ADOPTED RULES

Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the rule (Government Code, §2001.036). If a rule is adopted without change to the text of the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 351. COORDINATED PLANNING AND DELIVERY OF HEALTH AND HUMAN SERVICES

SUBCHAPTER B. ADVISORY COMMITTEES

DIVISION 1. COMMITTEES

1 TAC §351.805

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §351.805, concerning State Medicaid Managed Care Advisory Committee.

Section 351.805 is adopted with changes to the proposed text as published in the July 19, 2024, issue of the *Texas Register* (49 TexReg 5215). This rule will be republished.

BACKGROUND AND JUSTIFICATION

The amendment is necessary to extend the State Medicaid Managed Care Advisory Committee (SMMCAC) and align the rule with HHSC advisory committee rule standards. Under the general authority of the Executive Commissioner, the SMMCAC was re-established in 2016 to consider managed care issues and make recommendations to HHSC. The SMMCAC is currently set to abolish on December 31, 2024. The rule amendment changes the SMMCAC abolish date from December 31, 2024, to December 31, 2028, which will allow SMMCAC to continue providing recommendations and ongoing input to HHSC on the statewide operation of Medicaid managed care programs for an additional four years. Additionally, the rule amendment restructures membership subcategories to increase representation for youth and adult populations and adds a new membership subcategory for persons transitioning from children to adult Medicaid managed care programs. The rule amendment will align §351.805 with agency standards for advisory committees by including a subsection on how eligible SMMCAC members may be reimbursed for travel.

COMMENTS

The 31-day comment period ended August 19, 2024.

During this period, HHSC did not receive any comments regarding the proposed rule.

HHSC revised §351.805(a) and subsection (h)(3) to update two Texas Government Code citations to implement House Bill 4611, 88th Legislature, Regular Session, 2023, which makes non-substantive revisions to the Texas Government Code that make the statute more accessible, understandable, and usable. These changes were not in response to a public comment.

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Government Code §531.012, which authorizes the Executive Commissioner to establish advisory committees by rule.

§351.805. State Medicaid Managed Care Advisory Committee.

(a) Statutory authority. The State Medicaid Managed Care Advisory Committee (SMMCAC) is established under Texas Government Code §523.0201 and is subject to §351.801 of this division (relating to Authority and General Provisions).

(b) Purpose. The SMMCAC advises the Texas Health and Human Services Commission (HHSC) executive commissioner and the health and human services system (HHS) on the statewide operation of Medicaid managed care, including:

(1) program design and benefits;

(2) systemic concerns from consumers and providers;

(3) efficiency and quality of services;

(4) contract requirements;

(5) provider network adequacy;

(6) trends in claims processing; and

(7) other issues as requested by the HHSC executive commissioner.

(c) Tasks. The SMMCAC performs the following tasks:

(1) makes recommendations to HHSC;

(2) advises HHSC on Medicaid managed care issues;

(3) disseminates Medicaid managed care best practice information as appropriate;

(4) adopts bylaws to guide the operation of the SMMCAC; and

(5) performs other tasks consistent with its purpose.

(d) Reporting requirements.

(1) Report to the HHSC executive commissioner. No later than December 31st of each year, the SMMCAC files an annual written report with the HHSC executive commissioner covering the meetings and activities in the immediately preceding fiscal year. The report includes:

(A) a list of the meeting dates;

(B) the members' attendance records;

(C) a brief description of actions taken by the SMMCAC;

(D) a description of how the SMMCAC accomplished its tasks;

(E) a summary of the status of any recommendations that the SMMCAC made to HHSC;

(F) a description of activities the SMMCAC anticipates undertaking in the next fiscal year;

(G) recommended amendments to this section; and

(H) the costs related to the SMMCAC, including the cost of HHSC staff time spent supporting the SMMCAC's activities and the source of funds used to support the SMMCAC's activities.

(2) Report to the Texas Legislature. By December 31st of each even-numbered year, the SMMCAC files a written report with the Texas Legislature of any policy recommendations made to the HHSC executive commissioner.

(e) Meetings.

(1) Open meetings. The SMMCAC complies with the requirements for open meetings under Texas Government Code Chapter 551 as if it were a governmental body.

(2) Frequency. The SMMCAC will meet quarterly.

(3) Quorum. Thirteen members constitute a quorum.

(f) Membership.

(1) The SMMCAC is composed of no more than 24 members appointed by the HHSC executive commissioner. In selecting members to serve on the SMMCAC, HHSC:

(A) considers the applicant's qualifications, background, and interest in serving; and

(B) tries to choose committee members who represent the diversity of all Texans, including ethnicity, gender, and geographic location.

(2) The SMMCAC consists of representatives of the following categories:

(A) ten people who are enrolled in Medicaid managed care or represent a person enrolled in Medicaid managed care and who are appointed from one or more of the following subcategories:

(i) a person who has low-income, a family member of the person, or an advocate representing people with low-income;

(ii) a person with an intellectual, a developmental, or a physical disability, including a person with autism spectrum disorder, or a family member of the person, or an advocate representing people with an intellectual, a developmental, or a physical disability, including persons with autism spectrum disorder;

(iii) a person using mental health services, a family member of the person, or an advocate representing people who use mental health services;

(iv) a person using non-emergency medical transportation services, a family member of the person, or an advocate representing persons using non-emergency medical transportation;

(v) a person who is dually enrolled in Medicaid and Medicare, a family member of the person, or an advocate representing persons who are dually enrolled in Medicaid and Medicare;

(vi) a family member of a child who is a Medicaid recipient or an advocate representing children who are Medicaid recipients, except for a child with special health care needs listed in clause (vii) of this subparagraph;

(vii) a family member of a child with special health care needs or an advocate representing children with special health care needs;

(viii) a person who is 18 years of age or older who will transition or has transitioned from a child and adolescent managed care program to an adult managed care program, a guardian of the person, or an advocate representing persons transitioning from a child and adolescent managed care program to an adult managed care program; or

(ix) a person who is 65 years of age or older, the person's family member, or an advocate representing persons who are 65 years of age or older;

(B) ten providers contracted with Texas Medicaid managed care organizations, appointed from one or more of the following subcategories:

(i) rural providers;

(ii) hospitals;

(iii) primary care providers;

(iv) pediatric health care providers;

(v) dentists;

(vi) obstetrical care providers;

(vii) providers serving people dually enrolled in Medicaid and Medicare;

(viii) providers serving people who are 21 years of age or older and have a disability;

(ix) non-physician mental health providers;

(x) long-term services and supports providers, including nursing facility providers and direct service workers; or

(xi) an organization, association, corporation that is representative of and located in, or in close proximity to, a community where it serves or conducts outreach for:

(I) people enrolled in Medicaid;

(II) children from families that are low-income;

(III) children with special health care needs;

(IV) people with disabilities;

(V) people 65 years of age or older; or

(VI) people needing perinatal care; and

(C) four managed care organizations participating in Texas Medicaid, including:

(i) national plans;

(ii) community-based plans; and

(iii) dental maintenance organizations (for the purpose of this section).

(3) HHSC appoints members for staggered terms so that terms of an equal or almost equal number of members expire on August 31st of each year. Regardless of the term limit, a member serves until

his or her replacement has been appointed. This ensures sufficient, appropriate representation.

(A) If a vacancy occurs, the HHSC executive commissioner will appoint a person to serve the unexpired portion of that term.

(B) Except as may be necessary to stagger terms, the term of each member is three years. A member may apply to serve one additional term.

(g) Officers. The SMMCAC selects a chair and vice chair of the committee from among its members.

(1) The chair serves until December 1st of each even-numbered year. The vice chair serves until December 1st of each odd-numbered year.

(2) A member may serve up to two consecutive terms as chair or vice chair.

(h) Required Training. Each member must complete training, which will be provided by HHSC, on relevant statutes and rules, including:

(1) this section;

(2) §351.801 of this division;

(3) Texas Government Code §523.0201;

(4) Texas Government Code Chapters 551, 552, and 2110;

(5) the HHS Ethics Policy;

(6) the Advisory Committee Member Code of Conduct; and

(7) other relevant HHS policies.

(i) Travel Reimbursement. To the extent permitted by the current General Appropriations Act, HHSC may reimburse a SMMCAC member for his or her travel to and from SMMCAC meetings only if:

(1) funds are appropriated and available; and

(2) the member:

(A) receives Medicaid services or is a family member of a client that receives Medicaid services; and

(B) submits the request for travel reimbursement in accordance with the HHSC Travel Policy.

(j) Date of abolition. The SMMCAC is abolished, and this section expires, on December 31, 2028.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on October 31, 2024.

TRD-202405215
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: November 20, 2024
Proposal publication date: July 19, 2024
For further information, please call: (512) 438-2910

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TITLE 7. BANKING AND SECURITIES

PART 4. DEPARTMENT OF SAVINGS AND MORTGAGE LENDING

CHAPTER 55. RESIDENTIAL MORTGAGE LOAN ORIGINATORS

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (SML), adopts new rules in 7 TAC Chapter 55: §§55.1 - 55.6, 55.100 - 55.114, 55.200 - 55.205, 55.300 - 55.303, 55.310, and 55.311. The commission's proposal was published in the September 6, 2024, issue of the *Texas Register* (49 TexReg 6864). The rules are adopted without changes to the published text and will not be republished.

Explanation of and Justification for the Rules

The preexisting rules under 7 TAC Chapter 81, Mortgage Bankers and Residential Mortgage Loan Originators, affect mortgage bankers registered with SML and individual residential mortgage loan originators (originators) licensed by SML under Finance Code Chapter 157.

Changes Concerning the Reorganization (Relocation) of Residential Mortgage Loan Originator Rules from Chapter 81 to Chapter 55

SML has determined it should reorganize its rules concerning originators by relocating them to Chapter 55, a vacant chapter, and devoting such chapter exclusively to rules affecting originators. The adopted rules effectuate these changes.

Changes Concerning General Provisions (Subchapter A)

The adopted rules: in §55.2, Definitions, adopt new definitions for "E-Sign Act," "making a residential mortgage loan," "person," "SML," "State Examination System," and "trigger lead," while eliminating definitions for "Commissioner's designee," and "Department"; in §55.3, Formatting Requirements for Notices, adopt formatting requirements for the various disclosures an originator is required to make; in §55.4, Electronic Delivery and Signature of Notices, clarify that any notice or disclosure made by an originator may be delivered and signed electronically; and, in §55.5, Computation of Time, clarify how time periods measured in calendar days are computed.

Changes Concerning Licensing (Subchapter B)

The adopted rules: in §55.100, Licensing Requirements, clarify when an originator license is required (including as it relates to a loan processor or underwriter who is an independent contractor); in §55.102, Fees, clarify that the license fee charged by SML is exclusive of fees charged by the Nationwide Multistate Licensing System (NMLS), and clarify that an insufficient funds fee under Finance Code §157.013(d) may be charged if the originator makes a payment to SML by automated clearing house and that payment fails; in §55.103, Renewal of the License, clarify that a license approved with a pending deficiency is a conditional license and requires the originator to resolve the deficiency within 30 days after the date the license is approved, and clarify that, if a license is not renewed within the reinstatement period provided by Finance Code §157.016, the individual must apply for a new license; in §55.105, Conditional License, clarify the terms and conditions under which a conditional license may be granted; in §55.106, Surrender of the License, clarify circumstances under which SML may not grant a request made by the originator to surrender his or her license; in §55.107, Sponsorship of the Originator, clarify that an originator may be sponsored by more

than one mortgage company or mortgage banker, and establish requirements for an originator sponsored by more than one mortgage company or mortgage banker; in §55.108, Required Education, clarify that the pre-licensing examination required by Finance Code §180.057 means the uniform national examination approved by NMLS on or after April 1, 2013; and, in §55.109, Temporary Authority, clarify that the maximum duration for temporary authority under Finance Code §180.0511 is 120 days.

Changes Concerning Duties and Responsibilities (Subchapter C)

The adopted rules: in §55.200, Required Disclosures, remove the requirement that the disclosure to consumers required by Finance Code §156.004(a) or §157.0021(a) be signed by the originator and the mortgage applicant; in §55.202, Fraudulent, Misleading, or Deceptive Practices and Improper Dealings, clarify that an originator commits a violation if the originator knowingly misrepresents the lien position of a residential mortgage loan, create requirements concerning the use of trigger leads, clarify that an originator commits a violation if the originator solicits a consumer on the federal do-not-call registry, clarify that an originator commits a violation if the originator issues a conditional pre-qualification letter or conditional approval letter that is inaccurate, erroneous, or negligently-issued, and clarify that an originator commits a violation if the originator acts as an originator when his or her license is inactive; in §55.204, clarify that the books and records of an originator must be maintained by the mortgage company or mortgage banker sponsoring his or her license, and require that the originator work diligently and cooperatively with the mortgage company or mortgage banker to fulfill such requirements; and, in §55.205, Mortgage Call Reports, clarify that mortgage call reports are filed by the mortgage company or mortgage banker sponsoring the originator's license, and remove that seeming requirement.

Changes Concerning Supervision and Enforcement (Subchapter D)

The adopted rules: in §55.300, Examinations, provide that examinations are conducted using the State Examination System, and that SML may participate in, leverage, or accept an examination conducted by another state agency or regulatory authority; in §55.302, Confidentiality of Examination, Investigation, and Inspection Information, clarify the confidentiality of information arising from an examination, investigation, or inspection by SML; in §55.303, Corrective Action, clarify when SML may direct an originator to voluntarily take corrective action, and creating requirements for refunds made to consumers; in §55.310, Appeals, establish various deadlines by which an originator or other individual subject to an enforcement action must appeal; and, in §55.311, Hearings, clarify how hearing costs under Finance Code §157.017(f) are calculated.

Other Modernization and Update Changes

The adopted rules make changes to modernize and update the rules including: adding and replacing language for clarity and to improve readability; removing unnecessary or duplicative provisions; and updating terminology.

Summary of Public Comments

Publication of the commission's proposal recited a deadline of 30 days to receive public comments. No comments were received.

SUBCHAPTER A. GENERAL PROVISIONS

7 TAC §§55.1 - 55.6

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). The rules are also adopted under the authority of Finance Code §180.004(a), authorizing the commission to adopt rules necessary to implement Finance Code Chapter 180 and as required to carry out the intentions of the federal SAFE Act.

The adopted rules affect the statutes in Finance Code: Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act; and Chapter 180, the Texas Secure and Fair Enforcement for Mortgage Licensing Act of 2009.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 3, 2024.

TRD-202405262
Iain A. Berry
General Counsel
Department of Savings and Mortgage Lending
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Proposal publication date: September 6, 2024
For further information, please call: (512) 475-1535

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SUBCHAPTER B. LICENSING

7 TAC §§55.100 - 55.114

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). The rules are also adopted under the authority of Finance Code §180.004(b), authorizing the commission to adopt rules necessary to implement Finance Code Chapter 180 and as required to carry out the intentions of the federal SAFE Act. §55.100 is also adopted under the authority of, and to implement, Finance Code: §§156.002(4-a), 156.004(a), 156.105(a), 157.012, 157.0021, 157.02012(a), 180.051, and 180.152. §55.101 is also adopted under the authority of, and to implement, Finance Code: §§157.013, 157.015, and §180.053. §55.102 is also adopted under the authority of, and to implement, Finance Code: §§157.013, 157.015, 180.058, and 180.061(2). §55.103 is also adopted under the authority of, and to implement, Finance Code: §157.0141, 157.015, 157.016, 180.059, and 180.060. §55.104 is also adopted under the authority of, and to implement, Finance Code §180.061. §55.105 is also adopted under the authority of, and to implement, Finance Code §157.0141. §55.106 is also adopted under the authority of, and to implement, Finance Code §180.061(4). §55.107 is also adopted under the authority of, and to implement, Finance Code: §157.019 and

§180.061(4). §55.108 is also adopted under the authority of, and to implement, Finance Code: §§180.056, 180.057, and 180.060. §55.109 is also adopted under the authority of, and to implement, Finance Code §180.0511. §55.110 is also adopted under the authority of, and to implement, Occupations Code Chapter 55. §55.111 and §55.112 are also adopted under the authority of, and to implement: Finance Code: §§157.0132, 180.054, 180.055, and 180.061(1); and Government Code §411.1385. §55.113 is also adopted under the authority of, and to implement, Occupations Code §53.025. §55.114 is also adopted under the authority of, and to implement, Occupations Code Chapter 53, Subchapter D.

The adopted rules affect the statutes in Finance Code: Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act; and Chapter 180, the Texas Secure and Fair Enforcement for Mortgage Licensing Act of 2009.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER C. DUTIES AND RESPONSIBILITIES

7 TAC §§55.200 - 55.205

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). The rules are also adopted under the authority of Finance Code §180.004(b), authorizing the commission to adopt rules necessary to implement Finance Code Chapter 180 and as required to carry out the intentions of the federal SAFE Act. §55.200 is also adopted under the authority of, and to implement, Finance Code: §§156.004, 157.0021, 180.061(4) and 180.151. §55.201 is also adopted under the authority of, and to implement, Finance Code: §§156.105, 157.0023(b), and 157.02012. §55.202 and §55.203 are also adopted under the authority of, and to implement, Finance Code: §§157.02015, 157.024(a)(2) and (3), 180.151, 180.152, and §180.153. §55.204 is also adopted under the authority of, and to implement, Finance Code: §157.02015(b) and §180.061(5). §55.205 is also adopted under the authority of, and to implement, Finance Code §157.020(a-1) and §180.101.

The adopted rules affect the statutes in Finance Code: Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act; and Chapter 180, the Texas Secure and Fair Enforcement for Mortgage Licensing Act of 2009.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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General Counsel
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SUBCHAPTER D. SUPERVISION AND ENFORCEMENT

7 TAC §§55.300 - 55.303, 55.310, 55.311

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). The rules are also adopted under the authority of Finance Code §180.004(b), authorizing the commission to adopt rules necessary to implement Finance Code Chapter 180 and as required to carry out the intentions of the federal SAFE Act. §§55.300 - 55.303 are also adopted under the authority of, and to implement, Finance Code: §§157.021, 157.0211, 157.025, 180.061(5), and 180.062. §55.310 is also adopted under the authority of, and to implement, Finance Code: §§157.017, 157.023, 157.024, and 157.031. §55.311 is also adopted under the authority of, and to implement, §157.017.

The adopted rules affect the statutes in Finance Code: Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act; and Chapter 180, the Texas Secure and Fair Enforcement for Mortgage Licensing Act of 2009.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Iain A. Berry
General Counsel
Department of Savings and Mortgage Lending
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For further information, please call: (512) 475-1535

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CHAPTER 56. RESIDENTIAL MORTGAGE LOAN COMPANIES

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (SML), adopts new rules in 7 TAC Chapter 56: §§56.1 - 56.6, 56.100 - 56.108, 56.200 - 56.206, 56.210, 56.300 - 56.304, 56.310, and 56.311. The commission's proposal was published in the September 6, 2024, issue of the *Texas Register* (49 TexReg 6881). The rules are adopted without changes to the published text and will not be republished.

Explanation of and Justification for the Rules

The preexisting rules under 7 TAC Chapter 80, Residential Mortgage Loan Companies, affect residential mortgage loan companies (mortgage companies) licensed by SML under Finance Code Chapter 156 (Chapter 156).

Changes Concerning the Reorganization (Relocation) of Mortgage Company Rules from Chapter 80 to Chapter 56

SML has determined it should reorganize its rules concerning mortgage companies by relocating them to Chapter 56, a vacant chapter. The adopted rules effectuate this change.

Changes Concerning General Provisions (Subchapter A)

The adopted rules: in §56.2, Definitions, adopt new definitions for "E-Sign Act," "engage in or conduct the business of a mortgage company," "making a residential mortgage loan," "mortgage banker," "SML," "State Examination System," "trigger lead," "UETA," "wrap lender," and "wrap mortgage loan" while eliminating definitions for "Commissioner's designee," and "Department"; in §56.3, Formatting Requirements for Notices, adopt formatting requirements for the various disclosures a mortgage company is required to make; in §56.4, Electronic Delivery and Signature of Notices, clarify that any notice or disclosure made by a mortgage company may be delivered and signed electronically; and, in §56.5, Computation of Time, clarify how time periods measured in calendar days are computed.

