RESIDENT'S RIGHTS

PI-YI MAYO, C.E.L.A.
Attorney at Law
5223 Garth Road
Baytown, TX 77521
(281) 421-5774
Fax: (281) 421-1103

Chapter 9

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RESIDENT'S RIGHTS

I. INTRODUCTION

At some point in their career every Elder Law attorney will get a phone call from a frantic spouse or family member on the verge of tears because the nursing home has told them their loved one is going to be evicted from the nursing home and that they must either pick the person up today or they will be transported to the home of the relative and left there. At the time of this call these clients will be at their wits end and stressed to an unimaginable level over the prospect of having to immediately drop everything in their life and prepare to somehow care for their ailing relative. Most often they did everything humanly possible to care for the person at home before they were forced to seek the nursing home care in the first place and the thought of having to provide the care again is more than most can rationally cope with. This is where you as an Elder Law attorney can make a real difference in people's lives by your very specialized knowledge. This paper is intended to give you the legal knowledge necessary to prepare for this eventual phone call. Your knowledge and skill as well as your confident demeanor will be a lifeline to this drowning person in this emergency situation. After confirming just a few facts you should be able to assure the desperate caller that the nursing home is prevented by state and federal law from doing any such thing and then you will most likely be able to stop any further actions by the nursing home with a few phone calls.

II. SOURCES OF LAW

A. Federal Law

The rights of residents in nursing homes as well as the responsibilities of the providers of their care are spelled out very clearly in the federal law. Most of the federal law is then enacted in one form or another by the State of Texas. The main source of laws in this area is The Nursing Home Reform Act of 1987 (NHRA). This was contained in Public Law 100-203, Subtitle C part of the Omnibus Budget Act of 1987. Most of the nursing home industry refers to the law as "OBRA-87". NRHA is codified at Title 42 of the United States Code, §§ 1395I-3 and 1396r. The federal regulations that mirror these USC provisions are found at Title 42 §§ 483.5 through 483.75 of the Code of Federal Regulations. Any nursing home that accepts money from either Medicare or Medicaid must comply with the provisions of the NHRA. The requirements of the law and the extent to which they describe the duties and obligations of nursing homes to residents are astounding. Every aspect of a resident's life and their care is proscribed by these laws and regulations. If nursing home work is a significant part of your practice you should study and be familiar with all of these sections as they control basically all of the interactions between the resident and the facility. These regulations are further explained in HCF Transmittal No. 274 (June 1995). In this transmittal the Health Care Financing Administration takes the regulations and sets forth "Guidance to Surveyors" to explain to field surveyors how the regulations are to be implemented and instructions on how to verify or determine if the regulations are being complied with. These guidelines are unbelievably specific such as instructing the surveyors to observe the types of flooring the nursing home has in different parts of the nursing home to make sure that Medicaid recipients are not housed in wings with tile floors when private pay patients are in areas with carpeted hallways.

B. Texas Law

In order to deal with the phone call from your client you do not have to resort to the federal law mentioned above at all. Most of the Code of Federal Regulations (CFR) sections dealing with the discharge of a resident have been copied word for word and set forth in the Texas Administrative Code (TAC). In comparing the CFR to the TAC the only deviations that can be observed are when the TAC includes additional protections for a resident that the CFR does not have. The Texas Administrative Code sections that deal with most aspects of nursing home regulations are found at Title 40 Social Services and Assistance, Part 1 Texas Department of Human Services, Chapter 19

Nursing Facility Requirements for Licensure and Medicaid Certification. The specific sections dealing with Discharge Rights are found at 40 Tex. Admin. Code § 19.502. These sections set forth the only legal basis upon which a nursing home may involuntarily discharge a resident and the procedures required to do so. Since the TAC sections mirror the CFR only references to the TAC will be set forth in the following parts of the paper.

