

# MEMORANDUM

## Texas Department of Human Services (DHS) Long Term Care-Regulatory Policy \* Survey and Certification Clarification

**TO:** Long Term Care-Regulatory  
Regional Directors and State Office Managers

**FROM:** Veronda L. Durden  
Acting Assistant Deputy Commissioner  
Long Term Care-Regulatory (LTC-R)

**SUBJECT:** Questions and Answers from DHS LTC-R Provider Forums Held Between October 2002 and March 2003 — **S&CC #04-07 (Replaces S&CC #04-06)**

**APPLIES TO:** All LTC-R Provider Types

**DATE:** July 16, 2004

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In an effort to improve communication between DHS and providers, DHS LTC-R held multiple provider forums between October 2002 and March 2003. Questions asked by providers at these forums were gathered in an effort to share questions and answers (Q&As) with all providers at a later date. The Q&As addressed in this memorandum include statutory and regulatory references and are verified as correct as of the date of this memorandum. Click on the designated link below for provider-specific Q&As.

- [Adult Day Care](#)
- [Adult Foster Homes](#)
- [Assisted Living Facilities](#)
- [Intermediate Care Facilities for Persons with Mental Retardation](#)
- [Nursing Facilities](#)
- [Residential Care Facilities](#)
- [General](#)
- [Home and Community Support Services Agencies](#)

Surveyors and providers are encouraged to review the Q&As, reference designated web sites, and maintain the most current state and federal rules, policies and procedures to maintain compliance. For questions about a specific Q&A, please contact the LTC-R Policy Unit in State Office, at (512) 438-3161.

[signature on file]

Veronda L. Durden

VLD:skp

# Adult Foster Homes Care

**Q: How does the Community Based Alternatives (CBA) interest list impact the Day Activity and Health Services (DAHS) interest list?**

**A:** The CBA interest list doesn't impact the DAHS interest list. An individual can be on both lists at the same time, and his or her name can be released from the lists at different times.

**Q: Does DHS provide training for clients, family members and the public? Families would benefit from training on topics such as restraint free environments, however sufficient notice must be given to clients and family members.**

**A:** Families are welcome to register and attend joint-training sessions. The topics center around the top ten deficient practices in geriatric facilities and intermediate care facilities for mental retardation (ICF/MR). The responsibility of LTC Educational Services is to provide joint-training sessions for the provider industry and surveyors. However, those who have a vested interest in resident care are welcome to attend. The facility is responsible for the educating of family members related to the specific care needs of the residents and rules that impact the care of the resident/client while attending the day care program. *[Ref: State: Human Resource Code (HRC) § 22.039(c)]*

**Q: Would DHS produce and deliver more joint training opportunities for surveyors and providers?**

**A:** LTCR is required by current legislation to provide joint training on at least one of the top 10 deficient practices in Texas for all nursing facilities, assisted living facilities, and ICF/MRs. Approximately 12 training sessions per month are offered throughout the state. See the following website for training opportunities: <http://www.dads.state.tx.us/providers/training/jointtraining.cfm> . At this time, adult day care facilities are not covered in this group. *[Ref: State: Resource Code (HRC) § 22.039(c)]*

**Q: How can you provide adult day care without going through the licensing process?**

**A:** Providing services to three or fewer persons unrelated to the owner as an adult day care program on a daily or regular basis and does not require a license. Any facility providing those services to four or more persons without a license is in violation of state law and should be reported to DHS at 1-800-458-9858. *[Ref: State: Human Resource Code (HRC) § 103.0041; 40 Texas Administrative Code (TAC) § 98.2(3), 98.11(a)]*

**Q: What is the role of the nurse liaison in adult day care facilities?**

**A:** Legislation mandated improved communications between LTCR and the providers in nursing facilities, assisted living facilities, and ICF/MRs. In response to this mandate, LTCR created the position of facility/surveyor liaison (or nurse liaison).

There is no mandate for the nurse liaison to have a role in the adult day care program. The nurse liaisons' role, if requested by the regional director, is to enhance communication between providers and the survey team or to address a particular concern related to regulations. *[Ref: State: Senate Bill 1839, 77th Legislative Session]*

**Q: Will DHS develop a mechanism to encourage/facilitate regular, ongoing dialogue with providers, for example, hold regular unit meetings?**

**A:** When possible, regional LTCR management staff will periodically schedule meetings to provide a forum for information sharing, identification of issues, training, and team building.

**Q: Will LTCR provide education opportunities for providers on the top 10 deficiencies and how to improve care so that deficient practices can be eliminated?**

**A:** Joint training on the top 10 deficient practices is currently being offered across the state. Check the following website for training opportunities in your area: <http://www.dads.state.tx.us/providers/Training/jointtraining.cfm>. At this time, Education Services does not provide a training for ADC providers.

**Q: Do surveyors receive training on adult day care standards?**

**A:** Adult day care standards have not yet been offered as a separate training for surveyors. Surveyors receive orientation/training regarding the standards for adult day care facilities from the regional staff during their six-month orientation period.

# Adult Foster Homes

**Q: Will DHS produce and deliver more training for adult foster home providers in El Paso with emphasis on the positives?**

**A:** Lynn Garner, the regional director for Long Term Care Services in El Paso, will contact and work with the Adult Foster Home Association to coordinate/facilitate training opportunities.

## **Assisted Living FAQs**

- Aging in Place
- Communication and Training
- Community Based Alternatives
- Facility Operations and Staffing
- Funding, Rates, and Payments
- Licensing and Regulations
- Life Safety Code
- Medication
- Miscellaneous
- Quality Assurance
- Surveys and the Survey Process

## ***Aging in Place***

**Q: When does a resident become unsuited to living in an assisted living community? Why does DHS refer to an "aging in place" resident as inappropriate, when the law allows aging in place?**

**A:** The law allows "aging in place" under certain conditions. A resident must be appropriate when admitted to the facility. The resident may "age in place" and become inappropriate due to the services that are now required. A resident becomes inappropriate for an assisted living facility when he or she requires the services of facility-licensed nurses on a daily or regular basis. Individuals with a terminal condition or who are experiencing a short-term, acute episode, per definition, are excluded from this requirement. Residents should not be admitted to the facility who do not meet the care levels of an assisted living facility. A resident may also become inappropriate when he or she no longer meets the evacuation criteria for the facility. Once a resident is determined to be inappropriately placed by DHS, the facility may request a waiver for the resident to remain at the facility. *[Ref: State: HSC § 247.066; 40 TAC § 92.3(33) & (36), 92.41 (e)(1)(A) & (B), 92.41(f)(1)(A-C) and (2)(A)&(B); Provider Letter #02-32]*

**Q: With "aging in place" as a goal, may an admission be DHS-supported if additional services are necessary and if all written concurrence is available and all life safety code requirements are met (i.e., surgically created feeding tube — nursing to feed always — or endotracheal tube)?**

**A:** No. The requirement is specific that the facility must not admit residents who require licensed nursing care by a facility staff person on a daily or regular basis. The admission of a resident with these needs would be a violation of the regulations. The "aging in place" concept applies only to residents who are already residents of a facility when the aging process creates a change in their condition that would make their residing at the facility inappropriate. It does not apply to people whose admission to the facility is inappropriate at the time of admission. "Aging in place" is intended to allow a long term resident in the facility to remain at the facility. *[Ref: State: 40 TAC § 92.41 (e)(1)(A)&(B)]*

**Q: May the "aging in place" requirement be changed so that providers can send a letter of notification, with no acknowledgement required, by the fire marshal? What does DHS need from a provider when requesting a waiver?**

**A:** No. Written notification forms for evacuation waivers to the fire marshal/state fire marshal and to the fire suppression authority require acknowledgement signatures from those entities. DHS requires facilities to submit all required documents no later than the 10th business day after the date the facility is informed in writing of the specific basis of the surveyor's determination. The

region is required to review the materials and determine if the waiver will be granted or denied. The facility will receive a response from the region within 10 working days from the date the request is received. The waiver of evacuation will be reviewed annually during the facility licensing inspection. The specific documentation requirements and forms are detailed in the regulations and in Provider Letter 02-32. [Ref: State: HSC § 247.066; 40 TAC § 92.41 (f)(1) (A-C) & (2)(C); Provider Letter 02-32]

**Q: On the aging in place notification to local fire authorities, could the signature line be removed and make it true notification instead of requiring a signature?**

**A:** No. Regulations require the provider to notify the local fire authorities that the facility now houses residents with lower evacuation capability than originally presented to them. The notification form is a uniform method of establishing what was conveyed to the fire marshal and that the fire marshal received it when the signature is present. [Ref: State: HSC § 247.066 (c)(4); 40 TAC § 92.41 (f)(2)(A)(vi)]

## ***Communication and Training***

**Q: When will the Community Based Alternatives (CBA) classes be held on cost reporting and cost analysis? Who do you call to find out when they are rescheduled?**

**A:** The training schedule was finalized in November 2003. The schedule and registration forms are posted on the Texas Health and Human Services Commission (HHSC) website at [www.hhsc.state.tx.us/medicaid/programs/rad/index.html](http://www.hhsc.state.tx.us/medicaid/programs/rad/index.html). [Ref: State: 1 TAC § 355.102(d); 40 TAC § 20.102(d)]

**Q: Can the rules be changed to allow an LVN instead of an RN to train staff in an assisted living CBA-contracted facility?**

**A:** There is no requirement in the assisted living facility rules or in the CBA contracting rules for a nurse to provide training. There are rules under other licensing and certification regulations that require an RN to perform training, i.e., home health agencies. Check the regulations governing your license or certification to verify your requirements.

**Q: Does DHS provide training for clients, family members, and the public?**

**A:** Families are welcome to register and attend joint-training sessions. The topics center around the top ten deficient practices in geriatric and ICF/MR facilities.

The responsibility of LTC Educational Services is to provide joint-training sessions for the provider industry and surveyors. However, those who have a vested interest in resident care are welcome to attend. See the following website for training opportunities:

<http://www.dhs.state.tx.us/programs/ltc/Training/jointtraining.cfm>. [Ref: State: HRC § 22.039(c)]

**Q: Would DHS provide more joint-training opportunities for surveyors and providers?**

**A:** LTCR is required by current legislation to provide joint-training on the top ten deficient practices in Texas. Approximately 12 training sessions per month are offered throughout the state. Currently, there are trainings for ICF/MR and geriatric facilities. See the following website for training opportunities:  
<http://www.dhs.state.tx.us/programs/ltc/Training/jointtraining.cfm>. [Ref: State: HRC § 22.039(c)]

**Q: Will DHS develop a mechanism to encourage/facilitate regular, ongoing dialogue with providers?**

**A:** When possible, regional LTCR management staff will schedule meetings to provide a forum for information sharing, identification of issues, training, and team building.

**Q: Would DHS consider hosting/conducting health expos for assisted living facilities?**

**A:** LTCR regional staff will determine if this can be accomplished in their area. If plausible, regional staff will also need to determine how it can be done.

**Q: Will LTCR provide education opportunities for providers on the top ten deficiencies cited and how to improve care so that deficient practice can be eliminated?**

**A:** Joint-training on the top 10 deficient practices is currently being offered across the state. Check the webpage for training opportunities in your area: See the following website for training opportunities:  
<http://www.dhs.state.tx.us/programs/ltc/Training/jointtraining.cfm>. You may also want to see the LTCR Annual Report for fiscal year 2003 which includes the top ten complaints and deficiencies:  
<http://www.dhs.state.tx.us/programs/ltc/reports/index.html>. [Ref: State: HRC § 22.039(c)]

**Q: Could the stakeholders have a new list of websites to use when searching for information and training materials?**

**A:** LTCR Education Services provides monthly training sessions around the state for both providers and surveyors that are listed on the DHS website:  
<http://www.dhs.state.tx.us/programs/ltc/Training/jointraining.cfm>.

The Long Term Care Regulatory Policy website includes a list of related links (<http://www.dhs.state.tx.us/business/LTC-Policy/links.html>) as does the DHS website: <http://www.dhs.state.tx.us/links>.

The development and distribution of a new list of informative websites will be researched, developed, and distributed by the LTCR regional automation coordinator. Facilities also should contact their respective provider organizations for more information and training opportunities.

**Q: Would DHS provide a list of sources needed to start and to function within the regulations for assisted living facilities? We need a checklist of required forms and websites for obtaining information. This could include outside sources such as Nurse Practice Act, etc.**

**A:** All of the regulatory requirements are available to providers on the LTC Policy website at: [www.dhs.state.tx.us/providers/ltc-policy](http://www.dhs.state.tx.us/providers/ltc-policy), under Related Links. Providers may contact Complaint and Intake Management with specific questions at 1-800-458-9858. Nursing questions may be addressed to the Board of Nurse Examiners at: [webmaster@bne.state.tx.us](mailto:webmaster@bne.state.tx.us). A checklist used by the survey team during an inspection may be found on the Policy website.

DHS will perform architectural reviews for all new buildings or additions to existing buildings for a fee. [Ref: State: HSC § 247.0261; Provider Letter #02-38]

**Q: Will surveyors be allowed to teach/train facility staff during a survey like they once did?**

**A:** The state has adopted Centers for Medicare and Medicaid Services (CMS) guidelines that direct DHS "to provide reference information regarding best practices to assist facilities in developing additional sources and networking tools for program enhancement." However, surveyors are not allowed to act as facility consultants.

## ***Community Based Alternatives***

**Q: What is the role of the Community Based Alternatives (CBA) and Medicare home health nurses when a resident lives in a facility with/without a nurse on staff? Which RN does the delegation of medication administration — the CBA RN or the facility RN? Our CBA RNs do not touch medications.**

**A:** Assisted living facilities (ALFs) are required to follow their licensure rules regardless of the payor source of the resident. When other contracting services are involved, each of those entities must follow their regulations or contractual agreements with the facility. ALFs are not required to administer medications in the licensure rules, but may do so under the delegation of a RN following the rules of delegation of the Texas Board of Nurse Examiners (BNE). The facility would determine, based on their contracts with outside sources and their internal policies, which RN would delegate to the unlicensed person. *[Ref: State: 40 TAC § 92.41 (j) (1)(A)]*

**Q: When you release the CBA names, do you release the names of CBA assisted living facilities?**

**A:** No. DHS releases the number of names to the regional case manager, who gives the applicant the choice of receiving services from any of the contracted CBA providers.

**Q: Please explain more about CBA slots.**

- a. How many slots do you have?**
- b. How do you determine who receives the slots?**
- c. If you have 100 slots and release 200 names, what happens to the other 100 names/slots?**

**A:** In order the answers are:

- a. The number of slots for the current fiscal year (2004) is 30,290.
- b. The slots are allocated to the DHS regions based on a formula that takes into consideration various factors, such as how many individuals are registered on the CBA interest list in the region, how many individuals are living in nursing facilities in the region, etc.
- c. They would continue to be registered on an interest list in the same order they had before the names were released.

**Q: Can CBA funds be made retroactive so a facility is not forced into charity care?**

**A:** DHS does not regulate this reimbursement issue. Medicaid does not pay for assisted living services unless provided under a Medicaid waiver program, such as the CBA program. The CBA waiver is not an entitlement program. There are more than 50,000 individuals registered on the CBA interest list. Individuals are removed from the CBA interest list on a first-come, first-served basis, unless the individual meets a by-pass criteria. The criteria states children age 21 who are no longer eligible for the Medically Dependent Children Program or the Texas Health Steps program and were previously receiving nursing services, can by-pass the interest list.

Because waiver services provided in an assisted living facility are not an entitlement, DHS cannot pay an assisted living provider for services until:

- funding is available
- the individual is released from the CBA interest list
- he or she meets all CBA eligibility criteria
- CBA services can be approved effective the day he or she meets the eligibility criteria

*[Ref: State: 40 TAC § 48.6003]*

**Q: Will DHS provide more training and information for surveyors regarding the regulation and licensing of Community Based Alternatives (CBA) facilities?**

**A:** LTCR licenses home health agencies and assisted living facilities that have CBA contracts. All home health surveyors are given training that includes licensure regulations. Surveyors also receive a course designed to give basic information on CBA and other waiver programs that are contracted by DHS.

## ***Facility Operations and Staff Issues***

### **Q: Are long-term care employees tracked nationwide?**

**A:** Currently, there is no system for states to uniformly report and inquire on long-term care employees.

### **Q: Can the rules be changed to allow probation for an individual who commits acts of misconduct while working in a DHS-regulated facility?**

**A:** The Employee Misconduct Registry (EMR) statute does not address probation for unlicensed individuals who commit acts of misconduct while working in DHS-regulated facilities and agencies. Therefore, the agency is prohibited from doing so. *[Ref: State: HSC § 253.003, 253.007(a)(b)(c) and 253.0075; 40 TAC § 93.48 and 93.62]*

### **Q: How long after a facility reports an employee for stealing can a facility expect to find the person on the EMR?**

**A:** When an investigation substantiates an allegation that results in a referral to the EMR, the employee must be provided due process pursuant to the Administrative Procedure Act (APA). Findings upheld during due process result in an individual's name being placed on the EMR. If the individual does not challenge his or her referral, then his or her name is placed on the EMR quickly. If he or she choose to request a formal hearing and the finding is upheld at that hearing, it may be a year before his or her name is placed on the EMR. Individuals employed in a DHS-regulated facility are offered an informal reconsideration (in the region) and a subsequent formal hearing. *[Ref: State: HSC § 253.003-253.0075; 40 TAC § 93.61]*

### **Q: Do all reports about employees automatically generate an investigation?**

**A:** No. Licensing standards require an assisted living facility to notify DHS of alleged violations involving mistreatment, neglect, or abuse, including exploitation/misappropriation. The facility is to provide evidence to DHS, in the form of a written report of the investigation, that the facility thoroughly investigated all alleged violations and prevented further abuse while investigating. LTCR may triage self-reported incidents as not needing an on-site investigation until the provider investigation and administrative review of the provider's written investigation report is complete. If so, LTCR state office conducts an administrative review of the provider's written investigation report to determine whether further investigation by DHS is required to ensure compliance with state or local laws. *[Ref: State: HSC § 247.043(a); 40 TAC § 92.102; Provider Letter #03-01]*

**Q: When do facilities report employee incidents to the EMR and when do they report them to the incident hotline?**

**A:** Assisted living facilities do not report incidents to the EMR; rather they report incidents to the LTCR Complaint and Intake Management Section (1-800-458-9858 or 512-428-2633) in accordance with agency requirements. Current information may be found at: [www.dads.state.tx.us/business/LTC-Policy/](http://www.dads.state.tx.us/business/LTC-Policy/). [Ref: State: HRC § 48.051(b); 40 TAC §92.102(a), 40 TAC § 93.48; Provider Letter #03-01]

**Q: Are assisted living facilities required to have resident councils?**

**A:** There is no requirement for resident councils in an assisted living facility. However, if the facility has a resident council, the facility must provide privacy to the residents during these meetings. [Ref: State: HSC § 247.064 (b)(7); 40 TAC § 92.125 (a)(3)(R)]

**Q: Are ALFs required to check food temperatures?**

**A:** Facilities must store, prepare, and serve foods in a manner that will ensure residents not receive food-borne illnesses. Regulations mandate the appropriate temperatures to store foods. Depending on the size of the facility, the food preparations must follow the Texas Food Establishment rules. [Ref: State: HSC § 247.026 (b)(3); 40 TAC § 92.41 (m)(8)-(11)(18)]

**Q: May we take a new physician's order from a doctor's nurse or receptionist?**

**A:** The Texas Board of Medical Examiners gives physicians authority to delegate tasks to unlicensed personnel, which may include calling in his orders to a facility. The facility must follow their own policies and procedures for accepting physician's orders. When accepting the order, the ALF documents to whom they spoke, including the time and date. A corresponding order must be recorded for this interaction and must be countersigned by the physician. [Ref: State: Occupation Code § 157.001]

**Q: Must facilities include specific low-concentrated sweets food items in daily and weekly menus?**

**A:** Therapeutic diets, such as no concentrated sweets, as ordered by a resident's physician must be provided according to the service plan. Therapeutic diets that cannot customarily be prepared by a layperson must be calculated by a qualified dietician. Therapeutic diets that can customarily be prepared by a person in a family setting may be served by the assisted living facility. [Ref: State: HSC § 247.026 (b)(3); 40 TAC § 92.41 (m)(4)]

**Q: Does the facility need to have an area that is secured (either in the room or in the facility) for valuables?**

**A:** Each resident has the right to retain and use personal property in his or her immediate living quarters and to have an individual locked area (cabinet, closet, drawer, footlocker, etc.) in which to keep personal property. [Ref: State: HSC § 247.064 (b)(3); 40 TAC § 92.125(a)(3)(U)]

**Q: In some assisted living facilities, there is no RN on staff. If the LVN cannot delegate tasks, what is the activity called where an LVN can train and direct unlicensed personal assistant?**

**A:** The ALF regulations don't require facilities to staff an RN or LVN. Only a registered nurse may delegate nursing tasks to unlicensed staff. Any task required of the unlicensed staff requiring delegation, i.e., medication administration, must be done by an RN according to the ALF rules and the Texas Board of Nurse Examiner (BNE) rules. LVNs must review the requirements regulating their license to ensure they don't exceed their license requirements. For more information, the facility/LVN may visit the BNE website at: <http://bne.state.tx.us> or phone 512-305-7400. [Ref: State: Occupation Code, Chapter 301 - Nurse Practice Act; 22 TAC Chapters 224 and 225; 40 TAC § 92.41(j)(1) (A) (i)-(iii)]

**Q: Why are facilities penalized when self-reporting an incidence of abuse and neglect, even when they have already terminated the alleged abuser?**

**A:** Protection of the resident is of paramount importance. Although employees may be terminated after an allegation of abuse/neglect, there may be a breakdown in the facility's overall system of resident protection. Termination of an employee may not correct the practice that caused the abuse and neglect. The surveyor reviews the licensing standards to see what facility practice may have led to the occurrence of abuse and cites the violation based on that failure. [Ref: State: HSC § 247.043 (b)(1); 40 TAC § 92.102, 92.105(c) and 92.151]

**Q: Is there anything in place to deal with emergency placement? What do you consider as emergency placement?**

**A:** Residents placed in the facility due to an emergency situation must be treated like any other facility resident. This applies to admission records, comprehensive assessments, etc. An emergency placement of a resident would be when there is threat to the health and safety of that resident at their current residence. [Ref: State: HSC § 247.042 (d); 40 TAC § 92.41 (c) (4), 92.351, 92.361, and 92.362]

## ***Funding, Rates, and Payment***

### **Q: What is DHS doing to ensure assisted living facility (ALF) providers receive timely payments?**

**A:** This is not a DHS regulatory function; however, providers that bill using electronic claim submission (TDHConnect) can expect payment within five to seven days of the date the claim was successfully submitted. DHS encourages providers to bill electronically to ensure timely receipt of warrants.

A variety of errors may cause the claim to be denied before it can be successfully submitted, thereby taking the claim out of the payment cycle until the problems have been corrected. Common denial reasons for Community Living Assistance and Support Services (CLASS) claims include:

- Service authorization dates not available for this client for this service
- Service has already been paid
- No units available for client service authorization
- Provider not authorized to provide services for this client

Resources available to help CLASS and other DHS providers handle claim submission problems are listed under DHS LTC near the back of the *Long Term Care Bulletin* mailed quarterly to providers. The providers may contact Texas Medicaid and Healthcare Partnership (TMHP) website at: <http://www.tmhp.com>. They include contacts for:

- Client service authorization: contact your caseworker or case manager
- Provider policies and procedures: contact the contract manager
- The CLASS program: 1-877-438-5658

For further information on claims submission procedures, help (including "Getting Paid"), training, etc. access the TMHP website: <http://www.tmhp.com>. [Ref: State: Texas Government Code 2251.021]

### **Q: How can DHS assist in changing legislation so that assisted living facilities can have standardized bed hold rates?**

**A:** The agency does not change legislation nor regulate this reimbursement issue. DHS informs legislators regarding the programs and clients served by the agency in an effort to allow the legislators to make informed decisions during legislative sessions. The bed hold rates for assisted living/residential care services are already a fixed daily rate. [Ref: State: 40 TAC § 46.49(c-f)]

**Q: Can DHS plan ahead to prevent Title XX funds from running out in early July every year?**

**A:** This is not a regulatory function for the agency. DHS administrative staff distribute Title XX funds each fiscal year to the DHS regions. This money is used to fund several community care programs; it is not allocated by program. Regional staff decide how to use the limited funds to best meet the needs of the population they serve. Because this funding is limited, when the funding for the fiscal year is exhausted, no new clients can be enrolled in the programs funded by Title XX. *[Ref: State: Texas Government Code § 2105; Texas Human Resource Code (HRC) § 22.002(a) Federal: Social Security Act § 2001(4); 42 United States Code § 1397]*

**Q: How can DHS help providers influence the budget to get fees for services increased?**

**A:** Providers always have an opportunity to discuss legislative issues with legislative representatives. DHS does not propose legislation to the Legislature, rather the agency provides current data to the Legislature on topics under its authority.

**Q: Can DHS providers implement programs to supplement employee salaries and benefits?**

**A:** Providers are encouraged to come up with creative and innovative approaches for employee retention. Incentive rates are available to those ALFs participating in the Attendant Compensation Rate Enhancement program. For more information, go to: [www.dhs.state.tx.us/programs/communitycare/infoletters/](http://www.dhs.state.tx.us/programs/communitycare/infoletters/). *[Ref: State: Title 1, TAC § 355.112; 40 TAC § 20.112]*

**Q: We would like to have resources about grants, loans, or scholarships for renovating, adding handicap/disabled features to assisted living facilities, and for adding on to an existing facility to meet the needs of residents and licensing regulations.**

**A:** DHS does not maintain this type of information. LTCR will provide guidance with the regulations for assisted living facilities. LTCR has a facility option to perform plan reviews (for a fee) for potential licensees or additions to existing facilities. Grants, loans, or scholarships are not a function of the agency. DHS may provide technical assistance to an applicant by making brief inspections of the assisted living facility proposed to be licensed and making recommendations concerning actions necessary to meet standards for assisted living facilities. *[Ref: State: HSC § 247.022 (c); 40 TAC § 92.64]*

**Q: Why doesn't Medicare fund assisted living facilities?**

**A:** DHS does not have authority over reimbursement issues. Assisted living facilities may go to their federal legislators for this information.

## ***Licensing and Regulations***

**Q: Why are some assisted living facilities (ALFs) given a license after being closed by the state, especially when operated by the same owners?**

**A:** DHS conducts an analysis of all applicants for licensure. In each case, the agency determines if the applicant was the operator of a previously closed facility. DHS considers the circumstances related to the closure and determines if the rules require that the license be granted or denied. *[Ref: State: HSC § 247.023(a) and 247.025; 40 TAC § 92.17]*

**Q: When a facility license is about to expire, what kind of inspection can an assisted living facility expect and when?**

**A:** A license can not be renewed until DHS has determined that the facility complies with licensure rules. Compliance can be determined based on previous inspection or investigations, or it might require an additional inspection before the renewal date. The region may base compliance on a health inspection only or may base it on both health and Life Safety Code (LSC) surveys. Annual LCS surveys are not required in some instances. *[Ref: State: HSC § 247.027; 40 TAC § 92.15(g) and 92.81.]*

**Q: What does DHS do when it determines a facility is operating without a license?**

**A:** Unless DHS determines that residents are in immediate jeopardy, the facility is generally given the opportunity to become licensed or stop providing assisted living services. If the facility continues to violate state law by providing assisted living care without a license, DHS can refer the facility to the Office of the Attorney General for civil penalties and other sanctions. Anyone aware of an unlicensed facility providing assisted living services should report that information to DHS at 1-800-458-9858. *[Ref: State: HSC § 247.021(a), 247.044(a)(2) and 247.045(a)(b); 40 TAC § 92.2 (b)(1) and 92.302]*

**Q: How is DHS dealing with the recent increase in "board and care" facilities operating as pseudo assisted living facilities in order to circumvent the more restrictive assisted living regulations and the Life Safety Code? (These establishments tell clients to write two checks for payment: one check for rent and food to the board and care and another check as direct payment for labor for "private sitters" who act as medication aides, attendants, etc.)**

**A:** An assisted living facility is an establishment that furnishes, in one or more facilities, food and shelter to four or more persons who are unrelated to the proprietor of the establishment and provides personal care services.

If DHS finds that a facility is operating without a license, in violation of Chapter 247, Health and Safety Code, it may pursue a temporary restraining order or temporary injunction to prevent the operator from operating a facility without a license. DHS may also pursue an award of civil penalties against an operator that operates an assisted living facility without a license.

Knowledge of an unlicensed facility should be reported to the Complaint and Intake Management hotline at 1-800-458-9858. DHS will investigate the facility to determine if it is operating in violation of Chapter 247. *[Ref: State: HSC § 247.021 (a), 247.044 and 247.045; 40 TAC § 92.2 (b) (1) and 92.81(a)]*

**Q: Will the assisted living regulations become similar to the nursing home regulations?**

**A:** Currently, there are no plans to change the assisted living rules to make them similar to the nursing home rules. State statute, Chapter 247, Health and Safety Code, requires assisted living regulations to clearly differentiate an assisted living facility from a nursing facility. *[Ref: State: HSC § 247.026 (b)(1)]*

**Q: You mentioned that the Legislature would need to change things, but can't the rules simply be changed? It's just a policy group in Austin that has to do that, not the Texas Legislature, right?**

**A:** Assisted living facilities are regulated under Chapter 247, Health and Safety Code, and Chapter 92, Title 40 of the Texas Administrative Code. Chapter 247 is changed by the Legislature, while the Texas Board of Human Services changes Chapter 92 to meet the intent of the legislative changes. Chapter 247 gives DHS the authority to regulate ALFs and the authority to write specific rules/regulations. ALFs will be notified of applicable new rules when the rules are filed with the *Texas Register*. *[Ref: State: HSC § 247.025; 40 TAC § 92.2 (a) and 92.126]*

**Q: Does the agency have any plans to revise the standards to make them more easily understood?**

**A:** Agency rules are being rewritten in plain language using a question-and-answer format. In accordance with a DHS initiative, rules are being rewritten in a clear, understandable fashion that will allow clients, providers, and the public to more easily understand/comply with program rules.

