs require transfer, such as a medical emergency;
 - 3) In the event of a disaster when the client's health and safety is at risk in accordance with provisions of §97.256 of this chapter (relating to Emergency Preparedness Planning and Implementation);
 - 4) For the protection of staff or a client after the agency has made a documented reasonable effort to notify the client, the client's family and physician, and appropriate state or local authorities of the agency's concerns for staff or client safety, and in accordance with agency policy;
 - 5) According to physician orders; or
 - 6) If the client fails to pay for services, except as prohibited by federal law.
- f) An agency must keep the following in the client's file:
- 1) A copy of the written notification provided to the client or the client's parent, family, spouse, significant other or legal representative;
 - 2) Documentation of the personal contact with the client if the required notice was delivered by mail; and
 - 3) Documentation that the client's attending physician or practitioner was notified of the date of discharge.

§97.296 Physician Delegation and Performance of Physician-Delegated Tasks

- a) An agency must adopt and enforce a written policy that states whether or not physician delegation will be honored by the agency. If an agency accepts physician delegation, the agency must comply with the Medical Practice Act, Occupations Code, Chapter 157, concerning physician delegation.
- b) An agency may accept delegation from a physician only if the agency receives the following from the physician:
 - 1) The name of the client;
 - 2) The name of the delegating physician;
 - 3) The task(s) to be performed;
 - 4) The name of the individual(s) to perform the task(s);
 - 5) The time frame for the delegation order; and

- 6) If the task is medication administration, the medication to be given, route, dose and frequency.

§97.297 Receipt of Physician Orders

An agency must adopt and enforce a written policy describing protocols and procedures agency staff must follow when receiving physician orders.

- 1) The policy must address the time frame for countersignature of physician verbal orders.
- 2) Signed physician orders may be submitted via facsimile machine. The agency is not required to have the original signatures on file. However, the agency must be able to obtain original signatures if an issue surfaces that would require verification of an original signature. The policy must include protocols to follow when accepting physician orders via facsimile. If physician orders are accepted via facsimile, the policy must:
 - A. Outline safeguards to assure that transmitted information is sent to the appropriate individual; and
 - B. Outline the procedures to be followed in the case of misdirected transmission.

§97.298 Delegation of Nursing Tasks by Registered Professional Nurses to Unlicensed Personnel and Tasks Not Requiring Delegation

- a) An agency must adopt and enforce a written policy to ensure compliance with the following rules adopted by the Texas Board of Nursing:
 - 1) 22 TAC, Chapter 224 (relating to Delegation of Nursing Tasks by Registered Professional Nurses to Unlicensed Personnel for Clients with Acute Conditions or in Acute Care Environments); and
 - 2) 22 TAC, Chapter 225 (relating to RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions).
- b) Requirements for RN delegation for personal assistance service clients are located in §97.404 of this chapter (relating to Standards Specific to Agencies Licensed to Provide Personal Assistance Services).

§97.299 Nursing Education, Licensure and Practice

If providing nursing services, an agency must adopt and enforce a written policy to ensure compliance with the rules of the Texas Board of Nursing adopted at 22 TAC Chapters 211-226 (relating to Nursing Continuing Education, Licensure, and Practice in the State of Texas).

§97.300 Medication Administration

- a) This section applies only to clients to whom agency staff administer medications.
- b) An agency must adopt and enforce a written policy for maintaining a current medication list and a current medication administration record.
 - 1) A client's practitioner must order administration of medication.
 - 2) An agency may incorporate a current medication list and medication administration record into one document.
 - A. An agency must use the medication list to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies and contraindications.
 - B. An agency must document in the medication administration record or clinical notes any medication that is not administered and the reason it was not administered.
 - 3) An individual delivering care must report any adverse reaction to a supervisor and document this in the client's record on the day of occurrence. If the adverse reaction occurs after regular business hours, the individual delivering care must report the adverse reaction as soon as it is disclosed.

§97.301 Client Records

- a) In accordance with accepted principles of practice, an agency must establish and maintain a client record system to ensure that the care and services provided to each client are completely and accurately documented, readily accessible and systematically organized to facilitate the compilation and retrieval of information.

- 1) An agency must establish a record for each client and must maintain the record in accordance with and contain the information described in paragraph (9) of this subsection. An agency must keep a single file or separate files for each category of service provided to the client and the client's family. Hospice services provided to a client's family must be documented in the clinical record.
- 2) The agency must adopt and enforce written procedures regarding the use and removal of records, the release of information, and when applicable, the incorporation of clinical, progress, or other notes into the client record. An agency may not release any portion of a client record to anyone other than the client except as allowed by law.
- 3) All information regarding the client's care and services must be centralized in the client's record and be protected against loss or damage.
- 4) The agency must establish an area for original active client record storage at the agency's place of business. The original active client record must be stored at the place of business (parent agency, branch office or alternate delivery site) from which services are actually provided. Original active client records must not be stored at an administrative support site or records storage facility.
- 5) The agency must ensure that each client's record is treated with confidentiality, safeguarded against loss and unofficial use, and is maintained according to professional standards of practice.
- 6) A clinical record must be an original, a microfilmed copy, an optical disc imaging system or a certified copy.
 - A. An original record is a signed paper record or an electronically signed computer record. A signed paper record may include a physicians' stamped signature if the agency meets the following requirements:

- i. An agency must have on file at the agency a current written authorization letter from the physician whose signature the stamp represents, stating that he is the only person authorized to have the stamp and use it.
 - ii. The authorization letter must be dated before a stamped record from the physician was accepted by the agency.
 - iii. An agency must obtain a new authorization letter from the physician annually. A physician authorization letter is void one year from the date of the letter.
 - iv. The authorization letter must be manually signed by the physician and include a copy of the stamped signature that the physician will use.
 - B. Computerized records must meet all requirements of paper records including protection from unofficial use and retention for the period specified in subsection (b) of this section.
 - C. An agency must ensure that entries regarding the delivery of care or services are not altered without evidence and explanation of such alteration.
- 7) Each entry to the client record must be current, accurate, signed and dated with the date of entry by the individual making the entry. The record must include all services whether furnished directly or under arrangement. Correction fluid or tape must not be used in the record. Corrections must be made by striking through the error with a single line and must include the date the correction was made and the initials of the person making the correction.

- 8) Inactive client records may be preserved on microfilm, optical disc or other electronic means and may be stored at the parent agency location, branch office, alternate delivery site, administrative support site or records storage facility. Security must be maintained and the record must be readily retrievable by the agency.
- 9) Each client record must include the following elements as applicable to the scope of services provided by the agency:
 - A. Client application for services including, but not limited to: full name; sex; date of birth; name, address and telephone number of parent(s) of a minor child or legal guardian, or other(s) as identified by the individual; physician's name and telephone numbers, including emergency numbers; and services requested;
 - B. Initial health assessment, pertinent medical history and subsequent health assessments;
 - C. Care plan, plan of care, or individualized service plan, as applicable. The care plan or the plan of care must include, as applicable, medication, dietary, treatment, and activities orders. The requirements for the individualized service plan for personal assistance service clients are located in §97.404 of this chapter (relating to Standards Specific to Agencies Licensed to Provide Personal Assistance Services). The requirements for the plan of care for hospice clients are located in §97.403 of this chapter (relating to Standards Specific to Agencies Licensed to Provide Hospice Services);
 - D. Clinical and progress notes. Such notes must be written the day service is rendered and incorporated into the client record within 14 working days;
 - E. Current medication list;

- F. Medication administration record (if medication is administered by agency staff). Notation must also be made in the medication administration record or in the clinical notes of medications not given and the reason. Any adverse reaction must be reported to a supervisor and documented in the client record;
- G. Records of supervisory visits;
- H. Complete documentation of all known services and significant events. Documentation must show that effective interchange, reporting, and coordination of care occurs as required in §97.288 of this chapter (relating to Coordination of Services);
- I. For clients 60 years and older, acknowledgment of the client's receipt of a copy of the Human Resources Code, Chapter 102, Rights of the Elderly;
- J. Acknowledgment of the client's receipt of the agency's policy relating to the reporting of abuse, neglect or exploitation of a client;
- K. Documentation that the client has been informed of how to register a complaint in accordance with §97.282(d) of this chapter (relating to Client Conduct and Responsibility and client Rights);
- L. client agreement to and acknowledgment of services by home health medication aides, if home health medication aides are used;
- M. Discharge summary, including the reason for discharge or transfer and the agency's documented notice to the client, the client's physician (if applicable), and other individuals as required in §97.295 of this chapter (relating to Client Transfer or Discharge Notification Requirements);
- N. Acknowledgement of receipt of the notice of advance directives;

- O. Services provided to the client's family (as applicable); and
 - P. Consent and authorization and election forms, as applicable.
- b) An agency must adopt and enforce a written policy relating to the retention of records in accordance with this subsection.
 - 1) An agency must retain original client records for a minimum of five years after the discharge of the client.
 - 2) The agency may not destroy client records that relate to any matter that is involved in litigation if the agency knows the litigation has not been finally resolved.
 - 3) There must be an arrangement for the preservation of inactive records to insure compliance with this subsection.

§97.302 Pronouncement of Death

An agency must adopt and enforce a written policy on pronouncement of death if that function is carried out by an agency registered nurse. The policy must be in compliance with the Health and Safety Code, §671.001 (concerning Determination of Death and Autopsy Reports).

§97.303 Standards for Possession of Sterile Water or Saline, Certain Vaccines or Tuberculin, and Certain Dangerous Drugs

An agency that possesses sterile water or saline, certain vaccines or tuberculin, or certain dangerous drugs as specified by this section must comply with the provisions of this section.

- 1) Possession of sterile water or saline. An agency or its employees who are registered nurses or licensed vocational nurses may purchase, store or transport for the purpose of administering to their home health or hospice clients under physician's orders:
 - A. Sterile water for injection and irrigation; and
 - B. Sterile saline for injection and irrigation.
- 2) Possession of certain vaccines or tuberculin.
 - A. An agency or its employees who are registered nurses or licensed vocational nurses may purchase, store or transport for the purpose of administering to the agency's employees, home health or hospice clients, or client family members under physician's standing orders the following dangerous drugs:

- i. Hepatitis B vaccine;
 - ii. Influenza vaccine;
 - iii. Tuberculin purified protein derivative for tuberculosis testing; and
 - iv. Pneumococcal polysaccharide vaccine.
- B. An agency that purchases, stores or transports a vaccine or tuberculin under this section must ensure that any standing order for the vaccine or tuberculin:
 - i. Is signed and dated by the physician;
 - ii. Identifies the vaccine or tuberculin covered by the order;
 - iii. Indicates that the recipient of the vaccine or tuberculin has been assessed as an appropriate candidate to receive the vaccine or tuberculin and has been assessed for the absence of any contraindication;
 - iv. Indicates that appropriate procedures are established for responding to any negative reaction to the vaccine or tuberculin; and
 - v. Orders that a specific medication or category of medication be administered if the recipient has a negative reaction to the vaccine or tuberculin.

3) Possession of certain dangerous drugs.

- A. In compliance with Health and Safety Code, §142.0063, an agency or its employees who are registered nurses or licensed vocational nurses may purchase, store, or transport for the purpose of administering to their home health or hospice patients, in accordance with subparagraph (C) of this paragraph, the following dangerous drugs:
 - i. Any of the following items in a sealed portable container of a size determined by the dispensing pharmacist:
 - I. 1,000 milliliters of 0.9% sodium chloride intravenous infusion;

- II. 1,000 milliliters of 5.0% dextrose in water injection; or
 - III. sterile saline; or
- ii. Not more than five dosage units of any of the following items in an individually sealed, unused portable container:
 - I. Heparin sodium lock flush in a concentration of 10 units per milliliter or 100 units per milliliter;
 - II. Epinephrine HCl solution in a concentration of one to 1,000;
 - III. Diphenhydramine HCl solution in a concentration of 50 milligrams per milliliter;
 - IV. Methylprednisolone in a concentration of 125 milligrams per two milliliters;
 - V. Naloxone in a concentration of one milligram per milliliter in a two-milliliter vial;
 - VI. Promethazine in a concentration of 25 milligrams per milliliter;
 - VII. Glucagon in a concentration of one milligram per milliliter;
 - VIII. Furosemide in a concentration of 10 milligrams per milliliter;
 - IX. Lidocaine 2.5% and prilocaine 2.5% cream in a five-gram tube; or
 - X. Lidocaine HCL solution in a concentration of 1% in a two-milliliter vial.
- B. An agency or the agency's authorized employees may purchase, store, or transport dangerous drugs in a sealed portable container only if the agency has established policies and procedures to ensure that:

- i. The container is handled properly with respect to storage, transportation, and temperature stability;
 - ii. A drug is removed from the container only on a physician's written or oral order;
 - iii. The administration of any drug in the container is performed in accordance with a specific treatment protocol; and
 - iv. The agency maintains a written record of the dates and times the container is in the possession of a registered nurse or licensed vocational nurse.
- C. An agency or the agency's authorized employee who administers a drug listed in subparagraph (A) of this paragraph may administer the drug only in the client's residence under physician's orders in connection with the provision of emergency treatment or the adjustment of:
 - i. Parenteral drug therapy; or
 - ii. Vaccine or tuberculin administration.
- D. If an agency or the agency's authorized employee administers a drug listed in subparagraph (A) of this paragraph pursuant to a physician's oral order, the agency must receive a signed copy of the order:
 - i. Not later than 24 hours after receipt of the order, reduce the order to written form and send a copy of the form to the dispensing pharmacy by mail or facsimile transmission; and
 - ii. Not later than 20 days after receipt of the order, send a copy of the order as signed by and received from the physician to the dispensing pharmacy.
- E. A pharmacist that dispenses a sealed portable container under this subsection will ensure that the container:

- i. Is designed to allow access to the contents of the container only if a tamper-proof seal is broken;
 - ii. Bears a label that lists the drugs in the container and provides notice of the container's expiration date, which is the earlier of:
 - I. The date that is six months after the date on which the container is dispensed; or
 - II. The earliest expiration date of any drug in the container; and (iii) remains in the pharmacy or under the control of a pharmacist, registered nurse, or licensed vocational nurse.
- F. If an agency or the agency's authorized employee purchases, stores, or transports a sealed portable container under this subsection, the agency must deliver the container to the dispensing pharmacy for verification of drug quality, quantity, integrity, and expiration dates not later than the earlier of:
 - i. The seventh day after the date on which the seal on the container is broken; or
 - ii. The date for which notice is provided on the container label.
- G. A pharmacy that dispenses a sealed portable container under this section is required to take reasonable precautionary measures to ensure that the agency receiving the container complies with subparagraph (F) of this paragraph. On receipt of a container under subparagraph (F) of this paragraph, the pharmacy will perform an inventory of the drugs used from the container and will restock and reseal the container before delivering the container to the agency for reuse.

Division 5, Branch Offices and Alternate Delivery Sites

§97.321 Standards for Branch Offices

- a) A branch office operates as a part of the parent agency and must comply with the same regulations as the parent agency. The parent agency is responsible for ensuring that its branches comply with licensing standards.
- b) A branch office providing licensed and certified home health services must comply with the standards for certified agencies in §97.402 of this chapter (relating to Standards Specific to Licensed and Certified Home Health Services).
- c) The service area of a branch office must be located within the parent agency's service area.
 - 1) A branch office must not provide services outside its licensed service area.
 - 2) A branch office must maintain adequate staff to provide services and to supervise the provision of services within the service area.
 - 3) A branch office may expand its service area at any time during the licensure period.
 - A. Unless exempted under subparagraph (B) of the paragraph, a branch office must submit to DADS a written notice to expand its service area at least 30 days before the expansion. The notice must include:
 - i. Revised boundaries of the branch office's original service area;
 - ii. The effective date of the expansion; and
 - iii. An updated list of management and supervisory personnel (including names), if changes are made.
 - B. An agency is exempt from the 30-day written notice requirement under subparagraph (A) of this paragraph if DADS determines an emergency exists that would impact client health and safety. An agency must notify DADS immediately of a possible emergency. DADS determines if an exemption can be granted.

- 4) A branch office may reduce its service area at any time during the licensure period by sending DADS written notification of the reduction, revised boundaries of the branch office's original service area, and the effective date of the reduction.
- d) A parent agency and a branch office providing home health or personal assistance services must meet the following requirements:
 - 1) The parent agency administrator or alternate administrator, or supervising nurse or alternate supervising nurse must conduct an on-site supervisory visit to the branch office at least monthly. The parent agency may visit the branch office more frequently considering the size of the service area and the scope of services provided by the parent agency. The supervisory visits must be documented and include the date of the visit, the content of the consultation, the individuals in attendance, and the recommendations of the staff.
 - 2) The original active clinical record must be kept at the branch office.
 - 3) The parent agency must approve all branch office policies and procedures. This approval must be documented and filed in the parent and branch offices.
- e) DADS issues or renews a branch office license for applicants who meet the requirements of this section.
 - 1) Issuance or renewal of a branch office license is contingent upon compliance with the statute and this chapter by the parent agency and branch office.
 - 2) DADS may take enforcement action against a parent agency license for a branch office's failure to comply with the statute or this chapter in accordance with Subchapter F of this chapter (relating to Enforcement).
 - 3) Revocation, suspension, denial, or surrender of a parent agency license will result in the same revocation, suspension, denial, or surrender of a branch office license for all branch office licenses of the parent agency.
- f) A branch office may offer fewer health services or categories than the parent office but may not offer health services or categories that are not also offered by the parent agency.

§97.322 Standards for Alternate Delivery Sites

- (a) An alternate delivery site (ADS) must comply with the statute and this chapter, including the additional standards in Subchapter H of this chapter (relating to Standards Specific to Agencies Licensed to Provide Hospice Services).
- (b) If certified by CMS, an ADS must comply with the applicable federal rules and regulations for hospice agencies in 42 CFR, Part 418, Hospice Care.
- (c) A parent agency and an ADS must meet the following requirements:
 - (1) The parent agency administrator or alternate administrator, or supervising nurse or alternate supervising nurse must conduct an on-site supervisory visit to the ADS at least monthly. The parent agency may visit the ADS more frequently considering the size of the service area provided by the parent agency. The supervisory visits must be documented and include the date of the visit, the content of the consultation, the individuals in attendance, and the recommendations of the staff.
 - (2) The parent agency must approve all ADS policies and procedures. This approval must be documented and filed in the parent agency and ADS.
- (d) Issuance or renewal of an ADS license is contingent upon compliance by the parent agency and ADS with the statute and this chapter.
 - (1) DADS may take enforcement action against a parent agency license for an ADS' failure to comply with the statute or this chapter in accordance with Subchapter F of this chapter (relating to Enforcement).
 - (2) Revocation, suspension, denial or surrender of a parent agency license results in the same revocation, suspension, denial or surrender of all ADS licenses of the parent agency.

Subchapter D, Add'l Standards – License Category & Special Services

§97.401 Standards Specific to Licensed Home Health Services

- a) In addition to the standards in Subchapter C of this chapter (relating to Minimum Standards for All Licensed Home and Community Support Services Agencies), an agency providing licensed home health services must also meet the standards of this section.
- b) The agency must accept a client for home health services based on a reasonable expectation that the client's medical, nursing, and social needs can be met adequately in the client's residence. An agency has made a reasonable expectation that it can meet a client's needs if, at the time of the agency's acceptance of the client, the client and the agency have agreed as to what needs the agency would meet; for instance, the agency and the client could agree that some needs would be met but not necessarily all needs.
 - 1) The agency must start providing licensed home health services to a client within a reasonable time after acceptance of the client and according to the agency's policy. The initiation of licensed home health services must be based on the client's health service needs.
 - 2) An initial health assessment must be performed in the client's residence by the appropriate health care professional prior to or at the time that licensed home health services are initially provided to the client. The assessment must determine whether the agency has the ability to provide the necessary services.
 - A. If a practitioner has not ordered skilled care for a client, then the appropriate health care professional must prepare a care plan. The care plan must be developed after consultation with the client and the client's family and must include services to be rendered, the frequency of visits or hours of service, identified problems, method of intervention, and projected date of resolution. The care plan must be reviewed and updated by all appropriate staff members involved in client care at least annually, or more often as necessary to meet the needs of the client.

B. If a practitioner orders skilled treatment, then the appropriate health care professional must prepare a plan of care. The plan of care must be signed and approved by a practitioner in a timely manner. The plan of care must be developed in conjunction with agency staff and must cover all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits at the time of admission, prognoses, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, and any other appropriate items. The appropriate health care personnel must perform services as specified in the plan of care. The plan of care must be revised as necessary, but it must be reviewed and updated at least every six months.

- c) Agency staff must provide at least one home health service.
- d) All services must be provided and supervised by qualified personnel. The appropriate licensed health care professional must be available to supervise as needed, when services are provided. If medical social service is provided, the social worker must be licensed in the state of Texas to provide social work services.
- e) All staff providing services, delegation, and supervision must be employed by or be under contract with the agency.
- f) An agency is not required to employ home health aides. If an agency employs home health aides, the agency must comply with §97.701 of this chapter (relating to Home Health Aides).
- g) Unlicensed personnel employed by an agency to provide licensed home health services must:
 - 1) Have demonstrated competency in the task assigned when competency cannot be determined through education and experience; and
 - 2) Be at least 18 years of age or, if under 18 years of age, be a high school graduate or enrolled in a vocational education program.

§97.402 Standards Specific to Licensed and Certified Home Health Services

- a) In addition to the standards in Subchapter C of this chapter (relating to Minimum Standards for All Licensed Home and Community Support Services Agencies), an agency providing licensed and certified home health services must comply with the requirements of the Social Security Act and the regulations in Title 42 of the Code of Federal Regulations, Part 484. Copies of the regulations adopted by reference in this section are indexed and filed in the Texas Department of Human Services, 701 W. 51st Street, Austin, Texas 78751-2321, and are available for public inspection during regular working hours.
- b) An agency providing licensed and certified home health services that plans to implement a home health aide training and competency evaluation program must meet the requirements in §97.701(d)-(f) of this title (relating to Home Health Aides).
- c) An agency providing licensed and certified home health services that plans to implement a competency evaluation program must comply with §97.701(f) of this title (relating to Home Health Aides).
- d) An agency providing licensed and certified home health services may not use an individual as a home health aide unless:
 - 1) The individual has met the federal requirements under subsection (a) of this section;
 - 2) The individual qualifies as a home health aide on the basis of a:
 - A. Training and competency evaluation program, and the program meets the requirements of subsection (b) of this section; or
 - B. Competency evaluation program, and the program meets the requirements of subsection (c) of this section; or
 - 3) The individual is a licensed health care provider.
- e) Since the individual's most recent completion of a training and competency evaluation program or a competency evaluation program, if there has been a period of 24 consecutive months during which the individual has not furnished home health services, the individual will not be considered as having completed a training and competency evaluation program or a competency evaluation program.

§97.404 Standards Specific to Agencies Licensed to Provide Personal Assistance Services

- a) In addition to meeting the standards in Subchapter C of this chapter (relating to Minimum Standards for All Home and Community Support Services Agencies), an agency holding a license with the category of personal assistance services must meet the standards of this section.
- b) A person who is not licensed to provide personal assistance services under this chapter may not indicate or imply that the person is licensed to provide personal assistance services by the use of the words "personal assistance services" or in any other manner.
- c) Personal assistance services as defined in §97.2 of this chapter (relating to Definitions) may be performed by an unlicensed person who is at least 18 years of age and has demonstrated competency, when competency cannot be determined through education and experience, to perform the tasks assigned by the supervisor. An unlicensed person who is under 18 years of age, is a high school graduate or is enrolled in a vocational educational program, and has demonstrated competency to perform the tasks assigned by the supervisor, may perform personal assistance services.
- d) The following tasks may be performed under a personal assistance services category:
 - 1) Personal care as defined in §97.2 of this chapter;
 - 2) Health-related tasks provided by unlicensed personnel that may be delegated by an RN or that an RN determines do not require delegation in accordance with the agency's written policy adopted, implemented, and enforced to ensure compliance with the rules adopted by the Texas Board of Nursing in 22 TAC, Chapter 225 (relating to RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions);
 - 3) Health-related tasks that are not the practice of professional nursing under the memorandum of understanding between DADS and the Texas Board of Nursing; and

- 4) Health-related tasks that are delegated by a physician under the Occupations Code, Chapter 157.
- e) The agency must ensure that when developing its operational policies, the policies are considerate of principles of individual and family choice and control, functional need, and accessible and flexible services.
- f) In addition to the client record requirements in §97.301(a)(9) of this chapter (relating to Client Records), the client file must include the following:
 - 1) Documentation of determination of services based on an on-site visit by the supervisor where services will be primarily delivered and records of supervisory visits, if applicable;
 - 2) Individualized service plan developed, agreed upon, and signed by the client or family and the agency. The individualized service plan must include, but not be limited to the following:
 - A. Types of services, supplies, and equipment to be provided;
 - B. Locations of services;
 - C. Frequency and duration of services;
 - D. Planned date of service initiation;
 - E. Charges for services rendered if the charges will be paid in full or in part by the client or significant other(s), or on request; and
 - F. Plan of supervision; and
 - 3) Documentation that the services have been provided according to the individualized service plan.
- g) In addition to the written policies required by §97.245 of this chapter (relating to Staffing Policies) the agency must adopt and enforce a written policy addressing the supervision of personnel with input from the client or family on the frequency of supervision.
 - 1) Supervision of personnel must be in accordance with the agency's policies and applicable state laws and rules, including rules adopted by the Texas Board of Nursing in 22 TAC, Chapter 225.

- 2) A supervisor must be a licensed nurse or have completed two years of full-time study at an accredited college or university. An individual with a high school diploma or general equivalence diploma (GED) may substitute one year of full-time employment in a supervisory capacity in a health care facility, agency, or community-based agency for each required year of college.
 - 3) The client in a client managed attendant care program funded by DADS or the Department of Assistive and Rehabilitative Services is not required to meet the standard in paragraph (2) of this subsection.
- h) Tube feedings and medication administration through a permanently placed gastrostomy tube (g-tube) in accordance with subsection (d)(3) of this section may be performed by an unlicensed person only after successful completion of the training and competency program and procedures described in paragraphs (1)-(5) of this subsection.
- 1) The training and competency program for the performance of g-tube feedings by an unlicensed person must be taught by an RN, physician, physician assistant (PA), or qualified trainer. A qualified trainer must:
 - A. Have successfully completed the training and competency program described in paragraphs (2) and (3) of this subsection taught by an RN, physician, or PA;
 - B. Have demonstrated upon return demonstration to an RN, physician or PA the performance of the task and the ability to teach the task; and
 - C. Have been deemed competent by an RN, physician, or PA to train unlicensed personnel in these procedures. Documentation of competency to perform, train and teach must be maintained in the employee's or contractor's file. Competency must be evaluated and documented by an RN, physician or PA annually.
 - 2) The minimum training program must include:
 - A. A description of the g-tube placement, including its purpose;

- B. Infection control procedures and universal precautions to be utilized when performing g-tube feedings or medication administration through a g-tube;
 - C. A description of conditions that must be reported to the client or the primary caregiver, or in the absence of the primary caregiver, to the agency administrator, supervisor, or the client's physician. The description of conditions must include a plan to be effected if the g-tube comes out or is not positioned correctly to ensure medical attention is provided within one hour;
 - D. Review of a written procedure for g-tube feeding or medication administration through a g-tube. The written procedure must be equivalent to current acceptable nursing standards of practice, including addressing the crushing of medications;
 - E. Conditions under which g-tube feeding or medication administration must not be performed; and
 - F. Demonstration of a g-tube feeding and medication administration to a client. If the trainee will become a qualified trainer, the demonstration must be done by the RN, PA, or physician. If the trainee will not become a qualified trainer, the demonstration may be done by an RN, PA, physician, or qualified trainer.
- 3) The minimum competency evaluation must be documented and maintained in the employee's file and must include:
- A. A score of 100% on a written multiple choice test that consists of situational questions to include the criteria in paragraph (2)(A)-(E) of this subsection and an evaluation of the trainee's judgment and understanding of the essential skills, risks, and possible complications of a g-tube feeding or medication administration through a g-tube;

- B. A skills checklist demonstrating that the trainee has successfully completed the necessary skills for a g-tube feeding and medication administration via g-tube, and if the trainee will become a qualified trainer, the skills checklist must also demonstrate the ability to teach another person to perform the task. The skills checklist must be completed by an RN, physician, or PA if the trainee will become a qualified trainer. The skills checklist for a trainee who will not become a qualified trainer may be completed by an RN, physician, PA, or qualified trainer; and
 - C. Documentation of an accurate demonstration of the g-tube feeding and medication administration performed by the trainee as required by paragraph (2)(F) of this subsection. If the trainee will become a qualified trainer, documentation of competency to teach this task must be maintained in the file of the qualified trainer. The person responsible for the training of the trainee must document the successful demonstration of the g-tube feeding and medication administration via g-tube by the trainee and the trainee's competency to perform this task in the trainee's file.
- 4) The client or primary caregiver must provide information on the client's g-tube feeding or medication administration to the agency supervisor. If the client is not capable of directing his or her own care, the client's primary caregiver must be present to instruct and orient the supervisor regarding the client's g-tube feeding and medication regime. A copy of the current regime including unique conditions specific to the client must be placed in the client's file by the agency supervisor and provided to the respite caregiver. The respite caregiver must be oriented by the client, the client's primary caregiver, or the agency supervisor. The supervisor of the delivery of these services must have successfully completed a training and competency program outlined in paragraphs (2) and (3) of this subsection or be a qualified trainer.

- 5) Legend medications that are to be administered must be in a legally labeled container from a pharmacy that contains the name of the client. Instructions for dosages according to weight or age for over the counter drugs commonly given the client must be furnished by the primary caregiver to the respite caregiver performing the tube feeding or medication administration.

§97.405 Standards Specific to Agencies Licensed to Provide Home Dialysis Services

- a) License designation. An agency may not provide peritoneal dialysis or hemodialysis services in a client's residence, independent living environment, or other appropriate location unless the agency holds a license to provide licensed home health or licensed and certified home health services and designated to provide home dialysis services. In order to receive a home dialysis designation, the agency must meet the licensing standards specified in this section and the standards for home health services in accordance with Subchapter C of this title (relating to Minimum Standards for All Home and Community Support Services Agencies) and §97.401 of this title (relating to Standards Specific to Licensed Home Health Services) except for §97.401(b)(2)(A) and (B) of this title (relating to Standards Specific to Licensed Home Health Services). If there is a conflict between the standards specified in this section and those specified in Subchapter C of this title (relating to Minimum Standards for All Home and Community Support Services Agencies) §97.401 of this title (relating to Standards Specific to Licensed Home Health Services), the standards specified in this section will apply to the home dialysis services.
- b) Governing body. An agency must have a governing body. The governing body must appoint a medical director and the physicians who are on the agency's medical staff. The governing body must annually approve the medical staff policies and procedures. The governing body on a biannual basis must review and consider for approval continuing privileges of the agency's medical staff. The minutes from the governing body of the agency must be on file in the agency office.
- c) Qualifications and responsibilities of the medical director.
 - 1) Qualifications. The medical director must be a physician licensed in the State of Texas who:

- A. Is eligible for certification or is certified in nephrology or pediatric nephrology by a professional board; or
 - B. During the five-year period prior to September 1, 1996, served at least 12 months as director of a dialysis facility or program.
- 2) Responsibilities. The medical director must:
 - A. Participate in the selection of a suitable treatment modality for all clients;
 - B. Assure adequate training of nurses in dialysis techniques;
 - C. Assure adequate monitoring of the client and the dialysis process; and
 - D. Assure the development and availability of a client care policy and procedures manual and its implementation.
- d) Personnel files. An agency must have individual personnel files on all physicians, including the medical director. The file must include the following:
 - 1) A curriculum vitae which documents undergraduate, medical school, and all pertinent post graduate training; and
 - 2) Evidence of current licensure, and evidence of current United States Drug Enforcement Administration certification, Texas Department of Public Safety registration, and the board eligibility or certification, or the experience or training described in subsection (c)(1) of this section.
- e) Provision of services. An agency that provides home staff-assisted dialysis must, at a minimum, provide nursing services, nutritional counseling, and medical social service. These services must be provided as necessary and as appropriate at the client's home, by telephone, or by a client's visit to a licensed ESRD facility in accordance with this subsection. The use of dialysis technicians in home dialysis is prohibited.
 - 1) Nursing services.

- A. A registered nurse (RN), licensed by the State of Texas, who has at least 18 months experience in hemodialysis obtained within the last 24 months and has successfully completed the orientation and skills education described in subsection (f) of this section, must be available whenever dialysis treatments are in progress in a client's home. The agency administrator must designate a qualified alternate to this registered nurse.
 - B. Dialysis services must be supervised by an RN who meets the qualifications for a supervising nurse as set out in §97.244(c)(2) of this title (relating to Administrator Qualifications and Conditions and Supervising Nurse Qualifications).
 - C. Dialysis services must be provided by a qualified licensed nurse who:
 - i. Is licensed as a registered or licensed vocational nurse by the State of Texas;
 - ii. Has at least 18 months experience in hemodialysis obtained within the last 24 months; and
 - iii. Has successfully completed the orientation and skills education described in subsection (f) of this section.
- 2) Nutritional counseling. A dietitian who meets the qualifications of this paragraph must be employed by or under contract with the agency to provide services. A qualified dietitian must meet the definition of dietitian in §97.2 of this chapter (relating to Definitions) and have at least one year of experience in clinical nutrition after obtaining eligibility for registration by the American Dietetic Association, Commission on Dietetic Registration.
- 3) Medical social services. A social worker who meets the qualifications established in this paragraph must be employed by or be under contract with the agency to provide services. A qualified social worker is a person who:

- A. Is currently licensed under the laws of the State of Texas as a social worker and has a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education; or
 - B. Has served for at least two years as a social worker, one year of which was in a dialysis facility or program prior to September 1, 1976, and has established a consultative relationship with a licensed master social worker.
- f) Orientation, skills education, and evaluation.
 - 1) All personnel providing dialysis in the home must receive orientation and skills education and demonstrate knowledge of the following:
 - A. Anatomy and physiology of the normal kidney;
 - B. Fluid, electrolyte, and acid-base balance;
 - C. Pathophysiology of renal disease;
 - D. Acceptable laboratory values for the client with renal disease;
 - E. Theoretical aspects of dialysis;
 - F. Vascular access and maintenance of blood flow;
 - G. Technical aspects of dialysis;
 - H. Peritoneal dialysis catheter, testing for peritoneal membrane equilibration, and peritoneal dialysis adequacy clearance, if applicable;
 - I. The monitoring of clients during treatment, beginning with treatment initiation through termination;
 - J. The recognition of dialysis complications, emergency conditions, and institution of the appropriate corrective action. This includes training agency personnel in emergency procedures and how to use emergency equipment;
 - K. Psychological, social, financial, and physical complications of chronic dialysis;
 - L. Care of the client with chronic renal failure;

- M. Dietary modifications and medications for the uremic client;
 - N. Alternative forms of treatment for ESRD;
 - O. The role of renal health team members (physician, nurse, social worker, and dietitian);
 - P. Performance of laboratory tests (hematocrit and blood glucose);
 - Q. The theory of blood products and blood administration; and
 - R. Water treatment to include:
 - i. Standards for treatment of water used for dialysis as described in §3.2.1 (Hemodialysis Systems) and §3.2.2 (Maximum Level of Chemical Contaminants) of the American National Standard, Hemodialysis Systems, March 1992 Edition, published by the Association for the Advancement of Medical Instrumentation (AAMI), 3330 Washington Boulevard, Suite 500, Arlington, Virginia 22201. Copies of the standards are indexed and filed in the Department of Aging and Disability Services, 701 W. 51st Street, Austin, Texas 78751-2321, and are available for public inspection during regular working hours;
 - ii. Systems and devices;
 - iii. Monitoring; and
 - iv. Risks to clients of unsafe water.
- 2) The requirements for the orientation and skills education period for licensed nurses are as follows.
- A. The agency must develop an 80-hour written orientation program that includes classroom theory and direct observation of the licensed nurse performing procedures on a client in the home.

- i. The orientation program must be provided by a registered nurse qualified under subsection (e)(1) of this section to supervise the provision of dialysis services by a licensed nurse.
 - ii. The licensed nurse must pass a written skills examination or competency evaluation at the conclusion of the orientation program and prior to the time the licensed nurse delivers independent client care.
- B. The licensed nurse must complete the required classroom component as described in paragraph (1)(A)-(E), (K)-(O), (Q) and (R) of this subsection and satisfactorily demonstrate the skills described in paragraph (1)(F)-(J) and (P) of this subsection. The orientation program may be waived by successful completion of the written examination as described in subparagraph (A)(ii) of this paragraph.
- C. The supervising nurse or qualified designee must complete an orientation competency skills checklist for each licensed nurse to reflect the progression of learned skills, as described in subsection (f)(1) of this section.
- D. Prior to the delivery of independent client care, the supervising nurse or qualified designee must directly supervise the licensed nurse for a minimum of three dialysis treatments and ensure satisfactory performance. Dependent upon the trainee's experience and accomplishments on the skills checklist, additional supervised dialysis treatments may be required.
- E. Continuing education for employees must be provided quarterly.
- F. Performance evaluations must be done annually.