Changes Concerning Licensing Requirements (§56.100)

The adopted rules, in §56.100, Licensing Requirements, clarify when a mortgage company license is required. §56.100(c) clarifies, among other things, the requirements of Finance Code §156.202(a-1)(3), which provides that an "owner of residential real estate who in any 12-consecutive month period makes no more than three residential mortgage loans to purchasers of the property for all or part of the purchase price of the residential real estate against which the mortgage is secured" (emphasis added) is exempt from the requirement to be licensed by SML as a mortgage company under Chapter 156 (meaning, a person who acts as the lender and makes more than three such loans is not exempt and must be licensed). In response to an early precomment draft of the rules published on SML's website, SML received an informal comment from the Texas Land Developers Association (TLDA) asserting that §56.100(c) seeks to impose licensing requirements on certain seller-finance mortgage lenders selling residential real estate (seller-finance lenders) currently operating under the belief that a mortgage company license is not required if the seller-finance lender secures the services of an entity licensed or registered by SML to provide residential mortgage loan origination services in making the loan, and that lender does not actually originate the mortgage loan. According to TLDA, this belief has its origins in informal guidance posted on SML's website as late as 2016 in the form of an answer to a "frequently asked question," as follows: "Q: May an individual or entity owner finance more than five properties within a 12 month period without being licensed if they use a licensed RMLO to facilitate the transaction?; A: Yes, assuming that they only act as the lender in the transaction and do not take an application or negotiate rate and terms with potential borrowers" (at that time, the statutory threshold for exempt transactions was five). However, the licensing requirements referenced by §56.100(c) are imposed by Finance Code §156.202(a-1)(3), not the rule, and the statute plainly states a mortgage company license is required for a person that makes (as the lender) more than the number of exempt transactions allowed under the statute. §56.100(c) clarifies the statutory requirements of Finance Code §156.202(a-1)(3) and dispels the belief that a license is not required under the circumstances described above. Given the apparent pervasiveness of this belief, §56.100 is adopted with a delayed effective date of January 2026, to provide time for industry to move toward compliance and allow the Texas Legislature to consider this issue during the 89th legislative session.

Other Changes Concerning Licensing (Subchapter B)

The adopted rules: in §56.102, Fees, clarify that the license fee charged by SML is exclusive of fees charged by the Nationwide Multistate Licensing System (NMLS), and clarify that an insufficient funds fee under Finance Code §156.203(e) may be charged if the mortgage company makes a payment to SML by automated clearing house and that payment fails; in §56.103, Renewal of the License, clarify that a license approved with a pending deficiency is a conditional license and requires the mortgage company to resolve the deficiency within 30 days after the date the license is approved, and clarify that, if a license is not renewed within the reinstatement period provided by Finance Code §156.2081, a person must apply for a new license; in §56.104, NMLS License Records; Notices Sent to the Mortgage Company, change the contact person in NMLS to whom notices are sent from the contact person under "Identifying Information" to the contact person designated as the "Primary Company Contact" under "Contact Employee"; in §56.105, Conditional License, clarify the terms and conditions under which a conditional license may be granted; in §56.106, Surrender of the License, clarify circumstances under which SML may not grant a request made by the mortgage company to surrender its license; in §56.107, Sponsorship of the Originator; Responsibility for Originator's Actions, provide that a mortgage company license will revert to inactive status if the mortgage company fails to maintain a sponsored individual residential mortgage loan originator; and, in §56.108, Qualified Individual, establish a requirement that the contact information for the Qualified Individual for the mortgage company must match the principal address of the mortgage company in NMLS.

Changes Concerning Books and Records (§56.204)

Pursuant to Finance Code §156.301(a), SML may conduct inspections (examinations) of a mortgage company or an individual residential mortgage loan originator (originator) sponsored by a mortgage company (sponsored originator) to determine compliance with the requirements of Chapter 156 and the rules adopted thereunder. Examinations include inspection of the mortgage company's or sponsored originator's "books, records, documents, operations, and facilities . . . and access to any documents required under rules adopted under [Chapter 156]" (Finance Code §156.301(a)). Pursuant to Finance Code

§156.301(b), SML, upon receipt of a signed, written complaint against a mortgage company "shall investigate the actions and records" of the mortgage company or its sponsored originator. Pursuant to Finance Code §156.301(e), the commission "by rule shall . . . determine the information and records to which [SML] may demand access during an inspection or an investigation." Pursuant to Finance Code §156.102(c), the commission may "adopt rules regarding books and records that a [mortgage company] is required to keep, including the location at which the books and records must be kept." Meanwhile, with respect to sponsored originators, pursuant to Finance Code §157.021(a), SML may conduct examinations of an originator to determine compliance with Chapter 157 and the Texas SAFE Act, or the rules adopted thereunder. Examinations include inspection of the originator's "books, records, documents, operations, and facilities" (Finance Code §157.021(a)). Pursuant to Finance Code §157.021(b), SML, upon receipt of a signed written complaint against an originator, "shall investigate the actions and records" of the originator. Pursuant to Finance Code §157.021(e), the commission "by rule shall . . . determine the information and records [of the originator] to which [SML] may demand access during an inspection or an investigation." Pursuant to Finance Code §157.02015(b), the commission "may adopt rules regarding books and records that [an originator] is required to keep, including the location at which the books and records must be kept." The adopted rules, in §56.204, Books and Records: clarify that a mortgage company must maintain books and records on behalf of its sponsored originators; expand preexisting requirements by establishing additional data points for the mortgage transaction log a mortgage company is required to maintain under existing rules; establish a requirement for a mortgage company to maintain books and records concerning home equity line of credit transactions; establish a requirement for a mortgage company to maintain records relating to home equity loans; establish a requirement for a mortgage company to maintain a loan processing and underwriting log to track loan processing and underwriting services the mortgage company provides; establish recordkeeping requirements for corrective action taken by the mortgage company under §56.304; and establish recordkeeping requirements for the handling of unclaimed funds of the consumer under §56.305. The records and information a mortgage company is required to maintain under §56.204 are required by other state and federal law or otherwise generated in the ordinary course of doing business. The adopted rules merely require that the mortgage company capture and maintain the records or information, including transposing certain information to the transaction logs required by the rule. Applicable state and federal law a mortgage company is required to comply with and that triggers the maintenance of the records and information includes, but is not limited to: Article XVI, Section 50, Texas Constitution; Finance Code Chapter 156; Finance Code Chapter 159; Finance Code Chapter 343; the federal Consumer Credit Protection Act, Truth in Lending Act (15 U.S.C. §1601 et seq.) and Regulation Z (12 C.F.R. §1026.1 et seq.); the federal Real Estate Settlement Procedures Act (12 U.S.C. §2601 et seq.) and Regulation X (12 C.F.R. §1024.1 et seq.); the federal Equal Credit Opportunity Act (15 U.S.C. §1691 et seq.) and Regulation B (12 C.F.R. §1002.1 et seq.); the federal Fair Credit Reporting Act (15 U.S.C. §1681 et seq.) and Regulation V (12 C.F.R. §1022.1 et seq.); the federal Gramm-Leach-Bliley Act (15 U.S.C. §6801 et seq.), Regulation P (12 C.F.R. §1016.1 et seq.), and the Federal Trade Commission's (FTC) Privacy of Consumer Financial Information Rules (16 C.F.R. §313.1 et seq.); the FTC's Standards for Safeguarding Customer Information Rule (16 C.F.R. §314.1 et seq.); the federal Secure and Fair Enforcement for Mortgage Licensing Act (12 U.S.C. §5101 et seq.) and Regulation H (12 C.F.R. §1008.1 et seq.); and Regulation N (Mortgage Acts and Practices-Advertising (MAP Rule); 12 C.F.R. §1014.1 et seq.).

Changes Concerning Reportable Incidents (§56.210)

The mortgage industry in recent years, like many other industries, has experienced increasing operational risks to cybersecurity posed by threat actors, including third-party service providers subject to such risks. SML has found that, in many instances, regulated persons do not self-report incidents that pose a threat to operations, and SML only learns of the incident through consumer complaints filed with SML, or through media reports, leaving SML in a poor position to mount a regulatory response. The adopted rules, in §56.210, Reportable Incidents, establish requirements for a mortgage company to report certain information to SML when the mortgage company experiences a "security event" or a "catastrophic event." A "security event" is defined by the rule to mean "an event resulting in unauthorized access to, or disruption or misuse of, an information system, information stored on such information system, or customer information held in physical form." A "catastrophic event" is defined by the rule to mean "an event, other than a security event, that is unforeseen and results in extraordinary levels of damage or disruption to operations." For an event to be reportable under the rule, it must present "a material risk, financial or otherwise, to a mortgage company's operations or its customers." SML asserts such information is necessary to facilitate SML's examination authority described in the Changes Concerning Books and Records (§56.204) section above. Under federal law, pursuant to the FTC's Standards for Safeguarding Customer Information rules (16 C.F.R. §314.1, et seq.), a mortgage company must "develop, implement, and maintain a comprehensive information security program" to safeguard customer information (16 C.F.R. §314.3(a)), and must, among other things: conduct periodic risk assessments of the information system; design and implement safeguards to control risks to the integrity of the information system (including data encryption and controlling access); regularly test or monitor the effectiveness of the safeguards; implement policies and procedures and internal controls to ensure personnel can execute the information security program; oversee service providers to ensure compliance with the information security program; continuously evaluate and adjust the information security program; establish a written incident response plan designed to promptly respond to, and recover from, any security event materially affecting the confidentiality, integrity, or availability of customer information; and, in the event of a breach involving the information of 500 or more consumers, report certain information to the FTC concerning the nature and extent of the breach. Meanwhile, pursuant to Business and Commerce Code §521.052, a mortgage company "shall implement and maintain reasonable procedures, including taking any appropriate corrective action, to protect from unlawful use or disclosure any sensitive personal information collected or maintained by the business in the regular course of business." Pursuant to Business and Commerce Code §521.053(i), for a breach involving the information of 250 or more Texas consumers, a mortgage company must report certain information to the attorney general. Considering the foregoing, the existing requirements of state and federal law already require a mortgage company to maintain the information required to be reported to SML under §56.210 in the event of a security event. Moreover, a report made to the FTC or to the attorney general described above generally satisfies

the requirements of the rule, other than the requirement to provide a "root cause analysis" concerning the "results or findings of an audit or investigation to determine the origin or root cause of security event, identify strategic measures to effectively contain and limit the impact of a security event, and to prevent a future security event"; however, SML asserts that a root cause analysis is subsumed under the existing requirements of state and federal law related to security events, as described above, in order to meaningfully comply with such requirements.

Other Changes Concerning Duties and Responsibilities (Subchapter C)

The adopted rules: in §56.200, Required Disclosures, remove the requirement that the disclosure to consumers required by Finance Code §156.004(a) or §157.0021(a) be signed by the individual residential mortgage loan originator and the mortgage applicant, remove the requirement that a mortgage company make the disclosure on social media sites, and establish the requirement for a mortgage company to disclose its website address on all correspondence sent to the mortgage applicant; in §56.201, Conditional Pre-Qualification and Conditional Approval Letters, establish the requirement that a conditional pre-qualification letter or conditional approval letter be signed by an individual residential mortgage loan originator acting on behalf of the mortgage company; in §56.202, Fraudulent, Misleading, or Deceptive Practices and Improper Dealings, clarify that a mortgage company commits a violation if the mortgage company knowingly misrepresents the lien position of a residential mortgage loan, create requirements concerning the use of trigger leads, clarify that a mortgage company commits a violation if the originator solicits a consumer on the federal do-not-call registry, clarify that a mortgage company commits a violation if the mortgage company issues a conditional pre-qualification letter or conditional approval letter that is inaccurate, erroneous, or negligently-issued, and clarify that a mortgage company commits a violation if the mortgage company engages in business when its license is inactive; in §56.203, Advertising, establish the requirement for a mortgage company to state its website address when making an advertisement, and establish requirements for the use of team names by a mortgage company; in §56.205, Mortgage Call Reports, clarify the required components of the mortgage call report, and clarify that mortgage call reports must be complete and accurate when filed.

Changes Concerning Supervision and Enforcement (Subchapter D)

The adopted rules: in §56.300, Examinations, provide that examinations are conducted using the State Examination System, and that SML may participate in, leverage, or accept an examination conducted by another state agency or regulatory authority; in §56.302, Confidentiality of Examination, Investigation, and Inspection Information, clarify the confidentiality of information arising from an examination, investigation, or inspection by SML; in §56.303, Corrective Action, clarify when SML may direct a mortgage company to take corrective action, and creating requirements for refunds made to consumers; in §56.304, establish requirements concerning the mortgage company's handling of unclaimed funds of the consumer, including requiring the maintenance of a log to track the handling of such funds; in §56.310, Appeals, establish various deadlines by which a mortgage company or other person subject to an enforcement action must appeal; and, in §56.311, Hearings, clarify how hearing costs under Finance Code §156.209(f) are calculated.

Other Modernization and Update Changes

The adopted rules make changes to modernize and update the rules, including: adding and replacing language for clarity and to improve readability; removing unnecessary or duplicative provisions; and updating terminology.

Summary of Public Comments

Publication of the commission's proposal recited a deadline of 30 days to receive public comments.

SML received a comment from the Texas Mortgage Bankers Association (TMBA). TMBA commented that §56.201(d), requiring a residential mortgage loan originator working for a mortgage company to sign a conditional pre-qualification letter or conditional approval letter, is unnecessarily burdensome on industry as it would require reprograming the loan origination systems used by mortgage companies and outweighs any public benefit derived from the rule. SML respectfully disagrees with the comment. A conditional pre-approval letter or conditional approval letter is used to document a mortgage applicant's purchasing power in the marketplace and is relied on by the mortgage applicant to make an offer on residential real property and execute a real estate sales contract. The contract typically requires the mortgage applicant to tender an option fee and earnest money of several thousand dollars. If the mortgage applicant fails to complete the purchase, that money is often forfeited. Most claims made on the recovery fund established pursuant to Finance Code Chapter 156, Subchapter F are as a result of improperly issued conditional pre-qualification and conditional approval letters. It is important to establish that a residential mortgage loan originator issued the letter as evidenced by his or her signature so that SML can properly evaluate claims made on the fund. SML notes that the form for the conditional pre-qualification letter and conditional approval letter (required by Finance Code §156.105) is unchanged from the preexisting rule and contemplates that a residential mortgage loan originator issue the letter. With respect to costs, SML notes that the rule does not require the use of loan origination systems. As such, costs associated with making changes to such systems as a result of the adopted rules are not directly related to the rules. TMBA commented that §56.107(a) should include provisions backdating the sponsorship of an originator in its employ to the time the request for sponsorship was made in the system. §56.107(a), among other things, requires that a mortgage company must not allow an originator to work on behalf of a mortgage company until that originator is officially sponsored of record by the mortgage company in NMLS, the licensing database system used by SML. SML respectfully disagrees with the comment. SML relies on NMLS to determine when an originator is properly sponsored. As stated in the rule, a mortgage company is responsible for violations of law committed by its sponsored originators. The backdating of sponsorship is not feasible in NMLS and would create uncertainty as to whether an originator is truly sponsored. Additionally, an originator who knows his or her sponsorship will be backdated may not be properly motivated to remedy deficiencies holding up approval of a sponsorship request in the system. TMBA commented that §56.210, concerning Reportable Incidents, is outside SML's statutory authority. SML respectfully disagrees with the comment. Statutory authority for the rule was recited in the commission's proposal. §56.210 requires a mortgage company to report to SML when it is subject to certain catastrophic events or security incidents. The rule is an extension of SML's examination authority and is similar to preexisting rules requiring a mortgage company to compile and maintain certain information in order to facilitate the examination process. As in-

dicated in the proposal, a mortgage company, in order to comply with federal law, is already required to compile the information that is reported to SML under the rule. TMBA commented that §56.303, concerning Corrective Action, is outside SML's statutory authority. SML respectfully disagrees with the comment. Statutory authority for the rule was recited in the commission's proposal. The rule lays out certain actions a mortgage company may be asked to take to correct violations of law determined during an examination. As stated in the rule, corrective action is voluntary. SML sees great benefit in establishing protocols in rule to help guide and facilitate corrective action so that industry is aware of SML's expectations.

SML received a comment from the Texas Land Developers Association (TLDA). TLDA's comment relates to §56.100, which clarifies the exemption from licensing requirements created by Finance Code §156.202(a-1), concerning seller-finance lenders. TLDA, among other things, commented that it disagrees with SML's evaluation of the costs associated with §56.100 and questioned the methodology of SML's analysis, insisting that SML underestimated the potential number of seller-finance lenders required to be licensed under Finance Code. SML respectfully disagrees with the comment. As stated in the proposal, the requirement to be licensed is imposed by the Finance Code, not §56.100. The proposal included an exhaustive analysis of the licensing requirements imposed by the Finance Code. This analysis was done based on publicly available data concerning the number of seller-finance lenders that is inherently difficult to discern. That analysis included cost estimates based on TLDA's own assertions as to the potential number of seller-finance lenders required to be licensed under the Finance Code. Although TLDA challenges SML's methodology and the conclusions it reached, TLDA fails to identify another source of publicly available information that it suggests SML should have relied on. As indicated in the proposal, §56.100 is adopted with a delayed implementation date of January 1, 2026, in order for industry to come into compliance with statutory requirements, and for the Legislature to potentially take up and consider this issue during the 89th Legislative Session.

TLDA included with its comment purported comments from eight individuals who appear to be consumers. The TLDA comment also included a comment from the Mayor of Los Indios, Texas, a small city (population 1,008 in the 2020 census) situated along the Texas/Mexico border in Cameron County. The commenters generally extol the importance of seller-finance lending in the mortgage industry and encourage the commission to take a position on the rules that would maintain access to seller-finance lending for those who might not qualify for traditional financing. SML recognizes the impact of the seller-finance industry in the residential mortgage loan market; however, SML must administer and enforce the licensing requirements of the Finance Code as enacted by the Texas Legislature.

SUBCHAPTER A. GENERAL PROVISIONS

7 TAC §§56.1 - 56.6

The rules are adopted under the authority of Finance Code §156.102, authorizing the commission to adopt rules necessary for the intent of or to ensure compliance with Finance Code Chapter 156, and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act).

The adopted rules affect the statutes in Finance Code Chapter 156, the Residential Mortgage Loan Company Licensing and Registration Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 3, 2024.

TRD-202405266
Iain A. Berry
General Counsel
Department of Savings and Mortgage Lending
Effective date: November 23, 2024
Proposal publication date: September 6, 2024
For further information, please call: (512) 475-1535

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SUBCHAPTER B. LICENSING

7 TAC §56.100

Statutory Authority

The rule is adopted under the authority of Finance Code §156.102, authorizing the commission to adopt rules necessary for the intent of or to ensure compliance with Finance Code Chapter 156, and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). §56.100 is also adopted under the authority of, and to implement, Finance Code §156.201 and §156.202.

The adopted rule affects the statutes in Finance Code Chapter 156, the Residential Mortgage Loan Company Licensing and Registration Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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7 TAC §§56.101 - 56.108

Statutory Authority

The rules are adopted under the authority of Finance Code §156.102, authorizing the commission to adopt rules necessary for the intent of or to ensure compliance with Finance Code Chapter 156, and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). §56.101 and §56.102 are also adopted under the authority of, and to

implement, Finance Code: §156.203 and §156.208. §56.103 is also adopted under the authority of, and to implement, Finance Code: §§156.208, 156.2081, and 156.210. §56.104 is also adopted under the authority of, and to implement, Finance Code §156.211. §56.105 is also adopted under the authority of, and to implement, Finance Code §156.210. §56.107 is also adopted under the authority of, and to implement, Finance Code: §156.201(c) and §156.211. §56.108 is also adopted under the authority of, and to implement, Finance Code: §156.201(c).

The adopted rules affect the statutes in Finance Code Chapter 156, the Residential Mortgage Loan Company Licensing and Registration Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER C. DUTIES AND RESPONSIBILITIES

7 TAC §§56.200 - 56.204, 56.206, 56.210

Statutory Authority

The rules are adopted under the authority of Finance Code §156.102, authorizing the commission to adopt rules necessary for the intent of or to ensure compliance with Finance Code Chapter 156, and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). §56.200 is also adopted under the authority of, and to implement, Finance Code §156.004. §56.201 is also adopted under the authority of, and to implement, Finance Code §156.105. §§56.202, 56.203, and 56.210 are also adopted under the authority of, and to implement, Finance Code §156.303(a)(2) and (3). §56.204 is also adopted under the authority of, and to implement, Finance Code: §156.102(c) and §156.301. §56.206 is also adopted under the authority of, and to implement, Finance Code §156.212.

The adopted rules affect the statutes in Finance Code Chapter 156, the Residential Mortgage Loan Company Licensing and Registration Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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7 TAC §56.205

Statutory Authority

The rule is adopted under the authority of Finance Code §156.102, authorizing the commission to adopt rules necessary for the intent of or to ensure compliance with Finance Code Chapter 156, and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). §56.205 is also adopted under the authority of, and to implement, Finance Code §156.213.

