

## TEXAS

---

Downloaded January 2011

Sec. 242.402. QUALITY OF CARE. An institution shall provide to each resident the necessary care or service needed to enable the resident to attain and maintain the highest practicable level of physical, emotional, and social well-being, in accordance with:

- (1) each resident's individual assessment and comprehensive plan of care; and
- (2) the rules and standards relating to quality of care adopted under this chapter.

Added by Acts 1997, 75th Leg., ch. 1159, Sec. 1.30, eff. Sept. 1, 1997.

Sec. 242.403. STANDARDS FOR QUALITY OF LIFE AND QUALITY OF CARE. (a) The department shall adopt standards to implement Sections 242.401 and 242.402. Those standards must, at a minimum, address:

- (1) admission of residents;
- (2) care of residents younger than 18 years of age;
  
- (3) an initial assessment and comprehensive plan of care for residents;
- (4) transfer or discharge of residents;
- (5) clinical records;
- (6) infection control at the institution;
- (7) rehabilitative services;
- (8) food services;
- (9) nutrition services provided by a director of food services who is licensed by the Texas State Board of Examiners of Dietitians or, if not so licensed, who is in scheduled consultation with a person who is so licensed as frequently and for such time as the department shall determine necessary to assure each resident a diet that meets the daily nutritional and special dietary needs of each resident;
- (10) social services and activities;
- (11) prevention of pressure sores;
- (12) bladder and bowel retraining programs for residents;

(13) prevention of complications from nasogastric or gastrostomy tube feedings;

(14) relocation of residents within an institution;

(15) postmortem procedures; and

(16) appropriate use of chemical and physical restraints.

(b) The department may require an institution to submit information to the department, including Minimum Data Set Resident Assessments, necessary to ensure the quality of care in institutions. Information submitted to the department that identifies a resident of an institution is confidential and not subject to disclosure under Chapter 552, Government Code.

(c) The department may adopt standards in addition to those required by Subsection (a) to implement Sections 242.401 and 242.402.

Added by Acts 1997, 75th Leg., ch. 1159, Sec. 1.30, eff. Sept. 1, 1997.

Amended by:

Acts 2005, 79th Leg., Ch. 667, Sec. 1, eff. September 1, 2005.

Sec. 242.404. POLICIES, PROCEDURES, AND PRACTICES FOR QUALITY OF CARE AND QUALITY OF LIFE. (a) Each institution shall comply with the standards adopted under this subchapter and shall develop written operating policies to implement those standards.

(b) The policies and procedures must be available to each physician, staff member, resident, and resident's next of kin or guardian and to the public.

Added by Acts 1997, 75th Leg., ch. 1159, Sec. 1.30, eff. Sept. 1, 1997.

**SEC. 242.505. PRESCRIPTION OF PSYCHOACTIVE MEDICATION. (A) IN THIS SECTION:**

(1) "Medication-related emergency" means a situation in which it is immediately necessary to administer medication to a resident to prevent:

(A) imminent probable death or substantial bodily harm to the resident; or

(B) imminent physical or emotional harm to another because of threats, attempts, or other acts the resident overtly or continually makes or commits.

(2) "Psychoactive medication" means a medication that is prescribed for the treatment of symptoms of psychosis or other severe mental or emotional disorders and that is used to exercise an effect on the central nervous system to influence and modify behavior, cognition, or affective

state when treating the symptoms of mental illness. The term includes the following categories when used as described by this subdivision:

- (A) antipsychotics or neuroleptics;
- (B) antidepressants;
- (C) agents for control of mania or depression;
- (D) antianxiety agents;
- (E) sedatives, hypnotics, or other sleep-promoting drugs; and
- (F) psychomotor stimulants.

(b) A person may not administer a psychoactive medication to a resident who does not consent to the prescription unless:

- (1) the resident is having a medication-related emergency; or
- (2) the person authorized by law to consent on behalf of the resident has consented to the prescription.

(c) Consent to the prescription of psychoactive medication given by a resident or by a person authorized by law to consent on behalf of the resident is valid only if:

- (1) the consent is given voluntarily and without coercive or undue influence;
- (2) the person prescribing the medication or that person's designee provided the following information, in a standard format approved by the department, to the resident and, if applicable, to the person authorized by law to consent on behalf of the resident:

- (A) the specific condition to be treated;
- (B) the beneficial effects on that condition expected from the medication;
- (C) the probable clinically significant side effects and risks associated with the medication; and
- (D) the proposed course of the medication;

(3) the resident and, if appropriate, the person authorized by law to consent on behalf of the resident are informed in writing that consent may be revoked; and

(4) the consent is evidenced in the resident's clinical record by a signed form prescribed by the facility or by a statement of the person prescribing the medication or that person's designee that documents that consent was given by the appropriate person and the circumstances under which the consent was obtained.

(d) A resident's refusal to consent to receive psychoactive medication shall be documented in the resident's clinical record.

(e) If a person prescribes psychoactive medication to a resident without the resident's consent because the resident is having a medication-related emergency:

(1) the person shall document in the resident's clinical record in specific medical or behavioral terms the necessity of the order; and

(2) treatment of the resident with the psychoactive medication shall be provided in the manner, consistent with clinically appropriate medical care, least restrictive of the resident's personal liberty.