- G. The supervising nurse or qualified designee must provide direct supervision to the licensed nurse providing dialysis services monthly or more often if necessary. Direct supervision means that the supervising nurse is on the premises but not necessarily immediately present where dialysis services are being provided.
- g) Hospital transfer procedure. An agency must establish an effective procedure for the immediate transfer to a local Medicare-certified hospital for clients requiring emergency medical care. The agency must have a written transfer agreement with such a hospital, or all physician members of the agency's medical staff must have admitting privileges at such a hospital.
- h) Backup dialysis services. An agency that supplies home staff-assisted dialysis must have an agreement with a licensed end stage renal disease (ESRD) facility to provide backup outpatient dialysis services.
- i) Coordination of medical and other information. An agency must provide for the exchange of medical and other information necessary or useful in the care and treatment of clients transferred between treating facilities. This provision must also include the transfer of the client care plan, hepatitis B status, and long-term program.
- j) Transplant recipient registry program. An agency must ensure that the names of clients awaiting cadaveric donor transplantation are entered in a recipient registry program.
- k) Testing for hepatitis B. An agency must conduct routine testing of home dialysis clients and agency employees to ensure detection of hepatitis B in employees and clients.
 - 1) An agency must offer hepatitis B vaccination to previously unvaccinated, susceptible new staff members in accordance with 29 Code of Federal Regulations, §1910.1030(f)(1) (2) (Bloodborne Pathogens).
 - A. Staff vaccination records must be maintained in each staff member's personnel file.

- B. New staff members providing home dialysis care must be screened for hepatitis B surface antigen (HBsAg) and the results reviewed prior to the staff providing client care, unless the new staff member provides the agency documentation of positive serologic response to hepatitis B vaccine.
 - C. An agency must establish, implement, and enforce a policy for repeated serologic screening of staff. The repeated serologic screening must be based on each staff member's HBsAg/antibody to HBsAg (anti-HBs), and must be congruent with Appendices i and ii of the National Surveillance of Dialysis Associated Disease in the United States, 1993, published by the United States Department of Health and Human Services (USDHHS). This document may be obtained by writing the Home and Community Support Services Program, Department of Aging and Disability Services, 701 W. 51st Street, Austin, Texas 78751-2321 or calling 438-3011 or writing the United States Department of Health and Human Services at the Public Health Service, Centers for Disease Control and Prevention, National Center for Infectious Diseases, Hospital Infection Program, Mail Stop C01, Atlanta, Georgia 30333, or calling 404-639-2318.
- 2) With the advice and consent of a client's nephrologist or attending physician, an agency must make the hepatitis B vaccine available to a client who is susceptible to hepatitis B, provided that the client has coverage or is willing to pay for vaccination.
- A. An agency must make available to clients literature describing the risks and benefits of the hepatitis B vaccination.
 - B. Candidates for home dialysis must be screened for HBsAg within one month before or at the time of admission to the agency.
 - C. Repeated serologic screening must be based on the antigen or antibody status of the client.

- D. Monthly screening for HBsAg is required for clients whose previous test results are negative for HBsAg.
 - E. Screening of HbsAg-positive or anti-HbsAg-positive clients may be performed on a less frequent basis, provided that the agency's policy on this subject remains congruent with Appendices i and ii of the National Surveillance of Dialysis Associated Diseases in the United States, 1993, published by the USDHHS.
- l) CPR certification. All direct client care employees must have current CPR certification.
 - m) Initial admission assessment. Assessment of the client's residence must be made to ensure a safe physical environment for the performance of dialysis. The initial admission assessment must be performed by a qualified registered nurse who meets the qualifications under subsection (e)(1)(A) of this section.
 - n) Client long-term program. The agency must develop a long-term program for each client admitted to home dialysis. Criteria must be defined in writing and must provide guidance to the agency in the selection of clients suitable for home staff-assisted dialysis and in noting changes in a client's condition that would require discharge from the program. For the purposes of this subsection, Long-term program means the written documentation of the selection of a suitable treatment modality and dialysis setting which has been selected by the client and the interdisciplinary team.
 - o) Client history and physical. The agency must ensure that the history and physical is conducted upon the client's admission or no more than six months prior to the date of admission, then annually after the date of admission.
 - p) Physician orders. If home staff-assisted dialysis is selected, the physician must prepare orders outlining specifics of prescribed treatment.
 - 1) If these physician's orders are received verbally, they must be confirmed in writing within a reasonable time frame. An agency must adopt and enforce a policy on the time frame for the countersignature of a physician's verbal orders. Medical orders for home staff-assisted dialysis must be revised as necessary but reviewed and updated at least every six months.

- 2) The initial orders for home staff-assisted dialysis must be received prior to the first treatment and must cover all pertinent diagnoses, including mental status, prognosis, functional limitations, activities permitted, nutritional requirements, medications and treatments, and any safety measures to protect against injury. Orders for home staff-assisted dialysis must include frequency and length of treatment, target weight, type of dialyzer, dialysate, dialysate flow rate, heparin dosage, and blood flow rate, and must specify the level of preparation required for the caregiver, such as a licensed vocational nurse or registered nurse.
- q) Client care plan. The client care plan must be developed after consultation with the client and the client's family by the interdisciplinary team. The interdisciplinary team must include the physician, the registered nurse, the dietitian, and the qualified social worker responsible for planning the care delivered to the home staff-assisted dialysis patient.
 - 1) The initial client care plan must be completed by the interdisciplinary team within ten calendar days after the first home dialysis treatment.
 - 2) The client care plan must implement the medical orders and must include services to be rendered, such as the identification of problems, methods of intervention, and the assignment of health care personnel.
 - 3) The client care plan must be in writing, be personalized for the individual, and reflect the ongoing medical, psychological, social, nutritional, and functional needs of the client, including treatment goals.
 - 4) The client care plan must include written evidence of coordination with other service providers, such as dialysis facilities or transportation providers, as needed to assure the provision of safe care.
 - 5) The client care plan must include written evidence of the client's or client's legal representative's input and participation, unless they refuse to participate. At a minimum, the client care plan must demonstrate that the content was shared with the client or the client's legal representative.

- 6) For non-stabilized clients, where there is a change in modality, unacceptable laboratory work, uncontrolled weight changes, infections, or a change in family status, the client care plan must be reviewed at least monthly by the interdisciplinary team. Evidence of the review of the client care plan with the client and the interdisciplinary team to evaluate the client's progress or lack of progress toward the goals of the care plan, and interventions taken when progress toward stabilization or the goals are not achieved, must be documented and included in the client record.
 - 7) For a stable client, the client care plan must be reviewed and updated as indicated by any change in the client's medical, nutritional, or psychosocial condition or at least every six months. The long-term program must be revised as needed and reviewed annually. Evidence of the review of the client care plan with the client and the interdisciplinary team to evaluate the client's progress or lack of progress toward the goals of the care plan, and interventions taken when the goals are not achieved, must be documented and included in the client record.
- r) Medication administration. Medications must be administered only by licensed personnel.
- s) Client records. In addition to the applicable information described in §97.301(a)(9) of this chapter (relating to Client Records), records of home staff assisted dialysis clients must include the following:
- 1) A medical history and physical;
 - 2) Clinical progress notes by the physician, qualified licensed nurse, qualified dietitian, and qualified social worker;
 - 3) Dialysis treatment records;
 - 4) Laboratory reports;
 - 5) A client care plan;
 - 6) A long-term program; and
 - 7) Documentation of supervisory visits.
- t) Water treatment.

- 1) Water used for dialysis purposes must be analyzed for chemical contaminants every six months. Additional chemical analysis must be conducted if test results exceed the maximum levels of chemical contaminants listed in §3.2.2 (Maximum Level of Chemical Contaminants) of the American National Standards for Hemodialysis Systems, March 1992 Edition, published by the AAMI. Copies of the standards are indexed and filed in the Department of Aging and Disability Services, 701 W. 51st Street, Austin, Texas 78751-2321, and are available for public inspection during regular working hours.
 - 2) Water used for dialysis must be treated as necessary to maintain a continuous water supply that is biologically and chemically compatible with acceptable dialysis techniques.
 - 3) Water used to prepare dialysate must meet the requirements set forth in §3.2.1 (Hemodialysis Systems) and §3.2.2 (Maximum Level of Chemical Contaminants), March 1992 Edition, published by the AAMI. Copies of the standards are indexed and filed in the Department of Aging and Disability Services, 701 W. 51st Street, Austin, Texas 78751-2321, and are available for public inspection during regular working hours.
 - 4) Records of test results and equipment maintenance must be maintained at the agency.
- u) Equipment testing. An agency must adopt and enforce a policy to describe how the nurse will check the machine for conductivity, temperature, and pH prior to treatment, and describe the equipment required for these tests. The equipment must be available for use prior to each treatment. This policy must reflect current standards.
- v) Preventive maintenance for equipment. An agency must develop, and enforce a written preventive maintenance program to ensure client care related equipment receives electrical safety inspections, if appropriate, and maintenance at least annually or more frequently if recommended by the manufacturer. The preventive maintenance may be provided by agency or contract staff qualified by training or experience in the maintenance of dialysis equipment.

- 1) All equipment used by a client in home dialysis must be maintained free of defects, which could be a potential hazard to clients, the client's family or agency personnel.
 - A. Agency staff must be able to identify malfunctioning equipment and report such equipment to the appropriate agency staff. Malfunctioning equipment must be immediately removed from use.
 - B. Written evidence of all preventive maintenance and equipment repairs must be maintained.
 - C. After repairs or alterations are made to any equipment, the equipment must be thoroughly tested for proper operation before returning to service.
 - D. An agency must comply with the federal Food, Drug, and Cosmetic Act, 21 United States Code (USC), §360i(b), concerning reporting when a medical device as defined in 21 USC, §321(h) has or may have caused or contributed to the injury or death of an agency client.
- 2) In the event that the water used for dialysis purposes or home dialysis equipment is found not to meet safe operating parameters, and corrections cannot be effected to ensure safe care promptly, the client must be transferred to a licensed hospital (if inpatient care is required) or licensed ESRD facility until such time as the water or equipment is found to be operating within safe parameters.
- w) Reuse or reprocessing of medical devices. Reuse or reprocessing of disposable medical devices, including but not limited to, dialyzers, end-caps, and blood lines must be in accordance with this subsection.
 - 1) An agency's reuse practice must comply with the American National Standard, Reuse of Hemodialyzers, 1993 Edition, published by the AAMI. An agency must adopt and enforce a policy for dialyzer reuse criteria (including any agency-set number of reuses allowed) which is included in client education materials.

- 2) A transducer protector must be replaced when wetted during a dialysis treatment and must be used for one treatment only.
- 3) Arterial lines may be reused only when the arterial lines are labeled to allow for reuse by the manufacturer and the manufacturer-established protocols for the specific line have been approved by the United States Food and Drug Administration.
- 4) An agency must consider and address the health and safety of clients sensitive to disinfectant solution residuals.
- 5) An agency must provide each client and the client's family or legal representative with information regarding the reuse practices of the agency, the opportunity to tour the reuse facility used by the agency, and the opportunity to have questions answered.
- 6) An agency practicing reuse of dialyzers must:
 - A. Ensure that dialyzers are reprocessed via automated reprocessing equipment in a licensed ESRD facility or a centralized reprocessing facility;
 - B. Maintain responsibility and accountability for the entire reuse process;
 - C. Adopt and enforce policies to ensure that the transfer and transport of used and reprocessed dialyzers to and from the client's home does not increase contamination of the dialyzers, staff, or the environment; and
 - D. Ensure that DADS staff has access to the reprocessing facility as part of an agency inspection.
- x) Laboratory services. Provision of laboratory services must be as follows.
 - 1) All laboratory services ordered for the client by a physician must be performed by a laboratory which meets the Clinical Laboratory Improvement Amendments of 1988, 42 United States Code, §263a, Certification of Laboratories (CLIA 1988) and in

accordance with a written arrangement or agreement with the agency. CLIA 1988 applies to all agencies with laboratories that examine human specimens for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings.

- 2) Copies of all laboratory reports must be maintained in the client's medical record.
- 3) Hematocrit and blood glucose tests may be performed at the client's home in accordance with §97.284 of this title (relating to Laboratory Services). Results of these tests must be recorded in the client's medical record and signed by the qualified licensed nurse providing the treatment. Maintenance, calibration, and quality control studies must be performed according to the equipment manufacturer's suggestions, and the results must be maintained at the agency.
- 4) Blood and blood products must only be administered to dialysis clients in their homes by a licensed nurse or physician.

y) Home dialysis supplies. Supplies for home dialysis must meet the following requirements.

- 1) All drugs, biologicals, and legend medical devices must be obtained for each client pursuant to a physician's prescription in accordance with applicable rules of the Texas State Board of Pharmacy.
- 2) In conjunction with the client's attending physician, the agency must ensure that there are sufficient supplies maintained in the client's home to perform the scheduled dialysis treatments and to provide a reasonable number of backup items for replacements, if needed, due to breakage, contamination, or defective products. All dialysis supplies, including medications, must be delivered directly to the client's home by a vendor of such products. However, agency personnel may transport prescription items from a vendor's place of business to the client's home for the client's convenience, so long as the item is properly labeled with the client's name and direction for use. Agency personnel may transport medical devices for reuse.

- z) Emergency procedures. The agency must adopt and enforce policies and procedures for medical emergencies and emergencies resulting from a disaster.
- 1) Procedures must be individualized for each client to include the appropriate evacuation from the home and emergency telephone numbers. Emergency telephone numbers must be posted at each client's home and must include 911 if available, the number of the physician, the ambulance, the qualified registered nurse on call for home dialysis, and any other phone number deemed as an emergency number.
 - 2) The agency must ensure that the client and the client's family know the agency's procedures for medical emergencies and emergencies resulting from a disaster.
 - 3) The agency must ensure that the client and the client's family know the procedure for disconnecting the dialysis equipment.
 - 4) The agency must ensure that the client and the client's family know emergency call procedures.
 - 5) A working telephone must be available during the dialysis procedure.
 - 6) Depending on the kinds of medications administered, an agency must have available emergency drugs as specified by the medical director.
 - 7) In the event of a medical emergency or an emergency resulting from a disaster requiring transport to a hospital for care, the agency must assure the following:
 - A. The receiving hospital is given advance notice of the client's arrival;
 - B. The receiving hospital is given a description of the client's health status; and
 - C. The selection of personnel, vehicle, and equipment are appropriate to effect a safe transfer.

§97.406 Standards for Agencies Providing Psychoactive Services

An agency that provides skilled nursing psychoactive treatments must comply with the requirements of this section.

- 1) An agency must adopt and enforce a written policy relating to the provision of psychoactive treatments consistent with this section.
- 2) Skilled nursing psychoactive treatments must be under the direction of a physician. Psychoactive treatments may only be provided by a physician or a registered nurse.
- 3) A registered nurse providing skilled nursing psychoactive treatments must have one of the following qualifications:
 - A. A master's degree in psychiatric or mental health nursing;
 - B. A bachelor's degree in nursing with one year of full-time experience in an active treatment unit in a mental health facility or outpatient clinic;
 - C. A diploma or associate degree with two years of full-time experience in an active treatment unit in a mental health facility or outpatient clinic; or
 - D. For a registered nurse for Medicare-certified agencies, as allowed by the fiscal intermediary for Texas contracting with the United States Department of Health and Human Services (USDHHS) Centers for Medicare & Medicaid Services (CMS).
- 4) An agency must have written documentation that a registered nurse providing skilled nursing psychoactive treatments is qualified under paragraph (3) of this subsection.
- 5) The initial health assessment of a client receiving skilled nursing psychoactive treatments must include:
 - A. Mental status including psychological and behavioral status;
 - B. Sensory and motor function;
 - C. Cranial nerve function;
 - D. Language function; and
 - E. Any other criteria established by an agency's policy.

§97.407 Standards for Agencies Providing Home Intravenous Therapy

An agency furnishing intravenous therapy directly or under arrangement must comply with the following standards of care.

- 1) A physician's order must be written specifically for intravenous therapy.
- 2) Intravenous therapy must be provided by a licensed nurse.
- 3) To insure that prescribed care is administered safely, a licensed nurse must have the knowledge and documented competency to interpret and implement the written order.
- 4) Written policies and procedures regarding the agency's provision of intravenous therapy must include, but are not limited to, addressing initiation, medication administration, monitoring, and discontinuation. Responsibilities of the licensed nurse must be clearly delineated in written policies and procedures.
- 5) A registered nurse must be available 24 hours a day.
- 6) The client and caregiver must be assessed for the ability to safely administer the prescribed intravenous therapy as per agency written criteria.
- 7) If the client or caregiver is willing and able to safely administer the prescribed intravenous therapy, the agency must offer to teach the client or caregiver such administration. The teaching process is based on the client and caregiver needs and may include written instructions, verbal explanations, demonstrations, evaluation and documentation of competency, proficiency in performing intravenous therapy, scope of physical activities, and safe disposal of equipment.
- 8) Actions must be implemented prior to and during all intravenous therapy to minimize the risk of anaphylaxis or other adverse reactions as stated in the agency's written policy.
- 9) An ongoing assessment of client and caregiver compliance in performing intravenous therapy related procedures must be done at periodic intervals.
- 10) Care coordination must be provided in order to assure continuity of care.
- 11) The client and caregiver must be provided with 24-hour access to appropriate health care professionals employed by or having a contract with the agency.

Subchapter E, Licensure Surveys

§97.501 Survey Frequency

- a) At a minimum, DADS:
 - 1) Conducts an initial survey after an agency has notified DADS of its readiness. See §97.521 of this subchapter (relating to Requirements for an Initial Survey);
 - 2) Conducts a survey of the agency within 18 months after conducting an initial survey and conducts subsequent surveys at least every 36 months thereafter; and
 - 3) Conducts a survey to investigate a complaint alleging:
 - A. Abuse, neglect, or exploitation of a client as described in §97.502 (relating to State Agency Investigations of Complaints and Self-Reported Incidents);
 - B. A violation of this chapter or the statute in the provision of licensed home health services, licensed and certified home health services, hospice services, or personal assistance services; and
 - C. A violation of federal requirements in the provision of licensed and certified home health services or licensed and certified hospice services.
 - 4) Investigates a self-reported incident that includes allegations of abuse, neglect, or exploitation of a client as described in §97.502.
- b) DADS may conduct a survey for the renewal of a license or the issuance of a branch office or alternate delivery site license.

§97.502 State Agency Investigations of Complaints and Self-Reported Incidents

- a) This section applies when an alleged victim of abuse, neglect, or exploitation is an agency client and the alleged perpetrator of the abuse, neglect, or exploitation is an agency employee, volunteer, or contractor.
- b) In this section, facility regulated by DADS means any of the following:

- 1) An inpatient unit and residential unit licensed to provide hospice services to clients admitted to or residing in these units;
 - 2) A nursing facility;
 - 3) An assisted living facility;
 - 4) An adult day care facility;
 - 5) An adult foster care facility; and
 - 6) A licensed intermediate care facility serving persons with mental retardation and related conditions.
- c) The Department of Family and Protective Services investigates a complaint or self-reported incident alleging abuse, neglect, or exploitation when:
- 1) The client involved is elderly or disabled; and
 - 2) The alleged act occurs outside of a facility regulated by DADS as described in subsection (b) of this section.
- d) DADS investigates a complaint or self-reported incident alleging abuse, neglect, or exploitation of a client if the alleged act occurs in a facility regulated by DADS as described in subsection (b) of this section. DADS' investigation may include:
- 1) A visit to the facility;
 - 2) An interview with the client, if appropriate; and
 - 3) Interviews with persons believed to have knowledge of the circumstances.
- e) DADS investigates a complaint or a self-reported incident alleging abuse, neglect, or exploitation of a child if the alleged act occurs outside of a facility regulated by DADS as described in subsection (b) of this section. DADS' investigation may include:
- 1) An interview with the child after making a reasonable effort to inform each parent of the nature of the allegation and of the need to interview the child; and
 - 2) Interviews with persons believed to have knowledge of the circumstances.
- f) DADS may conduct an interview in private or may include any person DADS determines is necessary.

§97.503 Exemption from a Survey

Except for the investigation of complaints, an agency is exempt from additional surveys by DADS if the agency maintains accreditation status for the applicable services from JCAHO or CHAP.

§97.505 Notice of a Survey

DADS does not announce or give prior notice to an agency of a survey.

§97.507 Agency Cooperation with a Survey

- a) By applying for or holding a license, an agency consents to entry and survey by a DADS representative to verify compliance with the statute or this chapter.
- b) An agency must provide the surveyor access to all agency records required by DADS to be maintained by or on behalf of the agency.
- c) If a surveyor requests an agency record that is stored at a location other than the survey site, the agency must provide the record to the surveyor within eight working hours after the request.
- d) An agency must provide the surveyor with copies of agency records upon request.
- e) During a survey, agency staff must not:
 - 1) Make a false statement that a person knows or should know is false of a material fact about a matter under investigation by DADS;
 - 2) Willfully interfere with the work of a DADS representative;
 - 3) Willfully interfere with a DADS representative in preserving evidence of a violation; or
 - 4) Refuse to allow a DADS representative to inspect a book, record, or file required to be maintained by or on behalf of an agency.
- f) An agency must provide a DADS representative with a reasonable workspace and a safe workspace, free from hazards, at which to conduct a survey at a parent office, branch office, or alternate delivery site.

- g) If there is a disagreement between the agency and a DADS representative, the program manager or designee in the designated survey office determines what is reasonable and safe. After consulting with the program manager or designee and obtaining the program manager's agreement, the DADS representative will notify the agency administrator or designee if the requirement in subsection (f) of this section is not met. Within two working hours of this notice the agency must:
- 1) Provide a DADS representative with a different workspace at the agency that meets the requirement in subsection (f) of this section; or
 - 2) Correct the unmet requirement in such a way as to allow the representative to reasonably and safely conduct the survey.
- h) If an agency willfully refuses to comply with subsection (g) of this section, thereby interfering with the work of the DADS representative, the representative will terminate the survey and recommend enforcement action as described in subsection (i) of this section.
- i) DADS may assess an administrative penalty without an opportunity to correct for a violation of provisions in this section, or may take other enforcement action to deny, revoke, or suspend a license, if an agency does not cooperate with a survey.

§97.509 Survey of a Branch Office, Alternate Delivery Site, and Services Provided

- a) If an agency is applying for or renewing a branch office or alternate delivery site license, a survey covers all locations.
- b) If an agency is applying for a license to provide more than one category of service, a survey covers all provided services of the agency.

§97.521 Requirements for an Initial Survey

- a) No later than six months after the effective date of an agency's initial license, an agency must:
- 1) Admit and provide services to clients as described in subsection (b) of this section; and
 - 2) Except as provided in subsection (f) of this section, submit a written request for an initial licensure survey to the designated survey office as described in subsection (c) of this section.

- b) Before submitting a written request to DADS for an initial licensure survey, an agency must admit clients and provide services as described in this subsection. The categories of service on an initial license may include licensed home health services (LHHS), LHHS with home dialysis designation, hospice services, and personal assistance services (PAS).
- 1) When an initial license includes only one category of service, an agency must admit and provide services to at least one client.
 - 2) When an initial license includes the LHHS and the PAS categories, an agency must admit and provide LHHS to at least one client.
 - 3) When an initial license includes the LHHS and the LHHS with home dialysis designation categories, with or without the PAS category, an agency must admit and provide LHHS with home dialysis designation to at least one client.
 - 4) When an initial license includes the hospice services and the PAS categories, an agency must admit and provide hospice services to at least one client.
 - 5) When an initial license includes the LHHS and the hospice services categories, with or without the PAS category, an agency must admit and provide LHHS services to at least one client and admit and provide hospice services to at least one client.
 - 6) When an initial license includes the LHHS, the LHHS with home dialysis designation, and the hospice services categories, with or without the PAS category, an agency must admit and provide LHHS with home dialysis designation to at least one client. The agency must also admit and provide hospice services to at least one client.
- c) The agency's written request for an initial survey must be submitted to the designated survey office using DADS Form 2020 Notification of Readiness for Initial Survey. The written request must include the name, date of admission, and the category of service provided to each client admitted for services to demonstrate that the agency has admitted clients and provided services as described in subsection (b) of this section.

- d) An agency must have the following information available and ready for review by a surveyor upon the surveyor's arrival at the agency:
 - 1) A list of clients who are receiving services or who have received services from the agency for each category of service licensed. The list must comply with the requirements of §97.293 of this chapter (relating to Client List and Services);
 - 2) The client records for each client admitted during the licensing period before the initial survey;
 - 3) All agency policies as required by this chapter; and
 - 4) All personnel records of agency employees.
- e) DADS may propose to deny an application to renew, or revoke or suspend, an initial license for the reasons specified in §97.15(c) of this chapter (relating to Issuance of an Initial License).
- f) An agency is not required to request an initial survey in accordance with subsection (a)(2) of this section if the agency is exempt from the survey as specified in §97.503 of this subchapter (relating to Exemption From a Survey). To demonstrate that it is exempt, the agency must send the accreditation documentation from JCAHO or CHAP to the DADS designated survey office no later than six months after the effective date of its license.
- g) If an agency receives written notice of accreditation from JCAHO or CHAP after the agency submits a written request to DADS for an initial licensure survey, the agency may demonstrate that it is exempt from the survey by sending the accreditation documentation to the DADS designated survey office before DADS arrives at the agency to conduct an initial survey.

§97.523 Personnel Requirements for a Survey

- a) For an initial survey, the administrator or alternate administrator must be present at the entrance conference, available in person or by telephone during the survey, and present in person at the exit conference.
- b) For a survey other than an initial survey, the administrator or alternate administrator must be available in person or by telephone during the entrance conference and the survey, and must be present in person at the exit conference.

- c) The supervising nurse or alternate supervising nurse must be available in person or by telephone, if necessary, to provide information unique to the duties and functions of the position during the survey.
- d) If a required individual is unavailable during the survey process and is not at the agency when the surveyor arrives, the surveyor makes reasonable attempts to contact the individual.
- e) If a surveyor arrives during regular business hours and the agency is closed, an administrator, alternate administrator, or a designated agency representative must provide the surveyor entry to the agency within two hours after the surveyor's arrival at the agency. The administrator must designate in writing the agency representatives who may grant entry to a surveyor. The agency must comply with notice requirements described in §97.210 of this chapter (relating to Agency Operating Hours).
- f) If the surveyor is unable to contact a required individual or the agency fails to comply with subsection (e) of this section, the surveyor may recommend enforcement action against the agency.
- g) If compliance with this section would cause an interruption in client care being provided by the administrator, the alternate administrator, the supervising nurse, or the alternate supervising nurse, the administrator must contact its backup service provider to ensure continued client care.

§97.525 Survey Procedures

- a) Before beginning a survey, a surveyor holds an entrance conference, as specified in §97.523 (relating to Personnel Requirements for a Survey), to explain the purpose of the survey and the survey process and provides an opportunity to ask questions.
- b) During a survey, a surveyor:
 - 1) Conducts at least three home visits to determine an agency's compliance with licensing requirements;
 - 2) Reviews any agency records that the surveyor believes are necessary to determine an agency's compliance with licensing requirements; and
 - 3) Evaluates an agency's compliance with each standard.

- c) An agency accredited by CHAP or JCAHO must have the documentation of accreditation available at the time of a survey.
- d) DADS keeps agency records confidential, except as allowed by Texas Health and Safety Code, §142.009(d).
- e) A surveyor may remove original agency records from an agency only with the consent of the agency as provided in Texas Health and Safety Code, §142.009(e).

§97.527 Post-Survey Procedures

- a) After a survey is completed, the surveyor holds an exit conference with the administrator or alternate administrator to inform the agency of the preliminary findings.
- b) An agency may make an audio recording of the exit conference only if the agency:
 - 1) Records two tapes simultaneously;
 - 2) Allows the surveyor to review the tapes; and
 - 3) Gives the surveyor the tape of the surveyor's choice before leaving the agency.
- c) An agency may make a video recording of the exit conference only if the surveyor agrees to allow it and if the agency:
 - 1) Records two tapes simultaneously;
 - 2) Allows the surveyor to review the tapes; and
 - 3) Gives the surveyor the tape of the surveyor's choice before leaving the agency.
- d) An agency may submit additional written documentation and facts after the exit conference only if the agency describes the additional documentation and facts to the surveyor during the exit conference.
 - 1) The agency must submit the additional written documentation and facts to the designated survey office within two working days after the end of the exit conference.
 - 2) If an agency properly submits additional written documentation, the surveyor may add the documentation to the record of the survey.

- e) If DADS identifies additional violations or deficiencies after the exit conference, DADS holds an additional face-to-face exit conference with the agency regarding the additional violations or deficiencies.
- f) DADS provides official written notification of the survey findings to the agency within 10 working days after the exit conference.
- g) The official written notification of the survey findings includes a statement of violations and instructions for submitting an acceptable plan of correction, and provides an opportunity for an informal review of deficiencies (IRoD).
 - 1) If the official written notification of the survey findings declares that an agency is in violation of the statute or this chapter, an agency must follow DADS' instructions included with the statement of violations for submitting an acceptable plan of correction.
 - 2) An acceptable plan of correction includes the corrective measures and time frame with which the agency must comply to ensure correction of a violation. If an agency fails to correct each violation by the date on the plan of correction, DADS may take enforcement action against the agency. An agency must correct a violation in accordance with the following time frames:
 - A. A Severity Level B violation that results in serious harm to or death of a client or constitutes a serious threat to the health or safety of a client must be addressed upon receipt of the official written notice of the violations and corrected within two days.
 - B. A Severity Level B violation that substantially limits the agency's capacity to provide care must be corrected within seven days after receipt of the official written notice of the violations.
 - C. A Severity Level A violation that has or had minor or no health or safety significance must be corrected within 20 days after receipt of the official written notice of the violations.
 - D. A violation that is not designated as Severity Level A or Severity Level B must be corrected within 60 days after the date the violation was cited.

- 3) An agency must submit an acceptable plan of correction for each violation or deficiency no later than 10 days after its receipt of the official written notification of the survey findings.
- 4) If DADS finds the plan of correction unacceptable, DADS gives the agency written notice and provides the agency one additional opportunity to submit an acceptable plan of correction. An agency must submit a revised plan of correction no later than 30 days after the agency's receipt of DADS' written notice of an unacceptable plan of correction.
- h) An acceptable plan of correction does not preclude DADS from taking enforcement action against an agency.
- i) An agency must submit a plan of correction in response to an official written notification of survey findings that declares a violation or deficiency even if the agency disagrees with the survey findings.
- j) If an agency disagrees with the survey findings, the agency may request an IROD and submit additional written information to refute a violation or deficiency to demonstrate compliance in an informal setting.
 - 1) An IROD is available for:
 - A. A violation or deficiency cited during a visit;
 - B. A violation or deficiency that remains uncorrected from a previous visit and is re-cited with no change in findings, as long as the agency has not already had an IROD for the violation or deficiency from the original visit; and
 - C. A violation or deficiency that remains uncorrected from a previous visit and is re-cited with new findings.
 - 2) To request an IROD, an agency must:
 - A. Mail or fax a complete and accurate IROD request form to the address or fax number listed on the form, which must be postmarked or faxed within 10 days after the date of receipt of the official written notification of the survey findings;

- B. Mail or fax a rebuttal letter and supporting documentation to the address or fax number listed on the IRoD request form and ensure receipt by the DADS Survey and Certification Enforcement Unit within seven days after the postmark or fax date of the IRoD request form; and
 - C. Mail or fax a copy of the IRoD request form, rebuttal letter, and supporting documentation to the designated survey office within the same time frames each is submitted to the DADS Survey and Certification Enforcement Unit.
- 3) An agency may not submit information after the deadlines established in paragraph (2)(A) and (B) of this subsection unless DADS requests additional information. The agency's response to DADS' request for information must be received within three working days after the request is made.
 - 4) An agency waives its right to an IRoD if the agency fails to submit the required information to the DADS Survey and Certification Enforcement Unit within the required time frames.
 - 5) An agency must present sufficient information to the DADS Survey and Certification Enforcement Unit to support the agency's desired IRoD outcome.
 - 6) The rebuttal letter and supporting documentation must include:
 - A. The disputed deficiencies or violations;
 - B. The reason the deficiencies or violations are disputed;
 - C. The desired outcome for each disputed deficiency or violation; and
 - D. Attachments from client records, applicable policies and procedures, or other supporting documentation or information that directly demonstrates that the deficiency or violation should not have been cited.
 - 7) The written decision issued by DADS after the completion of its review is final.

Subchapter F – Enforcement

§97.601 Enforcement Actions

- a) Enforcement actions. DADS may take the following enforcement actions against an agency:
 - 1) License suspension;
 - 2) Immediate license suspension;
 - 3) License revocation;
 - 4) Immediate license revocation;
 - 5) Administrative penalties; and
 - 6) Denial of license application.
- b) Denial of license application. DADS may deny a license application for the reasons set out in §97.21 of this chapter (relating to Denial of an Application or a License).
- c) Suspension or revocation.
 - 1) DADS may suspend or revoke an agency's license if the license holder, the controlling person, the affiliate, the administrator, or the alternate administrator:
 - A. Fails to comply with this chapter;
 - B. Fails to comply with the statute; or
 - C. Violates Texas Occupations Code, §102.001 (relating to Soliciting Patients; Offense) and §102.006 (relating to Failure to Disclose; Offense).
 - 2) DADS may suspend or revoke an agency's license to provide licensed and certified home health services if the agency fails to maintain its certification qualifying the agency as a certified agency, as referenced in Health and Safety Code, §142.011(c).
- d) Administrative penalties.
 - 1) DADS may assess an administrative penalty against an agency in accordance with §97.602 of this chapter (relating to Administrative Penalties).
 - 2) DADS may consider the assessment of past administrative penalties when considering another enforcement action against an agency.

- e) Immediate licensure suspension or revocation. DADS may immediately suspend or revoke an agency's license when the health and safety of persons are threatened.
- 1) If DADS issues an order for immediate suspension or revocation of the agency's license, DADS provides immediate notice to the controlling person, administrator, or alternate administrator of the agency by fax and either by certified mail with return receipt requested or hand-delivery. The notice includes:
 - A. The action taken;
 - B. Legal grounds for the action;
 - C. The procedure governing appeal of the action; and
 - D. The effective date of the order.
 - 2) An order for immediate suspension or revocation goes into effect immediately.
 - 3) An agency is entitled to a formal administrative hearing not later than seven days after the effective date of the order for immediate suspension or revocation.
 - 4) If an agency requests a formal administrative hearing, the hearing is held in accordance with the Government Code, Chapter 2001, and with 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).
- f) Opportunity to show compliance.
- 1) Before revocation or suspension of an agency's license or denial of an application for the renewal of an agency's license, DADS gives the license holder:
 - A. A notice by personal service or by registered or certified mail of the facts or conduct alleged to warrant the proposed action, with a copy sent to the agency; and
 - B. An opportunity to show compliance with all requirements of law for the retention of the license by sending DADS Regulatory Services office a written request. The request must:

- i. Be postmarked within 10 days after the date of DADS notice and be received in DADS Regulatory Services office within 10 days after the date of the postmark; and
 - ii. Contain specific documentation refuting DADS allegations.
- 2) DADS limits its review to the documentation submitted by the license holder and information DADS used as the basis for its proposed action. An agency may not attend DADS meeting to review the opportunity to show compliance. DADS gives a license holder a written affirmation or reversal of the proposed action.
- 3) After an opportunity to show compliance, DADS sends a license holder a written notice that:
 - A. Informs the license holder of DADS decision; and
 - B. Provides the agency with an opportunity to appeal DADS decision through a formal hearing process.
- g) Notice of denial of application for license or renewal of a license, suspension or revocation of license. DADS sends an applicant or license holder notice by fax and either by certified mail with return receipt requested or hand-delivery of DADS denial of an application for an initial license or renewal of a license, suspension of a license or revocation of a license.
- h) Formal appeal. An applicant or license holder has the right to make a formal appeal after receipt of DADS notification of denial of an application for an initial license or renewal of a license and suspension or revocation of a license.
 - 1) An agency must request a formal administrative hearing within 20 days of receipt of DADS notice of denial of an application for an initial license or renewal of a license, suspension of a license or revocation of a license. To make a formal appeal, the applicant or agency must comply with the formal hearing procedures in 1 TAC, Chapter 357, Subchapter I and Chapter 91 of this title.

- 2) DADS presumes receipt of DADS notice to occur on the tenth day after the notice is mailed to the last known address unless another date is reflected on the return receipt.
- 3) If an agency does not meet the deadline for requesting a formal hearing, the agency has lost its opportunity for a formal hearing, and DADS takes the proposed action.
- 4) A formal administrative hearing is held in accordance with Government Code, Chapter 2001, and the formal hearing procedures in 1 TAC, Chapter 357, Subchapter I and Chapter 91 of this title.
- 5) Except for the denial of an application for an initial license, if an agency appeals, the license remains valid until all appeals are final, unless the license expires without a timely application for renewal submitted to DADS. The agency must continue to submit a renewal application in accordance with §97.17 of this chapter (relating to Application Procedures for a Renewal License) until the action to revoke, suspend, or deny renewal of the license is completed. However, DADS does not renew the license until it determines the reason for the proposed action no longer exists.
- 6) If an agency appeals, the enforcement action will take effect when all appeals are final and the proposed enforcement action is upheld. If the agency wins the appeal, the proposed action does not happen.
- 7) If DADS suspends a license, the suspension remains in effect until DADS determines that the reason for suspension no longer exists. A suspension may last no longer than the term of the license. DADS conducts a survey of the agency before making a determination to recommend cancellation of a suspension.
- 8) If DADS revokes or does not renew a license and one year has passed following the effective date of revocation or denial of licensure renewal, a person may reapply for a license by complying with the requirements and procedures in §97.13 of this chapter (relating to Application Procedures for an Initial License). DADS does not issue a license if the reason for revocation or nonrenewal continues to exist.

