This project implements two bills from the 86th Legislature, Regular Session, 2019. House Bill (H.B.) 1848 contains required elements for infection prevention and control. H.B. 3803 limits the daily amount of an administrative penalty assessed against an Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID). The project will also update rule references and agency names, amend rules to align with Centers for Medicare & Medicaid Services conditions of participation in the ICF/IID program, and edit the rules for clarity and consistency.

TITLE 26 HEALTH AND HUMAN SERVICES

PART 1 HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 551 INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITIONS

SUBCHAPTER A INTRODUCTION

§551.2. Scope.

(a) The purpose of this chapter is to promote the public health, safety, and welfare by providing for the development, establishment, and enforcement of standards for the provision of services to individuals residing in intermediate care facilities for persons with an intellectual disability or a related condition.

(b) The term "facility serving persons with an intellectual disability or related conditions," when used in this chapter, means an establishment or home that provides food, shelter, and treatment or services to four or more persons who are unrelated to the owner; is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or related conditions; and provides in a protected setting continuous evaluation, planning, 24-hour supervision, and coordination and integration of health or rehabilitative services to help each resident function at the resident's greatest ability.

(1) A person receiving services in a facility serving persons with an intellectual disability or related conditions must have a diagnosis of an intellectual disability or a related condition as defined under paragraph (2) of this subsection. Facilities serving persons with other developmental disabilities as a primary diagnosis do not fall under the scope of these standards.

(2) The term "related condition" means a severe, chronic disability that meets all of the following conditions:

(A) a condition attributable to:

(i) cerebral palsy or epilepsy; or

(ii) any other condition including autism, but excluding mental illness, found to be closely related to an intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with an intellectual disability and requires treatment or services similar to those required for these persons;

(B) a condition manifested before the person reaches age 22years;

(C) a condition likely to continue indefinitely; and

(D) a condition that results in substantial functional limitations in three or more of the following areas of major life activity:

(i) self-care;

(ii) understanding and use of language;

(iii) learning;

(iv) mobility;

(v) self-direction; and

(vi) capacity for independent living.

(c) This chapter does not apply to an establishment that:

(1) provides training, habilitation, rehabilitation, or education to individuals with an intellectual disability or a related condition; is operated under the jurisdiction of a state or federal agency; and is certified through inspection or evaluation as meeting the standards established by the state or federal agency; or

(2) is conducted by or for the adherents of a well-recognized church or religious denomination for the purpose of providing facilities for the care or treatment of the sick who depend exclusively on prayer or spiritual means for healing, without the use of any drug or material remedy, if the establishment complies with safety, sanitary, and quarantine laws and rules.

§551.3. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise. Individual subchapters may have definitions that are specific to the subchapter.

(1) Active treatment--A continuous program, which includes aggressive, consistent implementation of specialized and generic training, treatment, health services, and related services, that is directed toward:

(A) acquisition of the behaviors necessary for the resident to function with as much self-determination and independence as possible; and

(B) prevention or deceleration of regression or loss of current optimal functional status. (2) Actual harm--A negative outcome that compromises a resident's physical, mental, or emotional well-being.

(3) Addition--The addition of floor space to a facility.

(4) Administrator--The administrator of a facility.

(5) Administration of medication--Removing a unit or dose of medication from a previously dispensed, properly labeled container; verifying the medication with the medication order; giving the proper medication in the proper dosage to the proper resident at the proper time by the proper administration route; and recording the time of administration and dosage administered.

(6) Advanced practice nurse--A person licensed to practice professional nursing in accordance with Texas Occupations Code, Chapter 301, and authorized by the Texas Board of Nursing to practice as an advanced practice nurse.

(7) Applicant--A person applying for a license under Texas Health and Safety Code, Chapter 252.

(8) APA--The Administrative Procedure Act, Texas Government Code, Chapter 2001.

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

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

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

(C) is not addressed in a behavior therapy program; and

(D) does not occur during a medical or dental procedure.

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

(11) CDC--Centers for Disease Control and Prevention.

(12) Change of ownership--An event that results in a change to the federal taxpayer identification number of the license holder of a facility. The substitution of a personal representative for a deceased license holder is not a change of ownership.

(13) CFR--Code of Federal Regulations.

(14) CMS--Centers for Medicare & Medicaid Services. The federal agency that provides funding and oversight for the Medicare and Medicaid programs.

(15) Communicable disease--An illness due to an infectious agent or its toxic products that is transmitted directly to a well person from an infected person or animal, or indirectly through an intermediate plant or animal host, vector, or the inanimate environment. (16) Controlled substance--A drug, substance, or immediate precursor as defined in the Texas Controlled Substances Act, Texas Health and Safety Code, Chapter 481, as amended, or the Federal Controlled Substances Act, United States Code, Title 21, Chapter 13, as amended .

(17) Controlling person of an applicant, license holder, or facility--A person who, acting alone or with others, has the ability to directly or indirectly influence or direct the management, expenditure of money, or policies of an applicant or license holder or of a facility owned by an applicant or license holder.

(A) The term includes:

(i) a spouse of the applicant or license holder;

(ii) an officer or director, if the applicant or license holder is a corporation;

(iii) a partner, if the applicant or license holder is a partnership;

(iv) a trustee or trust manager, if the applicant or license holder is a trust;

(v) a person who operates or contracts with others to operate the facility;

(vi) a person who, because of a personal, familial, or other relationship is in a position of actual control or authority over the facility, without regard to whether the person is formally named as an owner, manager, director, officer, provider, consultant, contractor, or employee of the facility; and

(vii) a person who would be a controlling person of an entity described in clauses (i) - (vi) of this subparagraph, if that entity were the applicant or license holder.

(B) The term 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 facility.

(18) CPR--cardiopulmonary resuscitation.

(19) Dangerous drug--Any drug as defined in the Texas Dangerous Drug Act, Texas Health and Safety Code, Chapter 483.

(20) Designee--A state agency or entity with which HHSC contracts to perform specific, identified duties related to the fulfillment of a responsibility prescribed by this chapter.

(21) DFPS--Texas Department of Family and Protective Services.

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

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

(24) Drug (also referred to as medication)--A drug is:

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

(B) any substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in a person ;

(C) any substance (other than food) intended to affect the structure or any function of the human body; or

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

(25) DSHS--Texas Department of State Health Services.

(26) EMC--Emergency Management Coordinator.

(27) EPC--Emergency Preparedness Coordinator.

(28) Emergency situation--an impending or actual situation that:

(A) may interfere with normal activities of a facility or its residents;

(B) may cause:

(i) injury or death to a resident or staff member of the facility; or

(ii) damage to facility property;

(C) requires the facility to respond immediately to mitigate or avoid the injury, death, damage, or interference; and

(D) does not include a situation that arises from the medical condition of a resident such as cardiac arrest, obstructed airway, cerebrovascular accident.

(29) EMR--Employee Misconduct Registry.

(30) Establishment--A place of business or a place where business is conducted which includes staff, fixtures, and property.

(31) Facility--A facility serving persons with an intellectual disability or related conditions licensed under this chapter as described in §551.2 of this chapter (relating to Scope) and required to be licensed under the Texas Health and Safety Code, Chapter 252, or the entity that operates such a facility; or, in Subchapters C, D, and F of this chapter, a program provider that must comply with those subchapters in accordance with 40 TAC §9.212 (relating to Non-licensed Providers Meeting Licensure Standards).

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

(33) Guardian--A person who is appointed guardian under the Estates Code, Chapter 1101.

(34) Health authority--A physician designated to administer state and local laws relating to public health under the Local Public Health Reorganization Act, Texas Health and Safety Code, Chapter 121. The health authority may be:

(A) a local health authority appointed by the local government jurisdiction; or

(B) a regional director of DSHS if no physician has been appointed by the local government.

(35) Health care professional--A person licensed, certified, or otherwise authorized to administer health care, for profit or otherwise. The term includes a physician, licensed nurse, physician assistant, podiatrist, dentist, physical therapist, speech therapist, and occupational therapist.

(36) Hearing--A contested case hearing held in accordance with the APA and the formal hearing procedures in 1 TAC Chapter 357, Subchapter I (relating to Hearings Under the Administrative Procedure Act).

(37) HHSC--The Texas Health and Human Services Commission.

(38) HVAC--Heating, ventilating, and air-conditioning system.

(39) ICF/IID--An Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions.

(40) IDT--Interdisciplinary Team.

(41) Immediate jeopardy to health and safety of a resident--A situation in which immediate corrective action is necessary because the facility's noncompliance with one or more federal requirements has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in the certified facility.

(42) Immediate threat to the health or safety of a resident--A situation that causes, or is likely to cause, serious injury, harm, or impairment or death of a resident because of the facility’s noncompliance with one or more licensure requirements.

(43) Incident--An unusual or abnormal event or occurrence in, at, or affecting the facility or the residents of the facility.

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

(45) Inspection--Any on-site visit to or survey of a facility by HHSC for the purpose of inspection of care, licensing, monitoring, complaint investigation, architectural review, or similar purpose.

(46) IPP--Individual program plan. A plan developed by the interdisciplinary team of a facility resident that identifies the resident's training, treatment, and habilitation needs, and describes programs and services to meet those needs.

(47) Isolated--A situation in which a very limited number of residents are affected and a very limited number of staff are involved, or the situation has occurred only occasionally.

(48) Key infectious agents--Bacteria, viruses, and other microorganisms that cause the most common infections and infectious diseases in long-term care facilities, according to the CDC, and can be prevented by establishing, implementing, maintaining, and enforcing proper infection prevention and control policies and procedures.

(49) LAR--Legally authorized representative--A person authorized by law to act on behalf of a person regarding a matter described in this chapter, and may include a parent, guardian, or managing conservator of a minor, or the guardian of an adult. (50) Large facility--A facility with a capacity of 17 or more residents .

(51) License--Approval from HHSC to establish or operate a facility.

(52) License holder--A person who holds a license to operate a facility.

(53) Licensed nurse--A licensed vocational nurse, registered nurse, or advanced practice nurse.

(54) LIDDA--A Local Intellectual and Developmental Disability Authority.

(55) Life Safety Code--NFPA 101.

(56)) Life safety features--Fire safety components required by the Life Safety Code such as building construction, fire alarm systems, smoke detection systems, interior finishes, sizes and thicknesses of doors, exits, emergency electrical systems, and sprinkler systems.

(57) Local authorities--A local health authority, fire marshal, building inspector, etc., who may be authorized by state law, county order, or municipal ordinance to perform certain inspections or certifications.

(58) Local health authority--The physician having local jurisdiction to administer state and local laws or ordinances relating to public health, as described in the Texas Health and Safety Code, Chapter 121, Subchapter B .

(59) LVN--Licensed vocational nurse. A person licensed to practice vocational nursing in accordance with Texas Occupations Code, Chapter 301.

(60) Metered dose inhaler--A device that delivers a measured amount of medication as a mist that can be inhaled.

(61) Multidrug-resistant organisms--Bacteria and other microorganisms that have developed resistance to multiple types of medicine used to act against the microorganism.

(62) NAR--Nurse Aide Registry.

(63) NFPA--The National Fire Protection Association. If the term is immediately followed by a number, it is a reference to a publication of NFPA, as referenced in NFPA 101.

(64) NFPA 10--NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition.

(65) NFPA 13--NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition.

(66) NFPA 13D--NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, 2010 Edition.

(67) NFPA 13R--NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, 2010 Edition.

(68) NFPA 25--NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition.

(69) NFPA 37--NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 2010 Edition.

(70) NFPA 70--NFPA 70, National Electrical Code, 2011 Edition.

(71) NFPA 72--NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition.

(72) NFPA 90A--NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, 2012 Edition.

(73) NFPA 90B--NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, 2012 Edition. (74) NFPA 99--NFPA 99, Health Care Facilities Code, 2012 Edition. A publication of the NFPA that provides minimum requirements for the installation, testing, maintenance, performance, and safe practices for health care facilities and for material, equipment, and appliances, used for patient care in health care facilities. CMS has incorporated NFPA 99, 2012 Edition, except Chapters 7, 8, 12, and 13, by reference as a Condition of Participation in the ICF/IID program for facilities that meet the definition of a health care occupancy. Copies of NFPA 99 may be obtained from NFPA, 1 Batterymarch Park, Quincy, MA 02169.

(75) NFPA 101--NFPA 101, Life Safety Code, 2012 Edition. A publication of the NFPA that provides minimum requirements, with due regard to function, for the design, operation, and maintenance of buildings and structures for safety to life from fire. CMS has incorporated NFPA 101, 2012 Edition, by reference as a Condition of Participation in the ICF/IID program. Copies of NFPA 101 may be obtained from NFPA, 1 Batterymarch Park, Quincy, MA 02169. (76) NFPA 101A--NFPA 101A, Guide on Alternative Approaches to Life Safety, 2013 Edition.

(77) NFPA 220--NFPA 220, Standard on Types of Building Construction, 2012 Edition.

(78) NFPA 701--NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films, 2010 Edition.

(79) Online Portal--Texas Unified Licensure Information Portal (TULIP).

(80) Oral medication--Medication administered by way or through the mouth and does not include sublingual or buccal.

(81) Pattern of violation--Repeated, but not widespread in scope, failures of a facility to comply with Texas Health and Safety Code, Chapter 252, or a rule, standard or order adopted under Chapter 252 that:

(A) result in a violation; and

(B) are found throughout the services provided by the facility or that affect or involve the same residents or facility employees.

(82) Person--An individual, firm, partnership, corporation, association, or joint stock company, and any legal successor of those entities.

(83) Personal hold--

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

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

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

(B) Physical guidance or prompting of brief duration becomes a restraint if the resident resists the guidance or prompting. (84) Potential for minimal harm--A violation that has the potential for causing no more than a minor negative impact on a resident.

(85) Potential for more than minimal harm--A violation that results in minimal physical, mental, or psychological discomfort to the resident or has the potential to compromise the resident’s ability to reach and maintain the highest practicable physical, mental, and psychosocial well-being as defined for the resident.

(86) QIDP--Qualified intellectual disability professional. A person who has at least one year of experience working directly with persons with an intellectual disability or related conditions and is one of the following:

(A) a doctor of medicine or osteopathy;

(B) a registered nurse; or

(C) an individual who holds at least a bachelor's degree in one of the following areas:

(i) occupational therapy;

(ii) physical therapy;

(iii) social work;

(iv) speech-language pathology or audiology;

(v) recreation or a specialty area such as art, dance, music or physical education;

(vi) dietetics; or

(vii) human services, such as sociology, special education, rehabilitation counseling, or psychology (as specified in 42 CFR, §483.430(b)(5)(x).

.

(87) Rapid influenza diagnostic test--A test administered to a person with flu-like symptoms that can detect the influenza viral nucleoprotein antigen.

(88) Receiving facility--A facility that has agreed to receive the residents of another facility who are evacuated due to an emergency.

(89) Relocation--The new physical location of a facility.

(90) Remodeling--The construction, removal, or relocation of walls and partitions, or construction of foundations, floors, or ceiling-roof assemblies, including expanding of safety systems (e.g.., sprinkler systems, fire alarm systems), that will change the existing plan and use areas of the facility.

(91) Renovation--The restoration to a former better state by cleaning, repairing, or rebuilding (e.g., routine maintenance, repairs, equipment replacement, painting).

(92) Resident--A person who resides in a facility.

(93) Restraint--A manual method, or a physical or mechanical device, material, or equipment, attached or adjacent to the resident's body that the resident cannot remove easily, that restricts freedom of movement or normal access to the resident's body. This term includes a personal hold.

(94) RN--Registered nurse. A person licensed to practice professional nursing in accordance with Texas Occupations Code, Chapter 301.

(95) Seclusion--The involuntary separation of a resident away from other residents and the placement of the resident alone in an area from which the resident is prevented from leaving.

(96) Small facility--A facility with a capacity of 16 or fewer residents .

(97) Staff--Employee of an ICF/IID or a contracted staff working with residents living in an ICF/IID.

(98) Standards--The minimum conditions, requirements, and criteria with which a facility will have to comply to be licensed under this chapter.

(99) TIA--Tentative Interim Amendment.

(100) TAC--Texas Administrative Code.

(101) Topical medication--Medication applied to the skin, not including medication administered in the eyes.

(102) Universal precautions--The use of barrier precautions by facility staff to prevent direct contact with blood or other body fluids that are visibly contaminated with blood.

(103) Vaccine preventable diseases--The diseases included in the most current recommendations of the Advisory Committee on Immunization Practices of the CDC.

(104) Violation--Any noncompliance with Texas Health and Safety Code, Chapter 252, or any rule under this chapter.

(105) Well-recognized church or religious denomination--An organization which has been granted a tax-exempt status as a religious association from the state or federal government.

(106) Widespread in scope--A violation that:

(A) is pervasive throughout the services provided by the facility; or

(B) that affects or has the potential to affect a large portion of or all the residents of the facility.

TITLE 26 HEALTH AND HUMAN SERVICES

PART 1 HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 551 INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH AN

INTELLECTUAL DISABILITY OR RELATED CONDITIONS

SUBCHAPTER B APPLICATION PROCEDURES

§551.11. Criteria for Licensing.

(a) A person or governmental unit, acting jointly or severally, must be licensed by HHSC to establish, conduct, or maintain a facility in this state.

(b) An applicant for a license must submit a complete application form and license fee to HHSC through the online portal .

(c) An applicant for a license must affirmatively show that:

(1) the facility meets the standards of NFPA 101

(2) the facility meets the construction standards in Subchapter D of this chapter (relating to General Requirements for Facility Construction); and

(3) the facility meets the standards for operation based on an on-site survey.

(d) Before issuing a license, HHSC considers the background and qualifications of:

(1) the applicant or license holder;

(2) a controlling person of the applicant or license holder; and

(3) an individual with five percent or more direct ownership interest in the applicant or license holder.

(e) HHSC issues a license if it finds that the facility and any person described in subsection (d) of this section meets all requirements of this chapter. The license is valid for two or three years, as described in §551.15 of this subchapter (relating to Renewal Procedures and Qualifications). Each license specifies the maximum allowable number of residents to be cared for at any one time. The number of residents authorized by the license must not be exceeded.

§551.12. Building Approval.

(a) Local fire authority. All applications for licensure must include the written approval of the local fire authority having jurisdiction that the facility and its operation meet local fire ordinances.

(b) Local health authority. The following procedures allow the local health authority to provide recommendations to HHSC concerning licensure of a facility.

(1) New facility. The sponsor of a new facility under construction or a previously unlicensed facility must provide to HHSC a copy of a dated written notice to the local health authority that construction or modification has been or will be completed by a specific date. The sponsor must also provide a copy of a dated written notice of the approval for occupancy by the local fire marshal or local building code authority, if applicable. The local health authority may provide recommendations to HHSC regarding the status of compliance with local codes, ordinances, or regulations. An application for a new facility that was not included in the plan approved under the Texas Health and Safety Code, §533A.062 (relating to Plan on Long-Term Care for Persons with an Intellectual Disability) will not be approved by HHSC , as outlined under §551.14 of this subchapter (relating to Increase in Capacity).

(2) Increase in capacity. The license holder must submit an application through the online portal for an increase in capacity from HHSC . The license holder must arrange for and have the inspection of the facility completed by the local fire marshal before the application is submitted. Upon completion of the inspection, the license holder must notify the local health authority and HHSC by uploading the letter with the application through the online portal if the facility meets local code requirements. HHSC approves the application only if the facility is found to be in compliance with the standards. Approval to occupy the increased capacity, which cannot exceed six total residents, may be granted by HHSC prior to the issuance of the license covering the increased capacity after inspection by HHSC if standards are met. An application for an increase in capacity that was not included in the plan approved under Texas Health and Safety Code, §533A.062 (relating to Plan on Long-Term Care for Persons with an Intellectual Disability), will not be approved by HHSC, as outlined under §551.14 of this subchapter (Relating to Increase in Capacity) .

(3) Change of ownership. The applicant for a change of ownership license must provide to HHSC a copy of a letter notifying the local health authority of the request for a change of ownership by uploading the letter through the online portal.

(4) Renewal. HHSC sends the local health authority a copy of HHSC’s license renewal notice specifying the expiration date of the facility's current license. The local health authority may provide recommendations to HHSC regarding the status of compliance with local codes, ordinances, or regulations. The local authority may also recommend that a state license be issued or denied; however, the final decision on licensure status remains with HHSC .

(5) Relocation. Prior to relocation of a facility, a program provider must receive HHSC approval of a facility relocation by following the application process through the online portal. If HHSC approves the application for relocation, HHSC will initiate licensure and certification action of the relocated facility. The facility must provide a copy of the letter notifying the local health authority of a change in location.

§551.13. Applicant Disclosure Requirements.

(a) No person may apply for a license, change of ownership, increase in capacity, relocation, or renewal of a license to operate or maintain a facility without making a disclosure of information as required in this section.

(b) All applications must be made on forms prescribed by and available from HHSC through the online portal . Each application must be completed in accordance with HHSC instructions. Any changes to the information on an initial, change of ownership, or renewal application must be reported to HHSC within 30 calendar days from the effective date of the change. Changes include :

(1) persons with an ownership or control interest, as defined in 42 CFR §455.101 (relating to Definitions) ;

(2) officers, directors, agents, or managing employees;

(3) the corporation, association, or other company responsible for management of the facility;

(4) the facility's administrator; or

(5) a controlling person.