**Q: Can you provide specific dates of projected revisions, such as having quarterly revisions?**

**A:** There is no way to schedule rewrites or to project when revisions will become necessary. Revisions usually occur after a legislative session, every two years, and when changes are necessary. The rules are scheduled for a total rewrite, tentatively before 2005. *[Ref: State: Government Code § 2001.039]*

**Q: Why are there so many regulations for small facilities?**

**A:** Regulations are based on statutory requirements. There are some differences in requirements for a small versus a large facility. When rules are being written, DHS considers the impact the rules will have on facilities. *[Ref: State: HSC § 247.026(a)]*

**Q: Can you please provide a list of DHS contact names and telephone numbers for assisted living facility providers to use when questions arise regarding regulations?**

**A:** Providers should call their regional program manager or regional director for any inquiries about the program. If that person is unable to provide the requested information, they will research the inquiry with the appropriate current resources and respond with the most accurate information available. Currently, LTCR is developing a list of specialists/experts available to answer questions for the LTCR staff. For a contact number of the local LTCR office, go to: <http://www.dads.state.tx.us> or you may call 1-800-458-9858 in Austin to be directed to the appropriate source for information.

## ***Life Safety Code***

### **Q: Is an emergency plan mandated or optional for an assisted living facility (ALF)? Who do you contact locally?**

**A:** Facilities are required to have an emergency plan in case of fire or disaster. Each facility must provide emergency preparedness training in the four-hour orientation for all new employees. There is no mandate to have an emergency coordinator. The provider should contact the mayor or county judge in their area to coordinate the emergency plan with the local emergency management coordinator. *[Ref: State: 40 TAC § 92.41 (a)(4)(A)(vi); 92.62(d)]*

### **Q: May you have an electronic lock on both the patio door and the outside gate in an Alzheimer's facility?**

**A:** The 1988 edition of the Life Safety Code (LSC) limits delayed egress locks to one installation in any direction of egress. An occupant should not have to wait through more than one 15-30 second delay while trying to exit the building. In a Certified Alzheimer's facility, if locks are not delayed egress, but meet the requirements, a lock is allowed on both patio door and outside gate. *[Ref: State: 40 TAC § 92.61 (b)(4), 92.53(h)(8) and 92.53(h)(9)(B)]*

### **Q: May we have a locked unit even if we are not certified for Alzheimer's?**

**A:** The 1988 edition of the Life Safety Code does not allow locks against egress on small facilities; it allows delayed egress locks only on large facilities. The locks allowed in the regulations are permissible only if all the requirements are met. *[Ref: State: 40 TAC § 92.61 (b)(4)]*

### **Q: Why can't the city fire marshal and health inspector work with the state health and life safety surveyors? The city and state sets off the fire alarm, city checks food safety, state checks food safety, etc. Couldn't paperwork or documentation from the city suffice?**

**A:** The minimum requirements and enforcement capabilities differ from city to city and county to county. DHS trains surveyors to consistently enforce state requirements without regard to local requirements. The statute requires the state to inspect ALFs. *[Ref: State: HSC § 247.0272(a); 40 TAC § 92.11 (1) & (5)]*

### **Q: What are the different evacuation procedures for Type A, B, and E?**

**A:** Evacuation capability is defined in the LSC Residential Board and Care chapter. ALF residents have to be able to evacuate the building without assistance in Type A facilities and without continuous staff assistance in Type B facilities. The standards require that a Type A resident "must be able to demonstrate to DHS

that they can travel from their living unit to a centralized space, such as a lobby or living or dining room on the level of discharge within a 13-minute period without continuous staff assistance." A Type E facility is limited to residents who can demonstrate to DHS that they can travel from their living space to a centralized space within a 3-minute period without staff assistance. [Ref: State: 40 TAC § 92.4 (1) , (2) & (4), 92.62(a) & (b), 92.72(b)]

**Q: Will assisted living facilities be required to go to the newer editions of the LSC, such as the 2000 version? What are the implications for ALFs?**

**A:** ALFs will not go to the 2000 edition of NFPA 101, the Life Safety Code, to match nursing and ICF/MR facilities until new rules are adopted. The LSC has required newly licensed slow evacuation facilities (Type A) to install sprinklers starting with the 1994 edition of the code. Existing Type A facilities would not have to add sprinklers. [Ref: State: 40 TAC § 92.61 (b)(4)]

**Q: Can any ALFs use magnetic locks on the exit doors to keep people from wandering? Do they have to be a certified Alzheimer's facility to lock the residents inside a unit or facility?**

**A:** The LSC permits delayed egress locks on doors in large assisted living facilities. Small facilities cannot install delayed egress locks or locks allowed within the ALF Alzheimer's standards unless they meet all the requirements of the ALF Alzheimer's standards and are certified. [Ref: State: 40 TAC § 92.61 (b)(4) & 92.53(h)]

**Q: The fire marshal has still not come out for an inspection. We have been calling since December 2002. Our license expired in February 2003. What can you do to help us?**

**A:** Call the State Fire Marshal's Office at 512-305-7900 to request an inspection by a deputy state fire marshal. Their inspection is acceptable to DHS Provider Operations. [Ref: State: 40 TAC § 92.62 (g)(1); 92.62 (i)(1)]

**Q: Please define evacuation. Does this refer only to exiting the building, or can it mean going to a "safe" area, such as a stairwell or lobby, behind fire doors?**

**A:** Evacuation capability is defined in the LSC Residential Board and Care chapter. Residents in ALFs have to be able to evacuate the building without assistance in Type A facilities and without continuous staff assistance in Type B facilities. The standards require that a Type A resident "must be able to demonstrate to the DHS surveyor that they can travel from their living unit to a centralized space, such as a lobby, living or dining room on the level of discharge within a 13-minute period without continuous staff assistance." This might prevent a resident who

normally uses a walker or a wheelchair from living on an upper floor. *[State: 40 TAC § 92.4 (1), (2) & (4) and 92.62(a) & (b)]*

**Q: State and city fire codes do not agree. How can this be changed?**

**A:** The State Fire Marshal and DHS have adopted the NFPA codes. Cities may adopt the NFPA codes, the International Codes, other model codes, or any combination of these. A provider must meet the more stringent requirement when the various code requirements differ. *[State: 40 TAC § 92.61(b)(6)]*

**Q: Can DHS classify Life Safety Code violations as minor or major violations?**

**A:** DHS does not assign scope and severity to violations of the licensing standards or the LSC for assisted living facilities. The Centers for Medicare and Medicaid Services (CMS) developed guidelines for scoping certified facilities. DHS has not developed guidelines for licensed-only ALFs. *[Ref: State: HSC § 247.026(a); 40 TAC § 92.82(b)]*

**Q: How often are LSC surveys conducted in assisted living facilities?**

**A:** The annual licensure inspection required for an assisted living facility is conducted by the health team. According to regulations, the survey for a license renewal must include the observation of the care of residents. An LSC survey may not be required annually and is scheduled as determined by the regional office. When an LSC survey is conducted, the LSC surveyor must prioritize what fire safety features are studied in depth based on the time constraints. *[Ref: State: 40 TAC § 92.15(g), 92.81(a)-(b)]*

**Q: Is it appropriate for Life Safety Code surveyors to look into the owner's private living areas?**

**A:** Surveyors should first determine if the private living areas are separated from the licensed area or were part of the area licensed during the initial inspection. If the area is not separate or it was part of the initial inspection, then it is appropriate for a surveyor to observe the private areas during subsequent re-licensure inspections. *[State: 40 TAC § 92.62 (e)(1); National Fire Protection Association (NFPA) 101]*

**Q: Please address the citing of "floors and doors," i.e. what are you looking for?**

**A:** One of the most common violations written in ALFs during fiscal year 2002 was "floors must be maintained in good condition and cleaned regularly." For more information about this topic, contact the DHS Life Safety Code person in your region. *[Ref: State: 40 TAC § 92.62 (h)(8)]*

## **Medication**

**Q: If I have a client who takes an occasional PRN (as needed) medication for agitation. Does that mean this client's medication cannot be given by an unlicensed person? Does this mean that the client is "unstable?"**

**A:** Only a licensed nurse may assess residents to determine the need for a PRN medication. Refer to the rules for licensed nurses and medication administration. Unlicensed personnel may supervise medications, opening containers, and placing medications in a resident's hand. Unlicensed personnel cannot assess residents. *[Ref: State: 22 TAC § 225.9 (a)(1); 40 TAC § 92.41 (j)(1)]*

**Q: What is considered as "application" of topical medications? Does this apply to preventive ointments and creams?**

**A:** "Application" of a topical medication is considered administration of medication. If the ointment is prescribed by a physician and is applied by a staff person, that is administration. *[Ref: State: HSC § 247.002 (5)(B); 40 TAC § 92.3 (19)]*

**Q: Regarding supervision of medications, may we put the prescribed medications in residents' pillboxes? Do you then have to sign out that you gave each individual medication or do you only have to sign one area saying you administered all the 8 a.m. medications?**

**A:** Supervision allows staff to set up medications in medication boxes. Facilities must complete a medication profile record. Staff must document when a medication **is not** taken. The regulations do not require facilities to document when a medication is taken. Facilities may choose to document when a medication is taken, which is not required by regulation. *[Ref: State: HSC § 247.002 (5)(B); 40 TAC § 92.41 (j)(2)]*

**Q: If you have a Certified Medication Aide (CMA) passing medications, you do not have to worry about training, delegation, or having a written agreement from the resident or responsible party. Is this correct? May an LVN or a pharmacy tech supervise the CMA?**

**A:** No. Residents who choose not to or cannot self-administer medication must have their medication administered by a person who holds a current medication aide permit and acts under the authority of a person who holds a current nursing license under state law that authorizes the licensee to administer medication. A medication aide must function under the direct supervision of a licensed nurse on duty or on call by the facility. Each licensed nurse needs to check their regulations or regulatory board regarding their ability to supervise other individuals. *[Ref: State: HSC § 247.002 (5)(B), 247.030 (b); 22 TAC 224.9 (a); 40 TAC § 92.41 (j)(1)(A)(ii)]*

**Q: Does an expiration date have to be placed on both the medication bottle and the package?**

**A:** It is not clear what "package" means in this question. Facilities are required to put the date received from the pharmacy on the resident's medication profile record, if the medication is administered or supervised by the facility. The medication expiration dates should be provided by the pharmacy; the facility would be responsible for ensuring that residents do not receive expired medications. *[Ref: State: 40 TAC § 92.41 (j)(1)(D), 92.41(j)(2)(F)]*

**Q: May a nurse delegate the ordering of medication refills to an unlicensed person? Can a medication aide re-order medications?**

**A:** The medication aide rules, Chapter 95 of the Texas Administrative Code, specifically prohibits the CMA from re-ordering medications. The licensed individual should address this question to their respective licensing board. For information on RN delegation, go to the Texas Board of Nurse Examiners (BNE) website at <http://www.bne.state.tx.us> or phone 512-305-7400. The medication aide should refer to the terms of his or her certificate before performing a function that is beyond his or her certification. *[Ref: State: 22 TAC § 224.9 (c)(7); 40 TAC § 92.41 (j)(1)(A)(ii); 40 TAC § 95.105(b)(9)]*

**Q: Are facilities allowed to carry stock Tylenol, Ibuprofen, Imodium, etc. without a specific client's name on the bottle?**

**A:** DHS has no regulations related to a facility maintaining stock medications. However, all resident medications must be stored according to the regulations. *[Ref: State: 40 TAC § 92.41 (j)(5)]*

**Q: How often do the staff who have been trained by an RN to administer medication have to be retrained?**

**A:** The RN should address this question to the BNE for clarification.

**Q: May allergy shots be delegated? May a family member administer the first dose?**

**A:** No. Injectable medications, other than insulin, are not listed in the BNE rules as tasks that can be delegated to an unlicensed person. For further clarification, visit the BNE website at: <http://www.bne.state.tx.us> or phone 512-305-7400. *[Ref: State: 22 TAC § 224.9 (b)(3) and 225.12(5)(E)]*

**Q: What about sample drugs from the physician?**

**A:** Physician sample medications may be given to a resident by the facility provided the medication has specific dosage instructions for the individual resident. [Ref: State: 40 TAC § 92.41 (j)(1)(C)]

**Q: We use the Opus system. The prescription number and date issued are not on the medication record. When the prescription arrives, we put the delivery sheet in a folder in the medication room. The delivery sheet has the prescription number and date issued. Is this okay?**

**A:** The requirement states that facilities must document the date received from the pharmacy on the resident's medication profile record. That record must have the required information. The facility may store this record in any location, but must have it available for the surveyor during the survey process. [Ref: State: 40 TAC § 92.41 (j)(1)(D), 92.41 (j)(2)(F)]

**Q: Is there a regulation that requires assisted living facilities to have a locked box or cabinet for medications that are kept in the resident's room?**

**A:** Yes. Each ALF resident has the right to retain and use personal property in his or her immediate living quarters and to have an individual locked area (cabinet, closet, drawer, footlocker, etc.) in which to keep personal property. In addition, the facility must provide a locked area for medications stored in a resident's room. This lock may be the lock on the door to the resident's room. [Ref: State: HSC § 247.064 (b)(3); 40 TAC § 92.41 (j)(3)(A), 92.41(j)(5), 92.125 (a)(3)(U)]

**Q: Are the residents who keep some PRN medication in their room required to have monthly counseling?**

**A:** Residents who self-administer medications and keep them locked in their room must be counseled at least once a month by facility staff to ascertain if the resident continues to be capable of self-administering medications/treatments and if security of medications can continue to be maintained. The facility must keep a written record of this counseling. [Ref: State: 40 TAC § 92.41 (j)(3)(A)]

**Q: When we get a client to sign a release for help self-administering medication by unlicensed staff, does that release apply to my whole staff or should I get a release for each staff member?**

**A:** Supervision of medications does not require a consent be signed. Only when medications are **administered** by an unlicensed person under the delegation of an RN do the BNE rules specify the RN must ensure the client or client's responsible adult acknowledge in writing that the administration of medication(s)

under this section is delegated to an unlicensed person. [Ref: State: 22 TAC § 225.11(a)(5); 40 TAC § 92.41(j)(2)]

**Q: Does an RN need to do a supervisory visit every 14 days on clients who self-administer insulin?**

**A:** There is no requirement in the ALF regulations for an RN to visit the resident every 14 days. The ALF requirement regarding self-administration of medications is for residents to be counseled at least once a month by facility staff to ascertain if they continue to be capable of administering their own medications/treatments and if security of medications can continue to be maintained. The facility must keep a written record of this counseling. [Ref: State: 40 TAC § 92.41 (j)(3)(A)]

**Q: Is our facility allowed to keep an emergency kit containing Intramuscular (IM) Ativan for seizures and IM Glycogen emergency shots without having a particular resident's name on the kit? We have several patients with seizures and diabetics, and these patients have to pay co-pays on medication, even if it is never used. Do we have to order one for each client?**

**A:** There are no requirements for the facility to maintain those emergency medications. If facility residents require the medications, the facility should maintain the physician-ordered medications according to the regulations. How the facility does this is based on the facility's policy and procedure. [Ref: State: 40 TAC § 92.41 (j)(1)(D), 92.41(j)(2)(F), 92.41(j)(5)]

**Q: If we are delegating only application of topical creams or medications to unlicensed personnel, does the client have to sign permission? Does a licensed nurse have to give the initial dose?**

**A:** Yes, the application of topical medications would be administration of medications. The BNE is specific about an RN administering the initial dose of any medication unless specific requirements are met. For information regarding RN Delegation rules, go to the BNE website at <http://www.bne.state.tx.us> or phone (512) 305-7400. [Ref: State: 22 TAC § 224.9 (b)(2), 225.12(5)(E)]

## **Miscellaneous**

**Q: Can DHS pre-approve plans before a provider buys or remodels a home?**

**A:** Yes. DHS offers plan review to providers who submit plans with appropriate fees to the LTCR Architectural Program at state office. [State: 40 TAC § 92.20(d)]

**Q: What is DHS doing to implement Rider 37?**

**A:** DHS implemented Rider 37 (renamed Rider 28 in the Appropriations Bill, 78th Legislature) in September 2001. More than 2,200 Medicaid clients have moved from nursing facilities into the community as a result of Rider 37.

**Q: How do we find out if we are on the community care for the aged and disabled (CCAD) interest list?**

**A:** You can call your local DHS office for that information. For contact numbers, go the DHS website at: [www.dhs.state.tx.us](http://www.dhs.state.tx.us) and click on Regional Information. Select the region where the facility is located and click the area on the map. Contact information will provide names and numbers of all the various service areas for DHS in that region.

## ***Quality Assurance***

**Q: What if our accident/incident reports are part of our quality assurance process? Are they confidential?**

**A:** Yes. All resident records must be treated as confidential by the facility. However, in the event of accident or injury that requires emergency medical, dental, or nursing care, or in the event of apparent death, the assisted living facility (ALF) will describe and document the injury, accident, or illness on a separate report. The report must contain a statement of final disposition and be maintained on file. Because this report is required under the licensing rules, the facility must make the report available to DHS during the survey process, if requested. *[Ref: State: Health and Safety Code (HSC) § 247.043 (b)(4); 40 Texas Administrative Code (TAC) § 92.41 (h)(1) & (3) & 92.41(k) (1)(C)]*

**Q: Are there going to be Quality Reporting System (QRS) scores for assisted living facilities in the future?**

**A:** Yes. There are plans for QRS reports for the assisted living facilities, but there is no date set, at this time, for the roll out. *[Ref: State: HSC § 247.062 (c)]*

**Q: How will DHS use nurse liaisons in assisted living facilities?**

**A:** Legislation mandated improved communications between LTCR and providers in nursing facilities, assisted living facilities, and intermediate care facilities for mental retardation/related conditions. In response to this mandate, DHS created the position of facility/surveyor liaison or nurse liaison. The position is funded for

these programs only, but can be used on a limited basis in other types of facilities at the discretion of the regional director.

The nurse liaison enhances communication between facilities and surveyors. These positions do not include fact-finding or discussion of evidence during the survey process. The nurse liaison may be used to enhance communication between the provider and the survey team, but may not be used to discuss evidence in potential deficiencies. *[Ref: State: SB 1839, 77th Legislative Session]*

## ***Surveys and the Survey Process***

**Q: How can assisted living facilities (ALFs) receive the same information on background checks that surveyors receive?**

**A:** Typically, surveyors don't have access to criminal history backgrounds checks. If the facility submits the required information for the criminal history check, it will get a complete criminal history check for that individual. If there are problems, contact Bevo Morris, DHS Long Term Care-Regulatory Policy, at (512) 438-2363 for further assistance. *[Ref: State: Health and Safety Code(HSC) § 250.004(a); HSC § 253.003 and 253.007; 40 Texas Administrative Code (TAC) § 76.102(a)(1); and 40 TAC § 92.123]*

**Q: What do we do when surveyors cite unwritten rules? For example, a facility cannot barbecue outside.**

**A:** Surveyors should regulate in accordance with licensing standards. Violations must show the facility's noncompliance with the statute. The facility has the right to dispute the violations cited and may request an informal dispute resolution (IDR). *[Ref: State: 40 TAC § 92.82(h)]*

**Q: Can facilities be told of pending violations at exit instead of having violations appear in the mail weeks later?**

**A:** Facilities are informed of all deficiencies in a face-to-face exit conference. If additional deficiencies are cited related to the review of the findings, the surveyor must return to the facility and notify the agent of the deficient practice. This does not change the exit date or other timeframes related to the exit date. *[Ref: State: HSC § 247.0271(a)(b)(c); 40 TAC § 92.82(e)]*

**Q: Why do surveyors interview facility residents several times about sexual abuse during an investigation?**

**A:** All complaints, which meet regulatory guidelines, must be investigated. Surveyors must visit the facility and interview the resident. The current mandate directs surveyors to attempt to interview all perpetrators, witnesses, potential witnesses, and other sources deemed necessary to gather evidence related to the allegation(s). *[Ref: State: HSC § 247.043(a); 40 TAC § 92.105(c)]*

**Q: Can DHS consider giving warnings instead of writing violations?**

**A:** At this time, there are no leniency rulings for facilities that are out of compliance with the statutory licensing requirements. Facilities are required to know and follow the state licensure laws. Surveyors are required to survey the facility according to the statutes regulating the facility. To avoid a citation, the facility must be in compliance with all regulations. *[Ref: State: HSC § 247.0271(a); 40 TAC § 92.151]*

**Q: When violations refer to "P" numbers, should they be included in the licensing standards?**

**A:** "P" numbers are an internal numbering system used for the LTCR computer program to enable the surveyor to enter data from the survey. All violations are based on the regulations in Chapter 247, Health and Safety Code, and Title 40, Texas Administrative Code, Chapter 92.

**Q: Can facilities have a copy of the checklist used during licensing inspections?**

**A:** Yes. Individuals can access the checklists under "Forms" on the Long Term Care Policy website: <http://www.dhs.state.tx.us/business/LTC-Policy/forms/index.html>.

**Q: When is the statement of violations supposed to be sent to providers?**

**A:** Statement of violations should be generated within 10 working days of the exit conference. LTCR policy directs the surveyor to provide a copy of the appropriate checklist to the facility (if violations are cited) at the exit conference. The DHS-3724, Statement of Violations, is to be mailed to the facility within 10 working days of the exit. The facility has 10 calendar days to return their plan of correction to DHS. *[Ref: State: 40 TAC § 92.82 (d-g); Provider Letter #02-39]*

**Q: Does a "once-a-year survey" mean at anytime or is it generally considered to be in a certain window of time based on the last survey?**

**A:** The state will annually inspect a facility and may at any other point inspect a facility to ensure compliance with the regulations and the health and safety of the residents. Inspections are scheduled based on the licensing needs, the number of complaints, and the availability of survey staff to perform the inspection. There are no required timeframes for the annual licensing inspection. However, the license expires 12 months from the date of issue. The survey for a license renewal must include the direct observation of resident care. *[Ref: State: HSC § 247.023 (a), 247.027(a); 40 TAC § 92.15(a)&(g) and 92.81(a)]*

**Q: My facility was surveyed for licensure by one registered sanitarian. Are we within our rights to refuse to be surveyed by one person?**

**A:** No. The program manager makes assignments based on the needs of the unit, the size of the facility, and the surveyor's abilities. A survey may be conducted by one surveyor or a team of surveyors. All surveyors must attend training and pass the examination for assisted living facility regulations before performing an inspection by themselves. There are no requirements in the ALF rules that surveys be conducted by a specific discipline. *[Ref: State: HSC § 247.0272 (a) & (d); 40 TAC § 92.81 (b)]*

**Q: When a surveyor comes to a facility, the staff who need to be available have to rearrange meetings, in-service trainings, etc. If there is one day a week that does not work well, may a provider recommend DHS not come on that day for a routine survey?**

**A:** Surveys are required to be unannounced. There are required timeframes for certain visits to the facility that cannot be changed. DHS must meet these timeframes to be in compliance with internal policies and procedures. *[Ref: State: HSC § 247.027 (a); 40 TAC § 92.81 (a)(d)]*

**Q: Can complainants be identified during the survey process?**

**A:** No. DHS requires that surveyors protect and preserve confidentiality of complainant and client information. *[Ref: State: 40 TAC § 92.103(b)]*

**Q: Why do some surveys last 12 hours?**

**A:** Surveyors are not given specific times in which to complete on-site visits. Varying circumstances may prolong a survey, such as the issues identified, availability of residents and staff, and cooperation from the providers. *[Ref: State: 40 TAC 92.81]*

**Q: What determines if a complaint is immediate verses lower priority?**

**A:** DHS bases the priority of a complaint or incident on the immediacy of the threat to the health and safety of the residents alleged in the allegations.

**Q: Who addresses complaints against surveyors? Who is responsible for damage to equipment caused by a surveyor?**

**A:** Long Term Care Regulatory is directed by DHS to investigate all complaints against surveyors/employees according to mandates. Providers are encouraged to notify the surveyor's program manager with any concerns. If the resolution does not meet the provider's expectations, he or she should call the regional director, regional administrator, or the DHS hotline at 1-800-458-9858. Complaints may also be made by e-mail to the above-mentioned individuals or to Edie Zumwalt, Complaint and Intake Management, state office. Once a complaint has been investigated, it is reviewed by state office for appropriateness and the report forwarded to the Texas Health and Human Services Commission. For more details, please go to: [www.dhs.state.tx.us/business/LTC-Policy/](http://www.dhs.state.tx.us/business/LTC-Policy/). [Ref: State: Government Code § 531.056(a)(2); Provider letter #02-42]

**Q: Why does DHS take "frivolous" complaints from ex-employees?**

**A:** A complaint is defined as any allegation received by the DHS regarding abuse, neglect, or exploitation of a resident or a violation of state standards. This definition does not permit discrimination based on the source/type of an allegation. [Ref: State: HSC § 247.043(a); 40 TAC § 92.103(a)]

**Q: How can DHS address sending out non-clinical surveyors to address clinical issues?**

**A:** All surveyors are trained to investigate facilities related to their applicable standards. Specialty surveyors are available for consultation. All LTCR staff who survey assisted living facilities are required to pass an exam addressing assisted living standards as well as issues regarding "Aging in Place." [Ref: State: HSC § 247.0272 (a)(d)]

**Q: What is being done about surveyors confusing assisted living standards with nursing home and Medicare regulations?**

**A:** Ongoing training is provided to surveyors. A computer-based course on comparing nursing facility licensing standards to assisted living licensing standards is available for surveyors, as well. [Ref: State: HSC § 247.0272(a)]

**Q: Have surveyors had training on the new assisted living standards?**

**A:** All surveyors are mandated to pass an assisted living exam. A review of the assisted living licensing standards is necessary to complete the exam. *[Ref: State: HSC § 247.0272 (a)(d)]*

**Q: Will DHS train surveyors and provide information regarding CBA facilities and their licensure process?**

**A:** There would be no difference in the licensure inspection of an assisted living facility based on the payment source of the resident. Therefore, training for health surveyors is based on the licensing standards for assisted living facilities. *[Ref: State: HSC § 247.0272 (a)(d)]*

**Q: What is expected in a plan of correction (POC)?**

**A:** Facilities must submit an acceptable plan of correction to the DHS regional director within 10 calendar days after receiving notice that the final exit conference has been completed. An acceptable plan of correction must address the following areas:

- How corrective action will be accomplished for those residents affected by the violation(s)
- How the facility will identify other residents with the potential to be affected by the same violation(s)
- The measures that will be put into place or systemic changes made to ensure the violation(s) will not recur
- How the facility will monitor its corrective actions to ensure that the violation(s) are being corrected and will not recur
- Dates when corrective action will be completed

*[Ref: State: HSC § 247.0452 (a); 40 TAC § 92.82 (f)]*

# **Intermediate Care Facilities for the Mentally Retarded FAQs**

Communication and Training  
Employee Misconduct  
Funding and Reimbursement  
Licensing and Regulations  
Life Safety Code  
Medication, Medical Orders  
Miscellaneous  
Operations and Staffing  
Quality Assurance  
Surveys and the Survey Process

## ***Communication and Training***

### **Q: Does DHS provide training for clients, family members, and the public?**

A: Families are welcome to register and attend joint training sessions offered through the agency's website at: <http://www.dads.state.tx.us/business/ltr/Training/oasis.html>. Topics center around the top 10 deficient practices in Texas facilities. Long Term Care Education Services provides joint-training sessions for providers and surveyors. However, anyone who has an interest in resident care is welcome to attend. Advocacy groups, like the State Ombudsman program, also have information for the families of residents. The facility is responsible for educating family members related to specific resident care needs. [Ref: State: Human Resource Code (HRC) § 22.039(c); Federal: SSA § 1919(g)(1)(B)]

### **Q: Would DHS produce and deliver more joint training opportunities for surveyors and providers?**

A: LTCR is required to provide joint training on at least one of the top 10 deficient practices in Texas. Approximately 12 training sessions per month are offered throughout the state. Information can be found on the agency website at: <http://www.dads.state.tx.us/business/ltr/Training/oasis.html>. [Ref: State: HRC § 22.039(c)]

### **Q: Can DHS provide technical assistance?**

A: Current legislation mandated improved communications between LTCR and the providers in nursing facilities, assisted living facilities, and ICF-MRs. In response to this mandate, DHS created the position of facility/surveyor liaison. The nurse liaison position is a state-funded position for these programs, but can be used on a limited basis at the discretion of the regional director in other types of facilities/agencies regulated by DHS.

The nurse liaison position does not include fact-finding or discussing evidence during the survey process. The nurse liaison may be used to enhance communication between providers and survey teams, but may not be used to discuss evidence in potential deficiencies. The nurse liaison may provide facility with current information on best practice issues from the website. [Ref: State: SB 1839, 77th Legislative Session]

**Q: Will DHS develop a mechanism to encourage/facilitate regular, ongoing dialogue with providers, for example, hold regular Regional meetings?**

A: When possible, regional LTCR management staff periodically schedule meetings to provide a forum for information sharing, identification of issues, training and team building.

**Q: Will LTCR provide education opportunities for providers on the top ten deficiencies cited and how to improve care so that deficient practice can be eliminated?**

A: Joint training on the top 10 deficient practices is currently being offered across the state. Check the agency's website for training in your area:  
<http://www.dads.state.tx.us/business/ltr/Training/oasis.html>.

The LTCR website includes information about the top 10 deficiencies and complaints from fiscal year 2003:  
<http://www.dads.state.tx.us/business/ltr/reports/index.html>. [Ref: State: HRC § 22.039(c)]

**Q: Stakeholders have requested a new list of websites for providers to use when they are searching for information and training materials.**

A: Long Term Care Regulatory Education Services provides monthly training sessions around the state for providers and surveyors. Information can be found on the agency's website:  
<http://www.dads.state.tx.us/business/ltr/Training/oasis.html>.

The Long Term Care Regulatory Policy website has related links:  
<http://www.dads.state.tx.us/business/LTC-Policy/links.html> as does the DHS homepage: [http://www.dads.state.tx.us/news\\_info/Links/index.html](http://www.dads.state.tx.us/news_info/Links/index.html).

The development and distribution of a new list of informative websites will be researched, developed, and distributed by the LTCR regional automation coordinator. Facilities also may contact their respective provider organizations for more information and a list of training opportunities. [Ref: State: HRC § 22.039(c)]

**Q: Will surveyors once again be involved in teaching/training when surveying, like they used to be?**

A: According to the Centers for Medicare and Medicaid Services (CMS), surveyors are permitted to provide reference information regarding best practices to help facilities develop additional sources and networking tools for program enhancement. However, after informing the facility of the deficient practice, the surveyor can not prescribe how to correct it. CMS guidance is as follows: "Frequently, the explanation will embody the action needed to correct the problem. In situations where there may be several possible causes, it is not the surveyor's responsibility to delve into the facility's policies and procedures to determine the root cause of the deficiency." [Ref: Federal: SOM, Section 2727]

**Q: What is the best method of contacting DHS eligibility workers and persons at the Social Security Administration?**

A: The best method for contacting local DHS Medicaid eligibility staff is calling their office telephone number and leaving a detailed message if unable to talk to them directly. The Social Security Administration (1-800-772-1213) may have a preferred method other than by telephone.