- i) Agency dissolution. Upon suspension, revocation or nonrenewal of a license, the license holder must:
 - 1) Return the original license to DADS; and
 - 2) Implement its written plan required in §97.291 of this chapter (relating to Agency Dissolution).

§97.602 Administrative Penalties

- (a) Assessing penalties. DADS may assess an administrative penalty against a person who violates:
 - (1) The statute;
 - (2) A provision in this chapter for which a penalty may be assessed; or
 - (3) Texas Occupations Code, §102.001 (relating to soliciting patients; offense) or §102.006 (relating to failure to disclose; offense), if related to the provision of home health, hospice, or personal assistance services.
- (b) Criteria for assessing penalties. DADS assesses administrative penalties in accordance with the schedule of appropriate and graduated penalties established in this section.
 - (1) The schedule of appropriate and graduated penalties for each violation is based on the following criteria:
 - (A) The seriousness of the violation, including the nature, circumstances, extent, and gravity of the violation and the hazard of the violation to the health or safety of clients;
 - (B) The history of previous violations by a person or a controlling person with respect to that person;
 - (C) Whether the affected agency identified the violation as part of its internal quality assurance process and made a good faith, substantial effort to correct the violation in a timely manner;
 - (D) The amount necessary to deter future violations;
 - (E) Efforts made to correct the violation; and
 - (F) Any other matters that justice may require.
 - (2) In determining which violation warrants a penalty, DADS considers:

- (A) The seriousness of the violation, including the nature, circumstances, extent, and gravity of the violation and the hazard of the violation to the health or safety of clients; and
 - (B) Whether the affected agency identified the violation as part of its internal quality assurance program and made a good faith, substantial effort to correct the violation in a timely manner.
- (c) Opportunity to correct. Except as provided in subsections (e) and (f) of this section, DADS provides an agency with an opportunity to correct a violation in accordance with the time frames established in §97.527(g)(2) of this chapter (relating to Post-Survey Procedures) before assessing an administrative penalty if a plan of correction has been implemented.
- (d) Minor violations.
 - (1) DADS may not assess an administrative penalty for a minor violation unless the violation is of a continuing nature or is not corrected in accordance with an accepted plan of correction.
 - (2) DADS may assess an administrative penalty for a subsequent occurrence of a minor violation when cited within three years from the date the agency first received written notice of the violation.
 - (3) DADS does not assess an administrative penalty for a subsequent occurrence of a minor violation when cited more than three years from the date the agency first received written notice of the violation.
- (e) No opportunity to correct. DADS may assess an administrative penalty without providing an agency with an opportunity to correct a violation if DADS determines that the violation:
 - (1) Results in serious harm to or death of a client;
 - (2) Constitutes a serious threat to the health or safety of a client;
 - (3) Substantially limits the agency's capacity to provide care;
 - (4) Involves the provisions of Texas Human Resources Code, Chapter 102, Rights of the Elderly;

- (5) Is a violation in which a person:
- (A) Makes a false statement, that the person knows or should know is false of a material fact:
 - (i) On an application for issuance or renewal of a license or in an attachment to the application; or
 - (ii) With respect to a matter under investigation by DADS;
 - (B) Refuses to allow a representative of DADS to inspect a book, record, or file required to be maintained by an agency;
 - (C) Willfully interferes with the work of a representative of DADS or the enforcement of this chapter;
 - (D) Willfully interferes with a representative of DADS preserving evidence of a violation of this chapter or a rule, standard, or order adopted or license issued under this chapter;
 - (E) Fails to pay a penalty assessed by DADS under this chapter within 10 days after the date the assessment of the penalty becomes final; or
 - (F) Fails to submit:
 - (i) A plan of correction within 10 days after the date the person receives a statement of licensing violations; or
 - (ii) An acceptable plan of correction within 30 days after the date the person receives notification from DADS that the previously submitted plan of correction is not acceptable.
- (f) Violations relating to Advance Directives. As provided in Texas Health and Safety Code, §142.0145, DADS assesses an administrative penalty of \$500 for a violation of §97.283 of this chapter (relating to Advance Directives) without providing an agency with an opportunity to correct the violation.
- (g) Penalty calculation and assessment.

- (1) Each day that a violation occurs before the date on which the person receives written notice of the violation is considered one violation.
 - (2) Each day that a violation occurs after the date on which an agency receives written notice of the violation constitutes a separate violation.
- (h) Schedule of appropriate and graduated penalties.
- (1) If two or more rules listed in paragraphs (2) and (3) of this subsection relate to the same or similar matter, one administrative penalty may be assessed at the higher severity level violation.
 - (2) Severity Level A violations.
 - (A) The penalty range for a Severity Level A violation is \$100 - \$250 per violation.
 - (B) A Severity Level A violation is a violation that has or has had minor or no client health or safety significance.
 - (C) DADS assesses a penalty for a Severity Level A violation only if the violation is of a continuing nature or was not corrected in accordance with an accepted plan of correction.
 - (D) DADS may assess a separate Severity Level A administrative penalty for each of the rules listed in the following table.

| SEVERITY LEVEL A VIOLATIONS \$100 - \$250 per violation | |
|--|---|
| Rule Cite | Subject Matter |
| §97.210(c)(1)-(2); separate penalties | Providing information on how to contact the person in charge if an agency is closed during operating hours or between the hours of 8:00 a.m. and 5:00p.m., Monday through Friday. |
| §97.212 | Prohibiting material alteration of a license. |
| §97.213(a), (b)(1) and (2), and (c); separate penalties | Notification procedures for reporting a change in physical location. |
| §97.214(a)(1) and (2), (b), and (c); separate penalties | Notification procedures for reporting a change in agency contact information and agency operating hours. |

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| §97.217(b)(1)-(2); separate penalties | Procedures for notifying DADS of a voluntary suspension of operations. |
| §97.218(a)(1)-(4) and (b); separate penalties | Notification procedures for reporting a change in management personnel. |
| §97.219(a),(b), and (d); separate penalties | Notification procedures for adding or deleting a category of service to an agency's license. |
| §97.220(a) | Providing services only within an agency's licensed service area. |
| §97.220(c) and (d)(2)(A) and (B); separate penalties | Notification procedures for reporting an expansion of an agency's licensed service area. |
| §97.220(e) | Using the required DADS form and following DADS instructions to provide notice of an expansion or reduction of an agency's licensed service area. |
| §97.220(g) | Providing written notification of a reduction of an agency's licensed service area. |
| §97.220(j)(1) | Not reporting an expansion of the service area as required to continue to provide services to an existing client outside the service area. |
| §97.220(j)(4) | Not documenting the start and end date for services provided to a client outside the service area. |
| §97.220(k)(1)-(3) | Information an agency must provide to a client if leaving the agency's service area. |
| §97.242(a)-(b); separate penalties | Preparing and maintaining a current written description of the agency's organizational structure. |
| §97.243(b)(1)(A)-(E) and (G)-(J); separate penalties | Responsibilities of the administrator. |
| §97.243(b)(3) | Requirement that the administrator designate in writing an agency employee who must provide DADS surveyors entry to the agency. |
| §97.243(d) | Adoption of a written policy for the supervision of branch offices or alternate delivery sites, if established. |
| §97.244(b)(1)-(5); separate penalties | Conditions of the agency administrator and alternate administrator. |
| §97.245(a)-(b)(1)-(10); separate penalties | Adoption and enforcement of written policies governing all personnel staffed by the agency. |
| §97.246(a)(1)-(6)(A)-(B) and (b); separate penalties | An agency's personnel records and content of such records. |

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| §97.247(a)(4) and (b)(4); separate penalties | Providing unlicensed employees and volunteers with written information about the employee misconduct registry. |
| §97.247(c) | Documentation of compliance with verifying the employability and use of unlicensed applicants, employees, and volunteers. |
| §97.248(b), (b)(1), and (b)(3); separate penalties | The use of volunteers in an agency. |
| §97.249(b) | Adoption of a written policy for the reporting of alleged acts of abuse, neglect, and exploitation of clients. |
| §97.250(a) | Adoption of a written policy covering procedures for investigating known and alleged acts of abuse, neglect, and exploitation and other complaints. |
| §97.250(e) | Prohibiting an agency from retaliating against a person for filing a complaint, presenting a grievance, or providing, in good faith, information about the services provided by the agency. |
| §97.251 | Adoption of a written policy for ensuring that all professional disciplines comply with their respective professional practice acts or title acts for reporting and peer review. |
| §97.253 | Adoption of a written policy describing whether an agency will conduct drug testing of employees that describes the method and provides a copy of the policy. |
| §97.254 | Adoption of a written policy for ensuring that the agency submits accurate billings and insurance claims. |
| §97.255(a) | Adoption of a written policy to ensure compliance with the Texas Occupations Code, Chapter 102, relating to Solicitation of Patients. |
| §97.256(a) | Having a written emergency preparedness and response plan based on a risk assessment. |
| §97.256(b)(1)-(4); separate penalties | Agency personnel responsible for developing, maintaining and implementing a written emergency preparedness and response plan. |
| §97.256(c)(1)-(5); separate penalties | Contents of a written emergency preparedness and response plan. |
| §97.256(d)(1)-(4); separate penalties | Response and recovery phases of a written emergency preparedness and response plan. |

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| §97.256(e)(1)-(2); separate penalties | Procedures to triage clients in a written emergency preparedness and response plan. |
| §97.256(f) | Procedures in a written emergency preparedness and response plan to identify a client who may need evacuation assistance. |
| §97.256(g) | Assisting a client as requested to register with 2-1-1 for evacuation assistance. |
| §97.256(h)(1)-(4); separate penalties | Counseling each client about emergency preparedness. |
| §97.256(i) | Training agency personnel in their responsibilities in a written emergency preparedness and response plan. |
| §97.256(j) and (k); separate penalties | Annual review and update of a written emergency preparedness and response plan and annual test of the response phase of the plan. |
| §97.256(l) | Good faith effort to comply with rules on emergency preparedness planning and implementation. |
| §97.256(n) | Reproducing client records damaged during a disaster. |
| §97.256(o)(1)-(2) and (p); separate penalties | Notice of temporary changes due to an emergency or disaster. |
| §97.259(g) | Prohibiting use of the presurvey conference to meet initial training requirements for a first-time administrator and alternate administrator. |
| §97.260(d) | Prohibiting use of the pre-survey conference to meeting continuing education requirements for an administrator and alternate administrator. |
| §97.281(1)-(16); separate penalties | Adoption of a written policy that specifies the agency's client care practices. |
| §97.282(a)-(b), (d)- (f)(1)-(8), and (g)-(h); separate penalties | Adoption of a written policy governing client conduct and responsibility and client rights. |
| §97.284 | Adoption of a written policy for complying with the Clinical Laboratory Improvement Amendments of 1988, 42 USC, §263a, Certification of Laboratories (CLIA 1988). |
| §97.285 | Adoption of written policies addressing infection control. |
| §97.285(1)(A)-(C) and (2); separate penalties | Adoption and compliance with a written policy that addresses infection control. |
| §97.286(a) | Adoption of a written policy for safe handling and disposal of biohazardous waste and materials, if applicable. |

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| §97.288(a) | Adoption of a written policy on coordination of services. |
| §97.288(b) | Documentation of coordination of services. |
| §97.289(c)(2) | Providing written information about the employee misconduct registry to an unlicensed person providing services under arrangement. |
| §97.289(e)(1)-(3); separate penalties | Documentation of personnel qualifications and for unlicensed staff that provide services under arrangement. |
| §97.290(a) | Adoption of a written policy for ensuring that backup services are available when an agency employee or contractor is not available to deliver the services. |
| §97.290(a)(1)-(2) | Documentation that a client's designee agreed to provide backup services. |
| §97.290(a)(3) | Not coercing a client to accept backup services. |
| §97.290(b) | Adoption of a written policy for ensuring that clients are educated in how to access care from the agency or another health care provider after regular business hours. |
| §97.291 | Adoption of a written policy for an agency's written contingency plan. |
| §97.292(a) | Providing a client or a client's family with a written agreement for services and ensuring appropriate content of the agreement. |
| §97.292(b) | Obtaining acknowledgment that the client received an appropriate written agreement for services and ensuring that the acknowledgment is in the client's record. |
| §97.293 | Maintaining a current list of clients for each category of service licensed. |
| §97.294 | Adoption of a written policy for establishing a time frame for the initiation of care or services. |
| §97.295(c), (d), and (f); separate penalties | Delivery of written notice and documentation requirements pertaining to an agency's transfer or discharge of a client. |
| §97.296(a) | Adoption of a written policy that states whether physician delegation will be honored by the agency. |
| §97.296(b) | Information the agency must receive to accept physician delegation. |

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| §97.297 | Adoption of a written policy describing protocols and procedures agency staff must follow when receiving physician orders, if applicable. |
| §97.297(2) | Physician orders received by facsimile. |
| §97.298 | Adoption of a written policy for ensuring compliance with rules adopted by the Texas Board of Nursing in 22 TAC Chapter 224 (relating to Delegation of Nursing Tasks by Registered Professional Nurses to Unlicensed Personnel for Clients with Acute Conditions or in Acute Care Environments) and 22 TAC Chapter 225 (relating to RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions). |
| §97.299 | Adoption of a written policy for ensuring compliance with rules of the Texas Board of Nursing adopted at 22 TAC Chapters 211-226 (relating to Nursing Continuing Education, Licensure, and Practice in the State of Texas). |
| §97.300(b) | Adoption of a written policy for maintaining a current medication list and a current medication administration record. |
| §97.300(b)(2)(A)-(B); separate penalties | The administration of medication. |
| §97.301(a)(1)-(9)(A)-(P); separate penalties | Requirements for maintaining an agency's client records. |
| §97.301(b)(1)-(3); separate penalties | Adoption and enforcement of a written policy for retention of records. |
| §97.302 | Adoption of a written policy for pronouncement of death if that function is carried out by an agency registered nurse. |
| §97.321(a) | Branch office compliance with the regulations of its parent agency. |
| §97.321(c)(1) | Providing services only within a branch office licensed service area. |
| §97.321(c)(3) | Providing a written notification of an expansion of a branch office service area. |
| §97.321(c)(4) | Providing written notification of a reduction of a branch office licensed service area. |
| §97.321(d)(1)-(3); separate penalties | Requirements for branch offices. |

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| §97.321(f) | Requirement prohibiting branch offices from providing services not offered by the parent agency. |
| §97.322(a) and (c)(1)-(2); separate penalties | Standards for hospice alternate delivery sites. |
| §97.401(f) | The use of home health aides. |
| §97.402(b) | Requirement for implementing a home health aide training and competency program. |
| §97.404(e) | Requirement that an agency develops operational policies that are considerate of the principles of individual and family choice and control, functional need, and accessible and flexible services. |
| §97.404(f)(1)-(3); separate penalties | Additional requirements for maintaining client records in an agency that provides personal assistance services. |
| §97.404(g) | Adoption of a written policy that addresses the supervision of agency personnel with input from the client or family on the frequency of supervision. |
| §97.404(g)(1)-(2); separate penalties | Conditions and qualifications for supervision of agency personnel delivering personal assistance services. |
| §97.405(d) | Requirement for individual personnel files on all physicians. |
| §97.405(g) | A written transfer agreement with a local hospital for an agency that provides home dialysis services. |
| §97.405(h) | An agreement with a licensed end stage renal disease facility to provide backup outpatient dialysis services. |
| §97.405(j) | Ensuring that names of clients awaiting a donor transplant are entered in the recipient registry program. |
| §97.405(s)(1) and (4)-(7); separate penalties | Additional requirements for maintaining client records in an agency that provides home dialysis services. |
| §97.405(v) | Development of a written preventive maintenance program for home dialysis equipment. |
| §97.405(v)(1)(B) | Maintaining written evidence of preventive maintenance and equipment repairs. |
| §97.405(z) | Adoption of policies and procedures for medical emergencies and emergencies resulting from a disaster required of an agency that provides home dialysis services. |

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| §97.406(1) | Adoption of a written policy for the provision of psychoactive treatments, if applicable. |
| §97.523(a) | Staff availability for the initial survey. |
| §97.523(b) | Staff availability for survey other than the initial survey. |
| §97.523(e) | Providing surveyor entry to the agency during regular business hours and within two hours of the surveyor's arrival at the agency. |
| 97.525(c) | Having documentation of accreditation available at the time of a survey. |
| §97.527(b) | Providing surveyor with audio recording of the exit conference if made by the agency. |
| §97.527(c) | Providing surveyor with video recording of the exit conference if made by the agency. |
| §97.527(g)(1)-(2)(A)-(D) | Submitting an acceptable plan of correction and correcting a violation within the required time frame. |
| §97.801(a) | Adoption of written policies relating to the standards for providing hospice services. |
| §97.801(e) | Restriction on use of the word "hospice" if not licensed to provide hospice services. |
| §97.811(c)(1)-(8); separate penalties | Factors to consider in the hospice comprehensive assessment. |
| §97.812(a) and (b)(1)-(3); separate penalties | Requirements for updating the hospice comprehensive assessment. |
| §97.813(a) and (b)(1)-(5); separate penalties | Including data elements in the hospice comprehensive assessment to measure outcomes. |
| §97.820(d) | Designating an interdisciplinary team responsible for establishing the policies governing the provision of hospice services. |
| §97.821(d)(1)-(5); separate penalties | The content of a hospice plan of care. |
| §97.821(d)(6) | Documenting client understanding, involvement, and agreement with the hospice plan of care. |
| §97.844(b) and (c); separate penalties | Requirements for hospice homemaker services. |
| §97.845(a) and (b)(1)-(2); separate penalties | Using a qualified hospice homemaker to provide hospice homemaker services. |
| §97.846(a) and (b); separate penalties | A hospice agency's use of and coordination with services provided under a state Medicaid personal care benefit. |

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| §97.850(a)(1) and (2); separate penalties | Organization and administration of hospice services. |
| §97.851(b)(1) and (2); separate penalties | Hospice services provided by a licensed person. |
| §97.853(d) | Hospice providing infection control education. |
| §97.854(a) and (b)(1)-(3); separate penalties | Hospice professional management responsibility for contracted services. |
| §97.855(a) and (b); separate penalties | Additional hospice requirements for criminal background checks. |
| §97.856(d) | Including a hospice alternate delivery site in the written and actual organizational structure of the parent agency. |
| §97.857(1)-(2) and (4)-(5); separate penalties | Hospice staff training. |
| §97.858(a)-(c); separate penalties | Hospice medical director. |
| §97.859(a)-(g) separate penalties | Hospice discharge or transfer of care. |
| §97.860(f), (g)(1)-(2), (j), (k)(1)-(5), (l)(1) and (3), and (m); separate penalties | Provision of drugs and biologicals by a hospice. |
| §97.861(e)(1)-(8); separate penalties | Written contract for providing hospice short-term inpatient care. |
| §97.871(a)(2)(A)-(G), (d)(1)-(4), (e)(1)-(5), (f), (g)(1), (l)(16), (m)(4), and (n)(4); separate penalties | Physical environment in a hospice inpatient unit. |
| §97.880(b)(1)-(10), (c)(2), and (e); separate penalties | Providing hospice care to residents of a skilled nursing facility, nursing facility, or an intermediate care facility for individuals with an intellectual disability or related conditions. |

(3) Severity Level B violations.

- (A) The penalty range for a Severity Level B violation is \$500-\$1,000 per violation.
- (B) A Severity Level B violation is a violation that:

- (i) Results in serious harm to or death of a client;
 - (ii) Constitutes an actual serious threat to the health or safety of a client; or
 - (iii) Substantially limits the agency's capacity to provide care.
- (C) The penalty for a Severity Level B violation that:
 - (i) Results in serious harm to or death of a client is \$1,000;
 - (ii) Constitutes an actual serious threat to the health or safety of a client is \$500 - \$1,000; and
 - (iii) Substantially limits the agency's capacity to provide care is \$500 - \$750.
- (D) As provided in subsection (e) of this section, a Severity Level B violation is a violation for which DADS may assess an administrative penalty without providing an agency with an opportunity to correct the violation.
- (E) DADS may assess a separate Severity Level B administrative penalty for each of the rules listed in the following table.

| SEVERITY LEVEL B VIOLATIONS \$500 - \$1,000 per violation | |
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| Rule Cite | Subject Matter |
| §97.11(d) | Requirement to have a separate license for each place of business. |
| §97.23 | A license may not be sold or assigned to another person. |
| §97.220(b) | Maintaining adequate staff to provide services and supervise the provision of services. |
| §97.220(k)(1)-(3) | Information an agency must provide to a client if leaving the agency's service area. |
| §97.241(a), (c), and (d); separate penalties | Management responsibilities. |

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| §97.243(a)(1) | Designating a qualified agency administrator. |
| §97.243(a)(2) | Designating a qualified agency alternate administrator. |
| §97.243(b)(1)(A)-(I) and (2)-(3); separate penalties | Responsibilities of an agency administrator. |
| §97.243(c)(1) | Requirement to directly employ or contract with a qualified individual to serve as the supervising nurse. |
| §97.243(c)(2) | Requirement to designate a qualified alternate supervising nurse. |
| §97.243(c)(2)(A)(i)-(iv); separate penalties | Supervisory responsibilities of the supervising nurse or alternate supervising nurse. |
| §97.243(c)(2)(B) | Allowing the supervising nurse to be the administrator if the supervising nurse meets the qualifications of the administrator. |
| §97.243(c)(3) | Requirements for the supervision of physical, occupational, speech, or respiratory therapy; medical social services; or nutritional counseling. |
| §97.243(d) | Enforcing a written policy for the supervision of branch offices or alternate delivery sites, if established. |
| §97.244(a)(1) | Qualifications of the agency administrator and alternate administrator for agencies licensed to provide licensed home health services, licensed and certified home health services or hospice services. |
| §97.244(a)(2) | Additional qualifications for the agency administrator and alternate administrator for agencies licensed to provide hospice services. |
| §97.244(a)(3) | Qualifications of the agency administrator and alternate administrator for agencies licensed to provide only personal assistance services. |
| §97.244(b)(1)-(5); separate penalties | Conditions of the agency administrator and alternate administrator. |
| §97.244(c)(1) | Qualifications of the supervising nurse and alternate supervising nurse for agencies without the home dialysis designation. |
| §97.244(c)(2) | Qualifications of the supervising nurse and alternate supervising nurse for agencies with the home dialysis designation. |
| §97.245(a)-(b)(1)-(10); separate penalties | Enforcement of staffing policies that govern all personnel used by the agency. |

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| §97.247(a)(1)-(3) and (5)(A)-(B)-(6)(A)-(B) and (b)(1)-(3) and (5)(A)-(B)-(6)(A)-(B); separate penalties | Verifying the employability and use of unlicensed applicants, employees and volunteers. |
| §97.248(b), (b)(1), and (b)(3); separate penalties | The use of volunteers in an agency. |
| §97.249(c) | Reporting alleged acts of abuse, neglect, and exploitation of clients. |
| §97.250(b)(1)-(3), (c)(1)-(2), and (d)-(e); separate penalties | Enforcement of an agency's written policy for investigation of known and alleged acts of abuse, neglect, and exploitation and other complaints. |
| §97.251 | Compliance with the agency's written policy to ensure that all professional disciplines comply with their respective professional practice acts or title acts for reporting and peer review. |
| §97.252(1)-(2) | An agency's financial ability to carry out its functions. |
| §97.256(a) | Having a written emergency preparedness and response plan based on a risk assessment. |
| §97.256(b)(1)-(4); separate penalties | Agency personnel responsible for developing, maintaining and implementing a written emergency preparedness and response plan. |
| §97.256(c)(1)-(5); separate penalties | Contents of a written emergency preparedness and response plan. |
| §97.256(d)(1)-(4); separate penalties | Response and recovery phases of a written emergency preparedness and response plan. |
| §97.256(e)(1)-(2); separate penalties | Procedures to triage clients in a written emergency preparedness and response plan. |
| §97.256(f) | Procedures in a written emergency preparedness and response plan to identify a client who may need evacuation assistance. |
| §97.256(g) | Assisting a client as requested to register with 2-1-1 for evacuation assistance. |
| §97.256(h)(1)-(4); separate penalties | Counseling each client about emergency preparedness. |
| §97.256(i) | Training agency personnel in their responsibilities in a written emergency preparedness and response plan. |
| §97.256(j) and (k); separate penalties | Annual review and update of a written emergency preparedness and response plan and annual test of the response phase of the plan. |

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| §97.256(l) | Good faith effort to comply with rules on emergency preparedness planning and implementation. |
| §97.256(n) | Reproducing client records damaged during a disaster. |
| §97.256(o)(1)-(2) and (p); separate penalties | Notice of temporary changes due to an emergency or disaster. |
| §97.259(b)-(e); separate penalties | Initial educational training requirements for a first-time agency administrator and alternate administrator. |
| §97.259(f) | Documentation requirements for initial educational training of a first-time administrator and alternate administrator. |
| §97.260(a) | Annual continuing education requirements for an agency administrator and alternate administrator. |
| §97.260(b) | Continuing education requirements for an agency administrator and alternate administrator who has not served for 180 days or more immediately preceding the date of designation. |
| §97.260(c) | Documentation requirements for continuing education of an administrator and alternate administrator. |
| §97.281(1)-(16); separate penalties | Enforcement of a written policy for client care practices. |
| §97.282(a)-(f)(1)-(8) and (g)-(h); separate penalties | Compliance with an agency policy on client conduct and responsibility and client rights. |
| §97.284 | Compliance with the Clinical Laboratory Improvement Amendments of 1988. |
| §97.285 | Compliance with written policies addressing infection control. |
| §97.285(1)(A)-(C) and (2); separate penalties | Enforcement and compliance with written policies on infection control. |
| §97.286(b) | Compliance with 25 TAC §§1.131 - 1.137 (relating to Definition, Treatment, and Disposition of Special Waste from Health Care-Related Facilities). |
| §97.287(a)(1)-(3) and (b)-(c); separate penalties | An agency's Quality Assessment and Performance Improvement Program. |
| §97.288(a)-(b); separate penalties | Compliance with an agency's written policy for coordination of services and documentation requirements. |
| §97.289(a)-(b); separate penalties | An agency's use of and agreement with independent contractors and arranged services. |
| §97.289(c)(1) and (3); separate penalties | Initial searches and searches at least every 12 months of the nurse aide registry and employee misconduct registry for unlicensed staff providing services under arrangement. |

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| §97.289(d)(1)-(2); separate penalties | Conducting and reviewing a criminal history check for an unlicensed person that provides services under arrangement. |
| §97.290(a) | Enforcing a written policy that backup services are available when needed. |
| §97.290(a)(1)-(2) | Documentation that a client's designee agreed to provide backup services. |
| §97.290(b) | Enforcing a written policy that clients are educated in how to access care after hours. |
| §97.291(1)-(2); separate penalties | Implementing a written policy for an agency's written contingency plan. |
| §97.292(a) | Complying with the terms of a written agreement for services that the agency provided to a client or a client's family. |
| §97.295(a)(1)-(2); separate penalties | Providing a client with written notification, and notifying a client's attending physician if applicable, of transfer or discharge. |
| §97.295(b) | An agency providing written notification of a client's transfer or discharge within the required time frame. |
| §97.296(a) | Enforcement of an agency's policy regarding acceptance of physician delegation orders. |
| §97.296(b) | Information the agency must receive to accept physician delegation. |
| §97.297 | Enforcement of a written policy describing protocols and procedures agency staff must follow when receiving physician orders, if applicable. |
| §97.297(1) | Countersignature of physician verbal orders. |
| §97.298 | Enforcement of a written policy for ensuring compliance with the rules adopted by the Texas Board of Nursing in 22 TAC Chapter 224 (relating to Delegation of Nursing Tasks by Registered Professional Nurses to Unlicensed Personnel for Clients with Acute Conditions or in Acute Care Environments) and 22 TAC Chapter 225 (relating to RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions). |
| §97.300(b) | Enforcement of a written policy for maintaining a current medication list and a current medication administration record. |
| and (3); separate penalties | The administration of medication. |
| §97.303(1)-(3)(A)-(F); separate penalties | The possession and use of sterile water or saline, certain vaccines or tuberculin, and certain dangerous drugs. |

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| §97.321(c)(2) | Maintaining adequate staff to provide and supervise services at a branch office. |
| §97.322(a) and (c)(1); separate penalties | Standards for hospice alternate delivery sites. |
| §97.401(b)(1)-(2)(A)-B); separate penalties | Acceptance of a client for home health services and the initiation of services. |
| §97.401(d) | Requirement that qualified personnel provide and supervise all services. |
| §97.401(e) | Requirement that all staff providing services, delegation, and supervision be employed by or be under contract with the agency. |
| §97.401(g) | Age and competency of unlicensed persons providing licensed home health services. |
| §97.402(a) | Compliance with the Medicare Conditions of Participation (Social Security Act, Title 42, Code of Federal Regulations, Part 484.) |
| §97.402(c)-(e); separate penalties | Compliance with §97.701(f) of this chapter (relating to Home Health Aides) for an agency that implements a competency evaluation program. |
| §97.404(c) | Qualifications of agency staff performing personal assistance services. |
| §97.404(d) | Tasks authorized under a personal assistance services license category. |
| §97.404(g) | Enforcement of a written policy that addresses the supervision of agency personnel with input from the client or family on the frequency of supervision. |
| §97.404(g)(1)-(2); separate penalties | Conditions and qualifications for supervising agency personnel delivering personal assistance services. |
| §97.404(h)(1)-(5); separate penalties | Performance of gastrostomy tube feedings and medication administration for an agency that provides personal assistance services. |
| §97.405(a) | Requirements for agencies that provide peritoneal dialysis or hemodialysis services. |
| §97.405(c)(1)-(2); separate penalties | Qualifications and responsibilities of the medical director for an agency that provides home dialysis services. |
| §97.405(e)(1)(A)-(C); separate penalties | Provision and supervision of nursing services for an agency that provides home dialysis services. |
| §97.405(e)(2) | Provision of nutritional counseling for an agency that provides home dialysis services. |

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| §97.405(e)(3) | Provision of medical social services for an agency that provides home dialysis services. |
| §97.405(f)(1) | Requirements for orientation and training of personnel providing direct care to clients receiving home dialysis services. |
| §97.405(f)(2)(A)-(G); separate penalties | Requirement for an orientation and skills education period for licensed nurses. |
| §97.405(i) | Requirement that an agency coordinate the exchange of medical and other important information when transferring a home dialysis client to a health-care facility for treatment. |
| §97.405(k) | Requirement for routine hepatitis testing of home dialysis clients and agency employees providing dialysis care. |
| §97.405(k)(1)(A)-(C); separate penalties | Requirements for hepatitis B screening and vaccinations for staff. |
| §97.405(k)(2)(A)-(E); separate penalties | Requirements for hepatitis B screening and vaccinations for clients. |
| §97.405(l) | Requirements for employees providing direct care to clients to have a current CPR certification. |
| §97.405(m) | Requirement for initial admission assessment of a client for home dialysis services. |
| §97.405(n) | Requirement for development of a long-term program for a client receiving home dialysis services. |
| §97.405(o) | Requirement that the agency conducts a history and physical of a home dialysis client at admission and annually. |
| §97.405(p)(1)-(2); separate penalties | Requirement for physician orders for home self-assisted dialysis treatment. |
| §97.405(q)(1)-(7); separate penalties | Requirements for development and implementation of a care plan for a home dialysis client. |
| §97.405(r) | Requirement for medication administration by licensed personnel for an agency that provides home dialysis services. |
| §97.405(s)(2)-(3); separate penalties | Additional requirements for maintaining client records in an agency that provides home dialysis services. |
| §97.405(t)(1)-(4); separate penalties | Requirements for use of water in the home dialysis setting. |
| §97.405(u) | Adoption and enforcement of a policy to test dialysis equipment prior to each treatment. |

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| §97.405(v) | Enforcing the agency's written preventive maintenance program for home dialysis equipment. |
| §97.405(v)(1), (1)(A), (1)(C)-(D), and (2); separate penalties | Implementing requirements for a written preventive maintenance program for home dialysis equipment. |
| §97.405(w)(1)-(6); separate penalties | Reuse of disposable medical devices in the home dialysis setting. |
| §97.405(x)(1)-(2) | Provision of laboratory services. |
| §97.405(x)(3)-(4); separate penalties | Provision of laboratory services. |
| §97.405(y)(1)-(2); separate penalties | Supplies for home dialysis services. |
| §97.405(z)(1)-(7); separate penalties | Compliance with policies and procedures for medical emergencies and emergencies resulting from a disaster required of an agency that provides home dialysis services. |
| §97.406(2)-(5) separate penalties | Provision of psychoactive services. |
| §97.407(1)-(11); separate penalties | Provision of intravenous therapy services. |
| §97.523(e) | Requirement to grant the surveyor entry to the agency if closed when the surveyor arrives during regular business hours. |
| §97.701(a)-(f)(1)-(7); separate penalties | Home health aides. |
| §97.801(a) | Adoption or enforcement of written policies relating to the standards for providing hospice services. |
| §97.801(d) | Compliance with the Medicare Conditions of Participation in 42, CFR, Part 418, Hospice care. |
| §97.810(a) and (b); separate penalties | Time requirements for completing a hospice initial assessment and using it to initiate hospice services. |
| §97.811(a)(1)-(4), (b), and (c)(1)-(8); separate penalties | Requirements for the hospice comprehensive assessment. |
| §97.812(a) and (b)(1)-(3); separate penalties | Requirements for updating the hospice comprehensive assessment. |
| §97.813(a) and (b)(1)-(5); separate penalties | Including data elements in the hospice comprehensive assessment to measure outcomes. |
| §97.820(a) | Approach to service delivery by the hospice interdisciplinary team. |

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| §97.820(a), (b)(1)-(4), (c) and (d); separate penalties | Requirements for a hospice interdisciplinary team. |
| §97.821(a)-(d)(1)-(6) and (e); separate penalties | Requirements for a hospice plan of care for a client. |
| §97.822(a) and (b); separate penalties | Review and revision of a hospice plan of care. |
| §97.823(1) | Interdisciplinary team responsibilities for coordinating hospice services. |
| §97.830(a)(1)-(4) and (c); separate penalties | Requirements for the provision of hospice core services. |
| §97.831(a)-(d); separate penalties | Providing and supervising hospice physician services. |
| §97.832(a) and (b); separate penalties | Providing hospice nursing services. |
| §97.833(a), (c), and (d); separate penalties | Social worker qualifications and providing hospice medical social services. |
| §97.834(a), (b)(1)(A)-(D), (b)(2) and (b)(3)(A)-(C); separate penalties | Requirements for hospice counseling services. |
| §97.840(a)(1)-(5) and (b); separate penalties | Providing hospice non-core services. |
| §97.841 | Providing hospice therapy services. |
| §97.842(b)(1)-(4), (c)(1)-(6), (d)(1)-(2), and (e)(1)-(5); separate penalties | Requirements for hospice aide services. |
| §97.843(a)-(c)(1)-(3), (d)(1)-(6), (e)(1)-(3), and (f); separate penalties | Using a qualified hospice aide to provide hospice aide services. |
| §97.844(b)-(d); separate penalties | Requirements for hospice homemaker services. |
| §97.845(a) and (b)(1)-(2); separate penalties | Using a qualified hospice homemaker to provide hospice homemaker services. |
| §97.846(a) and (b); separate penalties | A hospice agency's use and coordination with services provided under a state Medicaid personal care benefit. |
| §97.850(a)(1)-(2), (c)(1)-(9), (d)(1)-(3), (e)(1)-(7), and (f); separate penalties | Requirements for the organization and administration of hospice services. |

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| §97.851(a) and (b)(1)-(2); separate penalties | Hospice services provided by a licensed person. |
| §97.852 (a) and (b)(1)-(2); separate penalties | Responsibilities of a hospice governing body and administrator. |
| §97.853(a)-(c)(1)-(2) and (d); separate penalties | Hospice infection control program. |
| §97.854(a) and (b)(1)-(3); separate penalties | Hospice professional management responsibility for contracted services. |
| §97.855(a) and (b); separate penalties | Additional hospice requirements for criminal background checks. |
| §97.856(c)-(e); separate penalties | Hospice alternate delivery sites. |
| §97.857(1)-(5); separate penalties | Hospice staff training. |
| §97.858(a)-(g); separate penalties | Hospice medical director. |
| §97.859(a)-(g); separate penalties | Hospice discharge or transfer of care. |
| §97.860(a)-(d), (e)(1)-(2), (f), (g)(1)-(2), (h)-(j), (k)(1)-(5), (l)(1)-(3), (m), (n)(1)-(2), and (o)-(q); separate penalties | Provision of drugs, biologicals, medical supplies, and durable medical equipment by a hospice. |
| §97.861(a)-(d) and (e)(1)-(8); separate penalties | Hospice short-term inpatient care. |
| §97.870(a) and (b)(1)-(3); separate penalties | Staffing in a hospice inpatient unit. |
| §97.871(a)(1)-(2)(A)-(G), (b)(1)-(4), (c)(1) and (4)(A)-(D), (d)(1)-(4), (e)(1)-(5), (f), (g)(1)-(2), (h)-(k)(1)-(3), (l)(1)-(16), (m)(1)-(4), (n)(1)(A)-(C) and (2)-(4); separate penalties | Physical environment in a hospice inpatient unit. |
| §97.880(a), (b)(1)-(10), (c)(1)-(3), (d)(1)-(3), and (e); separate penalties | Providing hospice services to residents of a skilled nursing facility, nursing facility, or an intermediate care facility for individuals with an intellectual disability or related conditions. |

- (i) Violations for which DADS may assess an administrative penalty of \$500.
 - (1) DADS may assess an administrative penalty of \$500 for each of the violations listed in subsection (e)(4) and (5) of this section, without providing an agency with an opportunity to correct the violation.
 - (2) A separate penalty may be assessed for each of these violations.
- (j) Proposal of administrative penalties.
 - (1) If DADS assesses an administrative penalty, DADS provides a written notice of violation letter to an agency. The notice includes:
 - (A) A brief summary of the violation;
 - (B) The amount of the proposed penalty; and
 - (C) A statement of the agency's right to a formal administrative hearing on the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty.
 - (2) An agency may accept DADS determination within 20 days after the date on which the agency receives the notice of violation letter, including the proposed penalty, or may make a written request for a formal administrative hearing on the determination.
 - (A) If an agency notified of a violation accepts DADS determination, the DADS commissioner or the DADS commissioner's designee issues an order approving the determination and ordering that the agency pay the proposed penalty.
 - (B) If an agency notified of a violation does not accept DADS determination, the agency must submit to the Health and Human Services Commission a written request for a formal administrative hearing on the determination and

must not pay the proposed penalty. Remittance of the penalty to DADS is deemed acceptance by the agency of DADS determination, is final, and waives the agency's right to a formal administrative hearing.