(c) General information required. An applicant must submit to HHSC, through the online portal, an application that contains:

(1) for initial applications, relocation, and change of ownership only, evidence of the right to possession of the facility at the time the application will be granted, which may be satisfied by the submission of applicable portions of a lease agreement, deed or trust, or appropriate legal document. The names and addresses of any persons or organizations listed as owner of record in the real estate, including the buildings and grounds and property documents, must be disclosed to HHSC ;

and

(2) for initial applications and change of ownership , tax ID documentation and a copy of the partnership agreement if a partnership exists. For other changes associated with tax ID, tax ID documentation must be provided.

§551.14. Increase in Capacity.

(a) During the license term, a license holder may not increase capacity without approval from HHSC . The license holder must submit to HHSC a complete application, through the online portal, for increase in capacity and the fee required in §551.19 of this subchapter (relating to License Fees).

(b) An application for an increase in capacity that was not included in the plan approved under §533A.062  of Texas Health and Safety Code, Plan on Long-Term Care for Persons with an Intellectual Disability, will not be approved by HHSC .

(c) Upon approval of an increase in capacity, HHSC will issue a new license.

§551.15. Renewal Procedures and Qualifications.

(a) A license expires three years after the date it is issued . HHSC does not automatically renew a license. For a license to remain in effect after its expiration date, a license holder must apply to renew the license in accordance with this section.

(b) To renew a license, a license holder must submit to HHSC a timely and sufficient application to renew the license through the online portal. A license holder has submitted a timely and sufficient application to renew a license if:

(1) the license holder submits the following to HHSC so HHSC receives it no later than the 45th day before the license expires:

(A) the fee required by §551.19(a)(1) of this subchapter (relating to License Fees); and

(B) one of the following:

(i) a complete application; or

(ii) an incomplete application with a letter explaining the circumstances that prevent the license holder from including the missing information; or

(2) the license holder submits the following to HHSC so HHSC receives it during the 45-day period ending on the date the license expires:

(A) the fee and documentation described in paragraph (1)(A) and (B) of this subsection; and

(B) the late renewal fee described in §551.19(a)(4) of this subchapter (relating to License Fees).

(c) If HHSC receives an application that is submitted before the submission deadline, the application is considered timely.

(d) Regardless of whether HHSC sends advance notice that a license is expiring, providers are responsible for applying to renew their licenses in a timely manner. Furthermore, operating an ICF without a license is a violation of state law.

§551.16. Change of Ownership and Notice of Changes.

(a) A license holder may not transfer its license. If a change of ownership occurs, the license holder's license becomes invalid on the date of the change of ownership. The prospective new license holder must obtain a license in accordance with subsection (b) of this section; however, the original license holder remains responsible until HHSC approves the change of ownership.

(b) A prospective new license holder must submit to HHSC :

(1) a complete application for a license through the online portal under §551.11 of this subchapter (relating to Criteria for Licensing) or an incomplete application with a letter explaining the circumstances that prevented the inclusion of the missing information through the online portal;

(2) the application fee, in accordance with §551.19 of this subchapter (relating to License Fees); and

(3) signed, written notice from the facility's existing license holder of intent to transfer operation of the facility to the applicant beginning on a date specified by the applicant, unless waived in accordance with subsection (d) of this section.

(c) To avoid a facility operating without a license, a prospective license holder must submit all items in subsection (b) of this section at least 30 days before the anticipated date of the change of ownership.

(d) The notice required by subsection (b)(3) of this section may be waived by HHSC if HHSC determines that the prospective license holder presented evidence showing that circumstances prevented the submission of the notice and that not waiving the notice would create a threat to resident welfare or health and safety.

(e) HHSC conducts an on-site health inspection to verify compliance with the licensure requirements before issuing a license as a result of a change of ownership. HHSC may conduct a desk review instead of an on-site health inspection before issuing a license as a result of a change of ownership if:

(1) less than 50 percent of the direct or indirect ownership interest in the former license holder changed, when compared to the new license holder; or

(2) every owner with a disclosable interest in the new license holder had a disclosable interest in the former license holder.

(f) HHSC , in its sole discretion, may conduct an on-site Life Safety Code inspection before issuing a license as a result of a change of ownership.

(g) The effective date of the license is the same date as the effective date of the change of ownership and cannot precede the date the application was received by HHSC through the online portal .

(h) If a license holder changes its name but does not undergo a change of ownership, the license holder must notify HHSC and submit documentation evidencing a legal name change by submitting an application through the online portal. On receipt of the notice and documentation, HHSC reissues the current license in the license holder's new name.

(i) If a license holder adds an owner with a disclosable interest, but the license holder does not undergo a change of ownership, the license holder must notify HHSC of the addition no later than 30 days after the addition of the owner by submitting an application through the online portal.

§551.17. Criteria for Denying a License or Renewal of a License.

(a) HHSC may deny an initial license or refuse to renew a license if any person described in §551.11(d) of this subchapter (relating to Criteria for Licensing):

(1) is subject to denial or refusal as described in 26 TAC, Chapter 560 (relating to Denial or Refusal of License) during the time frames described in that chapter;

(2) substantially fails to comply with the requirements described in §551.42 of this chapter (relating to Standards for a Facility), including:

(A) noncompliance that poses a serious threat to health and safety, as described in Appendix Q of the State Operations Manual, "Core Guidelines for Determining Immediate Jeopardy”; or

(B) a failure to maintain compliance on a continuous basis, including decertification, contract termination, denial of certification, or license revocation;

(3) aids, abets, or permits a substantial violation described in paragraph (2) of this subsection about which the person had or should have had knowledge;

(4) fails to provide the required information, facts, or references;

(5) provides the following false or fraudulent information:

(A) knowingly submits false or intentionally misleading statements to HHSC ;

(B) uses subterfuge or other evasive means of filing;

(C) engages in subterfuge or other evasive means of filing on behalf of another who is unqualified for licensure;

(D) knowingly conceals a material fact; or

(E) is responsible for fraud;

(6) fails to pay the following fees, taxes, and assessments when due:

(A) licensing fees as described in §551.19 of this subchapter (relating to License Fees);

(B) reimbursement of emergency assistance funds within one year after the date on which the funds were received by the trustee in accordance with the provisions of §551.238(e) of this chapter (relating to Involuntary Appointment of a Trustee);

(C) administrative penalties within 60 days after the order assessing the penalties in accordance with §551.236 of this chapter (relating to Administrative Penalties); or

(D) franchise taxes;

(7) has a history of any of the following actions during the five-year period preceding the date of the application:

(A) operation of a facility that has been decertified or had its contract cancelled under the Medicare or Medicaid program in any state;

(B) federal or state long term care facility sanctions or penalties, including vendor holds, monetary penalties, downgrading the status of a facility license, proposals to decertify, directed plans of correction, or the denial of payment for new Medicaid admissions;

(C) unsatisfied final judgments;

(D) eviction involving any property or space used as a facility in any state; or

(E) suspension of a license to operate a health care facility, long term care facility, assisted living facility, or a similar facility in any state.

(b) Concerning subsection (a)(7) of this section, HHSC may consider exculpatory information provided by any person described in §551.11(d) of this subchapter and grant a license if HHSC finds that person able to comply with the rules in this chapter.

(c) HHSC does not issue a license to an applicant to operate a new facility if the applicant has a history of any of the following actions during the five-year period preceding the date of the application:

(1) revocation of a license to operate a health care facility, long term care facility, assisted living facility, or similar facility in any state;

(2) debarment or exclusion from the Medicare or Medicaid programs by the federal government or a state;

(3) a court injunction prohibiting any person described in §551.11(d) of this subchapter from operating a facility; or

(4) failure to comply with or breach of an administrative settlement agreement between the applicant and HHSC.

(d) Only final actions are considered for purposes of subsections (a)(7) and (c) of this section. An action is final when routine administrative and judicial remedies are exhausted. All actions, whether pending or final, must be disclosed.

(e) If an applicant for a new license owns multiple facilities, HHSC examines the overall record of compliance in all of the applicant's facilities. Denial of a new license will not preclude the renewal of licenses for the applicant's other facilities with a history of compliance with licensing regulations.

(f) HHSC does not approve as meeting licensing standards new beds or the expansion of a facility serving persons with an intellectual disability or related conditions that participates in the medical assistance program under Title XIX of the Social Security Act, as provided by the Texas Health and Safety Code §533A.062 (relating to Plan on Long-term Care for Persons with an Intellectual Disability) , unless the new beds or the expansion was included in the plan as well as the applicant including the approval letter to be approved by HHSC in accordance with Texas Health and Safety Code, §533A.062 .

(g) If HHSC denies an application for a new license, the applicant may request an administrative hearing. If HHSC refuses to issue a renewal of a license, the licensee may request an informal reconsideration, as specified in §551.18 of this subchapter (relating to Informal Reconsideration) and an administrative hearing. An administrative hearing is held under HHSC's rules in 1 TAC, Chapter 357, Subchapter I (relating to Hearings Under the Administrative Procedure Act).

§551.18. Informal Reconsideration.

(a) Before the institution of proceedings to revoke or suspend a license or deny an application for the renewal of a license, HHSC gives the license holder:

(1) notice by personal service or by registered or certified mail of the facts or conduct alleged to warrant the proposed action; and

(2) an opportunity to show compliance with all requirements of law for the retention of the license by sending the director of HHSC a written request for an informal review. The request must:

(A) be postmarked within ten days of the date of HHSC’s notice and be received in the state office of the director of HHSC within ten days of the date of the postmark; and

(B) contain specific documentation refuting HHSC’s allegations.

(b) HHSC’s review will be limited to a review of documentation submitted by the license holder and information used by HHSC as the basis for its proposed action. HHSC’s review will not be conducted as an adversarial hearing. HHSC will give the license holder a written affirmation or reversal of the proposed action.

§551.19. License Fees.

(a) Basic fees.

(1) Initial and renewal license. The license fee for a three-year initial or renewal license is $225 plus $7.50 for each unit of capacity for which the license is sought.

(2) Increase in capacity. If a license holder requests an increase in the capacity of its facility, the license holder must pay HHSC an additional fee of $7.50 for each unit of capacity approved.

(3) Change of administrator. If a license holder hires a new administrator for a facility, the license holder must notify HHSC through the online portal not later than the 30th day after the date on which the change of administrator becomes effective and pay HHSC a $20 fee.

(4) Late renewal fee. If a license holder submits an application for renewal during the 45-day period before a license expires, the license holder must pay a late renewal fee in an amount equal to one-half of the fee for a license renewal described in paragraph (1) of this subsection.

(b) Emergency Assistance Fee.

(1) HHSC may collect an annual fee to be used to make emergency assistance money available to a facility.

(2) The fee collected under this subsection must be in the amount allowed by Texas Health and Safety Code §252.095(b), and must be deposited to the credit of the fund established under the Texas Health and Safety Code §242.096 (relating to Nursing and Convalescent Home Trust Fund and Emergency Assistance Funds).

(3) HHSC disburses money to a trustee to alleviate an immediate threat to the health or safety of a facility's residents in accordance with Texas Health and Safety Code §252.095(c).

(4) HHSC disburses emergency assistance money if a court order is issued in accordance with Texas Health and Safety Code §252.095(d).

(c) Method of Payment. HHSC accepts the prescribed form of accepted payment through the online portal . HHSC does not refund a fee except as provided by Chapter 2005 of the Texas Government Code (relating to Miscellaneous Provisions Relating to State Licenses and Permits).

(d) Quality Assurance Fee. HHSC collects a quality assurance fee from a license holder in accordance with 40 TAC Chapter 11 (relating to Quality Assurance Fee).

§551.20. Plan Review Fees.

(a) HHSC charges a fee to review plans for new buildings, additions, conversion of buildings not licensed by HHSC , and remodeling of existing licensed facilities.

(b) The fee schedule is as follows.

(1) New small facility (with a capacity of 4 to 16 based on NFPA 101, Chapter 32, New Residential Board and Care Occupancies:

(A) single story--$1,100;

(B) multiple story--$1,650; and

(C) additions or remodeling--2 percent of construction cost with a $350 minimum fee and a maximum of 50 percent of the plan review fee for a new facility of the same type.

(2) New large facility (with a capacity of 17 or more based on NFPA 101, Chapter 18, New Health Care Occupancies:

(A) single story:

(i) facilities with a capacity of 17-80 --$1,600;

(ii) facilities with a capacity of 81-120 --$2,150; and

(iii) facilities with a capacity of 121+ --$18 per bed.

(B) multiple story:

(i) facilities with a capacity of 17-80 --$2,100;

(ii) facilities with a capacity of 81-120 --$2,650; and

(iii) facilities with a capacity of 121+ --$22 per bed.

(C) additions or remodeling--2 percent of construction cost with $500 minimum fee and a maximum of 50 percent of the plan review fee for a new facility of the same type.

§551.21. Time Periods for Processing License Applications.

(a) An application is complete when all requirements for licensing have been met, including compliance with standards. If an inspection for compliance is required, the application is not complete until the inspection has occurred, reports are reviewed, and the applicant complies with the standards.

(b) If the application is submitted through the online portal by the filing deadline, the application is considered to be timely filed .

(c) HHSC notifies applicants within 30 days of receipt of the application if any of the following applications are incomplete: initial application, change of ownership, renewal, and increase in capacity.

(d) A license is issued or denied within 30 days of the receipt of a complete application or within 30 days before the expiration date of the license. HHSC may delay action on an application for renewal of a license for up to six months if the facility is subject to a proposed or pending licensure termination action on or within 30 days before the expiration date of the license. The issuance of the license constitutes HHSC’s official written notice to the facility of the acceptance and filing of the application.

(e) Reimbursement of fees.

(1) In the event the application is not processed in the time periods as stated, the applicant has a right to request of the program director full reimbursement of all filing fees paid in that particular application process. If the program director does not agree the established periods have been violated or finds good cause existed for exceeding the established periods, the request will be denied. Good cause for exceeding the period established is considered to exist if:

(A) the number of applications to be processed exceeds by 15 percent or more the number processed in the same calendar quarter of 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 periods.

(2) If the request for full reimbursement is denied, the applicant may appeal directly to the Commissioner of HHSC for resolution of the dispute. The applicant must send a written statement to the Commissioner that describes the request for reimbursement and the reasons for it. The program also may send a written statement to the Commissioner that describes the program's reasons for denying reimbursement. The Commissioner makes a timely decision concerning the appeal and notifies the applicant and the program in writing of the decision.

§551.22. Relocation.

(a) A license holder may not relocate a facility to another location without approval from HHSC . The license holder must submit a complete application and the fee required under §551.19 of this subchapter (relating to License Fees) to HHSC , through the online portal, before the relocation.

(b) Residents may not be relocated until the new building has been inspected and approved as meeting the standards of the Life Safety Code as applicable to intermediate care facilities serving persons with an intellectual disability or a related condition.

(c) Following Life Safety Code approval by HHSC , the license holder must notify HHSC of the date residents will be relocated. If the new facility meets the standards for operation based on an on-site survey, a license will be issued.

(d) The effective date of the license will be the date all residents are relocated.

(e) The license holder must continue to maintain the license at the current location and must continue to meet all requirements for operation of the facility until the date of the relocation.

(f) This section applies to relocation of a currently licensed facility, as described in §551.14 of this subchapter (relating to Increase in Capacity) for regulations governing capacity increases.

TITLE 26 HEALTH AND HUMAN SERVICES

PART 1 HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 551 INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH AN

INTELLECTUAL DISABILITY OR RELATED CONDITIONS

SUBCHAPTER C STANDARDS FOR LICENSURE

§551.42. Standards for a Facility .

(a) Purpose. The purpose of this section is to promote the public health, safety, and welfare by providing for the development, establishment, and enforcement of standards:

(1) for the habilitation of residents based on an active treatment program in facilities governed by this chapter; and

(2) for the establishment, construction, maintenance, and operation of such facilities that view an intellectual disability and related conditions within the context of a developmental model in accordance with the principle of normalization.

(b) Active treatment . A facility regulated by the standards in this section is known as an ICF/IID . A resident living in a facility has the same civil rights, equal liberties, and due process of law as other individuals, plus the right to receive active treatment and habilitation. A facility must provide and promote services that enhance the development of each resident , maximize their achievement through an interdisciplinary approach , and create an environment, to the extent possible, that is normalized and normalizing. A facility must:

(1) have the IDT prepare and implement, for each resident, an IPP within 30 days after admission;

(2) ensure each resident receives a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the IPP, as identified by the IDT; and

(3) ensure each resident’s IPP is reviewed at least annually by a QIDP and revised as necessary, including situations in which a resident has successfully completed an objective identified in the IPP.(c) Standards. Each ICF/IID must comply with regulations promulgated by the United States Department of Health and Human Services in Title 42, Code of Federal Regulations (CFR), Part 483, Subpart I, §§483.400 - 483.480. Additionally, HHSC adopts by reference the federal regulations governing conditions of participation for the ICF/IID program as specified in 42 CFR, Part 483, Subpart I, §§483.410, 483.420, 483.430, 483.440, 483.450, 483.460, 483.470, 483.475, and 483.480 as licensing standards.

(d) Precertification training conference for new providers of service. Each new provider must attend the precertification/prelicensure training conference prior to licensing by HHSC . The purpose of the training is to ensure that providers of services are familiar with the licensing requirements and to facilitate the delivery of quality services to residents in facilities serving persons with an intellectual disability or related conditions.

(1) A new provider is an entity which has not had at least one year of administering services in a facility serving persons with an intellectual disability or related conditions in Texas. All new providers must attend a precertification training conference prior to the life safety code survey.

(2) Each new provider must designate at least one individual who will be involved with the direct management of the facility to attend the training conference prior to a health survey being scheduled.

(3) Each new provider will be responsible for taking the required training .

(e) Additional requirements.

(1) Abuse, neglect, and exploitation. A facility must develop and implement policies and procedures for reporting abuse, neglect, and exploitation, as well as other reportable incidents to HHSC .

(2) CPR. A facility must:

(A) Ensure at least one staff person per shift and on duty is trained by a CPR instructor and certified by an organization, such as the American Heart Association or the Red Cross, whose training includes a hands-on in-person skills assessment; and

(B) Ensure that staff members maintain their certification as recommended by the training organization .

(3) Behavior management. Seclusion of residents may not be used.

(4) Physical restraints.

(A) A facility must not use a restraint:

(i) in a manner that:

(I) obstructs a resident's airway, including the placement of anything in, on, or over the resident's mouth or nose;

(II) impairs a resident's breathing by putting pressure on the resident's torso;

(III) interferes with a resident's ability to communicate;

(IV) extends a resident’s muscle groups away from each other;

(V) uses hyperextension of joints on the resident; or

(VI) uses pressure points or pain on the resident;

(ii) for disciplinary purposes, that is, as retaliation or retribution;

(iii) for the convenience of staff or other residents; or

(iv) as a substitute for effective treatment or habilitation.

(B) A facility may use a restraint:

(i) in a behavioral emergency;

(ii) as an intervention in a behavior therapy program that addresses inappropriate behavior exhibited voluntarily by a resident;

(iii) during a medical or dental procedure if necessary to protect the resident or others and as a follow-up after a medical or dental procedure or following an injury to promote the healing of wounds;

(iv) to protect the resident from involuntary self-injury; and

(v) to provide postural support to the resident or to assist the resident in obtaining and maintaining normative bodily functioning.

(C) In order to decrease the frequency of the use of restraint and to minimize the risk of harm to a resident, a facility must ensure that the IDT :

(i) with the participation of a physician, or a physician assistant or an advanced practice nurse acting within the scope of his or her practice, identifies:

(I) the resident's known physical or medical conditions that might constitute a risk to the resident during the use of restraint;

(II) the resident's ability to communicate; and

(III) other factors that must be taken into account if the use of restraint is considered, including the resident's:

(-a-) cognitive functioning level;

(-b-) height;

(-c-) weight;

(-d-) emotional condition (including whether a resident has a history of having been physically or sexually abused); and

(-e-) age;

(ii) documents the conditions and factors identified in accordance with clause (i) of this subparagraph, and, as applicable, limitations on specific restraint techniques or mechanical restraint devices in the resident's record; and

(iii) reviews and updates with a physician, physician assistant, or licensed nurse, at least annually or when a condition or factor documented in accordance with clause (ii) of this subparagraph changes significantly, information in the resident's record related to the identified condition, factor, or limitation.

(D) If a facility restrains a resident as provided in subparagraph (B) of this paragraph, the facility must:

(i) take into account the conditions, factors, and limitations on specific restraint techniques or mechanical restraint devices documented in accordance with subparagraph (C)(ii) and (iii) of this paragraph;

(ii) use the minimal amount of force or pressure that is reasonable and necessary to ensure the safety of the resident and others;

(iii) safeguard the resident's dignity, privacy, and well-being; and

(iv) not secure the resident to a stationary object while the resident is in a standing position.

(E) If a facility uses a restraint in a circumstance described in subparagraph (B)(i) or (ii) of this paragraph:

(i) the facility may only use a personal hold in which the resident's limbs are held close to the body to limit or prevent movement and that does not violate the provisions of subparagraph (A)(i) of this paragraph; and

(ii) if a resident rolls into a prone or supine position during restraint, the facility must transition the resident to a side, sitting, or standing position as soon as possible. A facility may only use a prone or supine hold:

(I) as a transitional hold, and only for the shortest period of time necessary to ensure the protection of the resident or others;

(II) as a last resort, when other less restrictive interventions have proven to be ineffective; and

(III) except in a small facility, when an observer who is trained to identify risks associated with positional, compression, or restraint asphyxiation and with prone and supine holds is ensuring that the resident's breathing is not impaired.