III. LEGAL REQUIREMENTS FOR DISCHARGE

The Federal law and the Texas Administrative Code recognize only six limited justifications for involuntary discharge from a nursing home. Prior to listing the six reasons however the definition of a discharge is set forth at 40 TAC §19.502 (a). A transfer or discharge includes movement of a resident to a bed outside the certified facility, whether that bed is the same physical plant or not. Transfer and discharge does not refer to movement within the same certified facility. Note however, a resident has a right to refuse certain transfers within a facility as well. 40TAC §19.421. The term *transfer* refers to a movement from one certified institution to another certified institution. The term *discharge* refers to a movement from a certified institution to a non-institutional setting such as a private residence. The law further specifies that the policies regarding transfer, discharge and the provision of services must be identical for all individuals regardless of the source of payment for their care. 40 TAC §19.504. This is one of the first lines of inquiry when you are contacted by a client. First, determine how the resident is paying for their care and then find out if they are being treated differently from other residents that have a different payment source. If you discover differences in treatment between private pay residents and Medicare or Medicaid residents then the discharge is illegal.

A. The Six Legal Basis For Discharge

The NHRA prohibits a nursing home from discharging or transferring a resident unless the facility can document that the transfer or discharge was made in compliance with one of the following six requirements. This should be the basis for your second line of inquiry when you get that phone call. If you cannot determine that the transfer is being made for one of these six reasons then the transfer or discharge is illegal.

1. Resident's Welfare

The transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the facility. 40TAC §19.502 (b) (1).

2. Resident Medical Improvement

The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility. 40 TAC § 19.592(b) (2).

3. Safety Of Other Residents And Staff

The safety of individuals in the facility is endangered. 40 TAC §19.502 (b) (3).

4. Health Of Other Residents

The health of other individuals in the facility would otherwise be endangered. 40 TAC §19.502 (b).

5. Failure To Pay

The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid. 40 TAC §19.502 (b) (5).

6. Nursing Home Closes Or Stops Accepting Medicaid

The facility ceases to operate or participate in the program which pays for the resident's care. If the facility voluntarily withdraws from participation in Medicaid, but continues to provide nursing facility services: 40 TAC §19.502 (b) (7).

a. The facility's voluntary withdrawal from Medicaid is not an acceptable basis for the

transfer or discharge of residents who were residing in the facility on the day before the effective date of the withdrawal (including those residents who were not entitled to Medicaid assistance as of such day);

b. for individuals who begin residence in the facility after the effective date of the withdrawal, the
facility must provide notice orally and in a prominent manner in writing on a separate page of the admission agreement at the time the resident begins residence and document receipt in writing, signed by the individual, and separate from other documents signed by the individual of the following
information:

(i) The facility is not participating in the Medicaid program with respect to these residents.

(ii) The facility may transfer or discharge these residents if they are unable to pay the charges of the facility, even though the resident may have become eligible for Medicaid nursing facility services.

B. Documentation Requirements

If the nursing home intends to involuntarily transfer or discharge a resident under any of the provisions set forth above except for subsection A6 above concerning closing of the nursing home, the basis for the action must be documented in the resident's clinical record. Further, if the basis for the discharge in Section A 1 Resident's Welfare or A 2 Resident Medical Improvement the documentation of the clinical record *must be made by the resident's physician.* If the basis for the transfer or discharge is section A 4 Health Of Other Residents then the documentation *must be made by a physician*. The documentation may be made by any staff member if the basis is other than these specific sections. 40 TAC 119.502 (c). The difference between the requirement of *the resident's physician* and *any physician* is an illusory requirement because as a practical matter in most nursing homes one physician will be the "treating physician" for every resident in the home. This requirement of the involvement of any physician however could be fertile ground for inquiry concerning the discharge as there have been some recent cases in which physicians have been hit with large liability verdicts for rubber stamping transfers of nursing home residents.

C. Notice Requirements

The nursing home is required to give the resident notice of any proposed involuntary transfer or discharge and the regulations are specific as to the timing and the contents of the notice. 40 TAC §19.502 (d), (e), (f). The regulations governing this area are generally straight forward and easy to deal with. This is not the case with the requirements for the timing of the notice of discharge. The aforementioned TAC section 19.502 becomes very convoluted when describing the required time the nursing home must give notice prior to the intended action.

1. Timing Of Notice Of Transfer Or Discharge

If the basis for the transfer or discharge is that the resident has failed to pay a bill (see #5. Failure To Pay above) or that the nursing home is closing or no longer accepting Medicaid (see #6. Nursing Home Closes or Stops Accepting Medicaid above) the notice of transfer or discharge must be made by the facility *at least 30 days before the resident is transferred or discharged.*

If the basis of the discharge is any of the other six legal requirements set forth above Resident's Welfare; Resident Medical Improvement; Safety Of Other Residents And Staff; Health Of Other Residents; or the resident has not resided in the facility for at least 30 days then the notice may be made as soon as practical before transfer or discharge. There is no definition of what is "practical" in the TAC or in the Federal Law. As a practicable matter the notice must give the resident time to file an appeal of the transfer or discharge as discussed below.