- (C) If an agency notified of a violation fails to respond to the notice of violation letter within the required time frame, the DADS commissioner or the DADS commissioner's designee issues an order approving the determination and ordering that the agency pay the proposed penalty.
- (D) If an agency requests a formal administrative hearing, the hearing is held in accordance with the statute, §142.0172, §142.0173, 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).

§97.603 Court Action

- a) If a person operates an agency without a license issued under this chapter, the person is liable for a civil penalty of not less than \$1,000 or more than \$2,500 for each day of violation.
- b) If a person violates the licensing requirements of the statute, DADS may petition the district court to restrain the person from continuing the violation.

§97.604 Surrender or Expiration of a License

- a) After a survey in which a surveyor cited deficiencies, an agency may surrender its license or allow its license to expire to avoid enforcement action by DADS.
- b) If an agency surrenders its license before the expiration date, the agency must return its original license and provide the following information to DADS:
 - 1) The effective date of closure;
 - 2) The location of client records;
 - 3) The name and address of the client record custodian;

- 4) A statement signed and dated by the license holder agreeing to the surrender of the license; and
- 5) The disposition of active clients at the time of closure.
- c) If an agency surrenders its license or allows its license to expire, DADS denies an application for license by the agency, its license holder, and its affiliate for one year after the date of the surrender or expiration.

Subchapter G – Home Health Aides

§97.701 Home Health Aides

- a) A home health aide may be used by an agency providing licensed home health services if the aide meets one of the following requirements:
 - 1) A minimum of one year full-time experience in direct client care in an institutional setting (hospital or nursing facility);
 - 2) One year full-time experience within the last five years in direct client care in an agency setting;
 - 3) Satisfactorily completed a training and competency evaluation program that complies with the requirements of this section;
 - 4) Satisfactorily completed a competency evaluation program that complies with the requirements of this section;
 - 5) Submitted to the agency documentation from the director of programs or the dean of a school of nursing that states that the individual is a nursing student who has demonstrated competency in providing basic nursing skills in accordance with the school's curriculum; or
 - 6) Be on the Texas Department of Human Services' (DHS's) nurse aide registry with no finding against the aide relating to client abuse or neglect or misappropriation of client property.
- b) A home health aide must have provided home health services within the previous 24 months to qualify under subsection (a)(3) or (4) of this section.

- c) Assignment, delegation, and supervision of services provided by home health aides must be performed in accordance with rules in this chapter governing the agency's license category.
- d) The training portion of a training and competency evaluation program for home health aides must be conducted by or under the general supervision of an RN who possesses a minimum of two years of nursing experience, at least one year of which must be in the provision of home health care. The training program may contain other aspects of learning, but must contain the following:
 - 1) A minimum of 75 hours as follows:
 - A. An appropriate number of hours of classroom instruction; and
 - B. A minimum of 16 hours of clinical experience which will include in-home training and must be conducted in a home, a hospital, a nursing home, or a laboratory;
 - 2) Completion of at least 16 hours of classroom training before a home health aide begins clinical experience working directly with clients under the supervision of qualified instructors;
 - 3) If licensed vocational nurse (LVN) instructors are used for the training portion of the program, the following qualifications and supervisory requirements apply:
 - A. An LVN may provide the home health aide classroom training under the supervision of an RN who has two years of nursing experience, at least one year of which must be in the provision of home health care;
 - B. LVNs, as well as RNs, may supervise home health aide candidates in the course of the clinical experience; and
 - C. An RN must maintain overall responsibility for the training and supervision of all home health aide training students; and
 - 4) An assessment that the student knows how to read and write English and carry out directions.

- e) The classroom instruction and clinical experience content of the training portion of a training and competency evaluation program must include, but is not limited to:
- 1) Communication skills;
 - 2) Observation, reporting, and documentation of a client's status and the care or service furnished;
 - 3) Reading and recording temperature, pulse, and respiration;
 - 4) Basic infection control procedures and instruction on universal precautions;
 - 5) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor;
 - 6) Maintenance of a clean, safe, and healthy environment;
 - 7) Recognizing emergencies and knowledge of emergency procedures;
 - 8) The physical, emotional, and developmental needs of and ways to work with the populations served by the agency including the need for respect for the client and his or her privacy and property;
 - 9) Appropriate and safe techniques in personal hygiene and grooming that include:
 - A. Bed bath;
 - B. Sponge, tub, or shower bath;
 - C. Shampoo, sink, tub, or bed;
 - D. Nail and skin care;
 - E. Oral hygiene; and
 - F. Toileting and elimination;
 - 10) Safe transfer techniques and ambulation;
 - 11) Normal range of motion and positioning;
 - 12) Adequate nutrition and fluid intake;
 - 13) Any other task the agency may choose to have the home health aide perform in accordance with §97.298 of this chapter; and
 - 14) The rights of the elderly.

- f) This section addresses the requirements for the competency evaluation program or the competency evaluation portion of a training and competency evaluation program.
- 1) The competency evaluation must be performed by an RN.
 - 2) The competency evaluation must address each of the subjects listed in subsection (e)(2)-(13) of this section.
 - 3) Each of the areas described in subsection (e)(3) and (9)-(11) of this section must be evaluated by observation of the home health aide's performance of the task with a client or person.
 - 4) Each of the areas described in subsection (e)(2), (4)-(8), (12), and (13) of this section may be evaluated through written examination, oral examination, or by observation of a home health aide with a client.
 - 5) A home health aide is not considered to have successfully completed a competency evaluation if the aide has an unsatisfactory rating in more than one of the areas described in subsection (e)(2)-(13) of this section.
 - 6) If an aide receives an unsatisfactory rating, the aide must not perform that task without direct supervision by an RN or LVN until the aide receives training in the task for which he or she was evaluated as unsatisfactory and successfully completes a subsequent competency evaluation with a satisfactory rating on the task.
 - 7) If an individual fails to complete the competency evaluation satisfactorily, the individual must be advised of the areas in which he or she is inadequate.
- g) If a person, who is not an agency licensed under this section, desires to implement a home health aide training and competency evaluation program or a competency evaluation program, the person must meet the requirements of this section in the same manner as set forth for an agency.

Subchapter H Standards Specific to Agencies Licensed to Provide Hospice Services

§97.801 Subchapter H Applicability

- (a) This subchapter applies to an agency licensed with the hospice services category. An agency licensed to provide hospice services must adopt and enforce written policies in accordance with this subchapter.
- (b) A hospice that provides inpatient care directly in its own inpatient unit must comply with the additional standards in Division 7 of this subchapter (relating to Hospice Inpatient Units).
- (c) A hospice that provides hospice care to a resident of a skilled nursing facility, nursing facility, or an intermediate care facility for individuals with an intellectual disability or related conditions must comply with the additional standards in Division 8 of this subchapter (relating to Hospices that Provide Hospice Care to Residents of a Skilled Nursing Facility, Nursing Facility, or Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions).
- (d) A Medicare-certified hospice agency must comply with the Medicare Conditions of Participation in 42 CFR, Part 418, Hospice Care.
- (e) A person who is not licensed to provide hospice services may not use the word "hospice" in a title or description of a facility, organization, program, service provider, or services or use any other words, letters, abbreviations, or insignia indicating or implying that the person holds a license to provide hospice services.
- (f) For the purposes of this subchapter, the term "attending practitioner":
 - (1) Includes a physician or an advanced practice nurse identified by a hospice client at the time he or she elects to receive hospice services as having the most significant role in the determination and delivery of the client's medical care; and
 - (2) Is synonymous with "attending physician," as defined in 42 CFR §418.3.

- (g) For the purposes of this subchapter, election of hospice care occurs on the effective date included in a client's hospice election statement. A hospice election statement must include:
- (1) Identification of the hospice that will provide care to the client;
 - (2) The client's or the client's legal representative's acknowledgement that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the client's terminal illness;
 - (3) Acknowledgement by Medicare beneficiaries that certain Medicare services, as described in 42 CFR §418.24(d), are waived by the election;
 - (4) The effective date of the election of hospice care, which may be later but not earlier than the date of the client's or the client's legal representative's signature and may be the first day of hospice care or a later date; and
 - (5) The signature of the client or legal representative.
- (h) For the purposes of this subchapter, the term "comprehensive assessment" means a thorough evaluation of a client's physical, psychosocial, emotional, and spiritual status related to the terminal illness and related conditions. This includes a thorough evaluation of the caregiver's and family's willingness and capability to care for the client.

§97.810 Initial Hospice Assessment

- (a) A hospice registered nurse (RN) must complete an initial assessment of a client where hospice services will be delivered within 48 hours after the election of hospice care, unless the client's physician, the client, or the client's legal representative requests that the initial assessment be completed in less than 48 hours.
- (b) The initial assessment must assess a client's immediate physical, psychosocial, and emotional status related to the terminal illness and related conditions. The information gathered must be used by the hospice to begin the plan of care and to provide care and services to treat a client's and a client's family's immediate care and support needs.

§97.811 Hospice Comprehensive Assessment

- (a) The hospice must conduct and document a client-specific comprehensive assessment that identifies a client's need for hospice care and services. The comprehensive assessment must:
 - (1) Identify the client's physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the client's well-being, comfort, and dignity throughout the dying process;
 - (2) Include all areas of hospice care related to the palliation and management of the client's terminal illness and related conditions;
 - (3) Accurately reflect the client's health status at the time of the comprehensive assessment and include information to establish and monitor a plan of care; and
 - (4) Identify the caregiver's and family's willingness and capability to care for the client.
- (b) The hospice interdisciplinary team, in consultation with the client's attending practitioner, if any, must complete the comprehensive assessment within five days after the election of hospice care.
- (c) The comprehensive assessment must take into consideration the following factors:
 - (1) The nature of the condition causing admission, including the presence or lack of objective data and the client's subjective complaints;
 - (2) Complications and risk factors that could affect care planning;
 - (3) The client's functional status, including the client's ability to understand and participate in the client's own care;
 - (4) The imminence of the client's death;
 - (5) The severity of the client's symptoms;
 - (6) A review of all of the client's prescription and over-the-counter drugs, herbal remedies, and other alternative treatments that could affect drug therapy, to identify the following:

- (A) The effectiveness of drug therapy;
 - (B) Drug side effects;
 - (C) Actual or potential drug interactions;
 - (D) Duplicate drug therapy; and
 - (E) Drug therapy currently associated with laboratory monitoring;
- (7) An initial bereavement assessment of the needs of the client's family and other persons that:
 - (A) Focuses on the social, spiritual, and cultural factors that may impact their ability to cope with the client's death; and
 - (B) Gathers information that must be incorporated into the plan of care and considered in the bereavement plan of care; and
- (8) The need for the hospice to refer the client or the client family member to appropriate health professionals for further evaluation.

§97.812 Update of the Hospice Comprehensive Assessment

- (a) The hospice interdisciplinary team, in collaboration with a client's attending practitioner, if any, must update the client's comprehensive assessment as frequently as the condition of the client requires, but no less than every 15 days.
- (b) The update of the comprehensive assessment must include:
 - (1) Changes that have taken place since the initial assessment;
 - (2) Information on the client's progress toward desired outcomes; and
 - (3) A reassessment of the client's response to care.

§97.813 Hospice Client Outcome Measures

- (a) The comprehensive assessment must include data elements that allow the hospice to measure client outcomes. The hospice must measure and document data in the same way for all clients.
- (b) The data elements must:

- (1) Consider aspects of care related to hospice and palliation;
- (2) Be an integral part of the comprehensive assessment;
- (3) Be documented by the hospice in a systematic and retrievable way for each client;
- (4) Be used by the hospice in individual client care planning and in the coordination of a client's services; and
- (5) Be used in the aggregate for the hospice's quality assessment and performance improvement program.

§97.820 Hospice Interdisciplinary Team

- (a) A hospice must designate an interdisciplinary team (IDT) composed of persons who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of a hospice client and family facing terminal illness and bereavement. The IDT members must provide the care and services offered by the hospice and all of the members of the IDT must supervise the care and services the hospice provides.
- (b) An IDT must include persons who are qualified and competent to practice in the following professional roles:
 - (1) A physician who is an employee or under contract with the hospice, who may also be the hospice medical director or physician designee;
 - (2) A registered nurse (rn);
 - (3) A social worker; and
 - (4) A pastoral or other counselor.
- (c) The hospice must designate an RN who is a member of the client's IDT to provide coordination of care and to ensure continuous assessment of the client's and family's needs and implementation of the interdisciplinary plan of care.
- (d) A hospice may have more than one IDT. If the hospice has more than one IDT, the hospice must identify the IDT specifically designated to establish policies governing the day-to-day provision of hospice care and services.

§97.821Hospice Plan of Care

- (a) A hospice must designate an interdisciplinary team (IDT) to prepare a written plan of care for a client in consultation with the client's attending practitioner, if any, the client or the client's legal representative, and the primary caregiver, if any of them so desire.
- (b) The IDT must develop an individualized written plan of care for each client. The plan of care must reflect client and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments.
- (c) The hospice must provide care and services to a client and the client's family in accordance with an individualized written plan of care established by the hospice IDT.
- (d) The client's plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions. The plan of care must include:
 - (1) Interventions to manage pain and symptoms;
 - (2) A detailed statement of the scope and frequency of services necessary to meet the specific client and family needs;
 - (3) Measurable outcomes anticipated from implementing and coordinating the plan of care;
 - (4) Drugs and treatments necessary to meet the needs of the client;
 - (5) Medical supplies and equipment necessary to meet the needs of the client; and
 - (6) The IDT's documentation in the client record of the client's or the client's legal representative's level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice's policies.
- (e) The hospice must ensure that the client and the client's primary caregiver receives education and training provided by hospice staff as appropriate to the client's and the client's primary caregiver's responsibilities for providing the care and services specified in the client's plan of care.

§97.822 Review of the Hospice Plan of Care

- (a) A hospice interdisciplinary team, in collaboration with a client's attending practitioner, if any, must review, revise and document the individualized plan of care as frequently as the client's condition requires, but no less than every 15 days.
- (b) A revised plan of care must include information from the client's updated comprehensive assessment and must note the client's progress toward outcomes and goals specified in the plan of care.

§97.823 Coordination of Services by the Hospice

In addition to the requirements in §97.288 of this chapter (relating to Coordination of Services), a hospice must develop and maintain a system of communication and integration in accordance with its written policy on coordination of services. The policy must:

- (1) Ensure that the interdisciplinary team maintains responsibility for directing, coordinating, and supervising the care and services provided to a client;
- (2) Provide for and ensure the ongoing sharing of information between all hospice personnel providing care and services in all settings, whether the care and services are provided directly or under contract; and
- (3) Provide for an ongoing sharing of information with other non-hospice health care providers furnishing services unrelated to the terminal illness and related conditions.

§97.830 Provision of Hospice Core Services

- (a) A hospice must routinely provide substantially all core services directly by hospice employees in a manner consistent with accepted standards of practice. A hospice must provide the following core services:
 - (1) Physician services;
 - (2) Nursing services;
 - (3) Medical social services; and
 - (4) Counseling services.
- (b) A hospice may contract for physician services as specified in §97.831 of this division (relating to Hospice Physician Services).

- (c) A hospice may use contracted staff if necessary to supplement hospice employees to meet the needs of clients under extraordinary or other non-routine circumstances. A Medicare-certified hospice may also enter into a written contract with another Medicare-certified hospice to provide core services if necessary to supplement hospice employees to meet the needs of a client. The contracting hospice must maintain professional management responsibility for the services provided in accordance with §97.854 of this subchapter (relating to Hospice Professional Management Responsibility). Circumstances under which the hospice may enter into a written contract for the provision of core services include:
- (1) Unanticipated periods of high client loads;
 - (2) Staffing shortages due to illness or other short-term temporary staffing situations that could interrupt client care; and
 - (3) Temporary travel of a client outside of the hospice's service area.

§97.831 Hospice Physician Services

- (a) The hospice medical director, physician employees, and contracted physicians of the hospice, in conjunction with a client's attending practitioner, if any, are responsible for the palliation and management of a client's terminal illness and related conditions.
- (b) A physician employee or a contracted physician must function under the supervision of the hospice medical director.
- (c) A physician employee or a contracted physician must meet the requirement in subsection (a) of this section by either providing physician services directly or by coordinating a client's care with the attending practitioner.
- (d) If an attending practitioner is unavailable, the medical director, a hospice physician employee, or a contracted physician is responsible for meeting the medical needs of the client.

§97.832 Hospice Nursing Services

- (a) A hospice must provide nursing services by or under the supervision of a registered nurse (RN). An RN must ensure that the nursing needs of a client are met as identified in the client's initial assessment, comprehensive assessment, and updated assessments.

- (b) An advanced practice nurse providing nursing services to a client and acting within the nurse's scope of practice may write orders for the client in accordance with a hospice's written policies and applicable state law, including the Texas Occupations Code, Chapter 157, Authority of Physician to Delegate Certain Medical Acts; Texas Occupations Code, Chapter 301, Nurses; and Texas Health and Safety Code, Chapter 481, Texas Controlled Substances Act, and Chapter 483, Dangerous Drugs.
- (c) A hospice may provide highly specialized nursing services under contract if the hospice provides such nursing services to a client so infrequently that providing them by a hospice employee would be impracticable and prohibitively expensive. A hospice may determine that a nursing service, such as complex wound care, infusion specialties, and pediatric nursing, is highly specialized by the nature of the service and the level of nursing skill required to be proficient in the service.

§97.833 Hospice Medical Social Services

- (a) Medical social services must be provided to a client by a qualified social worker. A qualified hospice social worker must meet one of the following requirements:
 - (1) Active licensure in the state of Texas as a master social worker (MSW) and one year of social work experience in a health care setting; or
 - (2) Active licensure in the state of Texas as a baccalaureate social worker, one year of social work experience in a health care setting, and if employed by a hospice after December 2, 2008, must be supervised by a qualified MSW.
- (b) A qualified licensed baccalaureate social worker employed by a hospice before December 2, 2008, is exempt from the MSW supervision requirement.
- (c) Medical social services must be provided under the direction of a physician.
- (d) The social work services provided must be based on:
 - (1) The client's and family's needs as identified in the client's psychosocial assessment; and
 - (2) The client's and family's acceptance of these services.

§97.834 Hospice Counseling Services

- (a) Counseling services must be available to a client and family to assist the client and family in minimizing the stress and problems that arise from the terminal illness, related conditions, and the dying process.
- (b) Counseling services must include bereavement, dietary, and spiritual counseling.
 - (1) Bereavement counseling. Bereavement counseling means emotional, psychosocial, and spiritual support and services provided before and after the death of the client to assist with issues related to grief, loss, and adjustment. A hospice must have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling. A hospice must:
 - (A) Develop a bereavement plan of care that notes the kind of bereavement services to be offered to the client's family and other persons and the frequency of service delivery;
 - (B) Make bereavement services available to a client's family and other persons in the bereavement plan of care for up to one year following the death of the client;
 - (C) Extend bereavement counseling to residents of a skilled nursing facility, a nursing facility, or an intermediate care facility for individuals with an intellectual disability or related conditions when appropriate and as identified in the bereavement plan of care; and
 - (D) Ensure that bereavement services reflect the needs of the bereaved.
 - (2) Dietary counseling. Dietary counseling means education and interventions provided to a client and family regarding appropriate nutritional intake as a hospice client's condition progresses. Dietary counseling, when identified in the plan of care, must be performed by a qualified person. A qualified person includes a dietitian, nutritionist, or registered nurse. A person that provides dietary counseling must be appropriately trained and qualified to address and assure that the specific dietary needs of a client are met.

- (3) Spiritual counseling. A hospice must provide spiritual counseling that meets the client's and the client's family's spiritual needs in accordance with their acceptance of this service and in a manner consistent with their beliefs and desires. A hospice must:
 - (A) Provide an assessment of the client's and family's spiritual needs;
 - (B) Make all reasonable efforts to the best of the hospice's ability to facilitate visits by local clergy, a pastoral counselor, or other persons who can support a client's spiritual needs; and
 - (C) Advise the client and family of the availability of spiritual counseling services.

§97.840 Provision of Hospice Non-Core Services

- (a) A hospice must provide the following non-core services in a manner consistent with accepted standards of practice:
 - (1) Physical therapy services;
 - (2) Occupational therapy services;
 - (3) Speech-language pathology services;
 - (4) Hospice aide and hospice homemaker services; and
 - (5) Volunteers.
- (b) A hospice must provide non-core services directly or through a written contract.

§97.841 Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services

Physical therapy services, occupational therapy services, and speech-language pathology services must be available and, when provided, offered by the hospice in a manner consistent with accepted standards of practice.

§97.842 Hospice Aide Services

- (a) Hospice aide services must be provided by a hospice aide who meets the training and competency evaluation requirements or the competency evaluation requirements specified in §97.843 of this subchapter (relating to Hospice Aide Qualifications).

- (b) A client's hospice aide services must be:
 - (1) Ordered by the designated interdisciplinary team (IDT);
 - (2) Included in the client's plan of care;
 - (3) Performed by a hospice aide in accordance with state law and applicable rules, including 22 TAC, Part 11, Chapter 224 (relating to Delegation of Nursing Tasks by Registered Professional Nurses to Unlicensed Personnel for Clients with Acute Conditions or in Acute Care Environments), and 22 TAC, Part 11, Chapter 225 (relating to RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments For Clients with Stable and Predictable Conditions); and
 - (4) Consistent with a hospice aide's documented training and competency skills.
- (c) A registered nurse (RN) who is a member of a client's designated IDT must assign a hospice aide to a specific client. An RN who is responsible for the supervision of a hospice aide as specified in subsection (d) of this section must prepare written client-care instructions for the hospice aide. The duties of a hospice aide include:
 - (1) Providing Hands-On Personal Care;
 - (2) Performing Simple Procedures As An Extension Of Therapy Or Nursing Services;
 - (3) Assisting With Ambulation Or Exercises;
 - (4) Assisting With Self-Administered Medication;
 - (5) Reporting Changes In A Client's Medical, Nursing, Rehabilitative, And Social Needs To An Rn As The Changes Relate To The Client's Plan Of Care And The Hospice's Quality Assessment And Improvement Activities; And
 - (6) Completing Client Record Documentation In Compliance With The Hospice's Policies And Procedures.

- (d) An RN must make an on-site visit to a client's home to supervise the hospice aide services at least every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice IDT meet the client's needs. The hospice aide does not have to be present during this visit.
 - (1) If the RN notes an area of concern in the care provided by the aide, the RN must make an on-site visit to the location where the client is receiving care to observe and assess the hospice aide while the aide performs care.
 - (2) If, during the on-site visit to observe the hospice aide, the RN confirms an area of concern in the aide's skills, the hospice must ensure that the aide completes a competency evaluation in accordance with §97.843 of this subchapter.
- (e) An RN must make an annual on-site visit to the location where a hospice client is receiving care to observe and assess each hospice aide while the aide performs care. During this on-site visit, the RN must assess the aide's ability to demonstrate initial and continued satisfactory performance in meeting outcome criteria including:
 - (1) Following the client's plan of care for completion of tasks assigned to the hospice aide by an RN;
 - (2) Creating successful interpersonal relationships with the client and the client's family;
 - (3) Demonstrating competency with assigned tasks;
 - (4) Complying with infection control policies and procedures; and
 - (5) Reporting changes in the client's condition.

§97.843 Hospice Aide Qualifications

- (a) A hospice must use a qualified hospice aide to provide hospice aide services. A qualified hospice aide is a person who has successfully completed:
 - (1) A training program and competency evaluation program that complies with the requirements in subsections (c) and (d) of this section; or

- (2) A competency evaluation program that complies with the requirements in subsection (d) of this section.
- (b) A person who has not provided home health or hospice aide services for compensation in an agency during the most recent continuous period of 24 consecutive months must successfully complete the programs described in subsection (a)(1) of this section or the program described in subsection (a)(2) of this section before providing hospice aide services.
- (c) A hospice aide training program must address each of the subject areas listed in paragraph (1) of this subsection through classroom and supervised practical training totaling at least 75 hours. At least 16 hours must be devoted to supervised practical training. At least 16 hours of classroom training must be completed before the supervised practical training begins.
 - (1) Subject areas that must be addressed in a hospice aide training program include:
 - (A) Communication skills, including the ability to read, write, and verbally report clinical information to clients, caregivers, and other hospice staff;
 - (B) Observation, reporting, and documentation of a client's status and the care or service provided;
 - (C) Reading and recording temperature, pulse, and respiration;
 - (D) Basic infection control procedures;
 - (E) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor;
 - (F) Maintenance of a clean, safe, and healthy environment;
 - (G) Recognizing emergencies and the knowledge of emergency procedures and their application;
 - (H) The physical, emotional, and developmental needs of and ways to work with the populations served by the hospice, including the need for respect for a client and his or her privacy and property;

- (I) Appropriate and safe techniques for performing personal hygiene and grooming tasks, including:
 - (i) Bed bath;
 - (ii) Sponge, tub, and shower bath;
 - (iii) Hair shampoo in sink, tub, and bed;
 - (iv) Nail and skin care;
 - (v) Oral hygiene; and
 - (vi) Toileting and elimination;
 - (J) Safe transfer techniques and ambulation;
 - (K) Normal range of motion and positioning;
 - (L) Adequate nutrition and fluid intake; and
 - (M) Other tasks that the hospice may choose to have an aide perform. The hospice must train hospice aides, as needed, for skills not listed in subparagraph (I) of this paragraph.
- (2) The classroom training of hospice aides and the supervision of hospice aides during supervised practical training must be conducted by or under the general supervision of an RN who possesses a minimum of two years of nursing experience, at least one of which must be in the provision of home health or hospice care. Other persons, such as a physical therapist, occupational therapist, medical social worker, and speech-language pathologist may be used to provide instruction under the supervision of a qualified RN who maintains overall responsibility for the training.
- (3) An agency must maintain documentation that demonstrates that its hospice aide training program meets the requirements in this subsection. Documentation must include a description of how additional skills, beyond the basic skills listed in paragraph (1) of this subsection, are taught and tested if the agency requires a hospice aide to perform more complex tasks.

- (d) A hospice aide competency evaluation program must address each of the subject areas listed in paragraphs (2) and (3) of this subsection.
 - (1) An RN, in consultation with the other persons described in subsection (c)(2) of this section, must perform the competency evaluation.
 - (2) The RN must observe and evaluate the hospice aide's performance of tasks with a client in the following areas:
 - (A) Communication skills, including the ability to read, write, and verbally report clinical information to clients, caregivers, and other hospice staff;
 - (B) Reading and recording temperature, pulse, and respiration;
 - (C) Appropriate and safe techniques for performing personal hygiene and grooming tasks, including:
 - (i) Bed bath;
 - (ii) Sponge, tub, and shower bath;
 - (iii) Hair shampoo in sink, tub, and bed;
 - (iv) Nail and skin care;
 - (v) Oral hygiene; and
 - (vi) Toileting and elimination;
 - (D) Safe transfer techniques and ambulation; and
 - (E) Normal range of motion and positioning.
 - (3) The RN must evaluate a hospice aide's performance of each of the tasks listed in this paragraph by requiring the aide to submit to a written examination, an oral examination, or by observing the hospice aide's performance with a client. The tasks must include:
 - (A) Observing, reporting, and documenting client status and the care or service provided;
 - (B) Basic infection control procedures;

- (C) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor;
 - (D) Maintaining a clean, safe, and healthy environment;
 - (E) Recognizing emergencies and knowing emergency procedures and their application;
 - (F) The physical, emotional, and developmental needs of and ways to work with the populations served by the hospice, including the need for respect for a client and his or her privacy and property;
 - (G) Adequate nutrition and fluid intake; and
 - (H) Other tasks the hospice may choose to have the hospice aide perform. The hospice must evaluate the competency of a hospice aide, as needed, for skills not listed in paragraph (2)(c) of this subsection.
- (4) A hospice aide has not successfully completed a competency evaluation program if the aide has an unsatisfactory rating in more than one subject area listed in paragraphs (2) and (3) of this subsection.
- (5) If a hospice aide receives an unsatisfactory rating in any of the subject areas listed in paragraphs (2) and (3) of this subsection, the aide must not perform that task without direct supervision by an RN until after:
- (A) The aide receives training in the task for which the aide was evaluated as unsatisfactory; and
 - (B) Successfully completes a subsequent competency evaluation with a satisfactory rating on the task.
- (6) An agency must maintain documentation that its hospice aide competency evaluation program meets the requirements in this subsection. The agency's documentation of a hospice aide's competency evaluation must demonstrate the aide's competency to provide services to a client that exceed the basic skills taught and tested before the aide is assigned to care for a client who requires more complex services.

- (e) A hospice aide must receive at least 12 hours of in-service training during each 12-month period. The agency may provide the 12 hours of in-service training during the 12 month calendar year, or within 12 months after a hospice aide's employment or contract anniversary date.
 - (1) The in-service training must be supervised by an RN.
 - (2) An agency may provide hospice aide in-service training supervised by an RN while the aide is providing care to a client. The RN must document the exact new skill or theory taught in the client's residence and the duration of the training. The in-service training provided in a client's residence must not be a repetition of a hospice aide's competency in a basic skill.
 - (3) An agency must maintain documentation that demonstrates the agency meets the hospice aide in-service training requirements in this subsection.
- (f) An agency that hires or contracts to use a hospice aide who completes a training program and competency evaluation program or a competency evaluation program provided by another agency or a person who is not licensed as an agency must ensure that the programs or program completed comply with the requirements in subsection (c) and (d) of this section.
- (g) A Medicare-certified hospice agency must also comply with 42 CFR §418.76(b) and 42 CFR §418.76(f).

§97.844 Hospice Homemaker Services

- (a) Homemaker services must be provided by a qualified hospice homemaker as described in §97.845 of this subchapter (relating to Hospice Homemaker Qualifications).
- (b) A member of a client's designated interdisciplinary team (IDT) must coordinate and supervise the homemaker services provided and prepare written instructions for the duties a hospice homemaker performs.
- (c) Hospice homemaker services may include assistance in maintaining a safe and healthy environment and services to enable the client and the client's family to carry out the hospice treatment plan. Hospice homemaker services do not include providing personal care or any hands-on services.

- (d) A hospice homemaker must report all concerns about a client or the client's family to the member of the IDT responsible for coordinating the hospice homemaker services.

§97.845 Hospice Homemaker Qualifications

- (a) A hospice must use a qualified hospice homemaker to provide hospice homemaker services. A qualified hospice homemaker is a person who:
 - (1) Successfully completes an agency's hospice orientation and training as specified in subsection (b) of this section; or
 - (2) Is a qualified hospice aide as described in §97.843 of this subchapter (relating to hospice aide qualifications).
- (b) The orientation for a hospice homemaker must address the needs and concerns of a client and a client's family who are coping with a terminal illness. The training for a hospice homemaker must include:
 - (1) Assisting in maintaining a safe and healthy environment for a client and the client's family; and
 - (2) Providing homemaker services to help the client and the client's family to carry out the treatment plan.
- (c) If there is a direct conflict between the requirements of this chapter and federal regulations, the requirements that are more stringent apply to a Medicare-certified hospice agency.

§97.846 Services Provided Under a State Medicaid Personal Care Benefit

- (a) If a client receives services under a state Medicaid personal care benefit, a hospice may use the services provided under the Medicaid personal care benefit to the extent the hospice would routinely use the services of a hospice client's family in implementing the client's plan of care.
- (b) The hospice must coordinate its hospice aide and homemaker services with the Medicaid personal care benefit to ensure that the client receives the hospice aide and homemaker services the client needs.

§97.850 Organization and Administration of Hospice Services

- (a) A hospice must organize, manage, and administer its hospice program to provide hospice care and support services to a client, the client's caregivers, and the client's family that are necessary for the palliation and management of a client's terminal illness and related conditions. A hospice must provide hospice care and support services that:
 - (1) Optimize the client's comfort and dignity; and
 - (2) Are consistent with the client's and the client's family's needs and goals with priority given to the client's needs and goals.
- (b) Hospice services may be provided in the client's residence or independent living environment and, when needed, in a hospice inpatient unit or in a Medicare/Medicaid-certified facility where the hospice makes inpatient care available under arrangement.
- (c) A hospice must be primarily engaged in providing the following care and services and must do so in a manner that is consistent with accepted standards of practice:
 - (1) Physician services;
 - (2) Nursing services;
 - (3) Medical social services;
 - (4) Counseling services, including bereavement, dietary, and spiritual counseling;
 - (5) Physical therapy, occupational therapy, and speech-language pathology services;
 - (6) Hospice aide and hospice homemaker services;
 - (7) Volunteer services;
 - (8) Short-term inpatient care; and
 - (9) Medical supplies and appliances, durable medical equipment, and drugs and biologicals.
- (d) A hospice must make the following services routinely available 24 hours a day, seven days a week:
 - (1) Nursing services;
 - (2) Physician services; and

- (3) Drugs and biologicals.
- (e) A hospice must make the following services available 24 hours a day when reasonable and necessary to meet the client's and the client's family's needs:
 - (1) Medical social services;
 - (2) Counseling services, including bereavement, dietary, and spiritual counseling;
 - (3) Physical therapy, occupational therapy, and speech-language pathology services;
 - (4) Hospice aide and hospice homemaker services;
 - (5) Volunteer services;
 - (6) Short-term inpatient care; and
 - (7) Medical supplies and appliances and durable medical equipment.
- (f) A Medicare-certified hospice may not discontinue or reduce care provided to a Medicare or Medicaid beneficiary because of the beneficiary's inability to pay for the care.

§97.851 Hospice Services Provided by a Licensed Person

- (a) Services provided by a licensed person directly or under contract by a hospice must be authorized, delivered, and supervised only by a qualified licensed person who practices under the hospice's policies and procedures. For the purpose of this section, services provided by a licensed person include skilled nursing care, physical therapy, occupational therapy, speech language pathology, and medical social services.
- (b) A licensed person providing hospice services directly or under contract must:
 - (1) Actively participate in the coordination of all aspects of a client's hospice care, in accordance with accepted standards of practice, including participating in ongoing interdisciplinary comprehensive assessments, developing and evaluating the plan of care, and contributing to client and family counseling and education; and

- (2) Participate in the hospice's quality assessment and performance improvement program and hospice-sponsored in-service training.

§97.852 Hospice Governing Body and Administrator

- (a) The hospice must have a governing body that assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement.
- (b) The governing body must appoint an administrator who:
 - (1) Meets the qualifications and conditions specified in §97.244(a)(1) and (2) of this chapter (relating to Administrator Qualifications and Conditions and Supervising Nurse Qualifications); and
 - (2) Reports to the governing body or persons serving as the governing body.

§97.853 Hospice Infection Control Program

- (a) In addition to the requirements in §97.285 of this chapter (relating to Infection Control), a hospice must maintain an effective infection control program that protects clients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.
- (b) A hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.
- (c) A hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the hospice's quality assessment and performance improvement program. The infection control program must include:
 - (1) A method of identifying infectious and communicable disease problems; and
 - (2) A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.

- (d) A hospice must provide infection control education to employees, volunteers, contract staff, clients, and family members and other caregivers.

§97.854 Hospice Professional Management Responsibility

- (a) A hospice that has a written contract with another agency, person, or organization to furnish services must retain administrative and financial management and oversight of staff and services for all contracted services to ensure the provision of quality care.
- (b) In addition to the requirements in §97.289 of this chapter (relating to Independent Contractors and Arranged Services), a hospice's written contracts must require that all services are:
 - (1) Authorized by the hospice;
 - (2) Furnished in a safe and effective manner by qualified personnel; and
 - (3) Delivered in accordance with a client's plan of care.