The adopted rule affects the statutes in Finance Code Chapter 156, the Residential Mortgage Loan Company Licensing and Registration Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER D. SUPERVISION AND ENFORCEMENT

7 TAC §§56.300 - 56.304, 56.310, 56.311

Statutory Authority

The rules are adopted under the authority of Finance Code §156.102, authorizing the commission to adopt rules necessary for the intent of or to ensure compliance with Finance Code Chapter 156, and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). §§56.300 - 56.304 are also adopted under the authority of, and to implement, Finance Code: §156.301 and §156.305. §56.310 is also adopted under the authority of, and to implement, Finance Code: §§156.209, 156.302, 156.303, and 156.406. §56.311 is also adopted under the authority of, and to implement, Finance Code §156.209.

The adopted rules affect the statutes in Finance Code Chapter 156, the Residential Mortgage Loan Company Licensing and Registration Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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CHAPTER 57. MORTGAGE BANKERS

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (SML), adopts new rules in 7 TAC Chapter 57: §§57.1 - 57.6, 57.100 - 57.104, 57.106, 57.107, 57.200 - 57.207, 57.210, 57.300 - 57.304, 57.310, and 57.311. The commission's proposal was published in the September 6, 2024, issue of the *Texas Register* (49 TexReg 6905). The rules are adopted without changes to the published text and will not be republished.

Explanation of and Justification for the Rules

The preexisting rules under 7 TAC Chapter 81, Mortgage Bankers and Residential Mortgage Loan Originators, affect mortgage bankers registered with SML and individual residential mortgage loan originators licensed by SML under Finance Code Chapter 157.

Changes Concerning the Reorganization (Relocation) of Mortgage Banker Rules from Chapter 81 to Chapter 57

SML has determined it should reorganize its rules concerning mortgage bankers by relocating them to Chapter 57, a vacant chapter, and devoting such chapter exclusively to rules affecting mortgage bankers. The adopted rules effectuate these changes.

Changes Concerning General Provisions (Subchapter A)

The adopted rules: in §57.2, Definitions, adopt new definitions for "control person," "E-Sign Act," "making a residential mortgage loan," "person," "SML," "State Examination System," "trigger lead," "UETA," "wrap lender," and "wrap mortgage loan," while eliminating definitions for "Commissioner's designee," and "Department"; in §57.3, Formatting Requirements for Notices, adopt formatting requirements for the various disclosures a mortgage banker is required to make; in §57.4, Electronic Delivery and Signature of Notices, clarify that any notice or disclosure made by a mortgage banker may be delivered and signed electronically; and, in §57.5, Computation of Time, clarify how time periods measured in calendar days are computed.

Changes Concerning Registration (Subchapter B)

The adopted rules: in §57.100, Registration Requirements, clarify when a mortgage banker registration is required; in §57.101, Applications for Registration, establish requirements for applying for a mortgage banker registration; in §57.102, Fees, clarify that the registration fee charged by SML is exclusive of fees charged by the Nationwide Multistate Licensing System (NMLS); in §57.103, Renewal of the Registration, clarify the requirements to renew the registration, clarify that a registration approved with a pending deficiency requires the mortgage banker to resolve the deficiency within 30 days after the date the registration is approved, and clarify that, if a registration is not renewed within the reinstatement period provided by Finance Code §157.0062, a person must apply for a new registration; in §57.104, NMLS Records; Notices Sent to the Mortgage Banker, establish requirements for the mortgage banker to update its registration records in NMLS and establish requirements concerning how SML will contact the mortgage banker using such records; in §57.106, Surrender of the Registration, clarify circumstances under which SML may not grant a request made by a mortgage banker to surrender its registration; and, in §57.107, Sponsorship of the Originator; Responsibility for Originator's Actions, establish requirements for which a mortgage banker is responsible for the actions of the individual residential mortgage loan originators it allows to act on its behalf, and provide that a mortgage banker registration will revert to inactive status if the mortgage banker fails to maintain a sponsored individual residential mortgage loan originator.

Changes Concerning Books and Records (§57.204)

Pursuant to Finance Code §157.0022, SML "may request documentary and other evidence [~~from a mortgage banker~~] considered by [~~SML~~] as necessary to effectively evaluate [~~a consumer~~] complaint, including correspondence, loan documents, and disclosures . . . [~~and a~~] mortgage banker shall promptly provide any evidence requested by the commissioner." Meanwhile, with respect to originators sponsored by a mortgage banker, pursuant to Finance Code §157.021(a), the SML commissioner (commissioner) may conduct inspections (including examinations) of an originator to determine compliance with Chapter 157 and the Texas SAFE Act, or the rules of [~~SML~~] adopted thereunder. Inspections include inspection of the originator's "books, records, documents, operations, and facilities" (Finance Code §157.021(a)). Pursuant to Finance Code §157.021(b), the commissioner, upon receipt of a signed written complaint against an originator, "shall investigate the actions and records" of the originator. Pursuant to Finance Code §157.021(e), the commission "by rule shall . . . determine the information and records [~~of the originator~~] to which the commissioner may demand access during an inspection or an investigation." Pursuant to Finance Code §157.02015(b), the commission "may adopt rules regarding books and records that [~~an originator~~] is required to keep, including the location at which the books and records must be kept." The adopted rules, in §57.204, Books and Records: clarify that a mortgage banker must maintain books and records on behalf of the individual residential mortgage loan originators it sponsors; establish additional data points for the mortgage transaction log a mortgage banker is required to maintain under existing rules; establish a requirement for a mortgage banker to maintain books and records concerning home equity line of credit transactions it originates; establish a requirement for a mortgage banker to maintain certain additional records relating to home equity loans; establish a requirement for a mortgage banker to maintain a loan processing and underwriting log to track loan processing and underwriting services the mortgage banker provides; establish recordkeeping requirements for corrective action taken by the mortgage banker under adopted §57.304; and establish recordkeeping requirements for the handling of unclaimed funds of the consumer under adopted §57.305. Most of the records and information a mortgage banker is required to maintain under adopted §57.204 are required by other state and federal law or otherwise generated in the ordinary course

of doing business. The adopted rules merely require that the mortgage banker capture and maintain the records or information, including transposing certain information to the transaction logs required by the rule. Applicable state and federal law a mortgage banker is required to comply with and that triggers the maintenance of the records and information includes, but not limited to: Article XVI, Section 50, Texas Constitution; Finance Code Chapter 157; Finance Code Chapter 159; Finance Code Chapter 343; the federal Consumer Credit Protection Act, Truth in Lending Act (15 U.S.C. §1601 et seq.) and Regulation Z (12 C.F.R. §1026.1 et seq.); the federal Real Estate Settlement Procedures Act (12 U.S.C. §2601 et seq.) and Regulation X (12 C.F.R. §1024.1 et seq.); the federal Equal Credit Opportunity Act (15 U.S.C. §1691 et seq.) and Regulation B (12 C.F.R. §1002.1 et seq.); the federal Fair Credit Reporting Act (15 U.S.C. §1681 et seq.) and Regulation V (12 C.F.R. §1022.1 et seq.); the federal Gramm-Leach-Bliley Act (15 U.S.C. §6801 et seq.), Regulation P (12 C.F.R. §1016.1 et seq.), and the Federal Trade Commission's (FTC) Privacy of Consumer Financial Information Rules (16 C.F.R. §313.1 et seq.); the FTC's Standards for Safeguarding Customer Information Rule (16 C.F.R. §314.1 et seq.); the federal Secure and Fair Enforcement for Mortgage Licensing Act (12 U.S.C. §5101 et seq.) and Regulation H (12 C.F.R. §1008.1 et seq.); and Regulation N (Mortgage Acts and Practices-Advertising (MAP Rule); 12 C.F.R. §1014.1 et seq.).

Changes Concerning Reportable Incidents (§57.210)

The mortgage industry in recent years, like many other industries, has experienced increasing operational risks to cybersecurity posed by threat actors, including third-party service providers subject to such risks. SML has found that, in many instances, regulated persons do not self-report incidents that pose a threat to operations, and SML only learns of the incident through consumer complaints filed with SML, or through media reports, leaving SML in a poor position to mount a regulatory response. The adopted rules, in §57.210, Reportable Incidents, establish requirements for a mortgage banker to report certain information to SML when the mortgage banker experiences a "security event" or a "catastrophic event." A "security event" is defined by the rule to mean "an event resulting in unauthorized access to, or disruption or misuse of, an information system, information stored on such information system, or customer information held in physical form." A "catastrophic event" is defined by the rule to mean "an event, other than a security event, that is unforeseen and results in extraordinary levels of damage or disruption to operations." For an event to be reportable under the rule, it must present "a material risk, financial or otherwise, to a mortgage banker's operations or its customers." SML asserts such information is necessary to facilitate SML's inspection/examination authority described in the Changes Concerning Books and Records (§57.204) section above. Under federal law, pursuant to the FTC's Standards for Safeguarding Customer Information rules (16 C.F.R. §314.1, et seq.), a mortgage banker must "develop, implement, and maintain a comprehensive information security program" to safeguard customer information (16 C.F.R. §314.3(a)), and must, among other things: conduct periodic risk assessments of the information system; design and implement safeguards to control risks to the integrity of the information system (including data encryption and controlling access); regularly test or monitor the effectiveness of the safeguards; implement policies and procedures and internal controls to ensure personnel can execute the information security program; oversee service providers to ensure compliance with the information security program; continuously evaluate and adjust the information security program; establish a written incident response plan designed to promptly respond to, and recover from, any security event materially affecting the confidentiality, integrity, or availability of customer information; and, in the event of a breach involving the information of 500 or more consumers, report certain information to the FTC concerning the nature and extent of the breach. Meanwhile, pursuant to Business and Commerce Code §521.052, a mortgage banker "shall implement and maintain reasonable procedures, including taking any appropriate corrective action, to protect from unlawful use or disclosure any sensitive personal information collected or maintained by the business in the regular course of business." Pursuant to Business and Commerce Code §521.053(i), for a breach involving the information of 250 or more Texas consumers, a mortgage banker must report certain information to the attorney general. Considering the foregoing, the existing requirements of state and federal law already require a mortgage banker to maintain the information required to be reported to SML under adopted §57.210 in the event of a security event. Moreover, a report made to the FTC or to the attorney general described above generally satisfies the requirements of the rule, other than the requirement to provide a "root cause analysis" concerning the "results or findings of an audit or investigation to determine the origin or root cause of security event, identify strategic measures to effectively contain and limit the impact of a security event, and to prevent a future security event"; however, SML asserts that a root cause analysis is subsumed under the existing requirements of state and federal law related to security events, as described above, in order to meaningfully comply with such requirements.

Other Changes Concerning Duties and Responsibilities (Subchapter C)

The adopted rules: in §57.200, Required Disclosures, remove the requirement that the disclosure to consumers required by Finance Code §157.0021(a) be signed by the individual residential mortgage loan originator and the mortgage applicant, remove the requirement that a mortgage banker make the disclosure on social media sites, and establish the requirement for a mortgage banker to disclose its website address on all correspondence sent to the mortgage applicant; in §57.201, Conditional Pre-Qualification and Conditional Approval Letters, establish the requirement that a conditional pre-qualification letter or conditional approval letter be signed by an individual residential mortgage loan originator acting on behalf of the mortgage banker; in §57.202, Fraudulent, Misleading, or Deceptive Practices and Improper Dealings, clarify that a mortgage banker commits a violation if the mortgage banker knowingly misrepresents the lien position of a residential mortgage loan, create requirements concerning the use of trigger leads, clarify that a mortgage banker commits a violation if the mortgage banker solicits a consumer on the federal do-not-call registry, clarify that a mortgage banker commits a violation if the mortgage banker issues a conditional pre-qualification letter or conditional approval letter that is inaccurate, erroneous, or negligently-issued, and clarify that a mortgage banker commits a violation if the mortgage banker engages in business when its registration is inactive; in §57.203, Advertising, establish the requirement for a mortgage banker to state its website address when making an advertisement, and establish requirements for the use of team names by a mortgage banker; in §57.205, Mortgage Call Reports, clarify the required components of the mortgage call report, and clarify that mortgage call reports must be complete and accurate when filed; and in §57.207, Periodic Statements, establish a require-

ment that the mortgage banker comply with the requirements of federal law under Regulation Z (12 C.F.R. §1026.41), governing periodic statements sent to the borrower.

Changes Concerning Supervision and Enforcement (Subchapter D)

The adopted rules: in §57.300, Examinations, provide that examinations are conducted using the State Examination System, and that SML may participate in, leverage, or accept an examination conducted by another state agency or regulatory authority; in §57.302, Confidentiality of Examination, Investigation, and Inspection Information, clarify the confidentiality of information arising from an examination, investigation, or inspection by SML; in §57.303, Corrective Action, clarify when SML may direct a mortgage banker to take corrective action, and creating requirements for refunds made to consumers; in §57.304, Unclaimed Funds, establish requirements concerning the mortgage banker's handling of unclaimed funds of the consumer, including requiring the maintenance of a log to track the handling of such funds; and, in §57.310, Appeals, establish various deadlines by which a mortgage banker or other person subject to an enforcement action must appeal.

Other Modernization and Update Changes

The adopted rules make changes to modernize and update the rules including: adding and replacing language for clarity and to improve readability; removing unnecessary or duplicative provisions; and updating terminology.

Summary of Public Comments

Publication of the commission's proposal recited a deadline of 30 days to receive public comments.

SML received a comment from the Texas Mortgage Bankers Association (TMBA). TMBA commented that §57.201(d), requiring a residential mortgage loan originator working for a mortgage banker to sign a conditional pre-qualification letter or conditional approval letter, is unnecessarily burdensome on industry as it would require reprograming the loan origination systems used by mortgage bankers and outweighs any public benefit derived from the rule. SML respectfully disagrees with the comment. A conditional pre-approval letter or conditional approval letter is used to document a mortgage applicant's purchasing power in the marketplace and is relied on by the mortgage applicant to make an offer on residential real property and execute a real estate sales contract. The contract typically requires the mortgage applicant to tender an option fee and earnest money of several thousand dollars. If the mortgage applicant fails to complete the purchase, that money is often forfeited. Most claims made on the recovery fund established pursuant to Finance Code Chapter 156, Subchapter F are as a result of improperly issued conditional pre-qualification and conditional approval letters. It is important to establish that a residential mortgage loan originator issued the letter as evidenced by his or her signature so that SML can properly evaluate claims made on the fund. SML notes that the form for the conditional pre-qualification letter and conditional approval letter (required by Finance Code §157.02012) is unchanged from the preexisting rule and contemplates that a residential mortgage loan originator issue the letter. With respect to costs, SML notes that the rule does not require the use of loan origination systems. As such, costs associated with making changes to such systems as a result of the adopted rules are not directly related to the rules. TMBA commented that §57.107(a) should include provisions backdating the sponsorship of a residential mortgage loan originator in its employ to the time the request for sponsorship was made in the system. §57.107(a), among other things, requires that a mortgage banker must not allow a residential mortgage loan originator to work on behalf of a mortgage banker until that residential mortgage loan originator is officially sponsored of record by the mortgage banker in NMLS, the licensing database system used by SML. SML respectfully disagrees with the comment. SML relies on NMLS to determine when a residential mortgage loan originator is properly sponsored. As stated in the rule, a mortgage banker is responsible for violations of law committed by its sponsored originators. The backdating of sponsorship is not feasible in NMLS and would create uncertainty as to whether a residential mortgage loan originator is truly sponsored. Additionally, a residential mortgage loan originator who knows his or her sponsorship might be backdated may not be properly motivated to remedy deficiencies holding up approval of a sponsorship request in the system. TMBA commented that §57.210, concerning Reportable Incidents, is outside SML's statutory authority. SML respectfully disagrees with the comment. Statutory authority for the rule was recited in the commission's proposal. §57.210 requires a mortgage banker to report to SML when it is subject to certain catastrophic events or security incidents. The rule is an extension of SML's examination authority and is similar to preexisting rules requiring a mortgage banker to compile and maintain certain information in order to facilitate the examination process. As indicated in the proposal, a mortgage banker, in order to comply with federal law, is already required to compile the information that is reported to SML under the rule. TMBA commented that §57.303, concerning Corrective Action, is outside SML's statutory authority. SML respectfully disagrees with the comment. Statutory authority for the rule was recited in the commission's proposal. The rule lays out certain actions a mortgage banker may be asked to take to correct violations of law determined during an examination. As stated in the rule, corrective action is voluntary. SML sees great benefit in establishing protocols in rule to guide and facilitate corrective action so that industry is aware of SML's expectations.

SUBCHAPTER A. GENERAL PROVISIONS

7 TAC §§57.1 - 57.6

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act).

The adopted rules affect the statutes in Finance Code Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Iain A. Berry
General Counsel
Department of Savings and Mortgage Lending
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For further information, please call: (512) 475-1535

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SUBCHAPTER B. REGISTRATION

7 TAC §§57.100 - 57.104, 57.106, 57.107

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). §57.100 is also adopted under the authority of, and to implement, Finance Code §157.003. §§56.101 - 57.103 are also adopted under the authority of, and to implement, Finance Code §§157.006 - 157.0062. §57.104 is also adopted under the authority of, and to implement, Finance Code §157.005. §57.107 is also adopted under the authority of, and to implement, Finance Code §157.019.

The adopted rules affect the statutes in Finance Code Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Iain A. Berry
General Counsel
Department of Savings and Mortgage Lending
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SUBCHAPTER C. DUTIES AND RESPONSIBILITIES

7 TAC §§57.200 - 57.204, 57.206, 57.207, 57.210

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). §57.200 is also adopted under the authority of, and to implement, Finance Code §157.0021. §57.201 is also adopted under the authority of, and to implement, Finance Code §157.0023(b) and §157.02012. §§57.202, 57.203, 57.207, and 57.210 are also adopted under the authority of, and to implement, Finance Code §157.009. §57.204 is also adopted under the authority of, and to implement, Finance Code §157.02015(b). §57.206 is also adopted under the authority of, and to implement, Finance Code §157.003(6).

The adopted rules affect the statutes in Finance Code Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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7 TAC §57.205

Statutory Authority

The rule is adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). §57.205 is also adopted under the authority of, and to implement, Finance Code §157.020.

The adopted rule affects the statutes in Finance Code Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Iain A. Berry
General Counsel
Department of Savings and Mortgage Lending
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SUBCHAPTER D. SUPERVISION AND ENFORCEMENT

7 TAC §§57.300 - 57.304, 57.310, 57.311

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). §§57.300 - 57.304 are also adopted under the authority of, and to implement, Finance Code §§157.0022, 157.009(d), 157.021, and 157.0211. §57.310 is also adopted under the authority of, and to implement, Finance Code §157.003(e) and §157.009.

The adopted rules affect the statutes in Finance Code Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Department of Savings and Mortgage Lending
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CHAPTER 58. RESIDENTIAL MORTGAGE LOAN SERVICERS

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (SML), adopts new rules in 7 TAC Chapter 58: §§58.1 - 58.5, 58.100 - 58.104, 58.106, 58.107, 58.200, 58.207, 58.210, 58.301 - 58.304, 58.310 and 58.311. The commission's proposal was published in the September 6, 2024, issue of the *Texas Register* (49 TexReg 6924). The rules are adopted without changes to the published text and will not be republished.

Explanation of and Justification for the Rules

The preexisting rules under 7 TAC Chapter 79, Residential Mortgage Loan Servicers, affect residential mortgage loan servicers (mortgage servicers) registered with SML under Finance Code Chapter 158, Residential Mortgage Loan Servicers.

Changes Concerning the Reorganization (Relocation) of Residential Mortgage Loan Servicer Rules from Chapter 79 to Chapter 58

SML has determined it should reorganize its rules concerning mortgage servicers by relocating them to Chapter 58, a vacant chapter. The adopted rules effectuate this change.

Changes Concerning General Provisions (Subchapter A)

The adopted rules: in §58.2, Definitions, adopt new definitions for "control person," "dwelling," "E-Sign Act," "mortgage servicer," "mortgage servicer rights," "residential mortgage loan," "residential real estate," "SML," and UETA," while eliminating definitions for "Commissioner's designee," "Department," and "the Act"; in §58.3, Formatting Requirements for Notices, adopt formatting requirements for the various disclosures a mortgage servicer is required to make; in §58.4, Electronic Delivery and Signature of Notices, clarify that any notice or disclosure made by a mortgage servicer may be delivered and signed electronically; and, in §58.5, Computation of Time, clarify how time periods measured in calendar days are computed.

Changes Concerning Registration (Subchapter B)

The adopted rules: in §58.100, Registration Requirements, clarify when a mortgage servicer registration is required (including as it relates to master servicers); in §58.102, Fees, clarify that the registration fee charged by SML is exclusive of fees charged by the Nationwide Multistate Licensing System (NMLS); in §58.103, Renewal of Registration, clarify that a registration approved with a pending deficiency requires the mortgage servicer to resolve the deficiency within 30 days after the date the registration is approved, and clarify that, if registration is not renewed prior to its expiration, the person must apply for a new registration; in §55.104, NMLS Records; Notices Sent to the Mortgage Servicer, establish requirements for the mortgage servicer to update its registration records in NMLS and establish requirements concerning how SML will contact the mortgage servicer using such records; in §58.106, Surrender of the Registration, clarify circumstances under which SML may not a request made a mortgage servicer to surrender its registration; and, in §58.107, Surety Bond Requirement, establish a requirement to use an electronic surety bond, and establishing requirements governing the required amount of the surety bond.