## ***Employee Misconduct***

**Q: Do ICF-MR facilities have five working days or five calendar days to report incidents of abuse, neglect, or exploitation to DHS?**

A: Neither. The facility must report the incident to DHS upon learning of it. A written report is to be submitted no later than the fifth calendar day after the oral report is made for licensed ICF-MR facilities. Unlicensed ICF-MR facilities must submit a status report within five working days, and a copy of the Texas Department of Family and Protective Services final investigation report upon receipt. [Ref: State: HSC § 252.122(b)(c)&(d)(5)-(7); Provider Letter #99-34; Memorandum of Understanding (dated 3-25-96); Federal: 42 CFR § 483.420(d)(2)]

## ***Funding and Reimbursement***

**Q: Would DHS consider making children in the custody of Child Protective Services (CPS) eligible for Medicaid reimbursement if they are placed in an ICF-MR facility?**

**A:** DHS does not determine the eligibility status of long-term care facility residents. LTCR is only responsible for the inspection and licensing of ICF-MR facilities. This question may be related to the determination of the need for ICF-MR care, and the decisions regarding where children are placed. These should be addressed to the Texas Department of Mental Health Mental Retardation and the Texas Department of Family and Protective Services, respectively. For many children in institutions, the Medicaid eligibility is determined by the Social Security Administration in conjunction with eligibility determination for Supplemental Security Income. In general, Medicaid eligibility is determined based on the financial circumstances of the individual living in the facility and does not consider Medicaid eligibility solely on the custody arrangements regarding children. *[Ref: State: 40 TAC § 15.105]*

**Q: How do providers pay for medical exams, dental exams, and consultations, such as speech, hearing, eye, when the resident has not received his or her Medicaid card or eligibility is being held up for some reason?**

**A:** According to regulation, local DHS Medicaid eligibility staff can issue a Medicaid Eligibility Verification letter (Form 1027) to an eligible Texas Medicaid recipient who needs medical services in specific situations, for example, the client has been newly certified and has not received the Medicaid Identification (Form 3087) yet, or the monthly card has been lost or destroyed. This letter, like the regular monthly identification form, is issued only to individuals certified as eligible for Medicaid; this does not apply to individuals who have not been determined to be eligible for Medicaid. The rule states that the provider is responsible for ensuring the individual receives the care/services that they require. *[Ref: State: 40 TAC §15.615(b); Federal: CFR § 483.460 (a)(3)]*

## ***Licensing and Regulations***

### **Q: When are new federal regulations coming out?**

**A:** The Centers for Medicare and Medicaid Services (CMS) has not released any information regarding the new federal regulation release date. All proposed rule changes must be posted in the *Federal Register* to give the public an opportunity to comment on changes before they become final. Any interested person may access current and past editions of the *Federal Register* by going to the Government Printing Office website: <http://www.gpoaccess.gov/fr/index.html>. The *Federal Register* is published daily, Monday-Friday, except for federal holidays. The GPO website is updated on the same schedule.

### **Q: How many individuals must reside in a facility for an initial certification survey to be conducted? How long should they have resided in the facility before initial certification?**

**A:** The facility must be uninhabited for the initial Life Safety Code (LSC) survey. After the LSC inspection has approved the building for occupancy, the licensing officer will be notified that the facility has passed initial inspection. The LSC surveyors will inform the facility of their evacuation rating at the exit conference of the initial LSC inspection. Resident admission depends on the evacuation rating of the facility:

- **Impractical rating:** one resident must be admitted before the health inspection can take place
- **Slow rating:** two residents must be admitted before the health inspection can take place
- **Prompt rating:** all six residents must be admitted before the health inspection can take place

Because the initial health survey requires that active treatment be implemented for all of the residents of the facility, the facility must have had adequate time to perform a comprehensive functional assessment on each individual and establish and implement individual program plans for each resident before the initial health inspection. [Ref: State: 40 TAC § 90.60 (c)(1)&(2), 90.61(b)(2)(A) (iv), 90.61(b)(2)(B)(v), 90.61(b)(2)(C)(v)]

## ***Life Safety Code***

**Q: What are the fire drill requirements for a new admission? How should shifts be designated?**

**A:** If a facility does not have sprinklers, a newly admitted individual must have an Evacuation Difficulty Score (E-Score) calculated within 10 days of admission. This E-Score is based on four fire drills — two are to be conducted during the daytime and two at night (one after the first 30 minutes of sleep and one within the first three hours of sleep). *[Ref: State: HSC § 252.038 (b); 40 TAC § 90.74(b) and 90.61(b)(2)(B)-(C)]*

**Q: What are the fire drill criteria for facilities with sprinkler systems?**

**A:** Facilities must have one evacuation and/or fire drill per shift, per quarter, per year. Facilities must totally evacuate clients once a year on each shift. For facilities with an impractical rating, new employees must participate in a fire drill as soon as possible after beginning employment on their assigned shift. For facilities with a slow or prompt rating, new employees must participate in a fire drill within 10 days of employment on their assigned shift. *[Ref: State: HSC § 252.038 (b); 40 TAC § 90.74(b) and 90.61(b)(2)(A)-(C); Federal: 42 CFR § 483.470(i)(1)&(i)(2)(i)]*

**Q: If a resident is transferred from one facility to another within the same company, what are the staffing and fire drill requirements?**

**A:** The fire drill requirement is the same as for any newly admitted resident. Individuals leaving one vendor number to live in another vendor number are considered discharges, not transfers. *[Ref: State: HSC § 252.038 (b); 40 TAC § 90.74(b) and 90.61(b)]*

**Q: When evaluating fire drill requirements, would 7 p.m. be considered a daytime or nighttime drill if the drill occurred during the summer when, at 7 p.m., it is not dark?**

**A:** The shifts for the fire drills are determined by the facility. Daylight-saving time has no effect on the times of the shifts. *[Ref: State: HSC § 252.038 (b); 40 TAC § 90.74(b) and 90.61(b)]*

## ***Medication, Medical Orders***

### **Q: Could you please define a serious accidental injury?**

**A:** A physical injury is determined as serious by the examining physician. Examples may include: fracture, dislocation of any joint, internal injury, any contusion larger than 2.5 inches in diameter, concussion, or second or third degree burns. *[Ref: State: 40 TAC § 90.211(26)]*

### **Q: What constitutes a reportable injury?**

**A:** Regulations mandate that "Serious Accidental Injury" and "Serious Injuries of Unknown Origin" must be reported. The regulations define a serious physical injury as: "An injury determined to be serious by the examining physician. Examples of serious injury may include the following: fracture, dislocation of any joint, internal injury, any contusion larger than two and one half inch in diameter, concussion, or second or third degree burns." *[Ref: State: 40 TAC § 90.212(b)(1); Provider Letter #99-34; Federal: 42 CFR § 483.420(a)(5)]*

### **Q: Who can transcribe medication dosages to the Medication Administration Record?**

**A:** Facilities can designate any employee to copy doctor's orders to a Medication Administration Record; however, the qualified mental retardation professional is ultimately responsible for the care and services an individual receives in an ICF-MR. *[Ref: Federal: 42 CFR § 483.430(a); SOM, Appendix "J" W159]*

### **Q: What can be done if a physician refuses to provide information from a client's chart?**

**A:** Facilities are responsible for securing physician services that meet client needs. The physician must participate in establishing and updating the Individual Program Plan, if appropriate. Also, if physician services are not provided directly by the facility, there must be a written agreement with an outside service provider. This agreement must detail the functions, responsibilities, and terms agreed to by both parties. *[Federal: 42 CFR § 483.410(d) and §483.460(b); SOM, Appendix "J", W329, W330, and W117, W118, W119]*

## ***Miscellaneous***

### **Q: Are male facility residents over age 18 required to register with the Selective Service?**

**A:** This is not a DHS regulatory function. The facility should have policies to ensure that the qualified mental retardation professional identifies all the needs or requirements for clients in their care and address them appropriately.

## ***Operations and Staffing***

### **Q: How long does a facility have to prepare a discharge staffing?**

**A:** Regulations require that at the time of discharge, the facility must develop a final summary of the client's developmental, behavioral, social, health, and nutritional status. *[Ref: Federal: 42 CFR § 483.440(b)(5)(i)]*

### **Q: How can the facility locate dentists, psychiatrists, and physicians who will take Medicaid patients? Does the state offer any incentives to the doctors to participate in the Medicaid program?**

**A:** Information about Medicaid providers can be obtained through the Texas Health and Human Services Commission (HHSC) Medicaid Hotline at 1-800-252-8263. Enrollment of Medicaid providers is handled by the Medicaid contract administrator [previously NHIC; effective January 2004 the Texas Medicaid & Healthcare Partnership (TMHP)]. Questions regarding coverage, enrolled providers, the enrollment process, incentives, and payments should be directed to either HHSC or TMHP.

### **Q: How can we get Medicaid cards sooner for new clients so that medical and dental services are not delayed?**

**A:** Medical and dental services should not be delayed. Regulations require a complete extra- and intraoral dental exam not later than one month after admission unless it was completed within 12 months of admission. Also, regulation requires within 30 days after admission accurate assessments or reassessments are conducted to supplement preliminary evaluations done prior to admission. The facility is required to have a comprehensive functional assessment that includes physical development and health assessment.

The Forms 3087, Medicaid Identification, generally are printed on a monthly basis. However, for clients newly determined eligible for Medicaid, the initial

forms are printed on a more frequent schedule. For those clients who were already eligible for Medicaid prior to admission to the facility, the facility should request current month's form from the client or his caretaker; complete and transmit the Form 3618, Resident Transaction Notice; and notify the Social Security Administration of the admission of a Supplemental Security Income (SSI) recipient, if applicable. If the new resident is potentially eligible for SSI, the facility administrator should notify the Social Security Administration of the admission. *[Ref: Federal: 42 CFR § 483.440 (c)(3) and 483.460(f)(1)]*

**Q: How can facilities meet active treatment for older clients?**

**A:** Active treatment should be individualized to meet the needs of each client, regardless of age. The standards allow for age-appropriate activities. Active treatment is not only the improvement of skills for independence and self-determination, but it is also the prevention of deceleration or regression of skills. In addition, the facility is responsible for performing a comprehensive functional assessment of the individual's needs and must take into consideration the individual's age and the implications for active treatment at each stage of life. *[Ref: State: 40 Texas Administrative Code (TAC) § 90.42(c); Federal: 42 Code of Federal Regulations (CFR) § 483.440(a)(1)&(c)(3); State Operations Manual (SOM) § 2139(A), SOM, Appendix "J" W196 and W211]*

**Q: Can a nurse practitioner perform a resident's annual physical examination?**

**A:** The physician's use of a nurse practitioner is covered under the physician delegation rules. The performance of appropriate portions of the physical examination and the recording of physical findings are allowed under the standing physician delegation orders if the physician is supervising the services provided by the nurse practitioner. The licensing rules state that the "medical physician" will perform the annual physical examination of the client; therefore, the physician must do the annual physical examination for all licensed facilities. *[Ref: State: HSC § 252.152; 22 TAC § 193.4(2); 40 TAC § 90.42 (e)(11); Federal: 42 CFR § 483.460(b)&(c)]*

**Q: What is the requirement for a contract physician for the facility? Are consumers free to find their own physician and, if so, does the facility have to have a contract with that physician?**

**A:** Federal regulation requires that, if the services are not provided directly, the facility must have a written agreement with an outside program, resource or service to furnish the necessary service, including emergency and other health care. Individuals may use their own physician but there must be a written agreement between the facility and the physician to provide services. *[Ref: Federal: 42 CFR § 483.410(d)(1)]*

**Q: What should the facility do if the physician won't sign a contract?**

**A:** The facility must have a contractual agreement with any professional providing service to its clients. If a physician refuses to sign a contract, the facility must find another physician willing to meet the requirements for practicing medicine at the facility. *[Ref: Federal: CFR § 483.410(d)(1)]*

**Q: What type of infection control is required for water pic, dentures, and assistive devices?**

**A:** The facility must have written policies and procedures for infection control, which include implementation of universal precautions as recommended by the Centers for Disease Control (CDC). *[Ref: State: 40 TAC § 90.42 (e)(8); Federal: 42 CFR § 483.460(c)(5)(ii)]*

**Q: Can the facility prohibit sexual activity between two consenting adults? Can the guardian prohibit a resident from having sex in an ICF/MR facility?**

**A:** Adult ICF/MR clients who have not been adjudicated as lacking legal capacity retain the rights that all adults have. In addition, an ICF/MR provider is required to:

- ensure that all clients are informed of their rights and the rules of the facility
- allow and encourage clients to exercise their individual rights
- ensure that clients are not subject to physical, verbal, sexual, or psychological abuse or punishment
- provide each client with the opportunity for personal privacy
- ensure clients that opportunity to communicate, associate, and meet privately with individuals of their choice
- ensure clients the opportunity to participate in social, religious, and community group activities
- permit a husband and wife who both reside in the facility to share a room.

Depending on the terms of the guardianship order, a guardian might have the power to decide that a client may not engage in sexual activity. *[Ref: State: HSC § 252.006; Federal: 42 CFR § 483.420(a)]*

## **Quality Assurance**

### **Q: What is role and function of the quality monitors?**

**A:** Quality monitors provide technical assistance to facilities, using evidence-based best practices that have a basis in the clinical research literature. At the current time, only nursing facilities are receiving on-site visits. For more information, see the website at <http://mqa.dads.state.tx.us/QMWeb/>. [State: HSC § 255.003]

### **Q: What happened to the Quality Assurance Tax/Fee? How much is taken in and where is it going? What services are being provided?**

**A:** The current QA fee is 6 percent of a facility's gross revenue. The fee is determined by the Texas Health and Human Services Commission and can be found in the licensing rules at: [www.sos.state.tx.us](http://www.sos.state.tx.us). The fee is maintained in a fund outside the state treasury held by the Texas Treasury Safekeeping Trust Company. Quality assurance fees, combined with federal matching funds, will support or maintain an increase in Medicaid reimbursement for facilities. [Ref: State: HSC § 252.206(b) (1); 1 TAC § 352.3]

## **Surveys and the Survey Process**

### **Q: What would be the appropriate steps to take when previous complaints about a surveyor have not altered that surveyor's behavior?**

**A:** DHS investigates all complaints against surveyors according to state mandates. Providers are encouraged to notify the surveyor's program manager with concerns. If the provider does not feel there is an adequate response to their complaint, he or she should call the regional director, the regional administrator, or the DHS hotline at 1-800-458-9858. Complaints may also be made by e-mail to the above-mentioned individuals or to Edie Zumwalt, state office Customer Services. Once a complaint has been investigated, the report is forwarded to the Texas Health and Human Services Commission (HHSC). For more details, please go to: [www.dads.state.tx.us/business/LTC-Policy/](http://www.dads.state.tx.us/business/LTC-Policy/). [Ref: State: Government Code § 531.056(a)(2); Provider Letter #02-42; DHS Human Resource Services Handbook, "Standards of Ethics and Conduct", Section 7000]

**Q: Why does a plan of correction (PoC) have to be submitted when the facility has submitted a request for an Informal Dispute Resolution (IDR)?**

**A:** Facilities that disagree with the findings of deficient practice must submit acceptable plans of correction as the certification process continues. If the IDR process deletes the deficiency/violation, the facility will receive a revised statement of deficiencies/violations (CMS-2567/DHS-3724). If the IDR sustains the deficiency/violation, the plan of correction has already been submitted to meet the required federal and state timeframes and the facility would not be at risk of losing their provider agreement. *[Ref: State: HSC § 252.044 (c); 40 TAC 90.192(g); Federal: 42 CFR § 488.28(a); SOM, Section 2728(B)]*

**Q: Can you please clarify when an administrator designee can be the facility investigator?**

**A:** An administrator designee cannot be the facility investigator because the investigator cannot be the alleged perpetrator or involved in the allegation of abuse or neglect, the administrator or designee, owner, part owner, legal successor, or anyone with a controlling interest in the facility/corporation, ownership by proxy, person whose name goes on the license, and any family member by consanguinity or affinity per state regulations. *[Ref: State: 40 TAC § 90.212(c)(1)-(2)]*

**Q: What is the purpose of the federal look-behind surveys?**

**A:** A federal monitoring survey (look-behind) is a federal survey conducted within two months of the state agency survey by a group of federal surveyors to assess the state agency's performance in the interpretation, application, and enforcement of federal requirements. The Center for Medicare and Medicaid Services (CMS) conducts federal monitoring surveys within 30 days of the state survey, when possible. The purpose of the survey is to encourage consistency by the state agency in the performance of the survey process. *[Ref: Federal: SOM, Section 4157 (D)(1)]*

**Q: What is OSPATS? What does the acronym mean and what does it mean for facilities?**

**A:** OSPATS — Onsite Surveyor Performance Assessment and Training Survey — is an on-site evaluation survey whereby LTCR Quality Management surveyor(s) attend the LTCR regional survey to observe and assess the survey team's performance according to the SOM survey protocols. Data is used for training and/or management purposes. The OSPATS does not impact the facility's survey results; it is used for continuous quality improvement. The data is used internally by DHS for training survey teams

and ensuring the consistency of the survey process statewide. [Ref: State: HSC § 252.043; Federal: SOM, Section 7800, 8000–8005]

**Q: Is there an extension process for facility investigation of incidents if the facility can't complete the investigation within the five-day timeframe?**

**A:** State licensure requires the written report to be sent to DHS no later than the fifth calendar day after the oral report. The federal regulation requires that the results of all investigations be reported to the administrator or other officials in accordance with state law within five working days of the incident. [Ref: State: Health and Safety Code (HSC) § 252.122(c); 40 Texas Administrative Code (TAC) § 90.212(d)(7); Federal: 42 Code of Federal Regulations (CFR) § 483.420(d)(4)]

**Q: What determines if a complaint is immediate versus a lower priority?**

**A:** The Complaint and Intake Management Section determines the priority of all incoming complaints and incidents based on federal guidance. The alleged immediacy of the threat to the health and safety of facility residents is the guiding factor of if and when an on-site investigation will be initiated. [Ref: State: HSC § 252.036 (4); 40 TAC § 90.191 (a); Federal: CFR § 488.332(a)(1)&(b)(3); Survey and Certification letter #04-09]

**Q: Providers do not want a clean CMS 2567 as a result of an IDR unless they request it.**

**A:** According to mandates, facilities must be provided a corrected CMS-2567/DHS-3724 when findings have been changed during the IDR process. The Texas Health and Human Services Commission has determined that a clean copy of actual citations/violations will be prepared for the facility to post for the public, clients, and families at the facility if any changes are made. [Ref: State: Government Code §531.058; 1 TAC 393.1; 40 TAC § 90.326 (4); Federal: CFR § 488.331(c)]

**Q: What can a provider do if the provider disagrees with surveyor's observations that are listed in the CMS 2567?**

**A:** Any discrepancies may be refuted through the IDR process as outlined in the regulations. The provider may also supply additional information to the surveyor during the exit conference. [Ref: State: Government Code § 531.058(a)(2); Human Resource Code § 32.021 (d)(1); 1 TAC § 393.1; 40 TAC § 90.192(d); Federal: SSA § 1910(b)(2); 42 CFR § 488.331(a)(1)]

**Q: When investigations occur in a day program about an intermediate care facility or Home and Community Support (HCS) program client, why are the results or outcome of the investigation not shared with the provider?**

**A:** When DHS performs an investigation, the investigation is centered on the care of the client from the regulatory standpoint of the facility/agency. All findings of LTCR investigations are shared with the provider at the exit conference. DHS does not conduct investigations concerning individuals in the HCS program. *[Ref: State: HSC § 252.044 (b); 40 TAC § 90.192 (d)]*

**Q: Are surveys still outcome oriented? Issues that developed months prior to the survey are cited at the time of the survey.**

**A:** The annual survey process covers multiple areas of the facility's operation throughout the year. The surveyor may cite past non-compliance at the facility depending on their findings. *[Ref: State: HSC § 252.040 (a)]*

**Q: What is the timeframe when the surveys do not occur within the year or passed the expiration of the license?**

**A:** A Medicaid agency may extend a provider agreement for a single period of two months beyond the expiration date of the current license to avoid hardship on the provider or allow additional time for the provider to come in to compliance. *[Ref: Federal: 42 CFR § 442.16]*

# Nursing Facilities FAQs

- Communication and Training
- Employee Misconduct
- Funding and Reimbursement
- Licensing and Regulations
- Life Safety Code
- Medication, Medical Orders
- Miscellaneous
- Operations and Staffing
- Quality Assurance
- Surveyor Training
- Surveys and the Survey Process

## ***Communication and Training***

### **Q: How does DHS communicate regulatory changes to providers?**

**A:** Regulatory changes are published in the *Federal Register* and the *Texas Register* before they become effective. Any member of the public may comment on the proposed changes before they become final. Also, DHS notifies providers of regulatory changes through provider letters posted on the Long Term Care Policy website, <http://www.dads.state.tx.us/business/LTC-Policy/>, and through revisions to the Nursing Facility Requirements for Licensure and Medicaid Certification. Bulletins related to various issues are also posted to the LTC Policy website. Provider letters are mailed to licensed-only nursing facilities because they are not required to have Internet access to transmit documents. [Ref: State: Government Code § 2001.004, 2001.005, and 2002.002; Federal: 5 United States Code (USC) § 552(a)(1); 42 CFR § 401.106(a)]

### **Q: Does DHS provide training for clients, family members, and the public? Families would benefit from training on topics such as restraint-free environments.**

**A:** Families are welcome to register and attend joint training sessions offered through our Internet site. Topics covered are centered around the top 10 deficient practices in Texas facilities. LTC Educational Services provides joint training sessions for the provider industry and surveyors. However, anyone who has a vested interest in resident care is welcome to attend. Advocacy groups, like the State Ombudsman Program, also have information for the families and residents. Facilities are responsible for educating family members about specific resident care needs and may use their local ombudsman to assist with providing information to families. [Ref: State: HRC § 22.039(c); Federal: SSA § 1919 (g)(1)(B); 42 CFR 488.303(c), 488.334]

### **Q: Will DHS develop a mechanism to encourage/facilitate regular, ongoing dialogue with providers, for example, hold regular regional meetings?**

**A:** When possible, regional LTCR management will schedule meetings to provide a forum for information sharing, identification of issues, training, and team building.

### **Q: Will DHS offer more training for nursing facility administrators with continuing education units (CEUs)?**

**A:** Some of the LTCR joint training classes offer CEUs for nursing facility administrators. Check the training webpage for course information regarding administrator continuing education units.

<http://www.dads.state.tx.us/business/ltr/Training/oasis.html>. [Ref: State: HRC § 22.039(c)]

**Q: Will LTCR provide education opportunities for providers on the top 10 deficiencies cited and how to improve care so that deficient practice can be eliminated?**

**A:** Joint training on the top 10 deficient practices is currently being offered across the state. Check the following webpage for training opportunities in your area: <http://www.dads.state.tx.us/business/ltr/Training/oasis.html>. [Ref: State: HRC § 22.039(c); Federal: SSA § 1919 (g)(1)(B); 42 CFR § 488.303(c)]

**Q: Will surveyors ever be allowed to provide training/consulting for concerns at the facility?**

**A:** Surveyors are guided by the Centers for Medicare and Medicaid Services (CMS) to "provide reference information regarding best practices to assist facilities in developing additional sources and networking tools for program enhancement. State Health Facility Surveyors, however, should not act as consultants to nursing homes." [Ref: Federal: S&C Letter #03-08, SOM, Section 2727]

**Q: Are there any plans for training on documentation and care plans for nurses?**

**A:** Mandated joint training focuses on the top 10 deficient practices in Texas. When a specific deficient practice is addressed in joint training, such as infection control or dehydration and weight loss, care plan and documentation issues are addressed in the training. (Care plan requirements are included in the CMS Resident Assessment Instrument/Minimum Data Set (RAI/MDS) instructions.) [Ref: State: HRC § 22.039(c); Federal: SSA § 1919 (g)(1)(B); 42 CFR § 488.303(c), 488.334]

**Q: Would DHS produce and deliver more joint training opportunities for surveyors and providers?**

**A:** LTCR is required by current legislation to provide joint training semiannually on the top 10 deficient practices in Texas. Approximately 12 training sessions per month are offered throughout the state. See the following web page for training opportunities:  
<http://www.dads.state.tx.us/business/ltr/Training/oasis.html>. [Ref: State: HRC § 22.039(c); Federal: SSA § 1919 (g)(1)(B); 42 CFR § 488.303(c), 488.334]

## ***Employee Misconduct***

### **Q: Can you improve the automated menu on the hotline for facility self-reported incidents?**

**A:** DHS has designed the hotline to be user friendly while attempting to gather all required information. Incidents are listed on the opening menu. The incident menu has questions that may not apply to all types of providers, but the caller may skip those questions by pressing the pound ("#") key. Copies of the hotline script are available by calling the hotline at 1-800-458-9858, Monday through Friday, 8 a.m. to 5 p.m. In addition, Education Services offers training to providers on incident reporting and overview. Course information is provided at: <http://www.dads.state.tx.us/business/ltr/Training/oasis.html>.

### **Q: Why do self-reported incident investigations sometimes last four or five days?**

**A:** Surveyors are required to complete a thorough investigation of allegations of abuse, neglect, or exploitation regardless of how long it takes. There are requirements for certain tasks to be performed and specific persons to be contacted. [Ref: State: HSC § 242.126 (a)(e)(1-3); 40 TAC § 19.2008(d); Federal: SSA § 1919 (g)(1)(C); 1919(g)(4); 42 Code of Federal Regulations (CFR) § 488.335(h)]

### **Q: Are intake personnel trained to focus on the correct issue and remain objective?**

**A:** In accordance with the *Guiding Principles for Complaint Investigations* March 16, 1999 letter from Sally K. Richardson, director of Medicaid and State Operations, DHS intake personnel are professionally qualified program specialists who use their knowledge of federal and state licensing and certification requirements to evaluate the information available at intake concerning the nature of the alleged problem/noncompliance. Intake employees evaluate the extent of any alleged threat or potential threat to the health, safety, and well-being of consumers of long-term care services. These program specialists undergo on-the-job training, as well as extensive classroom training in areas such as program orientation, survey process, investigation skills, information collection and analysis, guiding customer conversations, and customer relations/services. The majority of these program specialists are Surveyor Minimum Qualification Test qualified, and include nurses, dietitians, social workers, and qualified mental retardation professionals. [Ref: State: HSC § 242.123; 40 TAC § 19.2006(a); Federal: 42 CFR § 488.332(a)(1); State Operations Manual (SOM), Section 3281]

**Q: Why is it so easy for a certified nurse aide (CNA) to get a determination of resident abuse overturned? They seem to be able to stay off the Employee Misconduct Registry (EMR) and keep their certification?**

**A:** Before a nurse aide's certificate of competency can be revoked and their name listed as unemployable on the Nurse Aide Registry (NAR), the nurse aide is entitled to an informal reconsideration in the region and a subsequent formal hearing before an administrative law judge, if timely requested. Only after all due process considerations are provided and findings are upheld, can a nurse aide have his or her certificate revoked. More than 90 percent of nurse aide referrals resolved in fiscal year 2002 resulted in revocation of nurse aide certification and more than 95 percent of unlicensed personnel referrals resulted in the individual listed as unemployable on the Employee Misconduct Registry. The EMR lists findings for employees who are not CNAs. *[Ref: State: HSC § 242.130; 40 TAC § 94.10(c-e); Federal: SSA § 1919 (g)(1)(C); 42 CFR § 488.335(c-f)]*

**Q: When a facility calls in a reportable incident, how do they know if an on-site review or a desk/professional review will be done? How will the facility know the outcome of a professional review?**

**A:** DHS does not inform the facility whether a self-reported incident will be investigated on-site or reviewed administratively. DHS also does not inform the facility of the outcome of a professional review. Providing such information could be tantamount to releasing advance information of an unannounced inspection, which is a third-degree felony. *[Ref: State: HSC § 242.126(a); 40 TAC § 19.2002(a); Federal: SSA § 1919 (g)(1)(C); 42 CFR § 488.332(b)(3)]*

## ***Funding and Reimbursement***

**Q: Is DHS aware that direct payments to hospice providers for nursing facility residents receiving hospice services is causing problems for nursing facilities?**

**A:** DHS is aware that under the current federal requirements the hospice provider submits the claim for Medicaid reimbursement. DHS has been informed that sometimes the hospice does not pay the nursing facility its portion as quickly as the nursing facility would prefer. *[Ref: State: 40 TAC § 30.60(c); Federal: SSA § 1102(d) (2)(A), 1905(o)(1)(A); 42 CFR § 418.302(a)(b)(4) and 1003.102; SOM § 2082]*

**Q: What is DHS doing to ensure nursing facilities get paid for services in a timely manner?**

**A:** Payments are being processed well within statutory requirements (within 30 days of the date the claim was successfully submitted through the Texas Medicaid and Healthcare Partnership [TMHP]). Claim processing may be delayed if the claim is defective in some manner. A defective claim must be corrected before payment can be made. Pursuant to statute, the claim shall be paid no later than 30 days after the date the claim is corrected. However, payment for a claim may be held if DHS, the State Comptroller, or another state agency has placed a hold on payments to the claimant.

DHS' support of LTC providers' claim submission efforts includes providing assistance in the following areas:

- **Online forms** — While DHS can send paper versions on request, required forms are available on the agency's website at: <http://www.dads.state.tx.us/handbooks/mpm-ltcf/>.
- **Submitting claims correctly** — Claims submission procedures, help, training, etc., are available by accessing the LTC page on the TMHP website: <http://www.tmhp.com>.
- **Researching claim problems** — Since May 2002, the formerly monthly Suspense and Error Report has been sent to nursing facility providers twice a month to help providers take corrective action more quickly
- **Exchanging information regarding current operations and upcoming changes** — This includes regular Information Letters and face-to-face discussions during the Claims Management System Advisory Council (CMSAC) meetings that DHS and TMHP sponsor with association representatives.