§97.855 Criminal Background Checks

- (a) In addition to the requirements in §97.247 of this chapter (relating to Verification of Employability and Use of Unlicensed Persons), a hospice must conduct a criminal history check on all hospice employees and volunteers with direct client contact or access to client records to verify each employee's or volunteer's criminal history report does not include a conviction that bars employment under Texas Health and Safety Code, §250.006, or a conviction that the hospice determines is a contraindication to employment.
- (b) In addition to the requirements in §97.289 of this chapter (relating to Independent Contractors and Arranged Services), hospice contracts to provide inpatient care must require that all contracted entities conduct a criminal history check on contracted staff who have direct client contact or access to client records to verify each contract staff's criminal history report does not include a conviction that bars employment under Texas Health and Safety Code, §250.006.

§97.856 Hospice Alternate Delivery Sites

- (a) If a hospice operates an ADS, the hospice must comply with this section.

- (b) A Medicare-certified hospice agency must have an ADS approved by CMS before providing Medicare-reimbursed hospice services to Medicare clients from the ADS.
- (c) An ADS must be part of the hospice and must share administration, supervision, and services with the parent agency.
- (d) In addition to the requirements in §97.242 of this chapter (relating to Organizational Structure and Lines of Authority), the lines of authority and professional and administrative control must be clearly delineated in the hospice's organizational structure and in practice and must be traced to the parent agency.
- (e) The hospice must continually monitor and manage all services provided by its ADS to ensure that services are delivered in a safe and effective manner and to ensure that a client and the client's family receives the necessary care and services outlined in the plan of care.

§97.857 Hospice Staff Training

In addition to the requirements in §97.245 of this chapter (relating to Staffing Policies), a hospice must:

- (1) Provide orientation about the hospice philosophy to all employees and contracted staff who have client and family contact;
- (2) Provide an initial orientation for an employee that addresses the employee's specific job duties;
- (3) Assess the skills and competence of all persons furnishing care, including volunteers furnishing services, and, as necessary, provide in-service training and education programs where required;
- (4) Have written policies and procedures describing its methods for assessing competency; and
- (5) Maintain a written description of the in-service training provided during the previous 12 months.

§97.858 Hospice Medical Director

- (a) A hospice must designate in writing one physician to serve as its medical director. The medical director must be a doctor of medicine or osteopathy who is an employee or under contract with the hospice. The medical director may also be a volunteer physician under the control of the hospice.

- (b) A hospice must designate in writing a physician designee to assume the same responsibilities and obligations as the medical director when the medical director is not available.
- (c) A hospice may contract for a physician to serve as its medical director with either a self-employed physician or a physician employed by a professional entity or physicians group. The contract for medical director services must specify the name of the physician who assumes the medical director responsibilities and obligations.
- (d) The medical director or physician designee assumes responsibility for the medical component of a hospice's client care program.
- (e) The medical director or physician designee must review a client's clinical information and provide written initial certification that the client's life expectancy is anticipated to be six months or less if the client's terminal illness runs its normal course.
- (f) Before each recertification period for the client, the medical director or physician designee must review the client's clinical information and provide written recertification of the client's terminal illness.
- (g) When determining the client's life expectancy is six months or less, the medical director or physician designee must consider:
 - (1) The primary terminal condition;
 - (2) Related diagnoses, if any;
 - (3) Current subjective and objective medical findings;
 - (4) Current medication and treatment orders; and
 - (5) Information about the medical management of any of the client's conditions unrelated to the terminal illness.

§97.859 Hospice Discharge or Transfer of Care

- (a) If a hospice transfers the care of a client to another facility or agency, the hospice must provide a copy of the hospice discharge summary and, if requested, a copy of the client's record to the receiving facility or agency.
- (b) If a client revokes the election of hospice care, or is discharged by the hospice for any reason listed in subsection (d) of this section, the hospice must provide a copy of the hospice discharge summary and, if requested, a copy of the client's record to the client's attending practitioner.

- (c) A hospice discharge summary must include:
 - (1) A summary of the client's stay, including treatments, symptoms, and pain management;
 - (2) The client's current plan of care;
 - (3) The client's latest physician orders; and
 - (4) Any other documentation needed to assist in post-discharge continuity of care or that is requested by the attending practitioner or receiving facility or agency.
- (d) In addition to the requirements in §97.295 of this chapter (relating to Client Transfer or Discharge Notification Requirements), a hospice may discharge a client if:
 - (1) the client moves out of the hospice's service area or transfers to another hospice;
 - (2) the hospice determines that the client is no longer terminally ill; or
 - (3) the hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause, that the behavior of the client or other person in the client's home is disruptive, abusive, or uncooperative to the extent that delivery of care to the client or the ability of the hospice to operate effectively is seriously impaired.
- (e) Before a hospice seeks to discharge a client for cause, the hospice must:
 - (1) Advise the client that a discharge for cause is being considered;
 - (2) Make a reasonable effort to resolve the problems presented by the client's behavior or situation;
 - (3) Document in the client's record the problems and efforts made by the hospice to resolve the problems; and
 - (4) Ascertain that the client's proposed discharge is not due to the client's use of necessary hospice services.
- (f) Before discharging a client for any reason listed in subsection (d) of this section, the hospice must obtain a written physician's discharge order from the hospice medical director. If the client has an attending practitioner involved in the client's care, the attending practitioner should be consulted before discharge and the practitioner's review and decision should be included in the discharge note.

- (g) A hospice must have a discharge planning process that addresses the possibility that a client's condition might stabilize or otherwise change such that the client cannot continue to be certified as terminally ill. A client's discharge planning must include any necessary family counseling, client education or other services before the hospice discharges the client based on a decision by the hospice medical director or physician designee that the client is no longer terminally ill.

§97.860 Provision of Drugs, Biologicals, Medical Supplies, and Durable Medical Equipment by a Hospice

- (a) While a client is under hospice care, a hospice must provide medical supplies and appliances, durable medical equipment, and drugs and biologicals related to the palliation and management of the terminal illness and related conditions, as identified in the hospice plan of care.
- (b) A hospice must ensure that the interdisciplinary team (IDT) confers with a person with education and training in drug management, as defined in hospice policies and procedures and state law, who is an employee of or under contract with the hospice to ensure that drugs and biologicals meet a client's needs. The hospice must be able to demonstrate that the person has specific education and training in drug management. Persons with education and training in drug management include:
 - (1) A licensed pharmacist, a physician who is board certified in palliative medicine, or a registered nurse (RN) who is certified in palliative care; or
 - (2) A physician, an RN, or an advanced practice nurse who completes a specific hospice or palliative care drug management course.
- (c) A hospice that provides inpatient care directly in its own inpatient unit must provide pharmaceutical services under the direction of a qualified licensed pharmacist who is an employee of or under contract with the hospice. The services provided by the pharmacist must include evaluation of a client's response to medication therapy, identification of potential adverse drug reactions, and recommended appropriate corrective action.
- (d) Only a physician or an advanced practice nurse, in accordance with the plan of care, may order drugs for a client.

- (e) If the drug order is verbal or given by or through electronic transmission:
 - (1) It must be given only to a licensed nurse, pharmacist, or physician; and
 - (2) The person receiving the order must record and sign it immediately and have the prescribing person sign it in accordance with the agency's policies and applicable state and federal regulations.
- (f) A hospice must obtain drugs and biologicals from community or institutional pharmacists or stock drugs and biologicals itself. A hospice that dispenses, stores, and transports drugs must do so in accordance with federal, state and local laws and regulations, as well as the hospice's own policies and procedures. A hospice that operates its own pharmacy must comply with the Texas Occupations Code, Subtitle J, relating to Pharmacy and Pharmacists.
- (g) A hospice that provides inpatient care directly in its own inpatient unit must:
 - (1) Have a written policy in place that promotes dispensing accuracy; and
 - (2) Maintain current and accurate records of the receipt and disposition of all controlled drugs.
- (h) The IDT, as part of the review of the plan of care, must determine the ability of the client or the client's family to safely administer drugs and biologicals to the client in his or her home.
- (i) Clients receiving care in a hospice inpatient unit may only be administered medications by the following persons:
 - (1) A licensed nurse, physician, or other health care professional in accordance with their scope of practice and state law;
 - (2) A home health medication aide; and
 - (3) A client, upon approval by the idt.
- (j) Drugs and biologicals must be labeled in accordance with currently accepted professional practice and must include appropriate usage and cautionary instructions, as well as an expiration date, if applicable.

- (k) A hospice must have written policies and procedures for the management and disposal of controlled drugs in a client's home. The policies and procedures must address the safe use and disposal of controlled drugs in a client's home, including:
 - (1) At the time when controlled drugs are first ordered;
 - (2) When controlled drugs are discontinued;
 - (3) When a new controlled drug is ordered;
 - (4) When the client dies; and
 - (5) The manner for disposing and documenting disposal of controlled drugs in the client's home.
- (l) At the time when controlled drugs are first ordered for use in a client's home, the hospice must:
 - (1) Provide a copy of the hospice's written policies and procedures on the management and disposal of controlled drugs in a client's home to the client or client representative and family;
 - (2) Discuss the hospice policies and procedures for managing the safe use and disposal of controlled drugs with the client or legally authorized representative and the family in a language and manner that they understand to ensure that these parties are educated regarding the safe use and disposal of controlled drugs in the client's home; and
 - (3) Document in the client record that the hospice provided and discussed its written policies and procedures for managing the safe use and disposal of controlled drugs in the client's home.
- (m) A hospice that provides inpatient care directly in its own inpatient unit must dispose of controlled drugs in compliance with the hospice's policy and in accordance with state and federal requirements, including the Texas Health and Safety Code, Chapter 481, Texas Controlled Substances Act. The hospice must maintain current and accurate records of the receipt and disposition of all controlled drugs.
- (n) A hospice that provides inpatient care directly in its own inpatient unit must comply with the following additional requirements:

- (1) All drugs and biologicals must be stored in secure areas. All controlled drugs listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1976 must be stored in locked compartments within such secure storage areas. Only personnel authorized to administer controlled drugs as noted in subsection (i) of this section may have access to the locked compartments.
 - (2) Discrepancies in the acquisition, storage, dispensing, administration, disposal, or return of controlled drugs must be investigated immediately by the pharmacist and hospice administrator and reported to the Director of Controlled Substances Registration in accordance with 37 TAC Chapter 13 (relating to Controlled Substances). A hospice must maintain a written account of its investigation and make it available to state and federal officials if requested.
- (o) A hospice must ensure that manufacturer recommendations for performing routine and preventive maintenance on durable medical equipment are followed. The equipment must be safe and work as intended for use in the client's environment. Where a manufacturer recommendation for a piece of equipment does not exist, the hospice must ensure that repair and routine maintenance policies are developed. The hospice may use persons under contract to ensure the maintenance and repair of durable medical equipment.
 - (p) A hospice must ensure that a client, where appropriate, as well as the family or other caregivers, receive instruction in the safe use of durable medical equipment and supplies. The hospice may use persons under contract to ensure client and family instruction. The client, family, or caregiver must be able to demonstrate the appropriate use of durable medical equipment to the satisfaction of the hospice staff.
 - (q) A hospice may only contract for durable medical equipment services with a durable medical equipment supplier that meets the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies Supplier Quality and Accreditation Standards at 42 CFR §424.57.

§97.861 Hospice Short-term Inpatient Care

- (a) A hospice must make inpatient care available when needed for pain control, symptom management, and respite purposes.
- (b) A hospice must ensure that inpatient care for pain control and symptom management is provided in either:
 - (1) A hospice inpatient unit that meets the additional standards in Division 7 of this subchapter (relating to Hospice Inpatient Units) and the Medicare Conditions of Participation for providing inpatient care directly as specified in 42 CFR §418.110; or
 - (2) A Medicare-certified hospital or skilled nursing facility that also meets:
 - (A) The licensing standards specified in §97.870(b)(1)-(2) of this subchapter (relating to Staffing in a Hospice Inpatient Unit) and §97.871(d)(1)-(4) of this subchapter (relating to Physical Environment in a Hospice Inpatient Unit) regarding 24-hour nursing services and client areas; and
 - (B) The federal Medicare standards specified in 42 CFR §418.110(b) and (e) regarding 24-hour nursing services and patient areas.
- (c) A hospice must ensure that inpatient care for respite purposes is provided either by:
 - (1) A facility specified in subsection (b)(1) or (2) of this section; or
 - (2) A medicare- or medicaid-certified nursing facility that also meets the licensing standards specified in §97.871(d)(1) - (4) of this subchapter regarding client areas and the federal medicare standards specified in 42 cfr §418.110(e) regarding patient areas.
- (d) A facility providing respite care must provide 24-hour nursing services that meet the nursing needs of all clients and are furnished in accordance with each client's plan of care. Each client must receive all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

- (e) In addition to the requirements in §97.289(b) of this chapter (relating to Independent Contractors and Arranged Services), if a hospice has an agreement with a facility to provide for inpatient care, there must be a written contract coordinated by the hospice that specifies:
- (1) That the hospice supplies the facility with a copy of the client's plan of care and specifies the inpatient services to be furnished;
 - (2) That the facility has established client care policies consistent with those of the hospice and agrees to abide by the palliative care protocols and plan of care established by the hospice for its clients;
 - (3) That the facility's clinical record for a hospice client includes documentation of all inpatient services furnished and events regarding care that occurred at the facility;
 - (4) That a copy of the discharge summary be provided to the hospice at the time of discharge;
 - (5) That a copy of the inpatient clinical record is available to the hospice at the time of discharge;
 - (6) That the facility has identified a person within the facility who is responsible for the implementation of the provisions of the agreement;
 - (7) That the hospice retains responsibility for ensuring that the training of personnel who will be providing the client's care in the facility has been provided and that a description of the training and the names of those giving the training are documented; and
 - (8) A method for verifying that the requirements in paragraphs (1) - (7) of this subsection are met.

§97.870 Staffing in a Hospice Inpatient Unit

- (a) A hospice is responsible for staffing its inpatient unit with the numbers and types of qualified, trained, and experienced staff to meet the care needs of every client in the inpatient unit to ensure that plan of care outcomes are achieved and negative outcomes are avoided.

- (b) A hospice inpatient unit must provide 24-hour nursing services that meet the nursing needs of all clients and are furnished in accordance with each client's plan of care.
 - (1) A client must receive all nursing services as prescribed in the plan of care and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.
 - (2) If at least one client in the hospice inpatient unit is receiving general inpatient care for pain control or symptom management, then each shift must include a registered nurse who provides direct client care.
 - (3) A hospice inpatient unit must have a nurse call system. The hospice must install in a client's room a system that:
 - (A) Is equipped with an easily activated, functioning device accessible to the client; and
 - (B) Allows the client to call for assistance from a staff person on the unit.

§97.871 Physical Environment in a Hospice Inpatient Unit

- (a) Safety Management. A hospice inpatient unit must maintain a safe physical environment free of hazards for clients, staff, and visitors.
 - (1) A hospice inpatient unit must address real or potential threats to the health and safety of the clients, others, and property.
 - (2) In addition to §97.256 of this chapter (relating to Emergency Preparedness Planning and Implementation), a hospice inpatient unit must have a written disaster preparedness plan that addresses the core functions of emergency management as described in subparagraphs (A) - (G) of this paragraph. The facility must maintain documentation of compliance with this paragraph.
 - (A) The portion of the plan on direction and control must:
 - (h) Designate a person by position, and at least one alternate, to be in charge during implementation of an emergency response plan, with authority to execute a plan to evacuate or shelter in place;

- (iii) Include procedures the facility will use to maintain continuous leadership and authority in key positions;
 - (iv) Include procedures the facility will use to activate a timely response plan based on the types of disasters identified in the risk assessment;
 - (v) Include procedures the facility will use to meet staffing requirements;
 - (vi) Include procedures the facility will use to warn or notify facility staff about internal and external disasters, including during off hours, weekends, and holidays;
 - (vii) Include procedures the facility will use to maintain a current list of who the hospice will notify once warning of a disaster is received;
 - (viii) Include procedures the facility will use to alert critical facility personnel once a disaster is identified; and
 - (ix) Include procedures the facility will use to maintain a current 24-hour contact list for all personnel.
- (B) The portion of the plan on communication must include procedures:
- (i) For continued communication, including procedures during an evacuation to maintain contact with critical personnel and with all vehicles traveling in an evacuation caravan;
 - (ii) To maintain an accessible, current list of the phone numbers of:
 - I. Client family members;
 - II. Local shelters;
 - III. Prearranged receiving facilities;

- IV. The local emergency management agencies;
 - V. Other health care providers; and
 - VI. State and federal emergency management agencies;
- (iii) To notify staff, clients, families of clients, families of critical staff, prearranged receiving facilities, and others of an evacuation or the plan to shelter in place;
 - (iv) To provide a contact number for out-of-town family members to call for information; and
 - (v) To use the web-based system (facility information, vacancy, and evacuation status), designed for facilities regulated by dads to help each other relocate and track clients during disasters that require mass evacuations.
- (C) The portion of the plan on resource management must include procedures:
- (i) To maintain contracts and agreements with vendors as needed to ensure the availability of the supplies and transportation needed to execute the plan to shelter in place or evacuate;
 - (ii) To develop accurate, detailed, and current checklists of essential supplies, staff, equipment, and medications;
 - (iii) To designate responsibility for completing the checklists during disaster operations;
 - (iv) For the safe and secure transportation of adequate amounts of food, water, medications, and critical supplies and equipment during an evacuation; and
 - (v) To maintain a supply of sufficient resources for at least seven days to shelter in place, which must include:

- I. Emergency power, including backup generators and accounts for maintaining a supply of fuel;
 - II. Potable water in an amount based on population and location;
 - III. The types and amounts of food for the number and types of clients served;
 - IV. Extra pharmacy stocks of common medications; and
 - V. Extra medical supplies and equipment, such as oxygen, linens, and any other vital equipment.
- (D) The portion of the plan on sheltering in place must:
- (i) Be developed using information about the building's construction and Life Safety Code (LSC) systems;
 - (ii) Describe the criteria to be used to decide whether to shelter in place versus evacuate;
 - (iii) Include procedures to assess whether the building is strong enough to withstand the various types of possible disasters and to identify the safest areas of the building;
 - (iv) Include procedures to secure the building against damage;
 - (v) Include procedures for collaborating with the local emergency management agencies regarding the decision to shelter in place;
 - (vi) Include procedures to assign each task in the sheltering plan to facility staff;

- (vii) Describe procedures to shelter in place that allow the facility to maintain 24-hour operations for a minimum of seven days to maintain continuity of care for the number and types of clients served; and
 - (viii) Include procedures to provide for building security.
- (E) The portion of the plan on evacuation must:
- (i) Include contracts with prearranged receiving facilities, including a hospice inpatient facility, skilled nursing facility, nursing facility, assisted living facility, or hospital, with at least one facility located at least 50 miles away;
 - (ii) Include procedures to identify and follow evacuation and alternative routes for transporting clients to a receiving facility and to notify the proper authorities of the decision to evacuate;
 - (iii) Include procedures to protect and transport client records and to match them to each client;
 - (iv) Include procedures to maintain a checklist of items to be transported with clients, including medications and assistive devices, and how the items will be matched to each client;
 - (v) Include staffing procedures the facility will use to ensure that staff accompanies evacuating clients when the hospice transports clients to a receiving facility;
 - (vi) Include procedures to identify and assign staff responsibilities, including how clients will be cared for during evacuations and a backup plan for lack of sufficient staff;
 - (vii) Include procedures facility staff will use to account for all persons in the building

during the evacuation and to track all persons evacuated;

- (viii) Include procedures for the use, protection, and security of the identifying information the facility will use to identify evacuated clients;
 - (ix) Include procedures facility staff will follow if a client becomes ill or dies in route when the hospice transports clients to a receiving facility;
 - (x) Include procedures to make a hospice counselor available when staff accompanies clients during transport by the hospice to a receiving facility;
 - (xi) Include the facility's policy on whether family of staff and clients can shelter at the hospice and evacuate with staff and clients;
 - (xii) Include procedures to coordinate building security with the local emergency management agencies;
 - (xiii) Include procedures facility staff will use to determine when it is safe to return to the geographical area;
 - (xiv) Include procedures facility staff will use to determine if the building is safe for reoccupation; and
 - (xv) Be approved by the local emergency management coordinator (emc) at least annually and when updated.
- (F) The portion of the plan on transportation must:
- (i) Describe how the hospice prearranges for a sufficient number of vehicles to provide suitable, safe transportation for the type and number of clients being served; and
 - (ii) Include procedures to contact the local emc to coordinate the facility's

transportation needs in the event its prearrangements for transportation fail for reasons beyond the facility's control. The hospice may also register its facility with 2-1-1 Texas.

(G) The portion of the plan on training must include:

- (i) Procedures that specify when and how the disaster response plan is reviewed with clients and family members;
- (ii) Procedures to review the role and responsibility of a client able to participate with the plan;
- (iii) Procedures for initial and periodic training for all facility staff to carry out the plan;
- (iv) The frequency for conducting disaster drills and demonstrations to ensure staff are fully trained with respect to their duties under the plan; and
- (v) Procedures to conduct emergency response drills at least annually either in response to an actual disaster or in a planned drill, which may be in addition to or combined with the drills required by the lsc as specified in subsection (c)(1) of this section.

(b) Physical plant and equipment. A hospice must develop procedures for controlling the reliability and quality of:

- (1) The routine storage and prompt disposal of trash and medical waste;
- (2) Light, temperature, and ventilation and air exchanges throughout the hospice inpatient unit;
- (3) Emergency gas and water supply; and
- (4) The scheduled and emergency maintenance and repair of all equipment.

(c) Fire protection. Except as otherwise provided in this subsection:

- (1) A hospice must meet the provisions applicable to the health care occupancy chapters of the 2000 edition of the LSC of the National Fire Protection Association (NFPA). Chapter 19.3.6.3.2, exception number 2 of the 2000 edition of the LSC does not apply to hospices.
- (2) In consideration of a recommendation by DADS, CMS may waive, for periods deemed appropriate, specific provisions of the LSC which if rigidly applied would result in unreasonable hardship for the hospice, but only if the waiver would not adversely affect the health and safety of clients.
- (3) The provisions of the adopted edition of the LSC do not apply in a state if CMS finds that a fire and safety code imposed by state law adequately protects clients in hospices.
- (4) Notwithstanding any provisions of the 2000 edition of the LSC to the contrary, a hospice inpatient unit may place alcohol-based hand rub dispensers in its facility if:
 - (A) Use of alcohol-based hand rub dispensers does not conflict with any state or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;
 - (B) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;
 - (C) The dispensers are installed in a manner that adequately protects against access by vulnerable populations; and
 - (D) The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the LSC, as amended by NFPA temporary interim amendment 00-1(101), issued by the standards council of the national fire protection association on April 15, 2004.
- (d) Client areas. A hospice inpatient unit must provide a home-like atmosphere and ensure that client areas are designed to preserve the dignity, comfort, and privacy of clients. A hospice inpatient unit must provide:
 - (1) Physical space for private client and family visiting;

- (2) Accommodations for family members to remain with the client throughout the night;
 - (3) Physical space for family privacy after a client's death; and
 - (4) The opportunity for the client to receive visitors at any hour, including infants and small children.
- (e) Client rooms. A hospice must ensure that client rooms are designed and equipped for nursing care, as well as the dignity, comfort, and privacy of clients. A hospice must accommodate a client and family request for a single room whenever possible. A client's room must:
 - (1) Be at or above grade level;
 - (2) Contain a suitable bed and other appropriate furniture for the client;
 - (3) Have closet space that provides security and privacy for clothing and personal belongings;
 - (4) Accommodate no more than two clients and their family members; and
 - (5) Provide at least 80 square feet for a client residing in a double room and at least 100 square feet for a client residing in a single room.
- (f) Toilet and bathing facilities. A client room in an inpatient unit must be equipped with, or conveniently located near, toilet and bathing facilities.
- (g) Plumbing facilities. A hospice inpatient unit must:
 - (1) Have an adequate supply of hot water at all times; and
 - (2) Have plumbing fixtures with control valves that automatically regulate the temperature of the hot water used by a client.
- (h) Infection control. A hospice inpatient unit must maintain an infection control program that protects clients, staff, and others by preventing and controlling infections and communicable disease in accordance with §97.853 of this subchapter (relating to Hospice Infection Control Program).

- (i) Sanitary environment. A hospice inpatient unit must provide a sanitary environment by following accepted standards of practice, including nationally recognized infection control precautions, and avoiding sources and transmission of infections and communicable diseases.
- (j) Linen. A hospice inpatient unit must have available at all times a quantity of clean linen in sufficient amounts for a client's use. Linens must be handled, stored, processed, and transported in such a manner as to prevent the spread of contaminants.
- (k) Meal service and menu planning. A hospice inpatient unit must furnish meals to a client that are:
 - (1) Consistent with the client's plan of care, nutritional needs, and therapeutic diet;
 - (2) Palatable, attractive, and served at the proper temperature; and
 - (3) Obtained, stored, prepared, distributed, and served under sanitary conditions.
- (l) Use of restraint or seclusion. A client in a hospice inpatient unit has the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the client, a staff member, or others and must be discontinued at the earliest possible time.
 - (1) Restraint or seclusion may only be used when less restrictive interventions are determined to be ineffective to protect the client, a staff member, or others from harm.
 - (2) The type or technique of restraint or seclusion used must be the least restrictive intervention that is effective to protect the client, a staff member, or others from harm.
 - (3) The use of restraint or seclusion must be:
 - (A) In accordance with a written modification to the client's plan of care; and
 - (B) Implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospice policy.

- (4) The use of restraint or seclusion must be in accordance with the order of a physician authorized to order restraint or seclusion by hospice policy.
- (5) An order for the use of restraint or seclusion must never be written as a standing order or on an as needed basis.
- (6) The medical director or physician designee must be consulted as soon as possible if the attending practitioner did not order the restraint or seclusion.
- (7) An order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the client, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:
 - (A) Four hours for adults 18 years of age or older;
 - (B) Two hours for children and adolescents nine to 17 years of age; or
 - (C) One hour for children under nine years of age.
- (8) After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician authorized to order restraint or seclusion by hospice policy must see and assess the client.
- (9) Each order for restraint used to ensure the physical safety of a non-violent or non-self-destructive client may be renewed as authorized by hospice policy.
- (10) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.
- (11) The condition of the client who is restrained or secluded must be monitored by a physician or trained staff who have completed the training criteria specified in subsection (o) of this section at an interval determined by hospice policy.

- (12) Training requirements for a physician and for an attending practitioner must be specified in hospice policy. At a minimum, a physician and an attending practitioner authorized to order restraint or seclusion by hospice policy must have a working knowledge of hospice policy regarding the use of restraint or seclusion.
- (13) When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the client, a staff member, or others:
 - (A) The client must be seen face-to-face within one hour after the initiation of the intervention by a physician or registered nurse (RN) who has been trained in accordance with the requirements specified in subsection (m) of this section; and
 - (B) The physician or RN must evaluate:
 - (i) The client's immediate situation;
 - (ii) The client's reaction to the intervention;
 - (iii) The client's medical and behavioral condition; and
 - (iv) The need to continue or terminate the restraint or seclusion.
- (14) If the face-to-face evaluation specified in paragraph (13) of this subsection is conducted by a trained RN, the trained RN must consult the medical director or physician designee as soon as possible after the completion of the one-hour face-to-face evaluation.
- (15) All requirements specified under this paragraph are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion is only permitted if the client is continually monitored:
 - (A) Face-to-face by an assigned, trained staff member; or
 - (B) By trained staff using both video and audio equipment. This monitoring must be in close proximity to the client.

- (16) When restraint or seclusion is used, there must be documentation in the client's record of:
 - (A) The one-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior;
 - (B) A description of the client's behavior and the intervention used;
 - (C) Alternatives or other less restrictive interventions attempted, if applicable;
 - (D) The client's condition or symptoms that warranted the use of the restraint or seclusion; and
 - (E) The client's response to the interventions used, including the rationale for continued use of the intervention.
- (m) Restraint or seclusion staff training requirements. A client has the right to safe implementation of restraint or seclusion by trained staff.
 - (1) Client care staff working in the hospice inpatient unit must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a client in restraint or seclusion:
 - (A) Before performing any of the actions specified in paragraph (1) of this subsection;
 - (B) As part of orientation; and
 - (C) Subsequently on a periodic basis consistent with hospice policy.
 - (2) A hospice must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the client population in:
 - (A) Techniques to identify staff and client behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion;

- (B) The use of nonphysical intervention skills;
 - (C) Choosing the least restrictive intervention based on an individualized assessment of the client's medical or behavioral status or condition;
 - (D) The safe application and use of all types of restraint or seclusion used in the hospice, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia);
 - (E) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary;
 - (F) Monitoring the physical and psychological well-being of a client who is restrained or secluded, including but not limited to respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospice policy associated with the one-hour face-to-face evaluation; and
 - (G) The use of first-aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.
- (3) Persons providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address a client's behaviors.
- (4) A hospice must document in the staff personnel records that the training and demonstration of competency were successfully completed.
- (n) Death reporting requirements. A hospice must report deaths associated with the use of seclusion or restraint in its inpatient unit.
- (1) The hospice must report:
 - (A) An unexpected death that occurs while a client is in restraint or seclusion;
 - (B) An unexpected death that occurs within 24 hours after the client has been removed from restraint or seclusion; and

- (C) A death known to the hospice that occurs within one week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to the client's death. The term "reasonable to assume" in this context includes but is not limited to death related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation.
- (2) The hospice must report a death described in paragraph (1) of this subsection to DADS by telephone at 1-800-458-9858 within 24 hours after knowledge of a client's death.
- (3) The hospice must complete Provider Investigation Report For Home and Community Support Services Agency (DADS Form 3613) and send it to DADS Complaint Intake Unit within 10 days after reporting the death to DADS by telephone.
- (4) Hospice personnel must document in the client's record the date and time the death was reported to DADS.

§97.880 Providing Hospice Care to a Resident of a Skilled Nursing Facility, Nursing Facility, or Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions

- (a) Professional management. A hospice must assume responsibility for professional management of the hospice services it provides to a resident of a skilled nursing facility (SNF), nursing facility (NF), or an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID), in accordance with the hospice plan of care. The hospice must make arrangements as necessary for hospice-related inpatient care in a participating Medicare or Medicaid facility in accordance with §97.850 of this subchapter (relating to Organization and Administration of Hospice Services) and §97.861 of this subchapter (relating to Hospice Short-term Inpatient Care).

- (b) Written contract. A hospice and SNF, NF, or ICF/IID must have a written contract that allows the hospice to provide services in the facility. The contract must be signed by an authorized representative of the hospice and the SNF, NF, or ICF/IID before hospice services are provided. In addition to the requirements in §97.289(b) of this chapter (relating to Independent Contractors and Arranged Services), the written contract must include:
- (1) The manner in which the SNF, NF, or ICF/IID and the hospice are to communicate with each other and document such communications to ensure that the needs of a client are addressed and met 24 hours a day;
 - (2) A provision that the SNF, NF, or ICF/IID immediately notifies the hospice of:
 - (A) A significant change in the client's physical, mental, social, or emotional status;
 - (B) Clinical complications that suggest a need to alter the plan of care;
 - (C) The need to transfer the client from the snf, nf, or icf/iid; or
 - (D) The death of a client;
 - (3) A provision stating that if the SNF, NF, or ICF/IID transfers the client from the facility that the hospice makes arrangements for, and remains responsible for, any necessary continuous care or inpatient care related to the terminal illness and related conditions;
 - (4) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided;
 - (5) An agreement that the SNF, NF, or ICF/IID is responsible for furnishing 24-hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home at the same level of care provided before the client elected hospice care;
 - (6) An agreement that the hospice is responsible for providing services at the same level and to the same extent as those services would be provided if the SNF, NF, or ICF/IID resident were in his or her own home;

- (7) A delineation of the hospice's responsibilities, which include providing medical direction and management of the client; nursing; counseling, including spiritual, dietary and bereavement counseling; social work; medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions;
 - (8) A provision that the hospice may use the SNF, NF, or ICF/IID nursing personnel where permitted by state law and as specified by the SNF, NF, or ICF/IID to assist in the administration of prescribed therapies included in the plan of care, only to the extent that the hospice would routinely use the services of a hospice client's family in implementing the plan of care;
 - (9) A provision stating that the hospice must report an alleged violation involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of client property by non-hospice personnel to the SNF, NF, or ICF/IID administrator within 24 hours after the hospice becomes aware of the alleged violation; and
 - (10) A delineation of the responsibilities of the hospice and the SNF, NF, or ICF/IID to provide bereavement services to SNF, NF, or ICF/IID staff.
- (c) Hospice plan of care. In accordance with §97.821 of this subchapter (relating to Hospice Plan of Care), a written hospice plan of care must be established and maintained in consultation with SNF, NF, or ICF/IID representatives. Hospice care must be provided in accordance with the hospice plan of care.
- (1) A hospice plan of care must identify the care and services needed to care for the client and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care.

- (2) A hospice plan of care must reflect the participation of the hospice, representatives of the SNF, NF, or ICF/IID, and the client and family to the extent possible.
 - (3) Any changes in the hospice plan of care must be discussed with the client or the client's legally authorized representative, and SNF, NF, or ICF/IID representatives, and must be approved by the hospice before implementation.
- (d) Coordination of services. In addition to the requirements in §97.288 of this chapter (relating to Coordination of Services) and §97.823 of this subchapter (relating to Coordination of Services by the Hospice), a hospice must:
- (1) Designate a member of each interdisciplinary team (IDT) that is responsible for a client who is a resident of a SNF, NF, or ICF/IID who is responsible for:
 - (A) Providing overall coordination of the hospice care of the SNF, NF, or ICF/IID resident with SNF, NF, or ICF/IID representatives; and
 - (B) Communicating with SNF, NF, or ICF/IID representatives and other health care providers participating in the provision of care for the terminal illness and related conditions and other conditions to ensure quality of care for the client and family; and
 - (2) Ensure that the hospice IDT communicates with the SNF, NF, or ICF/IID medical director, the client's attending practitioner, and other physicians participating in the provision of care to the client as needed to coordinate hospice care with medical care provided by other physicians; and
 - (3) Provide the SNF, NF, or ICF/IID with:
 - (A) The most recent hospice plan of care specific to the client;
 - (B) The hospice election form and any advance directives specific to the client;
 - (C) Physician certification and recertification of the terminal illness specific to the client;

- (D) Names and contact information for hospice personnel involved in hospice care of the client;
 - (E) Instructions on how to access the hospice's 24-hour on-call system;
 - (F) Hospice medication information specific to the client; and
 - (G) Hospice physician and, if any, attending practitioner orders specific to the client.
- (e) Orientation and training of staff. Hospice personnel must assure that SNF, NF or ICF/IID staff who provide care to the hospice's clients have been oriented and trained in the hospice philosophy, including the hospice's policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, how a person may respond to death, the hospice's client rights, the hospice's forms, and the hospice's record keeping requirements.

Texas Department of Aging and Disability Services

Denial or Refusal of License

Revision: 12-1

§99.1 Definitions

In this chapter, facility means:

- 1) A nursing home licensed under Chapter 242 of the Texas Health and Safety Code;
- 2) An assisted living facility licensed under Chapter 247 of the Texas Health and Safety Code;
- 3) A home and community support services agency licensed under Chapter 142 of the Texas Health and Safety Code;
- 4) An adult day care facility licensed under Chapter 103 of the Texas Human Resources Code; or
- 5) An intermediate care facility for persons with mental retardation licensed under Chapter 252 of the Texas Health and Safety Code.

§99.2 Convictions Barring Licensure

- a) The Department of Aging and Disability Services (DADS) may deny an initial facility license, or refuse to renew a facility license, if an applicant for a license, a license holder, or any other person whose criminal history must be verified before a license is issued:
 - 1) Has been convicted, regardless of the date of conviction, of any of the following misdemeanor or felony offenses:
 - A) An offense listed in Texas Health and Safety Code, §250.006(a) or (c) (relating to Convictions Barring Employment);
 - B) An offense relating to the practice of a health-related profession without a license;
 - C) An offense relating to drugs, dangerous drugs, or controlled substances; or
 - D) An offense under any of the following sections of the Texas Penal Code:
 - i) Section 22.015, Coercing, soliciting, or inducing gang membership;
 - ii) Section 22.09, Tampering with consumer product;

- iii) Section 22.10, Leaving a child in a vehicle;
- iv) Section 32.42, Deceptive business practices;
- v) Section 32.51, Fraudulent use or possession of identifying information;
- vi) Section 35.02, Insurance fraud;
- vii) Section 42.072, Stalking;
- viii) Section 42.10, Dog fighting;
- ix) Section 43.05, Compelling prostitution;
- x) Section 43.24, Sale, distribution, or display of harmful material to minor;
- xi) Section 43.25, Sexual performance by a child;
- xii) Section 43.251, Employment harmful to children;
- xiii) Section 43.26, Possession or promotion of child pornography;
- xiv) Section 46.06, Unlawful transfer of certain weapons;
- xv) Section 46.13, Making a firearm accessible to a child;
- xvi) Section 48.02, Prohibition of the purchase and sale of human organs;
- xvii) Section 49.07, Intoxication assault; or
- xviii) Section 49.08, Intoxication manslaughter; or

2) Has been convicted, during the five years preceding the date of the facility license application, of any of the following misdemeanor or felony offenses:

- A) An offense listed in Texas Health and Safety Code, §250.006(b); or
- B) An offense under any of the following sections of the Texas Penal Code:
 - i) Section 30.03, Burglary of coin-operated or coin collection machines;
 - ii) Section 30.04, Burglary of vehicles;

- iii) Section 31.03, Theft;
 - iv) Section 31.04, Theft of service;
 - v) Section 32.21, Forgery;
 - vi) Section 32.31, Credit card or debit card abuse;
 - vii) Section 32.33, Hindering secured creditors;
 - viii) Section 32.48, Simulating legal process;
 - ix) Section 33.02, Breach of computer security;
 - x) Section 42.061, Silent or abusive calls to 9-1-1 service;
 - xi) Section 42.07, Harassment; or
 - xii) Section 42.091, Attack on assistance animal.
- b) DADS may revoke a facility license if DADS becomes aware of:
 - 1) A conviction described in subsection (a)(1) of this section regardless of the date of the conviction; or
 - 2) A conviction described in subsection (a)(2) of this section if the conviction occurred during the five years preceding the date DADS became aware of the conviction.
- c) DADS considers a conviction of an offense under the laws of another state, federal law, or the Uniform Code of Military Justice containing elements that are substantially similar to the elements of an offense listed in subsection (a) of this section as if it is a conviction of one of the listed offenses.
- d) DADS considers the following information when deciding if it will deny a facility license, refuse to renew a facility license, or revoke a facility license in accordance with this section:
 - 1) The nature and seriousness of the offense;
 - 2) The relationship of the offense to the operation of a facility;
 - 3) The extent to which a license might offer an opportunity for the person to engage in activity similar to the offense;
 - 4) The age of the person at the time of the offense;

- 5) The amount of time since the offense; and
 - 6) Any other information provided by the person to explain the circumstances of the offense or to evidence the person's conduct since the offense.
- e) For purposes of this section, a person who is placed on deferred adjudication community supervision for an offense listed in this section, successfully completes the period of deferred adjudication community supervision, and receives a dismissal and discharge in accordance with Section 5(c), Article 42.12, Code of Criminal Procedure, is not considered convicted of the offense for which the person received deferred adjudication community supervision.