(F) A facility must release a resident from a restraint:

(i) as soon as the resident no longer poses a risk of imminent physical harm to the resident or others; or

(ii) if the resident in restraint experiences a medical emergency, as soon as possible as indicated by the medical emergency.

(G) If a facility restrains a resident as provided in subparagraph (B)(i) of this paragraph, the facility must obtain a written order authorizing the restraint from a health care professional acting within his or her scope of practice by the end of the first business day after the use of a restraint.

(H) A facility must ensure that each resident and the resident's LAR are notified of HHSC rules and the facility's policies related to restraint and seclusion.

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

(5) Pharmacy services.

(A) All pharmacy services must comply with the Texas State Board of Pharmacy requirements, the Texas Pharmacy Act, and rules adopted thereunder, the Texas Controlled Substances Act, and Texas Health and Safety Code, Chapter 483 (relating to Dangerous Drugs).

(B) All medications must be ordered orally or in writing by a health care professional acting within the scope of his or her practice. Oral orders may be taken only by a licensed nurse, a pharmacist, physician assistant, or physician, and must be immediately transcribed and signed by the individual taking the order. Oral orders must be signed by the health care professional who ordered the medication within seven working days after issuing the order.

(C) A facility, with input from the consultant pharmacist and a health care professional acting within the scope of his or her practice, must develop and implement procedures regarding automatic stop orders for medications. These procedures must be utilized when the order for a medication does not specify the number of doses to be given or the time for discontinuance or re-order.

(6) Specialized nutrition support (delivery of parenteral nutrients and enteral feedings by nasogastric, gastrostomy, or jejunostomy tubes) must be given:

(A) by a health care professional acting within the scope of his or her practice or by a person to whom a health care professional has properly delegated performance of the task; and

(B) in accordance with an order issued by a health care professional acting within the scope of his or her practice.

(7) Self-administration of medication and emergency medication kits.

(A) A resident who has demonstrated the competency for self-administration of medication must have access to and maintain their own medication . The resident must have an individual storage space that permits them to store their medication under lock and key.

(B) A resident may participate in a self-administration of medication training program if the IDT determines that self-administration of medication is an appropriate objective. A resident participating in a self-administration of medication training program must have training in coordination with and as part of the resident's total active treatment program. The resident's training plan must be evaluated as necessary by a licensed nurse. The supervision and implementation of a self-administration of medication training program may be conducted by staff described in §551.43(a)(1), (3), and (4) of this subchapter (relating to Administration of Medication).

(C) A facility may maintain a supply of controlled substances in an emergency medication kit for a resident's emergency medication needs, as outlined under §551.324 and §551.325 of this chapter (relating to Emergency Medication Kit and Controlled Substances).

(8) Infection prevention and control. A facility must:

(A) establish, implement, enforce, and maintain an infection prevention and control policy and procedure designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection;

(B) comply with rules regarding special waste in 25 TAC, Chapter 1, Subchapter K (relating to Definition, Treatment, and Disposition of Special Waste from Health-Care Related Facilities);

(C) immediately report the name of any resident of a facility with a reportable disease, as specified in 25 TAC, Chapter 97, Subchapter A (relating to Control of Communicable Diseases) to the city health officer, county health officer, or health unit director having jurisdiction, and implement appropriate infection control procedures as directed by the local health authority; and

(D) have, implement, enforce, and maintain written policies for the control of communicable disease among employees and residents, which must address tuberculosis (TB) screening and the provision of a safe and sanitary environment for residents and employees.

(i) If an employee contracts a communicable disease that is transmissible to residents through food handling or direct resident care, the facility must exclude the employee from providing these services for the applicable period of communicability.

(ii) A facility must maintain evidence of compliance with local and state health codes or ordinances regarding employee and resident health status.

(iii) A facility must screen all employees for TB within two weeks of employment and annually, according to the CDC screening guidelines. A person who provides services under an outside resource contract must, upon request of the facility, provide evidence of compliance with this requirement.

(iii) A facility’s policies and practices for resident TB screening must ensure compliance with the recommendations of a resident’s attending physician and consistency with CDC guidelines.

(E) A facility’s infection prevention and control program established under paragraph (A) of this subsection must include written policies and procedures for:

(i) monitoring of key infectious agents, including multidrug-resistant organisms, as those terms are defined in §551.3 of this chapter (relating to Definitions);

(ii) wearing personal protective equipment, such as gloves, a gown, or a mask based on anticipated exposure, and properly cleaning hands before and after touching another resident;

(iii) cleaning and disinfecting environmental surfaces, including door knobs, handrails, light switches, and handheld electronic control devices;

(iv) using universal precautions for blood and bodily fluids; and

(v) removing soiled items (such as used tissues, wound dressings, adult briefs, and soiled linens) from the environment at least once daily, or more often if an infection or infectious disease is present or suspected.

(F) A facility must establish, implement, enforce, and maintain written policies and procedures for making a rapid influenza diagnostic test, as defined in §551.3, available to a resident who is exhibiting flu-like symptoms.

(G) Staff must handle, store, process, and transport linens to prevent the spread of infection.

(H) A facility must use universal precautions in the care of all residents.

(I) A facility must establish, implement, enforce, and maintain a written policy to protect a resident from vaccine preventable diseases in accordance with Texas Health and Safety Code, Chapter 224.

(i) The policy must:

(I) require an employee or a contractor providing direct care to a resident to receive vaccines for the vaccine preventable diseases specified by the facility, based on the level of risk the employee or contractor presents to residents by the employee's or contractor's routine and direct exposure to residents;

(II) specify the vaccines an employee or contractor is required to receive in accordance with clause (I) of this subparagraph;

(III) include procedures for a facility to verify that an employee or contractor has complied with the policy;

(IV) include procedures for a facility to exempt an employee or contractor from the required vaccines for the medical conditions identified as contraindications or precautions by the CDC;

(V) for an employee or contractor who is exempt from the required vaccines, include procedures the employee or contractor must follow to protect residents from exposure to disease, such as the use of protective equipment, such as gloves and masks, based on the level of risk the employee or contractor presents to residents by the employee's or contractor's routine and direct exposure to residents;

(VI) prohibit discrimination or retaliatory action against an employee or contractor who is exempt from the required vaccines for the medical conditions identified as contraindications or precautions by the CDC, except that required use of protective medical equipment, such as gloves and masks, may not be considered retaliatory action;

(VII) require a facility to maintain a written or electronic record of each employee's or contractor's compliance with or exemption from the policy; and

(VIII) include disciplinary actions a facility may take against an employee or contractor who fails to comply with the policy.

(ii) The policy may:

(I) include procedures for an employee or contractor to be exempt from the required vaccines based on reasons of conscience, including religious beliefs; and

(II) prohibit an employee or contractor who is exempt from the required vaccines from having contact with residents during a public health disaster, as defined in Texas Health and Safety Code §81.003 (relating to Communicable Diseases).

(9) Water activities. A facility must assure the safety of all residents who participate in facility-sponsored events. For the purpose of this section, a water activity is defined as an activity which occurs in or on water that is knee deep or deeper on the majority of residents participating in the event. To ensure the safety of all individuals who participate, the requirements in subparagraphs (A) - (F) of this paragraph apply.

(A) A facility must develop a policy statement regarding the water sites utilized by the facility. Water sites include lakes, amusement parks, and pools.

(B) A minimum of one staff person, who is certified and has demonstrated proficiency in CPR must be on duty and at the site when residents are involved in water activities.

(C) A minimum of one person with demonstrated proficiency in water life- saving skills must be on duty and at the site when activities take place in or on water that is deep enough to require swimming for life-saving retrieval. This person must maintain supervision of the activity for its duration.

(D) A sufficient number of staff or a combination of staff and volunteers must be available to meet the safety requirements of the group and specific residents .

(E) Each resident’s IPP must address each person's needs for safety when participating in water activities including medical conditions; physical disabilities and behavioral needs which could pose a threat to safety; the ability of residents to follow directions and instructions pertaining to water safety; the ability of residents to swim independently; and, when called for, special precautions.

(F) If the IDT recommends the use of a flotation device as a precaution for any resident to engage in water activities, it must be identified and the precautions outlined in the IPP . The device must be approved by the United States Coast Guard or be a specialized therapy flotation device utilized in the individual's therapy program.

(10) Communication. A facility may not prohibit a resident or employee from communicating in the person's native language with another resident or employee for the purpose of acquiring or providing care, training, or treatment.

(11) Physical exams. A facility must ensure that a resident is given at least one physical exam on a yearly basis by:

(A) a person licensed to practice medicine in accordance with Texas Occupations Code, Chapter 155 (relating to License to Practice Medicine);

(B) a person licensed as a physician assistant in accordance with Texas Occupations Code, Chapter 204 (relating to Physician Assistants); or

(C) a person licensed to practice professional nursing in accordance with Texas Occupations Code, Chapter 301 (relating to Nurses), and authorized by the Texas Board of Nursing to practice as an advanced practice nurse.

(f) Governing body and management. A facility must establish a governing body and the governing body must adopt, implement, and enforce the facility’s policies and procedures. The governing body must review and update the facility policies and procedures at least annually.

(g) Client protections. A facility must ensure the rights of a resident and through oversight, policy and investigative procedures, ensure a resident is free from all abuse, neglect, and exploitation.

(h) Facility staffing. A facility must ensure a resident receives professional and non-professional program services needed to implement the active treatment program defined by a resident’s IPP.

(i) Active treatment services. A facility must ensure a resident receives a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services in the IPP created by the IDT.

(j) Client behavior and facility practices. A facility must develop and implement written policies and procedures for the management of conduct between staff and residents and the management of inappropriate resident behavior.

(k) Health care services. A facility must provide or obtain preventative and general medical care for a resident and ensure a resident receives nursing services in accordance with their needs.

(l) Physical environment. A facility must provide sufficient space and equipment in dining, living, health services, recreation, and program areas to enable staff to provide a resident with needed services as required or identified in a resident’s IPP. Additionally, a facility must ensure all fire safety and surrounding safety conditions are maintained in accordance with Federal, State and local regulations.

(m) Emergency preparedness. A facility must establish and maintain an emergency preparedness program that meets all Federal, State, and local emergency preparedness requirements.

(n) Dietetic services. A facility must ensure a resident receives a nourishing, well-balanced diet including any modified or specifically-prescribed diets.§551.43. Administration of Medication.

(a) Administration of medication to a resident of a facility may be performed only by:

(1) a person who holds a license under state law that authorizes the person to administer medication;

(2) in a facility, as defined in §557.101 of this title (relating to Introduction):

(A) a person who holds a permit issued under Texas Health and Safety Code §242.610 (relating to Issuance and Renewal of Permit to Administer Medication) and acts under the authority of a person described in paragraph (1) of this subsection; or

(B) a person who is exempt from licensure or permit requirements in accordance with Texas Health and Safety Code §242.607 (relating to Exemptions for Nursing Students and Medication Aide Trainees);

(3) a person to whom an RN has delegated the administration of medication under 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) or 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); or

(4) in a facility with a licensed or certified capacity of less than 14 residents, an unlicensed person who administers medication in accordance with Texas Human Resource Code, Chapter 161, Subchapter D-1 (relating to Administration of Medication for Clients with Intellectual and Developmental Disabilities)may perform administration of medication without the requirement that an RN delegate or oversee each administration if:

(A) the medication is:

(i) an oral medication;

(ii) a topical medication; or

(iii) a metered dose inhaler;

(B) the medication is administered to a ~~t~~ resident for a stable or predictable condition;

(C) the resident has been personally assessed by an RN initially and in response to significant changes in the resident's health status, and the RN has determined that the resident's health status permits the administration of medication by an unlicensed person; and

(D) the unlicensed person has been:

(i) trained by an RN or LVN under the direction of an RN regarding proper administration of medication; or

(ii) determined to be competent by an RN or LVN under the direction of an RN regarding proper administration of medication, including through a demonstration of proper technique by the unlicensed person.

(b) An RN or an LVN under the supervision of an RN must review the administration of medication to a resident by a person described in subsection (a)(4) of this section at least annually and after any significant change in the resident's condition.

§551.44. Trauma-Informed Care Training.

A facility must ensure that an employee who is hired by a facility on or after May 1, 2016, and whose duties will require the employee to work directly with a resident, completes trauma-informed care training before the employee works directly with a resident. For purposes of this section, "to work directly with a resident" means to serve on a resident's IDT or otherwise work with a resident to implement the resident's IPP .

§551.45. Wheelchair Self-Release Seat Belts.

(a) For the purposes of this section, a "self-release seat belt" is a seat belt on a resident's wheelchair that the resident demonstrates the ability to fasten and release without assistance. A self-release seat belt is not a restraint.

(b) Except as provided in subsection (c) of this section, a facility must allow a resident to use a self-release seat belt if:

(1) the resident or the resident's LAR requests that the resident use a self-release seat belt;

(2) the resident consistently demonstrates the ability to fasten and release the self-release seat belt without assistance;

(3) the use of the self-release seat belt is documented in and complies with the resident's IPP; and

(4) the facility receives written authorization, signed by the resident or the resident's LAR, for the resident to use the self-release seat belt.

(c) A facility that advertises as a restraint-free facility is not required to allow a resident to use a self-release seat belt if the facility:

(1) provides a written statement to all residents that the facility is restraint-free and is not required to allow a resident to use a self-release seat belt; and

(2) makes reasonable efforts to accommodate the concerns of a resident who requests a self-release seat belt in accordance with subsection (b) of this section.

(d) A facility is not required to continue to allow a resident to use a self-release seat belt in accordance with subsection (b) of this section if:

(1) the resident cannot consistently demonstrate the ability to fasten and release the seat belt without assistance;

(2) the use of the self-release seat belt does not comply with the resident's IPP ; or

(3) the resident or the resident's LAR revokes in writing the authorization for the resident to use the self-release seat belt.

§551.50. Emergency Preparedness and Response.

(a) Definitions. In this section, "plan" means a facility's emergency preparedness and response plan.

.

(b) Administration. A facility must:

(1) develop and implement a written plan as described in subsection (c) of this section;

(2) maintain a current written copy of the plan that is accessible to all staff at all times;

(3) evaluate the plan to determine if information in the plan needs to change:

(A) within 30 days after an emergency situation;

(B) due to remodeling or making an addition to the facility; and

(C) at least every two years ;

(4) revise the plan within 30 days after information in the plan changes; and

(5) maintain documentation of compliance with this section.

(c) Emergency Preparedness and Response Plan. A facility's plan must:

(1) include a risk assessment of potential internal and external emergency situations, including a fire, failure of heating and cooling systems, a power outage, an explosion, a hurricane, a tornado, a flood, extreme snow and ice conditions for the area, a wildfire, terrorism, or a hazardous materials accident;

(2) include a description of the facility's resident population;

(3) include a description of the services and assistance needed by the residents in an emergency situation;

(4) include a section for each core function of emergency management that complies with subsection (d) of this section and is based on a facility's decision to either shelter-in-place or evacuate during an emergency situation; and

(5) include a fire safety plan that complies with subsection (f) of this section.

(d) Plan Requirements Regarding Eight Core Functions of Emergency Management.

(1) Direction and control. A facility's plan must contain a section for direction and control that:

(A) identifies the EPC , who is the facility staff person with the authority to manage the facility's response to an emergency situation in accordance with the plan;

(B) identifies the alternate EPC, who is the facility staff person with the authority to act as the EPC if the EPC is unable to serve in that capacity; and

(C) documents the name and contact information for the local EMC for the area in which the facility is located, as identified by the office of the local mayor or county judge.

(2) Warning. A facility's plan must contain a section for warning that:

(A) describes how the EPC will be notified of an emergency situation;

(B) identifies who the EPC will notify of an emergency situation and when the notification will occur, including during off hours, weekends, and holidays; and

(C) ensures monitoring of local news and weather reports.

(3) Communication. A facility's plan must contain a section for communication that:

(A) identifies the facility's primary mode of communication and alternate mode of communication to be used in an emergency situation;

(B) includes procedures for maintaining a current list of telephone numbers for residents' responsible parties;

(C) includes procedures for maintaining a current list of telephone numbers for potential places to which to evacuate, such as hotels, motels, and other facilities licensed under this chapter or certified to participate in the Medicaid ICF/IID Program;

(D) includes procedures for maintaining a current list of telephone numbers for the facility's staff, by residence or unit, that identifies the facility's EPC and administrative staff;

(E) identifies the location of the lists described in subparagraphs (B) - (D) of this paragraph, which must be a place where facility staff can obtain the information quickly;

(F) includes procedures to notify:

(i) facility staff about an emergency situation;

(ii) a receiving facility about an impending or actual evacuation of residents; and

(iii) residents, LARs , and other persons about an impending or actual evacuation;

(G) provides a method for persons to obtain resident information during an emergency situation; and

(H) includes procedures for the facility to maintain communication with:

(i) facility staff involved in an emergency situation;

(ii) a receiving facility, if applicable; and

(iii) the driver of a vehicle transporting residents, medications, records, food, water, equipment, or supplies during an evacuation.

(4) Sheltering Arrangements. A facility's plan must contain a section for sheltering arrangements that:

(A) includes procedures for implementing a decision to shelter-in-place that include:

(i) having access to medications, records, food, water, equipment and supplies; and

(ii) sheltering facility staff involved in responding to an emergency situation, and their family members, if necessary;

(B) includes procedures for notifying the HHSC regional office for the area in which the facility is located by telephone immediately after a decision to shelter-in-place has been made; and

(C) includes procedures for accommodating evacuated residents, if the facility serves as a receiving facility for a facility that has evacuated.

(5) Evacuation. A facility's plan must contain a section for evacuation that:

(A) requires posting building evacuation routes prominently throughout the facility, except in small one-story buildings where all exits are obvious;

(B) includes procedures for implementing a decision to evacuate residents to a receiving facility in an emergency situation, if applicable;

(C) identifies evacuation destinations and routes and includes a map that shows the destinations and routes;

(D) includes a current copy of the agreement with a receiving facility, if the evacuation destinations identified in accordance with subparagraph (C) of this paragraph include a receiving facility that is not owned by the same entity as the facility;

(E) includes procedures for:

(i) ensuring that facility staff accompany evacuating residents;

(ii) ensuring that residents and facility staff present in the building have been evacuated;

(iii) accounting for residents after they have been evacuated;

(iv) accounting for residents absent from the facility at the time of the evacuation;

(v) releasing resident information in an emergency situation to promote continuity of a resident's care;

(vi) contacting the local EMC to find out if it is safe to return to the geographical area; and

(vii) determining if it is safe to re-enter and occupy the building after an evacuation;

(F) includes procedures for notifying the local EMC regarding an evacuation of the facility;

(G) includes procedures for notifying the HHSC regional office for the area in which the facility is located by telephone immediately after a decision to evacuate is made; and

(H) includes procedures for notifying HHSC regional office for the area in which the facility is located by telephone that residents have returned to the facility, within 48 hours of their return to the facility after an evacuation.

(6) Transportation. A facility's plan must contain a section for transportation that:

(A) provides for a sufficient number of facility-owned vehicles to evacuate all residents and for alternate transportation arrangements if the facility-owned vehicles are not available;

(B) includes procedures for safely transporting residents, facility staff involved in an evacuation and, if necessary, their family members, and the facility's and residents' pets during an evacuation; and

(C) includes procedures to safely transport and have timely access to oxygen, medications, records, food, water, equipment, and supplies needed during an evacuation.

(7) Health and Medical Needs. A facility's plan must contain a section for health and medical needs that:

(A) identifies all of the facility's residents with special medical needs; and

(B) ensures that the needs of those residents are met during an emergency situation.

(8) Resource Management. A facility's plan must contain a section for resource management that:

(A) includes procedures for maintaining accurate and detailed checklists of medications, records, food, water, equipment and supplies needed during an emergency situation;

(B) identifies facility staff who are assigned to locate and ensure the transportation of the items on the list described in subparagraph (A) of this paragraph during an emergency situation; and

(C) includes procedures to ensure that medications are secure and stored at the proper temperatures during an emergency situation.

(e) Training. A facility must:

(1) inform a facility staff member of the staff member's responsibilities under the plan within five working days after assuming job duties;

(2) re-train a facility staff member at least annually on the staff member's responsibilities under the plan and when the staff member's responsibilities under the plan change; and

(3) conduct unannounced, annual drills with facility staff for severe weather and other emergency situations identified by the facility as likely to occur, based on the results of the risk assessment required by subsection (c)(1) of this section.