Resources available to help nursing facilities and other LTC providers handle claim submission problems are listed under DHS LTC near the back of the *Long Term Care Bulletin* mailed quarterly to all Texas LTC providers and published on the LTC page of the TMHP website at <http://www.tmhp.com>. These resources provide contact information for the DHS Provider Claims Services help desk which supports questions about nursing facilities, hospice, swing beds, and rehabilitation specialized services. Providers can call the hotline at 512-490-4666 or use the website at: <http://ausmis31.dads.state.tx.us/cmsmail>. [Ref: State: Government Code § 2251.021; HSC § 242.225; Federal: 42 CFR § 447.45(d)]

## ***Licensing and Regulations***

### **Q: Can the licensure requirements for administrators be re-evaluated?**

**A:** DHS welcomes input regarding rule changes. Individuals may contact their legislative representative to recommend changes in laws. Also, you may direct your comments and suggestions to Terri Phillips, Nursing Facility Administrator licensing manager, 512-231-5800. Proposed rule changes are published for 30 days in the *Texas Register* for public comment. Individuals have the opportunity to comment on the proposed changes. [Ref: State: Health and Safety Code 242.302(b)(5), 242.306, and 242.311; 40 Texas Administrative Code (TAC) 18.4, 18.5, 18.9, and 18.10; 1 TAC § 351(a); Federal: Social Security Act (SSA) § 1902(a)(29); 1908(c)(4)]

### **Q: How can I obtain a copy of the rules and revisions?**

**A:** The rules can be obtained via the DHS website or by calling the DHS hotline at 1-800-458-9858.

### **Q: Can DHS provide interpretive guidelines?**

**A:** The Centers for Medicare and Medicaid Services (CMS) State Operations Manual, Appendix PP, Guidance to Surveyors, can be obtained from CMS via the website: <http://cms.hhs.gov/manuals/pub07pdf/pub07pdf.asp> or by calling 214-767-6427.

### **Q: Why are automatic referrals of administrators made to their licensing board when substandard quality of care is found in a nursing facility?**

**A:** Federal law requires that nursing facility administrators automatically be referred to their licensing board when substandard quality of care is determined. The nursing facility administrator will be notified of the opportunity to a hearing before a sanction is imposed. [Ref: State: HSC § 242.015 (b)(2); 40 TAC § 18.13(e); Federal: SSA §1908 (c)(4); 42 CFR § 488.325(h)(2)]

### **Q: Does LTCR recognize Geriatric Certification?**

**A:** This certification is not a requirement for staff in nursing facilities and, therefore, is not reviewed during the survey process.

## ***Life Safety Code***

### **Q: Who can providers call when they have Life Safety Code questions?**

**A:** Providers should attempt to call the program manager in their region to get information. If unable to contact the regional program manager, they can call the state office, which has access to LSC personnel throughout the state. Providers may call Fred Worley at 512-438-2311 for all Life Safety Code questions.

## ***Medication, Medical Orders***

### **Q: What can facilities do when they cannot contact the responsible party regarding the use of psychoactive medications?**

**A:** Consent is required for psychoactive medications prescribed after July 1, 2002. The physician or designee prescribing the medication must obtain the consent. If the provider is unable to contact the responsible party in an emergency, the medication may be given and the situation documented. In a non-emergency, surveyors may cite the facility for giving the medication without consent.

Efforts to contact the responsible party must be documented. The need to give the medication without consent must be demonstrated by the facility.  
*[Ref: State: HSC § 242.505(b); 40 TAC § 19.1207(f); Provider Letter #02-22; Federal : SSA § 1919 (c)(1)(A)(ii), 1919(c)(1)(D); 42 CFR § 483.25(l)(2)*

## **Miscellaneous**

### **Q: What is the purpose of the Ombudsman Program?**

**A:** The Texas Ombudsman Program advocates for quality of life and care for residents in nursing homes and assisted living facilities. Please contact the Texas Department on Aging at 1-800-252-9240 or <http://www.tdoa.state.tx.us> for more information on this program. *[Ref: State: HRC, Chapter 101; Federal: SSA § 712 and 1919(g)(5)(B)]*

### **Q: Why does the LTCR spokesperson comment to the media about deficiencies that occurred and were cleared?**

**A:** The LTCR spokesperson usually responds to questions about a specific facility or a facility's compliance history. A deficiency/violation cited on a CMS-2567 or DHS-3724 is part of the record and is public information. The deficiency/violation is not erased from the facility history just because it is cleared on the follow-up visit. *[Ref: State: HSC § 242.042 (a)(3); 40 TAC § 19.2011(e); Federal: SSA § 1919 (g)(5)(A); 42 CFR § 431.115(a)(1), 488.325(a)]*

### **Q: Will you send out a regional organizational chart with names? Is the hiring freeze still in effect? Will we see consistently the same survey team members?**

**A:** DHS has a website that includes information about each DHS region: [www.dhs.state.tx.us](http://www.dhs.state.tx.us). Click on Regional Information, then select your region. There are contact numbers and job listings for the region. Surveyors are assigned based on the type survey to be performed and the surveyor's specialty/expertise.

### **Q: We have heard that DHS has a number of open positions. Will these openings effect our survey calendar?**

**A:** LTCR is mandated to perform each facility's annual survey within 15 months from the last survey exit date. The average time for annual certification surveys is not to exceed 12 months. DHS will conduct at least two inspections during each licensing period of each Texas licensed nursing facility. Licensing inspections can be performed at the same time as the certification survey or an abbreviated (complaint investigation) survey. *[Ref: State: HSC § 242.044; 40 TAC § 19.2002(a); Federal: SSA § 1919 (g)(2)(A)(iii)(I); 42 CFR § 488.308(a)(b)]*

**Q: DHS employee turnover causes surveyor staff to be unfamiliar with regulations.**

**A:** Surveying is a difficult job and turnover is higher than DHS would like. However, all qualified surveyors are licensed professionals and have to pass the Centers for Medicaid and Medicare Services Surveyor Minimum Qualification Test before being allowed to survey alone. [Ref: State: 40 TAC § 19.2002(a); Federal: SSA § 1919 (g)(2)(E)(iii); 42 CFR § 488.314(c)]

## ***Operations and Staffing***

**Q: How can facilities maintain accurate and current criminal background checks for all facility employees, especially for those who have been employed for many years?**

**A:** Providers who are authorized by statute to obtain information from the Texas Department of Public Safety (DPS) Non-Criminal Justice Crime Records Service can subscribe to either the DPS public database website or the DPS facility/agency secure database website. An online search through either of these websites provides an "instant" criminal history report.

Detailed information about the requirements for criminal history checks, subscribing to a DPS user account, and inquiries to the Employee Misconduct Registry and Nurse Aide Registry can be found in LTCR Policy Provider Letters at: [www.dads.state.tx.us/business/ltr-policy](http://www.dads.state.tx.us/business/ltr-policy). [Ref: State: HSC § 250.002, 250.003, 250.004, 250.006, 242.0371(a)(2); Provider Letters #01-22, #01-29 and #01-43; Federal: 42 CFR § 483.13 (c)(1)(ii)(iii)]

**Q: How can we avoid being penalized when we cannot find a registered nurse to work for us?**

**A:** The conditions that a nursing facility must meet in order to request a waiver of certain RN staffing requirements are outlined in the federal and state long-term care requirements. If a nursing facility believes it meets the conditions for a waiver, they can request a formal waiver to DHS. The agency reviews requests for nurse waivers and has final authority for granting waivers in nursing facilities. The Centers for Medicare and Medicaid Services has final authority for granting waivers in skilled nursing facilities. [Ref: State: 40 TAC § 19.1001 (3)(4); Federal: SSA § 1919(b)(4) (C); 42 CFR § 483.30(c)(d)]

**Q: What is timely for "STAT"? Time to arrive and make draw? Time to complete test and report? Do you know any labs that comply?**

**A:** Facilities must provide or obtain clinical laboratory services to meet resident needs. Facilities are responsible for the quality and timeliness of services.  
*[Ref: State: 40 TAC § 19.1908(a)]*

**Q: Does a facility's dietary supervisor have to complete the national approval exam? Also, while waiting to hire a dietary supervisor, can the activity director (who has already completed the approval exam) handle both duties?**

**A:** A facility's dietary supervisor, if not a qualified dietician, must meet the requirements for supervising all aspects of food service to meet residents' nutritional needs. An activity director must meet residents' activity needs. Facilities need to ensure that one person performing both functions could meet these needs based on the requirements. *[Ref: State: HSC § 242.403 (a)(9); 40 TAC § 19.702 and 19.1102 (3) &(4); Federal: SSA § 1919(b) (4)(A)(iv); 42 CFR § 483.35(a)(1)]*

**Q: What is the procedure for obtaining spend-down beds?**

**A:** In order to obtain a spend-down Medicaid bed, a facility must write a letter to DHS that identifies the resident and contains the information specified in requirements . The letter should be addressed to:

Texas Department of Human Services  
Mail Code E-342  
Contract Unit, LTCR  
P. O. Box 149030  
Austin, Texas 78714-9030  
Attention: Dot Cole

After the temporary spend-down Medicaid bed is approved, the facility must comply with all requirements for spend-down beds.

For additional information about spend-down Medicaid beds, facilities may call Dot Cole at 512-438-2530, Julie Mayton at 512-438-2335, or DeeAnn Toro at 512-438-2477. *[Ref: State: 40 TAC § 19.2322 (f)(6)]*

**Q: Why is it that efficiently run operations are penalized by the staffing enhancement program?**

**A:** The Direct Care Staff Enhancement and Accountability Program is not administered by DHS. The enhancement program is administered through the Texas Health and Human Services Commission Rate Analysis Unit. Information about the staff enhancement program can be found on the Rate Analysis website at: [www.hhsc.state.tx.us/Medicaid/programs/rad/index.html](http://www.hhsc.state.tx.us/Medicaid/programs/rad/index.html) or by calling the Rate Analysis unit at 512-685-3134. [Ref: State: Human Resources Code (HRC) § 32.028 (g)(1)(2); 1 TAC 355.308 (c)-(d); Federal: 42 CFR § 488.303 (b)]

**Q: What is the requirement for posting staff on duty?**

**A:** Effective Jan. 1, 2003, facilities are required to post daily, for each shift, the number of licensed and unlicensed nursing staff directly responsible for resident care. This information is to be displayed in a clearly visible place. A Centers for Medicare and Medicaid Services recommended format for displaying the information was offered to facilities. Beginning with surveys performed on and after Jan. 1, 2003, DHS will verify that nursing staff information is posted.

References can be located on the DHS (DADS) website at: [www.dads.state.tx.us/business/ltc-policy](http://www.dads.state.tx.us/business/ltc-policy). [Ref: State: 40 TAC § 19.1921(e)(12); Provider Letter #02-41; Federal: SSA § 1919(b)(8)(A); 42 USC 1395l-3(b), Section 1396r-(b)(8); Benefits Improvement and Protection Act (BIPA), Section 941]

**Q: Can nursing facility residents have cigarettes?**

**A:** Facilities must adopt and enforce a smoking policy that complies with federal, state, and National Fire Protection Association (NFPA) requirements. Effective Sept. 11, 2003, LTCR began surveying facilities for compliance with the 2000 Life Safety Code.

Nursing facility smoking policies must provide for the residents' safety. Facilities may elect to allow "safe smokers" to retain cigarettes or other smoking paraphernalia in their possession. Facilities will be held accountable for on-going resident evaluation and maintaining a safe environment. [Ref: State: 40 TAC § 19.326(k); Federal: 42 CFR § 483.25(h)(2); LSC, NFPA Section 18.7.4]

## ***Quality Assurance***

### **Q: The Quality Reporting System (QRS) is not adequate.**

**A:** The DHS Medical Quality Assurance (MQA) program is open to suggestions concerning Quality Reporting System report content. The current content reflects the data streams that are available to date.  
<http://mqa.dhs.state.tx.us/QMWeb/>

### **Q: What is the liaison nurse's role with DHS?**

**A:** Legislation mandated improved communications between LTCR and providers in nursing facilities, assisted living facilities, and intermediate care facilities for mental retardation/related conditions. In response to this mandate, DHS created the position of facility/surveyor liaison. The nurse liaison position is a state-funded position for these programs only, but can be used on a limited basis, at the discretion of the regional director, in other types of facilities.

The nurse liaison enhances communication between facilities and surveyors. The nurse liaison position does not include fact-finding or discussion of evidence during the survey process. The nurse liaison may be used to enhance communication between the provider and the survey team, but may not be used to discuss evidence in potential deficiencies. *[Ref: State: Senate Bill 1839, 77th Legislative Session]*

### **Q: Are reports of the nurse liaisons discoverable?**

**A:** All LTCR documents may be disclosed, unless they are expressly confidential under other laws. Confidential redaction is done pursuant to the statute, program policy, and Open Records Opinions from the Texas Attorney General's Office.

Requests for reports should be in writing and addressed to DHS Office of General Counsel, P.O. Box 149030, Austin, TX 78714 *[Ref: State: Government Code § 552]*

### **Q: What is the role and function of the quality monitor?**

**A:** Quality monitors provide technical assistance to facilities using evidence-based best practices that have a basis in the clinical research literature. At the current time, only nursing facilities are receiving on-site visits. For more information, see the website at: <http://mqa.dhs.state.tx.us/QMWeb/>. *[Ref: State: HSC § 255.003]*

**Q: Are reports by quality monitors discoverable?**

**A:** All LTCR documents may be disclosed, unless they are expressly confidential under other law. Confidential redaction pursuant to the statute or program policy and Open Records Opinions from the Texas Attorney General's Office. Requests for reports should be in writing and addressed to DHS Office of General Counsel, P.O. Box 149030, Austin, TX 78714. *[Ref: State: Government Code § 552; 40 TAC § 19.2011(e)]*

**Q: Why are facilities inundated by quality monitors and surveyors within days of each other?**

**A:** In order for the program to meet the requirements of current legislation, there may be occasions when this occurs. This is relatively rare and definitely not intentional. *[Ref: State: HSC § 255.003]*

**Q: How often does the quality monitoring team visit a facility?**

**A:** The goal of the program is to visit each facility several times a year. Facilities that appear to have greater need for technical assistance will receive visits more often. *[Ref: State: HSC § 255.003(b)]*

**Q: What can facilities expect from the Quality Monitoring program on follow-up visits, i.e., restraints or incontinence?**

**A:** Facilities can expect follow-up visits to focus on those topics currently in the scope of the monitoring program (DHS quality improvement initiatives) with which the facility continues to appear to need assistance. For example, if restraints were an issue during an initial visit and the facility eliminated all avoidable restraints prior to the follow-up visit, the follow-up would address topics such as toileting, pain management, fall risk assessment, immunization — issues other than restraints. *[Ref: State: HSC § 255.003(e) & (f)]*

**Q: Will there be an opportunity for surveyors to suggest a facility contact their quality monitor after finding a problem and/or issuing a citation during a survey or investigation?**

**A:** No. The statutory requirement states the monitoring visits must be unannounced and aperiodic. Surveyors can suggest to a facility that it contact the LTCR liaison for help in understanding the regulations or to request a Rapid Response Team visit for technical assistance. Such a visit may not occur within 60 days of the date of exit following an annual or follow-up inspection. *[Ref: State: HSC § 255.004]*

**Q: Why are some nursing homes not listed on the computer for viewing of compliance?**

**A:** All certified nursing homes are listed in the Quality Reporting System. Facilities that are licensed but not certified are listed separately in QRS, but survey data for licensed-only facilities is not yet available on QRS.  
<http://mqa.dads.state.tx.us/QMWeb/>

## ***Surveyor Training***

**Q: Do all surveyors undergo the same training?**

**A:** All surveyors are required to attend Centers for Medicare and Medicaid Services (CMS) training and pass the Surveyor Minimum Qualification Test (SMQT). DHS surveyors are required to complete a block of standardized courses designed and delivered by a centralized training section. Surveyors are also encouraged to attend the joint training sessions provided by LTC Education Services. *[Ref: State: HRC § 22.089(b); 40 TAC § 19.2002 (b); Federal: SSA § 1919 (g)(2)(E)(iii); 42 CFR § 488.314(c)]*

**Q: Does DHS teach communication skills to surveyors?**

**A:** Surveyors are required to attend a communications course designed by LTC Educational Services. The intent of this course is to improve communications between surveyors and providers. With the intent of current legislation, DHS created the nurse liaison positions in each region to improve communication between facilities and surveyors. *[Ref: State: HRC § 22.039(b)]*

**Q: Are the surveyors going to be educated on the new Health Insurance Portability and Accountability Act (HIPAA) guidelines and will this be included in the survey process?**

**A:** Surveyors are required to complete a computer-based training on HIPAA guidelines. They also have received an internal policy letter on how HIPAA directly affects LTCR program procedures. HIPAA guidelines do not directly impact the survey process. *[Ref: State: 40 TAC § 19.2002 (h)(4); Federal: 45 CFR § 160.103, 164.512(a)(1); S&C Letter #03-15]*

**Q: Surveyors seem to lack knowledge of the survey cycle and what constitutes an outstanding tag for the survey cycle. Are surveyors trained in this area?**

**A:** To become qualified as surveyors, state and federal training is required along with passing the CMS SMQT. This training encompasses the survey process including the follow-up time requirements for clearing "outstanding" tags. [Ref: State: 40 TAC § 19.2002(b); Federal: SSA § 1919 (g)(2)(E)(iii); 42 CFR § 488.314(c)]

**Q: Why are surveyors not trained in all areas of the regulations or assigned only to those areas they are familiar with?**

**A:** Surveyors receive training in the area of regulations in which they will be surveying. Therefore, the state and federal requirements for training takes at least three months to complete. CMS also requires each surveyor to pass the SMQT prior to being able to perform tasks for the survey process without supervision. [Ref: State: 40 TAC § 19.2002(b); Federal: SSA § 1919 (g)(2)(E)(iii); 42 CFR § 488.314(c)]

**Q: Are surveyors trained not to disrupt daily routines while the survey is being conducted?**

**A:** Surveyors are asked to keep any disruptions of daily routines at a minimum. However, in order to follow the survey protocols, minimal disruption may be necessary. [Ref: Federal: SSA § 1919 (g)(2)(E)(iii); 42 CFR § 488.314(c)]

## ***Surveys and the Survey Process***

**Q: What procedures do providers follow when making a complaint regarding a surveyor?**

**A:** LTCR investigates all complaints against surveyors. Providers are encouraged to notify the surveyor's program manager immediately with any concerns. Providers may also call the regional director, the regional administrator and/or the DHS hotline at 1-800-458-9858. Complaints may also be made by e-mail to the above-mentioned individuals or to Edie Zumwalt, Complaint and Intake Management, state office at [edie.zumwalt@dhs.state.tx.us](mailto:edie.zumwalt@dhs.state.tx.us). [Ref: State: Government Code § 531.056(a)(2); Provider Letter #02-42]

**Q: Does DHS stress to complainants that "frivolous" complaints can be prosecuted?**

**A:** No. DHS is committed to providing fair, ethical, and respectful customer service to everyone on a nondiscriminatory basis, as well as to ensuring the health, safety, and well-being of each individual served by long-term care facilities. All allegations of abuse, neglect, or exploitation must be documented and reviewed by the state survey process. *[Ref: State: HSC § 242.123(a), 242.124, and 242.132; 40 TAC § 19.2006(a), 19.2008(f); Federal: SSA § 1919 (g)(1)(C) and 1919(g)(4)(A); 42 CFR § 488.335(b)]*

**Q: Is it possible to devise a system in which repeat, unsubstantiated complaints by the same person are no longer re-investigated or are addressed differently?**

**A:** DHS must ensure the health, safety, and well-being of each individual served by long-term care facilities. The agency is required to investigate all allegations of violations of state law or rules or federal regulations, regardless of the source of the complaint. The state has the right not to investigate a complaint that is deemed harassment of the facility by the complainant. *[Ref: State: HSC § 242.126(a) and 242.554; 40 TAC § 19.2006(a); Federal: SSA § 1919 (g)(1)(C); 42 CFR § 483.13(c) and 488.335(b)]*

**Q: Could a system be devised in which non-emergency complaints are handled in a group to minimize the disruption to facilities and residents?**

**A:** The regions attempt to consolidate complaints to maximize resources and minimize the disruption of resident care. However, DHS is mandated in the State Operation Manual (SOM) to follow specific timeframes when investigating complaints based on the nature/severity of the allegations. DHS may perform investigations sooner, but must meet certain dates based on priority. *[Ref: State: HSC § 242.126(c); 40 TAC § 19.2002(a); Federal: SSA § 1919 (g)(4)(A)]*

**Q: Why can't you let us know a little more about the complaint you are investigating? Why don't surveyors inform the facility of the nature of the complaint before starting their investigation?**

**A:** The Centers for Medicare and Medicaid Services (CMS) and LTCR's protocol to protect the identity of the complainant/resident is to inform the facility only of the complaint's general nature during the entrance conference. Surveyors are directed not to provide information that may cause them to lose opportunities for pertinent observations, interviews, and record reviews required for a thorough investigation. *[Ref: State: HSC § 242.552; 40 TAC § 19.604(b); Federal: SSA § 1919 (g)(4)(A); 42 CFR § 488.332(b)]*

**Q: Why does DHS take anonymous complaints? Can DHS require all complainants to reveal their identity?**

**A:** DHS cannot require a complainant to reveal his or her identity. DHS does not discriminate based on the source of an allegation. All allegations that demonstrate a violation of state or federal standards must be investigated regardless of the source. *[Ref: State: HSC § 242.124, 242.553; 40 TAC § 19.2006(c); Federal: SSA § 1919 (g)(4)(A); 42 CFR § 488.332(a)(2)]*

**Q: Does DHS have a zero-tolerance policy for deficiencies? What is the definition of zero tolerance? What is the agency's current position regarding zero tolerance?**

**A:** The term "zero tolerance" is not part of state or federal guidance or requirements. DHS is required by statute to document all violations of state or federal regulations. *[Ref: State: HSC § 242.0445(a); 40 TAC § 19.2004(c); Federal: 42 CFR § 488.18 (a) and 488.26 (b)]*

**Q: How does a negative finding during the survey process become a deficient practice?**

**A:** A negative finding is a deficiency/violation when the negative finding constitutes a violation of federal regulations or state rules. The survey team reviews the survey findings and determines the facility's compliance with the requirements. *[Ref: State: HSC § 242.0445(a); 40 TAC § 19.2004; Federal: 42 CFR § 488.26 (c)]*

**Q: Why do surveyors write multiple tags (in different areas) when it relates to the same concern?**

**A:** A negative outcome may be the result of violations of more than one rule or regulation. Surveyors must cite all negative findings during a survey. *[Ref: State: HSC § 242.0445(a); 40 TAC § 19.2004; Federal: 42 CFR § 488.18 (a)]*

**Q: Why don't surveyors go back to writing only tags on pattern issues instead of isolated instances?**

**A:** DHS is required to document all violations of state and federal regulations. *[State: HSC § 242.0445(a); Federal: 42 CFR § 488.18 (a)]*

**Q: Why do surveyors cite providers when they fail to write and investigate an incident within 24 hours even though surveyors may not investigate until months later?**

**A:** Providers are required to initiate an investigation upon discovery. Facilities are required to submit the results of the investigation to DHS within five working days of the incident. For allegations of abuse, the facility must prevent further abuse while their investigation is in progress. DHS follows specific timeframes for investigating incidents that require an on-site visit. *[Ref: State: HSC § 242.122(c); 40 TAC § 19.601(c)(2) and 19.602(b)(2); Federal: 42 CFR § 483.13 (c)(2-4)]*

**Q: How does the team decide to write a deficiency after exit when they did not express a concern at exit conference?**

**A:** Survey teams share their preliminary findings with a facility at the exit conference. Upon reviewing the survey information gathered, DHS may identify additional violations after the survey team has exited the facility. The facility will be given another exit conference and an opportunity to present evidence of compliance with the additional deficiencies being cited. *[Ref: State: HSC § 242.0445(b); 40 TAC § 19.2004(c); Federal: 42 CFR § 488.18 (a)]*

**Q: Why do surveyors still write a deficiency self-identified problems for which a facility already has an action plan?**

**A:** DHS is required by statute to document all violations of state and federal regulations. If DHS finds a facility to be in violation of a state or federal regulations while on-site, it is required to document that violation. *[Ref: State: HSC § 242.0445; 40 TAC § 19.1917(d); Federal: 42 CFR § 488.18 (a)]*

**Q: Why do surveyors write a deficiency if they do not receive paperwork?**

**A:** By paperwork, LTCR assumes the questioner is referring to information that proves compliance with the regulations, i.e., health care plans or abuse prohibition policies. Certain documents are required for the certification/licensure of nursing facilities. For example, if the facility does not submit their abuse policy or a resident admission agreement, surveyors would cite a deficiency because the facility is required to have these documents.

Paperwork submitted as "additional information" to show compliance with surveyor negative findings, may not be adequate to prove compliance with the requirements, i.e., providing documentation dated the day the surveyor informed the facility of a concern. This does not correct the system that failed to meet compliance. *[Ref: State: HSC § 242.0445; 40 TAC § 19.2002(h); Federal: 42 CFR § 488.18 (a)]*

**Q: Can the statement of deficiencies, CMS-2567, and violations, DHS-3724, be sent to facilities on floppy disc or by e-mail?**

**A:** No. There are no regulations or plans to change program policy or procedures to make this available in those formats.

**Q: Why is the CMS 2567 sometimes faxed late on Fridays?**

**A:** DHS requires that the CMS-2567 be sent to the provider within 10 working days. Due to time constraints, schedules, and following the CMS process for enforcement, the CMS-2567 is sometimes finished on the 10th working day and sent to the facility via their fax, as well as by mail, to get the information to the facility in a timely manner. *[Ref: State: 40 TAC § 19.2004(c); Federal: 42 CFR § 488.330 (c); SOM, Section 2728]*

**Q: Providers wanted to know the reason DHS has 10 working days to forward the survey results to them, yet the providers have 10 calendar days to forward the plan of correction (POC) to DHS. Can this policy be changed by state office?**

**A:** During the survey process, the facility is kept informed of the survey findings. At the exit conference, the team provides a written list of preliminary findings. This may allow the facility time to develop a POC for the noncompliant practices noted by the survey team before they receive the actual list of deficiencies/violations. There are no plans at this time to change the policy. *[Ref: State: 40 TAC § 19.2004(c); Federal: 42 CFR § 488.18(b); SOM]*

**Q: How is it possible for a facility to be deficiency-free for five years?**

**A** LTCR surveys all facilities in the state annually and as-needed. Surveyors are required to make determinations of compliance based on their survey findings. Some facilities have deficiency-free surveys. *[Ref: State: Health and Safety Code (HSC) § 242.0445 (a)&(b); 40 Texas Administrative Code (TAC) § 19.2004(a); Federal: 42 Code of Federal Regulation (CFR) § 488.330(a)(2)]*

**Q: Why are citations given related to complaints called in by terminated facility staff members?**

**A:** Licensure violations or deficiencies are written based on the findings of surveyors during the survey process. If surveyors determine that a licensure violation or deficiency has occurred, that licensure violation or deficiency will be cited. The source of the findings may be from observations, record reviews, or interviews of residents, staff, visitors, or terminated employees. At the end of the survey, surveyors review all pertinent data collected or provided by the facility and make compliance determinations based on these findings. *[Ref: State: HSC § 242.0445 (a)&(b); 40 TAC § 19.2004 (a); Federal: 42 CFR § 488.330(a)(2)]*

**Q: If the facility had a broken system but has fixed it, will a deficiency still be written?**

**A:** Surveyors collect and evaluate data to determine when a facility is out of compliance with the rules. A deficient practice found during a survey may be cited based on these findings. Although a facility has identified a deficient practice before the survey, if the deficient practice is found during the information gathering process, surveyors may cite the deficiency. At times, surveyors may note past noncompliance and this may be cited due to the nature of the facility's failure to follow the rules. *[Ref: State: HSC § 242.126(a) and 242.0445(a)&(b); 40 TAC § 19.2004(a); Federal: 42 CFR § 488.330(a)(2)]*

**Q: Can a citation still be written even if it is a paper compliance issue with no negative outcome?**

**A:** If there is a violation of the rules, a violation or deficiency will be cited. Nursing facilities are required to comply with all rules, regardless of the nature of those rules. *[Ref: State: HSC § 242.0445 (a)&(b); 40 TAC § 19.2004 (a); Federal: 42 CFR § 488.330(a)(2)]*

**Q: Do surveyors have to cite a certain number of deficiencies?**

**A:** There are no deficiency quotas. Surveyors must perform surveys according to state and federal guidance. The surveyor guidance is to cite deficient practices when identified during the course of the survey. *[Ref: State: HSC § 242.0445 (a)&(b); 40 TAC § 19.2004(c); Federal: 42 CFR § 488.330(a)(2)]*

**Q: Can we get a history of deficiencies cited by a particular surveyor?**

**A:** No. DHS does not track an individual surveyor's history of cited deficiencies.

**Q: What do you mean by "reconciled"?**

**A:** Surveyors have to reconcile their findings and provider information with the nursing facility rules to determine compliance or noncompliance. Surveyors meet to discuss their findings as a team before the exit conference. If the team determines, based upon the available information, that no rule violations have occurred, there will be no deficiency/violation cited. *[Ref: State: HSC § 242.0445(b); 40 TAC § 19.2004(a); Federal: 42 CFR § 488.330 (a)(2)]*

**Q: Are surveyors required to hold a pre-exit conference? How much time is customarily provided between the pre-exit conference and formal exit conference?**

**A:** No. There is no requirement for a "pre-exit" meeting with the facility. During the exit conference, facilities should be provided the opportunity to discuss and supply additional information that they believe is pertinent to the negative findings discussed during the course of the survey. *[Ref: State: 40 TAC § 19.2004(c)]*

**Q: At the exit conference, can DHS provide facilities with a list of F-tags that will be cited along with the scope and severity?**

**A:** No. Surveyors are trained to provide facilities with a list of preliminary survey team findings at the exit conference. Surveyors do not discuss F-tags or the scope and severity of noncompliance at the exit conference. All findings are documented on the CMS-2567/DHS-3724 and reviewed by the regional enforcement team. Facilities receive the CMS-2567/DHS-3724 within 10 working days of the exit conference. *[Ref: State: 40 TAC § 19.2004(c); Federal: 42 CFR § 488.26 (d); SOM, Section 2724]*

**Q: If a survey lasts more than one day, do surveyors give a "mini-exit" or summation of concerns at the end of each day?**

**A:** Surveyors are trained to maintain an open, ongoing communication with facility staff. The survey team meets daily, but there is no requirement for a daily "mini-exit" with facility staff.