§99.3 Adverse Licensing Record

DADS may deny an application for a license or refuse to renew a license if:

- 1) Any of the following persons are listed in a record maintained by a health and human services agency under Texas Government Code §531.952:
 - A) The applicant or license holder;
 - B) A person listed on an initial or renewal application; or
 - C) A controlling person of the applicant or license holder; and
- (2) The agency's action that resulted in the person being listed in a record maintained under Texas Government Code §531.952 is based on:
 - A) An act or omission that resulted in physical or mental harm to an individual in the care of the person;
 - B) A threat to the health, safety, or well-being of an individual in the care of the person;
 - C) The physical, mental, or financial exploitation of an individual in the care of the person; or
 - D) A determination by the agency that the person has committed an act or omission that renders the person unqualified or unfit to fulfill the obligations of the license, listing, or registration.

Chapter 142. Home and Community Support Services

Subchapter A. Home and Community Support Services License

Sec. 142.001 Definitions.

In this chapter:

- 1) "Administrative support site" means a facility or site where a home and community support services agency performs administrative and other support functions but does not provide direct home health, hospice, or personal assistance services.
- 2) "Alternate delivery site" means a facility or site, including a residential unit or an inpatient unit:
 - A) That is owned or operated by a hospice;
 - B) That is not the hospice's principal place of business;
 - C) That is located in the geographical area served by the hospice; and
 - D) From which the hospice provides hospice services.
- 3) "Bereavement" means the process by which a survivor of a deceased person mourns and experiences grief.
- 4) "Bereavement services" means support services offered to a family during bereavement.
- 5) "Branch office" means a facility or site in the geographical area served by a home and community support agency where home health or personal assistance services are delivered or active client records are maintained.
- 6) "Certified agency" means a home and community support services agency, or a portion of the agency, that:
 - (A) Provides a home health service; and
 - (B) Is certified by an official of the Department of Health and Human Services as in compliance with conditions of participation in Title XVIII, Social Security Act (42 U.S.C. Section 1395 et seq.).
- 7) "Certified home health services" means home health services that are provided by a certified agency.

- 8) "Chief financial officer" means an individual who is responsible for supervising and managing all financial activities for a home and community support services agency.
- 9) "Controlling person" means a person who controls a home and community support services agency or other person as described by Section 142.0012.
- 10) "Council" means the Home and Community Support Services Advisory Council.
- 11) "Counselor" means an individual qualified under Medicare standards to provide counseling services, including bereavement, dietary, spiritual, and other counseling services, to both the client and the family.
- 11-a) "Department" means the Department of Aging and Disability Services.
- 11-b) "Executive commissioner" means the executive commissioner of the Health and Human Services Commission.
- 12) "Home and community support services agency" means a person who provides home health, hospice, or personal assistance services for pay or other consideration in a client's residence, an independent living environment, or another appropriate location.
- 12-a) "Home and community support services agency administrator" or "administrator" means the person who is responsible for implementing and supervising the administrative policies and operations of the home and community support services agency and for administratively supervising the provision of all services to agency clients on a day-to-day basis.
- 13) "Home health service" means the provision of one or more of the following health services required by an individual in a residence or independent living environment:
 - (A) Nursing, including blood pressure monitoring and diabetes treatment;
 - (B) Physical, occupational, speech, or respiratory therapy;
 - (C) Medical social service;

- (D) Intravenous therapy;
 - (E) Dialysis;
 - (F) Service provided by unlicensed personnel under the delegation or supervision of a licensed health professional;
 - (G) The furnishing of medical equipment and supplies, excluding drugs and medicines; or
 - (H) Nutritional counseling.
- 14) "Hospice" means a person licensed under this chapter to provide hospice services, including a person who owns or operates a residential unit or an inpatient unit.
- 15) "Hospice services" means services, including services provided by unlicensed personnel under the delegation of a registered nurse or physical therapist, provided to a client or a client's family as part of a coordinated program consistent with the standards and rules adopted under this chapter. These services include palliative care for terminally ill clients and support services for clients and their families that:
- (A) Are available 24 hours a day, seven days a week, during the last stages of illness, during death, and during bereavement;
 - (B) Are provided by a medically directed interdisciplinary team; and
 - (C) May be provided in a home, nursing home, residential unit, or inpatient unit according to need. These services do not include inpatient care normally provided in a licensed hospital to a terminally ill person who has not elected to be a hospice client.
- 16) "Inpatient unit" means a facility that provides a continuum of medical or nursing care and other hospice services to clients admitted into the unit and that is in compliance with:
- (A) The conditions of participation for inpatient units adopted under Title XVIII, Social Security Act (42 U.S.C. Section 1395 et seq.); and
 - (B) Standards adopted under this chapter.

- 17) "Independent living environment" means:
- (A) A client's individual residence, which may include a group home or foster home; or
 - (B) Other settings where a client participates in activities, including school, work, or church.
- 18) "Interdisciplinary team" means a group of individuals who work together in a coordinated manner to provide hospice services and must include a physician, registered nurse, social worker, and counselor.
- 19) "Investigation" means an inspection or survey conducted by a representative of the department to determine if a licensee is in compliance with this chapter.
- 20) "Palliative care" means intervention services that focus primarily on the reduction or abatement of physical, psychosocial, and spiritual symptoms of a terminal illness.
- 21) "Person" means an individual, corporation, or association.
- 22) "Personal assistance service" means routine ongoing care or services required by an individual in a residence or independent living environment that enable the individual to engage in the activities of daily living or to perform the physical functions required for independent living, including respite services. The term includes:
- (A) Personal care;
 - (B) Health-related services performed under circumstances that are defined as not constituting the practice of professional nursing by the Texas Board of Nursing through a memorandum of understanding with the department in accordance with Section 142.016; and
 - (C) Health-related tasks provided by unlicensed personnel under the delegation of a registered nurse or that a registered nurse determines do not require delegation.
- 22-a) "Personal care" means the provision of one or more of the following services required by an individual in a residence or independent living environment:
- (A) Bathing;

- (B) Dressing;
 - (C) Grooming;
 - (D) Feeding;
 - (E) Exercising;
 - (F) Toileting;
 - (G) Positioning;
 - (H) Assisting with self-administered medications;
 - (I) Routine hair and skin care; and
 - (J) Transfer or ambulation.
- 23) "Place of business" means an office of a home and community support services agency that maintains client records or directs home health, hospice, or personal assistance services. The term does not include an administrative support site.
- 24) "Residence" means a place where a person resides and includes a home, a nursing home, a convalescent home, or a residential unit.
- 25) "Residential unit" means a facility that provides living quarters and hospice services to clients admitted into the unit and that is in compliance with standards adopted under this chapter.
- 26) "Respite services" means support options that are provided temporarily for the purpose of relief for a primary caregiver in providing care to individuals of all ages with disabilities or at risk of abuse or neglect.
- 27) "Social worker" means an individual licensed as a social worker under Chapter 505, Occupations Code.
- 28) "Support services" means social, spiritual, and emotional care provided to a client and a client's family by a hospice.
- 29) "Terminal illness" means an illness for which there is a limited prognosis if the illness runs its usual course.
- 30) "Volunteer" means an individual who provides assistance to a home and community support services agency without compensation other than reimbursement for actual expenses.

Sec. 142.0011. Scope, Purpose, and Implementation.

- a) The purpose of this chapter is to ensure that home and community support services agencies in this state deliver the highest possible quality of care. This chapter and the rules adopted under this chapter establish minimum standards for acceptable quality of care, and a violation of a minimum standard established or adopted under this chapter is a violation of law. For purposes of this chapter, components of quality of care include:
 - 1) Client independence and self-determination;
 - 2) Humane treatment;
 - 3) Continuity of care;
 - 4) Coordination of services;
 - 5) Professionalism of service providers;
 - 6) Quality of life; and
 - 7) Client satisfaction with services.
- b) The department shall protect clients of home and community support services agencies by regulating those agencies and:
 - 1) Adopting rules relating to quality of care and quality of life;
 - 2) Strictly monitoring factors relating to the health, safety, welfare, and dignity of each client;
 - 3) Imposing prompt and effective remedies for violations of this chapter and rules and standards adopted under this chapter;
 - 4) Enabling agencies to provide services that allow clients to maintain the highest possible degree of independence and self-determination; and
 - 5) Providing the public with helpful and understandable information relating to agencies in this state.

Sec. 142.0012. Controlling Person.

- a) A person is a controlling person if the person, acting alone or with others, has the ability to directly or indirectly influence, direct, or cause the direction of the management, expenditure of money, or policies of a home and community support services agency or other person.

- b) For purposes of this chapter, "controlling person" includes:
- 1) A management company or other business entity that operates or contracts with others for the operation of a home and community support services agency;
 - 2) A person who is a controlling person of a management company or other business entity that operates a home and community support services agency or that contracts with another person for the operation of a home and community support services agency; and
 - 3) Any other individual who, because of a personal, familial, or other relationship with the owner, manager, or provider of a home and community support services agency, is in a position of actual control or authority with respect to the agency, without regard to whether the individual is formally named as an owner, manager, director, officer, provider, consultant, contractor, or employee of the agency.
- c) A controlling person described by Subsection (b)(3) does not include an employee, lender, secured creditor, or other person who does not exercise formal or actual influence or control over the operation of a home and community support services agency.
- d) The department may adopt rules that specify the ownership interests and other relationships that qualify a person as a controlling person.

Sec. 142.002. License Required.

- a) Except as provided by Section 142.003, a person, including a health care facility licensed under this code, may not engage in the business of providing home health, hospice, or personal assistance services, or represent to the public that the person is a provider of home health, hospice, or personal assistance services for pay without a home and community support services agency license authorizing the person to perform those services issued by the department for each place of business from which home health, hospice, or personal assistance services are directed. A certified agency must have a license to provide certified home health services.

- b) A person who is not licensed to provide home health services under this chapter may not indicate or imply that the person is licensed to provide home health services by the use of the words "home health services" or in any other manner.
- c) A person who is not licensed to provide hospice services under this chapter may not use the word "hospice" in a title or description of a facility, organization, program, service provider, or services or use any other words, letters, abbreviations, or insignia indicating or implying that the person holds a license to provide hospice services under this chapter.
- d) A license to provide hospice services issued under this chapter authorizes a hospice to own or operate a residential unit or inpatient unit at the licensed site in compliance with the standards and rules adopted under this chapter.
- e) A license issued under this chapter may not be transferred to another person, but may be transferred from one location to another location. A change of ownership or location shall be reported to the department.
- f) A person who is not licensed to provide personal assistance services under this chapter may not indicate or imply that the person is licensed to provide personal assistance services by the use of the words "personal assistance services" or in any other manner.

Sec. 142.0025. Temporary License.

If a person is in the process of becoming certified by the United States Department of Health and Human Services to qualify as a certified agency, the department may issue a temporary home and community support services agency license to the person authorizing the person to provide certified home health services. A temporary license is effective as provided by rules adopted by the executive commissioner.

Sec. 142.003. Exemptions from Licensing Requirement.

- a) The following persons need not be licensed under this chapter:
 - 1) A physician, dentist, registered nurse, occupational therapist, or physical therapist licensed under the laws of this state who provides home health services to a client only as a part of an incidental to that person's private office practice;

- 2) A registered nurse, licensed vocational nurse, physical therapist, occupational therapist, speech therapist, medical social worker, or any other health care professional as determined by the department who provides home health services as a sole practitioner;
- 3) A registry that operates solely as a clearinghouse to put consumers in contact with persons who provide home health, hospice, or personal assistance services and that does not maintain official client records, direct client services, or compensate the person who is providing the service;
- 4) An individual whose permanent residence is in the client's residence;
- 5) An employee of a person licensed under this chapter who provides home health, hospice, or personal assistance services only as an employee of the license holder and who receives no benefit for providing the services, other than wages from the license holder;
- 6) A home, nursing home, convalescent home, assisted living facility, special care facility, or other institution for individuals who are elderly or who have disabilities that provides home health or personal assistance services only to residents of the home or institution;
- 7) A person who provides one health service through a contract with a person licensed under this chapter;
- 8) A durable medical equipment supply company;
- 9) A pharmacy or wholesale medical supply company that does not furnish services, other than supplies, to a person at the person's house;
- 10) A hospital or other licensed health care facility that provides home health or personal assistance services only to inpatient residents of the hospital or facility;
- 11) A person providing home health or personal assistance services to an injured employee under Title 5, Labor Code;
- 12) A visiting nurse service that:

- A) Is conducted by and for the adherents of a well-recognized church or religious denomination; and
 - B) Provides nursing services by a person exempt from licensing by Section 301.004, Occupations Code, because the person furnishes nursing care in which treatment is only by prayer or spiritual means;
- 13) An individual hired and paid directly by the client or the client's family or legal guardian to provide home health or personal assistance services;
 - 14) Business, school, camp, or other organization that provides home health or personal assistance services, incidental to the organization's primary purpose, to individuals employed by or participating in programs offered by the business, school, or camp that enable the individual to participate fully in the business's, school's, or camp's programs;
 - 15) A person or organization providing sitter-companion services or chore or household services that do not involve personal care, health, or health-related services;
 - 16) A licensed health care facility that provides hospice services under a contract with a hospice;
 - 17) A person delivering residential acquired immune deficiency syndrome hospice care who is licensed and designated as a residential AIDS hospice under Chapter 248;
 - 18) The Texas Department of Criminal Justice;
 - 19) A person that provides home health, hospice, or personal assistance services only to persons enrolled in a program funded wholly or partly by the Texas Department of Mental Health and Mental Retardation and monitored by the Texas Department of Mental Health and Mental Retardation or its designated local authority in accordance with standards set by the Texas Department of Mental Health and Mental Retardation; or

- 20) An individual who provides home health or personal assistance services as the employee of a consumer or an entity or employee of an entity acting as a consumer's fiscal agent under Section 531.051, Government Code.
- b) A home and community support services agency that owns or operates an administrative support site is not required to obtain a separate license under this chapter for the administrative support site.
- c) A hospice that operates or provides hospice services to an inpatient unit under a contract with a licensed health care facility is not required to obtain an alternate delivery site license for that inpatient unit.

Sec. 142.004. License Application.

- a) An applicant for a license to provide home health, hospice, or personal assistance services must:
 - 1) File a written application on a form prescribed by the department indicating the type of service the applicant wishes to provide;
 - 2) Cooperate with any surveys required by the department for a license; and
 - 3) Pay the license fee prescribed by this chapter.
- b) In addition to the requirements of Subsection (a), if the applicant is a certified agency when the application for a license to provide certified home health services is filed, the applicant must maintain its Medicare certification. If the applicant is not a certified agency when the application for a license to provide certified home health services is filed, the applicant must establish that it is in the process of receiving its certification from the United States Department of Health and Human Services.
- c) The board by rule shall require that, at a minimum, before the department may approve a license application, the applicant must provide to the department:
 - 1) Documentation establishing that, at a minimum, the applicant has sufficient financial resources to provide the services required by this chapter and by the department during the term of the license;

- 2) A list of the management personnel for the proposed home and community support services agency, a description of personnel qualifications, and a plan for providing continuing training and education for the personnel during the term of the license;
 - 3) Documentation establishing that the applicant is capable of meeting the minimum standards established by the board relating to the quality of care;
 - 4) A plan that provides for the orderly transfer of care of the applicant's clients if the applicant cannot maintain or deliver home health, hospice, or personal assistance services under the license;
 - 5) Identifying information on the home and community support services agency owner, administrator, and chief financial officer to enable the department to conduct criminal background checks on those persons;
 - 6) Identification of any controlling person with respect to the applicant; and
 - 7) Documentation relating to any controlling person identified under Subdivision (6), if requested by the department and relevant to the controlling person's compliance with any applicable licensing standard required or adopted by the board under this chapter.
- d) Information received by the department relating to the competence and financial resources of the applicant or a controlling person with respect to the applicant is confidential and may not be disclosed to the public.
- e) A home and community support services agency owned or operated by a state agency directly providing services is not required to provide the information described in Subsections (c)(1) and (5).
- f) The department shall evaluate and consider all information collected during the application process.

Sec. 142.005. Compliance Record in Other States.

The department may require an applicant or license holder to provide the department with information relating to compliance by the applicant, the license holder, or a controlling person with respect to the applicant or license holder with regulatory requirements in any other state in which the applicant, license holder, or controlling person operates or operated a home and community support services agency.

Sec. 142.006. License Issuance; Term.

- a) The department shall issue a home and community support services agency license to provide home health, hospice, or personal assistance services for each place of business to an applicant if:
 - 1) The applicant:
 - A) Qualifies for the license to provide the type of service that is to be offered by the applicant;
 - B) Submits an application and license fee as required by this chapter; and
 - C) Complies with all applicable licensing standards required or adopted by the board under this chapter; and
 - 2) Any controlling person with respect to the applicant complies with all applicable licensing standards required or adopted by the board under this chapter.
- b) A license issued under this chapter expires two years after the date of issuance. The executive commissioner of the Health and Human Services Commission by rule may adopt a system under which licenses expire on various dates during the two-year period. For the year in which a license expiration date is changed, the department shall prorate the license fee on a monthly basis. Each license holder shall pay only that portion of the license fee allocable to the number of months for which the license is valid. A license holder shall pay the total license renewal fee at the time of renewal. The department may issue an initial license for a shorter term to conform expiration dates for a locality or an applicant. The department may issue a temporary license to an applicant for an initial license.
- c) The department may find that a home and community support services agency has satisfied the requirements for licensing if the agency is accredited by an accreditation organization, such as the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, and the department finds that the accreditation organization has standards that meet or exceed the requirements for licensing under this chapter. A license fee is required of the home and community support services agency at the time of a license application.

d) to f) Repealed by Acts 2003, 78th Leg., ch. 198, Sec. 2.156(a)(1).

- g) The license must designate the types of services that the home and community support services agency is authorized to provide at or from the designated place of business.

Sec. 142.0061. Possession of Sterile Water or Saline.

A home and community support services agency or its employees who are registered nurses or licensed vocational nurses may purchase, store, or transport for the purpose of administering to their home health or hospice patients under physician's orders:

- (1) sterile water for injection and irrigation; and
- (2) sterile saline for injection and irrigation.

Sec. 142.0062. Possession of Certain Vaccines or Tuberculin.

- (a) A home and community support services agency or its employees who are registered nurses or licensed vocational nurses may purchase, store, or transport for the purpose of administering to the agency's employees, home health or hospice patients, or patient family members under physician's standing orders the following dangerous drugs:

- (1) hepatitis B vaccine;
- (2) influenza vaccine;
- (3) tuberculin purified protein derivative for tuberculosis testing; and
- (4) pneumococcal polysaccharide vaccine.

- (b) A home and community support services agency that purchases, stores, or transports a vaccine or tuberculin under this section shall ensure that any standing order for the vaccine or tuberculin:

- (1) is signed and dated by the physician;
- (2) identifies the vaccine or tuberculin covered by the order;
- (3) indicates that the recipient of the vaccine or tuberculin has been assessed as an appropriate candidate to receive the vaccine or tuberculin and has been assessed for the absence of any contraindication;
- (4) indicates that appropriate procedures are established for responding to any negative reaction to the vaccine or tuberculin; and

- (5) orders that a specific medication or category of medication be administered if the recipient has a negative reaction to the vaccine or tuberculin.

Sec. 142.0063. Possession of Certain Dangerous Drugs.

- (a) A home and community support services agency in compliance with this section or its employees who are registered nurses or licensed vocational nurses may purchase, store, or transport for the purpose of administering to their home health or hospice patients in accordance with Subsection (c) the following dangerous drugs:
 - (1) any of the following items in a sealed portable container of a size determined by the dispensing pharmacist:
 - (A) 1,000 milliliters of 0.9 percent sodium chloride intravenous infusion;
 - (B) 1,000 milliliters of five percent dextrose in water injection; or
 - (C) sterile saline; or
 - (2) not more than five dosage units of any of the following items in an individually sealed, unused portable container:
 - (A) heparin sodium lock flush in a concentration of 10 units per milliliter or 100 units per milliliter;
 - (B) epinephrine HCl solution in a concentration of 1 to 1,000;
 - (C) diphenhydramine HCl solution in a concentration of 50 milligrams per milliliter;
 - (D) methylprednisolone in a concentration of 125 milligrams per two milliliters;
 - (E) naloxone in a concentration of one milligram per milliliter in a two-milliliter vial;
 - (F) promethazine in a concentration of 25 milligrams per milliliter;
 - (G) glucagon in a concentration of one milligram per milliliter;
 - (H) furosemide in a concentration of 10 milligrams per milliliter;

- (I) lidocaine 2.5 percent and prilocaine 2.5 percent cream in a five-gram tube; or
 - (J) lidocaine HCl solution in a concentration of one percent in a two-milliliter vial.
- (b) A home and community support services agency or the agency's authorized employees may purchase, store, or transport dangerous drugs in a sealed portable container under this section only if the agency has established policies and procedures to ensure that:
 - (1) the container is handled properly with respect to storage, transportation, and temperature stability;
 - (2) a drug is removed from the container only on a physician's written or oral order;
 - (3) the administration of any drug in the container is performed in accordance with a specific treatment protocol; and
 - (4) the agency maintains a written record of the dates and times the container is in the possession of a registered nurse or licensed vocational nurse.
- (c) A home and community support services agency or the agency's authorized employee who administers a drug listed in Subsection (a) may administer the drug only in the patient's residence under physician's orders in connection with the provision of emergency treatment or the adjustment of:
 - (1) parenteral drug therapy; or
 - (2) vaccine or tuberculin administration.
- (d) If a home and community support services agency or the agency's authorized employee administers a drug listed in Subsection (a) pursuant to a physician's oral order, the physician shall promptly send a signed copy of the order to the agency, and the agency shall:
 - (1) not later than 24 hours after receipt of the order, reduce the order to written form and send a copy of the form to the dispensing pharmacy by mail or facsimile transmission; and

- (2) not later than 20 days after receipt of the order, send a copy of the order as signed by and received from the physician to the dispensing pharmacy.
- (e) A pharmacist that dispenses a sealed portable container under this section shall ensure that the container:
 - (1) is designed to allow access to the contents of the container only if a tamper-proof seal is broken;
 - (2) bears a label that lists the drugs in the container and provides notice of the container's expiration date, which is the earlier of:
 - (A) the date that is six months after the date on which the container is dispensed; or
 - (B) the earliest expiration date of any drug in the container; and
 - (3) remains in the pharmacy or under the control of a pharmacist, registered nurse, or licensed vocational nurse.
- (f) If a home and community support services agency or the agency's authorized employee purchases, stores, or transports a sealed portable container under this section, the agency shall deliver the container to the dispensing pharmacy for verification of drug quality, quantity, integrity, and expiration dates not later than the earlier of:
 - (1) the seventh day after the date on which the seal on the container is broken; or
 - (2) the date for which notice is provided on the container label.
- (g) A pharmacy that dispenses a sealed portable container under this section shall take reasonable precautionary measures to ensure that the home and community support services agency receiving the container complies with Subsection (f). On receipt of a container under Subsection (f), the pharmacy shall perform an inventory of the drugs used from the container and shall restock and reseal the container before delivering the container to the agency for reuse.

Sec. 142.0065. Display of License.

A license issued under this chapter shall be displayed in a conspicuous place in the designated place of business and must show:

- (1) the name and address of the licensee;
- (2) the name of the owner or owners, if different from the information provided under Subdivision (1);
- (3) the license expiration date; and
- (4) the types of services authorized to be provided under the license.

Sec. 142.007. Notice of Drug Testing Policy.

An agency licensed under this chapter shall provide to the following persons a written statement describing the agency's policy for the drug testing of employees who have direct contact with clients:

- (1) each person applying for services from the agency; and
- (2) any person requesting the information.

Sec. 142.008. Branch Office.

- (a) The department may issue a branch office license to a person who holds a license to provide home health or personal assistance services.
- (b) The board by rule shall establish eligibility requirements for a branch office license.
- (c) A branch office license expires on the same date as the license to provide home health or personal assistance services held by the applicant for the branch office license.

Sec. 142.0085. Alternate Delivery Site License.

- (a) The department shall issue an alternate delivery site license to a qualified hospice.
- (b) The board by rule shall establish standards required for the issuance of an alternate delivery site license.
- (c) An alternate delivery site license expires on the same date as the license to provide hospice services held by the hospice.

Sec. 142.009. Surveys; Consumer Complaints.

- (a) The department or its representative may enter the premises of a license applicant or license holder at reasonable times to conduct a survey incidental to the issuance of a license and at other times as the department considers necessary to ensure compliance with this chapter and the rules adopted under this chapter.
- (a-1) A license applicant or license holder must provide the department representative conducting the survey with a reasonable and safe workspace at the premises. The executive commissioner may adopt rules to implement this subsection.
- (b) A home and community support services agency shall provide each person who receives home health, hospice, or personal assistance services with a written statement that contains the name, address, and telephone number of the department and a statement that informs the recipient that a complaint against a home and community support services agency may be directed to the department.
- (c) The department or its authorized representative shall investigate each complaint received regarding the provision of home health, hospice, or personal assistance services, including any allegation of abuse, neglect, or exploitation of a child under the age of 18, and may, as a part of the investigation:
 - (1) Conduct an unannounced survey of a place of business, including an inspection of medical and personnel records, if the department has reasonable cause to believe that the place of business is in violation of this chapter or a rule adopted under this chapter;
 - (2) Conduct an interview with a recipient of home health, hospice, or personal assistance services, which may be conducted in the recipient's home if the recipient consents;
 - (3) Conduct an interview with a family member of a recipient of home health, hospice, or personal assistance services who is deceased or other person who may have knowledge of the care received by the deceased recipient of the home health, hospice, or personal assistance services; or

- (4) Interview a physician or other health care practitioner, including a member of the personnel of a home and community support services agency, who cares for a recipient of home health, hospice, or personal assistance services.
- (d) The reports, records, and working papers used or developed in an investigation made under this section are confidential and may not be released or made public except:
 - (1) to a state or federal agency;
 - (2) to federal, state, or local law enforcement personnel;
 - (3) with the consent of each person identified in the information released;
 - (4) in civil or criminal litigation matters or licensing proceedings as otherwise allowed by law or judicial rule;
 - (5) on a form developed by the department that identifies any deficiencies found without identifying a person, other than the home and community support services agency;
 - (6) on a form required by a federal agency if:
 - (A) the information does not reveal the identity of an individual, including a patient or a physician or other medical practitioner;
 - (B) the service provider subject to the investigation had a reasonable opportunity to review the information and offer comments to be included with the information released or made public; and
 - (C) the release of the information complies with any other federal requirement; or
 - (7) as provided by Section 142.0092.
- (e) The department's representative shall hold a conference with the person in charge of the home and community support services agency before beginning the on-site survey to explain the nature and scope of the survey. When the survey is completed, the department's representative shall hold a conference with the person who is in charge of the agency and shall identify any records that were duplicated. Agency records may be removed from an agency only with the agency's consent.

- (f) At the conclusion of a survey or complaint investigation, the department shall fully inform the person who is in charge of the home and community support services agency of the preliminary findings of the survey at an exit conference and shall give the person a reasonable opportunity to submit additional facts or other information to the department's authorized representative in response to those findings. The response shall be made a part of the record of the survey for all purposes. The department's representative shall leave a written list of the preliminary findings with the agency at the exit conference.
- (g) After a survey of a home and community support services agency by the department, the department shall provide to the home and community support services agency administrator:
 - (1) specific and timely written notice of the official findings of the survey, including:
 - (A) the specific nature of the survey;
 - (B) any alleged violations of a specific statute or rule;
 - (C) the specific nature of any finding regarding an alleged violation or deficiency; and
 - (D) if a deficiency is alleged, the severity of the deficiency;
 - (2) information on the identity, including the name, of each department representative conducting or reviewing the results of the survey and the date on which the department representative acted on the matter; and
 - (3) if requested by the agency, copies of all documents relating to the survey maintained by the department or provided by the department to any other state or federal agency that are not confidential under state law.
- (g-1) If the department or the department's authorized representative discovers any additional violations during the review of field notes or preparation of the official statement of deficiencies for a home and community support services agency, the department or the department's representative shall conduct an additional exit conference regarding the additional violations. The additional exit conference must be held in person and may not be held over the telephone, by e-mail, or by facsimile transmission.

- (h) Except for the investigation of complaints, a home and community support services agency licensed by the department under this chapter is not subject to additional surveys relating to home health, hospice, or personal assistance services while the agency maintains accreditation for the applicable service from the Joint Commission for Accreditation of Healthcare Organizations, the Community Health Accreditation Program, or other accreditation organizations that meet or exceed the regulations adopted under this chapter. Each provider must submit to the department documentation from the accrediting body indicating that the provider is accredited when the provider is applying for the initial license and annually when the license is renewed.
- (i) Repealed by Acts 2003, 78th Leg., ch. 198, Sec. 2.156(a)(1).
- (i) Except as provided by Subsection (h), the department may not renew an initial home and community support services agency license unless the department has conducted an initial on-site survey of the agency.
- (j) Except as provided by Subsections (h) and (l), an on-site survey must be conducted within 18 months after a survey for an initial license. After that time, an on-site survey must be conducted at least every 36 months.
- (k) If a person is renewing or applying for a license to provide more than one type of service under this chapter, the surveys required for each of the services the license holder or applicant seeks to provide shall be completed during the same surveyor visit.
- (l) The department and other state agencies that are under the Health and Human Services Commission and that contract with home and community support services agencies to deliver services for which a license is required under this chapter shall execute a memorandum of understanding that establishes procedures to eliminate or reduce duplication of standards or conflicts between standards and of functions in license, certification, or compliance surveys and complaint investigations. The Health and Human Services Commission shall review the recommendation of the council relating to the memorandum of understanding before considering approval. The memorandum of understanding must be approved by the commission.

Sec. 142.0091. Training.

- (a) The department shall provide specialized training to representatives of the department who survey home and community support services agencies. The training must include information relating to:
 - (1) the conduct of appropriate surveys that do not focus exclusively on medical standards under an acute care model; and
 - (2) acceptable delegation of nursing tasks.
- (b) In developing and updating the training required by Subsection (a), the department shall consult with and include providers of home health, hospice, and personal assistance services, recipients of those services and their family members, and representatives of appropriate advocacy organizations.
- (c) The department at least semiannually shall provide joint training for home and community support services agencies and surveyors on subjects that address the 10 most common violations of federal or state law by home and community support services agencies. The department may charge a home and community support services agency a fee, not to exceed \$50 per person, for the training.

Sec. 142.0092. Consumer Complaint Data.

- (a) The department shall maintain records or documents relating to complaints directed to the department by consumers of home health, hospice, or personal assistance services. The department shall organize the records or documents according to standard, statewide categories as determined by the department. In determining appropriate categories, the department shall make distinctions based on factors useful to the public in assessing the quality of services provided by a home and community support services agency, including whether the complaint:
 - (1) was determined to be valid or invalid;
 - (2) involved significant physical harm or death to a patient;
 - (3) involved financial exploitation of a patient; or
 - (4) resulted in any sanction imposed against the agency.
- (b) The department shall make the information maintained under this section available to the public in a useful format that does not identify individuals implicated in the complaints.

Sec. 142.0093. Retaliation Prohibited.

- (a) A person licensed under this chapter may not retaliate against another person for filing a complaint, presenting a grievance, or providing in good faith information relating to home health, hospice, or personal assistance services provided by the license holder.
- (b) This section does not prohibit a license holder from terminating an employee for a reason other than retaliation.

Sec. 142.0094. Use of Regulatory Survey Reports and Other Documents.

- (a) Except as otherwise provided by this section, a survey report or other document prepared by the department that relates to regulation of a home and community support services agency is not admissible as evidence in a civil action to prove that the agency violated a standard prescribed under this chapter.
- (b) Subsection (a) does not:
 - (1) bar the admission into evidence of department survey reports or other documents in an enforcement action in which the state or an agency or political subdivision of the state is a party, including:
 - (A) an action seeking injunctive relief under Section 142.013;
 - (B) an action seeking imposition of a civil penalty under Section 142.014;
 - (C) a contested case hearing involving imposition of an administrative penalty under Section 142.017; and
 - (D) a contested case hearing involving denial, suspension, or revocation of a license issued under this chapter;
 - (2) bar the admission into evidence of department survey reports or other documents that are offered:
 - (A) to establish warning or notice to a home and community support services agency of a relevant department determination; or
 - (B) under any rule or evidentiary predicate of the Texas Rules of Evidence;

- (3) prohibit or limit the testimony of a department employee, in accordance with the Texas Rules of Evidence, as to observations, factual findings, conclusions, or determinations that a home and community support services agency violated a standard prescribed under this chapter if the observations, factual findings, conclusions, or determinations were made in the discharge of the employee's official duties for the department; or
- (4) prohibit or limit the use of department survey reports or other documents in depositions or other forms of discovery conducted in connection with a civil action if use of the survey reports or other documents appears reasonably calculated to lead to the discovery of admissible evidence.

Sec. 142.010. Fees.

- (a) The department shall set license fees for home and community support services agencies in amounts that are reasonable to meet the costs of administering this chapter, except that the fees may not be less than \$600 or more than \$2,000 for a license to provide home health, hospice, or personal assistance services.
- (b) The board shall consider the size of the home and community support services agency, the number of clients served, the number of services provided, and the necessity for review of other accreditation documentation in determining the amount of initial and renewal license fees.
- (c) A fee charged under this section is nonrefundable.

Sec. 142.0104. Change in Application Information.

- (a) If certain application information as specified by executive commissioner rule changes after the applicant submits an application to the department for a license under this chapter or after the department issues the license, the license holder shall report the change to the department and pay a fee not to exceed \$50 not later than the time specified by executive commissioner rule.
- (b) The executive commissioner by rule shall:

- (1) specify the information provided in an application that a license holder shall report to the department if the information changes;
- (2) prescribe the time for reporting a change in the application information required by Subdivision (1);
- (3) establish which changes required to be reported under Subdivision (1) will require department evaluation and approval; and
- (4) set the amount of a late fee to be assessed against a license holder who fails to report a change in the application information within the time prescribed under Subdivision (2).

Sec. 142.0105. License Renewal.

- (a) A person who is otherwise eligible to renew a license may renew an unexpired license by submitting a completed application for renewal and paying the required renewal fee to the department not later than the 45th day before the expiration date of the license. A person whose license has expired may not engage in activities that require a license.
- (b) An applicant for a license renewal who submits an application later than the 45th day before the expiration date of the license is subject to a late fee in accordance with department rules.
- (c) Not later than the 120th day before the date a person's license is scheduled to expire, the department shall send written notice of the impending expiration to the person at the person's last known address according to the records of the department. The written notice must include an application for license renewal and instructions for completing the application.

Sec. 142.011. Denial, Suspension, or Revocation of License.

- (a) The department may deny a license application or suspend or revoke the license of a person who:
 - (1) fails to comply with the rules or standards for licensing required by this chapter; or
 - (2) engages in conduct that violates Section 102.001, Occupations Code.

- (b) The department may immediately suspend or revoke a license when the health and safety of persons are threatened. If the department issues an order of immediate suspension or revocation, the department shall immediately give the chief executive officer of the home and community support services agency adequate notice of the action taken, the legal grounds for the action, and the procedure governing appeal of the action. A person whose license is suspended or revoked under this subsection is entitled to a hearing not later than the seventh day after the effective date of the suspension or revocation.
- (c) The department may suspend or revoke a home and community support services agency's license to provide certified home health services if the agency fails to maintain its certification qualifying the agency as a certified agency. A home and community support services agency that is licensed to provide certified home health services and that submits a request for a hearing as provided by Subsection (d) is subject to the requirements of this chapter relating to a home and community support services agency that is licensed to provide home health services, but not certified home health services, until the suspension or revocation is finally determined by the department or, if the license is suspended or revoked, until the last day for seeking review of the department order or a later date fixed by order of the reviewing court.
- (d) A person whose application is denied or whose license is suspended or revoked is entitled to a hearing before the department if the person submits a written request to the department. Chapter 2001, Government Code and the department's rules for contested case hearings apply to hearings conducted under this section and to appeals from department decisions.