If the basis for the transfer or discharge is Safety Of Other Residents And Staff or Health Of Other Residents, and the discharge is not to a hospital, the nursing home must immediately call the staff of the state office LTC-R Customer Service Section of the Texas Department of

Human Services (DHS) to report their intention to discharge and submit the required physician documentation regarding the discharge. 40 TAC §19.502 (e) (4).

2. Contents And Delivery of Notice Of Transfer Or Discharge

The facility must notify the resident *and*, if known, a responsible party or family or legal representative of the resident about the transfer or discharge and the reasons for the move in writing, and in a language and manner they will understand. The written notice must contain the following:

a. the effective date of transfer or discharge;
b. the location to which the resident is transferred or discharged;
c. a statement that the resident has the right to appeal the action as outlined in DHS's Fair Hearings, Fraud, and Civil Rights Handbook by requesting a hearing through the Medicaid eligibility worker at the local DHS office within 10 days;
d. the reason for the transfer or discharge;
e. the name, address, and telephone number of the regional representative of the Office of the State Long Term Care Ombudsman, Texas Department on Aging, and of the toll-free number of the Texas Long Term Care Ombudsman, 1-800-252-2412;
f. In the case of a resident with mental illness or mental retardation, the address and phone number of the state mental health/mental retardation authority, which is: Texas Department of Mental Health and Mental Retardation, P.O. Box 12668, Austin, Texas 78711-2668, 1-800-252-8154; and the phone number of the agency responsible for the protection and advocacy of persons with mental illness or mental retardation and/or related conditions, which is: Advocacy Incorporated, 7800 Shoal Creek Boulevard, Suite 175-E, Austin, Texas 78757, 1-800-252-9108. 40 TAC §19.502 (f).

D. Preparation And Orientation Of Resident

Anytime a resident is to be discharged from a nursing home, the facility must prepare a Discharge Summary or a Discharge Plan of Care. 40 TAC §19.803. The regulations specify what the facility must do in preparing such a plan. One of the requirements is that the discharge plan must be developed with the participation of the resident, a family representative, responsible party, and/or legal guardian, which will, after discharge, assist the resident to adjust to his new living environment. *If the discharge is involuntary, the facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility*. 40 TAC §19.502(g). One of the requirements of the discharge plan is that a final summary of the resident's status including items from what is called Resident Assessment Protocols (RAP's) must be available at the time of discharge. A little knowledge about how the RAP's are created can be very useful thing at this time. Within 14 days of the resident's admission, the facility must prepare a comprehensive assessment of a residents needs, using the Resident Assessment Instrument (RAI), including the Minimum Data Set (MDS), specified by DHS. The MDS contains standardized data about the resident's condition. Based on the MDS, a care plan is created by an interdisciplinary team composed of representatives from all of the departments of the facility. The care plan is composed of specific plans and treatments to deal with the specific medical problems and needs of the resident.

If the discharge summary or discharge care plan has not been prepared, or the family was not offered an opportunity to participate in the development of the plan, then this is a procedural flaw that should prevent the discharge if challenged. If the discharge care plan has been created, it should be compared with the RAP's and the information on the

MDS that was prepared when the resident first entered the facility to see if the discharge care plan adequately provides for the needs of the resident.

IV. CHALLENGING A DISCHARGE

At the time of the frantic call, the most important thing is to look to the procedural aspects of the actions of the facility and determine if the proposed transfer or discharge can be stopped with a phone call to the legal counsel for the facility. In most cases the nursing home will have failed to follow any of the legal steps required to evict the resident. At the most basic point, find out if they have given a written notice at all. In many cases, the relative will simply be told by a representative of the nursing home that they must remove the resident.

A. Right To A Fair Hearing

If you are unsuccessful at stopping the proposed transfer or discharge with phone calls, then the next step is a Fair Hearing. Any individual who receives a discharge notice from a facility has 10 days to appeal. If the recipient appeals, he or she may remain in the facility, except in the circumstances described in III.A.5. Failure to pay above or 40 TAC §19.502 (e)(3) (the section that talks about as soon as practicable discharge), until the hearing officer makes a final determination. 40 TAC §19.502 (i). If the recipient has left the facility, Medicaid eligibility will remain in effect until the hearing officer makes a final determination.