Changes Concerning Reportable Incidents (§58.210)

The mortgage industry in recent years, like many other industries, has experienced increasing operational risks to cybersecurity posed by threat actors, including third-party service providers subject to such risks. SML has found that, in many instances, regulated persons do not self-report incidents that pose a threat to operations, and SML only learns of the incident through consumer complaints filed with SML, or through media reports, leaving SML in a poor position to mount a regulatory response. The adopted rules, in §58.210, Reportable Incidents, establish requirements for a mortgage servicer to report certain information to SML when the mortgage servicer experiences a "security event" or a "catastrophic event." A "security event" is defined by the rule to mean "an event resulting in unauthorized access to, or disruption or misuse of, an information system, information stored on such information system, or customer information held in physical form." A "catastrophic event" is defined by the rule to mean "an event, other than a security event, that is unforeseen and results in extraordinary levels of damage or disruption to operations." For an event to be reportable under the rule, it must present "a material risk, financial or otherwise, to a mortgage servicer's operations or its customers." SML asserts such information is necessary to facilitate SML's investigation authority described in Finance Code §158.102. Under federal law, pursuant to the Federal Trade Commission's (FTC) Standards for Safeguarding Customer Information rules (16 C.F.R. §314.1, et seq.), a mortgage servicer must "develop, implement, and maintain a comprehensive information security program" to safeguard customer information (16 C.F.R. §314.3(a)), and must, among other things: conduct periodic risk assessments of the information system; design and implement safeguards to control risks to the integrity of the information system (including data encryption and controlling access); regularly test or monitor the effectiveness of the safeguards; implement policies and procedures and internal controls to ensure personnel can execute the information security program; oversee service providers to ensure

compliance with the information security program; continuously evaluate and adjust the information security program; establish a written incident response plan designed to promptly respond to, and recover from, any security event materially affecting the confidentiality, integrity, or availability of customer information; and, in the event of a breach involving the information of 500 or more consumers, report certain information to the FTC concerning the nature and extent of the breach. Meanwhile, pursuant to Business and Commerce Code §521.052, a mortgage servicer "shall implement and maintain reasonable procedures, including taking any appropriate corrective action, to protect from unlawful use or disclosure any sensitive personal information collected or maintained by the business in the regular course of business." Pursuant to Business and Commerce Code §521.053(i), for a breach involving the information of 250 or more Texas consumers, a mortgage servicer must report certain information to the attorney general. Considering the foregoing, the existing requirements of state and federal law already require a mortgage servicer to maintain the information required to be reported to SML under adopted §58.210 in the event of a security event. Moreover, a report made to the FTC or to the attorney general described above generally satisfies the requirements of the rule, other than the requirement to provide a "root cause analysis" concerning the "results or findings of an audit or investigation to determine the origin or root cause of security event, identify strategic measures to effectively contain and limit the impact of a security event, and to prevent a future security event"; however, SML asserts that a root cause analysis is subsumed under the existing requirements of state and federal law related to security events, as described above, in order to meaningfully comply with such requirements.

Other Changes Concerning Duties and Responsibilities (Subchapter C)

The adopted rules: in §58.200, Required Disclosures, remove the requirement that the disclosure to consumers required by Finance Code §158.101 be included on all correspondence sent to the borrower, and, instead, establish a requirement to make the disclosure on the first notice sent to the borrower that notifies the borrower of the mortgage servicer's role in servicing the loan, and establish a requirement to include the disclosure on the mortgage servicer's website; and, in §58.207, Periodic Statements, establish a requirement that the mortgage servicer comply with the requirements of federal law under Regulation Z (12 C.F.R. §1026.41), governing periodic statements sent to the borrower.

Changes Concerning Supervision and Enforcement (Subchapter D)

The adopted rules: in §58.302, Confidentiality of Investigation Information, clarify the confidentiality of information arising from an investigation by SML; in §58.303, Corrective Action, clarify when SML may direct a mortgage servicer to take corrective action, and creating requirements for refunds made to consumers; in §58.304, Unclaimed Funds, establish requirements concerning the mortgage servicer's handling of unclaimed funds of the consumer, including requiring the maintenance of a log to track the handling of such funds; and, in §58.310, Appeals, establish various deadlines by which a mortgage servicer or other person subject to an enforcement action must file an appeal.

Other Modernization and Update Changes

The adopted rules make changes to modernize and update the rules including: adding and replacing language for clarity and to improve readability; removing unnecessary or duplicative provisions; and updating terminology.

Summary of Public Comments

Publication of the commission's proposal recited a deadline of 30 days to receive public comments.

SML received a comment from the Texas Mortgage Bankers Association (TMBA). TMBA commented that §58.210, concerning Reportable Incidents, is outside SML's statutory authority. SML respectfully disagrees with the comment. Statutory authority for the rule was recited in the commission's proposal. §58.210 requires a mortgage servicer to report to SML when it is subject to certain catastrophic events or security incidents. The rule is an extension of SML's investigation authority. As indicated in the proposal, a mortgage servicer, in order to comply with federal law, is already required to compile the information that is reported to SML under the rule. TMBA commented that §58.303, concerning Corrective Action, is outside SML's statutory authority. SML respectfully disagrees with the comment. Statutory authority for the rule was recited in the commission's proposal. The rule lays out certain actions a mortgage servicer may be asked to take to correct violations of law determined during examination. As stated in the rule, corrective action is voluntary. SML sees great benefit in establishing protocols in rule to guide and facilitate corrective action so that industry is aware of SML's expectations.

SUBCHAPTER A. GENERAL PROVISIONS

7 TAC §§58.1 - 58.5

The rules are adopted under the authority of Finance Code §158.003, authorizing the commission to adopt rules necessary for the purposes of or to ensure compliance with Finance Code Chapter 158.

The adopted rules affect the statutes in Finance Code Chapter 158, the Residential Mortgage Loan Servicer Registration Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Iain A. Berry
General Counsel
Department of Savings and Mortgage Lending
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SUBCHAPTER B. REGISTRATION

7 TAC §§58.100 - 58.104, 58.106

Statutory Authority

The rules are adopted under the authority of Finance Code §158.003, authorizing the commission to adopt rules necessary for the purposes of or to ensure compliance with Finance Code Chapter 158. §58.100 is also adopted under the authority of, and to implement, Finance Code §158.051. §58.101 and

§58.102 are also adopted under the authority of, and to implement, Finance Code: §158.053 and §158.058. §58.103 is also adopted under the authority of, and to implement, Finance Code §158.058. §58.104 is also adopted under the authority of, and to implement, Finance Code §158.054.

The adopted rules affect the statutes in Finance Code Chapter 158, the Residential Mortgage Loan Servicer Registration Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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7 TAC §58.107

Statutory Authority

The rule is adopted under the authority of Finance Code §158.003, authorizing the commission to adopt rules necessary for the purposes of or to ensure compliance with Finance Code Chapter 158. §58.107 is also adopted under the authority of, and to implement, Finance Code §158.055.

The adopted rule affects the statutes in Finance Code Chapter 158, the Residential Mortgage Loan Servicer Registration Act.

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SUBCHAPTER C. DUTIES AND RESPONSIBILITIES

7 TAC §§58.200, 58.207, 58.210

Statutory Authority

The rules are adopted under the authority of Finance Code §158.003, authorizing the commission to adopt rules necessary for the purposes of or to ensure compliance with Finance Code Chapter 158. §58.200 is also adopted under the authority of Finance Code §158.101.

The adopted rules affect the statutes in Finance Code Chapter 158, the Residential Mortgage Loan Servicer Registration Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER D. SUPERVISION AND ENFORCEMENT

7 TAC §§58.301 - 58.304, 58.310, 58.311

Statutory Authority

The rules are adopted under the authority of Finance Code §158.003, authorizing the commission to adopt rules necessary for the purposes of or to ensure compliance with Finance Code Chapter 158. §§58.301 - 58.304 are also adopted under the authority of, and to implement, Finance Code §158.102 and §158.106. §58.310 is also adopted under the authority of, and to implement, Finance Code: §§158.058 - 158.060, 158.103, 158.105, and 158.106.

The adopted rules affect the statutes in Finance Code Chapter 158, the Residential Mortgage Loan Servicer Registration Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Department of Savings and Mortgage Lending
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CHAPTER 59. WRAP MORTGAGE LOANS

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (SML), adopts new rules in 7 TAC Chapter 59: §§59.1 - 59.5, 59.100 - 59.102, 59.200, 59.201, 59.300 - 59.303, 59.400 - 59.403. The commission's proposal was published in the September 6, 2024, issue of the *Texas Register* (49 TexReg 6932). The rules are adopted without changes to the published text and will not be republished.

Explanation of and Justification for the Rules

The preexisting rules under 7 TAC Chapter 78, Wrap Mortgage Loans, affect wrap mortgage lenders, borrowers, and any person who collects or receives a payment from a wrap borrower under the terms of a wrap mortgage loan, including servicers of a wrap mortgage loan under Finance Code Chapter 159, Wrap Mortgage Loan Financing.

Changes Concerning the Reorganization (Relocation) of Wrap Mortgage Loan Rules from Chapter 78 to Chapter 59

SML has determined it should reorganize its rules concerning wrap mortgage loans by relocating them to Chapter 59, a vacant chapter. The adopted rules effectuate this change.

Changes Concerning General Provisions (Subchapter A)

The adopted rules: in §59.2, Definitions, adopt a new definition for "SML," while eliminating a definition for "Department"; in §59.3, Formatting Requirements for Notices, adopt formatting requirements for the various disclosures required under Finance Code Chapter 159; in §59.4, Electronic Delivery and Signature of Notices, clarify that any required notice or disclosure may be delivered and signed electronically; and, in §59.5, Computation of Time, clarify how time periods measured in calendar days are computed.

Other Modernization and Update Changes

The adopted rules make changes to modernize and update the rules including: adding and replacing language for clarity and to improve readability; removing unnecessary or duplicative provisions; and updating terminology.

Summary of Public Comments

Publication of the commission's proposal recited a deadline of 30 days to receive public comments. No comments were received.

SUBCHAPTER A. GENERAL PROVISIONS

7 TAC §§59.1 - 59.5

Statutory Authority

The rules are adopted under the authority of Finance Code §159.108, authorizing the commission to adopt and enforce rules for the intent of or to ensure compliance with Finance Code Chapter 159.

The adopted rules affect the statutes in Finance Code Chapter 159, Wrap Mortgage Loan Financing.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Iain A. Berry
General Counsel
Department of Savings and Mortgage Lending
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For further information, please call: (512) 475-1535

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SUBCHAPTER B. LENDER REQUIREMENTS AND RESPONSIBILITIES

7 TAC §§59.100 - 59.102

Statutory Authority

The rules are adopted under the authority of Finance Code §159.108, authorizing the commission to adopt and enforce rules for the intent of or to ensure compliance with Finance Code Chapter 159. §59.101 is also adopted under the authority of, and to implement, Finance Code: §159.101 and §159.102. §59.102 is also adopted under the authority of, and to implement, Finance Code §159.105.

The adopted rules affect the statutes in Finance Code Chapter 159, Wrap Mortgage Loan Financing.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER C. BORROWER'S RIGHTS AND RESPONSIBILITIES

7 TAC §59.200, §59.201

Statutory Authority

The rules are adopted under the authority of Finance Code §159.108, authorizing the commission to adopt and enforce rules for the intent of or to ensure compliance with Finance Code Chapter 159. §59.201 is also adopted under the authority of, and to implement, Finance Code §159.202.

The adopted rules affect the statutes in Finance Code Chapter 159, Wrap Mortgage Loan Financing.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER D. WRAP LENDER AND SERVICER REQUIREMENTS

7 TAC §§59.300 - 59.303

Statutory Authority

The rules are adopted under the authority of Finance Code §159.108, authorizing the commission to adopt and enforce rules for the intent of or to ensure compliance with Finance Code Chapter 159. §59.301 and §59.303 are also adopted under the authority of, and to implement, Finance Code §159.152. §59.302 is also adopted under the authority of, and to implement, Finance Code §159.151.

The adopted rules affect the statutes in Finance Code Chapter 159, Wrap Mortgage Loan Financing.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER E. SUPERVISION AND ENFORCEMENT

7 TAC §§59.400 - 59.403

Statutory Authority

The rules are adopted under the authority of Finance Code §159.108, authorizing the commission to adopt and enforce rules for the intent of or to ensure compliance with Finance Code Chapter 159. §§59.401 - 59.403 are also adopted under the authority of, and to implement, Finance Code §159.252.

The adopted rules affect the statutes in Finance Code Chapter 159, Wrap Mortgage Loan Financing.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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CHAPTER 78. WRAP MORTGAGE LOANS

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (SML), adopts the repeal of all preexisting rules in 7 TAC Chapter 78: §§78.1 - 78.3, 78.100 - 78.102, 78.200, 78.201, 78.300 - 78.303, and 78.400 - 78.403. The commission's proposal was published in the September 6, 2024, issue of the *Texas Register* (49 TexReg 6941). The rules are adopted without changes to the published text and will not be republished.

Explanation of and Justification for the Rules

The preexisting rules under 7 TAC Chapter 78, Wrap Mortgage Loans, affect wrap mortgage lenders, borrowers, and any person who collects or receives a payment from a wrap borrower under the terms of a wrap mortgage loan, including servicers of a wrap mortgage loan under Finance Code Chapter 159, Wrap Mortgage Loan Financing.

Changes Concerning the Reorganization (Relocation) of Wrap Mortgage Loan Rules from Chapter 78 to Chapter 59

SML has determined it should reorganize its rules concerning wrap mortgage loans by relocating them to Chapter 59, a vacant chapter. The adopted rules repeal all preexisting rules in Chapter 78. In a related adoption published elsewhere in this issue of the *Texas Register*, SML adopts new rules in Chapter 59 affecting wrap mortgage lenders, borrowers, and any person who collects or receives a payment from a wrap borrower under the terms of a wrap mortgage loan. The new rules are patterned after the preexisting rules in Chapter 78.

Summary of Public Comments

Publication of the commission's proposal recited a deadline of 30 days to receive public comments. No comments were received.

SUBCHAPTER A. GENERAL PROVISIONS

7 TAC §§78.1 - 78.3

Statutory Authority

The rules are adopted under the authority of Finance Code §159.108, authorizing the commission to adopt and enforce rules for the intent of or to ensure compliance with Finance Code Chapter 159.

The adopted rules affect the statutes in Finance Code Chapter 159, Wrap Mortgage Loan Financing.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER B. LENDER REQUIREMENTS AND RESPONSIBILITIES

7 TAC §§78.100 - 78.102

The rules are adopted under the authority of Finance Code §159.108, authorizing the commission to adopt and enforce rules for the intent of or to ensure compliance with Finance Code Chapter 159.

The adopted rules affect the statutes in Finance Code Chapter 159, Wrap Mortgage Loan Financing.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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General Counsel
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SUBCHAPTER C. BORROWER'S RIGHTS AND RESPONSIBILITIES

7 TAC §78.200, §78.201

Statutory Authority

The rules are adopted under the authority of Finance Code §159.108, authorizing the commission to adopt and enforce rules for the intent of or to ensure compliance with Finance Code Chapter 159.

The adopted rules affect the statutes in Finance Code Chapter 159, Wrap Mortgage Loan Financing.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Iain A. Berry
General Counsel
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SUBCHAPTER D. WRAP LENDER AND SERVICER REQUIREMENTS

7 TAC §§78.300 - 78.303

Statutory Authority

The rules are adopted under the authority of Finance Code §159.108, authorizing the commission to adopt and enforce rules for the intent of or to ensure compliance with Finance Code Chapter 159.

The adopted rules affect the statutes in Finance Code Chapter 159, Wrap Mortgage Loan Financing.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER E. COMPLIANCE AND ENFORCEMENT

7 TAC §§78.400 - 78.403

Statutory Authority

The rules are adopted under the authority of Finance Code §159.108, authorizing the commission to adopt and enforce rules for the intent of or to ensure compliance with Finance Code Chapter 159.

The adopted rules affect the statutes in Finance Code Chapter 159, Wrap Mortgage Loan Financing.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Iain A. Berry
General Counsel
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CHAPTER 79. RESIDENTIAL MORTGAGE LOAN SERVICERS

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (SML), adopts the repeal of all preexisting rules in 7 TAC Chapter 78: §§78.1 - 78.3, 78.100 - 78.102, 78.200, 78.201, 78.300 - 78.303, and 78.400 - 78.403. The commission's proposal was published in the September 6, 2024, issue of the *Texas Register* (49 TexReg 6943). The rules are adopted without changes to the published text and will not be republished.

Explanation of and Justification for the Rules

The preexisting rules under 7 TAC Chapter 79, Residential Mortgage Loan Servicers, affect residential mortgage loan servicers

(mortgage servicers) registered with SML under Finance Code Chapter 158, Residential Mortgage Loan Servicers.

Changes Concerning the Reorganization (Relocation) of Residential Mortgage Loan Servicer Rules from Chapter 79 to Chapter 58

SML has determined it should reorganize its rules concerning mortgage servicers by relocating them to Chapter 58, a vacant chapter. The adopted rules repeal all preexisting rules in Chapter 79. In a related adoption published elsewhere in this issue of the *Texas Register,* SML adopts new rules in Chapter 59 affecting mortgage servicers that are patterned after the preexisting rules in Chapter 79.

Summary of Public Comments

Publication of the commission's proposal recited a deadline of 30 days to receive public comments. No comments were received.

SUBCHAPTER A. REGISTRATION

7 TAC §§79.1 - 79.5

Statutory Authority

The rules are adopted under the authority of Finance Code §158.003, authorizing the commission to adopt rules necessary for the purposes of or to ensure compliance with Finance Code Chapter 158.

The adopted rules affect the statutes in Finance Code Chapter 158, the Residential Mortgage Loan Servicer Registration Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Iain A. Berry
General Counsel
Department of Savings and Mortgage Lending
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SUBCHAPTER B. COMPLAINTS AND INVESTIGATIONS

7 TAC §79.20

Statutory Authority

The rule is adopted under the authority of Finance Code §158.003, authorizing the commission to adopt rules necessary for the purposes of or to ensure compliance with Finance Code Chapter 158.

The adopted rule affects the statutes in Finance Code Chapter 158, the Residential Mortgage Loan Servicer Registration Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Iain A. Berry
General Counsel
Department of Savings and Mortgage Lending
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SUBCHAPTER C. HEARINGS AND APPEALS

7 TAC §79.30

Statutory Authority

The rule is adopted under the authority of Finance Code §158.003, authorizing the commission to adopt rules necessary for the purposes of or to ensure compliance with Finance Code Chapter 158.

The adopted rule affects the statutes in Finance Code Chapter 158, the Residential Mortgage Loan Servicer Registration Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Iain A. Berry
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SUBCHAPTER D. INTERPRETATIONS

7 TAC §79.40

Statutory Authority

The rule is adopted under the authority of Finance Code §158.003, authorizing the commission to adopt rules necessary for the purposes of or to ensure compliance with Finance Code Chapter 158.

The adopted rule affects the statutes in Finance Code Chapter 158, the Residential Mortgage Loan Servicer Registration Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Iain A. Berry
General Counsel
Department of Savings and Mortgage Lending
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SUBCHAPTER E. SAVINGS CLAUSE

7 TAC §79.50

Statutory Authority

The rule is adopted under the authority of Finance Code §158.003, authorizing the commission to adopt rules necessary for the purposes of or to ensure compliance with Finance Code Chapter 158.

The adopted rule affects the statutes in Finance Code Chapter 158, the Residential Mortgage Loan Servicer Registration Act.

§79.50. Savings Clause.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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CHAPTER 80. RESIDENTIAL MORTGAGE LOAN COMPANIES

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (SML), adopts the repeal of all preexisting rules in 7 TAC Chapter 80: §§80.1 - 80.5, 81.100 - 80.102, 80.105 - 80.107, 80.200 - 80.206, and 80.300 - 80.302. The commission's proposal was published in the September 6, 2024, issue of the *Texas Register* (49 TexReg 6945). The rules are adopted without changes to the published text and will not be republished.

Explanation of and Justification for the Rules

The preexisting rules under 7 TAC Chapter 80, Residential Mortgage Loan Companies, affect residential mortgage loan companies (mortgage companies) licensed by SML under Finance Code Chapter 156.