Sec. 142.012. Powers and Duties.

- (a) The executive commissioner shall adopt rules necessary to implement this chapter. The executive commissioner may adopt rules governing the duties and responsibilities of home and community support services agency administrators, including rules regarding:
 - (1) an administrator's management of daily operations of the home and community support services agency;

- (2) an administrator's responsibility for supervising the provision of quality care to agency clients;
 - (3) an administrator's implementation of agency policy and procedures; and
 - (4) an administrator's responsibility to be available to the agency at all times in person or by telephone.
- (b) The executive commissioner by rule shall set minimum standards for home and community support services agencies licensed under this chapter that relate to:
 - (1) qualifications for professional and nonprofessional personnel, including volunteers;
 - (2) supervision of professional and nonprofessional personnel, including volunteers;
 - (3) the provision and coordination of treatment and services, including support and bereavement services, as appropriate;
 - (4) the management, ownership, and organizational structure, including lines of authority and delegation of responsibility and, as appropriate, the composition of an interdisciplinary team;
 - (5) clinical and business records;
 - (6) financial ability to carry out the functions as proposed;
 - (7) safety, fire prevention, and sanitary standards for residential units and inpatient units; and
 - (8) any other aspects of home health, hospice, or personal assistance services as necessary to protect the public.
- (c) The initial minimum standards adopted under Subsection (b) for hospice services must be at least as stringent as the conditions of participation for a Medicare certified provider of hospice services in effect on April 30, 1993, under Title XVIII, Social Security Act (42 U.S.C. Section 1395 et seq.).
- (d) The department shall prescribe forms necessary to perform its duties.
- (e) The department shall require each person or home and community support services agency providing home health, hospice, or personal assistance services to implement and enforce the applicable provisions of Chapter 102, Human Resources Code.

Sec. 142.013. Injunction.

- (a) A district court, on petition of the department and on a finding by the court that a person is violating this chapter, may by injunction:
 - (1) prohibit the person from continuing the violation; or
 - (2) grant any other injunctive relief warranted by the facts.
- (b) The attorney general shall institute and conduct a suit authorized by this section at the request of the department and in the name of the state.
- (c) A suit for injunctive relief must be brought in Travis County.

Sec. 142.014. Civil Penalty.

- (a) A person who engages in the business of providing home health, hospice, or personal assistance service, or represents to the public that the person is a provider of home health, hospice, and personal assistance services for pay, without a license issued under this chapter authorizing the services that are being provided is liable for a civil penalty of not less than \$1,000 or more than \$2,500 for each day of violation. Penalties may be appropriated only to the department and to administer this chapter.
- (b) An action to recover a civil penalty is in addition to an action brought for injunctive relief under Section 142.013 or any other remedy provided by law. The attorney general shall bring suit on behalf of the state to collect the civil penalty.

Sec. 142.0145. Violation of Law Relating to Advance Directives.

- (a) The department shall assess an administrative penalty against a home and community support services agency that violates Section 166.004.
- (b) A penalty assessed under this section shall be \$500.
- (c) The penalty shall be assessed in accordance with department rules. The rules must provide for notice and an opportunity for a hearing.

Sec. 142.015. Advisory Council.

- (a) The Home and Community Support Services Advisory Council is composed of the following 13 members, appointed by the governor:

- (1) three consumer representatives;
 - (2) two representatives of agencies that are licensed to provide certified home health services;
 - (3) two representatives of agencies that are licensed to provide home health services but are not certified home health services;
 - (4) three representatives of agencies that are licensed to provide hospice services, with one representative appointed from:
 - (A) a community-based non-profit provider of hospice services;
 - (B) a community-based proprietary provider of hospice services; and
 - (C) a hospital-based provider of hospice services; and
 - (5) three representatives of agencies that are licensed to provide personal assistance services.
- (b) Repealed by Acts 1991, 72nd Leg., 1st C.S., ch. 17, Sec. 7.01(18), eff. Nov. 12, 1991.
- (c) The council shall advise the department on licensing standards and on the implementation of this chapter. At each meeting of the council, the department shall provide an analysis of enforcement actions taken under this chapter, including the type of enforcement action, the results of the action, and the basis for the action. The council may advise the department on its implementation of the enforcement provisions of this chapter.
- (d) Members of the council serve staggered two-year terms, with the terms of seven members expiring on January 31 of each even-numbered year and the terms of six members expiring on January 31 of each odd-numbered year.
- (e) The council shall elect a presiding officer from among its members to preside at meetings and to notify members of meetings. The presiding officer shall serve for one year and may not serve in that capacity for more than two years.
- (f) The council shall meet at least once a year and may meet at other times at the call of the presiding officer, any three members of the council, or the commissioner.
- (g) Members of the council serve without compensation.

Sec. 142.016. Memorandum Of Understanding Relating To Nursing Services; Guidelines.

- (a) The Texas Board of Nursing and the department shall adopt a memorandum of understanding governing the circumstances under which the provision of health-related tasks or services do not constitute the practice of professional nursing. The agencies periodically shall review and shall renew or modify the memorandum as necessary.
- (b) The Texas Board of Nursing and the department shall consult with an advisory committee in developing, modifying, or renewing the memorandum of understanding. The advisory committee shall be appointed by the Texas Board of Nursing and the department and at a minimum shall include:
 - (1) one representative from the Texas Board of Nursing and one representative from the department to serve as cochairmen;
 - (2) one representative from the Texas Department of Mental Health and Mental Retardation;
 - (3) one representative from the Texas Nurses Association;
 - (4) one representative from the Texas Association for Home Care, Incorporated, or its successor;
 - (5) one representative from the Texas Hospice Organization, Incorporated, or its successor;
 - (6) one representative of the Texas Respite Resource Network or its successor; and
 - (7) two representatives of organizations such as the Personal Assistance Task Force or the Disability Consortium that advocate for clients in community-based settings.
- (c) The department shall prepare guidelines according to the memorandum of understanding required by Subsection (a) for licensed home and community support services agencies in providing personal assistance services to clients.

Sec. 142.017. Administrative Penalty.

- (a) The department may assess an administrative penalty against a person who violates:
 - (1) this chapter or a rule adopted under this chapter; or

- (2) Section 102.001, Occupations Code, if the violation relates to the provision of home health, hospice, or personal assistance services.
- (b) The penalty shall be not less than \$100 or more than \$1,000 for each violation. Each day of a violation that occurs before the day on which the person receives written notice of the violation from the department does not constitute a separate violation and shall be considered to be one violation. Each day of a continuing violation that occurs after the day on which the person receives written notice of the violation from the department constitutes a separate violation.
- (c) The department by rule shall specify each violation for which an administrative penalty may be assessed. In determining which violations warrant penalties, the department shall consider:
 - (1) the seriousness of the violation, including the nature, circumstances, extent, and gravity of the violation and the hazard of the violation to the health or safety of clients; and
 - (2) whether the affected home and community support services agency had identified the violation as a part of its internal quality assurance process and had made appropriate progress on correction.
- (d) The department by rule shall establish a schedule of appropriate and graduated penalties for each violation based on:
 - (1) the seriousness of the violation, including the nature, circumstances, extent, and gravity of the violation and the hazard or safety of clients;
 - (2) the history of previous violations by the person or a controlling person with respect to that person;
 - (3) whether the affected home and community support services agency had identified the violation as a part of its internal quality assurance process and had made appropriate progress on correction;
 - (4) the amount necessary to deter future violations;
 - (5) efforts made to correct the violation; and
 - (6) any other matters that justice may require.

- (e) Except as provided by Subsection (j), the department by rule shall provide the home and community support services agency with a reasonable period of time following the first day of a violation to correct the violation before assessing an administrative penalty if a plan of correction has been implemented.
- (f) An administrative penalty may not be assessed for minor violations unless those violations are of a continuing nature or are not corrected.
- (g) The department shall establish a system to ensure standard and consistent application of penalties regardless of the home and community support services agency location.
- (h) All proceedings for the assessment of an administrative penalty under this chapter are subject to Chapter 2001, Government Code.
- (i) The department may not assess an administrative penalty against a state agency.
- (j) The department may assess an administrative penalty without providing a reasonable period of time to the agency to correct the violation if the violation:
 - (1) results in serious harm or death;
 - (2) constitutes a serious threat to health or safety;
 - (3) substantially limits the agency's capacity to provide care;
 - (4) is a violation in which a person:
 - (A) makes a false statement, that the person knows or should know is false, of a material fact:
 - (i) on an application for issuance or renewal of a license or in an attachment to the application; or
 - (ii) with respect to a matter under investigation by the department;
 - (B) refuses to allow a representative of the department to inspect a book, record, or file required to be maintained by an agency;

- (C) wilfully interferes with the work of a representative of the department or the enforcement of this chapter;
- (D) wilfully interferes with a representative of the department preserving evidence of a violation of this chapter or a rule, standard, or order adopted or license issued under this chapter;
- (E) fails to pay a penalty assessed by the department under this chapter not later than the 10th day after the date the assessment of the penalty becomes final; or
- (F) fails to submit:
 - (i) a plan of correction not later than the 10th day after the date the person receives a statement of licensing violations; or
 - (ii) an acceptable plan of correction not later than the 30th day after the date the person receives notification from the department that the previously submitted plan of correction is not acceptable;
- (5) is a violation of Section 142.0145; or
- (6) involves the rights of the elderly under Chapter 102, Human Resources Code.

Sec. 142.0171. Notice; Request For Hearing.

- (a) If, after investigation of a possible violation and the facts surrounding that possible violation, the department determines that a violation has occurred, the department shall give written notice of the violation to the person alleged to have committed the violation. The notice shall include:
 - (1) a brief summary of the alleged violation;
 - (2) a statement of the amount of the proposed penalty based on the factors listed in Section 142.017(d); and
 - (3) a statement of the person's right to a hearing on the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty.

- (b) Not later than the 20th day after the date on which the notice is received, the person notified may accept the determination of the department made under this section, including the proposed penalty, or may make a written request for a hearing on that determination.
- (c) If the person notified of the violation accepts the determination of the department or if the person fails to respond in a timely manner to the notice, the commissioner or the commissioner's designee shall issue an order approving the determination and ordering that the person pay the proposed penalty.

Sec. 142.0172. Hearing; Order.

- (a) If the person notified requests a hearing, the department shall:
 - (1) set a hearing;
 - (2) give written notice of the hearing to the person; and
 - (3) designate a hearings examiner to conduct the hearing.
- (b) The hearings examiner shall make findings of fact and conclusions of law and shall promptly issue to the commissioner or the commissioner's designee a proposal for decision as to the occurrence of the violation and a recommendation as to the amount of the proposed penalty if a penalty is determined to be warranted.
- (c) Based on the findings of fact and conclusions of law and the recommendations of the hearings examiner, the commissioner or the commissioner's designee by order may find that a violation has occurred and may assess a penalty or may find that no violation has occurred.

Sec. 142.0173. Notice And Payment Of Administrative Penalty; Judicial Review; Refund.

- (a) The department shall give notice of the order under Section 142.0172(c) to the person alleged to have committed the violation. The notice must include:
 - (1) separate statements of the findings of fact and conclusions of law;
 - (2) the amount of any penalty assessed; and
 - (3) a statement of the right of the person to judicial review of the order.

- (b) Not later than the 30th day after the date on which the decision is final as provided by Chapter 2001, Government Code, the person shall:
 - (1) pay the penalty;
 - (2) pay the amount of the penalty and file a petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty; or
 - (3) without paying the penalty, file a petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty.
- (c) Within the 30-day period, a person who acts under Subsection (b)(3) may:
 - (1) stay enforcement of the penalty by:
 - (A) paying the penalty to the court for placement in an escrow account; or
 - (B) giving to the court a supersedeas bond that is approved by the court for the amount of the penalty and that is effective until all judicial review of the order is final; or
 - (2) request the court to stay enforcement of the penalty by:
 - (A) filing with the court a sworn affidavit of the person stating that the person is financially unable to pay the amount of the penalty and is financially unable to give the supersede as bond; and
 - (B) giving a copy of the affidavit to the department by certified mail.
- (d) If the department receives a copy of an affidavit under Subsection (c)(2), the department may file with the court, within 10 days after the date the copy is received, a contest to the affidavit. The court shall hold a hearing on the facts alleged in the affidavit as soon as practicable and shall stay the enforcement of the penalty on finding that the alleged facts are true. The person who files an affidavit has the burden of proving that the person is financially unable to pay the penalty and to give a supersede as bond.

- (e) If the person does not pay the penalty and the enforcement of the penalty is not stayed, the department may refer the matter to the attorney general for collection of the penalty.
- (f) Judicial review of the order:
 - (1) is instituted by filing a petition as provided by Subchapter G, Chapter 2001, Government Code; and
 - (2) is under the substantial evidence rule.
- (g) If the court sustains the occurrence of the violation, the court may uphold or reduce the amount of the penalty and order the person to pay the full or reduced amount of the penalty. If the court does not sustain the occurrence of the violation, the court shall order that no penalty is owed.
- (h) When the judgment of the court becomes final, the court shall proceed under this subsection. If the person paid the amount of the penalty under Subsection (b)(2) and if that amount is reduced or is not upheld by the court, the court shall order that the department pay the appropriate amount plus accrued interest to the person. The rate of the interest is the rate charged on loans to depository institutions by the New York Federal Reserve Bank, and the interest shall be paid for the period beginning on the date the penalty was paid and ending on the date the penalty is remitted. If the person paid the penalty under Subsection (c)(1)(A), or gave a supersede as bond, and if the amount of the penalty is not upheld by the court, the court shall order the release of the escrow account or bond. If the person paid the penalty under Subsection (c)(1)(A) and the amount of the penalty is reduced, the court shall order that the amount of the penalty be paid to the department from the escrow account and that the remainder of the account be released. If the person gave a supersedeas bond and if the amount of the penalty is reduced, the court shall order the release of the bond after the person pays the amount.

Sec. 142.0174. Use of Administrative Penalty.

An administrative penalty collected under this subchapter may be appropriated for the purpose of funding the grant program established under Section 161.074, Human Resources Code.

Sec. 142.0175. Expenses and Costs for Collection of Civil or Administrative Penalty.

- (a) If the attorney general brings an action against a person under Section 142.013 or 142.014 or to enforce an administrative penalty assessed under Section 142.0173 and an injunction is granted against the person or the person is found liable for a civil or administrative penalty, the attorney general may recover, on behalf of the attorney general and the department, reasonable expenses and costs.
- (b) For purposes of this section, reasonable expenses and costs include expenses incurred by the department and the attorney general in the investigation, initiation, and prosecution of an action, including reasonable investigative costs, attorney's fees, witness fees, and deposition expenses.

Sec. 142.018. Reports of Abuse, Exploitation, or Neglect.

- (a) In this section, "abuse," "exploitation," and "neglect" have the meanings applicable through a rule adopted by the executive commissioner of the Health and Human Services Commission under Section 48.002(c), Human Resources Code, except that if the executive commissioner has not adopted applicable rules under that section, the statutory definitions of those terms under Section 48.002(a), Human Resources Code, shall be used.
- (b) A home and community support services agency that has cause to believe that a person receiving services from the agency has been abused, exploited, or neglected by an employee of the agency shall report the information to:
 - (1) the department; and
 - (2) the Department of Protective and Regulatory Services or other appropriate state agency as required by Section 48.051, Human Resources Code.
- (c) This section does not affect the duty or authority of any state agency to conduct an investigation of alleged abuse, exploitation, or neglect as provided by other law. An investigation of alleged abuse, exploitation, or neglect may be conducted without an on-site survey, as appropriate.

Sec. 142.019. Certain Physician Referrals Prohibited.

A physician may not refer a patient to a home and community support services agency if the referral violates 42 U.S.C. Section 1395nn and its subsequent amendments.

Sec. 142.020. Disposal of Special or Medical Waste.

- (a) A home and community support services agency that generates special or medical waste while providing home health services must dispose of the waste in the same manner that the home and community support services agency disposes of special or medical waste generated in the agency's office location.
- (b) A home and community support services agency shall provide both verbal and written instructions to the agency's client regarding the proper procedure for disposing of sharps. Sharps include hypodermic needles; hypodermic syringes with attached needles; scalpel blades; razor blades, disposable razors, and disposable scissors used in medical procedures; and intravenous stylets and rigid introducers.

Sec. 142.0201. Registration for Evacuation; Disaster Preparedness.

A home and community support services agency shall:

- (1) assist clients as necessary with registering for disaster evacuation assistance through 2-1-1 services provided by the Texas Information and Referral Network; and
- (2) counsel clients as necessary regarding disaster preparedness.

SUBCHAPTER B. PERMITS TO ADMINISTER MEDICATION

Sec. 142.021. Administration of Medication.

A person may not administer medication to a client of a home and community support services agency unless the person:

- (1) holds a license under state law that authorizes the person to administer medication;
- (2) holds a permit issued under Section 142.025 and acts under the delegated authority of a person who holds a license under state law that authorizes the person to administer medication;
- (3) administers a medication to a client of a home and community support service agency in accordance with rules of the Texas Board of Nursing that permit delegation of the administration of medication to a person not holding a permit under Section 142.025; or
- (4) administers noninjectable medication under circumstances authorized by the memorandum of understanding adopted under Section 142.016.

Sec. 142.022. Exemptions for Nursing Students and Medication Aide Trainees.

- (a) Sections 142.021 and 142.029 do not apply to:
- (1) a graduate nurse holding a temporary permit issued by the Texas Board of Nursing;
 - (2) a student enrolled in an accredited school of nursing or program for the education of registered nurses who is administering medications as part of the student's clinical experience;
 - (3) a graduate vocational nurse holding a temporary permit issued by the Texas Board of Nursing;
 - (4) a student enrolled in an accredited school of vocational nursing or program for the education of vocational nurses who is administering medications as part of the student's clinical experience; or
 - (5) a trainee in a medication aide training program approved by the department under Section 142.024 who is administering medications as part of the trainee's clinical experience.
- (b) The administration of medications by persons exempted under Subdivisions (1) through (4) of Subsection (a) is governed by the terms of the memorandum of understanding executed by the department and the Texas Board of Nursing.

Sec. 142.023. Rules For Administration Of Medication.

The board by rule shall establish:

- (1) minimum requirements for the issuance, denial, renewal, suspension, emergency suspension, and revocation of a permit to a home health medication aide;
- (2) curricula to train a home health medication aide;
- (3) minimum standards for the approval of home health medication aide training programs and for rescinding approval;
- (4) the acts and practices that are allowed or prohibited to a permit holder; and
- (5) minimum standards for on-site supervision of a permit holder by a registered nurse.

Sec. 142.024. Home Health Medication Aide Training Programs.

- (a) An application for the approval of a home health medication aide training program must be made to the department on a form and under rules prescribed by the board.
- (b) The department shall approve a home health medication aide training program that meets the minimum standards adopted under Section 142.023. The department may review the approval annually.

Sec. 142.025. Issuance and Renewal of Home Health Medication Aide Permit.

- (a) To be issued or to have renewed a home health medication aide permit, a person shall apply to the department on a form prescribed and under rules adopted by the board.
- (b) The department shall prepare and conduct an examination for the issuance of a permit.
- (c) The department shall require a permit holder to satisfactorily complete a continuing education course approved by the department for renewal of the permit.
- (d) The department shall issue a permit or renew a permit to an applicant who:
 - (1) meets the minimum requirements adopted under Section 142.023;
 - (2) successfully completes the examination or the continuing education requirements; and
 - (3) pays a nonrefundable application fee determined by the board.
- (e) A permit is valid for one year and is not transferable.

Sec. 142.026. Fees for Issuance and Renewal of Home Health Medication Aide Permit.

- (a) The board shall set the fees in amounts reasonable and necessary to recover the amount projected by the department as required to administer its functions under this subchapter. The fees may not exceed:
 - (1) \$25 for a combined permit application and examination fee; and
 - (2) \$15 for a renewal permit application fee.
- (b) Fees received under this section may only be appropriated to the department to administer this subchapter.

Sec. 142.027. Violation of Home Health Medication Aide Permits.

- (a) For the violation of this subchapter or a rule adopted under this subchapter, the department may:
 - (1) deny, suspend, revoke, or refuse to renew a permit;
 - (2) suspend a permit in an emergency; or
 - (3) rescind training program approval.
- (b) Except as provided by Section 142.028, the procedure by which the department takes a disciplinary action and the procedure by which a disciplinary action is appealed are governed by the department's rules for a formal hearing and by Chapter 2001, Government Code.

Sec. 142.028. Emergency Suspension of Home Health Medication Aide Permits.

- (a) The department shall issue an order to suspend a permit issued under Section 142.025 if the department has reasonable cause to believe that the conduct of the permit holder creates an imminent danger to the public health or safety.
- (b) An emergency suspension is effective immediately without a hearing on notice to the permit holder.
- (c) If requested in writing by a permit holder whose permit is suspended, the department shall conduct a hearing to continue, modify, or rescind the emergency suspension.
- (d) The hearing must be held not earlier than the 10th day or later than the 30th day after the date on which the hearing request is received.
- (e) The hearing and an appeal from a disciplinary action related to the hearing are governed by the department's rules for a formal hearing and Chapter 2001, Government Code.

Sec. 142.029. Administration of Medication; Criminal Penalty.

- (a) A person commits an offense if the person knowingly administers medication to a client of a home and community support services agency and the person is not authorized to administer the medication under Section 142.021 or 142.022.
- (b) An offense under this section is a Class B misdemeanor.

Sec. 142.030. Dispensing Dangerous Drugs or Controlled Substances; Criminal Penalty.

- (a) A person authorized by this subchapter to administer medication to a client of a home and community support services agency may not dispense dangerous drugs or controlled substances without complying with Subtitle J, Title 3, Occupations Code.
- (b) An offense under this section is a Class A misdemeanor.

CHAPTER 48. INVESTIGATIONS AND PROTECTIVE SERVICES FOR ELDERLY AND DISABLED PERSONS

SUBCHAPTER A. General Provisions

Sec.48.001. Purpose.

The purpose of this chapter is to provide for the authority to investigate the abuse, neglect, or exploitation of an elderly or disabled person and to provide protective services to that person.

Sec.48.002. Definitions.

- (a) Except as otherwise provided under Section 48.251, in this chapter:
 - (1) "Elderly person" means a person 65 years of age or older.
 - (2) "Abuse" means:
 - (A) the negligent or wilful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical or emotional harm or pain to an elderly or disabled person by the person's caretaker, family member, or other individual who has an ongoing relationship with the person; or
 - (B) sexual abuse of an elderly or disabled person, including any involuntary or nonconsensual sexual conduct that would constitute an offense under Section 21.08, Penal Code (indecent exposure) or Chapter 22, Penal Code (assaultive offenses), committed by the person's caretaker, family member, or other individual who has an ongoing relationship with the person.
 - (3) "Exploitation" means the illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with an elderly or disabled person that involves using, or attempting to use, the resources of the elderly or disabled person, including the person's social security number or other identifying information, for monetary or personal benefit, profit, or gain without the informed consent of the elderly or disabled person.

- (4) "Neglect" means the failure to provide for one's self the goods or services, including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide such goods or services.
- (5) "Protective services" means the services furnished by the department or by a protective services agency to an elderly or disabled person who has been determined to be in a state of abuse, neglect, or exploitation or to a relative or caretaker of an elderly or disabled person if the department determines the services are necessary to prevent the elderly or disabled person from returning to a state of abuse, neglect, or exploitation. These services may include social casework, case management, and arranging for psychiatric and health evaluation, home care, day care, social services, health care, respite services, and other services consistent with this chapter. The term does not include the services of the department or another protective services agency in conducting an investigation regarding alleged abuse, neglect, or exploitation of an elderly or disabled person.
- (6) "Protective services agency" means a public or private agency, corporation, board, or organization that provides protective services to elderly or disabled persons in the state of abuse, neglect, or exploitation.
- (7) "Department" means the Department of Protective and Regulatory Services.
- (8) "Disabled person" means a person with a mental, physical, or developmental disability that substantially impairs the person's ability to provide adequately for the person's care or protection and who is:
 - (A) 18 years of age or older; or
 - (B) under 18 years of age and who has had the disabilities of minority removed.
- (9) "Legal holiday" means a state holiday listed in Subchapter B, Chapter 662, Government Code, or an officially declared county holiday.
- (10) "Volunteer" means a person who:

- (A) performs services for or on behalf of the department under the supervision of a department employee; and
 - (B) does not receive compensation that exceeds the authorized expenses the person incurs in performing those services.
- (b) The definitions of "abuse," "neglect," and "exploitation" adopted by the department as prescribed by Section 48.251 apply to an investigation of abuse, neglect, or exploitation in a facility subject to Subchapters F and H.
- (c) Except as provided by Subsection (b), the executive commissioner by rule may adopt definitions of "abuse," "neglect," and "exploitation," as an alternative to the definitions of those terms under Subsection (a), for purposes of conducting an investigation under this chapter or Chapter 142, Health and Safety Code.

Sec.48.003. Investigations in Nursing Homes, Assisted Living Facilities, and Similar Facilities.

- (a) This chapter does not apply if the alleged or suspected abuse, neglect, or exploitation occurs in a facility licensed under Chapter 242 or 247, Health and Safety Code.
- (b) Alleged or suspected abuse, neglect, or exploitation that occurs in a facility licensed under Chapter 242 or 247, Health and Safety Code, is governed by Chapter 260A, Health and Safety Code.

Sec.48.004. Risk Assessment.

The executive commissioner by rule shall develop and maintain risk assessment criteria for use by department personnel in determining whether an elderly or disabled person is in imminent risk of abuse, neglect, or exploitation or in a state of abuse, neglect, or exploitation and needs protective services. The criteria must:

- (1) provide for a comprehensive assessment of the person's:
 - (A) environmental, physical, medical, mental health, and financial condition;
 - (B) social interaction and support; and
 - (C) need for legal intervention; and
- (2) specify the circumstances under which a caseworker must consult with a supervisor regarding a case.

Sec.48.005. Maintenance of Records.

Notwithstanding Chapter 441, Government Code, or any other law, and subject to the availability of funds, the department shall maintain in an electronic format a summary of all records related to investigations of reports made under Section 48.051 that includes only critical information with respect to those investigations that will enable the department to research the history of a person's involvement in the investigated cases.

Sec.48.006. Community Satisfaction Survey.

- (a) Subject to the availability of funds, the department shall develop a community satisfaction survey that solicits information regarding the department's performance with respect to providing investigative and adult protective services. In each region, the department shall send the survey at least biennially to:
 - (1) stakeholders in the adult protective services system, including local law enforcement agencies and prosecutors' offices;
 - (2) protective services agencies, including nonprofit agencies; and
 - (3) courts with jurisdiction over probate matters.
- (b) The department shall send the results of each region's survey to:
 - (1) the region for evaluation by regional and program administrators and implementation of changes necessary to address community concerns;
 - (2) the presiding judge of the statutory probate courts in that region; and
 - (3) courts with jurisdiction over probate matters in that region.
- (c) The department may not include any confidential information in the results of the survey provided under Subsection (b)(2) or (3) unless ordered by a court.

Sec.48.007. Memorandum of Understanding Regarding Certain Abuse, Neglect, or Exploitation Investigations.

The Health and Human Services Commission, the department, the Department of Aging and Disability Services, the office of independent ombudsman for state supported living centers, and the Health and Human Services Commission's office of inspector general shall enter into a memorandum of understanding regarding investigations of alleged abuse, neglect, or exploitation of residents or clients of state supported living centers or the ICF-MR component of the Rio Grande State Center that delineates the responsibilities of each agency under this chapter, Chapter 261, Family Code, and Chapter 555, Health and Safety Code, and amend the memorandum of understanding as necessary to reflect changes in those responsibilities. During the negotiation of the memorandum of understanding, the agencies shall jointly determine whether the forensic training received by relevant staff of the Department of Family and Protective Services is adequate. Specifically, the agencies shall assess and, if necessary, develop a plan to enhance the ability of department staff to identify and report incidences that constitute a potential criminal offense. The Health and Human Services Commission is the final arbiter of any dispute regarding the memorandum of understanding under this section.

SUBCHAPTER B. Reports of Abuse, Neglect, Or Exploitation: Immunities

Sec.48.051. Report.

- (a) Except as prescribed by Subsection (b), a person having cause to believe that an elderly or disabled person is in the state of abuse, neglect, or exploitation, including a disabled person receiving services as described by Section 48.252, shall report the information required by Subsection (d) immediately to the department.
- (b) If a person has cause to believe that an elderly or disabled person, other than a disabled person receiving services as described by Section 48.252, has been abused, neglected, or exploited in a facility operated, licensed, certified, or registered by a state agency, the person shall report the information to the state agency that operates, licenses, certifies, or registers the facility for investigation by that agency.

- (c) The duty imposed by Subsections (a) and (b) applies without exception to a person whose knowledge concerning possible abuse, neglect, or exploitation is obtained during the scope of the person's employment or whose professional communications are generally confidential, including an attorney, clergy member, medical practitioner, social worker, and mental health professional.
- (d) The report may be made orally or in writing. It shall include:
 - (1) the name, age, and address of the elderly or disabled person;
 - (2) the name and address of any person responsible for the elderly or disabled person's care;
 - (3) the nature and extent of the elderly or disabled person's condition;
 - (4) the basis of the reporter's knowledge; and
 - (5) any other relevant information.
- (e) If a person who makes a report under this section chooses to give self-identifying information, the caseworker who investigates the report shall contact the person if necessary to obtain any additional information required to assist the person who is the subject of the report.

Sec.48.052. Failure to Report; Penalty.

- (a) A person commits an offense if the person has cause to believe that an elderly or disabled person has been abused, neglected, or exploited or is in the state of abuse, neglect, or exploitation and knowingly fails to report in accordance with this chapter. An offense under this subsection is a Class A misdemeanor, except that the offense is a state jail felony if it is shown on the trial of the offense that the disabled person was a person with mental retardation who resided in a state supported living center, the ICF-MR component of the Rio Grande State Center, or a facility licensed under Chapter 252, Health and Safety Code, and the actor knew that the disabled person had suffered serious bodily injury as a result of the abuse, neglect, or exploitation.
- (b) This section does not apply if the alleged abuse, neglect, or exploitation occurred in a facility licensed under Chapter 242, Health and Safety Code. Failure to report abuse, neglect, or exploitation that occurs in a facility licensed under that chapter is governed by that chapter.

Sec.48.053. False Report; Penalty.

- (a) A person commits an offense if the person knowingly or intentionally reports information as provided in this chapter that the person knows is false or lacks factual foundation.
- (b) An offense under this section is a Class A misdemeanor.

Sec.48.054. Immunity.

- (a) A person filing a report under this chapter or testifying or otherwise participating in any judicial proceeding arising from a petition, report, or investigation is immune from civil or criminal liability on account of his or her petition, report, testimony, or participation, unless the person acted in bad faith or with a malicious purpose.
- (b) A person, including an authorized department volunteer, medical personnel, or law enforcement officer, who at the request of the department participates in an investigation required by this chapter or in an action that results from that investigation is immune from civil or criminal liability for any act or omission relating to that participation if the person acted in good faith and, if applicable, in the course and scope of the person's assigned responsibilities or duties.
- (c) A person who reports the person's own abuse, neglect, or exploitation of another person or who acts in bad faith or with malicious purpose in reporting alleged abuse, neglect, or exploitation is not immune from civil or criminal liability.
- (d) An employer whose employee acts under Subsection (a) or (b) is immune from civil or criminal liability on account of an employee's report, testimony, or participation in any judicial proceedings arising from a petition, report, or investigation. This subsection does not apply to an employer who is the subject of an investigation.

SUBCHAPTER C. Confidentiality

Sec.48.101. Confidentiality and Disclosure of Information; Agency Exchange of Information.

- (a) The following information is confidential and not subject to disclosure under Chapter 552, Government Code:
 - (1) a report of abuse, neglect, or exploitation made under this chapter;

- (2) the identity of the person making the report; and
 - (3) except as provided by this section, all files, reports, records, communications, and working papers used or developed in an investigation made under this chapter or in providing services as a result of an investigation.
- (b) Confidential information may be disclosed only for a purpose consistent with this chapter and as provided by department or investigating state agency rule and applicable federal law.
- (c) A court may order disclosure of confidential information only if:
 - (1) a motion is filed with the court requesting release of the information and a hearing on that request;
 - (2) notice of that hearing is served on the department or investigating state agency and each interested party; and
 - (3) the court determines after the hearing and an in camera review of the information that disclosure is essential to the administration of justice and will not endanger the life or safety of any individual who:
 - (A) is the subject of a report of abuse, neglect, or exploitation;
 - (B) makes a report of abuse, neglect, or exploitation; or
 - (C) participates in an investigation of reported abuse, neglect, or exploitation.
- (d) The executive commissioner shall adopt rules providing for the release, on request, to a person who is the subject of a report of abuse, neglect, or exploitation or to that person's legal representative of otherwise confidential information relating to that report. The department or investigating state agency shall edit the information before release to protect the confidentiality of information relating to the reporter's identity and to protect any other individual whose safety or welfare may be endangered by disclosure.
- (d-1) Subject to Subsection (e-1), the executive commissioner shall adopt rules providing for the release, on request, by the department or investigating state agency of otherwise confidential information relating to a person who is the subject of a report or investigation of abuse, neglect, or exploitation or to whom the department has provided protective services, to:

- (1) a court that has a matter pending before it that involves the person;
 - (2) the attorney ad litem or any other legal representative, other than a guardian, appointed for the person; and
 - (3) the person's legal guardian.
- (e) The executive commissioner may adopt rules relating to the release of information by the department or investigating state agency that is contained in the record of a deceased individual who was the subject of an investigation conducted by the department or investigating state agency or to whom the department has provided protective services. The rules must be consistent with the purposes of this chapter and any applicable state or federal law. The executive commissioner shall adopt rules, subject to Subsection (e-1), that provide for the release, on request, of otherwise confidential information in the deceased person's record to the personal representative appointed for the person's estate.
- (e-1) Information released by the department or an investigating state agency under Subsection (d-1) or to a personal representative under Subsection (e) may not include the identity of the person who made the report of abuse, neglect, or exploitation.
- (f) The department or investigating state agency may establish procedures to exchange with another state agency or governmental entity information that is necessary for the department, state agency, or entity to properly execute its respective duties and responsibilities to provide services to elderly or disabled persons under this chapter or other law. An exchange of information under this subsection does not affect whether the information is subject to disclosure under Chapter 552, Government Code.
- (g) The department may establish procedures to exchange with a community service provider or local governmental entity confidential information relating to a report made under Section 48.051(a) that is necessary for the department, provider, or entity to provide protective services, health care services, housing services, or social services to the person who is the subject of the report. An exchange of information under this subsection does not affect whether the information is subject to disclosure under Chapter 552, Government Code.

- (g-1) The executive commissioner by rule shall provide policies and procedures that are designed to guard against the unauthorized release or dissemination of confidential information that is exchanged under Subsection (g).

Sec.48.102. Reports of Investigations in Schools.

- (a) The department shall send a written report of the department's investigation of alleged abuse, neglect, or exploitation of a disabled adult at a school, as appropriate, to the Texas Education Agency, the agency responsible for teacher certification, the local school board or the school's governing body, and the school principal or director, unless the principal or director is alleged to have committed the abuse, neglect, or exploitation. The entity to which the report is sent shall take appropriate action.
- (b) On request, the department shall provide a copy of the report of the investigation to the person who is alleged to have suffered the abuse, neglect, or exploitation, to the legal guardian of that person, and to the person alleged to have committed the abuse, neglect, or exploitation.
- (c) The report of the investigation shall be edited to protect the identity of the person who made the report under Section 48.051.
- (d) The department shall adopt rules necessary to implement this section.

Sec.48.103. Notification of Licensing or Contracting Agency.

- (a) On determining after an investigation that an elderly or disabled person has been abused, exploited, or neglected by an employee of a home and community support services agency licensed under Chapter 142, Health and Safety Code, the department shall:
 - (1) notify the state agency responsible for licensing the home and community support services agency of the department's determination;
 - (2) notify any health and human services agency, as defined by Section 531.001, Government Code, that contracts with the home and community support services agency for the delivery of health care services of the department's determination; and

- (3) provide to the licensing state agency and any contracting health and human services agency access to the department's records or documents relating to the department's investigation.
- (b) Providing access to a confidential record or document under this section does not constitute a waiver of confidentiality.

SUBCHAPTER D. Investigations by All Agencies

Sec.48.151. Action on Report.

- (a) Not later than 24 hours after the department receives a report of an allegation of abuse, neglect, or exploitation under Section 48.051, the department shall initiate a prompt and thorough investigation as needed to evaluate the accuracy of the report and to assess the need for protective services, unless the department determines that the report:
 - (1) Is frivolous or patently without a factual basis; or
 - (2) Does not concern abuse, neglect, or exploitation, as those terms are defined by rules adopted by the executive commissioner under Section 48.002(c), except that if the executive commissioner has not adopted applicable rules under that section, the statutory definitions of those terms under Section 48.002(a) shall be used.
- (b) The department shall adopt rules for conducting investigations under this chapter.
- (c) The department by rule may assign priorities and prescribe investigative procedures for conducting investigations according to the degree of severity and immediacy of the alleged harm to the individual. Notwithstanding Subsection (a), the department's priorities and procedures may provide that an investigation is not required to be initiated within 24 hours in all cases.
- (d) The department shall prepare and keep on file a report of each investigation conducted by the department.
- (e) This section does not apply to investigations conducted under Subchapter F or H.