**Q: Do the federal surveyors ever come in after a state survey has been complete?**

**A:** Yes. CMS must complete comparative surveys for 5 percent of Texas nursing facilities within two months after the state survey team exits. During a comparative survey, the federal survey team may write deficiencies and may take any enforcement action necessary to ensure future compliance with the regulations. *[Ref: Federal: SSA § 1919(g) (3)(A-B); State Operations Manual (SOM) § 4157 (D)(1)]*

**Q: What is a Federal Oversight/Support Survey (FOSS)? Is there advance notice to the survey team that a FOSS will be done? What are the FOSS surveyors looking at?**

**A:** CMS receives the monthly schedule of planned surveys. The FOSS team schedules surveys based on the type of facility, location, and other criteria. CMS notifies the state teams in advance that federal surveyors will observe. CMS evaluates the survey team during the survey, from off-site preparation to reconciling concerns. Federal surveyors, as a part of the FOSS, observe state surveyors completing various survey tasks. They also can make their own

observations. Following the FOSS survey, the federal surveyors assess surveyor performance to identify educational and training needs of the state. *[Ref: Federal: SSA § 1919 (g)(3); SOM § 4157(D)(6)]*

**Q: Why is the informal dispute resolution (IDR) often delayed until after the time of the follow-up survey?**

**A:** The Texas Health and Human Services Commission (HHSC) has established timeframes for completing the IDR. At times, the due date for the follow-up visit will occur before the completion of the IDR because of mandated timeframes for completion of the follow-up visit. *[Ref: State: HSC § 242.071(d); Federal: 42 CFR § 488.331 (b)(1)]*

**Q: Why isn't DHS held to a 30-day deadline for responding to a facility's IDR request?**

**A:** DHS does not perform nursing facility IDRs. HHSC attempts to meet all timeframes for dispute resolutions. The facility has 10 days after receipt of the CMS-2567/DHS-3724 to request an IDR. The state has 30 days after the request and all required information is received. The date all required information is received may not be when the facility makes the request and therefore, would not be 30 days from the facility's original request. *[Ref: State: Government Code § 531.058(a)(2); Human Resource Code (HRC) § 32.021(d)(1)]*

**Q: Will DHS allow more fines to be used towards improving the facility?**

**A:** Amelioration of administrative penalties may be available if certain conditions apply. If a facility would prefer to pursue amelioration rather than paying an administrative penalty, it may propose a plan of amelioration in accordance with the statute and the DHS rules. *[Ref: State: HSC § 242.071; 40 TAC § 19.2115(a)]*

**Q: Why does DHS assess administrative penalties when they know it dilutes funds intended for patient care?**

**A:** The regulations outline criteria for recommending administrative penalties and appropriate penalty amounts. Guidelines for requesting amelioration of administrative penalties can be found at:  
<http://www.dads.state.tx.us/business/ltc-policy>. *[Ref: State: HSC § 242.066(a); 40 TAC § 19.2112; Provider Letter #02-36]*

**Q: Why are administrative penalties being imposed on all tags?**

**A:** An administrative penalty may be assessed against a person in accordance with the statutes. *[Ref: State: HSC § 242.066(a); 40 TAC § 19.2112(f)]*

**Q: How can providers correct inaccurate information reported by DHS on the Report of Contact (ROC)?**

**A:** If the ROC is inaccurate, the facility may contact the regional program manager or the regional director to inform them of the error. The region corrects the error and sends a corrected copy to the facility and to the state office.

**Q: The publication of quality indicators does not provide a clear explanation to those reading them. Can they be stated more clearly? We have noted a disparity between the number of quality indicators the quality monitor reviews (three) and what CMS publications are reporting (10). Please address the reason for this disparity?**

**A:** Quality indicators are based on the transmitted data from nursing facilities. This information is compiled by CMS. Any questions may be addressed to the CMS at their website: [www.cms.hhs.gov/](http://www.cms.hhs.gov/)

Currently, the nursing component of the quality monitor program is working on care issues related to three indicators. Because the purpose of the program is to improve resident outcomes and because not all important outcomes are depicted by CMS quality indicators, some future focus areas may not be CMS quality indicator conditions.

**Q: What triggers a rapid response team visit?**

**A:** An Early Warning System (EWS) that estimates the risk for an adverse survey outcome triggers rapid response team visits. *[Ref: State: HSC § 255.002]*

**Q: How do surveyors determine when a referral will be made?**

**A:** Licensed professionals, medication aides, nurse aides, etc., must conform to the standards of practice/conduct mandated by their professions. An investigation of a facility may result in the recommendation that an individual be referred to his/her respective board or registry for abuse, neglect, and/or a violation of standards of practice. The investigator reviews the standards that apply to the individual being considered for referral based on violation of standards of practice. *[Ref: State: HSC § 242.316; 40 TAC § 19.2009; Federal: SSA § 1919(g) (1)(C); 42 CFR § 488.335(c)]*

**Q: What are surveyors looking at related to restraint reduction?**

**A:** Surveyors investigate how physical restraints are used, i.e., are they required to treat the resident's medical condition. Surveyors observe to see that restraints are released and the resident repositioned as needed to prevent deterioration in the resident's condition. Residents must be monitored hourly

and, at a minimum, restraints must be released every two hours for a minimum of 10 minutes, and the resident repositioned. Use of restraints and their release must be documented in the clinical record. *[Ref: State: HSC § 242.501(a) (21); 40 TAC § 19.601 (a) (1) & (2); Federal: SSA § 1919 (c) (1) (A)(ii); 42 CFR § 483.13(a)]*

**Q: If providers remove restraints to evaluate for possible restraint reduction and the resident falls, will the surveyor issue a citation?**

**A:** Providers must assess each resident's level of supervision during the restraint-reduction process. Some residents will need a much higher level of supervision, and the facility is responsible for meeting the resident's needs. The assessment and monitoring must be documented and care planned by the facility. Based on the surveyor's observations, interviews, and record reviews, a determination of facility compliance will be made. *[Ref: State: HSC § 242.501(a) (21); 40 TAC § 19.601(a) (1) & (2); Federal: SSA § 1919 (c) (1) (A)(ii); 42 CFR § 483.13(a)]*

**Q: Does it help to send additional information to the regional office concerning a negative finding?**

**A:** Federal training states that additional information may be presented before the surveyors leave the facility. If a facility believes it's in compliance with a requirement, information should be made available while the survey team is on-site. *[Ref: Federal: SOM, Section 2724(B)]*

**Q: What can we do when surveyors refuse to accept additional information prior to exit?**

**A:** Federal guidance instructs surveyors to accept additional information during the exit conference. DHS recommends the facility contact the regional office program manager to discuss/resolve the issue and provide the additional information related to proposed deficiencies/violations. If your concern is not acted upon, you may contact the regional director, the regional administrator, or the State Office at 1-800-458-9858 to file a complaint. *[Ref: State: Provider Letter #02-42; Federal: SOM Section 2724(B)]*

**Q: What do you do about misspelled words, wrong dates, and wrong names in survey documents?**

**A:** If survey documents contain erroneous information, the facility should contact the local regional office program manager to discuss concerns.

**Q: Why do surveyors seem to be only seeking negative feedback in family interviews?**

**A:** Surveyors are looking for information during the interview process, whether negative or positive. The purpose of family interviews is to obtain information regarding the resident's prior and current preferences. This information helps surveyors determine whether the facility is individualizing resident services, care, and activities. This information is used to verify observations and/or record reviews as well as to investigate family member concerns. *[Ref: State: 40 TAC § 19.2002(a); Federal: 42 CFR § 488.26, 488.305(a)]*

**Q: Can a desk review be done instead of an on-site revisit?**

**A:** Yes. Revisits/follow-up visits may be conducted by desk review or on-site. The revisit (desk review or on-site) will depend on the scope and severity level of the deficiency/violation cited. *[Ref: State: 40 TAC 19.2002(a); State Survey and Certification Clarification (S&CC) Memo #03-10; Federal: SOM, Section 2732]*

**Q: Why don't surveyors have a manual for both regulations and interpretive guidelines available during the survey?**

**A:** Surveyors have this information available during the survey. However, it may be that only one surveyor per team carries this document on-site for the team's use.

**Q: How do you determine if the survey process is consistent among different surveyors and regions?**

**A:** The federal (certification) survey process as well as surveyor qualifications and training requirements are clearly stated in the regulations, and are mandated to surveys and surveyors throughout the state. Oversight surveys observe the survey process in all regions of the state for thorough, accurate, and consistent survey process. Our goal for surveys and surveyors statewide is to be as consistent as possible while allowing for the individual circumstances of each provider. LTCR Quality Management Section and the CMS Regional Office have conducted extensive federal and state oversight surveys throughout the state for the last three years. Feedback from the oversight teams has strengthened our training program and improved the consistency of the survey process. *[Ref: State: HSC § 242.048; 40 TAC 19.2002(i); Federal: SSA § 1919 (g)(2)(D); 42 CFR § 488.312]*

**Q: Why do the annual surveys have to be unannounced?**

**A:** Performance of unannounced surveys is required as directed in the state and federal regulations. *[Ref: State: HSC § 242.044(a); 40 TAC 19.2002(d); Federal: SSA § 1919 (g)(2)(A)(i); 42 CFR § 488.307(a)]*

**Q: If a surveyor has a question about a physician's order or a medication prescription, shouldn't the surveyor address the question to the appropriate staff?**

**A:** In the course of a survey or an investigation, it is likely that a surveyor will attempt to gather many pieces of information in several ways. Personal interviews with residents, responsible parties, nursing home staff, and others are important methods of information gathering. Surveyors are trained to corroborate information that may be held by only one person.

Surveyors interview persons believed to have knowledge of the information the surveyor is seeking. In relation to a physician's order or a medication prescription, there may be a number of questions that require exploration. Surveyors, therefore, would select persons to interview based on the particular issue that is being examined. *[Ref: State: 40 TAC 2002(a); Federal: SSA § 1919 (g)(2)(C)(i); 42 CFR § 488.305]*

**Q: Why is the professional opinion of the facility not as valid as the surveyor's opinion?**

**A:** LTCR recognizes regulatory/statutory requirements. The evidence, not opinions, of facility compliance determines regulatory violations. Facility compliance is evaluated by the regional enforcement team while reviewing evidence submitted by the survey team on the CMS-2567/DHS-3724. *[Ref: State: 40 TAC 19.2002(b); Federal: SSA § 1919 (g)(2)(C)(ii); 42 CFR § 488.26(c), 488.314(b)]*

**Q: Can the same team of surveyors who made the initial survey not make the follow-up visit?**

**A:** According to CMS guidance, DHS should attempt to send the same surveyor(s) on a follow-up visit, but this is not mandated. The regions prefer to send the same team on the revisit to maintain consistency, but this is not always possible due to the scheduling conflicts, deadlines and personnel schedules. *[Ref: Federal: SOM, Section 2732]*

**Q: Should a surveyor be allowed to come back into a facility after a facility successfully gets a deficiency overturned that was cited by that surveyor?**

**A:** Surveyors are professionals who should objectively assess the situation each time they enter a facility. If the provider feels the surveyor did not perform the survey according to the regulations, the provider should contact the

surveyor's program manager, the regional director, the regional administrator and/or the state office Complaint and Intake Management at 1-800-458-9858. For more details, go to: [www.dhs.state.tx.us/providers/ltc-policy](http://www.dhs.state.tx.us/providers/ltc-policy). [Ref: State: Government Code § 531.056(a)(2); Provider Letter #02-42]

**Q: Surveyors need to have more practical LTC nursing facility experience before being hired.**

**A:** Practical experience in a LTC facility is an asset to a new surveyor. However, DHS does not limit employee selections to only applicants with LTC facility experience. Currently, our training curriculum includes a 10 day observation period in a facility before completing the new surveyor's basic training, as well as training required by CMS. [Ref: State: HRC § 22.039(b); Federal: SSA § 1919 (g)(2)(E)(iii); 42 CFR § 488.314(c)]

**Q: Do survey teams hold group meetings with family councils as they do with resident councils? Are family councils mandated for nursing homes?**

**A:** During the survey process, the survey team must hold a group meeting with facility residents. No regulation mandates a family group meeting. Although there is no requirement to have a family council, facilities must provide a private meeting space for the family council at the facility. [Ref: State: HSC § 242.501(a) (6); 40 TAC § 19.407(1); Federal: SSA § 1919 (c)(1) (A)(iii); 42 CFR § 483.10(e) (1)]

**Q: Can the director of nursing make rounds with the surveyors rather than the charge nurse?**

**A:** Yes, although technically the surveyors are not required to allow a staff member with them on tour. Surveyors are directed to use facility staff, as needed, to gather necessary information during the initial tour/survey process. [Ref: Federal: SOM, Section 2713]

**Q: Why are surveyors not more consistent when interpreting state and federal rules and regulations?**

**A:** Surveyors receive training on rules and regulations. The State Quality Management staff performs oversight surveys throughout the state to determine where inconsistencies are present. All surveyors receive training from CMS and are required to pass the SMQT to perform the tasks of the survey. [Ref: State: HSC § 242.048; 40 TAC § 19.2002(i); Federal: SSA § 1919 (g)(2)(E)(iii); 42 CFR § 488.314(c)]

## ***Residential Care Facilities***

**Q: What is the role of the nurse liaison in residential care facilities?**

**A:** Sorry, there is no role for the nurse liaison in residential care facilities at this time. The nurse liaison position was created to meet legislative mandates for better communication between providers — nursing facilities, assisted living facilities, and intermediate care facilities for the mentally retarded and related conditions — and Long Term Care Regulatory (LTC-R). The nurse liaison may be used in other regulated facilities at the discretion of the regional director, but LTC-R does not regulate residential care facilities. *[Ref: State: Senate Bill 1839, 77th Legislative Session]*

**Q: Are residential care facilities required to be licensed when there are three persons or less residing at the facility?**

**A:** A facility with three or fewer persons unrelated to the proprietor of the establishment would not meet the requirements for an assisted living facility. A facility that is not required to be licensed as an assisted living facility must execute a contract with each of its residents that contain the mandated information. *[Ref: State: Human Resource Code § 105.003; Health and Safety Code § 247.002(1)]*

## **General FAQs**

**Q: How will Health Insurance Portability and Accountability Act (HIPAA) requirements impact electronic billing to National Heritage Insurance Company (NHIC)? [Note: Effective Jan. 1, 2004, NHIC transitioned to Texas Medicaid and Healthcare Partnerships (TMHP). See Provider Letter #04-02 for new EOB numbers.]**

**A:** HIPAA Electronic Data Interchange (EDI) provisions require electronic billing providers to use standard transaction formats. For example, for American National Standards Institute (ANSI) electronic billing transactions, DHS determined that providers will be required to submit the 837 Institutional (I), 837 Professional (P), and 837 Dental (D) claims formats in order to receive reimbursement for the various services.

HIPAA EDI provisions also require providers to use standard code sets. For example, effective 10/16/03, providers must use national standard codes, Health Care Common Procedural Coding System and Current Procedural Terminology (HCPCS, CPT-4, etc.) for place of service (POS), provider type (taxonomy), explanation of benefits (EOB), and health care services and procedures for HIPAA-compliant transactions.

Providers submitting claims using TDHConnect software should anticipate having to provide certain additional elements required by HIPAA; however, the impact on their operations should be minimal because this software will be modified to comply with the HIPAA rules and regulations. ANSI providers and providers who use clearinghouses to submit their claims should be aware that their information technology systems may require significant changes in order to comply with the HIPAA EDI requirements.

For specific information about DHS HIPAA activities, contact the project office at 512-482-3467. For more information about HIPAA implementation for the Texas Medicaid program, please visit the Texas Health and Human Services Commission HIPAA website at [www.hhsc.state.tx.us/NDIS/NDISTaskForce.html](http://www.hhsc.state.tx.us/NDIS/NDISTaskForce.html). [Ref: State: Government Code § 532.002; Federal: 45 Code of Federal Regulations (CFR), Section 162.900-162.1802; Public Law 104-191]

**Q: Where can we find the HIPAA risk assessment document?**

**A:** The DHS-HIPAA Risk Assessment document is in draft form and has not been finalized. Once the document has been finalized it will be shared upon request.

**Q: What are the time frames for HIPAA extensions? What is the definition and differences in large and small?**

**A:** There are no extensions for HIPAA privacy implementation. Covered entities were required to comply with these provisions by April 14, 2003.

Before May 2002, all covered entities, other than small health plans, were required to comply with HIPAA EDI Electronic Health Care Transactions and Code Sets standards by October 16, 2002. Small health plans were required to comply with these standards by October 16, 2003.

In December 2001, the Administrative Simplification Compliance Act (ASCA) extended the deadline for compliance with HIPAA EDI transactions and code set standards to Oct. 16, 2003. In order to qualify for this extension, covered entities, like DHS, were required to submit a compliance plan by Oct. 15, 2002. The Texas Medicaid Program submitted a compliance plan with CMS and will implement HIPAA EDI provisions by October 16, 2003. *[Ref: Federal: 45 CFR § 162.900 and 164.534; Public Law 107-105]*

**Q: Will HIPAA require nurse stations to be enclosed, consequently, separating staff from residents?**

**A:** DHS has no role in interpreting or enforcing the HIPAA privacy rules. The federal Health and Human Services Office of Civil Rights (OCR) is responsible for providing guidance on implementing privacy regulation. Previously guidance issued by OCR on this general topic can be found at: <http://www.hhs.gov/ocr/hipaa>. Please refer to Frequently Asked Questions. OCR has the authority to enforce the rules.

Covered entities must have in place appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information. This standard requires that covered entities make reasonable efforts to prevent uses and disclosures not permitted by the rule. The department does not consider facility restructuring to be a requirement under this standard. *[Ref: Federal: 45 CFR §164.502(a)(1)(iii)]*

**Q: What is the DHS stance on tort reform?**

**A:** Tort reform is a legislative issue. DHS provides the Legislature with current data and information. The agency does not have a position on this issue.

**Q: Does DHS have a legislative spokesperson who represents the different entities or agencies providing services?**

**A:** The DHS commissioner is the spokesperson for all legislative reform issues involving the agency. Providers have their own organizations/lobbyists to participate in the legislative process.

**Q: Can frequently asked questions and answers be posted online?**

**A:** DHS frequently asked questions are available online through at:  
<http://www.dhs.state.tx.us/faqs/index.html>.

**Q: Will reimbursement rates increase to cover the cost of HIPAA compliance?**

**A:** No. Administrative simplification is specifically intended to reduce the costs and administrative burdens of health care by making possible the standardized electronic transmission of many administrative and financial transactions that are currently carried out manually on paper. *[Ref: Federal: Public Law 104-191, Section 262]*

**Q: Websites for information are hard for facilities to work with and retrieve information from.**

**A:** Feedback about DHS website concerns/problems may be submitted to:  
[webmaster@dhs.state.tx.us](mailto:webmaster@dhs.state.tx.us).

**Q: Some providers are having trouble using DHS websites. Can system recommendations be sent out?**

**A:** Because some websites "interact" with web surfers, and this interaction relies on the technology of more recent web browser versions, we would suggest using Internet Explorer 4.x or higher or Netscape 4.x or higher, along with Adobe Acrobat Reader 4.x or higher, for any of these websites.

**Q: Is there a new list of websites for providers to use when they are searching for information and training materials?**

**A:** The development and distribution of a new list of informative websites will be researched, developed, and distributed by the Long Term Care Regulatory regional automation coordinator. Facilities also should contact their respective provider organizations for more information and training opportunities.

# Home and Community Support Services Agencies

- Abuse and Neglect
- CLASS Program
- Communication and Training
- Funding, Rates, and Payment
- Hospice Programs
- Licensing and Regulations
- Medication, Medical Orders
- Miscellaneous
- Operations and Staffing
- Personal Assistance Services
- Quality Assurance
- Surveys and the Survey Process

## ***Abuse and Neglect***

**Q: We had "abuse, neglect, and exploitation" on our consent forms but recently changed it to "reportable conduct." We also changed our policies and procedures to reportable conduct. Was this wrong for us to do or make this change?**

**A:** The HCSSA rules require the agency to adopt and enforce their written policy relating to the reporting of abuse, neglect, or exploitation (ANE) and "reportable conduct." If written consent forms contain adequate knowledge for the client and the staff to know that "reportable conduct" includes what constitutes abuse, neglect, and exploitation, then the agency should not experience any problems. If the client, responsible party, or the staff are unable to describe that "reportable conduct" includes ANE, the agency would be determined as noncompliant with this rule. *[Ref: State: Human Resource Code (HRC) § 48.002(a) (2)(3)&(4), 48.401(5)(A)-(D); 40 Texas Administrative Code (TAC) § 97.249, and 97.282 (4)(5)&(6); Federal: Social Security Act (SSA) § 1864(a); 42 Code of Federal Regulation (CFR) § 484.10 (b)(4)&(5)]*

**Q: What can a provider do if, after notifying the Texas Department of Family and Protective Services (FPS) about concern for a patient's safety, FPS determines there is no concern? After a second report, FPS states the case is closed. What is the next step?**

**A:** Once an agency has notified DHS at 1-800-228-1570 and FPS at 1-800-252-5400 regarding allegations of abuse, neglect, or exploitation, the agency is responsible for conducting their own investigation about complaints of ANE by an agency employee. If the information that the agency gathers determines abuse, neglect, or exploitation has occurred, this information must be given to DHS and FPS for review. DHS will forward appropriate information to other law enforcement agencies, as needed. *[Ref: State: Health and Safety Code (HSC) § 142.018, HRC § 48.051, 40 TAC § 97.250 (a)(1); Federal: SSA § 1864(a); 42 CFR 484.10(b)(5)]*

**Q: "Self-reporting" has generated a tremendous number of investigations by DHS per year. The home health agency is investigated twice — by the contract manager and DHS. Will there be less duplication in the future?**

**A:** No. An agency is required to report all allegations of abuse, neglect, or exploitation to both FPS and DHS and send the report of its own investigation to DHS. After a review of the agency investigation, DHS may conduct both a contract investigation and a licensure investigation based on either the allegation received or the results of the agency's internal investigation. DHS will investigate to determine if the agency has violated the terms of its

contract or the licensure rules. *[Ref: State: HRC § 48.003, 48.103; 40 TAC § 97.249(3), Provider Letter #02-19; Federal: SSA § 1864(a); 42 CFR § 484.10(b)(5)]*

**Q: What is the correct procedure for handling patient/client abuse to the provider?**

**A:** The agency is required, in advance of providing care to the client or during the initial evaluation before the initiation of services, to provide each client or their legal representative with a written notice of all policies governing client conduct and responsibility as well as client rights. An agency may discharge a client without five days notice for the protection of the staff after the agency has made a documented reasonable effort to notify the client, the client's family, physician (if applicable), and appropriate state and local authorities of the agency's concerns for staff safety, and in accordance with the agency's policy. *[Ref: State: 40 TAC § 97.282(1) and 97.295(b)(4)]*

**Q: Hospice regulations state that we must report any abuse, neglect, or exploitation by our employees. Does this apply to abuse we see committed by long-term care facility staff in their own facility?**

**A:** Yes. The rule applies to abuse, neglect, or exploitation perpetrated by employees of the home health/hospice agency; however, LTCR facility regulations stipulate that "if a person has cause to believe that an elderly or disabled person has been abused, neglected, or exploited in a facility operated, licensed, certified, or registered by a state agency other than the Texas Department of Mental Health and Mental Retardation, the person shall report the information to the state agency that operates, licenses, certifies, or registers the facility for investigation by that agency."

Please report all complaints of abuse, neglect, or exploitation in long-term care facilities to the DHS Complaint and Intake Management Section hotline at 1-800-458-9858. *[Ref: State: Human Resource Code (HRC) 48.051(b); 40 TAC § 97.249; Federal: 42 CFR § 483.13(c)]*

**Q: A community-care nurse was reported to the Department of Family and Protective Services for elder abuse. How can we find out the results of the investigation?**

**A:** Results of FPS investigations and concerns about those investigations should be directed to that department at 512-438-3209.

**Q: Once an individual is placed on the Employee Misconduct Registry (EMR), how long does he or she remain there? Can someone be placed on the registry for a lifetime?**

**A:** An individual's name remains on the registry indefinitely as unemployable in all DHS-regulated facilities and agencies. An individual may be removed from the EMR if DHS receives a written request from the person and determines that the person does not meet the requirement for inclusion in the registry. *[Ref: State: 40 TAC § 93.4(d)]*

**Q: Are EMR checks required for employees who conduct home visits only once a year? Are EMR checks required for volunteers who visit patient homes?**

**A:** A search of the EMR must be done on **all** unlicensed employees before hiring if the employee will come in contact with an agency consumer. This would include employees who conduct home visits only once a year. A volunteer must comply with the same requirements and standards that apply to an agency employee doing the same activities. This includes volunteers used in administrative and direct client care roles if that volunteer will have contact with an agency consumer. *[Ref: State: HSC § 253.008(a); 40 TAC § 97.247(a) and 40 TAC § 97.248(b)(1)]* **This replaces response in Provider letter O2-19 as it applies to 97.247.**

**Q: Are background checks required for nonlicensed personnel, such as sales representatives, who have contact with clients over the telephone?**

**A:** Unlicensed persons who apply for employment or are employed with an agency licensed by the state, whose duties would or do involve direct contact with an agency consumer, must have a criminal history check and a search of the Nurse Aide Registry and the EMR to determine if the person has a criminal conviction or has committed certain conduct that would bar them from employment with the agency. *[Ref: State: HSC § 250.001(2); 40 TAC § 97.247(a)]*

**Q: If a receptionist was not intended to deliver supplies, but a need arose for that person to do so, does the agency have to check the EMR?**

**A:** Yes. If the employee does or will have any direct contact with a consumer at any time, then they should be screened the same as someone who will have direct contact on a routine basis. These include: a screening of the EMR, criminal history check, and if indicated, the Nurse Aide Registry. *[Ref: State: 40 TAC § 97.247(a); Federal: SSA § 1929(k)(1)(B)]*

**Q: What is the rationale behind sending the parent agency criminal history checks and registry searches of employees or applicants for employment with a branch office?**

**A:** The parent agency is responsible for ensuring compliance with licensing standards by the branch agencies. To ensure that a criminal history check is complete, the parent submits the information to the state agency for confirmation of any criminal history. *[Ref: State: 40 TAC § 97.321(b)]*

**Q: When will agencies be required to start using the new complaint and incident hotline number?**

**A:** Effective April 1, 2004, the new hotline number for reporting abuse, neglect, or exploitation involving an agency employee was established. The new number is 1-800-458-9858. An agency will not be cited until after Aug. 15, 2004, for failing to provide the new 800 number in their written information to clients. *[Ref: 40 TAC § 97.249 and 97.282]*

**Q: When an agency reports an employee to the Employee Misconduct Registry and FPS, why does DHS then conduct a complaint survey?**

**A:** An agency does not report an employee to the EMR. An agency reports an employee to FPS and DHS. FPS may investigate the abuse, neglect, or exploitation and refer the perpetrator to the EMR following due process. DHS may conduct an abbreviated survey (incident investigation) to determine compliance with applicable rules and regulations. *[Ref: State: 40 TAC § 97.249, 250, & 282(11)(B); Federal: 42 CFR § 484.10(B)(4) and (5)]*

**Q: When does an agency self-report an incident of abuse, neglect, or exploitation by an employee?**

**A:** An agency that has cause to believe that an employee has abused, exploited, or neglected a client of the agency must report that information to FPS and DHS. The agency must conduct an investigation in accordance with their written policy. *[Ref: State: 40 TAC § 97.249 (3)]*

**Q: Do all self-reported incidents of abuse, neglect, or exploitation automatically result in an investigation?**

**A:** The statute requires that FPS investigate reports of abuse, neglect, or exploitation of an elderly or disabled client. DHS may "conduct an on-site survey . . . as it considers necessary to ensure compliance with the statute or the rules adopted under the statute." *[Ref: State: HRC § 48.151; 40 TAC § 97.501]*

**Q: When do agencies report employee incidents to the EMR and when do they report them to the complaint and incident hotline?**

**A:** An agency does not report an employee to the EMR. An agency reports an employee to FPS and DHS. FPS may investigate the abuse, neglect, or exploitation and refer the perpetrator to the EMR following due process. An agency reports employee incidents to the LTCCR hotline in accordance with the requirements. *[Ref: State: 40 TAC § 97.249]*

**Q: When do agencies report client complaints to FPS?**

**A:** Agencies report client complaints to FPS when they allege employee abuse, neglect, or exploitation and reportable conduct. The agency must report acts of abuse, neglect, or exploitation of clients and reportable conduct by an employee to FPS and DHS. *[Ref: State: 40 TAC § 97.249; 40 TAC § 97.282(11)(B)]*

**Q: Can the requirements at 49.13 and 49.14 (regarding the submission of complaint resolutions to DHS within 30 days) be changed?**

**A:** The rules that became effective April 1, 2004, state that the agency must complete the report within 30 days of receiving a complaint **unless** the agency has and documents "reasonable cause for delay." The new Community Care contracting rules that became effective Feb. 5, 2004, under 40 TAC § 49.17 do not require the submission of complaint resolutions to DHS. However, the complaint log must be accessible to DHS staff. *[Ref: State: 40 TAC § 49.17 and 40 TAC 97.250 (a)(4)]*

## ***CLASS Program***

**Q: When will the Community Living Assistance and Support Services (CLASS) program abandon "catchment areas" and follow regional lines?**

**A:** There are no plans to change the CLASS program "catchment areas" at this time.

**Q: The CLASS program rules state clients must have an annual nursing assessment; thus, we have an order in the plan of care to reflect this. Does this order put a client in the Licensed Home Health Services (LHHS) category? The client may not receive any therapies but only Personal Assistance Services (PAS).**

**A:** All CLASS providers are required to provide the full array of CLASS services. These services may be provided through the provider's own employees, subcontractors, or personal service agreements with qualified individuals. At a minimum, each CLASS provider is requested to have the category of LHHS. They also may have the category of PAS, if they want. Only certain tasks may be provided under the PAS category; those tasks are listed in the PAS rules. An annual assessment of the client does not change his or her status. *[Ref: State: 40 TAC § 45.301, 97.404(c)]*

## ***Communication and Training***

**Q: Can DHS provide the name of a Home and Community Support Services Agency (HCSSA) contact person available on weekends?**

**A:** Long Term Care Regulatory (LTCR) does not have a person on call for inquiries outside of normal business hours. Please contact your regional program manager or regional director about the program during regular business hours. There is a 24-hour hotline that can be used to report incidents. Messages left on the DHS hotline (1-800-458-9858) outside of normal business hours are monitored and returned according to their priority.