Changes Concerning the Reorganization (Relocation) of Mortgage Company Rules from Chapter 80 to Chapter 56

SML has determined it should reorganize its rules concerning mortgage companies by relocating them to Chapter 56, a vacant chapter. The adopted rules repeal all preexisting rules in Chapter 80. In a related adoption published elsewhere in this issue of the *Texas Register,* SML adopts new rules in Chapter 56 affecting mortgage companies that are patterned after the preexisting rules in Chapter 80.

Summary of Public Comments

Publication of the commission's proposal recited a deadline of 30 days to receive public comments. No comments were received.

SUBCHAPTER A. GENERAL PROVISIONS

7 TAC §§80.1 - 80.5

Statutory Authority

The rules are adopted under the authority of Finance Code §156.102, authorizing the commission to adopt rules necessary for the intent of or to ensure compliance with Finance Code Chapter 156, and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act).

The adopted rules affect the statutes in Finance Code Chapter 156, the Residential Mortgage Loan Company Licensing and Registration Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Iain A. Berry
General Counsel
Department of Savings and Mortgage Lending
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SUBCHAPTER B. LICENSING

7 TAC §§80.100 - 80.102, 80.105 - 80.107

Statutory Authority

The rules are adopted under the authority of Finance Code §156.102, authorizing the commission to adopt rules necessary for the intent of or to ensure compliance with Finance Code Chapter 156, and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act).

The adopted rules affect the statutes in Finance Code Chapter 156, the Residential Mortgage Loan Company Licensing and Registration Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER C. DUTIES AND RESPONSIBILITIES

7 TAC §§80.200 - 80.206

Statutory Authority

The rules are adopted under the authority of Finance Code §156.102, authorizing the commission to adopt rules necessary for the intent of or to ensure compliance with Finance Code Chapter 156, and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act).

The adopted rules affect the statutes in Finance Code Chapter 156, the Residential Mortgage Loan Company Licensing and Registration Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER D. COMPLIANCE AND ENFORCEMENT

7 TAC §§80.300 - 80.302

Statutory Authority

The rules are adopted under the authority of Finance Code §156.102, authorizing the commission to adopt rules necessary for the intent of or to ensure compliance with Finance Code Chapter 156, and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act).

The adopted rules affect the statutes in Finance Code Chapter 156, the Residential Mortgage Loan Company Licensing and Registration Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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CHAPTER 81. MORTGAGE BANKERS AND RESIDENTIAL MORTGAGE LOAN ORIGINATORS

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (SML), adopts the repeal of all preexisting rules in 7 TAC Chapter 81: §§81.1 - 81.5, 81.100 - 81.111, 81.200 - 81.206, and 81.300 - 81.302. The commission's proposal was published in the September 6, 2024, issue of the *Texas Register* (49 TexReg 6947). The rules are adopted without changes to the published text and will not be republished.

Explanation of and Justification for the Rules

The preexisting rules under 7 TAC Chapter 81, Mortgage Bankers and Residential Mortgage Loan Originators, affect mortgage bankers registered with SML and individual residential mortgage loan originators (originators) licensed by SML under Finance Code Chapter 157.

Changes Concerning the Reorganization (Relocation) of Mortgage Banker Rules from Chapter 81 to Chapter 57

SML has determined it should reorganize its rules concerning mortgage bankers by relocating them to Chapter 57, a vacant chapter, and devoting such chapter exclusively to rules affecting mortgage bankers. The adopted rules repeal all preexisting rules in Chapter 81 concerning mortgage bankers. In a related adoption published elsewhere in this issue of the *Texas Register,* SML adopts new rules in Chapter 57 affecting mortgage bankers that are patterned after the preexisting rules in Chapter 81.

Changes Concerning the Reorganization (Relocation) of Residential Mortgage Loan Originator Rules from Chapter 81 to Chapter 55

SML has determined it should reorganize its rules concerning originators by relocating them to Chapter 55, a vacant chapter, and devoting such chapter exclusively to rules affecting originators. The adopted rules repeal all preexisting rules in Chapter 81 concerning originators. In a related adoption published elsewhere in this issue of the *Texas Register,* SML adopts new rules in Chapter 55 affecting originators that are patterned after the preexisting rules in Chapter 81.

Summary of Public Comments

Publication of the commission's proposal recited a deadline of 30 days to receive public comments. No comments were received.

SUBCHAPTER A. GENERAL PROVISIONS

7 TAC §§81.1 - 81.5

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). The rules are also adopted under the authority of Finance Code §180.004(b), authorizing the commission to adopt rules necessary to implement Finance Code Chapter 180 and as required to carry out the intentions of the federal SAFE Act.

The adopted rules affect the statutes in Finance Code: Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act; and Chapter 180, the Texas Secure and Fair Enforcement for Mortgage Licensing Act of 2009.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Iain A. Berry
General Counsel
Department of Savings and Mortgage and Lending
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SUBCHAPTER B. LICENSING OF INDIVIDUAL ORIGINATORS

7 TAC §§81.100 - 81.111

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). The rules are also adopted under the authority of Finance Code §180.004(b), authorizing the commission to adopt rules necessary to implement Finance Code Chapter 180 and as required to carry out the intentions of the federal SAFE Act.

The adopted rules affect the statutes in Finance Code: Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act; and Chapter 180, the Texas Secure and Fair Enforcement for Mortgage Licensing Act of 2009.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER C. DUTIES AND RESPONSIBILITIES

7 TAC §§81.200 - 81.206

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). The rules are also adopted under the authority of Finance Code §180.004(b), authorizing the commission to adopt rules necessary to implement Finance Code Chapter 180 and as required to carry out the intentions of the federal SAFE Act.

The adopted rules affect the statutes in Finance Code: Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act; and Chapter 180, the Texas Secure and Fair Enforcement for Mortgage Licensing Act of 2009.

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Iain A. Berry
General Counsel
Department of Savings and Mortgage Lending
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SUBCHAPTER D. COMPLIANCE AND ENFORCEMENT

7 TAC §§81.300 - 81.302

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). The rules are also adopted under the authority of Finance Code §180.004(b), authorizing the commission to adopt rules necessary to implement Finance Code Chapter 180 and as required to carry out the intentions of the federal SAFE Act.

The adopted rules affect the statutes in Finance Code: Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act; and Chapter 180, the Texas

Secure and Fair Enforcement for Mortgage Licensing Act of 2009.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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TITLE 16. ECONOMIC REGULATION

PART 9. TEXAS LOTTERY COMMISSION

CHAPTER 401. ADMINISTRATION OF STATE LOTTERY ACT

SUBCHAPTER B. LICENSING AND SALES AGENTS

16 TAC §401.158, §401.160

The Texas Lottery Commission (Commission) adopts amendments to 16 TAC §401.158 (Suspension or Revocation of License) and §401.160 (Standard Penalty Chart) without changes to the proposed text as published in the September 27, 2024, issue of the *Texas Register* (49 TexReg 7703). The purpose of the amendments is to reinforce the Commission's zero tolerance policy regarding a Texas Lottery sales agent (retailer) selling lottery tickets to a minor by requiring revocation of the retailer's license in all cases involving a violation of a law or Commission rule where the licensee intentionally or knowingly sells or offers to sell a lottery ticket to a person that the licensee knows is younger than 18 years of age. See Texas Government Code §466.3051(a) (Sale of Ticket to or Purchase of Ticket by Person Younger Than 18 Years of Age).

The Commission received one comment opposing the proposed amendments from the Texas Food & Fuel Association (TFFA), which represents the wholesale and retail levels of the food and petroleum industries in Texas and whose members own, operate, or supply more than 16,500 retail convenience stores in Texas.

COMMENT: While TFFA does not condone sales to minors, it asserts the proposed amendments are excessively punitive by mandating the automatic revocation of a retailer's license for a first violation. TFFA notes the proposed amendments eliminate the Commission's discretion to issue an alternative penalty or consider mitigating circumstances, including the history of the retailer. TFFA also asserts that, because the Sunset Advisory Commission's review of the Commission is still in progress, this rulemaking is premature and should be placed on hold until legislation is passed to continue the Commission's operations.

RESPONSE: The prohibition of lottery ticket sales to minors is vitally important to maintaining the public's trust and ensuring the integrity of the Texas Lottery. While the Commission appreciates TFFA's comments, it is important to send a strong message to lottery retailers that preventing sales to minors must be a top priority for them, and the Commission believes that its zero tolerance policy and license revocation for a first violation is an appropriate measure to accomplish that.

These amendments are adopted under Texas Government Code §466.015(b)(3), which requires the Commission to adopt rules governing the enforcement of prohibitions on the sale of tickets to or by an individual younger than 18 years of age, and §467.102, which authorizes the Commission to adopt rules for the enforcement and administration of the laws under the Commission's jurisdiction.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Bob Biard
General Counsel
Texas Lottery Commission
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Proposal publication date: September 27, 2024
For further information, please call: (512) 344-5392

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CHAPTER 401. ADMINISTRATION OF STATE LOTTERY ACT

The Texas Lottery Commission (Commission) adopts the repeal of existing 16 TAC §401.315 ("Mega Millions"Draw Game Rule) and the new 16 TAC §401.315 ("Mega Millions"Draw Game Rule) without changes to the proposed text as published in the August 23, 2024, issue of the *Texas Register* (49 TexReg 6391). The rules will not be republished.

The purpose of the repeal and new rule is to conform the play of the Mega Millions game in Texas to game changes recently adopted by the Mega Millions Lotteries and the Multi-State Lottery Association (MUSL). These changes include (1) increasing the purchase price of a ticket from $2 to $5; (2) changing the game matrix from 5/70 plus 1/25 (selection of five numbers from a field of 70 numbers and then one number from a field of 25 numbers) to 5/70 plus 1/24 (selection of five numbers from a field of 70 numbers and then selection of one number from a field of 24 numbers); (3) removing Megaplier® and Just the Jackpot® features; (4) changing the play of the game to include a Multiplier automatically generated by the Lottery Gaming System (as defined in the new rule) as part of the cost of a Play, which will multiply the non-jackpot prizes by 2, 3, 4, 5 or 10 times; (5) revising certain game definitions and references; (6) updating grammar and/or sentence structure changes to provide clarity, including renaming the top prize as the Jackpot Prize instead of Grand Prize; and (7) adding that the Mega Millions Lotteries are removing the graduated percentage escalator for the thirty annual payment schedule. Mega Millions Lotteries will take responsibility for the schedule of prize payments for a thirty annual graduated payment schedule. The new Mega Millions game changes

are expected to be implemented on April 5, 2025, with the first drawing under the new rule expected to be on April 8, 2025. Accordingly, the current Mega Millions rule will remain in effect until the date the new rule is implemented, which currently is expected to be April 5, 2025.

The Commission is a member of MUSL and is authorized to conduct the Mega Millions game in Texas under the conditions of the Cross-Sell Agreement between MUSL and the Mega Millions Lotteries, MUSL rules, the laws of the State of Texas, this rule (16 TAC §401.315), and under such further instructions, directives, and procedures as the Commission executive director may issue in furtherance thereof. To be clear, the authority to participate in the Mega Millions game is provided to the Commission by MUSL through the Cross-Sell Agreement and the conduct and play of the Mega Millions game in Texas must conform to the MUSL Product Group's Mega Millions game rules.

The Commission received forty-two (42) written comments on the proposed repeal and new rule during the public comment period.

COMMENTS: All commenters were against the proposed price increase from $2 to $5 to play Mega Millions. Many commenters expressed that they would no longer play the Mega Millions game at the higher price. Several commented that raising the price causes the game to be out of reach for some players and causes others to spend more than they can afford, is not proportionate with the slight improvement of the odds and is greedy. Several also commented that they did not like losing the choice to "Megaply"or not, nor did they like losing the "Just the Jackpot"option. A few commenters also expressed that less people will play the game, resulting in less money for Texas public education.

RESPONSE: The Commission is authorized by the Cross-Sell Agreement between MUSL and the Mega Millions Lotteries to sell the Mega Millions game in Texas. In order to sell this lottery game, the Commission must adhere to the conditions of the Cross-Sell Agreement, as well as the MUSL rules regarding the Mega Millions game. The Mega Millions Lotteries control the management of the game, game changes and new game features. The Commission has no vote, choice, or input, on the cost of the Mega Millions game, the play of the game, or the odds of the game. The Commission only has a choice to sell Mega Millions lottery tickets in accordance with the Cross-Sell Agreement and MUSL rules, or to not participate in the game. In FY 2024, the sale of Mega Millions resulted in the Commission transferring $144,025,131.52 in revenue to the state. Whether the Jackpot prize is won in Texas or in another state, the proceeds from each ticket sold in Texas stay in Texas. Because of the significant revenue brought to the State with the Mega Millions game, the Commission intends to continue selling the Mega Millions game pursuant to the Cross-Sell Agreement and MUSL rules.

SUBCHAPTER D. LOTTERY GAME RULES

16 TAC §401.315

The repeal is adopted under Texas Government Code §466.015(c), which authorizes the Commission to adopt rules governing the operation of the lottery; §466.451, which authorizes the Commission to adopt rules relating to multijurisdiction lottery games; and §467.102, which authorizes the Commission to adopt rules for the enforcement and administration of the laws under the Commission's jurisdiction.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on October 30, 2024.

TRD-202405167
Bob Biard
General Counsel
Texas Lottery Commission
Effective date: April 5, 2025
Proposal publication date: August 23, 2024
For further information, please call: (512) 344-5324

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16 TAC §401.315

The new rule is adopted under Texas Government Code §466.015(c), which authorizes the Commission to adopt rules governing the operation of the lottery; §466.451, which authorizes the Commission to adopt rules relating to multijurisdiction lottery games; and §467.102, which authorizes the Commission to adopt rules for the enforcement and administration of the laws under the Commission's jurisdiction.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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TRD-202405168
Bob Biard
General Counsel
Texas Lottery Commission
Effective date: April 5, 2025
Proposal publication date: August 23, 2024
For further information, please call: (512) 344-5324

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TITLE 25. HEALTH SERVICES

PART 1. DEPARTMENT OF STATE HEALTH SERVICES

CHAPTER 97. COMMUNICABLE DISEASES

SUBCHAPTER A. CONTROL OF COMMUNICABLE DISEASES

25 TAC §§97.3, 97.4, 97.6

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC), on behalf of the Department of State Health Services (DSHS), adopts amendments to §97.3, concerning What Condition to Report and What Isolates to Report or Submit; §97.4, concerning When and How to Report a Condition or Isolate; and §97.6, concerning Reporting and Other Duties of Local Health Authorities and Regional Directors. The amendments to §§97.3, 97.4, and 97.6 are adopted without changes to the proposed text as published in the August 9, 2024,

issue of the *Texas Register* (49 TexReg 5907), and therefore will not be republished.

BACKGROUND AND JUSTIFICATION

The amendments are necessary to comply with Texas Health and Safety Code Chapter 81, amended by Senate Bill 969, 87th Regular Session, 2021, and update the list of notifiable conditions in Texas.

The amendment to §97.3 adds melioidosis and *Cronobacter spp.* in infants as notifiable conditions in Texas.

The amendments to §97.4 and to §97.6 implement the revisions to Texas Health and Safety Code Chapter 81 by updating the acceptable methods of reporting notifiable conditions to electronic data transmission, telephone, or fax. Notifiable conditions reported by telephone must be followed-up with an electronic data transmission through an approved electronic means within 24 hours of the original notification. The amendments improve the ability of public health entities to plan and implement response and mitigation measures, enhance public surveillance and timely reporting, and increase the availability of public health data in Texas.

COMMENTS

The 31-day comment period ended Monday, September 9, 2024.

During this period, DSHS did not receive any comments regarding the proposed rules.

STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.0055, and Texas Health and Safety Code §1001.075, which authorize the Executive Commissioner of HHSC to adopt rules for the operation and provision of services by DSHS and for the administration of Texas Health and Safety Code Chapter 1001; and Texas Health and Safety Code Chapter 81 (Communicable Disease Prevention and Control Act), which authorizes the Executive Commissioner to identify reportable diseases and prescribe the form and method for reporting.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on October 31, 2024.

TRD-202405214
Cynthia Hernandez
General Counsel
Department of State Health Services
Effective date: January 1, 2025
Proposal publication date: August 9, 2024
For further information, please call: (512) 776-7676

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CHAPTER 133. HOSPITAL LICENSING

The Texas Health and Human Services Commission (HHSC) adopts the repeal of §133.101, concerning Inspection and Investigation Procedures; and §133.102, concerning Complaint Against Department of State Health Services Surveyor; new §§133.101, concerning Integrity of Inspections and Investigations; 133.102, concerning Inspections; 133.103, concerning Complaint Investigations; 133.104, concerning Notice; 133.105, concerning Professional Conduct; and 133.106, concerning Complaint Against an HHSC Representative; and amendments to §133.47, concerning Abuse and Neglect Issues; and §133.121, concerning Enforcement.

The repeal of §133.101 and §133.102, and new §§133.104, 133.105, and 133.106 are adopted without changes to the proposed text as published in the May 10, 2024, issue of the *Texas Register* (49 TexReg 3106). These rules will not be republished.

New §§133.101, 133.102, and 133.103 and amended §133.47 and §133.121 are adopted with changes to the proposed text as published in the May 10, 2024, issue of the *Texas Register* (49 TexReg 3106). These rules will be republished.

BACKGROUND AND JUSTIFICATION

The adoption is necessary to implement House Bill (H.B.) 49, 88th Legislature, Regular Session, 2023. H.B. 49 amended Texas Health and Safety Code (HSC) §241.051 to make certain information related to hospital investigations subject to disclosure and create a requirement for HHSC to post certain information related to hospital investigations on the HHSC website.

The adoption is also necessary to update the inspection, complaint investigation, and enforcement procedures for general and special hospitals. These updates are necessary to hold hospitals accountable during the inspection and investigation processes and ensure hospitals provide necessary documentation in a timely manner to HHSC representatives. The adopted rules revise enforcement procedures to ensure conformity with current practices and statutes. These updates also ensure consistent practices across HHSC Health Care Regulation, correct outdated language and contact information, and reflect the transition of regulatory authority for hospitals from the Department of State Health Services (DSHS) to HHSC.

COMMENTS

The 31-day comment period ended June 10, 2024.

During this period, HHSC received comments regarding the proposed rules from four commenters, including Citizens Commission on Human Rights (CCHR), Disability Rights Texas (DRTx), Texas Hospital Association (THA), and Texas Medical Association (TMA). A summary of comments relating to the rules and HHSC's responses follows.

Comment: THA expressed appreciation for HHSC considering comments from the previous public comment period and incorporating some of the feedback THA and other stakeholders provided.

Response: HHSC acknowledges this comment.

Comment: CCHR recommended including 911 and the contact information for the federally mandated protection and advocacy system to the posting required by §133.47(c)(2) to eliminate the need for multiple postings. DRTx recommended the posting required by §133.47(c)(2) include the contact information for the federally mandated protection and advocacy system.

Response: HHSC declines to revise §133.47(c)(2) because this paragraph is specific to reporting allegations under HSC §161.132. HHSC notes this paragraph does not preclude a hospital from combining the signage with other required postings.

Comment: CCHR, DRTx, TMA commented on the timeframe requirements in §133.47(c)(3)(A) and §133.47(c)(3)(B).

Regarding §133.47(c)(3)(A), CCHR stated abuse and neglect allegations should be reported immediately because these allegations are criminal matters and time is of the essence. They also stated that in a busy hospital, it may be difficult to preserve a crime scene for an extended amount of time and patient safety and evidence collection and preservation should be top priorities.

Regarding §133.47(c)(3)(A), DRTx stated time is of the essence when reporting allegations of abuse or neglect and the ability to gather sufficient evidence is lessened as time passes. DRTx also stated that the report is the trigger to initiate protective actions for the alleged victim and secure the evidence and recommended that the timeframe for reporting be as soon as possible, but no later than one hour.

Regarding §133.47(c)(3)(B), CCHR recommended a 24-hour deadline for reporting illegal, unprofessional, or unethical conduct.

Regarding §133.47(c)(3)(B), DRTx expressed concern with the 48-hour deadline because the sooner a report is made, the sooner actions to protect the alleged victim and evidence collection can occur. DRTx recommended the report be made as soon as possible, but no later than 24 hours.

TMA stated the proposed amendments to §133.47(c)(3)(A) and (B) go beyond the scope of the summary of the proposed amendments HHSC listed for this section in the proposal preamble because they are substantive changes. TMA expressed concern about the time limits for reporting abuse, neglect, and exploitation and illegal, unprofessional, or unethical conduct because these timeframes may not always be possible or practical. TMA further stated these timeframes may discourage physicians and providers from even looking for signs of abuse, neglect, and exploitation and illegal, unprofessional, or unethical conduct because they may fear being held responsible for reporting under these timeframes or encourage overreporting. TMA recommended against HHSC adopting the proposed timeframes or any finite reporting limits and recommended HHSC revert to the "as soon as possible" language stated in HSC §161.132.