Sec.48.152. Investigation.

- (a) An investigation by the department or a state agency shall include an interview with the elderly or disabled person, if appropriate, and with persons thought to have knowledge of the circumstances. If the elderly or disabled person refuses to be interviewed or cannot be interviewed because of a physical or mental impairment, the department shall continue the investigation by interviewing other persons thought to have knowledge relevant to the investigation.
- (b) The investigation may include an interview with an alleged juvenile perpetrator of the alleged abuse, neglect, or exploitation.
- (c) The department or state agency may conduct an interview under this section in private or may include any person the department or agency determines is necessary.

Sec.48.1521. Investigation of Complex Cases.

- (a) The department shall develop and implement a system to ensure that, to the greatest extent possible, investigations conducted by the department that involve especially complex issues of abuse, neglect, or exploitation, such as issues associated with identity theft and other forms of financial exploitation, are:
 - (1) Assigned to personnel who have experience and training in those issues; and
 - (2) Monitored by a special task unit for complex cases.
- (b) Each county with a population of 250,000 or more shall appoint persons to serve as standing members of a special task unit to monitor cases that arise in the county and require monitoring as provided by Subsection (a). The standing members of each special task unit must include:
 - (1) A provider of mental health services or aging services or a representative of a nonprofit entity serving persons with disabilities;
 - (2) A representative of a law enforcement agency; and
 - (3) A legal expert.
- (c) In addition to the standing members specified by Subsection (b), the special task unit:

- (1) Must include, for purposes of monitoring a particular case, the caseworker on the case and the caseworker's supervisor; and
 - (2) May include a financial forensics expert and any other person with expertise that would be useful in monitoring a particular case.
- (d) The department shall develop and make available to each county described by Subsection (b) a manual to assist the county in establishing and operating the special task unit required by this section. The manual must describe:
- (1) The purpose and potential benefits of the unit;
 - (2) A description of the monitoring process the unit is expected to follow and potential problems the unit may encounter;
 - (3) The composition and administration of the unit; and
 - (4) The department's criteria for selecting cases to be monitored by the unit.
- (e) Before the special task unit makes a recommendation that a guardian be appointed for a person in a case being monitored by the unit, the unit shall thoroughly consider all less-restrictive alternatives for legal intervention in the case.

Sec.48.1522. Reports of Criminal Conduct to Law Enforcement Agency.

- (a) Except as provided by Subsection (b), if during the course of the department's or another state agency's investigation of reported abuse, neglect, or exploitation a caseworker of the department or other state agency, as applicable, or the caseworker's supervisor has cause to believe that the elderly or disabled person has been abused, neglected, or exploited by another person in a manner that constitutes a criminal offense under any law, including Section 22.04, Penal Code, the caseworker or supervisor shall:
- (1) immediately notify an appropriate law enforcement agency, unless the law enforcement agency reported the alleged abuse, neglect, or exploitation to the department; and
 - (2) provide the law enforcement agency with a copy of the investigation report of the department or other state agency, as applicable, in a timely manner.

- (b) If during the course of the department's investigation of reported abuse, neglect, or exploitation a caseworker of the department or the caseworker's supervisor has cause to believe that a disabled person who is a resident or client of a state supported living center or the ICF-MR component of the Rio Grande State Center has been abused, neglected, or exploited by another person in a manner that constitutes a criminal offense under any law, including Section 22.04, Penal Code, in addition to the report to the appropriate law enforcement agency required by Subsection (a), the caseworker shall immediately notify the commission's office of inspector general and promptly provide the commission's office of inspector general with a copy of the department's investigation report.

Sec.48.1523. Management Review Following Certain Investigations.

If the department receives and investigates a report made under Section 48.051, the subject of which is a person with respect to whom the department received and investigated two previous reports under that section and closed those investigations, an adult protective services supervisor shall:

- (1) Classify the case as a recidivist case;
- (2) Review the reports and investigation files concerning that person; and
- (3) Assist the caseworker and supervisor investigating the third report in developing a long-term plan for resolving the issues involved in the case.

Sec.48.153. Access to Investigation.

- (a) To implement an investigation of reported abuse, neglect, or exploitation, the probate court, or the county court when no probate court exists, may authorize entry of the place of residence of the elderly or disabled person.
- (b) A peace officer shall accompany and assist the person making a court-ordered entry under this section, if in the opinion of the court such action is necessary.

Sec.48.154. Access to Records or Documents.

- (a) The department or another state agency, as appropriate, shall have access to any records or documents, including client-identifying information, financial records, and medical and psychological records, necessary to the performance of the department's or state agency's duties under this chapter. The duties include but are not limited to the investigation of abuse, neglect, or exploitation or the provisions of services to an elderly or disabled person. A person, agency, or institution that has a record or document that the department or state agency needs to perform its duties under this chapter shall, without unnecessary delay, make the record or document available to the department or state agency that requested the record or document.
- (b) The department is exempt from the payment of a fee otherwise required or authorized by law to obtain a financial record from a person, agency, or institution or a medical record, including a mental health record, from a hospital or health care provider if the request for a record is made in the course of an investigation by the department.
- (c) If the department or another state agency cannot obtain access to a record or document that is necessary to properly conduct an investigation or to perform another duty under this chapter, the department or state agency may petition the probate court or the statutory or constitutional county court having probate jurisdiction for access to the record or document.
- (d) On good cause shown, the court shall order the person, agency, or institution who has a requested record or document to allow the department or state agency to have access to that record or document under the terms and conditions prescribed by the court.
- (e) A person, agency, or institution who has a requested record or document is entitled to notice and a hearing on a petition filed under this section.
- (f) Access to a confidential record under this section does not constitute a waiver of confidentiality.

Sec.48.155. Interference with Investigation or Services Prohibited.

- (a) A person, including a guardian and notwithstanding Section 675, Texas Probate Code, may not interfere with:

- (1) An investigation by the department or by a protective services agency of alleged abuse, neglect, or exploitation of an elderly or disabled person; or
 - (2) The provision of protective services to an elderly or disabled person.
- (b) The department or a protective services agency may petition the appropriate court to enjoin any interference with:
- (1) An investigation of alleged abuse, neglect, or exploitation; or
 - (2) The provision of protective services such as removal of the elderly or disabled person to safer surroundings or safeguarding the person's resources from exploitation.

Sec.48.156. Agency Reports.

A protective services agency shall make reports relating to its provision of protective services as the department or a court may require.

Sec.48.159. Internal Review of Department Investigation.

The department shall establish procedures for conducting an internal review of completed investigations conducted by the department under this chapter to:

- (1) determine whether information obtained during the intake process was sufficient and accurate;
- (2) assess whether telephone calls were appropriately routed;
- (3) assess whether investigations were appropriately classified and prioritized;
- (4) evaluate the case reports for any special issues or requirements;
- (5) assess whether appropriate law enforcement agencies were notified of any suspected criminal conduct; and
- (6) identify other relevant information to enable the department to take any corrective action necessary to improve the process of conducting investigations under this chapter.

SUBCHAPTER E. Provision of Services; Emergency Protection

Sec.48.201. Application of Subchapter.

Except as otherwise provided, this subchapter does not apply to a Texas Department of Mental Health and Mental Retardation investigation under Subchapter F or H.

Sec.48.202. Service Determination by Department or Agency.

- (a) In an investigation the department or state agency, as appropriate, shall determine:
 - (1) Whether the person needs protective services from the department;
 - (2) What services are needed;
 - (3) Whether services are available from the department, from the state agency, or in the community and how they can be provided;
 - (4) Whether the person, acting alone, would be capable of obtaining needed services and could bear the cost or would be eligible for services from the department or state agency;
 - (5) Whether a caretaker would be willing to provide services or would agree to their provision;
 - (6) Whether the elderly or disabled person desires the services;
 - (7) Whether the person needs legal intervention to resolve the person's abuse, neglect, or exploitation and, if so, what type of intervention is needed; and
 - (8) Other pertinent data.
- (b) If the department or state agency, as appropriate, determines under Subsection (a)(1) that a person needs protective services, the department or agency shall, in determining how those services can be provided as required by Subsection (a)(3), determine whether the person is eligible for community-based long-term care services and whether those services are available. If the person is eligible for those services, but the services are not immediately available, the department or state agency shall ensure that the person is placed on an appropriate waiting list for the services and that the person's abuse, neglect, or exploitation is resolved before the department closes the case.

Sec.48.203. Voluntary Protective Services.

- (a) An elderly or disabled person may receive voluntary protective services if the person requests or consents to receive those services.
- (b) The elderly or disabled person who receives protective services shall participate in all decisions regarding his or her welfare, if able to do so.
- (c) The least restrictive alternatives should be made available to the elderly or disabled person who receives protective services.
- (d) Except as provided by Section 48.208, if an elderly or disabled person withdraws from or refuses consent to voluntary protective services, the services may not be provided.

Sec.48.204. Agency Powers.

A protective services agency may furnish protective services to an elderly or disabled person with the person's consent or to a relative or caretaker of an elderly or disabled person on behalf of the elderly or disabled person with the relative's or caregiver's consent or, if the elderly or disabled person lacks the capacity to consent, without that person's consent as provided by this chapter.

Sec.48.205. Provision of Services.

- (a) Subject to the availability of funds, the department shall provide direct protective services or contract with protective services agencies for the provision of those services.
- (b) The department shall use existing resources and services of public and private agencies in providing protective services. If the department does not have existing resources to provide direct protective services to elderly or disabled persons, the department, subject to the availability of funds, shall contract with protective services agencies for the provision of those services, especially to elderly or disabled persons residing in rural or remote areas of this state or not previously served by the department.
- (c) The department and law enforcement officials, courts, and agencies shall cooperate when providing protective services.
- (d) The responsibilities prescribed by this chapter are exclusive of those designated to other state or federal agencies authorized or required by law to provide protective services to elderly or disabled persons determined to be in the state of abuse, neglect, or exploitation.

Sec.48.206. Cost of Services.

If the elderly or disabled person receiving the protective services is determined to be financially able to contribute to the payments for those services, the provider shall receive a reasonable reimbursement from the person's assets.

Sec.48.207. Objection to Medical Treatment.

This chapter does not authorize or require any medical treatment of a person who objects on the grounds that he is an adherent or member of a recognized church or religious denomination the tenets and practice of which may include reliance solely upon spiritual means through prayer for healing.

Sec.48.208. Emergency Order for Protective Services.

- (a) For purposes of this section, a person lacks the capacity to consent to receive protective services if, because of mental or physical impairment, the person is incapable of understanding the nature of the services offered and agreeing to receive or rejecting protective services.
- (b) If the department determines that an elderly or disabled person is suffering from abuse, neglect, or exploitation presenting a threat to life or physical safety, that the person lacks capacity to consent to receive protective services, and that no consent can be obtained, the department may petition the probate or statutory or constitutional county court that has probate jurisdiction in the county in which the elderly or disabled person resides for an emergency order authorizing protective services.
- (c) The petition shall be verified and shall include:
 - (1) The name, age, and address of the elderly or disabled person who needs protective services;
 - (2) The nature of the abuse, neglect, or exploitation;
 - (3) The services needed; and
 - (4) A medical report signed by a physician stating that the person is suffering from abuse, neglect, or exploitation presenting a threat to life or physical safety and stating that the person is physically or mentally incapable of consenting to services unless the court finds that an immediate danger to the health or safety of the elderly or disabled person exists and there is not sufficient time to obtain the medical report.

- (c-1) Notwithstanding Subsection (c)(4), in lieu of a medical report described by Subsection (c)(4), the petition may include an assessment of the elderly or disabled person's health status as described by Subsection (c-2) or psychological status as described by Subsection (c-3), or a medical opinion of the elderly or disabled person's health status as described by Subsection (c-4), if the department determines, after making a good faith effort, that a physician from whom the department may obtain the medical report is unavailable. The department shall ensure that the person who performs an assessment of the elderly or disabled person's health or psychological status has training and experience in performing the applicable assessment.
- (c-2) Except as provided by Subsection (c-4), an assessment of the elderly or disabled person's health status must be performed by a physician assistant or advanced practice nurse. The person performing the assessment shall sign a report stating:
- (1) That the elderly or disabled person is reported to be suffering from abuse, neglect, or exploitation, which may present a threat to the person's life or physical safety;
 - (2) Whether the elderly or disabled person has provided the person's medical history to the physician assistant or advanced practice nurse, as applicable; and
 - (3) That in the professional opinion of the physician assistant or advanced practice nurse, as applicable, the issuance of an emergency order authorizing protective services without the elderly or disabled person's consent is necessary under the circumstances.
- (c-3) An assessment of the elderly or disabled person's psychological status must be performed by a licensed psychologist or master social worker who has training and expertise in issues related to abuse, neglect, and exploitation. The person performing the assessment shall sign a report stating:
- (1) That the elderly or disabled person is reported to be suffering from abuse, neglect, or exploitation, which may present a threat to the person's life or physical safety; and

- (2) That in the professional opinion of the licensed psychologist or master social worker, as applicable, the issuance of an emergency order authorizing protective services without the elderly or disabled person's consent is necessary under the circumstances.
- (c-4) A registered nurse may perform a nursing assessment of the elderly or disabled person's health status. If the registered nurse, based on the registered nurse's professional nursing judgment, determines that the elderly or disabled person is likely to be suffering from abuse, neglect, or exploitation, which may present a threat to the person's life or physical safety, the registered nurse shall report that assessment to a physician. After the registered nurse reports the assessment, the physician shall sign a written opinion stating whether:
 - (1) The elderly or disabled person is reported to be suffering from abuse, neglect, or exploitation, which may present a threat to the person's life or physical safety; and
 - (2) The issuance of an emergency order authorizing protective services without the elderly or disabled person's consent is necessary under the circumstances.
- (c-5) The physician may use the registered nurse's assessment of the elderly or disabled person's health status as the basis of the physician's professional opinion under Subsection (c-4).
- (d) On finding that there is reasonable cause to believe that abuse, neglect, or exploitation presents a threat to life or physical safety for the elderly or disabled person and that the elderly or disabled person lacks capacity to consent to services, the court may:
 - (1) Order removal of the elderly or disabled person to safer surroundings;
 - (2) Order medical services; and
 - (3) Order other available services necessary to remove conditions creating the threat to life or physical safety, including the services of law enforcement officers or emergency medical services personnel.

- (d-1) If the court renders an order that is based on a petition including an assessment under Subsection (c-2) or (c-3) or a medical opinion under Subsection (c-4), the court shall order that the elderly or disabled person be examined by a physician not later than 72 hours after the time the provision of protective services begins. After performing the examination, the physician shall sign and submit to the court a medical report stating the physician's opinion whether the elderly or disabled person is:
- (1) Suffering from abuse, neglect, or exploitation presenting a threat to life or physical safety; and
 - (2) Physically or mentally incapable of consenting to services.
- (e) The emergency order expires on the earlier of the end of the 10th day after the date the order is rendered or the end of the 10th day after the date the person was removed to safer surroundings if the emergency order was rendered subsequent to the removal of the person to safer surroundings in accordance with Subsection (h), unless:
- (1) The emergency order terminates as provided by Subsection (e-1);
 - (2) The 10-day period ends on a Saturday, Sunday, or legal holiday in which event the order is automatically extended to 4 p.m. on the first succeeding business day; or
 - (3) The court extends the order as provided by Subsection (e-2).
- (e-1) An emergency order that was rendered based on a petition that included an assessment under Subsection (c-2) or (c-3) or a medical opinion under Subsection (c-4) immediately terminates if the medical report issued under Subsection (d-1) states the physician's opinion that the elderly or disabled person:
- (1) Is not suffering from abuse, neglect, or exploitation presenting a threat to life or physical safety; or
 - (2) is physically or mentally capable of consenting to services.

- (e-2) The court, after notice and a hearing, may extend an emergency order issued under this section for a period of not more than 30 days after the date the original emergency order for protective services was rendered. The court, after notice and a hearing and for good cause shown, may grant a second extension of an emergency order of not more than an additional 30 days. The court may not grant more than two extensions of the original emergency order. An extension order that ends on a Saturday, Sunday, or legal holiday is automatically extended to 4 p.m. on the first succeeding business day. The court may modify or terminate the emergency order on petition of the department, the incapacitated person, or any person interested in the person's welfare.
- (f) Any medical facility, emergency medical services provider, or physician who provides treatment to or who transports an elderly or disabled person pursuant to an emergency order under Subsection (d) or an emergency authorization under Subsection (h) is not liable for any damages arising from the treatment or transportation, except those damages resulting from the negligence of the facility, provider, or physician.
- (g) The court shall appoint an attorney ad litem to represent the elderly or disabled person in any proceeding brought by the department under this section. A reasonable fee, as determined by the court, shall be paid to the attorney ad litem from the general fund of the county.
- (h) If the department cannot obtain an emergency order under this section because the court is closed on a Saturday, Sunday, or legal holiday or after 5 p.m., the department may remove or authorize an appropriate transportation service, including an emergency medical services provider, to remove the elderly or disabled person to safer surroundings, authorize medical treatment, or authorize or provide other available services necessary to remove conditions creating the threat to life or physical safety. The department must obtain an emergency order under this section not later than 4 p.m. on the first succeeding business day after the date on which protective services are provided. If the department does not obtain an emergency order, the department shall cease providing protective services and, if necessary, make arrangements for the immediate return of the person to the place from which the person was removed, to the person's place of residence in the state, or to another suitable place.

- (i) If the department's removal of a person from the person's place of residence under this section results in that residence being vacant, the department shall notify the appropriate law enforcement agency of the vacancy to facilitate the law enforcement agency's monitoring of the residence.

Sec.48.209. Referral for Guardianship Services.

- (a) The department shall refer an individual to the Department of Aging and Disability Services for guardianship services under Subchapter E, Chapter 161, if the individual is:
 - (1) A minor in the conservatorship of the department who:
 - (A) Is 16 years of age or older; and
 - (B) The department has reason to believe will, because of a physical or mental condition, be substantially unable to provide for the individual's own food, clothing, or shelter, to care for the individual's own physical health, or to manage the individual's own financial affairs when the individual becomes an adult; or
 - (2) An elderly or disabled person who:
 - (A) Has been found by the department to be in a state of abuse, neglect, or exploitation; and
 - (B) The department has reason to believe is an incapacitated person as defined by Section 601(14)(B), Texas Probate Code.
- (b) Notwithstanding Subsection (a), if a less restrictive alternative to guardianship is appropriate and available for the individual, the department shall pursue that alternative instead of making a referral to the Department of Aging and Disability Services for guardianship services.
- (c) The department and the Department of Aging and Disability Services shall enter into a memorandum of understanding that sets forth in detail the roles and duties of each agency regarding the referral for guardianship services under Subsection (a) and the provision of guardianship services to individuals under Subchapter E, Chapter 161.

- (d) Nothing in this section shall prohibit the department from also making a referral of an individual to a court having probate jurisdiction in the county where the individual is domiciled or found, if the court has requested the department to notify the court of any individuals who may be appropriate for a court-initiated guardianship proceeding under Section 683, Texas Probate Code. In making a referral under this subsection and if requested by the court, the department shall, to the extent allowed by law, provide the court with all relevant information in the department's records relating to the individual. The court, as part of this process, may not require the department to:
 - (1) Perform the duties of a guardian ad litem or court investigator as prescribed by Section 683, Texas Probate Code; or
 - (2) Gather additional information not contained in the department's records.
- (e) The department may not be appointed to serve as temporary or permanent guardian for any individual.

Sec.48.210. Representation.

- (a) Except as provided by Subsection (b), the prosecuting attorney representing the state in criminal cases in the county court shall represent the department in any proceeding under this chapter unless the representation would be a conflict of interest.
- (b) In a county having a population of more than 2.8 million, the prosecuting attorney representing the state in civil cases in the county court shall represent the department in any proceeding under this chapter unless the representation would be a conflict of interest.

Sec.48.211. Report to Guardianship Court.

If the elderly or disabled person has a guardian, a written notification of the findings of the investigation shall be sent to the court to which the guardian is accountable.

SUBCHAPTER F. Investigations In Certain Facilities, Community Centers, And Local Mental Health And Mental Retardation Authorities

Sec.48.251. Definitions.

The department by rule shall adopt definitions of "abuse," "neglect," and "exploitation" to govern an investigation under this subchapter and Subchapter H.

Sec.48.252. Investigation of Reports in Certain Facilities and in Community Centers.

- (a) The department shall receive and investigate reports of the abuse, neglect, or exploitation of an individual with a disability receiving services:
 - (1) In:
 - (A) A mental health facility operated by the Department of State Health Services; or
 - (B) A facility licensed under Chapter 252, Health and Safety Code;
 - (2) In or from a community center, a local mental health authority, or a local mental retardation authority; or
 - (3) Through a program providing services to that person by contract with a mental health facility operated by the Department of State Health Services, a community center, a local mental health authority, or a local mental retardation authority.
- (b) The department shall receive and shall investigate reports of the abuse, neglect, or exploitation of an individual with a disability receiving services:
 - (1) In a state supported living center or the ICF-MR component of the Rio Grande State Center; or
 - (2) Through a program providing services to that person by contract with a state supported living center or the ICF-MR component of the Rio Grande State Center.
- (c) The department by rule shall define who is "an individual with a disability receiving services."
- (d) In this section, "community center," "local mental health authority," and "local mental retardation authority" have the meanings assigned by Section 531.002, Health and Safety Code.

Sec.48.253. Action on Report.

On receipt by the department of a report of alleged abuse, neglect, or exploitation under this subchapter, the department shall initiate a prompt and thorough investigation as needed to evaluate the accuracy of the report unless the department, in accordance with rules adopted under this subchapter, determines that the report:

- (1) Is frivolous or patently without a factual basis; or
- (2) Does not concern abuse, neglect, or exploitation.

Sec.48.254. Forwarding of Certain Reports.

In accordance with department rules, the department shall forward a copy of the initial intake report and a copy of the completed investigation report relating to alleged or suspected abuse, neglect, or exploitation to the appropriate facility, community center, mental health authority, mental retardation authority, or program providing mental health or mental retardation services under contract with the facility, community center, or authority.

Sec.48.255. Rules for Investigations Under this Subchapter.

- (a) The department, the Department of Aging and Disability Services, and the Department of State Health Services shall develop joint rules to facilitate investigations in state mental health facilities and state supported living centers.
- (b) The department, the Department of Aging and Disability Services, and the Department of State Health Services by joint rules shall establish procedures for resolving disagreements between the department and the Department of Aging and Disability Services or the Department of State Health Services concerning the department's investigation findings.
- (c) The department, the Department of Aging and Disability Services, and the Department of State Health Services shall develop joint rules to facilitate investigations in community centers, mental health authorities, and mental retardation authorities.
- (c-1) The executive commissioner shall adopt rules regarding investigations in a facility licensed under Chapter 252, Health and Safety Code, to ensure that those investigations are as consistent as practicable with other investigations conducted under this subchapter.

- (d) A confirmed investigation finding by the department may not be changed by a superintendent of a state mental health facility, by a director of a state supported living center, by a director of a community center, or by a mental health authority or mental retardation authority.
- (e) The department shall provide by rule for an appeals process by the alleged victim of abuse, neglect, or exploitation under this section.
- (f) The department by rule may assign priorities to an investigation conducted by the department under this section. The primary criterion used by the department in assigning a priority must be the risk that a delay in the investigation will impede the collection of evidence.

Sec.48.256. Single Tracking System for Reports and Investigations.

- (a) The department, the Department of Aging and Disability Services, and the Department of State Health Services shall jointly develop and implement a single system to track reports and investigations under this subchapter.
- (b) To facilitate implementation of the system, the department, the Department of Aging and Disability Services, and the Department of State Health Services shall use appropriate methods of measuring the number and outcome of reports and investigations under this subchapter.

SUBCHAPTER G. Investigations in Certain Facilities

Sec.48.301. Investigation of Reports in Other State Facilities.

- (a) If the department receives a report of suspected abuse, neglect, or exploitation of an elderly or disabled person, other than a disabled person receiving services as described by Section 48.252, in a facility operated, licensed, certified, or registered by a state agency, the department shall refer the report to that agency.
- (b) A state agency that receives a report under this section shall make a thorough investigation promptly after receiving a report that an elderly or disabled person has been or may be abused, neglected, or exploited in a facility operated, licensed, certified, or registered by the agency. The primary purpose of the investigation is the protection of the elderly or disabled person.

- (c) Each state agency that may receive reports under this section shall adopt rules relating to the investigation and resolution of reports received under this section.
- (d) The state agency shall prepare and keep on file a complete written report of each investigation conducted by the state agency under this section.
- (e) A state agency that receives a complaint relating to an investigation conducted under this section shall refer the complaint to its governing board or other entity designated to receive such complaints for review and appropriate action.
- (f) The Health and Human Services Commission by rule shall adopt minimum standards for the investigation of suspected abuse, neglect, or exploitation of an elderly or disabled person under this section.
- (g) A rule or policy adopted by a state agency or institution under Subsection (c) must be consistent with the minimum standards adopted by the Health and Human Services Commission.

Sec.48.302. APPROVAL OF RULES.

The Health and Human Services Commission shall review and approve the rules to ensure that all agencies implement appropriate standards for the conduct of investigations and that uniformity exists among agencies in the investigation and resolution of reports.

Sec.48.303. Memorandum of Understanding.

- (a) The department shall adopt a memorandum of understanding with each state agency that operates, licenses, certifies, or registers a facility in which elderly or disabled persons are located that clarifies each agency's responsibility under this chapter.
- (b) Not later than the last month of each state fiscal year, the department and the other agencies shall review and update the memorandum.

Sec.48.304. Statistics.

- (a) Each state agency, other than the Texas Department of Mental Health and Mental Retardation, that operates, licenses, certifies, or registers a facility in which elderly or disabled persons are located shall compile and maintain statistics on the incidence of abuse, neglect, or exploitation of elderly or disabled persons that occurs in the facilities.

- (b) The agency shall make the statistics available to the Health and Human Services Commission on request.

SUBCHAPTER H. Investigations of Providers of Home and Community-Based Services Contracting With TDMHMR

Sec.48.351. Definitions.

In this subchapter:

- (1) "Community center" has the meaning assigned by Section 531.002, Health and Safety Code.
- (2) "Department facility" means:
 - (A) a facility listed in Section 532.001, Health and Safety Code; or
 - (B) a state-operated community services program operated by the Texas Department of Mental Health and Mental Retardation or a facility of the department.
- (3) "Home and community-based services" means the services described by 42 U.S.C. Section 1396n(c) that are provided by a person under a contract with the Texas Department of Mental Health and Mental Retardation.
- (4) "Local mental health authority" has the meaning assigned by Section 531.002, Health and Safety Code.
- (5) "Local mental retardation authority" has the meaning assigned by Section 531.002, Health and Safety Code.
- (6) "Provider" means a person who contracts with the Texas Department of Mental Health and Mental Retardation to provide home and community-based services. The term includes an officer, employee, or agent of the provider, and any person with whom the provider subcontracts for the provision of those services.

Sec.48.352. Investigation of Reports Relating to Home and Community-Based Services.

- (a) The department shall receive and investigate reports of abuse, neglect, or exploitation of an individual receiving home and community-based services from a provider if the provider is or may be the person alleged to have committed the abuse, neglect, or exploitation.

- (b) The department shall receive and investigate reports of abuse, neglect, or exploitation of an elderly or disabled individual residing in a residence owned, operated, or controlled by a provider in which the home and community-based services are provided, regardless of whether the individual receives those services, if the provider is or may be the person alleged to have committed the abuse, neglect, or exploitation.
- (c) If the provider is a department facility, a local mental health or mental retardation authority, or a community center, Subchapter F also applies.

Sec.48.353. Action on Report.

- (a) On receipt by the department of a report of alleged abuse, neglect, or exploitation under this subchapter, the department shall initiate a prompt and thorough investigation as needed to evaluate the accuracy of the report and to assess the need for emergency protective services, unless the department determines, in accordance with rules adopted under Subchapter F, that the report:
 - (1) Is frivolous or patently without a factual basis; or
 - (2) Does not concern abuse, neglect, or exploitation.
- (b) On learning that a provider is or may be the person who committed the alleged abuse, neglect, or exploitation, the department shall notify the following persons that the department has initiated an investigation:
 - (1) The chief executive of the provider and any other personnel of the provider as necessary to facilitate the investigation;
 - (2) The designated administrator at the Texas Department of Mental Health and Mental Retardation; and
 - (3) Any other governmental entity that the investigator believes should be notified as necessary to assist in the investigation or in the provision of services.
- (c) The provider shall:
 - (1) Cooperate completely with the investigation;
 - (2) Provide complete access to all sites owned, operated, or controlled by the provider; and
 - (3) Provide complete access to clients and client records.

- (d) The department shall adopt rules for conducting investigations under this subchapter.

Sec.48.354. Forwarding of Completed Investigation Report.

- (a) The department shall forward to the chief executive of a provider and to the designated administrator at the Texas Department of Mental Health and Mental Retardation:
 - (1) A copy of any report the department received under this subchapter; and
 - (2) A copy of the department's investigation findings and report.
- (b) The allegation report and the investigation report shall be edited to protect the identity of the person who made the report under Section 48.051.

Sec.48.355. Provision of Services to Recipient of Home and Community-Based Services.

- (a) The Texas Department of Mental Health and Mental Retardation is responsible for providing services to an individual receiving home and community-based services as necessary to alleviate abuse, neglect, or exploitation if the department determines that the person needs the services because of the failure of a provider to furnish contracted services.
- (b) The department may provide emergency services necessary to immediately protect the individual from serious physical harm or death and, if necessary, obtain an emergency order for protective services under Section 48.208.
- (c) The department and the Texas Department of Mental Health and Mental Retardation shall develop joint rules governing the provision of services under this section.

Sec.48.356. Provision of Services to Individual Not Receiving Home and Community-Based Services.

The department shall provide services in accordance with Subchapter E to an elderly or disabled individual who does not receive home and community-based services but who lives in a residence owned, operated, or controlled by a provider in which home and community-based services are provided.

Sec.48.357. Responsibilities of TDMHMR.

- (a) At least once each calendar quarter, the Texas Department of Mental Health and Mental Retardation shall provide to the department:
 - (1) The name and address of each provider who has a contract with the Texas Department of Mental Health and Mental Retardation to provide home and community-based services;
 - (2) The name and telephone number of the chief executive of each provider described by Subdivision (1); and
 - (3) The address of each residence owned, operated, or controlled by each provider described by Subdivision (1) in which home and community-based services are provided.
- (b) The Texas Department of Mental Health and Mental Retardation shall make available to the department the name and telephone number of each person to notify if an individual receiving home and community-based services needs services to alleviate abuse, neglect, or exploitation.
- (c) The Texas Department of Mental Health and Mental Retardation shall require each provider to:
 - (1) provide to the Texas Department of Mental Health and Mental Retardation each calendar quarter the provider's business address and telephone number and the name of the provider's chief executive;
 - (2) provide to the Texas Department of Mental Health and Mental Retardation a telephone number at which the chief executive, or a designated representative, can be reached during normal business hours, if different from the telephone number required by Subdivision (1);
 - (3) Provide to the Texas Department of Mental Health and Mental Retardation each calendar quarter the name, if any, address, and telephone number of any residence owned, operated, or controlled by the provider in which home and community-based services are provided; and
 - (4) Post in a conspicuous location inside any residence owned, operated, or controlled by the provider in which home and community-based services are provided, a sign that states:

- (A) The name, address, and telephone number of the provider;
- (B) The effective date of the provider's contract with the Texas Department of Mental Health and Mental Retardation to provide home and community-based services; and
- (C) The name of the legal entity that contracted with the Texas Department of Mental Health and Mental Retardation to provide those services.

Sec.48.358. Retaliation Prohibited.

- (a) A provider may not retaliate against a person for filing a report or providing information in good faith relating to the possible abuse, neglect, or exploitation of an individual receiving services from the provider or residing in a residence owned, operated, or controlled by the provider in which services are provided.
- (b) This section does not prohibit a provider from terminating an employee for a reason other than retaliation.

SUBCHAPTER I. Employee Misconduct Registry

Sec.48.401. Definitions.

In this subchapter:

- (1) "Agency" means:
 - (A) An entity licensed under Chapter 142, Health and Safety Code;
 - (B) A person exempt from licensing under Section 142.003(a)(19), Health and Safety Code;
 - (C) A facility licensed under Chapter 252, Health and Safety Code; or
 - (D) An entity investigated by the department under Subchapter F or under Section 261.404, Family Code.
- (2) "Commissioner" means the commissioner of the Department of Family and Protective Services.
- (3) "Employee" means a person who:
 - (A) Works for an agency;

- (B) Provides personal care services, active treatment, or any other personal services to an individual receiving agency services or to an individual who is a child for whom an investigation is authorized under Section 261.404, Family Code; and
 - (C) Is not licensed by the state to perform the services the person performs for the agency.
- (4) "Employee misconduct registry" means the employee misconduct registry established under Chapter 253, Health and Safety Code.
- (5) "Reportable conduct" includes:
 - (A) Abuse or neglect that causes or may cause death or harm to an individual receiving agency services;
 - (B) Sexual abuse of an individual receiving agency services;
 - (C) Financial exploitation of an individual receiving agency services in an amount of \$25 or more; and
 - (D) Emotional, verbal, or psychological abuse that causes harm to an individual receiving agency services.

Sec.48.402. Rules Relating to Reportable Conduct.

The department may adopt rules to further define reportable conduct.

Sec.48.403. Finding.

After an investigation and following the procedures of this subchapter, if the department confirms or validates the occurrence of reportable conduct by an employee, the department shall immediately forward the finding to the Department of Aging and Disability Services to record the reportable conduct in the employee misconduct registry under Section 253.007, Health and Safety Code.

Sec.48.404. Notice of Finding.

- (a) The department shall give written notice of the department's findings under Section 48.403 to the employee. The notice must include:

- (1) A brief summary of the department's findings;
 - (2) A statement of the employee's right to a hearing on the department's findings; and
 - (3) A statement notifying the employee that if the employee fails to timely respond to the notice, the finding that the employee committed the reportable conduct will be recorded in the employee misconduct registry under Section 253.007, Health and Safety Code.
- (b) Not later than the 30th day after the date the notice is received, the employee notified may accept the finding of the department made under Section 48.403 or may make a written request for a hearing on that finding.
- (c) If the employee notified of the violation accepts the finding of the department or fails to timely respond to the notice, the commissioner or the commissioner's designee shall issue an order approving the finding and ordering that the department's findings be forwarded to the Department of Aging and Disability Services to be recorded in the employee misconduct registry under Section 253.007, Health and Safety Code.

Sec.48.405. Hearing; Order.

- (a) If the employee requests a hearing, the department or its designee shall:
 - (1) Set a hearing;
 - (2) Give written notice of the hearing to the employee; and
 - (3) Designate an administrative law judge to conduct the hearing.
- (b) The administrative law judge shall make findings of fact and conclusions of law and shall promptly issue an order regarding the occurrence of the reportable conduct.
- (c) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1056, Sec. 17, eff. September 1, 2011.

Sec.48.406. Notice; Judicial Review.

- (a) The department shall give notice of the order under Section 48.405 to the employee alleged to have committed the reportable conduct. The notice must include:

- (1) Separate statements of the findings of fact and conclusions of law;
 - (2) A statement of the right of the employee to judicial review of the order; and
 - (3) A statement that the reportable conduct will be recorded in the employee misconduct registry under Section 253.007, Health and Safety Code, if:
 - (A) The employee does not request judicial review of the finding; or
 - (B) the finding is sustained by the court.
- (b) Not later than the 30th day after the date the decision becomes final as provided by Chapter 2001, Government Code, the employee may file a petition for judicial review contesting the finding of the reportable conduct. If the employee does not request judicial review of the finding, the department shall send a record of the department's findings to the Department of Aging and Disability Services to record in the employee misconduct registry under Section 253.007, Health and Safety Code.
- (c) Judicial review of the order:
- (1) Is instituted by filing a petition as provided by Subchapter G, Chapter 2001, Government Code; and
 - (2) Is under the substantial evidence rule.
- (d) If the court sustains the finding of the occurrence of the reportable conduct, the department shall forward the finding of reportable conduct to the Department of Aging and Disability Services to record the reportable conduct in the employee misconduct registry under Section 253.007, Health and Safety Code.

Sec.48.407. Informal Proceedings.

The executive commissioner by rule shall adopt procedures governing informal proceedings held in compliance with Section 2001.056, Government Code.

Sec.48.408. Information for the Employee Misconduct Registry.

- (a) When the department forwards a finding of reportable conduct to the Department of Aging and Disability Services for recording in the employee misconduct registry, the department shall provide the employee's name, the employee's address, the employee's social security number, if available, the name of the agency, the address of the agency, the date the reportable conduct occurred, and a description of the reportable conduct.
- (b) If a governmental agency of another state or the federal government finds that an employee has committed an act that constitutes reportable conduct, the department may send to the Department of Aging and Disability Services, for recording in the employee misconduct registry, the employee's name, the employee's address, the employee's social security number, if available, the name of the agency, the address of the agency, the date of the act, and a description of the act.