If the resident has already been discharged and the hearing officer determines that the discharge was inappropriate, the facility, upon written notification by the hearing officer, must readmit the resident immediately, or to the next available bed. If the discharge has not yet taken place, and the hearing officer finds that the discharge will be inappropriate, the facility, upon written notification by the hearing officer, must allow the resident to remain in the facility. In addition to notifying the facility of the inappropriate discharge, the hearing officer is required to report their finds to Long Term Care-Regulatory for investigation of possible noncompliance by the nursing home.

If the basis for the discharge is one of the grounds that allows your client to remain in the facility pending the outcome of the appeal, you have effectively put off the proposed discharge for at least 30 days or more. Practical experience with the fair hearing process in the State of Texas would indicate that it most always takes at least 30 days to get a fair hearing scheduled. Once the hearing is held, depending on the docket of the hearing officer, it may take another several weeks to get a decision.

B. Winning The Appeal

The failure of the nursing home to follow the required procedure in a transfer or discharge matter is the easiest way to challenge the action of the nursing home. Each of the procedural steps set forth above should be examined to determine if the facility has skipped any steps, or even has valid legal reason for the transfer in the first place. Although a thorough examination of the different techniques that can be used to defeat a proposed transfer or discharge is beyond the scope of this paper, some very common reasons for challenging a transfer can be:

1. New Facility Is No Better Than This One

If the reason for the transfer is not based on a true inability to care for the resident, then what type of facility does the discharge plan propose for the resident? If the new facility is the same type, and for all practical purposes cannot provide any different medical treatment than the current facility, then the basis for the transfer does not comply with the law. How can the facility

justify a transfer based on their inability to care for the needs of the resident and then provide in the discharge plan for placement in a facility that cannot provide any different care.

2. Resident Is Not A Danger To Safety Or Health Of Others

Many times a nursing home resident will be stricken with a disease that affects their mental status and causes them to exhibit disruptive or unpleasant behavior. If the nursing home is just trying to rid themselves of such a resident because they require a lot of staff time and attention, then the transfer or discharge is inappropriate. Always obtain copy of the Resident Assessment Instrument and the Minimum Data Set and determine what Resident Assessment Protocols were created to deal with the behavior problems of the resident. Discharge of the resident should not be the option of choice for their facility as the regulations require that the facility must provide medically-related social services to attain the highest practicable physical, mental, or psychological well-being of each resident. 40 TAC §19.703(a). If the care plan does not set forth the goals or methods that the facility plans to utilize to obtain the highest practical mental well-being for the resident, then they should not be allowed to discharge the resident. Further, no matter how disruptive they may be, they are most likely not a danger to the safety of the other residents or the staff. Unless they pose such a danger then the discharge is inappropriate.

V. CONCLUSION

The practical side of dealing with the frantic phone call mentioned above may be that you do not want to oppose the transfer. In the exercise of your function as counselor, it may be that the best thing you can do for your client is to utilize your knowledge to help them find an alternative placement for the person. Once the emergency can be averted, then the long-term aspects of the situation should be evaluated. Does the caller really want their loved one to stay in this facility if another appropriate placement can be found? However, there are many times when the transfer or discharge should be challenged. It may be necessary to oppose the transfer or discharge in order to have the time to find another facility. Sometimes, because of the behavior of the resident, changing the facility is not the answer. Forcing the facility to provide the care as required by the law is what is needed. Sometimes when the family or care givers of the resident are too vocal in the demands they make of the facility for the care of the person, the nursing home will simply try to get rid of the resident rather than deal with the demands of the family.

In the cases where it is in the best interest of the resident to remain in the facility, the Federal law as well as the laws of the State of Texas give your client many protections from a unlawful discharge. This paper will give you a start on finding and applying the law. If you need further help, there are several advocacy groups in the country that can provide additional help in the law and techniques to deal with a wide range of issues concerning nursing homes. The foremost of these is the National Citizens; Coalition for Nursing Home Reform. They have a website at http://www.nccnhr.org that can provide additional resources.