(f) Fire Safety Plan. A facility's fire safety plan must:

(1) for a large facility, include the provisions described in the Operating Features section of NFPA 101, Chapter 18 (for new healthcare occupancies) and Chapter 19 (for existing healthcare occupancies) concerning:

(A) use of alarms;

(B) transmission of alarms to fire department;

(C) emergency phone calls to fire department;

(D) response to alarms;

(E) isolation of fire;

(F) evacuation of immediate area;

(G) evacuation of smoke compartment;

(H) preparation of floors and building for evacuation; and

(I) extinguishment of fire;

(2) for a small facility, include the provisions described in the Operating Features section of NFPA 101, Chapter 32 (for new residential board and care occupancies) and Chapter 33 (for existing residential board and care occupancies) concerning:

(A) use of alarms;

(B) staff response in the event of a fire;

(C) fire protection procedures for a resident;

(D) actions to take if the primary escape route is blocked; and

(E) specification of an assembly point after a resident evacuates from the facility; and

(3) include procedures for:

(A) rehearsing the fire safety plan at least once per quarter on each work shift;

(B) evacuating residents as follows:

(i) for a small facility that has a prompt or slow evacuation capability, during every fire drill; or

(ii) for a large facility or facility with an impractical evacuation capability, during at least one fire drill each year on each work shift;

(C) completing the HHSC form 4719 titled “Fire Drill Report” or a form containing, at a minimum, the information on the HHSC form; and

(D) providing residents and facility staff with experience in egressing through all exits and means of escape.

(g) Reporting Fires. A facility must report a fire at the facility to HHSC as follows:

(1) by calling 1-800-458-9858 within 24 hours after the fire; and

(2) by submitting a completed HHSC form 3707 titled "Fire Report for Long Term Care Facilities" within 15 days after the fire.

TITLE 26 HEALTH AND HUMAN SERVICES

PART 1 HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 551 INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH AN

INTELLECTUAL DISABILITY OR RELATED CONDITIONS

SUBCHAPTER D GENERAL REQUIREMENTS FOR FACILITY CONSTRUCTION

§551.60. Construction and Initial Survey of Completed Construction.

(a) Construction phase.

(1) HHSC in Austin, Texas, must be notified in writing of construction start.

(2) All construction must be done in accordance with minimum licensing requirements. It is the sponsor's responsibility to employ qualified personnel to prepare the contract documents for construction of a new facility or remodeling of an existing facility. Contract documents for additions and remodeling and for the construction of an entirely new facility must be prepared by an architect licensed by the Texas Board of Architectural Examiners (TBAE). Drawings must bear the seal of the architect. Certain parts of final plans, designs, and specifications must bear the seal of a registered professional engineer approved by the Texas Board of Professional Engineers to operate in Texas. These certain parts include sheets and sections covering structural, electrical, mechanical, and sanitary engineering.

(A) Remodeling is the construction, removal, or relocation of walls and partitions; the construction of foundations, floors, or ceiling-roof assemblies; the expanding or altering of safety systems (including sprinkler, fire alarm, and emergency systems); or the conversion of space in a facility to a different use.

(B) General maintenance and repairs of existing material and equipment, repainting, applications of new floor, wall, or ceiling finishes, or similar projects are not included as remodeling, unless as a part of new construction. HHSC must be provided flame spread documentation for new materials applied as finishes.

(b) Contract documents.

(1) Site plan documents must include grade contours; streets (with names); north arrow; fire hydrants; fire lanes; utilities, public or private; fences; unusual site conditions, such as ditches, low water levels, other buildings on-site; and indications of buildings five feet or less beyond site property lines.

(2) Foundation plan documents must include general foundation design and details.

(3) Floor plan documents must include room names, numbers, and usages; doors (numbered) including swing; windows; legend or clarification of wall types; dimensions; fixed equipment; plumbing fixtures; and kitchen basic layout; and identification of all smoke barrier walls (outside wall to outside wall) or fire walls.

(4) For both new construction and additions or remodeling to existing buildings, an overall plan of the entire building must be drawn or reduced to fit on an 8 1/2 inch by 11 inch sheet; submit two reduced plans for file record, as described in §551.60(c)(3) of this subchapter (relating to Construction and Initial Survey of Completed Construction).

(5) Schedules must include door materials, widths, types; window materials, sizes, types; room finishes; and special hardware.

(6) Elevations and roof plan must include exterior elevations, including material note indications and any roof top equipment; roof slopes, drains, and gas piping; and interior elevations where needed for special conditions.

(7) Details must include wall sections as needed (especially for special conditions); cabinet and built-in work, basic design only; cross sections through buildings as needed; and miscellaneous details and enlargements as needed.

(8) Building structure documents must include structural framing layout and details (primarily for column, beam, joist, and structural frame building); roof framing layout (when this cannot be adequately shown on cross section); cross sections in quantity and detail to show sufficient structural design and structural details as necessary to assure adequate structural design, also calculated design loads.

(9) Electrical documents must include electrical layout, including lights, convenience outlets, equipment outlets, switches, and other electrical outlets and devices; service, circuiting, distribution, and panel diagrams; exit light system (exit signs and emergency egress lighting); emergency electrical provisions (such as generators and panels); fire alarm and similar systems (such as control panel, devices, and alarms); sizes and details sufficient to assure safe and properly operating systems; and a staff communication system.

(10) Plumbing documents must include plumbing layout with pipe sizes and details sufficient to assure safe and properly operating systems, water systems, sanitary systems, gas systems, other systems normally considered under the scope of plumbing, fixtures, and provisions for combustion air supply.

(11) (HVAC) documents must include sufficient details of HVAC systems and components to assure a safe and properly operating installation including, heating, ventilating, and air-conditioning layout, ducts, protection of duct inlets and outlets, combustion air, piping, exhausts, and duct smoke or fire dampers; and equipment types, sizes, and locations.

(12) Sprinkler system documents must include plans and details of NFPA designed systems; plans and details of partial systems provided only for hazardous areas; electrical devices interconnected to the alarm system.

(13) Other layouts, plans, or details as may be necessary for a clear understanding of the design and scope of the project; including plans covering private water or sewer systems must be reviewed by the local health or wastewater authority having jurisdiction. If no local authority, then the plans will be reviewed by HHSC .

(14) Specifications must include installation techniques, quality standards, manufacturers, references to specific codes and standards, design criteria, special equipment, hardware, painting, and any others as needed to amplify drawings and notes.

(c) Initial survey of completed construction.

(1) Upon completion of construction, including grounds and basic equipment and furnishings, a final construction inspection (initial survey) of the facility, including additions or remodeled areas, is required to be performed by HHSC prior to occupancy. The completed construction must have the written approval of the local authorities having jurisdiction, including the fire marshal, and building inspector.

(2) After the completed construction has been surveyed by a representative of the architectural section of HHSC and found acceptable, this information will be conveyed to the licensing specialist as part of the information needed to issue a license to the facility. In the case of additions or remodeling of existing facilities, a revision or modification to an existing license may be necessary. Note that the building, grades, drives, parking and grounds must be essentially 100 percent complete at the time of this initial survey visit for occupancy approval and licensing, including basic furnishings and operational needs.

(3) A copy of the following documents must be available to HHSC’s surveyor at the time of the survey of the completed building:

(A) written approval of local authorities as called for in paragraph (1) of this subsection;

(B) written certification of the fire alarm system by the installing agent (Form FML-009A of the Texas State Fire Marshal);

(C) documentation of materials used in the building which are required to have a specific limited fire or flame spread rating, including, special wall finishes or floor coverings, flame retardant curtains (including cubicle curtains), and rated ceilings. This must include a signed letter from the installer verifying that the material installed is the same material named in the laboratory test document;

(D) approval of the completed sprinkler system installation by the designing engineer. A copy of the material list and test certification must be available;

(E) service contracts for maintenance and testing of systems, including, alarm systems and sprinkler systems;

(F) a copy of gas test results of the facility's gas lines from the meter;

(G) a written statement from an architect or engineer stating that he or she certifies that the building was constructed to meet NFPA 101 and all locally applicable codes, and that the facility is in substantial conformance with minimum licensing requirements; and

(H) the contract documents specified in subsection (b) of this section.

(d) Non-approval of new construction.

(1) If, during the initial on-site survey of completed construction, the surveyor finds certain basic requirements not met, he or she may recommend to HHSC that the facility not yet be licensed and approved for occupancy. Such basic items may include the following:

(A) construction which does not meet minimum code or licensure standards for basic requirements such as corridor widths being less than eight feet clear width, ceilings installed at less than the minimum seven feet six inches height, resident bedroom dimensions less than required width, and other such features which would disrupt or otherwise adversely affect the residents and staff if corrected after occupancy;

(B) no written approval by local authorities;

(C) fire protection systems not completely installed or not functioning properly including, fire alarm systems, emergency power and lighting, and sprinkler systems;

(D) required exits are not all usable according to NFPA 101 requirements;

(E) telephone not installed or not properly working;

(F) sufficient basic furnishings, essential appliances and equipment are not installed or not functioning; and

(G) any other basic operational or safety feature which the surveyor, as the authority having jurisdiction, encounters which in his or her judgment would preclude safe and normal occupancy by residents on that day.

(2) If the surveyor encounters deficiencies that do not affect the health and safety of the residents, licensure may be recommended based on an approved written plan of correction by the facility's administrator.

(3) Copies of reduced size floor plan on an 8 1/2 inch by 11 inch sheet must be submitted in duplicate to HHSC for record/file use and for such uses by the facility as evacuation planning and fire alarm zone identification. The plan must contain basic legible information such as overall dimensions, room usage names, actual bedroom numbers, doors, windows, and any other pertinent information.

§551.61. Introduction, Application, and General Requirements for Facilities for Persons with an Intellectual Disability or Related Conditions.

(a) Scope. The requirements of this section are applicable to both new and existing facilities unless stated otherwise.

(b) Purpose.

(1) The concept of requirements for fire safety with regard to the residents is based on evacuation capability as published in NFPA 101. These standards are written with the premise that the residents will be capable of self-evacuation without continuous staff assistance. Residents that are not normally capable of self-evacuation nor capable of negotiating stairs unassisted must not be housed above or below the floor of exit discharge unless the facility meets the construction requirements of NFPA 101, Chapter 18, New Health Care Occupancies, or Chapter 19, Existing Health Care Occupancies, for large facilities, or the "impractical" requirements for small facilities as found in NFPA 101, Chapter 32, New Residential Board and Care Occupancies, or Chapter 33, Existing Residential Board and Care Occupancies. Examples of residents who may not be capable of self-evacuation are as follows:

(A) a person with a physical disability of a nature that he or she is not capable of maneuvering in a wheelchair, walker, or other assistive device unaided;

(B) a person with an intellectual disability who will not take or cannot understand instructions from a staff member; or

(C) a person that is taking medication before bedtime which will make it difficult for a staff member to arouse the person quickly.

(2) The method of determining the evacuation capability of residents under NFPA 101, Chapter 32, New Residential Board and Care Occupancies or Chapter 33, Existing Residential Board and Care Occupancies, is by rating each resident and each staff member to determine an evacuation difficulty score (E-score). If the E-score is 1.5 or less, the evacuation capability of the facility is prompt, greater than 1.5 to five is slow, greater than five is impractical. The worksheets to be completed are located in NFPA 101A, Chapter 6, Evacuation Capability Determination for Board and Care Occupancies. Facilities with capacity for 16 residents or less must meet the evacuation requirement for their designated Chapter 32, New Residential Board and Care Occupancies or Chapter 33, Existing Residential Board and Care Occupancies rating. The ratings and their requirements are as follows :

(A) Impractical rating.

(i) The facility must have one fire drill per shift each calendar quarter (minimum of 12 drills per year).

(ii) The facility must actually evacuate residents once a year on each shift.

(iii) All facility staff, including relief and substitute staff, must participate in drills as soon as possible after beginning employment on their shift.

(iv) E-scores are not required for certification under this rating.

(B) Slow rating.

(i) The facility must have one fire drill per shift each calendar quarter (minimum of 12 drills per year).

(ii) The facility must actually evacuate residents during all drills.

(iii) Staff on each shift must participate in drills.

(iv) New, relief, and substitute staff must participate in a drill within ten days of employment on their assigned shift.

(v) E-scores must be calculated as soon as possible, but within ten calendar days of admission.

(vi) Initial E-scores are based on four drills, as follows:

(I) two conducted during the daytime, and

(II) two conducted during the nighttime, after the first 30 minutes and within the first three hours of sleep.

(vii) After the initial E-scores are obtained, a worksheet for rating residents must be completed for all newly admitted residents to obtain an E-score. The evacuation capability is calculated as described in clause (vi) of this subparagraph.

(viii) E-scores must be updated annually or sooner if significant changes occur in any resident’s evacuation capability. These updated scores are based on the group's overall performance during fire drills as they are conducted throughout the year. Scores do not have to be calculated in accordance with the drills required for newly admitted residents based on the requirements stated in clause (vii) of this subparagraph.

(C) Prompt rating.

(i) The facility must have one fire drill per shift each calendar quarter (minimum of 12 drills per year).

(ii) The facility must actually evacuate residents during all drills.

(iii) Staff on each shift must participate in drills.

(iv) New, relief, and substitute staff must participate in a drill within ten days of employment on their assigned shift.

(v) E-scores must be calculated as soon as possible, but within ten calendar days of admission.

(vi) Initial E-scores are based on four drills, as follows:

(I) two conducted during the daytime, and

(II) two conducted during the nighttime, after the first 30 minutes and within the first three hours of sleep.

(vii) After the initial E-scores are obtained, a worksheet for rating residents must be completed for all newly admitted residents to obtain an E-score. The evacuation capability is calculated as described in clause (vii) of this subparagraph.

(viii) E-scores must be updated annually or sooner if significant changes occur that would affect a resident’s evacuation capability. These updated scores are based on the group's overall performance during fire drills as they are conducted throughout the year. Scores do not have to be calculated in accordance with the drills required for newly admitted residents based on the requirements stated in clause (vi)of this subparagraph.

(3) The "E" score will determine which NFPA 101 features are to be installed and maintained in the facility. These features include construction, fire alarm systems, smoke detector systems, interior finish, sprinkler systems, separation of bedrooms, and egress from the building.

(c) Construction.

(1) New construction is any construction work that began on or after July 5, 2016. The provisions of NFPA 101, Chapter 18, New Health Care Occupancies are applicable for large facilities, and Chapter 32, New Residential Board and Care Occupancies for small facilities.

(2) An existing facility is one that was operating with a license as a facility for persons with an intellectual disability or related conditions before November 1, 2016, and has not subsequently become unlicensed. The provisions of NFPA 101, Chapter 19, Existing Health Care Occupancies are applicable for large facilities, and Chapter 33, Existing Residential Board and Care Occupancies for small facilities.

(3) Alterations or new installations of building services equipment, such as mechanical and electrical systems, generators, fire alarm, and detection systems must be accomplished in conformance with the requirements for new construction as required by NFPA 101.

(4) Site approval, as required by the local health officer, building department, or fire marshal having jurisdiction, must be obtained. Any conditions considered to be a fire, safety, or health hazard will be grounds for disapproval of the site by the HHSC unless applied in an arbitrary or discriminating manner.

(5) Facilities that renovate must provide documentation for the flame spread rate of any new materials applied as an interior finish.

(6) Life safety features and equipment that have been installed in existing buildings and are now in excess of that required by NFPA 101 must continue to be maintained or must be removed at the direction of HHSC .

(7) When an existing licensed facility plans building additions or remodeling, which includes construction of additional resident beds, then the ratio of bathing units must be reevaluated to meet minimum standards and the square footage of dining and living areas must be reevaluated by HHSC . Conversion of existing living, dining, or activity areas to resident bedrooms must not reduce these functions to an area less than required by minimum standards.

(8) Buildings must be of recognized permanent type construction. They must be structurally sound with regard to actual or expected dead, live, and wind loads according to applicable building codes.

(9) Each building must be classified as to the building construction type for fire resistance rating purposes in accordance with NFPA 220 and NFPA 101.

(d) Applicable codes and standards. Except as provided in paragraph (9) of this subsection, a facility must comply with NFPA 101, NFPA 99, and a TIA issued by the NFPA for NFPA 99 or NFPA 101, including the TIAs listed in paragraphs (1) and (2) of this subsection. A facility must also comply with other NFPA publications referenced in this chapter and a TIA issued for a publication referenced in this chapter, unless otherwise approved or required by HHSC .

(1) The following TIAs have been issued for NFPA 101:

(A) TIA 12-1 to NFPA 101, issued August 11, 2011;

(B) TIA 12-2 to NFPA 101, issued October 30, 2012;

(C) TIA 12-3 to NFPA 101, issued October 22, 2013; and

(D) TIA 12-4 to NFPA 101, issued October 22, 2013.

(2) The following TIAs have been issued for NFPA 99:

(A) TIA 12-2 to NFPA 99, issued August 11, 2011;

(B) TIA 12-3 to NFPA 99, issued August 9, 2012;

(C) TIA 12-4 to NFPA 99, issued March 7, 2013;

(D) TIA 12-5 to NFPA 99, issued August 1, 2013; and

(E) TIA 12-6 to NFPA 99, issued March 3, 2014.

(3) If the municipality has a building code and a plumbing code, then those codes must govern in those areas of construction. Where local codes or ordinances are applicable, the most restrictive parts concerning the same subject item must apply unless otherwise determined by the authority having jurisdiction for local codes and HHSC .

(4) In the absence of such governing municipal codes, nationally recognized codes must be used, such as the Standard Building Code and the Standard Plumbing Code, both of the Southern Building Code Congress International, Inc. Such nationally recognized codes, when used, must all be publications of the same group or organization to assure the intended continuity.

(5) Heating, ventilating, and air-conditioning systems must be designed and installed in accordance with NFPA 90A and NFPA 90B, as applicable, and the American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE), except as may be modified in this subchapter.

(6) Electrical and illumination system must be designed and installed in accordance with NFPA 70 and the Lighting Handbook of the Illuminating Engineering Society of North America (IES) except as may be modified in this subchapter.

(7) The facility must meet all applicable provisions and requirements concerning accessibility for individuals with disabilities in the following laws and regulations: the Americans with Disabilities Act of 1990 (Title 42, United States Code, Chapter 126); 28 CFR, Part 35, Nondiscrimination on the Basis of Disability in State and Local Government Services; Texas Government Code, Chapter 469, Elimination of Architectural Barriers; and 16 TAC , Chapter 68, Elimination of Architectural Barriers. Plans for new construction, substantial renovations, modifications, and alterations must be submitted to the Texas Department of Licensing and Regulation (Attention: Elimination of Architectural Barriers Program) for accessibility approval under Chapter 469.

(8) A facility with a boiler must meet all applicable provisions and requirements of Texas Health and Safety Code, Chapter 755, Boilers.

(9) A facility that is required to comply with NFPA 101, Chapter 33, Existing Residential Board and Care Occupancies, must be in compliance with Chapter 33.2.3.5.7.1 or 33.2.3.5.7.2 by July 5, 2019.

(e) General requirements.

(1) The facility must provide and maintain furnishings and decorations that meet the needs of the residents.

(2) The building, grounds, and equipment must be maintained in good repair, operational, sanitary, and free of hazards.

(3) There must be at least one telephone (other than a pay phone) in the facility, accessible to residents for use in making calls to summon help in case of emergency.

(4) The facility must have:

(A) floors that are free of irregularities and are substantially level (floor areas may be at different elevations with connecting stairs or ramps);

(B) floors that have a resilient, nonabrasive, and slip-resistant surface;

(C) nonabrasive carpeting, if the area used by residents is carpeted and serves residents who lie on the floor or ambulate with parts of their bodies, other than feet, touching the floor; and

(D) exposed floor surfaces and floor coverings that promote mobility in areas used by residents and promote maintenance of sanitary conditions.

(5) Walls and ceilings must be cleanable and in good repair.

(6) Walls and floors must be kept free of cracks. The joint between the walls and floors is to be maintained so as to be free of spaces which might harbor insects, rodents, or vermin.

(7) An adequate supply of hot water must be provided. The hot water system for resident use must be capable of being regulated to not exceed 110 degrees Fahrenheit at the fixtures.

(8) Draperies, curtains (including cubicle curtains), and other similar furnishings and decorations must be flame resistant in accordance with NFPA 701. Documentation must be kept on file in the facility.

(9) Wastebaskets must be of noncombustible material.

(10) An initial pressure test of facility gas lines from the meter must be provided. Additional pressure tests will be required when the facility has major renovations or additions where the gas service is interrupted. All gas heating systems must be checked for proper operation and safety prior to the heating season. Any unsatisfactory conditions must be corrected promptly.

(11) The IES recommendations must be followed to achieve proper illumination characteristics and lighting levels throughout the facility. Minimum illumination must be 10 footcandles in resident rooms during the day and 20 footcandles in corridors, staff stations, dining rooms, lobbies, toilets, bathing facilities, laundries, stairways, and elevators during the day. Illumination requirements for these areas apply to lighting throughout the space and must be measured at approximately 30 inches above the floor anywhere in the room. Minimum illumination for medication preparation or storage areas, kitchens, and staff station desks must be 50 footcandles during the day. Illumination requirements for these areas apply to the task performed and must be measured on the tasks.

(12) In addition to the required illumination (normal and emergency), the facility must keep on hand and readily available to night staff, no less than one working flashlight.

(13) Combustible attic areas larger than 3,000 square feet must be divided into compartments not exceeding 3,000 square feet or the attic area must be sprinkled. The separating barrier must be at least one layer of 1/2-inch gypsum board on one side of support members.

§551.62. Site and Grounds.

(a) General (All Facilities).

(1) Site grades must provide for positive surface water drainage so that there will be no ponding or standing water at or near the building such as would present a hazard to health or provide a breeding site or harborage for disease vectors.

(2) Outdoor activity, recreational, and sitting spaces must be provided and be accessible to all residents.

(3) Each facility must have parking space to satisfy the needs of residents, employees, staff, and visitors.