Response: HHSC revised §133.47(c)(3)(A) and (B) to remove the 24-hour and 48-hour timeframes. Hospitals must report allegations under these subparagraphs as soon as possible in accordance with HSC §161.132.

Comment: CCHR stated trainings under §133.47(c)(4) should be competency based and a trainee should be able to demonstrate understanding and competence in applying the material.

DRTx recommended trainings under §133.47(c)(4) be competency based. DRTx stated there should be physical evidence at the end of the training that the trainee understood and retained the information provided and the training should have a test to protect the trainer, the facility, and individuals receiving services. Further, DRTx recommended staff being allowed to take a test instead of re-taking the required 8-hour training if there are no recorded concerns about infractions over the past year.

Response: HHSC declines to revise §133.47(c)(4) because HSC §161.133(a) requires the facility to provide a minimum of 8-hours of annual in-service training to staff in identifying patient abuse or neglect and illegal, unprofessional, or unethical conduct by or in the facility.

Comment: CCHR and DRTx recommended that in §133.47(f)(1)(A) and (B), the reporter, alleged victim, and the alleged victim's LAR, if the alleged victim has an LAR, should be informed of any appeal process and the timeframe for submitting an appeal.

Response: HHSC declines to revise §133.47(f)(1)(A) and (B) because investigations under §133.47(b) do not provide an appeal process for a complainant or an alleged violator.

Comment: CCHR stated the complainant should be informed of any appeal timelines and procedures and opportunities to contact an ombudsman under §133.47(f)(2).

DRTx recommended a complainant should receive information about any appeal process and timeframes to submit an appeal request under §133.47(f)(2).

Response: HHSC declines to revise §133.47(f)(2) because investigations under §133.47(c) do not provide an appeal process for a complainant or an alleged violator.

Comment: DRTx recommended HHSC add language to §133.47(g)(4) to require HHSC to inform the complainant, in a timely manner, if HHSC decides not to investigate and of the final disposition of the allegation, including any referrals HHSC made.

Response: HHSC declines to revise §133.47(g)(4) because a complainant notification process is already included under 25 TAC §133.47(f).

Comment: THA stated there was a possible grammatical error or missing words in §133.101(a)(2) and suggested the paragraph instead state, "may not record, listen to, or eavesdrop on any HHSC internal discussions outside the presence of facility staff when HHSC has requested a private room or office or distanced themselves from facility staff unless it first informs HHSC and the facility obtains HHSC's written approval before beginning to record or listen to the discussion."

Response: HHSC revised §133.101(a)(2) by adding "unless the hospital first informs HHSC" to clarify that a hospital must first inform HHSC and then obtain HHSC's written approval before beginning to record or listen to an internal HHSC discussion.

Comment: THA requested HHSC revise §133.101(b) to clarify that a hospital must only inform HHSC of audio-capturing recording devices that are not readily visible. THA stated security cameras are present in many locations in hospitals, particularly hallways and common areas, and that it is possible cameras may be present while HHSC staff are having discussions. THA noted cameras in common areas would be visible to anyone and likely do not capture audio and should not require disclosure by the hospital.

Response: HHSC declines to revise §133.101(b) because HHSC staff need enhanced privacy for internal discussion and this paragraph is necessary to protect HHSC staff from intentional or unintentional eavesdropping.

Comment: THA expressed concern about §133.102(f) and §133.103(h), which require a hospital to permit HHSC access to interview members of a hospital's governing body, personnel, and patients, including the opportunity to request written statements. THA stated members of hospital governing bodies are often community members not involved in the hospital's daily operations and subjecting them to interviews may deter community involvement in hospital boards. THA further stated that requesting written statements from personnel and governing body members could lead to disputes and potential enforcement actions if statements are not provided or deemed unsatisfactory. THA requested HHSC remove the provisions allowing

interviews with governing body members and the requirement for written statements to avoid potential adversarial situations if a hospital declines HHSC's request.

Response: HHSC declines to revise §133.102(f) and §133.103(h) because it is important for HHSC staff to have the opportunity to talk to and request statements from relevant individuals, including, at times, members of a hospital's governing body. HHSC notes these subsections do not require a written statement and only allows HHSC the opportunity to request one.

Comment: THA questioned whether HHSC disclosing information to law enforcement agencies as allowed by §133.102(k)(4) and §133.103(m)(4) is appropriate or legally permissible. However, THA noted the statutory language supported this exception. THA stated that the Health Insurance Portability and Accountability Act (HIPAA) provides limited exceptions for disclosures to law enforcement, typically requiring specific legal processes like search warrants or subpoenas. THA further stated that the proposed rule may not comply with HIPAA and HSC §181.004. THA requested HHSC remove §133.102(k)(4) and §133.103(m)(4) because THA does not believe it is appropriate for HHSC to have rules specifically permitting the disclosure of confidential information to a law enforcement agency. Alternatively, THA requested HHSC revise §133.102(k)(4) and §133.103(m)(4) to state "law enforcement agencies as otherwise authorized or required by law."

Response: HHSC revised §133.102(k)(4) and §133.103(m)(4) to add "as allowed by law" to the end of the paragraphs.

Comment: CCHR expressed support for the inclusion of language added by H.B. 49, 88th Regular Session, 2023 at §133.102(l) and §133.103(n). H.B. 49 amended Texas Health and Safety Code (HSC) §241.051 to make certain information related to hospital investigations subject to disclosure and create a requirement for HHSC to post certain information related to hospital investigations on the HHSC website.

Response: HHSC acknowledges this comment.

Comment: TMA stated that §133.102(l) and §133.103(n) tracked the governing statute except for §133.102(l)(6) and §133.103(n)(6). TMA further stated Texas Government Code Chapter 552 generally gives the public the right to access government information on request, so §133.102(l)(6) and §133.103(n)(6) would make all inspection and investigation information, other than certain personally identifying information, subject to public disclosure, which conflicts with HSC §241.051(e). TMA recommended that §133.102(l)(6) and §133.103(n)(6) be removed to properly align with HSC §241.051(e).

Response: HHSC declines to remove §133.102(l)(6) and §133.103(n)(6) as recommended because these paragraphs state that HHSC will follow the requirements of public information laws, which prohibit disclosure of information made confidential by other laws, such as HSC §241.051. These paragraphs do not authorize disclosure of any information contrary to those laws.

Comment: THA expressed concern with the posting requirements at §133.103(a)(2) because the requirements will take time for hospitals to implement and there is a possible conflict with an existing rule at 25 TAC §1.191, which also mandates signage to notify patients where they can file complaints. THA requested HHSC withdraw §133.103(a)(2), review the rule at 25 TAC §1.191 alongside proposed §133.103(a)(2), and propose a unified rule that avoids duplicative or conflicting signage mandates. Alternatively, THA proposed an extended implementation period of at least 12 months for hospitals to comply with the signage requirements and for HHSC to provide guidance on how to reconcile the two rules.

Response: HHSC declines to remove §133.103(a)(2) because HHSC does not enforce 25 TAC §1.191 regarding hospitals. Section 133.103(a)(2) applies to hospitals regulated by HHSC, and 25 TAC §1.191 applies to facilities regulated by DSHS.

Comment: CCHR stated it hoped complaints regarding abuse, neglect, or exploitation, including verbal, physical, and sexual abuse, are given top priority under §133.103(c).

Response: HHSC acknowledges this comment.

Comment: DRTx commented on §133.103(c) and stated the current prioritization system relates to regulatory allegations but should not be used for abuse, neglect, and exploitation allegations. DRTx stated prioritizing one type of allegation over another results in some allegations being routinely delayed, such as verbal abuse or neglect allegations. DRTx recommended prioritizing investigations based on the likelihood of preserving evidence that could be used in making a final determination of the allegation. DRTx proposed that if an allegation is new (as in those reported within 24 hours), the allegation should receive top priority, regardless of the specific type of allegation. DRTx further stated if an allegation was reported several days after the event, the investigation should begin within 48 hours. DRTX stated if an allegation was reported a week or more after the event, delaying the investigation is justified because of the likelihood that the evidence has been contaminated or lost.

Response: HHSC declines to revise §133.103(c) because HHSC complaint prioritization and investigation initiation and completion timeframes are internal HHSC policy. HHSC notes that it investigates allegations of abuse, neglect, or exploitation involving individuals with disabilities, children, or elderly individuals in accordance with the investigation rules at 25 TAC Chapter 1, Subchapter Q and HHSC policies; investigates other abuse, neglect, and exploitation allegations in accordance with 25 TAC §133.47; and reports possible criminal acts to the appropriate law enforcement authorities in accordance with state law and HHSC policies. HHSC notes the HHSC Complaint & Incident Intake webpage contains information about the complaint intake process.

Comment: CCHR stated it assumed that §133.103(d) applies to a concurrent regulatory investigation after an allegation of abuse, neglect, or exploitation. CCHR noted Texas's unique statutory framework and stated that while coordination with the Centers for Medicare & Medicaid Services (CMS) may be desirable in certain cases, HHSC has the duty and funding to uphold laws, regardless of CMS involvement or funding. CCHR cited the HSC regarding electroconvulsive therapy (ECT) as an example and noted that CMS regulations on ECT do not fully align with Texas statutes. CCHR stated that despite state law and CMS regulations not fully aligning, HHSC must investigate violations of Texas law independent of CMS because of the potential for harm.

Response: HHSC declines to revise §133.103(d) because this subsection allows for coordination with CMS in accordance with HSC §222.026(a)(2), but §133.103(d) does not preclude HHSC from conducting investigations independent of CMS or from meeting the agency's responsibilities for conducting

investigations as described in Chapter 133 and HHSC internal policies.

Comment: DRTx recommended HHSC revise §133.103(d) by adding language regarding HHSC's duty to complete regulatory investigations regardless of CMS authorization. DRTx stated that HHSC and other state agencies have the authority and receive state funding to complete their responsibilities for facility investigations and regulatory oversight. DRTx further stated it is the responsibility of the state regulatory agency to protect Texas's vulnerable citizens, and HHSC should investigate allegations meeting the definitions of abuse and neglect in Texas law, even if CMS does not authorize an investigation. DRTx expressed concern with HHSC referring investigations of complaints involving psychiatric facilities that HHSC chose not to investigate to the Joint Commission. DRTx stated the Joint Commission is an accrediting body and does not perform investigations of abuse or neglect consistent with Texas regulations. DRTX also stated CMS does not provide any information about any investigation, review, or action on such referrals. DRTx stated such referrals result in the allegations not being addressed by any investigatory entity.

Response: HHSC declines to revise §133.103(d) because this subsection allows for coordination with CMS in accordance with HSC §222.026(a)(2), but §133.103(d) does not preclude HHSC from conducting investigations independent of CMS or from meeting the agency's responsibilities for conducting investigations as described in 25 TAC Chapter 1, Subchapter Q, Chapter 133, and HHSC internal policies.

Comment: THA requested HHSC extend the timeframe for hospitals to submit a plan of correction (POC) under §133.104(b)(2) because THA stated the proposed 10 calendar day timeframe was too compressed to develop an extensive POC and implementation plan. THA suggested language that would lengthen the timeframe to 30 calendar days for deficiencies that did not affect patient health and safety and language to allow flexibility for HHSC to require a shorter timeframe, but no earlier than 10 calendar days, for more urgent issues affecting or potentially affecting patient health and safety.

Response: HHSC declines to revise §133.104(b)(2) because 10 calendar days after receipt of a statement of deficiencies (SOD) is sufficient time to provide HHSC with a POC. HHSC notes a hospital is made aware of the issues HHSC found and the potential citations at the exit conference so the hospital can begin working on correcting any issues even before receipt of the SOD.

Comment: TMA stated §133.105 appears to impose reporting mandates on HHSC. TMA stated not every issue relating to the conduct of a licensed professional, intern, or application for professional licensure will necessarily warrant reporting to the licensing board. TMA recommended replacing "reports" with "may report" in §133.105 to allow HHSC to exercise discretion in its reporting.

Response: HHSC declines to revise §133.105 because the agency prefers to err on the side of caution regarding conduct of licensed professionals. HHSC notes licensing boards have discretion in responding to any complaint.

Comment: THA expressed concern with §133.106 not including the details related to HHSC's internal procedures regarding complaints against an HHSC representative, currently found at §133.102. THA stated it is important for facilities to understand how HHSC handles complaints against surveyors or investigators, including clear expectations for HHSC's response timeframe. THA requested HHSC include procedural details in the final rule to ensure transparency and provide facilities with an opportunity to provide input. Additionally, THA suggested the rule include clear anti-retaliation language to protect hospitals or individuals filing complaints, and proposed language prohibiting retaliation by HHSC or HHSC representatives against hospitals or persons filing a complaint against an HHSC representative.

Response: HHSC declines to revise §133.106 as requested because the agency addresses complaints against HHSC representatives in accordance with its policies, which include requiring staff to perform their duties in a lawful, professional, and ethical manner.

Comment: THA expressed concern with §133.121(1)(P) and stated participation in Medicare is voluntary and should not be a criterion for licensing decisions or penalties. THA requested HHSC remove this paragraph because THA stated a hospital terminating the hospital's Medicare provider agreement should not jeopardize the hospital's licensure status or result in penalties.

Response: HHSC revised §133.121(1)(P) to clarify this subparagraph applies if CMS terminates the hospital's Medicare provider agreement.

Comment: THA expressed concern with §133.121(2)(B)(ii) because THA stated the category is overly broad and that it is not uncommon for providers to make unintentional billing errors that result in Medicare sanctions, and in those cases the provider repays any amounts owed and associated penalties and is free to continue participating in the Medicare program. Further, THA stated other regulatory infractions of Medicare Conditions of Participation may result in citations and sanctions and penalties that are inconsequential and do not justify denying a hospital license.

Response: HHSC declines to revise §133.121(2)(B)(ii) because HHSC has jurisdiction to enforce violations if the facility discloses actions that could result in HHSC denying a license application or suspending or revoking a facility's license.

Comment: THA requested HHSC revise §133.121(2)(B)(iii) to state "federal or state tax liens that are unsatisfied after all avenues of dispute have been exhausted" because THA stated the category is overly broad and stated that the hospital may not have had the opportunity to dispute a lien and HHSC could deny the hospital's license for an unresolved lien for which a dispute is pending.

Response: HHSC declines to revise §133.121(2)(B)(iii) because unsatisfied federal or state tax liens could indicate that an applicant or licensee cannot meet their financial obligations, which may create health and safety concerns.

Comment: THA requested HHSC remove or revise §133.121(2)(B)(iv) because THA stated this clause is overly broad because there is no threshold amount in controversy, it does not account for audit exceptions that are still being disputed, civil judgments may be taken for many reasons that would have no bearing on the fitness to operate a hospital, and final judgments could still be on appeal and therefore be technically unsatisfied. Alternatively, THA requested HHSC revise this clause to specify the specific types of judgments that could result in denial and account for final judgments that may be on appeal and suggested for the rule to state "federal Medicare or state Medicaid audit exceptions that are unresolved after all avenues of dispute are exhausted."

Response: HHSC declines to remove or revise §133.121(2)(B)(iv) because this clause provides HHSC regulatory oversight and could also indicate that an applicant or licensee cannot meet their financial obligations, which may create health and safety concerns.

Comment: THA requested HHSC revise §133.121(2)(B)(vi) to state "federal Medicare or state Medicaid audit exceptions that are unresolved after all avenues of dispute are exhausted." THA stated this clause is overly broad because there is no threshold amount in controversy, and it does not account for audit exceptions that are still being disputed.

Response: HHSC declines to revise §133.121(2)(B)(vi) because HHSC has jurisdiction to enforce violations if the facility discloses actions that could result in HHSC denying a license application or suspending or revoking a facility's license.

Comment: Regarding §133.121(4), CCHR stated a 30-day probation period in lieu of license denial, suspension, or revocation is not a sufficient deterrent to prevent future behavior that may warrant license denial, suspension, or revocation.

Response: HHSC declines to revise §133.121(4) because the language in this paragraph is consistent with HSC §241.053(f). In addition, HSC §241.053(g) provides for HHSC to suspend or revoke the license of a hospital that does not correct items that were in noncompliance or that does not comply with the applicable requirements within the applicable probation period.

HHSC made an editorial change to §133.47(b)(1) to add an end parenthesis after a rule title.

HHSC made an editorial change to §133.47(d) to change the colon to a period to ensure consistency with rule drafting guidelines.

HHSC revised §133.101(a)(1) to connect paragraphs (1) and (2) with "or" instead of "and." HHSC made this change to ensure consistency with the freestanding emergency medical care facility rule at 26 TAC §509.81(a) and the limited services hospital rule at 26 TAC §511.111(a).

HHSC revised §133.102(e) by adding "video surveillance" to the list of items a hospital must permit HHSC to examine during any HHSC inspection. This change is made so that the list in §133.102(e) is consistent with §133.103(g), other HHSC rules in this rule project, and the list in 26 TAC §511.112(e) for a limited services rural hospital.

HHSC revised §133.102(l)(6) and §133.103(n)(6) to remove the word "request" because the laws are about public information laws and not public information request laws.

HHSC revised §133.103 to add new subsection (p), which states HHSC will notify a complainant within 10 business days after completing the investigation of the investigation's outcome.

SUBCHAPTER C. OPERATIONAL REQUIREMENTS

25 TAC §133.47

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Health and Safety Code §241.026, which requires HHSC to develop, establish, and enforce standards for the construction, maintenance, and operation of licensed hospitals.

§133.47. Abuse and Neglect Issues.

(a) Reporting. Incidents of abuse, neglect, exploitation, or illegal, unethical or unprofessional conduct as those terms are defined in subsections (b) and (c) of this section shall be reported to the Texas Health and Human Services Commission (HHSC) as provided in subsections (b) and (c)(3) of this section.

(b) Abuse or neglect of a child, and abuse, neglect, or exploitation of an elderly or disabled person. The following definitions apply only to this subsection.

(1) Abuse or neglect of a child, as defined in §1.204(a) and (b) of this title (relating to Abuse, Neglect, or Exploitation Defined).

(2) Abuse, neglect, or exploitation of an elderly or disabled person, as defined in §1.204(a) - (c) of this title.

(c) Abuse and neglect of individuals with mental illness, and illegal, unethical, and unprofessional conduct. The requirements of this subsection are in addition to the requirements of subsection (b) of this section.

(1) Definitions. The following definitions are in accordance with Texas Health and Safety Code (HSC) §161.131 and apply only to this subsection.

(A) Abuse--

(i) Abuse (as the term is defined in United States Code Title 42 (42 USC) Chapter 114 (relating to Protection and Advocacy for Individuals with Mental Illness) is any act or failure to act by an employee of a facility rendering care or treatment which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with mental illness, and includes acts such as:

(I) the rape or sexual assault of an individual with mental illness;

(II) the striking of an individual with mental illness;

(III) the use of excessive force when placing an individual with mental illness in bodily restraints; and

(IV) the use of bodily or chemical restraints on an individual with mental illness which is not in compliance with federal and state laws and regulations.

(ii) In accordance with HSC §161.132(j), abuse also includes coercive or restrictive actions that are illegal or not justified by the patient's condition and that are in response to the patient's request for discharge or refusal of medication, therapy or treatment.

(B) Illegal conduct--Illegal conduct (as the term is defined in HSC §161.131(4)) is conduct prohibited by law.

(C) Neglect--Neglect (as the term is defined in 42 USC §10801 et seq.) is a negligent act or omission by any individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to an individual with mental illness or which placed an individual with mental illness at risk of injury or death, and includes an act or omission such as the failure to establish or carry out an appropriate individual program plan or treatment plan for an individual with mental illness, the failure to provide adequate nutrition, clothing, or health care to an individual with mental illness, or the failure to provide a safe environment for an individual with mental illness, including the failure to maintain adequate numbers of appropriately trained staff.

(D) Unethical conduct--Unethical conduct (as the term is defined in HSC §161.131(11)) is conduct prohibited by the ethical standards adopted by state or national professional organizations for their respective professions or by rules established by the state licensing agency for the respective profession.

(E) Unprofessional conduct--Unprofessional conduct (as the term is defined in HSC §161.131(12)) is conduct prohibited under rules adopted by the state licensing agency for the respective profession.

(2) Posting requirements. A hospital shall prominently and conspicuously post for display in a public area that is readily visible to patients, residents, volunteers, employees, and visitors a statement of the duty to report abuse and neglect, or illegal, unethical, or unprofessional conduct in accordance with HSC §161.132(e). The statement shall be in English and in a second language appropriate to the demographic makeup of the community served and contain the current toll-free telephone number for submitting a complaint to HHSC as specified on the HHSC website.

(3) Reporting responsibility.