EXHIBIT 'A'

Texas Administrative Code

Next Rule>>

TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER E RESIDENT RIGHTS

RULE §§19.403 Notice of Rights and Services

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

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

(1) facility admission policies;

(2) a description of the protection of personal funds as described in §§19.404 of this title (relating to Protection of Resident Funds); and

(3) the Human Resources Code, Title 6, Chapter 102; or a written list of the rights and responsibilities contained in the Human Resources Code, Title 6, Chapter 102;

(4) a written description of the services available through the Office of the State Long Term Care Ombudsman, Texas Department on Aging. This information must be made available to each facility by the ombudsman program. Facilities are responsible for reproducing this information and making it available to residents, their families, and legal representatives; and

(5) a written statement describing the facility's policy for the drug testing of employees who have direct contact with residents.

(c) Receipt of information in subsections (a)-(b) of this section, and any amendments to it, must be acknowledged in writing by all parties receiving the information.

(d) The facility must post a copy of each document specified in subsections (a)-(b) of this section in a conspicuous location.

(e) The resident or his legal representative has the following rights:

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

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

(f) The resident has the right to be fully informed in language that he can understand of his total health status, including but not limited to, his medical condition.

(g) The resident has the right to refuse treatment, to formulate an advance directive (as specified in §§19.419 of this title (relating to Directives and Durable Powers of Attorney for Health Care)), and to refuse to participate in experimental research.

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

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

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

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

(i) The facility must furnish a written description of legal rights which includes:

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

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

(3) a statement that the resident may file a complaint with DHS concerning resident abuse, neglect, and misappropriation of resident property in the facility.

(j) The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his care.

(k) Notification of changes.

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

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

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

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

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

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

(A) a change in room or roommate assignment as described in §§19.701(5)(B) of this title (relating to Quality of Life); or

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

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

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

(1) provide the resident with the state-developed notice of rights under §§1919(e)(6) of the Social Security Act (see also §§19.402 of this title (relating to Exercise of Rights));

(2) inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of:

(A) the items and services that are included in nursing facility services provided under the State Plan and for which the resident may not be charged;

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

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

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

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

institutionalization; and

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

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

Source Note: The provisions of this §§19.403 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective March 1, 1998, 23 TexReg 1314; amended to be effective August 1, 2000, 25 TexReg 6779; amended to be effective July 1, 2001, 26 TexReg 3824

EXHIBIT 'B'

Texas Administrative Code

Next Rule>>

TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER F ADMISSION, TRANSFER, AND DISCHARGE RIGHTS IN MEDICAID-CERTIFIED FACILITIES

RULE §§19.501 Admissions Policy for Medicaid-certified Facilities

(a) The facility must not require:

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

(2) oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

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

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

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

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

EXHIBIT "C"

Texas Administrative Code

Next Rule>>

TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER F ADMISSION, TRANSFER, AND DISCHARGE RIGHTS IN MEDICAID-CERTIFIED FACILITIES

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

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

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

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

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

(3) the safety of individuals in the facility is endangered;

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

(5) the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;

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

(7) the facility ceases to operate or participate in the program which pays for the resident's care. See §§19.2310 of this title (relating to Nursing Facility Ceases to Participate). If the facility

voluntarily withdraws from participation in Medicaid, but continues to provide nursing facility services:

(A) the facility's voluntary withdrawal from Medicaid is not an acceptable basis for the transfer or discharge of residents who were residing in the facility on the day before the effective date of the withdrawal (including those residents who were not entitled to Medicaid assistance as of such day);

(B) for individuals who begin residence in the facility after the effective date of the withdrawal, the facility must provide notice orally and in a prominent manner in writing on a separate page of the admission agreement at the time the resident begins residence and document receipt in writing, signed by the individual, and separate from other documents signed by the individual of the following information:

(i) The facility is not participating in the Medicaid program with respect to these residents.

(ii) The facility may transfer or discharge these residents if they are unable to pay the charges of the facility, even though the resident may have become eligible for Medicaid nursing facility services.

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

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

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

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

(1) notify the resident and, if known, a responsible party or family or legal representative of the resident about the transfer or discharge and the reasons for the move in writing and in a language and manner they will understand;

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

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

(e) Timing of the notice.