(4) Protection must be provided for resident safety on facility grounds by the use of appropriate methods, such as fences, hedges, retaining walls, railings, or other landscaping. Such protection must not inhibit the free emergency egress to a safe distance away from the building.

(5) All outside areas, grounds, and adjacent buildings on the site must be maintained in good condition and kept free of rubbish, garbage, untended growth, and other conditions which may constitute a fire or health hazard.

(b) Additional site conditions (large facilities only).

(1) Auxiliary buildings located on the site within 20 feet of the main licensed structure and which contain hazardous operations or contents, such as laundries or storage buildings, must meet the same code requirements for safety as the main licensed structure, or the building must be moved to be 20 feet or farther away from the main building.

(2) Other buildings on the site must meet the appropriate occupancy section or separation requirements of NFPA 101 .

(3) A new building (or addition) must be set back at least ten feet from the property lines except as otherwise approved by HHSC .

(4) Exit doors from the building must not open directly onto a drive for vehicular traffic, but must be set back at least six feet from the edge of such drive (measured from the end of building wall in the case of a recessed door) to prevent accidents due to lack of visual warning. These doors are to have automatic or self-closures.

(5) Walks must be provided from all exits and must be of non-slip surfaces free of hazards. Walks must be at least 48 inches wide except as otherwise approved. Ramps must be used in lieu of steps where grade change is 21 inches or less, and where possible, for persons with physical disabilities or mobility impairment, and to facilitate bed or wheelchair removal in an emergency.

(6) Open or enclosed courts with resident rooms or living areas opening upon them must not be less than 20 feet in the smallest dimension unless otherwise approved by HHSC .

(7) There must be at least one approved readily accessible fire hydrant located within 300 feet of the building. The hydrant must be on a minimum six-inch service line, or else there must be an approved equivalent (such as a storage tank). The hydrant, its location, and service line, or equivalent must be approved by the local fire department and HHSC .

(8) The building must have suitable fire lanes for access as required by local fire authorities and HHSC .

§551.63. Fire Service.

(a) The facility must be served by a paid or volunteer fire department. The fire department must provide written assurance to HHSC that the fire department can respond to an emergency at the facility.

(b) Water supply for firefighting purposes must be as required and approved by the firefighting unit.

(c) The facility must have an annual inspection by the local fire marshal.

§551.64. Means of Egress.

(a) Corridors and other means of egress must be kept clear of obstructions and must not be used for any purpose which would interfere with its use as an exit, such as for storage, vending machines, seating, or similar purposes. The corridor width must be maintained at all times.

(b) Doors within the means of egress must not be equipped with a latch or lock which requires the use of a key or tool to open from the inside of the building. A latch or other fastening device on a door must be provided with a knob, handle, panic bar, or other simple type of releasing device, the method of operation of which is obvious, even in darkness. An exception is that large facilities are permitted to have doors which are locked, if residents can be rapidly removed by the use of remote control of locks or by keying all locks to keys readily available to staff who are in constant attendance.

(c) A hold-open device must be installed on each exit door of large facilities.

§551.65. Fire Alarms, Detection Systems, and Sprinkler Systems.

(a) General. Fire alarms, detection systems, and sprinkler systems must be as required by NFPA 101, NFPA 72, NFPA 13, NFPA 13R, or NFPA 13D, as specified in NFPA 101, Chapter 32, New Residential Board and Care Occupancies and Chapter 33, Existing Residential Board and Care Occupancies, and as modified in this section.

(1) Each building must have an approved fire alarm system.

(2) Components must be compatible and laboratory listed for the use intended.

(3) Wiring and circuitry for alarm systems must meet the applicable requirements of NFPA Codes, including NFPA 70, for such systems.

(4) Fire alarm systems must be installed, maintained, and repaired by an agent having a current certificate of registration with the state fire marshal's office of the Texas Commission on Fire Protection, in accordance with the state law. A fire alarm system installation certificate must be provided as required by the State Fire Marshal’s Office . An exception is that large facilities who have professional engineers on staff that are qualified in electrical and electronic installations are not required to have a certificate of registration with the State Fire Marshal’s Office , provided they do not sell, install, or maintain fire alarm systems commercially.

(5) Smoke detector sensitivity must be checked within one year after installation and every alternate year thereafter in accordance with NFPA 72. Documentation, including as-built installation drawings, operation and maintenance manuals, and a written sequence of operation must be available for examination by HHSC .

(b) Fire alarm and smoke detection and sprinkler systems for small facilities.

(1) A manual alarm initiating system must be provided and must be supplemented by an automatic smoke detection and alarm initiation system in accordance with NFPA 101, Chapter 9, Building Service and Fire Protection Equipment, Section 9-6, Fire Detection, Alarm, and Communications Systems.

(2) Smoke detectors must be installed in resident bedrooms, corridors, hallways, and common living/dining areas. Service areas such as laundries and kitchens must have heat detectors in lieu of smoke detectors.

(3) The fire alarm control panel must be located to be in view of staff. The primary power source for the complete fire alarm system must be commercial electric.

(4) Emergency power source must be from storage batteries or on-site engine-driven generator set.

(5) The operation of any alarm initiating device will sound an audible or visual alarm at the site.

(6) The facility must have a written contract with a fire alarm company or person licensed by the State Fire Marshal’s Office to maintain the fire alarm system semiannually, and the system will be inspected as specified in the contract.

(7) Facilities classified as "impractical evacuation capability," must be protected by a sprinkler system in compliance with NFPA 13, NFPA 13R, or NFPA 13D with additional requirements for coverage in all dwelling areas and all closets as specified by NFPA 101, Chapters 32, New Residential Board and Care Occupancies, and Chapter 33, Existing Residential Board and Care Occupancies.

(c) Fire alarm and emergency systems for large facilities.

(1) The fire alarm system must be designed so that whenever the general alarm is sounded by activation of any device (manual pull, smoke sensor, sprinkler, kitchen range hood extinguisher, or other device ) the following must occur automatically.

(A) Smoke and fire doors which are held open by approved devices must be released to close.

(B) Air handlers (air conditioning/heating distribution fans) serving three or more rooms or any means of egress must shut down immediately.

(C) Smoke dampers must close.

(D) The proper zone indicating lights must show on the fire alarm control panel , including auxiliary panels.

(2) Fire alarm bells or horns must be located throughout the building for audible coverage. Flashing alarm lights (visual alarms) of proper intensity must be installed to be visible in corridors and public areas including dining rooms and living rooms.

(3) A master control panel must be visible at the main staff station which has alarm and trouble conditions by zones, power-on lights, and required signal devices for trouble conditions. All control panels must be listed in accordance with the provisions of the Underwriters Laboratories, Inc. (UL) for the intended use, i.e., manual, automatic, and water flow activation. Alarm and trouble zoning must be by smoke compartments and by floors in multi-story facilities.

(4) Remote annunciator panels equipped with alarm by zone and a common trouble signal (both audible and visual) must be located at auxiliary or secondary staff stations on each floor or major subdivisions of single story facilities, that will indicate the alarm condition of adjacent zones and the alarm conditions at all other staff stations.

(5) Manual pull stations must be provided at all exits, living rooms, dining rooms, and at or near the staff stations.

(6) The NFPA 13 sprinkler system must be interconnected with the fire alarm panel as a separate zone for alarm and trouble. Activation of the tamper switch will provide a trouble condition on the fire alarm panel which will not impair the operation of the alarm.

(7) The kitchen range hood extinguisher must be interconnected with the fire alarm system. This interconnection may be a separate zone on the panel or combined with other initiating devices located in the same zone as the range hood is located.

(8) The fire alarm system must be arranged to transmit an alarm automatically to the fire department legally committed to serve the area in which the facility is located by the most direct and reliable method allowed by NFPA 101.

(9) Partial sprinkler systems (those provided only for hazardous areas) must be interconnected to the fire alarm system and comply with NFPA 101. Each partial system must have a valve with a supervisory switch to sound a supervisory signal, water flow switch to activate the fire alarm, and an end of line test drain.

(10) Emergency electrical services must be provided to comply with the provisions of NFPA 70. This includes such items as emergency power provided by generator or batteries for fire alarm systems, emergency egress lighting, call systems, TV cameras and monitors (if used for corridor observation), life support systems, or designated wall receptacles. The system must comply with NFPA 99 and NFPA 37.

(11) Elevators, escalators, and moving walks. Elevators must comply with the provisions of NFPA 101 and American National Standards Institute (ANSI) Safety Code for Elevators and Escalators (American Society of Mechanical Engineers (ASME)) A17.1. Elevators are required for buildings having resident facilities (such as bedrooms, dining, or recreation areas) or services (such as diagnostic or therapy) located on other than the main entrance floor. Passenger elevators, escalators, and walks must be inspected by a qualified agent at least every six months. Freight elevators and dumbwaiters must be inspected every 12 months.

§551.66. Portable Fire Extinguishers.

(a) General. Portable fire extinguishers must be provided and maintained to comply with the provisions of NFPA 10 . This includes such items as type of extinguishers (A, B, or C), location and spacing, mounting heights, monthly inspections by staff, yearly inspections by a licensed agent (with any necessary servicing), and hydrostatic testing as recommended by the manufacturer.

(b) Types of extinguishers.

(1) Extinguishers in resident corridors must be spaced so that travel distance is not more than 75 feet. The minimum size of extinguishers must be either 2 1/2 gallon (pressurized water) for water type or 2-A: 10-B: C (five-pound dry chemical) for ABC type.

(2) Extinguishers must be installed on supplied hangers or brackets or be mounted in cabinets approved by HHSC .

(3) Extinguishers must be surface wall-mounted or recessed in cabinets where they are not subject to physical damage or dislodgement.

(4) Extinguishers having a gross weight not exceeding 40 pounds must be installed so that the top of the extinguisher is not more than five feet above the floor. Extinguishers with a gross weight greater than 40 pounds must be installed so the top of the extinguisher is not more than 3 1/2 feet above the floor. The clearance between the bottom of the extinguisher and the floor must not be less than four inches.

(5) Portable extinguishers provided in hazardous rooms must be located as close as possible to the exit door opening and on the latch (knob) side.

(6) Staff must be appropriately trained in the use of each type of extinguisher in the facility.

§551.67. Accessibility Provisions.

The physical plant must be designed for persons with physical disabilities or mobility impairments and must comply with applicable federal, state, and local requirements.

§551.68. Architectural Space Planning.

(a) Large facilities.

(1) Ancillary resident space. The minimum total ancillary resident-use space must be not less than 35 square feet per resident . Ancillary space includes areas for living, dining, recreation, therapy, training, and other such program areas. It does not include bedrooms, passageways, offices, kitchens, or laundries (more than 35 square feet per resident is usually needed in facilities with less than 60 residents ). A facility ~~Facilities~~ which has large proportions (approximately 65 percent or greater) of nonambulatory or bedfast residents must provide at least 50 square feet of ancillary space per resident unless otherwise approved by HHSC . An area providing less space than called for in this paragraph cannot be approved except on an individual basis where clearly justified.

(2) Resident bedrooms.

(A) A bedroom must be arranged and equipped for adequate personal care and for comfort and privacy. A bedroom must have full height walls that extend from floor to ceiling with doors. (Partial partitions or furnishings are not a substitute.) An exception is that an existing facility constructed prior to October 3, 1988, that has partial partitions in lieu of full-height walls, need not install the full-height walls unless there are major renovations or conversions.

(B) A bedroom must provide at least 80 square feet for a single occupancy (one resident ) and 60 square feet per resident for multiple occupancy. (Note: room configuration and usability are taken into consideration and there may be instances where the minimum square footage will not be acceptable.) The minimum room dimension must be at least eight feet for a single resident room and at least ten feet for a multiple-resident room, unless otherwise approved by HHSC. An exception is that a multi-occupancy bedroom for persons in wheelchairs must have 70 square feet per resident .

(C) No more than four residents may be in any one bedroom. An exception is HHSC may grant a variance from the limit of four residents per room only if a physician who is a member of the IDT and who is a QIDP:

(i) certifies that each resident to be placed in a bedroom accommodating ~~housing~~ more than four residents is so severely medically impaired as to require direct and continuous monitoring during sleeping hours; and

(ii) documents the reasons why accommodating ~~housing~~ in a room of only four or fewer residents would not be medically feasible.

(D) In the bedroom and for each resident there must be a bed with a comfortable mattress and appropriate bedding, functional furniture appropriate to residents' needs, and closet space providing security and privacy for clothing and personal belongings. Closet space must provide at least 24 inches of lineal hanging space per resident (in certain cases, such as for infants, exceptions may be made). Married couples may share a bed.

(E) Each bedroom must have at least one outside wall with an operable window giving outside exposure. Unless approved otherwise by the HHSC , the window sill of the required window must be no higher than 44 inches from the floor and must be at or above outside grade level. Other window requirements must be as called for in NFPA 101. The window area for a bedroom must be equal to at least 10 percent of the total room floor area.

(F) If a bedroom is below grade level, it must have a window that is usable as a second means of escape by a resident occupying the room. The window must be no more than 44 inches (measured to the window sill) above the floor.

(G) A resident bedroom must open onto an exit corridor, living area, or public area and must be arranged for convenient resident access to dining, living, and bathing areas.

(3) Social-diversional spaces.

(A) A living room, a day room, a lounge, or other social-diversional space ~~etc.~~, must be provided on a sliding scale as follows (as part of the minimum required ancillary space):

Figure: 26 TAC §551.68(a)(3)(A)

|  |  |
| --- | --- |
| Number of Residents | Area Per Resident (Minimum) |
| 1-15 | 18 square feet (Minimum 144 square feet) |
| 16-20> | 17 square feet |
| 21-25 | 16 square feet |
| 26-30 | 15 square feet |
| 31-35 | 14 square feet |
| 36-40 | 13 square feet |
| 41-50 | 12 square feet |
| 51-60 | 11 square feet |
| 61 and over | 10 square feet (Ex: 100 residents = 1,000 square feet) |

(B) Where a required way of exit is through a living area, a pathway equal to the corridor width will normally be deducted from that area. Such exit pathways must be kept clear of obstructions.

(C) Each living room and dining room must have at least one outside window. Normally, a resident classroom and a training area must also have an outside window unless otherwise approved by HHSC .

(4) Dining space. Dining space must provide at least 15 square feet per resident for single-shift feeding. If procedure is approved for feeding in two shifts, at least eight square feet per resident must be provided.

(5) Training spaces including academic, behavioral, occupational, physical, and speech therapy spaces . Classroom type space is anticipated for most training activities. The number and size of such spaces will be evaluated on an individual facility basis and according to program policies and procedures. Generally, a training room must provide at least 20 square feet per resident trainee within the room except that no training room may be less than 80 square feet. For purposes of calculation, space must be provided for at least one-third of the total population at any one time (i.e., plan space for 33 residents in a 100-resident facility).

(6) Kitchens (main/dietary).

(A) A kitchen must be evaluated on the basis of its performance in the sanitary and efficient preparation and serving of meals to residents. Consideration must be given to planning for the type of meals served, the overall building design, the food service equipment, arrangement, and the work flow involved in the preparation and delivery of food. Plans for construction of new facilities must contain a detailed kitchen layout prepared by, or under the direction of, a registered or licensed dietitian.

(B) A kitchen must be designed so that room temperature, at peak load, must not exceed an average temperature of 85 degrees Fahrenheit measured over the room at the five-foot level. The amount of supply air must take into account the large quantities of air exhausted at the range hood and dishwashing area.

(C) A kitchen must be provided with operational equipment as planned and scheduled by the facility's consultants for preparing and serving meals and for refrigerating and freezing perishable foods, as well as equipment in, or adjacent to, the kitchen or dining area for producing ice.

(D) A kitchen must be provided with facilities for washing and sanitizing dishes and cooking utensils. Such facilities will be provided for the number of meals served and the method of serving (permanent or disposable dishes, etc.). The kitchen must contain a compartmented sink large enough to immerse pots and pans. Separation of soiled and clean dish areas must be maintained, including air flow.

(i) A mechanical dishwasher must be used to sanitize dishes and utensils and must meet the requirements specified under 25 TAC §228, Subchapter D (relating to Equipment, Utensils, and Linens); or

(ii) Dishes and utensils must be manually sanitized in accordance with 25 TAC §228, Subchapter D, prior to placement in the dishwasher.

(E) A kitchen must be provided with a supply of hot and cold water. Hot water for sanitizing purposes must be 180 degrees Fahrenheit or the manufacturer's suggested temperature for chemical sanitizers, as specified for the system in use. For a mechanical dishwasher, the temperature measurement is at the manifold.

(F) A kitchen must be provided with at least one hand-washing lavatory or hand-sanitizing device. A hand-washing lavatory must be provided with hot and cold running water, soap, and individual towels, preferably paper towels; common use towels must not be used.

(G) In new construction, a staff restroom facility with a lavatory must be accessible to kitchen staff without traversing resident use areas. The restroom door must not open directly into the kitchen, e.g., provide a vestibule.

(H) In new construction, a janitorial facility must be provided exclusively for the kitchen and must be located in and entered from the kitchen.

(I) Nonabsorbent smooth finishes or surfaces must be used on kitchen floors, walls, and ceilings. Such surfaces must be capable of being sanitized to maintain a healthful environment.

(J) All operable window openings must be screened. A door opening to the outside of the building must have self-closing devices.

(7) Food storage areas (main/kitchen).

(A) In new construction, a food storage area must be planned on the basis of the number and type of resident meals to be served. The size and layout of dry foods storage must be prepared by or designed under the direction of a licensed or registered dietitian.

(B) Food storage areas must provide for storage of a four-day minimum supply of nonperishable foods at all times.

(C) Shelves must be movable metal or sealed lumber, and walls must be finished with a nonabsorbent finish to provide a cleanable surface.

(D) Dry food storage must have an approved venting system to provide for positive air circulation.

(E) The maximum room temperature for food storage must not exceed 85 degrees Fahrenheit at all times. The measurement must be taken at the five-foot level.

(F) Food storage areas may be located apart from the food preparation area as long as there is space adjacent to the kitchen for necessary daily stores.

(8) Food services areas.

(A) Where a service area other than the kitchen is used to dispense foods, this must be designated as a food service area and must have equipment for maintaining required food temperatures while serving.

(B) A separate food service area must have hand-washing facilities as a part of the food service area. An employee toilet must be provided.

(C) Finishes of all surfaces except ceilings must be the same as those required for dietary kitchens.

(9) Other spaces.

(A) A bathing unit (tubs or showers) must be provided at a minimum ratio of one per 15 residents . Toilets and sinks must be provided at a minimum ratio of one per eight residents . Bathing and toilet facilities must be of a type appropriate to the resident's varying needs and disabilities, and designed for privacy within the bathroom.

(B) Adequate storage space must be provided for equipment, carts, wheelchairs, etc., to eliminate the problem of such items being left or stored in corridors, or overcrowding bedroom space.

(b) Small facilities.

(1) Bedrooms.

(A) A bedroom must be arranged and equipped for adequate personal care and for comfort and privacy. A bedroom must have full height walls that extend from floor to ceiling with doors. (Partial partitions or furnishings are not a substitute.)

(B) A bedroom must provide at least 80 square feet for a single occupancy (one resident ) and 60 square feet per resident for multiple occupancy. (Note: room configuration and usability are taken into consideration and there may be instances where the minimum square footage will not be acceptable.) The minimum room dimension must be at least eight feet for a single resident room and at least ten feet for a multiple-resident room, unless otherwise approved by the HHSC . An exception is that a multi-occupancy bedroom for residents in wheelchairs must have 70 square feet per resident .

(C) No more than four residents may be in any one bedroom. An exception is that HHSC may grant a variance from the limit of four residents per room only if a physician who is a member of the IDT and who is a QIDP :

(i) certifies that each resident to be placed in a bedroom accommodating ~~housing~~ more than four residents is so severely medically impaired as to require direct and continuous monitoring during sleeping hours; and

(ii) documents the reasons why accommodating in a room of only four or fewer residents would not be medically feasible.

(D) In the bedrooms and for each resident there must be a bed with a comfortable mattress and appropriate bedding, functional furniture appropriate to residents' needs, and closet space providing security for personal clothing and belongings. Closet space must provide at least 24 inches of lineal hanging space per resident (in certain cases, such as for infants, exceptions may be made). Married couples may share a bed.

(E) Every bedroom must have at least one outside window that can be readily opened from the inside and provides a clear opening of at least 5.7 square feet (minimum width of 20 inches; minimum height of 24 inches). The bottom of the opening must be not more than 44 inches above the floor. Minimum dimensions for operable window section are 20 inches wide by 41.2 inches in height, or 24 inches in height by 34.2 inches wide to provide the minimum 5.7 feet of opening. If a bedroom has a second means of escape independent and remote from the primary means of escape, the bedroom must have a window with clear glass of area not less than 8 percent of the bedroom floor area. When opened, the window must have an open space of not less than 4 percent of the bedroom floor area.

(F) A bedroom door must be 20-minute fire rated or 1 3/4-inch solid bonded core wood. This door must have automatic closures and latch in their frames. Exceptions are as follows.

(i) A bedroom door needs only be smoke resistant and does not need automatic closure if the building has an approved sprinkler system throughout.

(ii) A bedroom door needs only be smoke resistant with automatic closures if the facility is classified "prompt" level of evacuation difficulty.