(f) A physician or a person designated by the physician is not liable for civil damages or an administrative penalty and is not subject to disciplinary action for a breach of confidentiality of medical information for a disclosure of the information provided under Subsection (c)(2) made by the resident or the person authorized by law to consent on behalf of the resident that occurs while the information is in the possession or control of the resident or the person authorized by law to consent on behalf of the resident.

Added by Acts 2001, 77th Leg., ch. 919, Sec. 2, eff. June 14, 2001.

Sec. 242.604. REPORTS OF MEDICATION ERRORS AND ADVERSE REACTIONS. An institution's nursing staff must report medication

errors and adverse reactions to the resident's physician in a timely manner, as warranted by an assessment of the resident's condition, and record the errors and reactions in the resident's clinical record.

Added by Acts 1997, 75th Leg., ch. 1159, Sec. 1.30, eff. Sept. 1, 1997.

#### **RULE §19.901 QUALITY OF CARE**

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, as defined by and in accordance with the comprehensive assessment and plan of care. If children are admitted to the facility, care and services must be provided to meet their unique medical and developmental needs.

(1) Activities of daily living. Based on the comprehensive assessment of the resident, the facility must ensure that:

(A) a resident's abilities in activities of daily living do not diminish unless the circumstances of the individual's clinical condition demonstrate that diminution is unavoidable. This includes the resident's abilities to:

(i) bathe, dress, and groom;

(ii) transfer and ambulate;

(iii) toilet;

(iv) eat; and

(v) use speech, language, or other functional communication systems;

(B) the resident is given the appropriate treatment and services to maintain or improve his abilities specified in paragraph (1) of this section;

(C) a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

(2) Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident:

(A) in making appointments; and

(B) by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

(3) Pressure sores. Based on the comprehensive assessment of the resident, the facility must ensure that:

(A) a resident who enters the facility without pressure sores does not develop pressure sores unless his clinical condition demonstrates that they are unavoidable; and

(B) a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.

(4) Urinary incontinence. Based on the comprehensive assessment of the resident, the facility must ensure that:

(A) a resident who enters the facility without an indwelling catheter is not catheterized unless his clinical condition demonstrates that catheterization is necessary; and

(B) a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

(5) Range of motion. Based on the comprehensive assessment of the resident, the facility must ensure that:

(A) a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

(B) a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

(6) Mental and psychosocial functioning. Based on the comprehensive assessment of the resident, the facility must ensure that:

(A) a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem; and

(B) a resident whose assessment does not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless his clinical condition demonstrates that such a pattern is unavoidable.

(7) Naso-gastric tube. Based on the comprehensive assessment of the resident, the facility must ensure that:

(A) a resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless his clinical condition demonstrates that use of a naso-gastric tube is unavoidable; and

(B) a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers, and to restore, if possible, normal eating skills.

(8) Accidents. The facility must ensure that:

(A) the resident environment remains as free of accident hazards as possible; and

(B) each resident receives adequate supervision and assistive devices to prevent accidents.

(9) Nutrition. Based on the comprehensive assessment of the resident, the facility must ensure that a resident:

(A) maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless his clinical condition demonstrates that this is not possible; and

(B) receives a therapeutic diet when there is a nutritional problem.

(10) Hydration. The facility must ensure that the resident is provided with sufficient fluid intake to maintain proper hydration and health.

(11) Special needs. The facility must ensure that residents receive proper treatment and care for the following special services:

(A) injections;

(B) parenteral or enteral fluids;

(C) colostomy, ureterostomy, or ileostomy care;

(D) tracheostomy care;

(E) tracheal suctioning;

(F) respiratory care;

(G) foot care; and

(H) prostheses.

(12) Unnecessary drugs.

(A) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

(i) in excessive dose (including duplicate drug therapy); or

(ii) for excessive duration; or

(iii) without adequate monitoring; or

(iv) without adequate indications for its use; or

(v) in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(vi) any combination of the circumstances in clauses (i)-(v) of this subparagraph.

(B) Antipsychotic drugs. Based on the comprehensive assessment of the resident, the facility must ensure that:

(i) residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and

(ii) residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue use of these drugs.

(13) Medication errors. The facility must ensure that:

(A) it is free of medication error rates of 5.0% or greater; and

(B) residents are free of significant medication errors.

#### **RULE §19.1006 NURSING FACILITY RESTORATIVE NURSING CARE**

The facility must have a program of restorative nursing care that is an integral part of nursing service and is directed toward helping each resident to achieve and maintain an optimal level of self-care and independence, as defined by the Comprehensive Assessment and Comprehensive Care Plan. Nursing personnel must be trained in restorative nursing and must provide restorative services daily for residents who require them. Nursing personnel must routinely record these services in the resident's clinical record.

