SEC. 242.158. IDENTIFICATION OF CERTAIN NURSING HOME RESIDENTS REQUIRING MENTAL HEALTH OR MENTAL RETARDATION SERVICES.

(a) Each resident of a nursing home who is considering making a transition to a community-based care setting shall be identified to determine the presence of a mental illness or mental retardation, regardless of whether the resident is receiving treatment or services for a mental illness or mental retardation.

(b) In identifying residents having a mental illness or mental retardation, the department shall use an identification process that is at least as effective as the mental health and mental retardation identification process established by federal law. The results of the identification process may not be used to prevent a resident from remaining in the nursing home unless the nursing home is unable to provide adequate care for the resident.

(c) The department shall compile and provide to the Texas Department of Mental Health and Mental Retardation information regarding each resident identified as having a mental illness or mental retardation before the resident makes a transition from the nursing home to a community-based care setting.

(d) The Texas Department of Mental Health and Mental Retardation shall use the information provided under Subsection (c) solely for the purposes of:

(1) determining the need for and funding levels of mental health and mental retardation services for residents making a transition from a nursing home to a community-based care setting;

(2) providing mental health or mental retardation services to an identified resident after the resident makes that transition; and

(3) referring an identified resident to a local mental health or mental retardation authority or private provider for additional mental health or mental retardation services.

(e) This section does not authorize the department to decide for a resident of a nursing home that the resident will make a transition from the nursing home to a community-based care setting.

SEC. 242.183. PLAN OF CARE.

(a) The institution and the person arranging the care must agree on the plan of care and the plan must be filed at the institution before the institution admits the person for the care.

(b) The plan of care must be signed by:

(1) a licensed physician if the person for whom the care is arranged needs medical care or treatment; or

(2) the person arranging for the respite care if medical care or treatment is not needed.

(c) The institution may keep an agreed plan of care for a person for not longer than six months from the date on which it is received. During that period, the institution may admit the person as frequently as is needed and as accommodations are available.


SUBCHAPTER I RESIDENT ASSESSMENT

RULE §19.801 RESIDENT ASSESSMENT

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

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

(2) Comprehensive assessments.

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

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

(ii) customary routine;

(iii) cognitive patterns;

(iv) communication;

(v) vision;

(vi) mood and behavior patterns;

(vii) psychosocial well-being;
(viii) physical functioning and structural problems;
(ix) continence;
(x) disease diagnoses and health conditions;
(xi) dental and nutritional status;
(xii) skin condition;
(xiii) activity pursuit;
(xiv) medications;
(xv) special treatments and procedures;
(xvi) discharge potential;
(xvii) documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and
(xviii) documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

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

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

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

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

(3) Quarterly review assessment. A facility must assess a resident using the quarterly review instrument specified by DHS and approved by the Centers for Medicare & Medicaid Services (CMS) not less frequently than once every three months.

(4) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident’s active record and use the results of the assessments to develop, review, and revise the resident’s comprehensive plan of care as specified in §19.802 of this title (relating to Comprehensive Care Plans).
(6) Automated data processing requirement for Medicaid-certified and dually certified facilities only.

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

(i) admission assessment;

(ii) annual assessment updates;

(iii) significant change in status assessments;

(iv) quarterly review assessments;

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

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

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

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

(ii) annual assessment;

(iii) significant change in status assessment;

(iv) significant correction of prior full assessment;

(v) significant correction of prior quarterly assessment;

(vi) quarterly review;

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

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

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

(E) Resident-identifiable information.

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

(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.
(7) Accuracy of assessments. The assessment must accurately reflect the resident's status.

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

(9) Certification.

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

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

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

(A) An individual who willfully and knowingly:

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

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

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

(12) Pediatric resident assessment.

(A) Pediatric assessments should be performed by licensed facility staff experienced in the care and assessment of children. Parents or guardians should be included in the assessment process. The potential for community transition should be discussed with the parents or guardians whenever an assessment occurs.

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

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

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

RULE §19.802 COMPREHENSIVE CARE PLANS

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

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

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

(b) The comprehensive care plan must be:

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

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

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

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

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

(1) meet professional standards of quality; and

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

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

RULE §19.803 DISCHARGE SUMMARY (DISCHARGE PLAN OF CARE)
(a) When the facility anticipates discharge, the resident must have a discharge summary that includes:

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

(2) a final summary of the resident's status, including items in §19.801(2)(B) of this title (relating to Resident Assessment), must be available for release to authorized persons and agencies with the consent of the resident or legal representative; and
(3) a post-discharge plan of care, developed with the participation of the resident, a family representative, responsible party, and/or legal guardian, which will, after discharge, assist the resident to adjust to his new living environment.

(b) The facility discharge summary must be available at the time of discharge when a resident is being discharged to a private residence, another nursing facility, a Medicare skilled nursing facility, another residential facility such as a board and care home, or an intermediate care facility for the mentally retarded.

**RULE §19.804 CAPACITY ASSESSMENT FOR SELF CARE AND FINANCIAL MANAGEMENT**

(a) A facility will perform a Capacity Assessment for Self Care and Financial Management for persons who will be referred to a court for guardianship if the person:

(1) is elderly, which is defined as a person 60 years of age or older; or

(2) has mental retardation or a developmental disability; or

(3) is suspected of being a person with mental retardation or a developmental disability.

(b) The assessment will be completed when:

(1) a facility determines that a guardian of the estate, or the person, or both, may be appropriate and a referral to a court for guardianship is anticipated; or

(2) requested to do so by a court.

(c) The facility will use the Capacity Assessment for Self Care and Financial Management instrument developed by the Texas Department of Mental Health and Mental Retardation.

(d) The Capacity Assessment for Self Care and Financial Management will be performed by the facility social worker, with assistance from other professionals as requested by the social worker.