**Q: How can I obtain the names and telephone numbers of the HCSSA surveyors in my region?**

**A:** You may call your regional office to contact these employees and/or leave a message for them.

**Q: Will you please provide the top 10 complaints that trigger investigations? What is the rate at which each complaint is substantiated? Can you provide training on the top 10 deficiencies? Can we get a quarterly report on the website?**

**A:** A list of the top 10 complaints and deficiencies is accessible on the DHS website: <http://www.dads.state.tx.us/business/ltrcr/reports/index.html>. Currently, the top 10 complaints and top 10 deficiencies for fiscal year 2003 are listed. At this time, there is no data available for disclosure of the frequency of substantiated complaint categories. Long Term Care Education Services offers training on the top ten deficiencies for geriatric facilities and intermediate care facilities for mental retardation (ICF-MR), but does not have a program for the HCSSA program. There are none planned at this time.

**Q: Can the hours a registered nurse (RN) receives for licensure be counted toward the six clock hours of administrator training?**

**A:** Administrators are required to complete a minimum of six clock hours per year of continuing education in subjects related to the duties of the administrator. If the continuing education units (CEUs) earned pertain to duties of the administrator, they would be counted. Please note that CEUs for nurses are not clock hours; therefore, computations will vary. *[Ref: State: 40 TAC § 97.244(a)(2)(D)]*

**Q: What are the in-service training requirements for an RN and a licensed vocational nurse (LVN)?**

**A:** Agency training policies must be written to include requirements for training for all employees according to their specific jobs. Please note that CEUs for nurses are not clock hours; therefore, computations will vary. *[Ref: State: 40 TAC § 97.245(1)]*

**Q: Can the in-service training requirements for attendants be met during their supervision?**

**A:** Home health agencies (HHAs) are required to adopt and enforce written policies that govern all personnel staffed by the agency. The policies must address participation by all personnel in appropriate employee development programs. The HHA identifies in their employee development policy their requirements regarding participation of all personnel in appropriate employee development programs. *[Ref: State: 40 TAC § 97.245 (2); Federal: N/A]*

**Q: Could you elaborate on the six administrative CEUs?**

**A:** The HCSSA rules that were effective 2-1-02 mandate that administrators must complete a minimum of six clock hours per year of continuing education in subjects related to their duties as administrator. Beginning 2-1-03, DHS surveyors began reviewing each agency's documents for compliance. The agency should define whether or not the six clock hours will be accrued per calendar year or employment year. This regulation does not require that the six hours be obtained at one time. *[Ref: State: 40 TAC § 97.244 (a)(2)(D)]*

**Q: Would DHS produce and deliver more joint training opportunities for surveyors and providers?**

**A:** LTC Education Services provides joint training on the top 10 deficient practices in Texas for nursing facilities, assisted living facilities, and ICF-MRs. Approximately 12 training sessions per month are offered throughout the state. See the following website for training opportunities: <http://www.dads.state.tx.us/business/ltr/Training/jointtraining.cfm>. At this time, there are no training sessions scheduled specific to home health agencies. *[Ref: State: HRC § 22.039(c)]*

**Q: Who is the liaison for home health? If there is not one, is it being considered?**

**A:** Legislation mandated improved communications between DHS and the providers in nursing facilities, assisted living facilities and ICF-MRs. In response to this mandate, DHS created the position of facility/surveyor liaison. The nurse liaison position is for these programs only, but can be used, on a limited basis at the discretion of the regional director, in other types of facilities.

If requested to assist with a home health agency, the nurse liaison's role would be to enhance communication during the survey process. The nurse liaison could only be called into the home health agency by the regional director. *[Ref: State: SB 1839, 77th Texas Legislature]*

**Q: Will DHS develop a mechanism to encourage/facilitate regular, ongoing dialogue with providers? For example, hold regular unit meetings?**

**A:** When possible, regional LTCR management will schedule meetings to provide a forum for information sharing, identification of issues, training, and team building.

**Q: Is DHS providing any training for home health agencies that deliver Community Based Alternatives (CBA) services?**

**A:** Because CBA is a contract program and only falls under regulatory responsibilities in the licensing category for home health agencies, DHS does not offer training on this topic. However, the agency does offer courses to instruct surveyors on contract issues and can refer agencies to the proper person to answer questions they may have. For more information, go to: <http://www.dads.state.tx.us/business/ltr/Training/jointtraining.cfm>.

**Q: The stakeholders requested a new list of websites for the providers to use when they are searching for information and training materials.**

**A:** Long Term Care Education Services provides monthly training sessions around the state for both providers and surveyors that are listed on the DHS website: <http://www.dads.state.tx.us/business/ltrcr/Training/jointtraining.cfm>

Long Term Care Regulatory Policy has a related links website at <http://www.dads.state.tx.us/business/LTC-Policy/links.html> that provides further information.

The development and distribution of a new list of informative websites will be researched, developed, and distributed by the LTRC regional automation coordinator. Facilities also should contact their respective provider organizations for more information and training opportunities.

**Q: Can certified nurse aides (CNAs) meet the 12 hours of training by earning them all in one month?**

**A:** Agencies must adopt and enforce written policies that govern all personnel staffed by the agency. The policies must include requirements for training of all personnel specific to their job. The agency must provide a continuing systematic program for training its employees. *[Ref: State: HSC § 142.004(c)(2), 40 TAC § 97.245(1); Federal: 484.36(b)(2)(iii)]*

**Q: At one time, surveyors were involved in teaching/training when surveying. Will this ever happen again?**

**A:** Not at this time. Surveyors are permitted to provide reference information regarding best practices to help facilities develop additional sources and networking tools for program enhancement. However, surveyors should not act as consultants to HCSSA. *[Ref: Federal: S&C 03-08; SOM, Section 2727]*

**Q: What type of training do surveyors receive?**

**A:** All DHS HCSSA surveyors receive a three-week basic job skills training as well as a basic training from the CMS. There are other required courses for survey staff, as well. New surveyors have a seasoned surveyor preceptor give direct, hands-on field experience. The focus of surveyor training is to ensure that surveyors understand the state and federal regulations that apply to home health agencies.

Surveyors do not receive specific training in the requirements and rules that govern the many programs covered by Medicaid payment, such as the Medically Dependent Children Program, Comprehensive Care Program, or the 24-Hour Attendant Care program. DHS has a training course to provide additional information to surveyors on the various programs. *[Ref: Federal: SSA § 1902(a)(4); 42 CFR § 432.1 and 432.30]*

**Q: Will DHS provide surveyors more training and information regarding Community Based Alternatives facilities and their regulations and licensure process?**

**A:** All home health surveyors are given training that includes licensure regulations for HCSSA. Surveyors also receive a course designed to give basic information on CBA and other waiver programs that are contracted by DHS.

## ***Funding, Rates, and Payment***

**Q: Why doesn't a home health agency (HHA) get reimbursed for an admission visit since the admission requires that a skilled nurse or therapist do the admission?**

**A:** Reimbursement for performing an admitting visit is not a DHS Long Term Care Regulatory issue. According to requirements, the agency must have policies that cover performing an initial resident assessment to determine eligibility for home health services. Medicare does not reimburse for the initial visit, but rather with the first provision of skilled care/services. *[Ref: State: 40 Texas Administrative Code (TAC) § 97.281; Federal: 42 Code of Federal Regulations (CFR) § 484.55(a), 42 CFR § 484.205(b)]*

**Q: In Harris County, health maintenance organizations (HMOs) are no longer giving contracts to agencies. What is DHS doing concerning clients who want to use agencies that do not have a contract with HMO?**

**A:** Clients have the right to choose any agency or insurance carrier they wish to provide their services. The client's payer (HMO) can provide the client with a list of agencies to choose from for which the HMO will pay for authorized services. If the client chooses to use an agency not on the HMO list the client can pay for the services privately. *[Ref: State: 40 TAC § 97.282 (3); Federal: 42 CFR § 484.10]*

## ***Hospice Programs***

**Q: Can the governing body for hospice be the same as the licensed and certified Medicare governing body?**

**A:** Yes, but the agency must demonstrate separate entity status for each license/certification. Federal guidance for demonstration of separate entity status can be found in the State Operations Manual. *[Ref: Federal: SSA § 1861(dd) (4)(B), 42 CFR § 418.52, 484.14]*

**Q: Why are more hospice patients being placed in nursing facilities and why is this a big issue?**

**A:** DHS is aware that there is a need for the public to know about hospice and how to access it in the community. Based on the numbers, this doesn't appear to be occurring. Ninety percent of the Medicaid hospice population resides in nursing facilities. Hospice patients have the right to select the services they need. The resident may already be in a nursing home setting or may require the 24-hour nursing care provided by a nursing facility. For more information on hospice, go to <http://www.cms.hhs.gov/providers/hospiceps>.

**Q: Are nursing facilities accountable for extended hospice stays? Shouldn't the hospice agency be accountable?**

**A:** The hospice and nursing facility are two different providers servicing a patient and must coordinate care. Both the hospice and nursing facility are responsible to meet the respective regulations concerning a patient. Regulation gives the individual the right to elect or continue hospice services. The hospice physician is responsible for determining if the hospice recipient is terminally ill and meets the certification as specified. *[Ref: State: 40 TAC § 30.14(e)(1); Federal: 42 CFR § 418.21; 42 CFR § 418.22(b)]*

**Q: Can a patient who is receiving hospice services also receive home health services if it is not related to the hospice diagnosis?**

**A:** A hospice recipient can receive home health services unrelated to the terminal illness. If the home health agency is the hospice provider as well, there must be sufficient staff to handle both programs separately. *[Ref: State: 40 TAC § 30.16 (d); Federal: 42 CFR § 418.24 (d); SMM, Section 4305.2]*

**Q: Can continuous care be provided by a contracted agency for hospice patients?**

**A:** Only a hospice provider can provide continuous home care in an individual's home or a nursing facility setting. Contracted staff can only be used for non-core services except under extraordinary circumstances. If the contract staff is used, the hospice must continue to maintain professional, financial, and administrative responsibility. *[Ref: State: 40 TAC § 30.54; Federal: 42 CFR § 418.204; SMM, section 4305.6]*

**Q: Is DHS considering making hospice payments for clients living in assisted living facilities or adult foster homes?**

**A:** No. Individuals can receive hospice care in any setting as long as they meet the Medicare or Medicaid hospice eligibility requirements. The hospice provider then assumes full responsibility for the professional management of the patient's hospice care. If necessary, the hospice is responsible for arranging inpatient care. There is no room and board fee payment for hospice care. *[Ref: State: 40 TAC §30.10(a)(3); Federal: SSA § 1861(dd)(1); 42 CFR § 418.20]*

**Q: What are the hospice educational requirements for hospital employees when hospice patients are admitted for pain control, etc.? How often should in-service training be provided to nursing home employees?**

**A:** The hospice must ensure that inpatient care is furnished only in a licensed nursing facility that meets the licensure rules and the hospice's arrangement for inpatient care must be described in a contract that meets the requirements for hospice licensure. At a minimum, the contract must contain requirements that the hospice retains responsibility for appropriate hospice care training (to include palliative and end-of-life issues) of the employees who provide the care under the agreement. *[Ref: State: 40 TAC § 97.403(f)(5) (); Federal: 42 CFR § 418.56 (e)(5)]*

**Q: In an attempt to coordinate services, which program is used first when medical supplies, adaptive equipment, respite services, and skilled care is needed for a client who is in the Hospice and Community Based Alternatives (CBA) programs?**

**A:** The hospice is required to provide "core services" and all medical supplies and appliances, including medications, as needed for the palliation and management of the terminal illness and the patient's related conditions. The CBA contractor would be responsible for providing all needed services/products unrelated to the terminal illness and related conditions. *[Ref: State: 40 TAC § 97.403(u); Federal: SSA § 1861(dd) (1)(E); 42 CFR § 418.80, 418.96]*

## ***Licensing and Regulations***

**Q: For a new Medicare agency, how long is the CMS 855 information valid before an amendment must be submitted? From what date does the validity start?**

**A:** Information on the Centers for Medicare and Medicaid Services (CMS) Form 855 [Medicare Fee-For-Service Provider/Supplier Enrollment] is considered valid — even if outdated — if caused by a delay in state agency surveys. If the application is more than six months old due to provider delays, then the applicant must update the 855A, as applicable, and sign a new certification statement. This information should be transmitted to the state agency and regional office. The provider is responsible for contacting their fiscal intermediary to keep the Form 855 information current.

**Q: What are the geographic limits for licensed and certified home health service, licensed home health (LHH) service, and personal assistance services (PAS)?**

**A:** An agency must be licensed by the state of Texas in order to provide services within the state. The state cannot authorize an agency to provide services beyond its the borders. Each agency must notify the state of the geographic region or service area in which it will provide services. An agency may not provide services outside its service area. An agency may expand or reduce its service area at anytime during its license period. Absent an emergency, as determined by DHS, an agency must provide DHS with at least 30 days written notice before expanding its service area. *[Ref: State: 40 TAC § 97.2(73), 97.220(e)]*

**Q: How many of the seven active patients in licensed and certified home health (LCHH) services should have a least two disciplines?**

**A:** The federal guidance to surveyors states the home health agency should be providing care to seven of 10 patients at the time of the initial Medicare survey. The agency must furnish all services to meet the application requirements of the provider or supplier definition. The surveyor must be able to determine an agency's compliance with all applicable regulations. The agency must demonstrate that it has furnished at least skilled nursing and one other therapeutic service. However, this does not mean that the agency must provide two or more services to every client — they must simply demonstrate their ability to do so. *[Reference: SOM, Section 2008]*

**Q: What notification, if any, is needed to DHS when there is a change in alternate administrator at an agency?**

**A:** None. An agency must notify DHS in writing immediately of any change in its agency administrator, controlling person, or chief financial officer. The licensee must also designate in writing a person who meets the qualifications of an administrator to act in the administrator's absence. There is no requirement to notify DHS when there is a change in the alternate for the administrator. *[Ref: State: 40 TAC § 97.243]*

**Q: What is the Outcome and Assessment Information System (OASIS) process needed when transferring patients from a Medicare branch agency to a Medicare parent to avoid having OASIS errors?**

**A:** The branch ID is entered on the patient tracking sheet (Item 0016) at start of care (SOC) and updated if a change occurs during the episode. Enter the 10-digit federal branch identification number specified for this branch as assigned by CMS. If an agency has branches but services are provided by the parent, enter a P followed by nine spaces. If an agency has no branches, enter an N followed by nine spaces. The OASIS Help Desk at 512-438-4122 is available to answer questions. *[Ref: State: 40 TAC § 97.402(a); Federal: 42 CFR §484.55]*

**Q: What is the OASIS final validation report?**

**A:** Once data is received at DHS, the OASIS System will validate the file structure and data content. These validations are based on the OASIS record specification. The system generates two reports: an OASIS Initial Feedback Report, which indicates that the submission has passed the initial check of header and trailer information, and the OASIS Final Validation Report, which provides a detailed account of any errors found during the validation of the records in the submitted OASIS file. Both reports are formatted as text files with column specifications so that they may be easily read, printed, or downloaded. See CMS Survey and Certification letter 03-13 for additional information: <http://www.cms.hhs.gov/medicaid/survey-cert/letters.asp>

The OASIS education coordinators offer free classes that review these reports and how to use them. OASIS Training Opportunities offered by DHS may be accessed at <http://www.dads.state.tx.us/business/ltr/Training/oasis.html> *[Ref: State: 40 TAC § 97.402(a); Federal: 42 CFR § 484.20(c)]*

**Q: How do you enter a lock on OASIS on a non-Medicare patient without exporting it?**

**A:** Section 704 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 temporarily suspends the requirement that Medicare-approved HHAs collect OASIS data on non-Medicare/non-Medicaid patients. For further information, please see CMS Survey and Certification (S&C) Letter 04-12 dated Dec. 11, 2003, available at the following link: <http://www.cms.hhs.gov/medicaid/survey-cert/letters.asp>. [Ref: Federal: CMS S&C Letter #04-12]

**Q: If a patient is discharged by the state due to no longer meeting the homebound definition or an inability to locate the patient, does the agency need to use the discharge OASIS form?**

**A:** If a Medicare or Medicaid patient is being discharged from the agency, then an OASIS discharge assessment is required. DHS does not discharge patients; the agency discharges a patient who no longer qualifies for services. [Ref: State: 40 TAC § 97.402(a); Federal: 42 CFR §484.55(d) (1)(3)]

**Q: Where do you report a complaint about a business or person taking care of multiple patients without a license? Who is responsible for the individuals in their care?**

**A:** You can report this kind of complaint to the DHS hotline at 1-800-228-1570. The statute states that individuals providing home health, hospice, or personal assistance services must have a license. The statute identifies individuals who are exempt from a Home and Community Support Services Agencies (HCSSA) license. [Ref: State: HSC § 142.002 and 142.003]

**Q: Does an agency need another CMS 855A when adding a service area with a branch office for licensed and certified home health and PAS services?**

**A:** No. Medicare Federal Health Care Provider/Supplier Enrollment Application (855 A) is not required to expand the service area or to add a branch or alternate delivery site. [Ref: Federal: 42 CFR § 484.2, SOM, Section 2182 ; S&C Letter #02-30]

**Q: Why would OASIS apply to CBA clients?**

**A:** A licensed agency that is not Medicare-certified and categorized to provide only "licensed home health" services is not required to meet Medicare Conditions of Participation (CoPs). Effective January 1, 2002, OASIS has to be collected on all Medicare and Medicaid patients (excluding patients less than 18 years old and maternity patients) receiving skilled care in Medicare certified agencies which are not operating licensed home health as a separate entity. With regard to applicability of Medicare CoPs will be applicable unless the agency can demonstrate that it is operating a separate entity. When Medicaid-waiver clients are served through the LHH category of services, the agency providing both LCHH and LHH categories of service must demonstrate separateness or the Medicare CoPs will apply. *[Ref: State: Provider Letter #01-46; Federal: Social Security Act (SSA) § 1861(o); 42 CFR §484.55; §484.20]*

**Q: What is a separate entity and how does operating a separate entity affect the license or contract status?**

**A:** If the agency has a Medicare category and a license-only category on their state license, the agency is alleging a separate entity. Also, if there is a sister agency with the same individual or corporation as owner, the two agencies are alleging to be separate entities. This allegation declares that the agencies are operating separately and that the conditions of participation do not apply to the license-only section. The burden of proof is on the provider. The provider needs to be able to demonstrate that the agency is separate and distinct from all other operating parts with regards to operation, consumer awareness, and staff allocations and awareness. *[Ref: Federal: SSA § 1861(o)(6)]*

**Q: Is an agency operating a separate entity required to meet OASIS requirements for non-Medicare patients?**

**A:** The client's payment source does not effect the requirements. If the agency can demonstrate that the client is not receiving services from the certified home health agency, but from the separate entity, then OASIS would not be required. If a Medicare-certified agency cannot demonstrate that it is operating as a separate entity, all patient care must meet the Medicare conditions of participation. *[Ref: State: Provider Letter #01-46; Federal: SSA § 1861(o); SOM, Section 2183 and 2196.3]*

**Q: Where can the qualification requirements of a home health medical director be found?**

**A:** DHS does not have requirements for a home health medical director. Requirements exist for a medical director for hospice and for in-home dialysis. A home health agency must follow the orders of the client's primary care physician.

**Q: Is an agency required to have a Clinical Laboratory Improvement Amendments (CLIA) certificate if they only perform testing with the patient or agency glucometer?**

**A:** Assisting individuals in administering their own tests, such as fingerstick blood glucose, is not considered testing the client to the CLIA regulations. However, if home health agency employees are actually responsible for measuring the blood glucose levels of clients, with an FDA-approved blood glucose monitor, and no other tests are being performed, a CLIA Certificate of Waiver is required because glucose testing with a blood glucose meter (approved by the FDA specifically for home use) and some prothrombin time tests are waived tests under the provisions of the CLIA regulations. For more information, go to: <http://www.cms.hhs.gov/clia>. [Ref: State: 40 TAC § 97.284; Federal: 42 CFR § 484.14(j); 42 CFR § 493.15]

**Q: Many companies offer services such as client transfer, bed baths, medication assistance, and incontinent care but they are not licensed as a PAS. Is this legal? If not, how can their activity be deterred?**

**A:** Any entity that provides these types of services must be licensed. Violations of this requirement should be reported to DHS at 1-800-228-1570. [Ref: State: HSC § 142.002]

**Q: How many patients are required yearly under a state home health license?**

**A:** The agency must provide and document the provision of services to one or more clients during each annual license period. The agency must maintain documentation that such services have been provided during the previous 12 months and make that documentation available to DHS surveyors. [Ref: State: 40 TAC § 97.12 (a)(2)]

**Q: Can a licensed home health agency have a patient who requires bathing only?**

**A:** An HCSSA with a category of licensed home health may provide services to clients who only require this or other unskilled services. [Ref: State: 40 TAC § 97.401(b)(2)(A)]

**Q: Do you have to have a PAS category to deliver unskilled services? Can the licensed home health agency category cover this service?**

**A:** An HCSSA with a category of licensed home health is not required to have a PAS license to deliver unskilled services. A licensed home health agency may deliver both skilled and unskilled services. *[Ref: State: 40 TAC § 97.401(b)(2)(A)]*

**Q: Can an outpatient therapy department make home visits without having an HCSSA license?**

**A:** No. State law requires any entity that delivers health services in a home or residence to have an HCSSA license. *[Ref: State: 40 TAC § 97.2 (35) (B), HSC § 142.002]*

**Q: Are managed care companies required to have an HCSSA license?**

**A:** Managed care companies are required to have an HCSSA license only if they provide home health services identified in HCSSA licensure rules. *[Ref: State: HSC § 142.002; 40 TAC § 97.1(a)(2); Federal: SOM, Section 2194]*

**Q: Under an HCSSA contract, are primary home care agencies required to provide services outside regular business hours? Is an answering machine acceptable after hours?**

**A:** The HCSSA regulations do not specify that agencies provide services outside regular business hours. The regulations require that agencies adopt and enforce a policy to ensure that clients are educated in accessing care after regular business hours. The agency should review their contract for the contract requirement. *[Ref: State: 40 TAC § 97.290(b)]*

**Q: Is there a special license for CBA homes?**

**A:** Homes or facilities that provide services to four or more CBA clients who are unrelated to the owner must have an assisted living facility license. CBA clients are placed based on a provider's contract agreement with the state. *[Ref: State: HSC § 247.002(a)]*

**Q: Is it possible for policies to be written in language that is precise and understandable?**

**A:** DHS has been charged to write all rules in a plain English format. In addition, the survey and enforcement subchapters are being rewritten in a new question and answer format. The intent is to provide clarity. The remaining subchapters also are scheduled to be rewritten in question and answer format.

**Q: Can DHS make regulatory changes once each year or quarterly at a maximum?**

**A:** On average, there have been only two major revisions to the HCSSA rules since the program was transferred to DHS in September 1999. In addition to these revisions, there have only been a couple of minor technical amendments. The revisions are consistent with DHS' charge to complete a rule review every four years. [Ref: State: Government Code, §2001.039]

**Q: How does DHS give the provider community input on the standards and regulations?**

**A:** Providers are welcome to comment on standards and regulations any time. When DHS is proposing changes to the standards and regulations, the agency holds meetings (rules workgroup) with interested stakeholders to solicit comments. Providers and interested parties may request to be notified when DHS plans to hold these meetings. All proposed changes are posted in the *Texas Register* with the invitation for comments. Proposed changes to the federal rules are posted in the *Federal Register* with comments invited. [Ref: State: Government Code, §2001 and §2002.002; Federal: SSA § 1871(b); 5 United States Code 552(a)(1); 42 CFR § 401.106]

**Q: Where can an agency obtain a copy of the State Operations Manual?**

**A:** The State Operations Manual can be viewed online at <http://cms.hhs.gov/manuals/pub07pdf/pub07pdf.asp>. You can also go to the website to request to purchase a copy of the manual.

**Q: Are we required to download and maintain paper copies of documents that can be obtained online?**

**A:** No, neither home health nor hospice licensure rules specifically require the agency to download and maintain paper copies of documents that can be obtained online.

**Q: Can we have a separate set of policies for each category of licensure?**

**A:** Home health agencies must adopt and enforce all of the policies required by Chapter 97 of the Texas Administrative Code for its category(ies) of licensure. DHS does not advise agencies on how to organize their policies; however, DHS surveyors review agencies' records to determine if they have adopted and are enforcing all the required policies.

**Q: Does physician discharge notification refer to all licensure categories or for licensed and certified only, as opposed to Community Based Alternatives and Primary Home Care?**

**A:** An agency planning to discharge a client must notify the client's attending physician (if there is a physician involved) five days before the date on which the client will be discharged, except in an emergency situation. *[State: 40 TAC § 97.295 (a)]*

**Q: Will there be changes affecting the Community Based Alternatives and Primary Home Care programs?**

**A:** There have been numerous changes to rules that affect the CBA and PHC programs in the past several months. Rules may be viewed online at: <http://www.dads.state.tx.us/business/LTC-Policy/links.html>

**Q: Where are new rules for consent forms?**

**A:** The most recent rule changes became effective Feb. 1, 2002. Rules pertaining to client consent do not dictate specific format that consent forms must take. There may be more specific rules governing consent forms under specific rules for state law, i.e., advance directives or out-of-hospital do not resuscitate forms. *[State: 40 TAC § 97.282, 97.283, 97.292]*

**Q: Do lesser requirements for a plan of care review and aide supervision apply to licensed-only entities, or must we follow agency policies if we are licensed and certified?**

**A:** Agencies must adopt and enforce policies regulating client care. The agency may demonstrate separate entity status within the organization and follow only the rules that apply to that entity's license requirements. If the client is under a licensed and certified agency, all conditions of participation apply to their care. *[Ref: State: 40 TAC § 97.281; Federal: SSA § 1861(o)(6); 42 CFR § 484.36 (d)(2)&(3), 484.55(d)(1); SOM § 2183]*

**Q: Our agency is Medicare certified/licensed. If we have specified separate entities and do not collect OASIS data on non-skilled care, does the plan of care on those clients have to be reviewed every 60 days or can it be reviewed every six to 12 months? In addition, if medications are being set-up is it considered skilled or non-skilled care in cases of personal care and medication box fills only?**

**A:** The agency must review the plan of care based on the licensing rules that apply to the entity providing services to the client. If the client is receiving services (whether skilled or unskilled) under the LCHH category, the POC must be reviewed every 60 days. If the client is receiving only non-skilled services under the LHH category, the care plan must be reviewed at least annually (if operating as a separate entity). If the client is receiving skilled services under the LHH category, the POC must be reviewed at least every six months (if operating as a separate entity). The filling of medication boxes is a skilled task that can be delegated by an RN to an unlicensed person. The RN is responsible for ensuring the unlicensed person is capable of performing the task and supervising the task in accordance with the Board of Nurse Examiners rules regarding RN delegation. *[Ref: State: 40 TAC § 97.298, 97.401(b) (2)(A)(B); Federal: 42CFR § 484.18(b)]*

**Q: Our licensed and certified agency only takes referrals for Medicare/Medicaid patients. In our same building, a licensed-only agency takes referrals on**

**A:** The location of the separate entity does not determine if the entity is separate. The division of duties, staff, and types of care delivery creates the separate entity status. *[Federal: SOM § 2183]*

**Q: Our agency offers both licensed and certified home health services and licensed home health services, each with a category of services of home health and personal assistance services. If PAS service is placed under the licensed home health service license on completing the applications or renewal, do we put the PAS clients in PAS or LHHS slots?**

**A:** Agencies must maintain a current list of clients for each category of service licensed. Only the license category(ies) held by the agency would be used to list clients. If there were no license for a PAS agency, there would be no list of clients under this category. *[State: 40 TAC § 97.293(1)]*

## ***Medication, Medical Orders***

**Q: What is the perfect foley order? What is the perfect O2 order?**

**A:** DHS does not regulate types of physician's orders or agency response to physician orders. The agency must adopt and enforce their own policies and procedures when receiving and carrying out the physician's orders. [Ref: State: 40 TAC § 97.297; Federal: 42 CFR 484.18(c)]

**Q: If a family member decides to discontinue a patient's meds, but the doctor has not approved it, can we take it off the 485?**

**A:** Agencies must adopt and enforce a written policy for maintaining a current medication list and medication administration record, which may be incorporated into one document. A notation must be made in the medication administration record or clinical note of any ordered medications not administered, the reason for not administering the medication, including the client's refusal of the medication, and the notification of the physician. [Ref: State: 40 TAC § 97.300; Federal: 42 CFR § 484.18 (b)(c)]

**Q: Regarding reporting falls to the physician, does this mean all falls or only falls with staff present?**

**A:** The registered nurse (RN) is responsible for evaluating and assessing the client, notifying the physician of changes in the client's condition, initiating and revising the nursing plan of care as needed, and initiating appropriate preventive and rehabilitative nursing procedures for the client. These items should be done according to the agency's policies and procedures for the delivery of client care. [Ref: State: 40 TAC § 97.281(6) (11) & (16), 97.243(b)(3)(D); Federal: 42 CFR § 484.18 (b), 484.30 (a)]

**Q: Why are agencies held responsible for hospital discharge orders and medications when neither the patient nor the hospital report orders to the agency?**

**A:** The statute requires the supervising nurse to assure that the client's needs are assessed by the appropriate health care professional after hospital discharge. Assessing the client's medications should be included in this assessment. The statute defines "Medication List" as a list of client's medications including the physician orders relating to dosage, frequency, and method of administration. The statute requires agencies to adopt and enforce a written policy for maintaining a current medication list.