(A) Reporting abuse and neglect. A person, including an employee, volunteer, or other person associated with the hospital who reasonably believes or who knows of information that would reasonably cause a person to believe that the physical or mental health or welfare of a patient of the hospital who is receiving mental health or chemical dependency services has been, is, or will be adversely affected by abuse or neglect (as those terms are defined in this subsection) by any person shall as soon as possible report the information supporting the belief to HHSC or to the appropriate state health care regulatory agency in accordance with HSC §161.132(a).

(B) Reporting illegal, unprofessional, or unethical conduct. An employee of or other person associated with a hospital, including a health care professional, who reasonably believes or who knows of information that would reasonably cause a person to believe that the hospital or an employee or health care professional associated with the hospital, has, is, or will be engaged in conduct that is or might be illegal, unprofessional, or unethical and that relates to the operation of the hospital or mental health or chemical dependency services provided in the hospital shall as soon as possible report the information supporting the belief to HHSC or to the appropriate state health care regulatory agency in accordance with HSC §161.132(b).

(4) Training requirements. A hospital that provides comprehensive medical rehabilitation, mental health, or substance use services shall annually provide as a condition of continued licensure a minimum of eight hours of in-service training designed to assist employees and health care professionals associated with the hospital in identifying patient abuse or neglect and illegal, unprofessional, or unethical conduct by or in the hospital and establish a means for monitoring compliance with the requirement.

(d) Investigations. A complaint under this subsection will be investigated or referred by HHSC as follows.

(1) Allegations under subsection (b) of this section will be investigated in accordance with §1.205 of this title (relating to Reports and Investigations) and §1.206 of this title (relating to Completion of Investigation).

(2) Allegations under subsection (c) of this section will be investigated in accordance with §133.103 of this chapter (relating to Complaint Investigations). Allegations concerning a health care professional's failure to report abuse and neglect or illegal, unprofessional, or unethical conduct will not be investigated by HHSC but will be referred to the individual's licensing board for appropriate disciplinary action.

(3) Allegations under both subsections (b) and (c) will be investigated in accordance with §1.205 and §1.206 of this title except as noted in paragraph (2) of this subsection concerning a health care professional's failure to report.

(e) Submission of complaints. A complaint made under this section may be submitted in writing or verbally to HHSC.

(f) Notification.

(1) For complaints under subsection (b) of this section, HHSC shall provide notification according to the following.

(A) HHSC shall notify the reporter, if known, in writing of the outcome of the completed investigation.

(B) HHSC shall notify the alleged victim, and the alleged victim's parent or guardian if a minor, in writing of the outcome of the completed investigation.

(2) For complaints under subsection (c) of this section, HHSC informs, in writing, the complainant who identifies themselves by name and address of the following:

(A) the receipt of the complaint;

(B) if the complainant's allegations are potential violations of this chapter warranting an investigation;

(C) whether the complaint will be investigated by HHSC;

(D) whether and to whom the complaint will be referred; and

(E) the findings of the complaint investigation.

(g) HHSC reporting and referral.

(1) Reporting health care professional to licensing board.

(A) In cases of abuse, neglect, or exploitation, as those terms are defined in subsection (b) of this section, by a licensed, certified, or registered health care professional, HHSC may forward a copy of the completed investigative report to the state agency that licenses, certifies, or registers the health care professional. Any information which might reveal the identity of the reporter or any other patients of the hospital must be blacked out or deidentified.

(B) A health care professional who fails to report abuse and neglect or illegal, unprofessional, or unethical conduct as required by subsection (c)(3) of this section may be referred by HHSC to the individual's licensing board for appropriate disciplinary action.

(2) Sexual exploitation reporting requirements. In addition to the reporting requirements described in subsection (c)(3) of this section, a mental health services provider must report suspected sexual exploitation in accordance with Texas Civil Practice and Remedies Code §81.006.

(3) Referral follow-up. HHSC shall request a report from each referral agency of the action taken by the agency six months after the referral.

(4) Referral of complaints. A complaint containing allegations which are not a violation of HSC Chapter 241 or this chapter will not be investigated by HHSC but shall be referred to law enforcement agencies or other agencies, as appropriate.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 1, 2024.

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Karen Ray
Chief Counsel
Department of State Health Services
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Proposal publication date: May 10, 2024
For further information, please call: (512) 834-4591

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SUBCHAPTER F. INSPECTION AND INVESTIGATION PROCEDURES

25 TAC §133.101, §133.102

STATUTORY AUTHORITY

The repeals are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Health and Safety Code §241.026, which requires HHSC to develop, establish, and enforce standards for the construction, maintenance, and operation of licensed hospitals.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Chief Counsel
Department of State Health Services
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♦ ♦ ♦

25 TAC §§133.101 - 133.106

STATUTORY AUTHORITY

The new sections are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Health and Safety Code §241.026, which requires HHSC to develop, establish, and enforce standards for the construction, maintenance, and operation of licensed hospitals.

§133.101. Integrity of Inspections and Investigations.

(a) In order to preserve the integrity of the Texas Health and Human Services Commission's (HHSC's) inspection and investigation process, a hospital:

(1) may not record, listen to, or eavesdrop on any HHSC interview with hospital staff or patients that the hospital staff knows HHSC intends to keep confidential as evidenced by HHSC taking reasonable measures to prevent from being overheard; or

(2) may not record, listen to, or eavesdrop on any HHSC internal discussions outside the presence of hospital staff when HHSC has requested a private room or office or distanced themselves from hospital staff unless the hospital first informs HHSC and the hospital obtains HHSC's written approval before beginning to record or listen to the discussion.

(b) A hospital shall inform HHSC when security cameras or other existing recording devices in the hospital are in operation during any internal discussion by or among HHSC staff.

(c) When HHSC by words or actions permits hospital staff to be present, an interview or conversation for which hospital staff are present does not constitute a violation of this rule.

(d) This section does not prohibit an individual from recording an HHSC interview with the individual.

§133.102. Inspections.

(a) The Texas Health and Human Services Commission (HHSC) may conduct an inspection of each hospital prior to the issuance or renewal of a license.

(1) A hospital is not subject to additional annual licensing inspections subsequent to the issuance of the initial license while the hospital maintains:

(A) certification under Title XVIII of the Social Security Act, 42 United States Code (USC), §§1395 et seq.; or

(B) accreditation from The Joint Commission, the American Osteopathic Association, or other national accreditation organization for the offered services.

(2) HHSC may conduct an inspection of a hospital exempt from an annual licensing inspection under paragraph (1) of this subsection before issuing a renewal license to the hospital if the certification or accreditation body has not conducted an on-site inspection of the hospital in the preceding three years and HHSC determines that an inspection of the hospital by the certification or accreditation body is not scheduled within 60 days of the license expiration date.

(b) HHSC may conduct an unannounced, on-site inspection of a hospital at any reasonable time, including when treatment services are provided, to inspect, investigate, or evaluate compliance with or prevent a violation of:

(1) any applicable statute or rule;

(2) a hospital's plan of correction;

(3) an order or special order of the HHSC executive commissioner or the executive commissioner's designee;

(4) a court order granting injunctive relief; or

(5) for other purposes relating to regulation of the hospital.

(c) An applicant or licensee, by applying for or holding a license, consents to entry and inspection of any of its hospitals by HHSC.

(d) HHSC inspections to evaluate a hospital's compliance may include:

(1) initial, change of ownership, or relocation inspections for the issuance of a new license;

(2) inspections related to changes in status, such as new construction or changes in services, designs, or bed numbers;

(3) routine inspections, which may be conducted without notice and at HHSC's discretion, or prior to renewal;

(4) follow-up on-site inspections, conducted to evaluate implementation of a plan of correction for previously cited deficiencies;

(5) inspections to determine if an unlicensed hospital is offering or providing, or purporting to offer or provide, treatment; and

(6) entry in conjunction with any other federal, state, or local agency's entry.

(e) A hospital shall cooperate with any HHSC inspection and shall permit HHSC to examine the hospital's grounds, buildings, books, records, video surveillance, and other documents and information maintained by or on behalf of the hospital, unless prohibited by law.

(f) A hospital shall permit HHSC access to interview members of the governing body, personnel, and patients, including the opportunity to request a written statement.

(g) A hospital shall permit HHSC to inspect and copy any requested information, unless prohibited by law. If it is necessary for HHSC to remove documents or other records from the hospital, HHSC provides a written description of the information being removed and when it is expected to be returned. HHSC makes a reasonable effort, consistent with the circumstances, to return any records removed in a timely manner.

(h) Upon entry, HHSC holds an entrance conference with the hospital's designated representative to explain the nature, scope, and estimated duration of the inspection.

(i) During the inspection, the HHSC representative gives the hospital representative an opportunity to submit information and evidence relevant to matters of compliance being evaluated.

(j) When an inspection is complete, the HHSC representative holds an exit conference with the hospital representative to inform the hospital representative of any preliminary findings of the inspection, including possible health and safety concerns. The hospital may provide any final documentation regarding compliance during the exit conference.

(k) HHSC shall maintain the confidentiality of hospital records as applicable under state or federal law. Except as provided by subsection (l) of this section, all information and materials in the possession of or obtained or compiled by HHSC in connection with an inspection are confidential and not subject to disclosure under Texas Government Code Chapter 552 (relating to Public Information), and not subject to disclosure, discovery, subpoena, or other means of legal compulsion for their release to anyone other than HHSC or its employees or agents involved in the enforcement action except that this information may be disclosed to:

(1) persons involved with HHSC in the enforcement action against the hospital;

(2) the hospital that is the subject of the enforcement action, or the hospital's authorized representative;

(3) appropriate state or federal agencies that are authorized to inspect, survey, or investigate hospital services;

(4) law enforcement agencies as allowed by law; and

(5) persons engaged in bona fide research, if all individual-identifying and hospital-identifying information has been deleted.

(l) The following information is subject to disclosure in accordance with Texas Government Code Chapter 552, only to the extent that all personally identifiable information of a patient or health care provider is omitted from the information:

(1) a notice of the hospital's alleged violation, which must include the provisions of law the hospital is alleged to have violated, and a general statement of the nature of the alleged violation;

(2) the number of investigations HHSC conducted of the hospital;

(3) the pleadings in any administrative proceeding to impose a penalty against the hospital for the alleged violation;

(4) the outcome of each investigation HHSC conducted of the hospital, including:

(A) reprimand issuance;

(B) license denial or revocation;

(C) corrective action plan adoption; or

(D) administrative penalty imposition and the penalty amount;

(5) a final decision, investigative report, or order issued by HHSC to address the alleged violation; and

(6) any other information required by law to be disclosed under public information laws.

(m) Within 90 days after the date HHSC issues a final decision, investigative report, or order to address a hospital's alleged violation, HHSC posts certain information on the HHSC website in accordance with Texas Health and Safety Code §241.051.

§133.103. Complaint Investigations.

(a) A hospital shall provide each patient and applicable legally authorized representative at the time of admission with a written statement identifying the Texas Health and Human Services Commission (HHSC) as the agency responsible for investigating complaints against the hospital.

(1) The statement shall inform persons that they may direct a complaint to HHSC Complaint and Incident Intake (CII) and include current CII contact information, as specified by HHSC.

(2) The hospital shall prominently and conspicuously post this statement in patient common areas and in visitor's areas and waiting rooms so that it is readily visible to patients, employees, and visitors. The information shall be in English and in a second language appropriate to the demographic makeup of the community served.

(b) HHSC evaluates all complaints. A complaint must be submitted using HHSC's current CII contact information for that purpose, as described in subsection (a) of this section.

(c) HHSC documents, evaluates, and prioritizes complaints directed to HHSC CII based on the seriousness of the alleged violation and the level of risk to patients, personnel, and the public.

(1) Allegations determined to be within HHSC's regulatory jurisdiction relating to a hospital may be investigated under this chapter.

(2) HHSC may refer complaints outside HHSC's jurisdiction to an appropriate agency, as applicable.

(d) HHSC conducts investigations to evaluate a hospital's compliance following a complaint of abuse, neglect, or exploitation; or a complaint related to the health and safety of patients. Complaint investigations may be coordinated with the federal Centers for Medicare

& Medicaid Services and its agents responsible for the inspection of hospitals to determine compliance with the Conditions of Participation under Title XVIII of the Social Security Act, (42 USC, §§1395 et seq.), so as to avoid duplicate investigations.

(e) HHSC may conduct an unannounced, on-site investigation of a hospital at any reasonable time, including when treatment services are provided, to inspect or investigate:

(1) a hospital's compliance with any applicable statute or rule;

(2) a hospital's plan of correction;

(3) a hospital's compliance with an order of the HHSC executive commissioner or the executive commissioner's designee;

(4) a hospital's compliance with a court order granting injunctive relief; or

(5) for other purposes relating to regulation of the hospital.

(f) An applicant or licensee, by applying for or holding a license, consents to entry and investigation of any of its facilities by HHSC.

(g) A hospital shall cooperate with any HHSC investigation and shall permit HHSC to examine the hospital's grounds, buildings, books, records, video surveillance, and other documents and information maintained by, or on behalf of, the hospital, unless prohibited by law.

(h) A hospital shall permit HHSC access to interview members of the governing body, personnel, and patients, including the opportunity to request a written statement.

(i) A hospital shall permit HHSC to inspect and copy any requested information, unless prohibited by law. If it is necessary for HHSC to remove documents or other records from the hospital, HHSC provides a written description of the information being removed and when it is expected to be returned. HHSC makes a reasonable effort, consistent with the circumstances, to return any records removed in a timely manner.

(j) Upon entry, the HHSC representative holds an entrance conference with the hospital's designated representative to explain the nature, scope, and estimated duration of the investigation.

(k) The HHSC representative holds an exit conference with the hospital representative to inform the hospital representative of any preliminary findings of the investigation. The hospital may provide any final documentation regarding compliance during the exit conference.

(l) Once an investigation is complete, HHSC reviews the evidence from the investigation to evaluate whether there is a preponderance of evidence supporting the allegations contained in the complaint.

(m) HHSC shall maintain the confidentiality of hospital records as applicable under state or federal law. Except as provided by subsection (n) of this section , all information and materials in the possession of or obtained or compiled by HHSC in connection with an investigation are confidential and not subject to disclosure under Texas Government Code Chapter 552, and not subject to disclosure, discovery, subpoena, or other means of legal compulsion for their release to anyone other than HHSC or its employees or agents involved in the enforcement action except that this information may be disclosed to:

(1) persons involved with HHSC in the enforcement action against the hospital;

(2) the hospital that is the subject of the enforcement action, or the hospital's authorized representative;

(3) appropriate state or federal agencies that are authorized to inspect, survey, or investigate hospital services;

(4) law enforcement agencies as allowed by law; and

(5) persons engaged in bona fide research, if all individual-identifying and hospital-identifying information has been deleted.

(n) The following information is subject to disclosure in accordance with Texas Government Code Chapter 552, only to the extent that all personally identifiable information of a patient or health care provider is omitted from the information:

(1) a notice of the hospital's alleged violation, which must include the provisions of law the hospital is alleged to have violated, and a general statement of the nature of the alleged violation;

(2) the number of investigations HHSC conducted of the hospital;

(3) the pleadings in any administrative proceeding to impose a penalty against the hospital for the alleged violation;

(4) the outcome of each investigation HHSC conducted of the hospital, including:

(A) reprimand issuance;

(B) license denial or revocation;

(C) corrective action plan adoption; or

(D) administrative penalty imposition and the penalty amount;

(5) a final decision, investigative report, or order issued by HHSC to address the alleged violation; and

(6) any other information required by law to be disclosed under public information laws.

(o) Within 90 days after the date HHSC issues a final decision, investigative report, or order to address a hospital's alleged violation, HHSC posts certain information on the HHSC website in accordance with Texas Health and Safety Code Section 241.051 (relating to Inspections).

(p) HHSC notifies complainants regarding the investigation's outcome within 10 business days after completing the investigation.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Karen Ray
Chief Counsel
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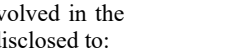

SUBCHAPTER G. ENFORCEMENT

25 TAC §133.121

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Health and Safety Code §241.026, which requires HHSC to develop, establish, and enforce standards for the construction, maintenance, and operation of licensed hospitals.

§133.121. Enforcement.

Enforcement is a process by which a sanction is proposed, and if warranted, imposed on an applicant or licensee regulated by the Texas Health and Human Services Commission (HHSC) for failure to comply with applicable statutes, rules, and orders.

(1) Denial, suspension or revocation of a license or imposition of an administrative penalty. HHSC has jurisdiction to enforce violations of the Act or the rules adopted under this chapter. HHSC may deny, suspend, or revoke a license or impose an administrative penalty for the following:

(A) failure to comply with any applicable provision of the Texas Health and Safety Code (HSC), including Chapters 241, 311, and 327;

(B) failure to comply with any provision of this chapter or any other applicable laws;

(C) the hospital, or any of its employees, committing an act which causes actual harm or risk of harm to the health or safety of a patient;

(D) the hospital, or any of its employees, materially altering any license issued by HHSC;

(E) failure to comply with minimum standards for licensure;

(F) failure to provide a complete license application;

(G) failure to comply with an order of the HHSC executive commissioner or another enforcement procedure under HSC Chapters 241, 311, or 327;

(H) a history of failure to comply with the applicable rules relating to patient environment, health, safety, and rights that reflect more than nominal noncompliance;

(I) the hospital aiding, committing, abetting, or permitting the commission of an illegal act;

(J) the hospital, or any of its employees, committing fraud, misrepresentation, or concealment of a material fact on any documents required to be submitted to HHSC or required to be maintained by the hospital pursuant to HSC Chapter 241 and the provisions of this chapter;

(K) failure to comply with other state and federal laws affecting the health, safety, and rights of hospital patients;

(L) failure to timely pay an assessed administrative penalty as required by HHSC;

(M) failure to submit an acceptable plan of correction for cited deficiencies within the timeframe required by HHSC;

(N) failure to timely implement plans of corrections to deficiencies cited by HHSC within the dates designated in the plan of correction;

(O) failure to comply with applicable requirements within a designated probation period; or

(P) if the hospital is participating under Title XVIII of the Social Security Act, 42 United States Code (USC), §1395 et seq, the Centers for Medicare & Medicaid Services terminating the hospital's Medicare provider agreement.

(2) Denial of a license. HHSC has jurisdiction to enforce violations of HSC Chapters 241, 311, and 327 and this chapter. HHSC may deny a license if the applicant:

(A) fails to provide timely and sufficient information required by HHSC that is directly related to the application; or

(B) has had the following actions taken against the applicant within the two-year period preceding the application:

(i) decertification or cancellation of its contract under the Medicare or Medicaid program in any state;

(ii) federal Medicare or state Medicaid sanctions or penalties;

(iii) unsatisfied federal or state tax liens;

(iv) unsatisfied final judgments;

(v) eviction involving any property or space used as a hospital in any state;

(vi) unresolved federal Medicare or state Medicaid audit exceptions;

(vii) denial, suspension, or revocation of a hospital license, a private psychiatric hospital license, or a license for any health care facility in any state; or

(viii) a court injunction prohibiting ownership or operation of a facility.

(3) Emergency suspension. Following notice and opportunity for hearing, the executive commissioner of HHSC or a person designated by the executive commissioner may issue an emergency order in relation to the operation of a hospital licensed under this chapter if the executive commissioner or the executive commissioner's designee determines that the hospital is violating this chapter, a rule adopted pursuant to this chapter, a special license provision, injunctive relief, an order of the executive commissioner or the executive commissioner's designee, or another enforcement procedure permitted under this chapter and the provision, rule, license provision, injunctive relief, order, or enforcement procedure relates to the health or safety of the hospital's patients.

(A) HHSC shall send written notice of the hearing and shall include within the notice the time and place of the hearing. The hearing must be held within 10 days after the date of the hospital's receipt of the notice.

(B) The hearing shall be held in accordance with HHSC's informal hearing rules.

(C) The order shall be effective on delivery to the hospital or at a later date specified in the order.

(4) Probation. In lieu of denying, suspending, or revoking the license, HHSC may place the hospital on probation for a period of not less than 30 days, if HHSC finds that the hospital is in repeated noncompliance with these rules or HSC Chapter 241, and the hospital's noncompliance does not endanger the public's health and safety.

(A) HHSC shall provide notice to the hospital of the probation and of the items of noncompliance not later than the 10th day before the probation period begins.

(B) During the probation period, the hospital shall correct the items of noncompliance and report the corrections to HHSC for approval.

(5) Administrative penalty. HHSC has jurisdiction to impose an administrative penalty against a hospital licensed or regulated under this chapter for violations of HSC Chapters 241, 311, and 327 and this chapter. The imposition of an administrative penalty shall be in accordance with the provisions of HSC §241.059, §241.060, and §327.008.