(G) Each small facility must have at least two remotely located means of escape that do not involve windows. The arrangement must be such that there is a primary means of escape from each sleeping room that provides a path of travel to the outside without traversing any corridor or other space exposed to unprotected vertical openings or common living spaces, such as living rooms and kitchens. Exceptions are as follows:

(i) A second means of escape or alternate protection is not required:

(I) if the bedroom has a door leading directly to the outside of the building, at or to grade level; or

(II) if the building is protected with an approved sprinkler system meeting NFPA 13, NFPA 13R, , or NFPA 13D .

(ii) Separated primary means of escape is not necessary if the building is single story; has 1 3/4-inch solid bonded core doors to bedrooms or smoke resistant doors with closures; 20-minute fire protection for the structure; Class A or B interior finish; bedroom windows of proper size; total smoke detection coverage of habitable spaces, including loft areas that are tied into the manual fire alarm system; and two remote means of escape.

(2) Living room space. Living room space must provide at least 15 square feet per resident (with a minimum of 120 square feet regardless of number of residents). Living room space can include one or more rooms or areas provided that the first such area is at least 80 square feet each.

(3) Dining space. Dining space must be large enough to accommodate all residents at one sitting, and must provide at least 15 square feet per resident. Living and dining space may be in one room or area providing a combined total of 30 square feet per resident (15 square feet living plus 15 square feet dining per resident).

(4) Bathrooms. Bathrooms must provide for individual privacy. Water closets and lavatories must be provided at a minimum ratio of one for each five residents. There must be at least one tub or shower for each eight residents. At least one bathroom (with water closets, lavatory, and tub or shower) must be provided on each sleeping floor accessible to the residents of that floor.

(5) Kitchen. The facility must have a kitchen to meet the general food service needs of the residents. It must include provisions for the storage, refrigeration, preparation, and serving of food; for dish and utensil cleaning; and for refuse storage and removal. A mechanical dishwasher must be provided.

(6) Office. An office or other space must be available for private individual counseling and for the safekeeping of files and records.

(7) Stairs. Buildings of two or more stories require at least two separate approved exit stairs from the upper floors. Usable space under the stairs is not allowed unless fire separated or protected in accordance with NFPA 101 . Open interior stairways which constitute an "unprotected vertical opening" to a required exit passageway on the upper floor must be provided with a barrier (wall and door) at either the lower or upper level to prevent the rapid rise of fire or smoke originating on the lower level from rendering the upstairs passageway to the second stair impassable.

(8) Fire rating. Interior wall and ceiling surfaces must have, as the finished surface or a substrate or sheathing, a fire resistance of not less than 20 minutes, similar to that provided by 3/8-inch gypsum board.

§551.69. Storage Requirements (All Facilities).

(a) Bulk storage of hazardous items such as janitor supplies and equipment must be provided in closets or spaces separate from resident use areas. Closets or spaces must be maintained in a safe and sanitary condition and ventilated in a manner commensurate with the use of the closet or space.

(b) There must be space for equipment for daily out-of-bed activity for all residents.

(c) There must be suitable storage space accessible to the resident for personal possessions such as toys, televisions, radios, prosthetic equipment, and clothing.

(d) Attics, mechanical rooms, boiler rooms, and other similar areas must not be used for storage purposes.

§551.70. Electrical Systems and HVAC --All Facilities.

(a) Cooling and heating must be provided, as necessary, for resident comfort. Heating systems in resident use areas must be capable of maintaining a minimum temperature of 68 degrees Fahrenheit, and cooling of 81 degrees Fahrenheit maximum, with humidity in the normal comfort range.

(b) The facility must be well ventilated through the use of windows, mechanical ventilation, or a combination of both. Rooms and areas which do not have outside windows and which are used by residents or staff must be provided with functioning mechanical ventilation to change the air on a basis commensurate with the room usage.

(c) Air systems must provide for the induction and mixing of at least 10 percent outside fresh air into the facility unless otherwise approved by HHSC , that is, 100 percent continuous recirculation of interior air in most areas is not acceptable; or the system must be designed to meet the American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) requirements.

(d) Operable outside windows must be provided with insect screens that prevent insect entry.

(e) Rooms such as baths, toilets, soiled linen, trash or garbage rooms, soiled utilities, janitor's closets, and other such areas which produce odors, fumes, excessive moisture, etc., must be provided with an exhaust system ducted to the exterior, meeting nationally recognized standards for capacity and function.

(f) Electrical and mechanical systems must be safe and in working order. HHSC may require the facility sponsor or licensee to submit evidence to this effect, consisting of a written report by the local fire marshal, city/county building official having jurisdiction, or a registered professional engineer.

(g) Use of electrical appliances, devices, and lamps must be such as not to overload circuits.

(h) Portable heaters and open-flame heating devices are prohibited. All fuel burning devices must be vented. Working fireplaces are acceptable if of safe design and construction, and if screened or otherwise suitably enclosed.

§551.71. Plumbing (All Facilities).

(a) The water supply must be of safe, sanitary quality, suitable for use, and adequate in quantity and pressure. The water must be obtained from a water supply system; the location, construction, and operation approved by the Texas Commission on Environmental Quality (TCEQ) .

(b) Sewage must be discharged into a state-approved sewerage system or septic system; otherwise, the sewage must be collected, treated, and disposed of in a manner approved by TCEQ .

§551.72. Maintenance (All Facilities).

(a) Walls, doors, and ceilings must be maintained free from holes, cracks, falling plaster or paint, and must be cleaned and painted.

(b) Paint or plaster inside the building that contains lead must be removed or covered so that it is not accessible to the residents.

(c) All abandoned utilities such as electrical wiring, ducts, and pipes must be removed from the facility when no longer usable.

§551.73. Environmental Services.

(a) Pest control.

(1) The facility must be kept free of insects, rodents, and vermin. The least toxic and least flammable effective chemicals must be used. Poisons must not be stored with food products and must be under lock.

(2) Garbage and trash must be stored in an enclosed container , protected against leakage, contact with disease vectors, and access to animals. It must be stored in an area separate from those used for the preparation and storage of food and must be removed from the premises in conformity with state and local practices. A garbage or trash container must be maintained free of accumulations and coatings of garbage. A garbage storage area must be kept clean and in good repair.

(b) Storage. Storage items must be neatly arranged and placed to minimize fire hazard. Gasoline, volatile materials, paint, and similar products, excluding personal items, must not be stored in the building accommodating residents except as may be approved by the local fire marshal. Accumulations of extraneous material and refuse must not be permitted.

(c) Laundry.

(1) There must be clean linen available at all times, and in a quantity to meet the needs of the residents.

(2) Clean linen must be stored in a clean storage area, which is easily accessible to staff .

(3) Soiled linen and clothing in a large facility must be transported or stored in approved containers or bags.

(A) Soiled laundry storage must be in a separate, well ventilated area and must not be permitted to accumulate in other areas of the facility.

(B) A soiled bag or container must not be used to convey clean linens.

(C) Soiled linens must not be sorted, laundered, rinsed, or stored in bathrooms, resident rooms, corridors, kitchens, or food storage areas.

§551.74. Safety Operations.

(a) The facility must have a program to inspect, test, and maintain the fire alarm system and must execute the program at least once every three months for large facilities and at least once every six months for small facilities.

(1) The facility must contract with a company that is registered by the State Fire Marshal's Office to execute the program.

(2) The person who performs a service under the contract must be licensed by the State Fire Marshal's Office to perform the service and must complete, sign, and date an inspection form similar to the inspection and testing form in NFPA 72 for a service provided under the contract.

(3) The facility must ensure that fire alarm system components that require visual inspection are visually inspected in accordance with NFPA 72.

(4) The facility must ensure that fire alarm system components that require testing are tested in accordance with NFPA 72.

(5) The facility must ensure that fire alarm system components that require maintenance are maintained in accordance with NFPA 72.

(6) The facility must ensure that smoke dampers are inspected and tested in accordance with NFPA 101.

(7) The facility must maintain onsite documentation of compliance with this subsection.

(b) The facility must have a program to inspect, test, and maintain the sprinkler system and must execute the program at least once every three months for large facilities and at least once every six months for small facilities.

(1) The facility must contract with a company that is registered by the State Fire Marshal's Office to execute the program.

(2) The person who performs a service under the contract must be licensed by the State Fire Marshal's Office to perform the service and must complete, sign, and date an inspection form similar to the inspection and testing form in NFPA 25 for a service provided under the contract.

(3) The facility must ensure that sprinkler system components that require visual inspection are visually inspected in accordance with NFPA 13, NFPA 13D, or NFPA 13R and in accordance with NFPA 25.

(4) The facility must ensure that sprinkler system components that require testing are tested in accordance with NFPA 13, NFPA 13D, or NFPA 13R and in accordance with NFPA 25.

(5) The facility must ensure that sprinkler system components that require maintenance are maintained in accordance with NFPA 13, NFPA 13D, or NFPA 13R and in accordance with NFPA 25.

(6) The facility must ensure that individual sprinkler heads are inspected and maintained in accordance with NFPA 13, NFPA 13D, or NFPA 13R and in accordance with NFPA 25.

(7) The facility must maintain onsite documentation of compliance with this subsection.

(c) The facility must formulate, adopt, and enforce smoking policies.

(1) The facility's policies must comply with all applicable codes, regulations, and standards, including local ordinances.

(2) The facility must inform residents, staff, visitors, and other affected parties of the facility's smoking policies.

(3) The facility must prohibit smoking in any room, ward, or compartment where flammable liquids, combustible gas, or oxygen is used or stored and in any other hazardous location. The facility must post a "No Smoking" sign in these areas.

(4) The facility must provide ashtrays of noncombustible material and safe design in all areas where smoking is permitted.

(5) The facility must provide a metal container with a self-closing cover device into which ashtrays can be emptied in all areas where smoking is permitted.

§551.75. Plans, Approvals, and Construction Procedures.

At the option of the applicant, HHSC will review plans for new buildings, additions, conversion of buildings not licensed by HHSC , or remodeling of existing licensed facilities. HHSC will, within 30 days, inform the applicant in writing of the results of the review. If the plans comply with HHSC’s architectural requirements, HHSC may not subsequently change the architectural requirement applicable to the project unless the change is required by federal law or the applicant fails to complete the project within two years. HHSC may grant a waiver of this two-year period for delays due to unusual circumstances. There is no time limit to complete a project, only a time limit for completing a project using requirements that have been revised after the project was reviewed.

(1) Submittal of plans.

(A) For review of plans, submit one copy of working drawings and specifications (contract documents) before construction begins. Documents must be in sufficient detail to interpret compliance with these standards and assure proper construction. Documents must be prepared according to accepted architectural practice and must include general construction, special conditions, and schedules.

(B) Final copies of plans must have (in the reproduction process by which plans are reproduced) a title block that shows name of facility, person, or organization preparing the sheet, sheet numbers, facility address, and drawing date. Sheets and sections covering structural, electrical, mechanical, and sanitary engineering final plans, designs, and specifications must bear the seal of a registered professional engineer approved by the Texas Board of Professional Engineers to operate in Texas. Contract documents for additions, remodeling, and construction of an entirely new facility must be prepared by an architect licensed by the Texas Board of Architectural Examiners (TBAE). Drawings must bear the seal of the architect.

(C) A final plan for a major addition to a facility must include a basic layout to scale of the entire building onto which the addition will connect. North direction must be shown. The entire basic layout usually can be to scale such as 1/16 inch per foot or 1/32 inch per foot for very large buildings.

(D) Plans and specifications for conversions or remodeling must be complete for all parts and features involved.

(E) The sponsor is responsible for employing qualified personnel to prepare the contract documents for construction. If the contract documents have errors or omissions to the extent that conformance with standards cannot be reasonably assured or determined, a revised set of documents for review may be requested.

(F) The review of plans and specifications by HHSC is based on general utility, the minimum licensing standards, and conformance of the Life Safety Code, and is not to be construed as all-inclusive approval of the structural, electrical, or mechanical components, nor does it include a review of building plans for compliance with the Texas Accessibility Standards as administered and enforced by the Texas Department of Licensing and Regulation.

(G) Fees for plan review will be required in accordance with §551.20 of this chapter (relating to Plan Review Fees).

(2) Contract documents.

(A) Site plan documents must include:

(i) grade contours;

(ii) streets (with names);

(iii) north arrow;

(iv) fire hydrants;

(v) fire lanes;

(vi) utilities, public or private;

(vii) fences; and

(viii) unusual site conditions, such as

(I) ditches,

(II) low water levels,

(III) other buildings on-site, and

(IV) indications of buildings five feet or less beyond site property lines.

(B) Foundation plan documents must include general foundation design and details.

(C) Floor plan documents must include:

(i) room names, numbers, and usages;

(ii) doors (numbered), including swing;

(iii) windows;

(iv) legend or clarification of wall types;

(v) dimensions;

(vi) fixed equipment;

(vii) plumbing fixtures;

(viii) kitchen basic layout; and

(ix) identification of all smoke barrier walls (outside wall to outside wall) or fire walls.

(D) For both new construction and additions or remodeling to existing buildings, an overall plan of the entire building must be drawn or reduced to fit on an 8 1/2-inch by 11-inch sheet.

(E) Schedules must include:

(i) door materials, widths, and types;

(ii) window materials, sizes, and types;

(iii) room finishes; and

(iv) special hardware.

(F) Elevations and roof plan must include:

(i) exterior elevations, including

(I) material note indications and

(II) any rooftop equipment;

(ii) roof slopes,

(iii) drains,

(iv) gas piping, etc., and

(v) interior elevations where needed for special conditions.

(G) Details must include:

(i) wall sections as needed, especially for special conditions;

(ii) cabinet and built-in work, basic design only;

(iii) cross sections through buildings as needed; and

(iv) miscellaneous details and enlargements as needed.

(H) Building structure documents must include:

(i) structural framing layout and details (primarily for column, beam, joist, and structural building);

(ii) roof framing layout (when it cannot be adequately shown on cross section); and

(iii) cross sections in quantity and detail to show sufficient structural design and structural details as necessary to assure adequate structural design and calculated design loads.

(I) Electrical documents must include:

(i) electrical layout, including lights, convenience outlets, equipment outlets, switches, and other electrical outlets and devices;

(ii) service, circuiting, distribution, and panel diagrams;

(iii) exit light system (exit signs and emergency egress lighting);

(iv) emergency electrical provisions (such as generators and panels);

(v) staff communication system;

(vi) fire alarm and similar systems (such as control panel, devices, and alarms); and

(vii) sizes and details sufficient to assure safe and properly operating systems.

(J) Plumbing documents must include:

(i) plumbing layout with pipe sizes and details sufficient to assure safe and properly operating systems;

(ii) water systems;

(iii) sanitary systems;

(iv) gas systems; and

(v) other systems normally considered under the scope of plumbing, fixtures, and provisions for combustion air supply.

(K) HVAC documents must include:

(i) sufficient details of HVAC systems and components to assure a safe and properly operating installation, including, heating, ventilating, and air-conditioning layout, ducts, protection of duct inlets and outlets, combustion air, piping, exhausts, and duct smoke or fire dampers; and

(ii) equipment types, sizes, and locations.

(L) Sprinkler system documents must include:

(i) plans and details of NFPA designed systems;

(ii) plans and details of partial systems provided only for hazardous areas; and

(iii) electrical devices interconnected to the alarm system.

(M) Specifications must include:

(i) installation techniques;

(ii) quality standards and manufacturers;

(iii) references to specific codes and standards;

(iv) design criteria;

(v) special equipment;

(vi) hardware;

(vii) finishes; and

(viii) any others as needed to amplify drawings and notes.

(N) Other layouts, plans, or details as may be necessary for a clear understanding of the design and scope of the project, including plans covering private water or sewer systems, must be reviewed by local health or wastewater authority having jurisdiction.

(3) Construction phase.

(A) HHSC must be notified in writing before construction starts.

(B) All construction not done in accordance with the completed plans and specifications as submitted for review and as modified in accordance with review requirements will require additional drawings if the change is significant.

(4) Initial survey of completed construction.

(A) Upon completion of construction, including grounds and basic equipment and furnishings, a final construction inspection (initial survey) of the facility must be performed by HHSC before admitting residents. An initial architectural inspection will be scheduled after HHSC receives a license application through the online portal, required fee, fire marshal approval, and a letter from an architect or engineer stating that to the best of their knowledge the facility meets the architectural requirements for licensure.

(B) After the completed construction has been surveyed by HHSC and found acceptable, this information will be forwarded to HHSC as part of the information needed to issue a license to the facility. In the case of additions or remodeling of existing facilities, a revision or modification to an existing license may be necessary. The building, including basic furnishings and operational needs, grades, drives, and parking, must essentially be 100 percent complete at the time of this initial visit for occupancy approval and licensing. A facility may accept up to three residents between the time it receives initial approval from HHSC and the time the license is issued.

(C) The following documents must be available to HHSC’s architectural inspecting surveyor at the time of the survey of the completed building:

(i) written approval of local authorities as required in subparagraph (A) of this paragraph;

(ii) written certification of the fire alarm system by the installing agency (the Texas State Fire Marshal's Fire Alarm Installation Certificate);

(iii) documentation of materials used in the building that are required to have a specific limited fire or flame spread rating, including special wall finishes or floor coverings, flame retardant curtains (including cubicle curtains), rated ceilings, etc., and, in the case of carpeting, a signed letter from the installer verifying that the carpeting installed is named in the laboratory test document;

(iv) approval of the completed sprinkler system installation by the Texas Department of Insurance or designing engineer. A copy of the material list and test certification must be available;

(v) service contracts for maintenance and testing of alarm systems, sprinkler systems, etc.;

(vi) a copy of gas test results of the facility's gas lines from the meter;

(vii) a written statement from an architect or engineer stating, to the best of his or her knowledge, the building was constructed in substantial compliance with the construction documents, the Life Safety Code, HHSC licensure standards, and local codes; and

(viii) any other such documentation as needed.

(5) Nonapproval of new construction.

(A) If, during the initial on-site survey of completed construction, the surveyor finds certain basic requirements not met, HHSC may recommend the facility not be licensed and approved for occupancy. Such items may include the following:

(i) substantial changes made during construction that were not submitted to HHSC for review and that may require revised "as-built" drawings to cover the changes. This may include architectural, structural, mechanical, and electrical items as specified in paragraph (3)(B) of this section;

(ii) construction that does not meet minimum code or licensure standards, such as corridors that are less than required width, ceilings installed at less than the minimum seven-foot six-inch height, resident bedroom dimensions less than required, and other such features that would disrupt or otherwise adversely affect the residents and staff if corrected after occupancy;

(iii) no written approval by local authorities;

(iv) fire protection systems, including, fire alarm systems, emergency power and lighting, and sprinkler systems, not completely installed or not functioning properly;

(v) required exits not all usable according to NFPA 101 requirements;

(vi) telephone not installed or not properly working;

(vii) sufficient basic furnishings, essential appliances, and equipment not installed or not functioning; and

(viii) any other basic operational or safety feature that would preclude safe and normal occupancy by residents on that day.

(B) If the surveyor encounters only minor deficiencies, licensure may be recommended based on an approved written plan of correction from the facility's administrator.

(C) Copies of reduced-size floor plans on an 8 1/2-inch by 11-inch sheet must be submitted in duplicate to HHSC for record/file use and for the facility's use for evacuation plan, fire alarm zone identification, etc. The plan must contain basic legible information such as scale, room usage names, actual bedroom numbers, doors, windows, and any other pertinent information.

TITLE 26 HEALTH AND HUMAN SERVICES

PART 1 HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 551 INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH AN

INTELLECTUAL DISABILITY OR RELATED CONDITIONS

SUBCHAPTER F INSPECTIONS, SURVEYS, AND VISITS

§551.191. Procedural Requirements.

(a) HHSC inspection and survey staff must perform inspections, surveys, follow-up visits, complaint investigations, investigations of abuse or neglect, and other contact visits from time to time as HHSC deems appropriate or as required for carrying out the responsibilities of licensing.

(b) A qualified surveyor or a team, of which one member is a specialized staff person who has expertise in developmental disabilities, conducts an inspection.

(c) To determine standard compliance that cannot be determined during regular working hours, HHSC may conduct night or weekend inspections to cover specific segments of operation. HHSC completes the inspections with the least possible interference to staff and residents.

(d) Generally, HHSC does not announce an inspection, survey, complaint investigation, or other visit, whether routine or non-routine, made for determining the appropriateness of resident care and day-to-day operations of a facility.

(e) HHSC may announce certain visits, including:

(1) an initial life safety code inspection;

(2) a life safety code capacity increase inspection;

(3) a final construction inspection;

(4) a visit to determine the progress of physical plant construction or repairs, equipment installation or repairs, or systems installation or repairs; or

(5) a visit resulting from an emergency, including a fire, a windstorm, or malfunctioning or nonfunctioning electrical or mechanical systems.

(f) Persons authorized to receive advance notice of unannounced inspections include:

(1) citizen advocates invited to attend inspections, as described in subsection (g) of this section;

(2) representatives of the United States Department of Health and Human Services whose programs relate to the Medicare/Medicaid long-term care program ; and

(3) representatives of HHSC whose programs relate to the Medicare/Medicaid long term care program.

(g) HHSC conducts at least two unannounced inspections of a facility during a two-year licensing period and at least three unannounced inspections of a facility during a three-year licensing period .