#### **RULE §19.1207 PRESCRIPTION OF PSYCHOACTIVE MEDICATION**

(a) In this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:

(1) Medication-related emergency--A situation in which it is immediately necessary to administer medication to a resident to prevent:

- (A) imminent probable death or substantial bodily harm (emotional or physical) to the resident; or
- (B) imminent physical or emotional harm to another because of threats, attempts, or other acts the resident overtly or continually makes or commits.

(2) Psychoactive medication--A medication prescribed for the treatment of symptoms of psychosis or other severe mental or emotional disorders and used to exercise an effect on the central nervous system to influence and modify behavior, cognition, or affective state when treating the symptoms of mental illness. The term includes the following categories when used as described by this subdivision:

- (A) anti-psychotics or neuroleptics;
- (B) antidepressants;
- (C) agents for control of mania or depression;
- (D) anti-anxiety agents;
- (E) sedatives, hypnotics, or other sleep-promoting drugs; and
- (F) psychomotor stimulants.

(b) A person may not administer a psychoactive medication to a resident who does not consent to the prescription unless:

- (1) the resident is having a medication-related emergency; or
- (2) the person authorized by law to consent on behalf of the resident has consented to the prescription.

(c) Consent to the prescription of psychoactive medication given by a resident, or by a person authorized by law to consent on behalf of the resident, is valid only if:

- (1) the consent is given voluntarily and without coercive or undue influence;
- (2) the person who prescribes the medication, or that person's designee, provides the resident and, if applicable, the person authorized by law to consent on behalf of the resident, with the following information in a single document identified as being for the purpose of consent to treatment with psychoactive medication:

- (A) the specific condition to be treated;
- (B) the beneficial effects on that condition expected from the medication;
- (C) the probable clinically significant side effects and risks associated with the medication, as reported in widely available pharmacy databases or the manufacturer's package insert; and
- (D) the proposed course of the medication;

(3) the resident and, if appropriate, the person authorized by law to consent on behalf of the resident, are informed in writing that consent may be revoked; and

(4) the consent is evidenced in the resident's clinical record by a signed form prescribed by the facility, or by a statement of the person who prescribes the medication or that person's designee, that documents consent was given by the appropriate person and the circumstances under which the consent was obtained.

(A) Consent is valid until:

(i) consent is withdrawn; or

(ii) the practitioner has discontinued the medication.

(B) For purposes of this rule, a medication will be considered to be discontinued if therapy has been suspended for more than 70 days. If the suspended therapy is resumed within the 70-day period, an oral explanation of side effects should be documented in the clinical record.

(d) The Health and Safety Code, Chapter 313, Consent to Medical Treatment, provides guidance on treatment decisions when a resident is comatose, incapacitated, or otherwise mentally or physically incapable of communication. An ethics committee also may prove helpful in such situations.

(e) A resident's refusal to consent to receive psychoactive medication must be documented in the resident's clinical record.

(f) If a person prescribes psychoactive medication to a resident without the resident's consent because the resident is having a medication-related emergency:

(1) the person must document the necessity of the order in the resident's clinical record in specific medical or behavioral terms; and

(2) treatment of the resident with the psychoactive medication must be provided in the manner, consistent with clinically appropriate medical care, least restrictive of the resident's personal liberty.

(g) A physician, or a person designated by the physician, is not liable for civil damages or an administrative penalty and is not subject to disciplinary action for a breach of confidentiality of medical information for a disclosure of the information provided under subsection (c)(2) made by the resident, or the person authorized by law to consent on behalf of the resident, that occurs while the information is in the possession or control of the resident or the person authorized by law to consent on behalf of the resident.

Source Note: The provisions of this §19.1207 adopted to be effective July 1, 2002, 27 TexReg 4362

#### **RULE §19.1601 INFECTION CONTROL**

(3) Vaccinations. Facilities are required to offer vaccinations in accordance with an immunization schedule adopted by the Texas Department of Health.

(A) Pneumococcal vaccine for residents. The facility must offer pneumococcal vaccination to all residents 65 years of age or older who have not received this immunization and to residents younger than 65 years of age, who have not received this vaccine, but are candidates for vaccination because of chronic illness. Pneumococcal vaccine must be offered both to residents who currently

reside in the facility and to new residents upon admission. Vaccination must be completed unless the vaccine is medically contraindicated by a physician or the resident refuses the vaccine. Vaccine administration must be in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention at the time of the vaccination.

(B) Influenza vaccinations for residents and employees. The facility must offer influenza vaccine to residents and employees in contact with residents, unless the vaccine is medically contraindicated by a physician or the employee or resident has refused the vaccine.

(i) Influenza vaccinations for all residents and employees in contact with residents must be completed by November 30 of each year. Employees hired or residents admitted after this date and during the influenza season (through February of each year) must receive influenza vaccinations, unless medically contraindicated by a physician or the employee or resident refuses the vaccine.

(ii) Vaccine administration must be in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention at the time of the most recent vaccination.

(C) Documentation of receipt or refusal of vaccination. Immunization records must be maintained for each employee in contact with residents and must show the date of the receipt or refusal of each annual influenza vaccination. The medical record for each resident must show the date of the receipt or refusal of the annual influenza vaccination and the pneumococcal vaccine.