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

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

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

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

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

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

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

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

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

(A) immediately call the staff of the state office LTC-R Customer Service Section of the Texas Department of Human Services (DHS) to report their intention to discharge; and

(B) submit the required physician documentation regarding the discharge.

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

(1) the reason for transfer or discharge;

(2) the effective date of transfer or discharge;

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

(4) a statement that the resident has the right to appeal the action as outlined in DHS's Fair Hearings, Fraud, and Civil Rights Handbook by requesting a hearing through the Medicaid eligibility worker at the local DHS office within 10 days;

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

(6) in the case of a resident with mental illness or mental retardation, the address and phone number of the state mental health/mental retardation authority, which is: Texas Department of Mental Health and Mental Retardation, P.O. Box 12668, Austin, Texas 78711-2668, 1-800-252-8154; and the phone number of the agency responsible for the protection and advocacy of persons with mental illness or mental retardation and/or related conditions, which is: Advocacy Incorporated, 7800 Shoal Creek Boulevard, Suite 175-E, Austin, Texas 78757, 1-800-252-9108.

(g) Orientation for transfer or discharge. A facility must provide sufficient preparation and

orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(h) Notice of relocation to another room. Except in an emergency, the facility must notify the resident and either the responsible party or the family or legal representative at least five days before relocation of the resident to another room within the facility. The facility must prepare a written notice which contains:

(1) the reasons for the relocation;

(2) the effective date of the relocation; and

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

(i) Fair hearings.

(1) Individuals who receive a discharge notice from a facility have 10 days to appeal. If the recipient appeals, he may remain in the facility, except in the circumstances described in subsections (b)(5) and (e)(3) of this section, until the hearing officer makes a final determination. Vendor payments and eligibility will continue until the hearing officer makes a final determination. If the recipient has left the facility, Medicaid eligibility will remain in effect until the hearing officer makes a final determination.

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

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

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

Source Note: The provisions of this §§19.502 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective March 1, 1998, 23 TexReg 1314; amended to be effective January 1, 2000, 24 TexReg 11781; amended to be effective August 1, 2000, 25 TexReg 6779

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TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER F ADMISSION, TRANSFER, AND DISCHARGE RIGHTS IN MEDICAID-CERTIFIED FACILITIES

RULE §§19.503 Notice of Bed-Hold Policy and Readmission in Medicaid-certified Facilities

(a) Notice before transfer. Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies:

(1) the duration of the bed-hold policy under the Medicaid State Plan (see §§19.2603 of this title (relating to Therapeutic Home Visits Away from the Facility) if any, during which the resident is permitted to return and resume residence in the facility; and

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

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

(c) Permitting resident to return to facility. A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State Plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident:

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

(2) is eligible for Medicaid nursing facility services.

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

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

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

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

Source Note: The provisions of this §§19.503 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective March 1, 1998, 23 TexReg 1314.

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TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER F ADMISSION, TRANSFER, AND DISCHARGE RIGHTS IN MEDICAID-CERTIFIED FACILITIES

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

(a) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the Medicaid State Plan for all individuals regardless of source of payment.

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

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

Source Note: The provisions of this §§19.504 adopted to be effective May 1, 1995, 20 TexReg 2393.

EXHIBIT "F"

Texas Administrative Code

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TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER F ADMISSION, TRANSFER, AND DISCHARGE RIGHTS IN MEDICAID-CERTIFIED FACILITIES

RULE §§19.505 Discharge Planning in Medicaid-certified Facilities

Discharge planning must be done by appropriate facility staff in accordance with the provisions outlined in §§19.803 of this title (relating to Discharge Summary (Discharge Plan of Care)).

Source Note: The provisions of this §§19.505 adopted to be effective May 1, 1995, 20 TexReg 2393

EXHIBIT "G"

Texas Administrative Code

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TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER H QUALITY OF LIFE

RULE §§19.701 Quality of Life

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

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

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

(A) choose activities, schedules, and health care consistent with his interests, assessments, and plans of care;

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

(C) make choices about aspects of his life in the facility that are significant to him.

(3) Participation in resident and family groups.

(A) A resident has the right to organize and participate in resident groups in the facility.

(B) A resident's family has the right to meet in the facility with the families of other residents in the facility.

(C) The facility must provide a resident or family group, if one exists, with private space.

(D) Staff or visitors may attend meetings at the group's invitation.