The hospital is obligated by its Medicare conditions of participation to perform discharge planning. If problems are noted with the hospital's discharge

planning of the client, notify the Texas Department of Health at: 1-888-973-0022 or 512-438-7111. *[Ref: State: 40 TAC § 97.243 (b)(3)(D) (iii); 40 TAC § 97.300; Federal: 42 CFR § 484.55(c)]*

**Q: Should a patient be discharged immediately after services have been completed as ordered by a physician, even though the episode period still remains?**

**A:** The agency is obligated to follow the physician's orders. When the physician's orders have been executed, and there is no need to coordinate care for future visits, the agency should follow its policies for discharging the client. *[Ref: State: 40 TAC § 97.295(b)(5); Federal: 42 CFR § 484.18; S&C Letter #01-15]*

**Q: Does the use of Thera-Band require a physician's order or inclusion on the plan of care (POC)?**

**A:** DHS does not regulate reimbursement issues. If the physician ordered the use of Thera-Band, then an order is required that specifies the type of therapy or exercise the patient is to perform, the frequency of performance, and the duration of use. The order must state whether physical therapy is involved, identify if physical therapy includes a home exercise program, and what that program would entail. If the therapist uses Thera-Band to meet the physician's therapy orders, the care plan should include the items listed above. The agency is responsible for checking with Medicare for reimbursement issues. *[Ref: State: 40 TAC § 97.297; Federal: 42 CFR § 484.10 and § 484.32]*

**Q: We are a licensed and certified agency that provides Community Based Alternatives (CBA) services and recently added respite care. Do respite patients require physician's orders?**

**A:** A licensed and certified agency is required to obtain physician's orders for treatment and to develop a plan of care. The care follows the written plan of care established by and reviewed by that physician. Unless the agency can show that the CBA and respite care patients are a separate entity from the home health agency (HHA), all requirements for the HHA apply to these patients. *[Ref: State: 40 TAC § 97.297; Federal: 42 CFR § 484.18]*

**Q: Is it acceptable for the nurse in a physician's office to give approval for physical therapy services over the phone? How do we document the order?**

**A:** The Texas Board of Medical Examiners gives physicians broad authority to delegate tasks to unlicensed personnel, which may include authorizing physical therapy. When accepting the order, the home health agency documents with whom they spoke, including the time and date. A corresponding order is recorded for this interaction that must be countersigned by the physician. *[Ref: State: Occupation Code §157.001; 40 TAC § 97.297; Federal: 42 CFR § 484.18(c)]*

**Q: What would the "date of onset of diagnosis" be if we did not know the exact date?**

**A:** The agency is required to develop a plan of care that covers all pertinent diagnoses. The physician is consulted if the plan of care cannot be completed. If the client is not able to provide a reliable history, the agency should consult with the physician, who will sign the plan of care, to request that the physician determine the diagnosis and date of onset. *[Ref: State: 40 TAC § 97.301(a)(9)(B); Federal: CFR 484.18(a)]*

**Q: The doctor ordered that a client should shower then cover a gangrenous foot with gauze and stretch gauze. Can that task be delegated to the aide?**

**A:** There are inadequate facts to provide a complete answer to this question. If the patient is receiving services under home health, the nurse is responsible for delegation, assessment, and developing a plan of care. The nurse uses his or her professional judgment concerning what tasks are delegated based on the agency's policies. The nurse communicates with the physician concerning any change or concerns in the patient's status. *[Ref: State: 40 TAC § 97.298; 22 TAC § 224.8]*

**Q: Does the Texas Board of Pharmacy include in their regulations that nurses may carry flu and pneumonia injections from agency to patient?**

**A:** The Board of Pharmacy rules govern pharmacists. The rule that applies to the transportation of flu and pneumonia vaccines is in the state requirements, which covers registered nurses or licensed vocational nurse's transportation of water, saline, vaccines, and certain dangerous drugs. *[Ref: State: 40 TAC § 97.303(2)(A)]*

**Q: Does the agency need a consent form to administer flu and pneumonia vaccines?**

**A:** Agencies should follow their policies and procedures related to vaccine administration. There is no specific requirement for a consent for flu and pneumonia vaccines. *[Ref: State: 40 TAC § 97.303(2)(B); Federal: S&C Letter #03-02]*

**Q: In adult foster care, when delegating medications to the adult foster care provider, when must the registered nurse provide instructions in person and when can instructions be provided over the telephone?**

**A:** The RN is responsible for delegating all tasks for patients/clients. Under the requirements, the RN is responsible for assuring that the clients' plan of care is executed as written and to see that a reassessment of client's needs is performed by the appropriate health care professional(s). The RN must ensure that medications are correctly administered, which should mean an assessment of the skills of the person responsible for administering medication. Assessments are required to be done in person. *[Ref: State: 40 TAC § 97.243(b)(3)(C)& (D)(i); Federal: 42 CFR § 484.55(c)]*

**Q: What is the time requirement for updating medication profiles?**

**A:** Regulations define a "Medication List" as a list of a client's medications that includes the physician orders relating to dosage, frequency, and method of administration. The medication list is used to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindications. The regulation specifies that the agency must adopt and enforce a written policy for maintaining a current medication list. It is the agency's responsibility to comply with its policy for maintaining the current medication list for all medications ordered by the physician. *[Ref: State: 40 TAC § 97.2(44); 40 TAC § 97.300; Federal: 42 CFR § 484.55(c)]*

**Q: How important is medication classification?**

**A:** A medication list is a list of a client's medications that includes the physician orders relating to dosage, frequency, and method of administration. The medication list is used to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindications. The medication list is required to be current for all medications ordered by the physician. *[Ref: State: 40 TAC § 97.2(44); Federal: 42 CFR § 484.55(c)]*

**Q: Can you please clarify physician delegation?**

**A:** Each agency must adapt and enforce a written policy which states whether or not it will honor physician delegation. If an agency accepts physician delegation, the agency must comply with the Medical Practice Act, Occupation Code, Chapter 157 concerning physician delegation. *[Ref: State: 40 TAC 97.296(a)]*

**Q: Is a physician's order required for Primary Home Care program patients? Can the need for a physician's order for the primary home care, as a requirement, be eliminated because this delays the initiation of services, thereby causing problems for the agencies?**

**A:** The Primary Home Care program requires a practitioner's statement to determine eligibility. This is not a physician's order. The agency is required to adopt and enforce written policies regarding physician's orders. *[Ref: State: 40 TAC § 97.281 and 97.297]*

**Q: Is it necessary to have a family practitioner give an order for an 1,800 calorie diet if the IDT team, which include a dietician, agrees and/or the psychiatrist gave an order?**

**A:** The regulation states that the agency must adopt and enforce a written policy describing protocols and procedures the agency staff must follow when receiving orders. If a psychiatrist has given a diet order, then it should not be necessary to contact the family practitioner for an order, as long as this practice does not conflict with agency policy. *[Ref: State: 40 TAC § 97.297; Federal: 42 CFR § 484.18]*

**Q: Does the 14-day rule to obtain physician signatures apply to private duty patients? Frequently, the written order taken by the nurse in the field does not arrive in the office for a week.**

**A:** The regulation does not specify when the physician signature must be obtained. The agency is required to have a policy that addresses the time frame for a physician's countersignature of verbal orders. *[Ref: State: 40 TAC § 97.297(1)]*

**Q: What happens when the patient is unable to buy the new medications to complete the process of carrying out the physician order?**

**A:** Coordination of care between the agency and caseworker is very important so that the patient's needs are met. This issue depends on the program in which the patient is enrolled. If the patient is under the licensed and certified category of home health, the nurse obtains a physician order for a social worker visit to explore available options. If the patient is under the category of licensed home health and if the patient is also in the CBA program, the caseworker would be contacted to determine the patient's options. If the agency is a licensed hospice, the agency must comply with the hospice rules, which includes covered services, i.e., medications. *[Ref: State: 40 TAC § 097.288(a) and 97.403(a) & (c); Federal: 42 CFR § 484.14(g)]*

**Q: Physician's orders are for 40 hours a week, but the client is authorized for only 20 hours a week. The HHA then has to write another order for decreased hours. Does the HHA follow physician orders or payment authorization? What does the HHA do when the client requires more services than Medicare will authorize?**

**A:** HCSSA is responsible for assessing all clients to ensure that their needs can be met by the home health agency. The physician's orders must be part of the each client's assessment and care planning. The agency should be knowledgeable regarding client needs and reimbursement issues by the fiscal intermediary. Based on the client's needs, reimbursement issues, and physician's orders, the agency should determine if they can meet that client's needs. *[Ref: State: 40 TAC § 97.401(b) (2), 97.402(a); Federal: 42 CFR § 488.18]*

**Q: The state rule requires a physician's order for a Tb vaccine. This conflicts with the new federal rule. Does the state rule supersede the federal rule?**

**A:** The more stringent rule must be followed. State rules allow the administration of flu, tuberculosis, pneumonia, and Hepatitis B by a registered nurse or licensed vocational nurse to the agency's employees, home health and hospice clients, or client's family members under physician's standing orders. The standing order must be signed and dated by the physician, as well as, following other requirements of the rules. *[Ref: State: HSC § 142.0062, 142.0063; 40 TAC § 97.303; Federal: 42 CFR 484.18(c)]*

**Q: Does the flu shot or pneumonia vaccine need to be included on the medication profile sheet?**

**A:** Yes. Agencies must adopt and enforce written policies for maintaining a current medication list and medication administration record. Agencies must perform a drug regimen review of all clients' medications during the comprehensive assessment. *[State: 40 TAC § 97.300; Federal: 42 CFR § 484.18(a) and 484.55(c)]*

**Q: You indicated we could administer flu shots to patients/families if the three requirements were met without a separate physician order. What about flu clinics or providing for companies under occupational health?**

**A:** DHS regulates the activities of home health agencies to ensure they are complying with the rules and statutes and to ensure that agencies provide the highest possible quality of care. DHS could revoke a license when the "health and safety of persons are threatened" and this is not limited to protecting only clients. According to the HCSSA rules, the agency may administer to its employees, clients, and clients' family under a standing order. *[Ref: State: HSC § 142.0011, 142.0062; 40 TAC § 97.303(2); Federal: 42 CFR § 488.20(b); S&C Letter 03-02]*

**Q: Can agencies go to assisted living or community facilities for vaccines if approved by the agency's medical director?**

**A:** Agencies are licensed to deliver vaccines to their employees, clients, and client family members according to a physician's standing orders. If an employee is going to an assisted living or community facility to receive a vaccine, there is no rule stating the employee cannot do this. If the agency is picking up vaccine solutions from these locations, the agency must follow their licensing rules. *[Ref: State: HSC § 142.0063(f), 40 TAC § 97.303(3)(F)]*

**Q: On the issue of the flu and pneumonia vaccines, what if the patient is already on services and the physician has sent the vaccine home with the patient? Are the same three areas required to give the shot?**

**A:** Agencies must follow their policies regarding the vaccine administration. Agencies are required to handle the vaccine solution just as any other medication sample sent from a physician's office. All medications should be administered per the rules of the agency license. *[Ref: State: 40 TAC § 97.303(2); Federal: 42 CFR § 484.18(c)]*

**Q: On administration of flu/pneumonia vaccines, can the home health agency administer vaccine during a courtesy visit if a physician asks the agency to do**

**this even if the person is not a patient of the agency? If yes, what documentation would you expect to see?**

**A:** No. According to the rules, the home health agency may administer vaccines to agency employees, clients, and clients' family under a standing physician's order. DHS could revoke a license when the "health and safety of persons are threatened" and this is not limited to protecting only clients. *[Ref: State: HSC § 142.0062; 40 TAC § 97.303(2)]*

**Q: Does the letter from CMS regarding flu and pneumonia vaccines apply to only licensed and certified home health agencies or can this be applied to licensed agencies?**

**A:** Although the federal conditions of participation for Medicare were revised, licensed agencies are still bound by state statute, which requires a physician's orders for the four vaccines — hepatitis B, influenza, tuberculin, and pneumococcal. An agency is allowed to purchase, store, or transport the vaccines for the purpose of administering them to its employees, home health or hospice patients, and patients' family members under a standing physician's order. *[Ref: State: HSC § 142.0062(a)(1)-(4); 40 TAC § 97.303(2)(A)&(B); Federal: 42 CFR § 484.18(c); S&C Letter #03-02]*

## **Miscellaneous**

### **Q: What is the Consolidated Waiver Program?**

**A:** The Consolidated Waiver Program (CWP) is a pilot program that tests the feasibility of combining five of the state's Medicaid waiver programs: Community Based Alternatives (CBA), Community Living and Support Services (CLASS), Medically Dependent Children Program (MDCP), Home and Community Based Services (HCS), and Deaf-Blind with Multiple Disabilities (DBMD). Medicaid waiver programs provide home and community-based services to individuals who meet the criteria for institutional care.

The CWP pilot is limited to serving 200 individuals in Bexar County or other areas as designated by the Texas Board of Human Services. Results of this pilot were reported to the Texas Legislature in January 2004. These rules are not intended to repeal or replace any existing statewide waiver rules or in the pilot area for individuals not participating in the pilot. The results of the pilot program may be viewed at: [http://www.hhsc.state.tx.us/pubs/121603\\_cwp.pdf](http://www.hhsc.state.tx.us/pubs/121603_cwp.pdf) (**Note:** This link contains a PDF file. If you do not have the Adobe Acrobat reader, you may download it free from [Adobe](#).) [Ref: State: Government Code § 531.0219; 40 TAC § 50.1; Federal: SSA §1915(c)]

### **Q: What constitutes a Medicare week?**

**A:** There are no regulations on this. The home health agency determines when they will begin and end their week for scheduling visits dependent on the needs of their clients. The agency should provide this information for the surveyor to evaluate during the survey process.

### **Q: If a patient is able to use Metro-Lift for transportation, are they considered homebound?**

**A:** A patient's homebound status is determined by the level of difficulty that the client has when leaving his or her home; not with how they leave the home. If the patient's absences are infrequent and leaving the home is taxing, the use of Metro-Lift would not affect the client's homebound status. Health care treatment, including regular absences to participate in therapeutic, psychosocial, or medical treatment in an adult day care program, will not negate the patient's homebound status. [Ref: State: Provider Letter #01-28; Federal: SSA § 1814(a) and 1835(a) ; CMS transmittal A-01-21]

**Q: How can we get PHC/CBA client referrals from DHS? How does DHS maintain equality/fairness in referrals?**

**A:** DHS does not regulate this issue. The agency's name must be on the list in the county/region where the service is provided. The case manager offers clients the list of agency choices. Unless the client needs a verbal referral, provider agencies receive referrals based on the following priorities: client's choice, physician's choice (if stated), and agency rotation of eligible providers. *[Ref: State: 40 TAC § 47.2901(a)(1) and (2)]*

**Q: What can we do to get referrals from hospitals that have hospital-based home health?**

**A:** Hospitals are required to allow the patient the right to choose the home health agency that the patient wants to use. If you believe there is a violation, please report your concern/complaint to the Texas Department of Health at 1-888-973-0022 or 512-438-7111. *[Ref: State: 40 TAC § 97.282(3); Federal: 42 CFR § 484.10]*

## ***Operations and Staffing***

**Q: Are there any plans to eliminate requirement that active patient rosters contain current certification period? Many computer systems do not provide this option/capability.**

**A:** No. The client list must include certification period, if applicable. The agency is responsible for how this information is maintained on the record. *[Ref: State: 40 TAC § 97.293(2)]*

**Q: Due to a pediatric patient being out with family or to an activity, skilled hours are missed and cannot always be made up. Why do surveyors write deficiencies for hours authorized and on the plan of care (POC)?**

**A:** Deficiencies/violations are cited based on rules and regulations for operation of a home health agency (HHA). The agency is required to assess each client and design a plan of care that will address all client needs, not just nursing needs. The agency is responsible for following the plan of care developed based on the assessment. *[Ref: State: 40 TAC § 97.282(2) & (3), 97.243(b)(3)(C), 97.404(e)(3); Federal: 42 CFR § 484.18]*

**Q: Can a licensed social worker function independently in a hospice program?**

**A:** No. Hospice rules require that a social worker have a bachelor's degree in social work from an accredited college or university and must be under the direction of a physician. *[Ref: State: 40 TAC § 97.403(o); Federal: SSA § 1861(dd) (1)(C); 42 CFR § 418.84]*

**Q: Does the use of contract nurses apply to using a staffing agency — a registered nurse (RN) for a shift at an inpatient unit (IPU)?**

**A:** A freestanding hospice that provides direct inpatient care must have on-site, 24-hour nursing service provided by RNs and licensed vocational nurses (LVNs). Staffing agency RNs and LVNs may be used to meet the staffing requirements during peak patient loads or under extraordinary circumstances. *[Ref: State: 40 TAC § 97.403(w) (1); Federal: 42 CFR § 418.80]*

**Q: Are agencies encouraged to perform T.I.L.E. assessment on their clients?**

**A:** If the client is in a nursing facility, the Medicaid hospice rules require both the nursing facility and the hospice nurses to complete the Client Assessment Review and Evaluation (CARE) form, Form 3652, to provide admission and subsequent assessment to a nursing facility resident in hospice. *[Ref: State: 1 TAC § 371.214(a); 40 TAC § 30.92; Provider Letter #01-27]*

**Q: When coordinating care with contracted agencies, what is expected of the agency in keeping the patient's medical record? This is a licensed-only agency, doing intravenous therapy (IV) at home and at an IV suite.**

**A:** Agencies must adopt and enforce policies to require that all service providers involved in the care of a client, including contracted health care professionals or another agency, are engaged in an effective interchange, reporting, and coordination of care regarding the client. The agency must document the steps taken to meet this rule in the client record. *[Ref: State: 40 TAC § 97.288(a) &(b), 97.407 (10)]*

**Q: If a Community Based Alternatives (CBA) nurse attempts to coordinate care with a Medicare skilled agency, how often do you need to coordinate care — every 30, 60, or 90 days?**

**A:** The agency must adopt and enforce policies that require that all service providers involved in the client's care are engaged in an effective interchange, reporting, and coordination of care based on the client's needs. The frequency of care coordination should be dictated by the client's needs. *[Ref: State: 40 TAC § 97.288; Federal: 42 CFR § 484.14 (g)]*

**Q: A licensed agency provides IV therapy in an IV suite and at home by skilled nurses. Is the infusion suite under pharmacy or home care?**

**A:** The IV suite is not regulated by DHS nor can a HCSSA use their office/license to operate an IV suite. If HCSSA nursing staff are providing care to patients under the agency license, the staff must follow the licensure rules specific to infusion therapy regulating that license. HCSSA may only provide these services in a residence or independent living environment. *[Ref: State: HSC § 142.001(13); 40 TAC § 97.407]*

**Q: Is application of antibiotic ointment or silvadine considered to be wound care covered by Medicare?**

**A:** DHS does not determine coverage of Medicare home health services. Dressing changes and physician-ordered care should be performed according to the client's service plan. The agency may call 1-800-442-2620 for Medicare coverage information. *[Ref: Federal: 42 CFR § 484.18 (c)]*

**Q: How do you feel about ranging visits, i.e., one to three times a week, then one to two times a week, then memo for one time a week, if needed? We get an order to increase visits if we are down to one to two times a week and have a need to increase to three times a week again. Is this okay?**

**A:** DHS surveyors review client records for the appropriateness of the care provided to the client. The agency is responsible for adopting and enforcing policies for specific client care needs. *[Ref: State: 40 TAC § 97.281; Federal: 42 CFR § 484.18 (a)&(b), 484.30 (a)]*

**Q: Who shall we call or file a complaint with when a personal assistance service (PAS) agency is unable to staff the client care for several weeks?**

**A:** DHS licenses PAS agencies. Complaints regarding these agencies should be directed to the DHS hotline at 1-800-228-1570 or 1-800-458-9858; via e-mail to charline.stowers@dhs.state.tx.us; or via regular mail to DHS LTCR Complaint and Intake Management Section, Mail Code E-349, P.O. Box 149030, Austin, TX 78714-9030. *[Ref: State: 40 TAC § 97.282 (11)(B)]*

**Q: If a client receives only PAS services and is assessed annually by a nurse, for purposes of the annual assessment, should the agency have a POC for the annual assessment and for PRN visits (i.e., post hospitalization, delegation etc)?**

**A:** Physician's orders are not required for assessment or supervision. They are only required for skilled treatment. *[Ref: State: 40 TAC § 97.404]*

**Q: I am an RN for a group home. When charting, I have a flow sheet where I document events as they happen. Is it necessary to do a monthly summary since I do a quarterly report?**

**A:** HCSSA does not regulate group homes. An RN must use the rules of any license/certification the group home is regulated by to determine documentation requirements.

**Q: Is it necessary to get lab reports on the client's chart? If so, what is the procedure if the doctor refuses to issue one?**

**A:** The clinical record is required to include complete documentation of all known services and significant events. In addition, the documentation must show that effective interchange, reporting, and coordination of care occurs. It is not a requirement to obtain the lab reports for the client's chart; however, having the lab results on the record documents care coordination. *[Ref: State: 40 TAC § 97.301(a)(9)(H); Federal: 42 CFR § 484.48]*

**Q: A nurse sees a patient once a week. In between visits the patient is admitted into and discharged from the hospital. The agency is not informed by the patient or family. When the agency finds out, do they write the nurse and request that he or she make the correction, or do they just make a note of the fact the patient was hospitalized?**

**A:** The regulations specify that the clinical record contains documentation of all significant events; a hospitalization is considered a significant health event. Once your agency staff has knowledge of the hospitalization this should be documented and the supervising nurse, under state requirements, must reassess the client's needs after the hospital discharge, even though several weeks may have passed since the discharge. *[Ref: State: 40 TAC § 97.301(a)(9)(H); 40 TAC § 97.243(b)(3)(D); Federal: 42 CFR § 484.18(b)]*

**Q: Our licensed home health agency provides services under a state contract. We have therapies in home with no nursing provided. Please state clearly if each —nursing and therapy — writes their own POC and if therapies have to include diet and medications on the POC?**

**A:** The plan of care for a client receiving skilled services under the licensed home health category of service must include medications and nutritional requirements (diet) as ordered by the physician. Therapy develops a POC for therapy services. If medications or nutritional requirements are part of the therapy, then the appropriate discipline is required to include these items in their POC. *[Ref: State: 40 TAC § 97.401(b)(2)(B)]*

**Q: Is it acceptable for a certified agency to accept home health aide competency evaluations from another agency who tested and evaluated the home health aide?**

**A:** Agencies must have documentation of the home health aide's training program. The agency is required to prove that the aide's competency has been evaluated by the current agency. *[Ref: State: 40 TAC § 97.245(1); Federal: 42 CFR § 484.36 (b)(1)]*

**Q: What should we do when our corporate human resources office is out of state along with our personnel records?**

**A:** Agencies are required to perform certain tasks/evaluations for all employees at the time of hire and throughout their employment. The original personnel files may be kept in any location as determined by the agency. Original personnel files must be accessible and readily retrievable for inspection by the DHS at the survey site. *[Ref: State: 40 TAC § 97.246(b); Federal: SOM, Section 2184]*

**Q: Must each agency have employees sign that they have read the entire policy manual? Could an agency have employees sign and acknowledge new policies quarterly?**

**A:** Yes to both of these questions. All direct-care personnel must sign a statement saying they have read, understand, and will comply with all applicable agency policies. The agency policy may require employees to read the entire policy manual. An agency may choose to implement a quarterly employee review of any new policies after the initial new-hire orientation. *[Ref: State: 40 TAC § 97.245 (9)]*

**Q: Can we consider decreasing supervisory nurse visit frequency versus under utilization?**

**A:** No. DHS surveyors are conscious of the nursing shortage. Agencies must meet all Medicaid conditions of participation (CoPs) to maintain licensure and certification. The CoPs are minimum requirements and must be met by the agency to ensure patient care. The agency assesses all patients before admitting them to their service and should not admit a client if the agency can not meet all of the client's medical needs.

**Q: If the order states "RN to visit once each week," is that any day within that week or every seven days on the same day?**

**A:** A physician's order for an RN once each week means that the RN visits the client as soon as possible from the date of the order, and then weekly thereafter according to the agency's policy. *[Ref: State: 40 TAC § 97.281; Federal: 42 CFR § 484.18]*

**Q: If a client falls frequently due to a diagnosis of poor balance, refuses assistance from the caregivers, and the RN assesses only if there is an injury reported, should we: a.) Report every fall or b.) Address frequency of reporting to the physician in the plan of care?**

**A:** Home health agencies are responsible for client assessment and reassessment. If the client falls, the attending physician should be notified, including frequency and severity of the fall. The client record should reflect documentation of the action taken by the home health agency and any physician orders. Fall prevention assessment and measures should be implemented in the plan of care. *[Ref: State: 40 TAC § 97.281(6) and (11); Federal: 42 CFR § 484.18(b) and 484.30(a)]*

**Q: Can an RN delegate filling a medication box to unlicensed assistant personnel if the RN and the client or client's responsible adult mutually agree upon this task?**

**A:** The Board of Nurse Examiners addresses delegation of certain nursing tasks for client's living independently who require assistance with certain tasks. Delegation of tasks must meet the conditions set forth in that regulation. [Ref: State: 22 TAC § 224-225]

**Q: Can an LVN pronounce death?**

**A:** No. The statute states an agency must adopt and enforce a written policy on pronouncement of death if that function is carried out by an agency RN. Only an RN or physician may pronounce death. For more information and answers to licensing questions, go to: <http://www.bne.state.tx.us> [Ref: State: 22 TAC § 193.9(a); Federal: S&CC letter #03-12]

**Q: Can an LVN take call for an agency?**

**A:** Home health agencies should include how the LVN is to communicate with the supervising RN and the client's physician in their policies and procedures. LVNs should receive relevant continuing education if they are assigned or expected to work outside of a structured health care setting in which the client/patient's condition may not be stable and predictable. LVNs may not triage, but may be on call to perform tasks as instructed. For more information regarding licensing standards for LVNs go to: <http://www.bne.state.tx.us>. [Ref: State: Occupations Code, 302, ; 40 TAC § 97.281(16) and § 97.290; Federal: 42 CFR § 484.55(a)(b)(2)]

**Q: When an agency sees a patient for seven days for intravenous antibiotics, and may or may not be asked to provide other services such as hydration, during the 60-day certification period should they be placed on hold?**

**A:** An agency may keep a patient on hold for the remainder of the initial certification period, so the patient's needs could be met if further skilled intervention is required. However, at the end of the initial certification period, if the patient had no further skilled needs, discharge is required. The patient also could be discharged at the end of the IV antibiotic course of treatment. The agency must make this determination related to each individual's need. [Ref: Federal: 42 CFR § 484.18(b); S&C Letter #01-15]

**Q: Why must an RN make the follow-up visit after a patient experiences low blood pressure — for which the physician was notified and interventions performed — if the visit is only a routine visit?**

**A:** The regulations specify that the supervising nurse is responsible for assuring that a client's needs are reassessed by the appropriate healthcare professional when there is a significant health status change. The LVN license does not permit an LVN to assess a client; therefore, when the client experiences a significant health status change an RN is responsible for performing the assessment. *[Ref: State: 40 TAC § 97.243(b)(3)(D); Federal: 42 CFR § 484.18(b); 484.30(a)]*

**Q: Why should the agency be held responsible for making an extra visit? For example, if the agency was authorized to do six visits and the nurse inadvertently made seven visits.**

**A:** The plan of care, care plan, and/or individualized service plan outline the services the agency is to provide. If the agency provides one more visit than ordered, the care plan needs to be amended, and the physician notified of changes in the client's condition. *[Ref: State: 40 TAC § 97.243(b)(3)(C); Federal: 42 CFR § 484.18(a)]*

**Q: Can a physical therapist initiate a home health aide care plan and supervise the aide for 14 days for a therapy-only case in licensed and certified agencies?**

**A:** Yes. A physical therapist can initiate a home health aide plan of care and supervise the aide, if the plan of care includes only restorative or maintenance therapy. The plan of care is for the overall care of the patient. The nurse aide's care plan is part of that plan. *[Ref: Federal: 42 CFR § 484.36(d)]*

**Q: How many days are allowed as a waiting period by which the initial evaluation must be completed: 48 hours, 72 hours, or is it arbitrary? Is the timeframe set by the policy of the individual agency?**

**A:** The agency's policy sets the time frames for when evaluations are to be performed. Regulations only requires timeliness. *[Ref: State: 40 TAC § 97.281(1); Federal: 42 CFR § 484.55]*

**Q: If a client is put on therapy services following a hospitalization during a certification period and is then re-certified with a need for the continuation of therapy services, do you need a new evaluation from therapy for new certification period or can an interim evaluation serve?**

**A:** No. The plan of care is reviewed at least once every 60 days by the physician and home health agency staff responsible for the care delivered. The therapist helps the physician develop and revise the plan of care, as necessary. *[Ref: State: Occupation Code 453.301(a), (b); Federal: 42 CFR § 484.18(b)]*

**Q: May therapy services be provided under the Comprehensive Care Program when the patient is at school, daycare, or home?**

**A:** The Comprehensive Care Program is not a DHS program, rather it is a Medicaid program for children. The domicile for a child may vary from home, school, or day care. This is an appropriate delivery of services. *[Ref: State: 2003 Texas Medicaid Provider Procedures]*

**Q: Do we collect Outcome and Assessment Information System (OASIS) data on clients receiving unskilled services or personal assistance services clients?**

**A:** Effective Dec. 8, 2003, and until further notice, surveyors will not cite home health agencies for failing to include OASIS data set as part of the patient-specific, comprehensive assessment for all non-Medicare/non-Medicaid patients. The agency is not required to perform assessments based on OASIS for non-skilled service clients. *[Ref: Federal: 42 CFR § 484.55; S&C Letter #04-12]*

**Q: Is a registered nurse required for post-hospital, increase in service, etc., under personal assistant services (PAS)?**

**A:** Client files must include documentation of determination of services based on an on-site visit by the supervisor where services will be primarily delivered and records of supervisory visits. All clients are to be assessed upon return from the hospital related to a potential for a significant change in condition. This does not necessarily change the status of the service provided. *[State: 40 TAC § 97.243(b)(3) (D), 97.404(e) & (f)(1)]*

**Q: For licensed home health, is the plan of care required every 12 months for unskilled services the same as the individualized service plan or should it be a specific plan of care form?**

**A:** If a practitioner has not ordered skilled care for a client, then the appropriate health care professional must prepare a care plan. The care plan must be developed after consulting with the client and the client's family and must include services to be rendered, the frequency of visits or hours of service, identified problems, intervention method, and projected date of resolution. The care plan must be reviewed and updated by all appropriate staff members involved in client care at least annually, or more often as necessary to meet the needs of the client. *[Ref: State: 40 TAC § 97.401(b)(2) (A)]*

**Q: What supplies are affected when an episode is opened, i.e., mail order supplies such as diabetic or nebulizer medications?**

**A:** DHS does not play a role in setting reimbursement rates or determining what goods or services are reimbursable. This is a provider/fiscal intermediary question. For more information, providers may go to [http://cms.hhs.gov/manuals/102\\_policy/bp102c07.pdf](http://cms.hhs.gov/manuals/102_policy/bp102c07.pdf) or the provider may call their fiscal intermediary for specific reimbursement information.