(1) HHSC conducts a sufficient number of inspections between the hours of 5:00 p.m. and 8:00 a.m. In randomly selected facilities, HHSC conducts a cursory after-hours inspection to determine staffing, emergency egress, resident care, medication security, food service or nourishments, sanitation, and other items determined necessary by HHSC. HHSC completes the inspections with minimal disruption to staff and residents .

(2) For at least two unannounced inspections each licensing period, HHSC may invite to the inspections at least one person as a citizen advocate who has an interest in or who is employed by or affiliated with an organization or agency that represents or advocates for persons with an intellectual disability or a related condition. HHSC provides to these organizations basic licensing information and requirements for the organizations' dissemination to their members who they engage to attend the inspections. Advocates participating in the inspections must follow all HHSC protocols. Advocates must provide their own transportation. The schedule of inspections in this category will be arranged confidentially in advance with the organizations. Participation by the advocates is not a condition precedent to conducting the inspection.

(h) A facility must make all books, records, and other documents that are maintained by or on behalf of the facility accessible to HHSC on request.

(1) HHSC may photocopy documents, photograph residents, and use any other available recording devices to preserve relevant evidence of conditions found during an inspection, survey, or investigation.

(2) Examples of records that HHSC may request and photocopy or otherwise reproduce are resident medical records, including nursing notes, pharmacy records, medication records, and physician's orders.

(3) When HHSC requests a facility furnish copies of documents, the facility may charge HHSC at a rate not to exceed the rate charged by HHSC for copies. The administrator or designee must ensure the documents are copied. If the documents must be removed from the facility to be copied, a representative of the facility must accompany the documents and ensure their order and preservation.

(4) HHSC protects the copies for privacy and confidentiality in accordance with recognized standards of medical records practice, applicable state laws, and HHSC policy.

(5) A facility must not falsify information contained in resident records.

(i) HHSC may provide a special team to conduct validation surveys or to verify findings of previous licensure surveys.

(1) At HHSC's discretion, based on record review, random sample, or any other determination, HHSC may assign a team to conduct a validation survey. HHSC may use the information to verify previous determinations or identify training needs to ensure consistency in deficiencies cited and in punitive actions recommended throughout the state.

(2) A facility must correct any additional deficiencies cited by a validation team but is not subject to any new or additional punitive action as a result of those deficiencies.

(j) During an investigation, survey, or inspection, HHSC may conduct an interview with a resident of a facility or staff employed by the facility in private. A facility must not retaliate against the resident or staff.

(k) Facility staff must be available at the facility within 45 minutes of telephone contact by survey staff.

§551.192. Determinations and Actions Pursuant to Inspections, Surveys, or Investigations.

(a) HHSC will determine if a facility meets licensure requirements through inspections, surveys, and investigations.

(b) During an investigation resulting from a complaint, HHSC does not disclose the source of the complaint.

(c) At the conclusion of an inspection, survey, or investigation, a representative of HHSC holds an exit conference with a representative of the facility and provides the facility representative a written list of preliminary findings .

(d) If HHSC cites additional violations during a review of field notes or preparation of the official final statement of licensing violations, HHSC :

(1) communicates the additional violations to the facility in writing within ten working days after the exit conference; and

(2) gives the facility an additional face-to-face exit conference regarding the additional violations.

(e) HHSC provides the facility with a clear and concise summary in nontechnical language of each licensure inspection or complaint investigation.

(f) The facility must submit a plan to correct cited violations to the regional director of the area in which the facility is located no later than 10 working days after the date the facility receives the final, official statement of violations. To be accepted by HHSC , a plan to correct violations must state when the corrective action will be completed and must address:

(1) how the facility will accomplish corrective action for residents directly affected by the cited violation;

(2) how the facility will identify other residents who may be affected by the cited violation; and

(3) how the facility will avoid having the violation recur.

(g) If a facility fails to submit a plan to correct violations that meets the requirements of subsection (f) of this section, HHSC may assess an administrative penalty against the facility in accordance with §551.236(a)(7) of this chapter (relating to Administrative Penalties).

TITLE 26 HEALTH AND HUMAN SERVICES

PART 1 HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 551 INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITIONS

SUBCHAPTER G ABUSE, NEGLECT, AND EXPLOITATION; COMPLAINT AND INCIDENT REPORTS AND INVESTIGATIONS

§551.212. Reporting Abuse, Neglect, and Exploitation to DFPS.

(a) A person, including a facility owner or employee, who has cause to believe that a resident of a facility has been or is being subjected to physical abuse, sexual abuse, sexual exploitation, verbal or emotional abuse, neglect, or exploitation, as those terms are defined in Chapter 711 of this title (relating to Investigations of Individuals Receiving Services from Certain Providers) , by a person other than a resident of the facility, must report the alleged abuse, neglect, or exploitation to DFPS, as required by Chapter 711 of this title (relating to Investigations of Individuals Receiving Services from Certain Providers), by calling 1-800-252-5400 .

(b) If the person making the report is not an employee of the facility, such as a resident or visitor, facility staff must assist the person in making the report, if necessary.

(c) The facility must assist an HHSC investigator by preserving and safeguarding evidence of the alleged abuse, neglect, or exploitation and by ensuring that facility employees are made available upon request by the investigator.

§551.213. Reporting Incidents to HHSC .

(a) In this section, serious physical injury is defined as in Chapter 711 of this title (relating to Investigations of Individuals Receiving Services from Certain Providers) .

(b) A facility must report any of the following incidents to HHSC’s Complaint and Incident Intake Section at 1-800-458-9858 within one hour after suspecting or learning of the incident:

(1) alleged (Class I) physical abuse of a resident, as defined in Chapter 711 of this title, that caused or may have caused serious physical injury;

(2) alleged (Class I) sexual abuse of a resident, as defined in Chapter 711 of this title;

(3) sexual activity between residents resulting from coercion, physical force, or taking advantage of the disability of a resident;

(4) sexual activity involving a resident less than 18 years of age;

(5) the pregnancy of a resident;

(6) resident-to-resident aggression that results in serious physical injury;

(7) the death of a resident; and

(8) a resident whose location has been unknown by the facility for more than eight hours or less than eight hours if there are circumstances that place the resident's health or safety at risk.

(c) Within five working days after making a report described in subsection (b) of this section, the facility must ensure an investigation of the incident is conducted and send a written investigation report on Form 3613A, Provider Investigation Report, or a form containing, at a minimum, the information required by Form 3613A, to HHSC’s Complaint and Incident Intake .

§551.214. Protection of Residents After Report of Abuse, Neglect, and Exploitation.

(a) A facility must ensure that physical and emotional care is provided to an alleged victim of abuse, neglect, or exploitation immediately but in no case more than one hour after the facility makes or learns of an allegation of abuse, neglect, or exploitation, and must ensure that such care is continued as needed.

(b) The facility must take measures to protect the rights and safety of the alleged victim and other residents of the facility after the facility makes or learns of an allegation of abuse, neglect, or exploitation, including immediately preventing the alleged perpetrator from having contact with residents.

(c) If the alleged perpetrator is not an employee of the facility and the alleged abuse, neglect, or exploitation occurred away from the facility premises, the facility must convene the IDT of the alleged victim to address the alleged perpetrator's access to the alleged victim while an investigation is being conducted. If the IDT recommends that a restriction be placed on an alleged perpetrator's access to the alleged victim, the facility's specially constituted committee must review and approve the restriction before it is implemented and the facility must document the restriction in the alleged victim's record.

(d) Within 24 hours of making or learning of an allegation of abuse, neglect, or exploitation, the facility must notify the alleged victim and the victim's LAR that an allegation of abuse, neglect, or exploitation involving the victim has been made and reported. If the facility cannot notify the LAR in person or by phone, the facility must notify the LAR by certified mail with a return receipt requested.

(e) If DFPS confirms an allegation of abuse, neglect, or exploitation against an employee of a facility, the facility must take prompt and appropriate disciplinary action against the employee.

§551.215. Employee Statement.

(a) A facility must require an employee of the facility to sign a statement:

(1) acknowledging that the employee may be criminally liable for failure to report suspected abuse, neglect, or exploitation; and

(2) acknowledging the employee's rights under Texas Health and Safety Code §252.132 (relating to Suit for Retaliation), which states that an employee has a cause of action against a facility, the owner of a facility, or another employee of a facility that suspends or terminates the employment of the employee or otherwise disciplines, discriminates against, or retaliates against the employee for:

(A) reporting to the employee's supervisor, an administrator of the facility, a state regulatory agency, or a law enforcement agency, a violation of law, including a violation of Texas Health and Safety Code, Chapter 252, or a rule adopted under that chapter; or

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

(b) The facility must maintain as a part of its personnel records and make available to HHSC upon request the statement described in subsection (a) of this section.

TITLE 26 HEALTH AND HUMAN SERVICES

PART 1 HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 551 INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITIONS

SUBCHAPTER H ENFORCEMENT

§551.231. Warning Letter.

When HHSC staff determine that a facility is out of compliance with licensure rules to a degree that places the facility at risk of the imposition of licensing actions, HHSC may send a warning letter to the facility. The warning letter notifies the facility that the violations of licensing rules must be corrected.

§551.232. License Suspension.

(a) HHSC may suspend a facility's license when the facility's violation of the licensure rules threatens to jeopardize the health and safety of the residents.

(b) Suspension of a license may occur simultaneously with any other enforcement provision available to HHSC .

(c) The facility will be notified by certified mail of HHSC’s intent to suspend the license, including the facts or conduct alleged to warrant the suspension. The facility has an opportunity to show compliance with all requirements of law for the retention of the license as provided in §551.18 of this chapter (relating to Informal Reconsideration). If the facility requests an informal reconsideration, HHSC will give the license holder a written affirmation or reversal of the proposed action.

(d) The facility will be notified by certified mail of HHSC’s suspension of the facility's license. The facility has 15 days from receipt of the certified mail notice to request a hearing in accordance with 1 TAC §357.484 (relating to Request for a Hearing ). The suspension will take effect when the deadline for appeal of the suspension passes, unless the facility appeals the suspension. If the facility appeals the suspension, the status of the license holder is preserved until final disposition of the contested matter.

(e) The suspension will remain in effect until HHSC determines that the reason for suspension no longer exists. HHSC will conduct an on-site investigation prior to making a determination. During the suspension, the license holder must return the license to HHSC .

§551.233. Revocation.

(a) HHSC may revoke a facility's license when:

(1) the facility's violation of the licensure rules jeopardizes the health and safety of the residents; or

(2) the facility has violated the requirements of the Health and Safety Code, Chapter 252, or the rules adopted under that chapter, in either a repeated or substantial manner.

(b) In addition, HHSC may revoke a license if the license holder:

(1) submitted false or misleading statements in the application for a license or any accompanying attachments;

(2) used subterfuge or other evasive means to obtain the license;

(3) concealed a material fact in the application for a license or failed to disclose information required in §551.13 of this chapter (relating to Applicant Disclosure Requirements) that would have been the basis to deny the license under §551.17 of this chapter (relating to Criteria for Denying a License or Renewal of a License); or

(4) received monetary or other remuneration from a person or agency that furnishes services or materials to the facility or individuals for a fee.

(c) Revocation of a license may occur simultaneously with any other enforcement provision available to HHSC .

(d) The facility will be notified by certified mail of HHSC’s intent to revoke the license, including the facts or conduct alleged to warrant the revocation. The facility has an opportunity to show compliance with all requirements of law for the retention of the license as provided in §551.18 of this chapter (relating to Informal Reconsideration). If the facility requests an informal reconsideration, HHSC will give the license holder a written affirmation or reversal of the proposed action.

(e) The facility will be notified by certified mail of HHSC’s intent to revoke the license, including the facts or conduct alleged to warrant the revocation. The facility has 15 days from receipt of the certified mail notice to request a hearing in accordance with 1 TAC §357.484 (relating to Request for a Hearing ). The revocation will take effect when the deadline for appeal of the revocation passes, unless the facility appeals the revocation. If the facility appeals the revocation, the status of the license holder is preserved until final disposition of the contested matter. Upon revocation, the license must be returned to HHSC .

§551.234. Emergency License Suspension and Closing Order.

(a) HHSC may suspend a facility's license or order an immediate closing of part of the facility if:

(1) HHSC finds that the facility is operating in violation of the licensure rules; and

(2) the violation creates an immediate threat to the health and safety of a resident.

(b) The order suspending a license or closing a part of a facility under this section is immediately effective on the date the license holder receives written notice or a later date specified in the order.

(c) The order suspending a license or ordering an immediate closing of a part of the facility is valid for ten days after the effective date of the order.

(d) When an emergency suspension has been ordered and the conditions in the facility indicate that residents need to be relocated, a facility must ensure :

(1) A resident's rights or freedom of choice in selecting treatment facilities will be respected.

(2) If a facility or part thereof is closed, the following rules apply:

(A) HHSC will notify the local health department director, city or county health authority, and representatives of the appropriate state agencies of the closure;

(B) facility staff must notify each resident's LAR and attending physician, advising them of the action in process;

(C) the resident or the resident's LAR will have an opportunity to designate a preference for a specific facility or for other arrangements;

(D) HHSC must contact the LIDDA to arrange for resident relocation to other facilities in the area in accordance with the resident's preference. A facility chosen for relocation must be in good standing with HHSC and, if certified under Titles XVIII and XIX of the Social Security Act, must be in good standing under its contract. The facility chosen must be able to meet the needs of the resident;

(E) if absolutely necessary, to prevent transport over substantial distances, HHSC will grant a waiver to a receiving facility to temporarily exceed its licensed capacity, provided the health and safety of residents is not compromised and the facility can meet the increased demands for direct care personnel and dietary services. A facility may exceed its licensed capacity under these circumstances, monitored by HHSC staff, until residents can be transferred to a permanent location;

(F) with each resident transferred, the following reports, records, and supplies must be transmitted to the receiving institution:

(i) a copy of the current physician's orders for medication, treatment, diet, and special services required;

(ii) personal information, such as name and address of next of kin or LAR,; attending physician; Medicare and Medicaid identification number; social security number; and other identification information as deemed necessary and available;

(iii) all medication dispensed in the name of the resident for which physician's orders are current. The medication must be inventoried and transferred with the resident. Medications past an expiration date or discontinued by physician order must be inventoried for disposition in accordance with state law;

(iv) the residents' personal belongings, clothing, and toilet articles. An inventory of personal property and valuables must be made by the closing facility; and

(v) resident trust fund accounts maintained by the closing facility. All items must be properly inventoried, and receipts obtained for audit purposes by the appropriate state agency;

(G) if the closed facility is allowed to reopen within 90 days, the relocated residents will have the first right to return to the facility. Relocated residents may choose to return, may stay in the receiving facility (if the facility is not exceeding its licensed capacity), or choose any other accommodations; and

(H) any return to the facility must be treated as a new admission, including, exchange of medical information, medications, and completion of required forms.

(e) A licensee whose facility is closed under this section is entitled to request an administrative hearing in accordance with 1 TAC §357.484 (relating to Request for a Hearing) ), but a hearing request does not suspend the effectiveness of the order.

§551.235. Referral to the Attorney General.

(a) HHSC may petition a district court for a temporary restraining order to restrain a person from continuing a violation of the standards prescribed by this chapter if HHSC finds that the violation threatens the health and safety of a resident .

(b) A district court, on petition by HHSC , may by injunction:

(1) prohibit a person from continuing a violation of the standards or licensing requirements prescribed by this chapter;

(2) restrain or prevent the establishment, conduct, management, or operation of a facility without a license issued under this chapter; or

(3) grant the injunctive relief warranted by the facts on a finding by the court that a person is violating the standards or licensing requirements prescribed by this chapter.

(c) HHSC may refer a facility to the Texas Office of the Attorney General for the assessment of civil penalties under the Texas Health and Safety Code, §252.064 (relating to Civil Penalty), for a violation that threatens the health and safety of a resident.

§551.236. Administrative Penalties.

(a) HHSC may assess an administrative penalty against a license holder if the license holder:

(1) violates Texas Health and Safety Code, Chapter 252, or any rule, standard, or order adopted or a license issued under such chapter and the violation creates a potential for more than minimal harm, results in actual harm, or poses an immediate threat to the health or safety of a resident;

(2) makes a false statement, that the person knows or should know is false, of a material fact:

(A) on an application for issuance or renewal of a license or in documentation submitted to HHSC in support of the application; or

(B) with respect to a matter under investigation by HHSC;

(3) refuses to allow a representative of HHSC to inspect:

(A) a book, record, or file required to be maintained by the person; or

(B) any portion of the premises of a facility;

(4) willfully interferes with the work of a representative of HHSC or the enforcement of Texas Health and Safety Code, Chapter 252;

(5) willfully interferes with a representative of HHSC preserving evidence of a violation of Texas Health and Safety Code, Chapter 252, or a rule, standard, or order adopted or license issued under such chapter;

(6) fails to pay a penalty assessed by HHSC under Texas Health and Safety Code, Chapter 252, not later than the 10th day after the date the assessment of the penalty becomes final;

(7) fails to submit an acceptable plan of correction to HHSC within 10 working days after receiving the final statement of licensing violations; or

(8) fails to notify HHSC of a change in ownership before the effective date of that change of ownership.

(b) In determining if a violation described in subsection (a)(1) of this section warrants an administrative penalty, HHSC considers:

(1) the seriousness of the violation, including the nature, circumstances, extent, and gravity of the violation;

(2) the hazard of the violation to the health and safety of a resident; and

(3) whether the affected license holder had identified the violation as part of its internal quality assurance process and had made appropriate progress on correction.

(c) HHSC does not assess an administrative penalty against a license holder because of a physician's or consultant's nonperformance beyond the license holder's control or if documentation clearly indicates the violation is beyond the license holder's control.

(d) An administrative penalty assessed in accordance with subsection (a)(1) of this section begins on the first date HHSC establishes that the violation that caused the penalty to be assessed exists.

(e) An administrative penalty assessed in accordance with subsection (a)(1) of this section ceases on the date the violation is corrected. A violation is corrected if the license holder:

(1) notifies HHSC in writing that the violation has been corrected;

(2) states the date of the correction in the notification; and

(3) maintains evidence that the violation was corrected on the date in the notification.

(f) An administrative penalty assessed in accordance with subsection (a)(1) of this section is determined based on the scope and severity of the violation, in accordance with the figures in this section.

Figure: 26 TAC §551.236(f)

Licensed Capacity of 60 Residents or More

S

E

V

E

R

I

T

Y

|  |  |  |  |
| --- | --- | --- | --- |
|  | Isolated | Pattern | Widespread |
| Immediate  threat | $2000-3000 | $3000-4000 | $4000-5000 |
| J | K | L |
| Actual  harm | $500-1000  G | $1000-1500  H | $1500-2000  I |
| No actual harm with a potential for more than minimal harm | $200-300  D | $300-400  E | $400-500  F |
| No actual harm with a potential for minimal harm | $0  A | $0  B | $0  C |

S C O P E

Note: To assist in using the scope and severity table, the following example is provided: a license holder that is cited for a violation that is an immediate threat to the health or safety of a resident and is widespread in scope will have an administrative penalty assessed in an amount of $4000-$5000, as shown in box “L.”

Licensed Capacity of Fewer than 60 Residents

S

E

V

E

R

I

T

Y

|  |  |  |  |
| --- | --- | --- | --- |
|  | Isolated | Pattern | Widespread |
| Immediate  threat | $700-800 | $800-900 | $900-1000 |
| J | K | L |
| Actual  harm | $300-400  G | $400-500  H | $500-600  I |
| No actual harm with a potential for more than minimal harm | $100-150  D | $150-200  E | $200-300  F |
| No actual harm with a potential for minimal harm | $0  A | $0  B | $0  C |

S C O P E

Note: To assist in using the scope and severity table, the following example is provided: a license holder that is cited for a violation that is an immediate threat to the health or safety of a resident and is widespread in scope will have an administrative penalty assessed in the amount of $900-$1000, as shown in box “L.”

(g) An administrative penalty assessed in accordance with subsection (a)(2), (3), (4), (5), (6), (7) or (8) of this section is in the following amount:

(1) for a facility with a licensed capacity of fewer than 60 residents :

(A) $500 for the first violation of the paragraph;

(B) $750 for the second violation of the same paragraph; and

(C) $1000 for the third violation of the same paragraph; and

(2) for a facility with a license capacity of 60 or more residents:

(A) $500 for the first violation of the paragraph;

(B) $3500 for the second violation of the same paragraph; and

(C) $5000 for the third violation of the same paragraph.

(h) Administrative penalties will be imposed on a per diem basis.(i) The total amount of a penalty assessed under this subsection on a single day may not exceed:

(A) $5,000 for a facility with a capacity of fewer than 60 residents; and

(B) $25,000 for a facility with a capacity of 60 residents or more.

(j) If HHSC determines that a violation has occurred and that an administrative penalty is proposed, HHSC notifies the license holder of the proposal to assess an administrative penalty. The notification includes:

(1) a brief summary of the alleged violation;

(2) a statement of the amount of the proposed penalty; and

(3) a statement of the license holder's right to request a hearing on the occurrence of the violation, the amount of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty.

(k) A license holder that is notified in accordance with subsection (j) of this section may file a request for a hearing with HHSC. To receive a hearing, a license holder must request a hearing in accordance with 1 TAC §357.484 (relating to Request for a Hearing) except, as provided by Texas Health and Safety Code, §252.066 (relating to Notice; Request for Hearing), the license holder must make a written request for a hearing within 20 calendar days after the date on which the license holder receives written notice of the administrative penalty. A hearing requested under this section is governed by 1 TAC Chapter 357, Subchapter I (relating to Hearings Under the Administrative Procedure Act).