(E) The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.

(F) When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

(G) The facility must assist residents to attend meetings.

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

(5) Accommodation of needs. A resident has the right to:

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

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

(6) Accommodations for children. Pediatric residents should be matched with roommates of similar age and developmental levels.

Source Note: The provisions of this §§19.701 adopted to be effective May 1, 1995, 20 TexReg 2393.

EXHIBIT "H"

Texas Administrative Code

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TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER H QUALITY OF LIFE

RULE §§19.703 Social Services General Requirements

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

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

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

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

(1) a bachelor's degree in social work, or a bachelor's degree in a human services field, including, but not limited to, sociology, special education, rehabilitation counseling, and psychology; and

(2) one year of supervised social work experience in a health care setting working directly with individuals.

Source Note: The provisions of this §§19.703 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective August 1, 2000, 25 TexReg 6779

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TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER I RESIDENT ASSESSMENT

RULE §§19.801 **Resident Assessment**

The facility must conduct initially and periodically a comprehensive accurate, standardized, reproducible assessment of each resident's functional capacity. In Medicaid-certified and dually certified nursing facilities, admission, annual, quarterly and significant change assessments must be transmitted electronically to the Texas Department of Human Services (DHS).

(1) Admission orders. At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.

(2) Comprehensive assessments.

(A) A facility must make a comprehensive assessment of a resident's needs, using the Resident Assessment Instrument (RAI), including the Minimum Data Set (MDS), specified by DHS. Licensed-only facilities do not have to complete Medicaid-specific sections.

(B) The assessment must include at least the following information:

(i) identification and demographic information;

(ii) customary routine;

(iii) cognitive patterns;

(iv) communication;

(v) vision;

(vi) mood and behavior patterns;

(vii) psychosocial well-being;

(viii) physical functioning and structural problems;

(ix) continence;

(x) disease diagnoses and health conditions;

(xi) dental and nutritional status;

(xii) skin condition;

(xiii) activity pursuit;

(xiv) medications;

(xv) special treatments and procedures;

(xvi) discharge potential;

(xvii) documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and

(xviii) documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

(C) A facility must conduct a comprehensive assessment of a resident as follows:

(i) within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.

(ii) within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.

(iii) not less often than once every 12 months.

(3) Quarterly review assessment. A facility must assess a resident using the quarterly review instrument specified by DHS and approved by the Health Care Financing Administration (HCFA) not less frequently than once every three months.

(4) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care as specified in §§19.802 of this title (relating to Comprehensive Care Plans).

(5) Preadmission Screening and Resident Review (PASARR). A Medicaid-certified facility must coordinate assessments with the PASARR program under Medicaid in Part 483, Subpart C to the maximum extent practicable to avoid duplicative testing and effort.

(6) Automated data processing requirement for Medicaid-certified and dually certified facilities only.

(A) Encoding data. Within seven days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:

(i) admission assessment;

(ii) annual assessment updates;

(iii) significant change in status assessments;

(iv) quarterly review assessments;

(v) a subset of items upon a resident's transfer, reentry, discharge, and death, using the reentry tracking form and/or discharge tracking form; and

(vi) background (face-sheet) information, if there is no admission assessment.

(B) Transmitting data. Within seven days after a facility completes a resident's assessment, a facility must be capable of transmitting to DHS information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by HCFA and DHS.

(C) Monthly transmittal requirements. A facility must electronically transmit, at least monthly (within 31 days of the lock date), encoded, accurate, complete MDS data to DHS for all assessments conducted during the previous month, including the following:

(i) admission assessment;

(ii) annual assessment;

(iii) significant change in status assessment;

(iv) significant correction of prior full assessment;

(v) significant correction of prior quarterly assessment;

(vi) quarterly review;

(vii) a subset of items upon a resident's transfer, reentry, discharge, and death; and

(viii) background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

(D) Data format. The facility must transmit data in the format specified by DHS and approved by HCFA.

(E) Resident-identifiable information.

(i) A facility may not release information that is resident-identifiable to the public.

(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

(7) Accuracy of assessments. The assessment must accurately reflect the resident's status.

(8) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

(9) Certification.

(A) A registered nurse must sign and certify that the assessment is completed.

(B) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(10) Penalty for falsification in Medicaid-certified and dually certified facilities.