**Q: Are hospital discharge planners required to inform the home health agency when their patient is discharged, providing you have informed them of that a particular person is your patient?**

**A:** DHS does not regulate the hospital discharge planners. The home health agency may call for more information on Medicare rules at 1-800-442-2620 or go to the CMS website: <http://www.cms.hhs.gov/cop/1.asp>.

**Q: If an agency wants to observe a home visit made by an employees, does the observer need to be a registered nurse or can it be an administrator who is not an RN?**

**A:** Supervisory visits may be made to the home of a client/patient based on the supervisor receiving permission from the client/patient to enter their home. Clients have the right to have their person and property treated with consideration, respect, and full recognition of their individuality and personal needs. Agency policy needs to be followed for supervisory visits. Who may conduct a supervisory visit depends on a number of factors, i.e., a registered nurse delegating to an unlicensed person or supervision of care delivered for a PAS. Review the rules to ensure that the appropriate discipline performs supervisory visits. *[Ref: State: 40 TAC § 97.282(9), 97.292(a)(4), 97.401(d), 97.404(c)&(f); Federal: 42 CFR § 484.10 (b), 484.30(a), 484.32(a)& (b), 484.34, 484.36(d), 484.38(d)]*

**Q: Are certified home health aides required to demonstrate clinical skills during their annual review?**

**A:** Home health agencies must complete a performance review of each home health aide no less frequently than every 12 months. The performance review is based on the agency policies and procedures for ensuring staff competency. *[State: 40 TAC § 97.245(5); Federal: 42 CFR 484.36(b)(2)(ii)]*

**Q: Is there required documentation for licensed vocational nurse supervision? If so, what is the timeframe? Is documentation that LVN is following the plan of care required in each patient's medical record when an LVN is used to perform a skilled visit?**

**A:** Agencies must adopt and enforce a written policy to ensure compliance with the rules of the Board of Nurse Examiners (BNE) relating to Vocational Nursing Education, Licensure and Practice in the State of Texas. There is no requirement specific to frequency/timeframe for LVN supervision. The LVN operates in accordance with his/her licensure rules. However, state and federal rules and regulations require that home health care be directed and supervised by an RN. *[State: 40 TAC § 97.243(b), 97.299; Federal: 42 CFR § 484.30(b)]*

**Q: Please explain a 60-day summary report. Is a copy sent to the client's doctor?**

**A:** A summary report is a compilation of the pertinent factors of a patient's clinical notes and progress notes. It is submitted to the patient's physician. *[Federal: 42 CFR § 484.14(g)]*

**Q: Are occupational therapists considered skilled and can they be on their own?**

**A:** Therapists must follow their own licensing requirements, as well as the licensing rules for the agency. According to the licensing rules, a qualified occupation therapist may provide care without supervision. *[Ref: State: 40 TAC § 97.401(c)(3); Federal: 42 CFR 484.18(c)]*

## ***Personal Assistance Services***

**Q: Are PAS-only patients required to sign new consents each year or only upon admission? What about individual service plans (ISPs)?**

**A:** Clients have the right to be informed in advance about the care to be furnished, the plan of care, expected outcomes, barriers to treatment, and changes in care. The agency must ensure that written, informed consent is obtained from all clients that specifies the type of care and services that may be provided by the agency. Clients or their legal representatives must sign or mark the consent form. The rules do not require an annual signature, but do require consent when there is a change in the plan of care. *[Ref: State: 40 TAC § 97.282(2), 97.404(e)&(f)(2)]*

**Q: In a state-contracted program being carried out under PAS licensure, using all non-licensed supervisors, what are the home health agencies' responsibilities with physician's delegation?**

**A:** Agencies must adopt and enforce a written policy that states whether physician delegation will be honored by the agency. Then, all requirements under the rules of physician delegation must be met. *[Ref: State: 40 TAC § 97.296(a) & (b), 97.404(a)]*

**Q: Do licensed health care providers have to provide PAS employees tuberculosis prevention?**

**A:** The state does not require home health agencies to do tuberculosis prevention. However, agencies have always been required to report infections acquired while on service with the agency. This applies to all types of agencies, including PAS. However, if an agency has a policy that requires annual Tb testing, the agency must follow that policy. *[State: 40 TAC § 97.285, Provider Letter #02-19; Federal: 42 CFR §]*

**Q: If an agency provides Medically Dependent Children Program (MDCP) non-skilled services and categorizes the client under the PAS category, is the MDCP client surveyed under PAS regulations?**

**A:** Long-term Care Regulatory will survey by the licensure rules for the licensure category, not by the client's payor source. LTC Services monitors waiver programs for compliance with their contractual requirements.

**Q: If a client receives annual evaluations from professional service areas (physical therapy or nursing) but no ongoing services are provided by that service profession, does this put this participant into a more stringently reviewed licensed category?**

**A:** An agency with the PAS category of license is required to have documentation of services based on an on-site visit by the supervisor, where services are primarily delivered, and records of supervisory visits. If supervisory visits are performed by a licensed health professional for a client being served under the PAS category, it does not mean they are subject to the supervision standards of another licensure category. If the client served under the PAS category is receiving skilled services delegated by an RN to an unlicensed person, those delegated tasks must be supervised according to the Board of Nurse Examiners rules regarding RN delegation. *[Ref: State: 40 TAC § 97.404(f)(1)]*

**Q: Are group homes in the PAS category? What level of care can group homes accept?**

**A:** The term group home is frequently used to identify assisted living facilities. If a group home has four or more clients unrelated to the owner who receive "personal assistance-type" services, the home must have an assisted living facility license or the services must be provided by an HCSSA that has a category of at least PAS. The facility would be required to have a nursing facility license or the HCSSA would be required to have an licensed home health category of licensure if skilled services were provided. *[State: HSC § 247.002 and 142.002]*

**Q: Is an HCSSA license the only license that a PAS provider may operate under?**

**A:** The only other license that would apply to the delivery of "personal assistance-type" services is an assisted living facility license. Otherwise, any entity that delivers PAS services must obtain an HCSSA license. *[Ref: State: HSC § 142.002 and § 247.021(a); 40 TAC § 97.201 and § 92.2]*

**Q: Under the personal assistance services (PAS) category, is a physician's order necessary for registered nurse delegation?**

**A:** Nurses have the authority to delegate certain nursing tasks to unlicensed personnel without a physician's order. *[Ref: State: 22 TAC §224.6-8; 40 TAC §97.404(2)&(3)]*

**Q: Is a PAS agency that performs no skilled services or delegation expected to have policies that pertain to peer review or delegation?**

**A:** A PAS must meet the standards, which does include writing and enforcing a peer review policy to comply with professional licensing acts or titles which relate to peer review. If the agency chooses not to perform delegated tasks, their policy can simply state that fact. If the agency does not employ nurses, they may have a similar policy regarding peer review. *[Ref: State: 40 TAC § 97.251; 40 TAC § 97.404(a)]*

## ***Quality Assurance***

**Q: Can a social worker represent a physical therapist (PT), speech therapist (ST), and occupational therapist (OT) in the Quality Assurance and Performance Improvement (QAPI) Committee or does a therapist need to be a part of QAPI as well as the social worker?**

**A:** At a minimum, the QAPI Committee must consist of at least:

- the administrator
- the supervising nurse/therapist, or the supervisor of an agency licensed to provide personal assistance services if delegating health-related tasks; and
- representation from skilled and unskilled disciplines providing services.

Therefore, if OT is providing services **and** the social worker also is providing services, only one would be required to be part of the QAPI committee.

*[Ref: State: 40 TAC § 97.287(b)(3); Provider Letter #02-19]*

**Q: If a registered dietician has evaluated a client under the CWP program, does the dietician have to sit on the QAPI team?**

**A:** At a minimum, the QAPI Committee must consist of at least:

- the administrator
- the supervising nurse/therapist, or the supervisor of an agency licensed to provide personal assistance services if delegating health-related tasks; and
- representation from skilled and unskilled disciplines providing services.

*[Ref: State: 40 TAC § 97.287(b)(3)]*

**Q: Regarding QAPI committee membership, a licensed and personal assistance services (PAS) agency provides Community Based Alternatives services only to our clients. The committee members are the administrator, director of nursing, and supervising nurse. Do we need to include a PAS attendant or a secretary?**

**A:** At a minimum, the QAPI Committee must consist of at least:

- the administrator
- the supervising nurse/therapist, or the supervisor of an agency licensed to provide personal assistance services if delegating health-related tasks; and
- representation from skilled and unskilled disciplines providing services.

Generally, a secretary provides administrative support to the agency, not unskilled client services. *[Ref: State: 40 TAC § 97.287(b)(3) Provider Letter 02-19]*

**Q: Are surveyors looking for each agency to have Outcome Based Quality Monitoring (OBQM) and Outcome Based Quality Indicator (OBQI) reports and plans of correction already cleared? When will they start looking at this and to what extent?**

**A:** The requirement that home health agencies incorporate the information from the OBQM and OBQI reports into their quality assessment and performance improvement activities is not yet mandatory in the Medicare regulations. The Centers for Medicare and Medicaid Services (CMS) published a notice of proposed rulemaking in 1997 that would require this, but the final rule has not been published as of the last review of FAQs for CMS (Jan. 22, 2004, update). Surveyors have been directed to use the OBQM, OBQI, and HHA provider reports as part of the offsite preparation for the survey process. *[Ref: State: 40 TAC § 97.287(a)(2); Federal: S&C letter #02-12 and S&C letter #03-13]*

**Q: Does the QAPI Committee have to meet before the initial survey? .**

**A:** No. There is no specific requirement to meet before the initial survey. However, the agency is required to have adopted and implemented a policy requiring all aspects of the QAPI program. *[Ref: State: 40 TAC § 97.287(a)(1)]*

**Q: What are the new regulations for Quality Assessment and Performance Improvement?**

**A:** The QAPI program must be ongoing, focused on client outcomes, and have a written plan of implementation. The plan must be reviewed, updated and/or revised at least once within a calendar year or more often if needed. *[Ref: State: 40 TAC § 97.287(a)-(c)]*

## ***Surveys and the Survey Process***

**Q: Why do we get cited for not giving a patient disclosure information when the patient is diagnosed with dementia or Alzheimer's? In our survey, two of two that were interviewed were cited. The surveyor was unwilling to listen to our argument.**

**A:** Agencies must adopt and enforce a written policy governing client conduct, responsibility, and rights in accordance with the rules. Before furnishing care to the client or during the initial evaluation before treatment begins, agencies must provide each client or their legal representative with a written notice of all policies governing client conduct, responsibility, and rights. Clients have the right to be informed in advance about the care to be furnished, the plan of care, expected outcomes, barriers to treatment, and any changes in the care to be furnished. Agencies must ensure that written, informed consent that specifies the type of care and services that may be provided by the agency has been obtained for every client, either from the client or their legal representative. The client or the legal representative must sign or mark the consent form. *[Ref: State: 40 TAC § 97.282(1) & (2); Federal: SSA § 1891(a)(1)(A); 42 CFR 484.10(a)(1)]*

**Q: How do you handle complaints from a disgruntled home health agency employee? Would such a complaint warrant a survey? Is it okay to warn the DHS regional office that a disgruntled ex-employee might complain?**

**A:** DHS welcomes communication with home health agencies. However, a complaint alleging violations of the statute or rules will be investigated, regardless of the source. A complaint containing allegations that are not a violation of the statute or rules will not be investigated by DHS, but may be referred to law enforcement agencies or other agencies as appropriate. *[Ref: State: HSC § 142.009(c), 40 TAC § 97.250 and 97.502; Federal: SSA § 1864(a); 42 CFR § 488.335(a)]*

**Q: What risks are surveyors looking for when making immediate jeopardy (IJ) call and how similar are the fines placed on an agency with that of a skilled nursing facility (SNF)? What steps do we take to have the immediate jeopardy lifted and prevent costly fines? Any new education to provider staff on the importance regarding immediate jeopardy?**

**A:** Immediate jeopardy is a threat to the health and safety of clients under the care of a home health agency. Immediate jeopardy is a federal term and only applies to certified agencies. A "threat to health and safety" applies to all agencies.

The surveyor must determine the immediacy of the threat when determining if an immediate jeopardy situation exists. The agency must immediately initiate a plan of correction to meet the requirements for licensure and/or certification. There are no plans for educational programs for home health agencies related to immediate jeopardy situations.

HCSSA remedies are not comparable to the SNF program remedies. For certified agencies, the only federal remedy is termination of the provider agreement. State remedies include injunction, administrative penalties, license revocation, denial of license renewal, immediate license suspension, or immediate license revocation. Administrative penalties are limited to \$1,000/day.

Skilled nursing facility remedies include, but are not limited to, administrative penalties up to \$10,000/day, civil penalties up to \$20,000/day, civil money penalties up to \$10,000/day, denial of payment for new admissions, denial of payment for all admissions, etc. *[Ref: State: HSC § 142.011(b); 40 TAC § 97.602(c)(1)(A); Federal: SSA § 1891(e)(1); 42 CFR § 488.24 (b)]*

**Q: Because wound care is a common area of deficiency, do you suggest photos of the wounds? If yes, what type of consent or release would you propose?**

**A:** DHS does not make recommendations to providers about how to operate their agency. Wound care should be provided in accordance with the physician-directed plan of care. Provision of care and documentation should be provided according to federal and state rules and regulations relative to patient/client care. Photographs must be obtained in accordance with the federal and state rules and regulations governing patient/client rights. *[Ref: State: 40 TAC § 97.282(9); Federal: 42 CFR § 484.10 (b)(1), 484.18 (a)]*

**Q: What steps must the agency take when a surveyor refuses to accept additional information before exit?**

**A:** Surveyors are instructed to offer providers the opportunity to ask questions regarding the findings or provide further pertinent information to consider offsite before citing deficiencies/violations. Surveyors are to consider the provided information and indicate their willingness to re-evaluate the findings before leaving the facility.

Providers may contact the surveyor's supervisor if they feel the surveyor did not evaluate the information provided that negates the deficient practice. Also, the provider may register a complaint against the surveyor for failing to follow survey protocol with the regional director, regional administrator, or the state office complaint hotline at 1-800-228-1570. *[Ref: State: Government Code § 531.056 (A)(2); Health and Safety Code (HSC) § 142.0091 (f); 40 TAC §*

*97.501(g)(8); 40 TAC § 97.501 (e); Federal: Social security Act, § 1819(d)(3); State Operations Manual (SOM), Section 2724]*

**Q: Please address the issue of the agency losing control of confidential patient information when the surveyor makes copies of client charts. How does the Health Insurance Portability and Accountability Act (HIPAA) address this issue?**

**A:** The agency does not "lose control" of the client record during the survey process. The agency is required to ensure that each client record is treated with confidentiality, safeguarded against loss and "unofficial" use, and is maintained according to professional standards. The agency may not prevent the photocopying of client records by a surveyor, but it still remains the responsibility of the agency to safeguard the record. These safeguards may be in the form of policies and procedures of how the agency will safeguard client information when the statutes require disclosure during the survey process. The state agency is required to maintain the confidentiality of all records reviewed or copied during a survey. *[Ref: State: HSC § 142.009(d); 40 TAC § 97.501(a)(5); Federal: 45 CFR § 164.512(a); 42 CFR § 484.501(a)(5)]*

**Q: For an initial survey, how many of the 10 patients must be Medicare or Medicaid?**

**A:** Home health agencies must meet certain requirements, including providing skilled home health services to a minimum of 10 patients, which is consistent with the Medicare home health conditions of participation (CoPs). The payment source does not matter. The only requirements for the 10 patients the agency must have served prior to survey are that seven must be active at the time of the initial survey. *[Ref: Federal: SOM, Section 2200(A); Survey and Certification (S&C) letter #01-02]*

**Q: When attempting to get 10 skilled patients for a Medicare survey, if there is a parent agency sufficiently close, can the parent agency move some of its patients to the branch agency requesting certification then when the survey is over move them back to the original parent agency?**

**A:** The patient's right to choose their home health agency is protected by regulation. An agency does not have the right to move patients back and forth among agencies. Only the patient has the right to choose to leave the agency and request care from another agency. *[Ref: Federal: 42 CFR § 484.10; S&C #01-02]*

**Q: What is the difference between the Medicare survey, the Chap Survey, and Deemed status?**

**A:** Medicare surveys are performed by the state surveyors to evaluate the agency's compliance with the Medicare CoPs. Community Health Accreditation Program (CHAP) surveys are performed by the CHAP surveyors and paid for by the home health agency. Deemed status is a classification given to facilities with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accrediting bodies. JCAHO surveyors perform Medicare surveys on request, and for a fee from the HHA, and those facilities are exempt from the state surveys for certification if the agency is determined to be and remains in compliance. *[Ref: State: 40 TAC 97.11(g)(3)(O); Federal: Social Security Act (SSA), Section 1865(e)]*

**Q: When will the Statement of Deficiencies be sent via e-mail?**

**A:** LTCR has no plans to e-mail deficiencies to the facilities at this time.

**Q: When a new clinical director starts with a company, finds a mess, and cleans up from the first day he or she started, will the director be held accountable on the survey for what happened before being hired?**

**A:** LTCR regulates the agency, not the clinical director. The agency should document the issues identified through the Quality Assurance Performance Improvement (QAPI) program. As deficient practices are determined, actions to improve performance should be identified, implemented, and reassessed. The clinical director should document all steps taken. At the time of the survey, the agency must provide the surveyor with the QAPI information that demonstrates the agency's recognition of deficient practice and the steps taken to resolve it. Just because QA or QI identified problems and is working on a solution does not mean that deficiencies will not be cited against the agency. It will depend upon the compliance or lack thereof, at the time of the survey. *[Ref: State: 40 TAC § 97.287; Federal: 42 CFR § 484.52]*

**Q: Agencies have to submit a plan of correction at the same time as a request for reconsideration and they have to develop a correction plan for each deficiency cited, which sometimes involves changing operational practices. Then if the deficiency is removed at reconsideration, the agency has already changed their operational practice, which may not have improved the agency. Can anything be done about this?**

**A:** Although an agency may request a reconsideration of the deficiencies, it is still required to submit an acceptable plan of correction as mandated by federal and state requirements. The plan of correction should address how the facility is going to correct the noncompliance with the regulation/standard but does not require the agency change operational practice. The agency

must look to see what steps led to the noncompliance and correct those issues before changing operations/policies. If the agency fails to send in the plan of correction within the mandated time frames and the reconsideration upholds the deficiency, the agency could lose its certification/license. [Ref: State: 40 TAC § 97.501; Federal: 42 CFR § 488.28; SOM, Section 2728]

**Q: Should the agency be informed of all deficiencies during the exit conference?**

**A:** A DHS representative will fully inform the person in charge of the agency of the preliminary survey findings during an exit conference. If other deficiencies are found based on a review of the findings, the state directs the surveyor to have another face-to-face exit conference with the agency's designated agent. [Ref: State: HSC § 142.009(f)(g); 40 TAC § 97.501(e); S&CC #03-14]

**Q: After the initial licensure survey, when is an agency required to be surveyed again?**

**A:** The survey time frame is within 18 months after a survey for an initial license and up to 36 months after that survey. However, DHS may enter the premises as considered necessary to ensure compliance with the statute or the rules adopted under the statute.

The agency's compliance history and whether or not a complaint has been alleged against the agency determine the length of time for consequent surveys. [Ref: State: 40 TAC § 97.501(a)(1) & 97.501(m); Federal: SOM, Section 2195]

**Q: Why would a surveyor site a nurse and accuse the nurse of diagnosing for the assessment and documentation of an irregular heart rhythm?**

**A:** Registered nurses are trained to assess cardiac status, which includes assessing irregular heart rhythms. Registered nurses in Texas are not licensed to practice medicine. Professional nursing is defined within the Nurse Practice Act. Therefore, the nurse is permitted to use a nursing diagnosis and inform the physician of his or her findings for medical interventions, as needed. [Ref: State: 22 TAC § 301.002]

**Q: Have the survey tools changed since the implementation of Prospective Payment System (PPS)/Outcome and Assessment Information System (OASIS) and will these tools be made available to home health agencies?**

**A:** Yes. The tool changed and was implemented on 5/01/03. You may review the tool and information related to it at <http://www.cms.hhs.gov/oasis/default.asp> or go to the state educational site at <http://www.dads.state.tx.us/business/ltrcr/Training/oasis.html> for more

information regarding the monthly training on the OASIS program. *[Ref: Federal: S&C #03-13]*

**Q: What help can we get to reduce repetitive/common deficiencies?**

**A:** Agency administrative representatives and employees must know the regulations. The agency's Quality Assessment and Performance Improvement (QAPI) program must be implemented to identify problems and revise policies when needed. All agencies have access to the requirements for certification and licensure via the internet. There is also a site for the 10 most frequently cited deficiencies at:  
[www.dads.state.tx.us/business/ltrcr/reports/index.html](http://www.dads.state.tx.us/business/ltrcr/reports/index.html). *[Ref: State: 40 TAC § 97.287(a)(b) and (c); Federal: 42 CFR § 484.52(a) and (b)]*

**Q: Is it common for an RN to be reported to the Texas Board of Nurse Examiners (BNE) due to a poor patient outcome when the RN delegated tasks to unlicensed agency personnel?**

**A:** The RN must comply with all requirements and standards that apply to an agency employee doing the same activities. This includes volunteers used in administrative and direct client care roles. The RN is responsible for ensuring that delegated tasks are given to those persons capable of performing the task. The State Operations Manual specifies the need to supervise and evaluate the home health aide performance on a routine basis. Also, refer to the BNE rules related to delegation of tasks. *[Ref: State: 40 TAC § 97.298, 97.404(c)(2), and 97.701; Federal: SOM, Appendix B, 42 CFR § 484.36(d)]*

**Q: Why would a surveyor report a registered nurse administrator to the BNE after a complaint survey when it was established the client had no negative outcome? This action seems almost retaliatory.**

**A:** Referral to the BNE is initiated when an RN is suspected of violating the provisions of the Nurse Practice Act. If during the course of the complaint investigation, the surveyor finds evidence that the RN has violated the Nurse Practice Act, the RN will be referred to the BNE. *[Ref: State: Texas Occupation Code, Section 301.407; Federal: 40 CFR § 484.12(c)]*

**Q: It is perceived as harassment when the surveyor arrives at 4 p.m. or conducts multiple surveys during the same period regarding similar complaints. How can you stop harassment or that feeling?**

**A:** DHS must investigate all complaints with allegations that an agency has violated regulations and/or state standards. The Centers for Medicare and Medicaid Services (CMS) and DHS require LTRC to investigate all certification and licensure complaints of abuse, neglect, or exploitation. Complaint investigations must be unannounced and may have specific

deadlines to meet regional timeframes for entry to the facility. *[Ref: State: 40 TAC § 97.502; Federal: SSA § 1929(k)(1)(B)]*

**Q: Explain effective interchange, reporting, and coordination of client care.**

**A:** Care coordination must be accomplished among all service providers involved in the care of a client. Service providers may include the physician, agency staff, contracted individuals, another agency, hospitals, durable medical equipment companies, dialysis centers, another physician, etc. The agency is responsible for verifying that the client's needs are being met. This requires communication with all of the service providers involved in the client's care, which should result in effective interchange, reporting, and coordination of client care. *[Ref: State: 40 TAC § 97.288(a); Federal: 42 CFR § 484.14(g)]*

**Q: Because the agency has 10 days to submit a plan of correction, when does day one begin?**

**A:** Day one is the date following the day the agency received the Statement of Deficiencies. *[Ref: State: 40 TAC § 97.501(h)(1); Federal: SOM, Section 7304 (D)]*

**Q: Why do surveyor(s) make so many copies of agency documents and client charts?**

**A:** Surveyors need copies of all information for which a deficiency will be cited. The CMS 485 form is often copied in order to complete required survey documents for a federal survey. The surveyor is responsible for identifying any records that are copied and for asking the agency if they wish to be reimbursed for the cost of any copies the surveyor made. *[Ref: State: 40 TAC § 97.501(d); Federal: SOM, Section 4205]*

**Q: Why should agency staff be responsible for making all copies of records requested by a surveyor?**

**A:** DHS acknowledges that the survey process can be disruptive. Please share your concerns with the surveyor and, if allowed by your agency policy, allow the surveyor to make the necessary copies themselves. The surveyor is responsible for identifying any records that were duplicated. All photocopies must be certified by the agency and must include a complete copy of all records requested by DHS. *[Ref: State: 40 TAC § 97.501(a)(5)]*

**Q: Suppose the agency does not have a copier? What would the surveyor do if he or she needed copies of agency documents?**

**A:** If an agency does not have a copier, and the surveyor needs copies of agency documents, the provider may:

- allow the surveyor to take the original documents to the DHS regional office or a copy store for copies. The surveyor is responsible for safely and confidentially transporting the documents and may take the records only with the agency's consent; or
- take the original documents to the DHS regional office or a copy store and meet the surveyor at a designated time. This enables agency employees to control the transportation of the documents and be present when copies are made.

Participation in the HCSSA program requires a survey. If the facility refuses to allow the surveyor to copy documents, the surveyor should report this to his or her supervisor, ask for further evidence, and exit, noting that the survey is incomplete. This should be referred to the state office, through regional operations, and enforcement action initiated, with licensure revocation. *[Ref: State: 40 TAC § 97.501]*

**Q: Are parameters required on all CMS 485s?**

**A:** The plan of care should cover all pertinent information necessary for patient care. *[Ref: State: 40 TAC § 97.301(a)(9)(C); Federal: 42 CFR § 484.18(a)]*

**Q: What are the rights of employees being interviewed?**

**A:** As part of the survey process, surveyors are required to interview key personnel and/or any other personnel deemed appropriate to determine care and services being delivered. There is no further guidance at this time from federal or state requirements. The person being interviewed may request confidentiality. *[Ref: Federal: 42 CFR § 488.26; SOM, Section 2714]*

**Q: Will a home health survey team be established in Beaumont or will Tyler and Houston continue to perform the visits for this region?**

**A:** The HCSSA Program has two surveyors in the Beaumont area. The headquarters are located at 3420 Fannin Street in Beaumont, 409-833-0072. They are supervised by Program Manager, Bill Jackson (located in Tyler) at (903) 533-4306.

**Q: Is it possible to have the same surveyor for each visit?**

**A:** DHS has no plans to assign a specific surveyor to a specific provider. Surveys are conducted according to established survey protocols to comply with the licensure rules and CMS guidelines. The protocols are designed to provide consistency in the survey process regardless of which surveyor conducts the survey. The use of multiple surveyors will allow for multiple, objective observations.

**Q: Except for initial surveys, why are surveys unannounced?**

**A:** The regulations specify that except for the initial survey, a survey conducted by DHS to verify compliance with the minimal standards established for the HCSSA program will be unannounced. *[Ref: State: 40 TAC § 97.501(b); Federal: SSA § 1929 (i)(3)(A); 42 CFR § 488.26; SOM, Section 2700(A)]*

**Q: Can the surveyor show up at the main office first so we can be better prepared?**

**A:** DHS or its authorized representative(s) may enter the premises of a license applicant or license holder at reasonable times during business hours to conduct an onsite survey incidental to the issuance of a license, and at other times as it considers necessary to ensure compliance with the statute or the rules adopted under the statute. As the branch office is a license holder, surveyors may enter the branch office or the parent office at any time to determine compliance with the regulations. *[Ref: State: 40 TAC § 97.501(a)(1); Federal: SSA § 1929 (i)(3)(A); 42 CFR § 488.26]*

**Q: Is there a required time frame for conducting the initial certification survey after it is requested?**

**A:** No. DHS has developed a priority system for each type of function performed by region staff and surveyors will conduct the initial survey as soon as workload, regional staffing levels, and the priority system permit. There is no specific deadline by which time the initial survey must be conducted.

**Q: What qualifications must one fulfill to be hired as a surveyor? Is having long-term care experience part of that criteria?**

**A:** Minimum requirements include a license (RN, social work, etc.). Each applicant's experience is evaluated through the interview process. We look for experience in the health care arena, but will also evaluate applicants on their overall job experience. For qualifications for the various surveyor positions please visit the HHSC website at: <http://jobs.hhsc.state.tx.us/>.

**Q: If an agency is participating in a pilot such as the Consolidated Waiver Program, will those cases be read by surveyors?**

**A:** The agency will be surveyed according to the federal and state requirements for survey. The surveyor will select a sample based on the requirements without regard to source of payment, waiver programs, or any other considerations. *[Ref: State: 40 TAC § 97.501(a)]*

**Q: Am I to understand all providers of home health and nursing care will be visited at some point?**

**A:** Yes. All licensed home health agencies are subject to survey by the state in accordance with the schedule required by statute and at other times, as DHS considers necessary. The exceptions are those agencies that are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Community Health Accreditation Program (CHAP). They remain subject to complaint investigations and surveys related to the provision of licensed and certified home health services. The frequency of surveys is determined by CMS. *[Ref: State: HSC § 142.009; 40 TAC § 97.501(a)(6); Federal: 42 CFR 484.20(b)]*

**Q: How will a surveyor conduct a survey on an agency that has computerized medical records?**

**A:** Automation does not prevent an agency from being surveyed. Agencies must make all requested documents available to surveyors. Agencies are responsible for providing surveyors with the data for each client. *[Ref: State: HSC § 142.009(c)(1); 40 TAC § 97.501(a) (5); Federal: SSA § 1891(c)]*

**Q: Can a surveyor ask an agency to close and start up again if the agency wants to do so?**

**A:** Surveys are performed according to federal regulations and state rules. At the completion of a survey, deficiencies may be written based on the findings. Surveyors recommend closure to DHS through the enforcement procedures based on the findings, but the agency is not required to close without due process. A surveyor should not request an agency to start up again. That would be the agency's decision. *[State: 40 TAC 97.501]*

**Q: Will deficiencies from a complaint survey change a licensed and certified agency's survey cycle? Will the agency be placed on a 12- month cycle?**

**A:** Surveyors are responsible for verifying compliance with federal regulations and state rules. The survey cycle may be determined by the findings of any survey. This may or may not change the survey cycle, based on the deficiency(ies)/violation(s) cited. *[State: 40 TAC § 97.501(m); Federal: SSA § 1891(c)(2) (A); 42 CFR § 488.26(c)]*