§551.237. Appointment of a Trustee by Agreement.

(a) A person holding a controlling interest in a facility may, at any time, request that HHSC assume the operation of the facility through the appointment of a trustee.

(b) If HHSC believes that the appointment of a trustee is desirable, HHSC may enter into an agreement with the person holding the controlling interest for the appointment of the trustee to take charge of the facility.

(c) Any agreement entered into under this section must:

(1) specify all terms and conditions of the trustee's appointment and authority; and

(2) preserve all rights of the residents as granted by law.

(d) The agreement will terminate either at a time specified in the agreement or upon receipt of notice of intent to terminate sent by either party.

(e) If HHSC determines that termination of the agreement by the person holding a controlling interest in the facility would not be in the best interest of the residents, HHSC will petition a court for an involuntary appointment under the terms of §551.238 of this subchapter (relating to Involuntary Appointment of a Trustee).

(f) The appointment of a trustee by agreement does not suspend the obligation of a facility to pay assessed civil money or administrative penalties.

§551.238. Involuntary Appointment of a Trustee.

(a) HHSC may petition a court of competent jurisdiction for the involuntary appointment of a trustee to operate a facility if one or more of the following conditions exist:

(1) the facility is operating without a license;

(2) the facility's license has been suspended or revoked;

(3) license suspension or revocation procedures against a facility are pending and an imminent threat to the health and safety of the residents exists;

(4) an emergency exists that presents an immediate threat to the health and safety of the residents; or

(5) the facility is closing (whether voluntarily or through an emergency closure order) and arrangements for relocation of the residents to other licensed facilities have not been made before closure.

(b) A trustee appointed under this section is entitled to a reasonable fee as determined by the court to be paid from the Nursing and Convalescent Home trust fund.

(c) The trustee may use the emergency assistance funds in the trust fund only to alleviate an immediate threat to the health and safety of the residents, through such disbursements as payments for food; medication; sanitation services; minor repairs ; supplies necessary for personal hygiene; or services necessary for the personal care, health and safety of the residents.

(d) Before emergency assistance funds may be dispersed, a court order must be entered authorizing HHSC to disburse emergency assistance funds to the facility.

(e) A facility that receives emergency assistance funds under this section must reimburse HHSC for the amounts received not later than one year after the date on which the funds were received by the trustee. The owner of the facility at the time the trustee was appointed is responsible for the reimbursement and must pay interest from the date the funds were disbursed on the amount outstanding at a rate equal to the rate of interest determined under Texas Finance Code, Chapter 302 (relating to Interest Rates) , to be applicable to judgments rendered during the month in which the money was disbursed to the facility. HHSC will deposit the reimbursement and the interest received under this subsection to the credit of the Nursing and Convalescent Home Trust Fund.

(f) Any amount remaining due at the end of one year becomes delinquent and will be referred to the attorney general.

(g) HHSC l may determine that the facility is ineligible for a Medicaid provider contract.

§551.239. Notification of Closure.

(a) In this section, the terms "close" and "closure" refer to a facility ceasing to operate. The terms do not include temporarily relocating residents of a facility.

(b) Except as provided in subsection (c) of this section, if a license holder intends to voluntarily close a facility, the license holder must, at least 60 days before the facility closes:

(1) send written notice of the license holder's intent to close the facility, including the anticipated date of closure, to:

(A) HHSC ; and

(B) all residents ; and

(2) make reasonable efforts to send written notice of the license holder's intent to close the facility, including the anticipated date of closure to:

(A) all residents’ LARs ; or

(B) if a resident does not have an LAR the resident's nearest relative.

(c) If, for reasons beyond the license holder's control, the license holder cannot provide the notice required by subsection (b) of this section at least 60 days before the license holder anticipates closing the facility, the license holder must state in the notice the reason why a shorter time period is necessary.

(d) If HHSC requires a facility to close or the facility's closure is in any other way involuntary, the license holder must, immediately after becoming aware that the facility is closing:

(1) send written notice of the closure, including the anticipated date of closure, to:

(A) HHSC, if HHSC is not requiring the facility to close; and

(B) all residents ; and

(2) make reasonable efforts to send written notice of the closure, including the anticipated date of closure to:

(A) all residents’ LARs ; or

(B) if a resident does not have an LAR , the resident's nearest relative.

(e) A license holder must submit the license of a closing facility to HHSC with the notice required by subsection (b)(1)(A) or (d)(1)(A) of this section. If notice is not provided in accordance with subsection (b)(1)(A) or (d)(1)(A) of this section because HHSC is requiring a facility to close, the license holder must submit the license to HHSC when the closure is final.

§551.240. Right to Correct.

(a) Except as provided in subsection (b) of this section, before imposing an administrative penalty, HHSC gives a reasonable period of time, not less than 45 days, to correct a violation if a plan of correction is implemented. A facility may request a shorter period of time to correct the violation by submitting a written request for an early inspection to clear the violation. If, during the requested early inspection, HHSC finds that the correction is not satisfactory, an administrative penalty may immediately be assessed from the first day of violation.

(b) HHSC does not give a facility a period of time to correct a violation before assessing an administrative penalty if HHSC determines that the violation:

(1) is a pattern of violation that results in actual harm;

(2) is widespread in scope and results in actual harm;

(3) is widespread in scope, creates a potential for more than minimal harm, and relates to:

(A) staff treatment of a resident, as described in 42 CFR §483.420 (relating to Condition of Participation: Client Protections); §551.42(g) of this chapter (relating to Standards for a Facility); §551.212 of this chapter (relating to Reporting Abuse, Neglect, and Exploitation to HHSC Provider Investigations ); §551.213 of this chapter (relating to Reporting Incidents to HHSC ); or §551.214 of this chapter (relating to Protection of Residents After Report of Abuse, Neglect, and Exploitation);

(B) active treatment, as described in 42 CFR §483.440 (relating to Condition of Participation: Active Treatment Services) and §551.42(i) of this chapter;

(C) client behavior and facility practices, as described in 42 CFR §483.450 (relating to Condition of Participation: Client Behavior and Facility Practices) and §551.42(j) of this chapter;

(D) health care services, as described in 42 CFR §483.460 (relating to Condition of Participation: Health Care Services) and §551.42(k) of this chapter;

(E) drug administration, as described in 42 CFR §483.460(k) (relating to Standard: Drug Administration) and §551.43 of this chapter (relating to Administration of Medication) ;

(F) infection control, as described in 42 CFR §483.470(l) (relating to Standard: Infection Control) and §551.42(l) of this chapter;

(G) food and nutrition services, as described in 42 CFR §483.480 (relating to Condition of Participation: Dietetic Services) and §551.42(n); or

(H) emergency preparedness and response, as described in 42 CFR §483.475 (relating to Condition of Participation: Emergency Preparedness) and §551.42(m) of this chapter :

(4) constitutes an immediate threat to the health or safety of a resident;

(5) substantially limits the facility's capacity to provide care; or

(6) is described in §551.236 (a)(2) - (8) of this subchapter (relating to Administrative Penalties).

(c) HHSC may not assess an administrative penalty for a minor violation that HHSC gave the facility time to correct if the facility corrects the violation not later than the 46th day after the facility receives notice of the violation.

(d) If the facility reports to HHSC that the violation has been corrected, HHSC inspects the facility or takes any other steps necessary to confirm that the violation has been corrected and notifies the facility that:

(1) the correction is satisfactory, and a penalty is not assessed; or

(2) the correction is not satisfactory, and a penalty is recommended.

(e) If the facility wishes to appeal the administrative penalty, the facility must file a notice to request a hearing on the violation or penalty no later than the 20th calendar day after the date on which the facility received the notice to pay an administrative penalty.

§551.241. Amelioration of Violation.

(a) In lieu of demanding payment of an administrative penalty, the commissioner may allow the person to use, under the supervision of HHSC , a portion of the penalty to ameliorate the violation or to improve services, other than administrative services, in the facility.

(b) HHSC will offer amelioration to a person for a violation if HHSC determines that the violation does not constitute immediate jeopardy to the health and safety of a resident.

(c) HHSC will not offer amelioration to a person if HHSC determines that the violation constitutes immediate jeopardy to the health and safety of a resident.

(d) HHSC will offer amelioration to a person not later than the 10th day after the date the person receives from HHSC a final notification of assessment of administrative penalty that is sent to the person after an informal dispute resolution process but before an administrative hearing.

(e) A person to whom amelioration has been offered must file a plan for amelioration not later than the 45th day after the date the person receives the offer of amelioration from HHSC . In submitting the plan, the person must agree to waive the person's right to an administrative hearing if HHSC approves the plan.

(f) At a minimum, a plan for amelioration must:

(1) propose changes to the management or operation of the facility that will improve services to or quality of care of residents;

(2) identify, through measurable outcomes, the ways in which and the extent to which the proposed changes will improve services to or quality of care of residents;

(3) establish clear goals to be achieved through the proposed changes;

(4) establish a timeline for implementing the proposed changes; and

(5) identify specific actions necessary to implement the proposed changes.

(g) HHSC may require that an amelioration plan propose changes that would result in conditions that exceed the minimum requirements for facility licensure.

(h) HHSC will approve or deny an amelioration plan not later than the 45th day after the date HHSC receives the plan. On approval of a person's plan, HHSC will deny a pending request for a hearing submitted by the person.

(i) HHSC will not offer amelioration to a person:

(1) more than three times in a two-year period; or

(2) more than one time in a two-year period for the same or similar violation.

TITLE 26 HEALTH AND HUMAN SERVICES

PART 1 HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 551 INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH AN

INTELLECTUAL DISABILITY OR RELATED CONDITIONS

SUBCHAPTER J RESPITE CARE

§551.281. Generally.

A facility licensed under this chapter may provide respite care for an individual who has a diagnosis of an intellectual disability or a related condition without regard to whether the individual is eligible to receive intermediate care services under federal law, according to a plan of care as provided under the Health and Safety Code, Chapter 252, Subchapter G (relating to Respite Care) .

§551.282. Definitions.

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

(1) Plan of care--A written description of the care, training, and treatment needed by a person during respite care.

(2) Respite care--The provision by a facility to a person, for not more than two weeks for each stay in the facility, of room, board, and care at the level ordinarily provided for permanent residents.

§551.283. Plan of Care.

(a) The facility and the person arranging the care must agree on the plan of care and the plan must be filed at the facility before the facility admits the person for the care.

(b) The plan of care must be signed by:

(1) a licensed physician if the person for whom the care is arranged need medical care or treatment; or

(2) the person arranging for the respite care if medical care or treatment is not needed.

(c) The facility may keep an agreed plan of care for a person for not longer than six months from the date on which it is received. After each admission, the facility must review and update the plan of care. During that period, the facility may admit the person as frequently as is needed and as accommodations are available.

(d) The clinical record of each respite care resident must contain:

(1) general identifying information necessary to care for the resident and maintain his or her clinical record;

(2) resident assessment according to facility policy and care plan according to §551.283 of this chapter (relating to Plan of Care);

(3) progress notes or flow sheets which document care/services;

(4) reports of diagnostic or lab studies done during resident stay;

(5) any physician's orders given during resident stay; and

(6) discharge and readmission information based on facility policy for respite care services.

§551.285. Inspections.

HHSC , at the time of a licensing inspection or at other times HHSC determines necessary, inspects a facility's records of respite care services, physical accommodations available for respite care, and the plan of care records to ensure that the respite care services comply with the licensing standards of this chapter.

§551.286. Suspension.

(a) HHSC may require a facility to cease providing respite care if HHSC determines that the respite care does not meet the standards required by this chapter and that the facility cannot comply with those standards in the respite care it provides.

(b) HHSC may suspend the license of a facility that continues to provide respite care after receiving a written order from HHSC to cease, as set out in §551.232 of this chapter (relating to License Suspension).

§551.287. Licensed Capacity.

When a facility provides respite care:

(1) the total number of individuals receiving services in the facility must not exceed the licensed capacity of the facility ; and

(2) any required staff to resident ratio will include any individual receiving respite care services regardless of the number of hours in the facility.

TITLE 26 HEALTH AND HUMAN SERVICES

PART 1 HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 551 INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH AN

INTELLECTUAL DISABILITY OR RELATED CONDITIONS

SUBCHAPTER L PROVISIONS APPLICABLE TO FACILITIES GENERALLY

§551.321. Determination of Employability.

(a) A facility must comply with Texas Health and Safety Code, Chapter 250 (relating to Nurse Aide Registry and Criminal History Checks of Employees and Applicants for Employment in Certain Facilities Serving the Elderly, Persons with Disabilities, or Persons with Terminal Illness).

(b) Before a facility hires an applicant for employment, the facility must search the EMR established under the Texas Health and Safety Code, §253.007, and the NAR established under Texas Health and Safety Code §253.008 to determine if the applicant is designated in the EMR or NAR as unemployable. The EMR and NAR may be accessed on the HHSC Internet website.

(c) In addition to the initial search of the EMR and NAR, a facility must conduct a search of the EMR and NAR to determine if the employee is designated in either registry as unemployable, as follows:

(1) for an employee most recently hired before September 1, 2009, by August 31, 2011 and at least every twelve months thereafter; and

(2) for an employee most recently hired on or after September 1, 2009, at least every twelve months.

(d) A facility must keep a copy of the results of the initial and annual searches of the EMR and NAR in the employee's personnel file and make it available to HHSC upon request.

(e) A facility is prohibited from hiring or continuing to employ a person who is listed in the EMR or NAR as unemployable.

(f) A facility must provide information about the EMR to an employee in accordance with 40 TAC §93.3 (relating to Employment and Registry Information).

§551.323. Procedures for Inspection of Public Records.

(a) Procedures for inspection of public records will be in accordance with the Texas Government Code, Chapter 552 (relating to Public Information), and as further described in this section.

(b) HHSC is responsible for the maintenance and release of records on licensed facilities, and other related records.

(c) The application for inspection of public records is subject to the following criteria:

(1) the application must be made to the HHSC Open Records Coordinator,, by mail at 4900 N. Lamar Blvd., MC-1070 Austin, TX 78751-2316, by fax 512-424-6586 email at openrecordsrequest@hhsc.state.tx.us.

(2) the requestor must identify himself;

(3) the requestor must give reasonable prior notice of the time for inspection or copying of records;

(4) the requestor must specify the records requested;

(5) on a written application , if HHSC is unable to ascertain the records being requested, HHSC may return the written application to the requestor for clarification; and

(6) HHSC will provide the requested records as soon as possible; however, if the records are in active use, or in storage, or time is needed for proper de-identification or preparation of the records for inspection, HHSC will so advise the requestor and set an hour and date within a reasonable time when the records will be available.

(d) Original records may be inspected or copied, but in no instance will original records be removed from HHSC offices.

(e) Records maintained by HHSC are open to the public, with the following exceptions:

(1) incomplete reports, audits, evaluations, and investigations made of, for, or by HHSC are confidential;

(2) all reports, records, and working papers used or developed by HHSC in an investigation of reports of abuse and neglect are confidential, and may be released to the public only as follows:

(A) completed written investigation reports are open to the public, provided the report is de-identified. The process of de-identification means removing all names and other personally identifiable data, including any information from witnesses and others furnished to HHSC as part of the investigation; and

(B) if HHSC receives written authorization from a facility resident or the resident's legal representative regarding an investigation of abuse or neglect involving that resident, HHSC will release the completed investigation report without removing the resident's name. The authorization must:

(i) be signed and dated within six months of the request or state a length of time the authorization is valid;

(ii) detail the information to be released;

(iii) identify to whom the information can be released; and

(iv) release HHSC from all liability for complying with the authorization.

(3) all names and related personal, medical, or other identifying information about a resident are confidential;

(4) information about any identifiable person which is defamatory, or an invasion of privacy is confidential;

(5) information identifying complainants or informants is confidential;

(6) itineraries of surveys and inspections are confidential;

(7) other information that is excepted from release by the Government Code, Chapter 552 (relating to Public Information), is not available to the public; and

(8) to implement this subsection, HHSC may not alter or de-identify original records. Instead, HHSC will make available for public review or release only a properly de-identified copy of the original record.

(f) HHSC will charge for copies of records upon request.

(1) If the requestor wants to inspect records, the requestor will specify the records to be inspected. HHSC will make no charge for this service, unless the director of HHSC determines a charge is appropriate based on the nature of the request.

(2) If the requestor wants copies of a record, the requestor will specify in writing the records to be copied on an appropriate HHSC form, and HHSC will complete the form by specifying the charge for the records, which the requestor must pay in advance. Checks and other instruments of payment must be made payable to HHSC .

(3) Any expenses for standard-size copies incurred in the reproduction, preparation, or retrieval of records must be borne by the requestor on a cost basis in accordance with costs established by the Office of the Attorney General or HHSC for office machine copies.

(4) For documents that are mailed, HHSC will charge for the postage at the time it charges for the production. All applicable sales taxes will be added to the cost of copying records.

(5) When a request involves more than one long-term care facility, each facility will be considered a separate request.

§551.324. Emergency Medication Kit.

Stocks of inventoried emergency medications may be kept in facilities.

(1) Emergency medication kits must be maintained in compliance with the Texas State Board of Pharmacy rules in 22 TAC §291.121 (relating to Remote Pharmacy Services).

(2) Facilities must have contracts with the provider pharmacy that provides the emergency medication kit. The contract must outline the services to be provided by the pharmacy and the responsibilities and accountabilities of each party in fulfilling the terms of the contract in compliance with federal and state laws and regulations.

§551.325. Controlled Substances.

The facility must adhere to the following procedures governing the use of drugs covered by the Controlled Substances Act.

(1) A separate record must be maintained for each drug covered by Schedules II, III, and IV of the Controlled Substances Act, Health and Safety Code, Chapter 481.

(2) The record for each drug must contain the prescription number, name, and strength of drug, date received by the facility, date and time administered, name of resident, dose, physician's name, signature of person administering dose, and original amount dispensed with the balance verifiable by drug inventory at every shift change.

(3) Schedule V drugs are exempt from the requirements in paragraphs (1) and (2) of this section.

§551.326. Required Postings.

A facility must prominently post for display in an area of the facility that is readily available to residents, employees, and visitors:

(1) the license issued under this chapter;

(2) a notice prescribed by HHSC describing complaint procedures;

(3) a notice providing instructions for reporting an allegation of abuse, neglect, or exploitation to HHSC Provider Investigations ;

(4) a notice in the form prescribed by HHSC stating that inspection and related reports are available at the facility for public inspection and providing HHSC’s toll-free telephone number that may be used to obtain information concerning the facility;

(5) a copy of the most recent inspection report relating to the facility; and

(6) a notice, in English and Spanish, stating that employees, other staff, residents, volunteers, and family members and guardians of residents are protected from discrimination or retaliation as specified in the Texas Health and Safety Code, §§252.132 - 252.133 (relating to Suit for Retaliation and Suit for Retaliation Against Volunteer, Resident, or Family Member or Guardian of Resident).

§551.327. Notice of Changes in Key Personnel.

A facility must notify the department no later than 30 days after the date of hire of the administrator.

§551.328. Retaliation Prohibited.

A facility must not discharge or otherwise retaliate against:

(1) an employee, resident, or other person because the employee, resident, or other person files a complaint, presents a grievance, or otherwise provides in good faith information relating to the misuse of restraint or seclusion at the facility; or

(2) a resident because someone on behalf of the resident files a complaint, presents a grievance, or otherwise provides in good faith information relating to the misuse of restraint or seclusion at the facility.

§551.329. Vaccine Preventable Diseases.

(a) Effective September 1, 2012, a facility must develop and implement a policy to protect a resident from vaccine preventable diseases in accordance with Texas Health and Safety Code, Chapter 224.

(b) The policy must:

(1) require an employee or a contractor providing direct care to a resident to receive vaccines for the vaccine preventable diseases specified by the facility based on the level of risk the employee or contractor presents to residents by the employee's or contractor's routine and direct exposure to residents;

(2) specify the vaccines an employee or contractor is required to receive in accordance with paragraph (1) of this subsection;

(3) include procedures for the facility to verify that an employee or contractor has complied with the policy;

(4) include procedures for the facility to exempt an employee or contractor from the required vaccines for the medical conditions identified as contraindications or precautions by the CDC ;

(5) for an employee or contractor who is exempt from the required vaccines, include procedures the employee or contractor must follow to protect residents from exposure to disease, such as the use of protective equipment, such as gloves and masks, based on the level of risk the employee or contractor presents to residents by the employee's or contractor's routine and direct exposure to residents;

(6) prohibit discrimination or retaliatory action against an employee or contractor who is exempt from the required vaccines for the medical conditions identified as contraindications or precautions by the CDC except that required use of protective medical equipment, such as gloves and masks, may not be considered retaliatory action;

(7) require the facility to maintain a written or electronic record of each employee's or contractor's compliance with or exemption from the policy; and

(8) include disciplinary actions the facility may take against an employee or contractor who fails to comply with the policy.

(c) The policy may:

(1) include procedures for an employee or contractor to be exempt from the required vaccines based on reasons of conscience, including religious beliefs; and

(2) prohibit an employee or contractor who is exempt from the required vaccines from having contact with residents during a public health disaster, as defined in Texas Health and Safety Code, §81.003 (relating to Definitions).