(A) An individual who willfully and knowingly:

(i) certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

(B) Clinical disagreement does not constitute a material and false statement.

(11) Use of independent assessors in Medicaid-certified facilities. If DHS determines, under a certification survey or otherwise, that there has been a knowing and willful certification of false statements under paragraph (10) of this section, DHS may require (for a period specified by DHS) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by DHS.

(12) Pediatric resident assessment.

(A) Pediatric assessments should be performed by licensed staff experienced in the care and

assessment of children. Parents or guardians should be included in the assessment process. The potential for community transition should be discussed with the parents or guardians whenever an assessment occurs.

(B) The comprehensive assessment for children must include a record of immunizations, blood screening for lead, and developmental assessment. The local school district's developmental assessment may be used if available. See §§19.1934 of this title (relating to Educational Requirements for Persons Under 22).

(C) Licensed facility staff should assess the child's functional status in relation to pediatric developmental levels, rather than adult developmental levels.

(D) The facility staff must ensure pediatric residents receive services in accordance with the guidelines established by the Texas Department of Health's Texas Health Steps (THSteps). For Medicaid-eligible pediatric residents between the ages of six months and six years, screening for lead poisoning must be done in accordance with THSteps guidelines.

(E) The facility must coordinate educational opportunities for pediatric residents from birth to age three with the local office of Early Childhood Intervention (ECI).

(F) The facility must coordinate educational opportunities for pediatric residents age three to 22 years with the local school district. See §§19.1934 of this title (relating to Educational Requirements for Persons Under 22).

(G) Not later than the third day after a child with a developmental disability is placed in a facility, the facility must notify:

(i) the local community resource coordination group (CRCG); and

(ii) the regional DHS office, which will notify the CRCG in the county of residence of the parent or guardian.

Source Note: The provisions of this §§19.801 adopted to be effective October 1, 1999, 24 TexReg 7767; amended to be effective January 1, 2000, 24 TexReg 11522

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TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER I RESIDENT ASSESSMENT

RULE §§19.802 Comprehensive Care Plans

(a) The facility must develop a comprehensive care plan for each resident that includes measurable short-term and long-term objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. If children are admitted to the facility, the comprehensive care plan must be based on each child's individual needs. The care plan must describe the following:

(1) the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §§19.901 of this title (relating to Quality of Care); and

(2) any services that would otherwise be required under §§19.901 but are not provided due to the resident's exercise of rights, including the right to refuse treatment under §§19.402(g) of this title (relating to Exercise of Rights).

(b) The comprehensive care plan must be:

(1) developed within seven days after completion of the comprehensive assessment;

(2) prepared by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's family or legal representative; and

(3) periodically reviewed and revised by a team of qualified persons after each assessment.

(c) A comprehensive care plan may include a palliative plan of care. This plan may be developed only at the request of the resident, surrogate decision maker or legal representative for residents with terminal conditions, end stage diseases or other conditions for which curative medical interventions are not appropriate. The plan of care must have goals that focus on maintaining a safe, comfortable and supportive environment in providing care to a resident at the end of life.

(d) The services provided or arranged by the facility must:

(1) meet professional standards of quality; and

(2) be provided by qualified persons in accordance with each resident's written plan of care.

(e) The care plan must be made available to all direct care staff.

Source Note: The provisions of this §§19.802 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective June 1, 2001, 26 TexReg 3824

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TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER I RESIDENT ASSESSMENT

RULE §§19.803 Discharge Summary (Discharge Plan of Care)

(a) When the facility anticipates discharge, the resident must have a discharge summary that includes:

(1) a recapitulation of the overall course of the resident's stay;

(2) a final summary of the resident's status, including items in §§19.801(2)(B) of this title (relating to Resident Assessment), must be available for release to authorized persons and agencies with the consent of the resident or legal representative; and

(3) a post-discharge plan of care, developed with the participation of the resident, a family representative, responsible party, and/or legal guardian, which will, after discharge, assist the resident to adjust to his new living environment.

(b) The facility discharge summary must be available at the time of discharge when a resident is

being discharged to a private residence, another nursing facility, a Medicare skilled nursing facility, another residential facility such as a board and care home, or an intermediate care facility for the mentally retarded.

Source Note: The provisions of this §§19.803 adopted to be effective May 1, 1995, 20 TexReg 2393.