(6) Licensure of persons or entities with criminal backgrounds. HHSC may deny a person or entity a license or suspend or revoke an existing license on the grounds that the person or entity has been convicted of a felony or misdemeanor that directly relates to the duties and responsibilities of the ownership or operation of a hospital. HHSC shall apply the requirements of Texas Occupations Code Chapter 53.

(A) HHSC is entitled under Texas Government Code Chapter 411 to obtain criminal history information maintained by the Texas Department of Public Safety, the Federal Bureau of Investigation, or any other law enforcement agency to investigate the eligibility of an applicant for an initial or renewal license and to investigate the continued eligibility of a licensee.

(B) In determining whether a criminal conviction directly relates, HHSC shall apply the requirements and consider the provisions of Texas Occupations Code Chapter 53.

(C) The following felonies and misdemeanors directly relate to the duties and responsibilities of the ownership or operation of a health care facility because these criminal offenses indicate an ability or a tendency for the person to be unable to own or operate a hospital:

(i) a misdemeanor violation of HSC Chapter 241;

(ii) a misdemeanor or felony involving moral turpitude;

(iii) a misdemeanor or felony relating to deceptive business practices;

(iv) a misdemeanor or felony of practicing any health-related profession without a required license;

(v) a misdemeanor or felony under any federal or state law relating to drugs, dangerous drugs, or controlled substances;

(vi) a misdemeanor or felony under Texas Penal Code (TPC), Title 5, involving a patient, resident, or a client of any health care facility, a home and community support services agency or a health care professional; or

(vii) a misdemeanor or felony under the TPC:

(I) Title 4;

(II) Title 5;

(III) Title 7;

(IV) Title 8;

(V) Title 9;

(VI) Title 10; or

(VII) Title 11.

(7) Offenses listed in paragraph (6)(C) of this subsection are not exclusive in that HHSC may consider similar criminal convictions from other state, federal, foreign, or military jurisdictions that indicate an inability or tendency for the person or entity to own or operate a hospital.

(8) HHSC shall revoke a license on the licensee's imprisonment following a felony conviction, felony community supervision revocation, revocation of parole, or revocation of mandatory supervision.

(9) Notice. If HHSC proposes to deny, suspend, or revoke a license, or impose an administrative penalty, HHSC shall send a notice of the proposed action by certified mail, return receipt requested, at the address shown in the current records of HHSC or HHSC may personally deliver the notice. The notice to deny, suspend, or revoke a license, or impose an administrative penalty, shall state the alleged facts or conduct to warrant the proposed action, provide an opportunity to demonstrate or achieve compliance, and shall state that the applicant or license holder has an opportunity for a hearing before taking the action.

(10) Acceptance. Within 20 calendar days after receipt of the notice, the applicant or licensee may notify HHSC, in writing, of acceptance of HHSC's determination or request a hearing.

(11) Hearing request.

(A) A request for a hearing by the applicant or licensee shall be in writing and submitted to HHSC within 20 calendar days of receipt of the notice of the proposed action described in paragraph (9) of this subsection. Receipt of the notice is presumed to occur on the third day after the date HHSC mails the notice to the last known address of the applicant or licensee.

(B) A hearing shall be conducted pursuant to Texas Government Code Chapter 2001, and Title 1, Chapter 357, Subchapter I (relating to Hearings under the Administrative Procedure Act).

(12) No response to notice. If an applicant or licensee does not request a hearing in writing within 20 calendar days after receiving the notice of the proposed action, the case shall be set for a hearing.

(13) Notification of HHSC's final decision. HHSC shall send the licensee or applicant a copy of HHSC's decision for denial, suspension or revocation of a license or imposition of an administrative penalty by certified mail, which shall include the findings of fact and conclusions of law on which HHSC based its decision.

(14) Admission of new patients upon suspension or revocation. Upon HHSC's determination to suspend or revoke a license, the license holder may not admit new patients until HHSC reissues the license.

(15) Decision to suspend or revoke. When HHSC's decision to suspend or revoke a license is final, the licensee must immediately cease operation, unless the district court issues a stay of such action.

(16) Return of original license. Upon suspension, revocation or non-renewal of the license, the original license shall be returned to HHSC within 30 calendar days of HHSC's notification.

(17) Reapplication following denial or revocation.

(A) One year after HHSC's decision to deny or revoke, or the voluntary surrender of a license by a hospital while enforcement action is pending, a hospital may petition HHSC, in writing, for a license. Expiration of a license prior to HHSC's decision becoming final shall not affect the one-year waiting period required before a petition can be submitted.

(B) HHSC may allow a reapplication for licensure if there is proof that the reasons for the original action no longer exist.

(C) HHSC may deny reapplication for licensure if HHSC determines that:

(i) the reasons for the original action continues;

(ii) the petitioner has failed to offer sufficient proof that conditions have changed; or

(iii) the petitioner has demonstrated a repeated history of failure to provide patients a safe environment or has violated patient rights.

(D) If HHSC allows a reapplication for licensure, the petitioner shall be required to meet the requirements as described in §133.22 of this chapter (relating to Application and Issuance of Initial License).

(18) Expiration of a license during suspension. A hospital whose license expires during a suspension period may not reapply for license renewal until the end of the suspension period.

(19) Surrender of a license. In the event that enforcement, as defined in this subsection, is pending or reasonably imminent, the surrender of a hospital license shall not deprive HHSC of jurisdiction in regard to enforcement against the hospital.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 1, 2024.

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Karen Ray
Chief Counsel
Department of State Health Services
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For further information, please call: (512) 834-4591

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CHAPTER 135. AMBULATORY SURGICAL CENTERS

The Texas Health and Human Services Commission (HHSC) adopts the repeal of §135.21, concerning Inspections; §135.24, concerning Enforcement; and §135.25, concerning Complaints; an amendment to §135.22, concerning Renewal of License; and new §135.61, concerning Integrity of Inspections and Investigations; §135.62, concerning Inspections; §135.63, concerning Complaint Investigations; §135.64, concerning Notice; §135.65, concerning Professional Conduct; §135.66, concerning Complaint Against an HHSC Representative; and §135.67, concerning Enforcement.

The repeal of §§135.21, 135.24, and 135.25; new §§135.64, 135.65, 135.66, and 135.67; and amended §135.22 are adopted without changes to the proposed text as published in the May 10, 2024, issue of the *Texas Register* (49 TexReg 3115). These rules will not be republished.

New §§135.61, 135.62, and 135.63 are adopted with changes to the proposed text as published in the May 10, 2024, issue of the *Texas Register* (49 TexReg 3115). These rules will be republished.

BACKGROUND AND JUSTIFICATION

The adoption is necessary to update the inspection, complaint investigation, and enforcement procedures for ambulatory surgical centers (ASCs). These updates are necessary to hold ASCs accountable during the inspection and investigation processes and ensure ASCs provide necessary documentation in a timely manner to HHSC representatives. The adopted rules revise enforcement procedures to ensure conformity with current practices and statutes. These updates also ensure consistent practices across HHSC Health Care Regulation, correct outdated language and contact information, and reflect the transition of regulatory authority for ASCs from the Department of State Health Services to HHSC.

COMMENTS

The 31-day comment period ended June 10, 2024.

During this period, HHSC received a comment regarding the proposed rules from one commenter, the Texas Medical Association (TMA).

Comment: TMA stated §135.65 appears to impose reporting mandates on HHSC. TMA stated not every issue relating to the conduct of a licensed professional, intern, or application for professional licensure will necessarily warrant reporting to the licensing board. TMA recommended replacing "reports" with "may report" in §135.65 to allow HHSC to exercise discretion in its reporting.

Response: HHSC declines to revise §135.65 because the agency prefers to err on the side of caution regarding conduct of licensed professionals. HHSC notes licensing boards have discretion in responding to any complaint.

HHSC revised §135.61(a)(1) to connect paragraphs (1) and (2) paragraphs with "or" instead of "and." HHSC made this change to ensure consistency with the freestanding emergency medical care facility rule at 26 TAC §509.81(a) and the limited services rural hospital rule at 26 TAC §511.111(a).

HHSC revised §135.61(a)(2) to add "unless the ASC first informs HHSC." The change is made to clarify a facility must first inform HHSC and then obtain HHSC written approval before beginning to record or listen to an internal HHSC discussion. The change also increases consistency with other HHSC rules in this rule project.

HHSC revised §135.62(d) and §135.63(g) by adding "video surveillance" to the list of items an ASC must permit HHSC to examine during any HHSC inspection. This change is made to increase consistency with other HHSC rules in this rule project and language in 26 TAC §511.112(e) for a limited services rural hospital.

HHSC revised §135.63 to add new subsection (n), which states HHSC will notify a complainant within 10 business days after completing the investigation of the investigation's outcome.

SUBCHAPTER A. OPERATING REQUIREMENTS FOR AMBULATORY SURGICAL CENTERS

25 TAC §§135.21, 135.24, 135.25

STATUTORY AUTHORITY

The repeals are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas

Health and Safety Code §243.009, which requires HHSC to adopt rules for licensing of ASCs; and §243.010, which requires those rules to include minimum standards applicable to ASCs.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Karen Ray
Chief Counsel
Department of State Health Services
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For further information, please call: (512) 834-4591

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25 TAC §135.22

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Health and Safety Code §243.009, which requires HHSC to adopt rules for licensing of ASCs; and §243.010, which requires those rules to include minimum standards applicable to ASCs.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Karen Ray
Chief Counsel
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For further information, please call: (512) 834-4591

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SUBCHAPTER D. INSPECTION, INVESTIGATION, AND ENFORCEMENT PROCEDURES

25 TAC §§135.61 - 135.67

STATUTORY AUTHORITY

The new rules are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Health and Safety Code §243.009, which requires HHSC to adopt rules for licensing of ASCs; and §243.010, which requires those rules to include minimum standards applicable to ASCs.

§135.61. Integrity of Inspections and Investigations.

(a) In order to preserve the integrity of the Texas Health and Human Services Commission's (HHSC's) inspection and investigation process, an ambulatory surgical center's (ASC's) staff:

(1) may not record, listen to, or eavesdrop on any HHSC interview with ASC staff or patients that the ASC staff knows HHSC intends to keep confidential as evidenced by HHSC taking reasonable measures to prevent from being overheard; or

(2) may not record, listen to, or eavesdrop on any HHSC internal discussions outside the presence of ASC staff when HHSC has requested a private room or office or distanced themselves from ASC staff unless the ASC first informs HHSC and the ASC obtains HHSC's written approval before beginning to record or listen to the discussion.

(b) An ASC shall inform HHSC when security cameras or other existing recording devices in the ASC are in operation during any internal discussion by or among HHSC staff.

(c) When HHSC by words or actions permits ASC staff to be present, an interview or conversation for which ASC staff are present does not constitute a violation of this rule.

(d) This section does not prohibit an individual from recording an HHSC interview with the individual.

§135.62. Inspections.

(a) The Texas Health and Human Services Commission (HHSC) may conduct an unannounced, on-site inspection of an ambulatory surgical center (ASC) at any reasonable time, including when treatment services are provided, to inspect, investigate, or evaluate compliance with or prevent a violation of:

(1) any applicable statute or rule;

(2) an ASC's plan of correction;

(3) an order or special order of the HHSC executive commissioner or the executive commissioner's designee;

(4) a court order granting injunctive relief; or

(5) for other purposes relating to regulation of the ASC.

(b) An applicant or licensee, by applying for or holding a license, consents to entry and inspection of any of its ASCs by HHSC.

(c) HHSC inspections to evaluate an ASC's compliance may include:

(1) initial, change of ownership, or relocation inspections for the issuance of a new license;

(2) inspections related to changes in status, such as new construction or changes in services, designs, or bed numbers;

(3) routine inspections, which may be conducted without notice and at HHSC's discretion, or prior to renewal;

(4) follow-up on-site inspections, conducted to evaluate implementation of a plan of correction for previously cited deficiencies;

(5) inspections to determine if an unlicensed ASC is offering or providing, or purporting to offer or provide, treatment; and

(6) entry in conjunction with any other federal, state, or local agency's entry.

(d) An ASC shall cooperate with any HHSC inspection and shall permit HHSC to examine the ASC's grounds, buildings, books, records, video surveillance, and other documents and information maintained by or on behalf of the ASC, unless prohibited by law.

(e) An ASC shall permit HHSC access to interview members of the governing body, personnel, and patients, including the opportunity to request a written statement.

(f) An ASC shall permit HHSC to inspect and copy any requested information, unless prohibited by law. If it is necessary for HHSC to remove documents or other records from the ASC, HHSC provides a written description of the information being removed and when it is expected to be returned. HHSC makes a reasonable effort, consistent with the circumstances, to return any records removed in a timely manner.

(g) HHSC shall maintain the confidentiality of ASC records as applicable under state and federal law.

(h) Upon entry, HHSC holds an entrance conference with the ASC's designated representative to explain the nature, scope, and estimated duration of the inspection.

(i) During the inspection, the HHSC representative gives the ASC representative an opportunity to submit information and evidence relevant to matters of compliance being evaluated.

(j) When an inspection is complete, the HHSC representative holds an exit conference with the ASC representative to inform the facility representative of any preliminary findings of the inspection, including any possible health and safety concerns. The ASC may provide any final documentation regarding compliance during the exit conference.

§135.63. Complaint Investigations.

(a) An ambulatory surgical center (ASC) shall provide each patient and applicable legally authorized representative at the time of admission with a written statement identifying the Texas Health and Human Services Commission (HHSC) as the agency responsible for investigating complaints against the ASC.

(1) The statement shall inform persons that they may direct a complaint to HHSC Complaint and Incident Intake (CII) and include current CII contact information, as specified by HHSC.

(2) The ASC shall prominently and conspicuously post this statement in patient common areas and in visitor's areas and waiting rooms so that it is readily visible to patients, employees, and visitors. The information shall be in English and in a second language appropriate to the demographic makeup of the community served.

(b) HHSC evaluates all complaints. A complaint must be submitted using HHSC's current CII contact information for that purpose, as described in subsection (a) of this section.

(c) HHSC documents, evaluates, and prioritizes complaints directed to HHSC CII based on the seriousness of the alleged violation and the level of risk to patients, personnel, and the public.

(1) Allegations determined to be within HHSC's regulatory jurisdiction relating to health care facilities may be investigated under this chapter.

(2) HHSC may refer complaints outside HHSC's jurisdiction to an appropriate agency, as applicable.

(d) HHSC conducts investigations to evaluate an ASC's compliance following a complaint of abuse, neglect, or exploitation; or a complaint related to the health and safety of patients.

(e) HHSC may conduct an unannounced, on-site investigation of an ASC at any reasonable time, including when treatment services are provided, to inspect or investigate:

(1) an ASC's compliance with any applicable statute or rule;

(2) an ASC's plan of correction;

(3) an ASC's compliance with an order of the HHSC executive commissioner or the executive commissioner's designee;

(4) an ASC's compliance with a court order granting injunctive relief; or

(5) for other purposes relating to regulation of the ASC.

(f) An applicant or licensee, by applying for or holding a license, consents to entry and investigation of any of its ASCs by HHSC.

(g) An ASC shall cooperate with any HHSC investigation and shall permit HHSC to examine the ASC's grounds, buildings, books, records, video surveillance, and other documents and information maintained by, or on behalf of, the ASC, unless prohibited by law.

(h) An ASC shall permit HHSC access to interview members of the governing body, personnel, and patients, including the opportunity to request a written statement.

(i) HHSC shall maintain the confidentiality of ASC records as applicable under state and federal law.

(j) An ASC shall permit HHSC to inspect and copy any requested information, unless prohibited by law. If it is necessary for HHSC to remove documents or other records from the ASC, HHSC provides a written description of the information being removed and when it is expected to be returned. HHSC makes a reasonable effort, consistent with the circumstances, to return any records removed in a timely manner.

(k) Upon entry, the HHSC representative holds an entrance conference with the ASC's designated representative to explain the nature, scope, and estimated duration of the investigation.

(l) The HHSC representative holds an exit conference with the ASC representative to inform the ASC representative of any preliminary findings of the investigation. The ASC may provide any final documentation regarding compliance during the exit conference.

(m) Once an investigation is complete, HHSC reviews the evidence from the investigation to evaluate whether there is a preponderance of evidence supporting the allegations contained in the complaint.

(n) HHSC notifies complainants regarding the investigations outcome within 10 business days after completing the investigation.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Karen Ray
Chief Counsel
Department of State Health Services
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For further information, please call: (512) 834-4591

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CHAPTER 140. HEALTH PROFESSIONS REGULATION

The Texas Health and Human Services Commission (HHSC) adopts the repeal of §140.433, concerning Licensing, Certifica-

tion, or Registration of Military Service Members, Military Veterans, and Military Spouses, and new §140.433, concerning Licensing, Certification, or Registration of Military Service Members, Military Spouses, and Military Veterans.

Repealed §140.433 and new §140.433 are adopted without changes to the proposed text as published in the July 19, 2024, issue of the *Texas Register* (49 TexReg 5258). These rules will not be republished.

BACKGROUND AND JUSTIFICATION

The adoption is necessary to implement Senate Bill (S.B.) 422, 88th Legislature, Regular Session, 2023. S.B. 422, in part, amended Texas Occupations Code (TOC) Chapter 55 to update requirements for a state agency's recognition of a military service member's and military spouse's out-of-state professional license, which includes a licensed chemical dependency counselor (LCDC) license.

The adoption increases consistency between the adopted rule, the HHSC rules at 1 Texas Administrative Code (TAC) §351.3 and §351.6, and the statutory requirements regarding the licensing process for military service members, military spouses, and military veterans. The adoption also retains and updates certain language currently found in 25 TAC §140.433.

COMMENTS

The 31-day comment period ended August 19, 2024.

During this period, HHSC received one comment regarding the proposed rules from one individual commenter. A summary of the comment relating to the rules and HHSC's response follows.

Comment: An individual commenter requested HHSC revise new §140.433 to allow LCDCs holding a master's degree in counseling, psychology, or any related field to provide mental health services under their LCDC license. The stakeholder noted that LCDCs are currently allowed to supervise licensed social workers with a bachelor's degree who provide mental health services.

Response: HHSC declines to revise new §140.433 because the decision to authorize LCDCs to provide mental health services is determined by the Legislature, and HHSC does not have authority over this decision.

SUBCHAPTER I. LICENSED CHEMICAL DEPENDENCY COUNSELORS

25 TAC §140.433

STATUTORY AUTHORITY

The repeal is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and Texas Occupation Code Chapter 504, which authorizes the Executive Commissioner to adopt rules governing the performance, conduct, and ethics for persons licensed as LCDCs.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Karen Ray
Chief Counsel
Department of State Health Services
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For further information, please call: (512) 834-4591

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25 TAC §140.433

STATUTORY AUTHORITY

The new section is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and Texas Occupation Code Chapter 504, which authorizes the Executive Commissioner to adopt rules governing the performance, conduct, and ethics for persons licensed as LCDCs.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Karen Ray
Chief Counsel
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For further information, please call: (512) 834-4591

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CHAPTER 157. EMERGENCY MEDICAL CARE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC), on behalf of the Department of State Health Services (DSHS), adopts amendments to §157.2, concerning Definitions; §157.125, concerning Requirements for Trauma Facility Designation Effective Through August 31, 2025; and §157.128, concerning Denial, Suspension, and Revocation of Trauma Facility Designation; the repeal of §157.123, concerning Regional Emergency Medical Services/Trauma Systems; §157.130, concerning Emergency Medical Services and Trauma Care System Account and Emergency Medical Services, Trauma Facilities, and Trauma Care System Fund; and §157.131, concerning Designated Trauma Facility and Emergency Medical Services Account; and new §157.123, concerning Regional Advisory Councils; §157.126, concerning Trauma Facility Designation Requirements Effective on September 1, 2025; and §157.130, concerning Funds for Emergency Medical Services, Trauma Facilities, and Trauma Care Systems, and the Designated Trauma Facility and Emergency Medical Services Account.

Sections 157.2, 157.123, 157.125, 157.126, and 157.130 are adopted with changes to the proposed text as published in the August 2, 2024, issue of the *Texas Register* (49 TexReg 5648) and these rules will be republished.

The amendment of §157.128 and the repeals of §§157.123, 157.130 and 157.131 are adopted without changes to the proposed text as published in the August 2, 2024, issue of the *Texas Register* (49 TexReg 5648) and the rules will not be republished.

BACKGROUND AND JUSTIFICATION

The amendments, repeal, and new sections update the content and processes with the advances, evidence-based practices, and system processes that have developed since these rules were adopted and to align with American College of Surgeons (ACS) standards. The rules also require amendments to implement legislation passed since the rules were last adopted. Senate Bill (S.B.) 330, 79th Legislature, Regular Session, 2005, amends Texas Health and Safety Code §773.203, requiring the development of regional stroke plans. House Bill (H.B.) 15, 83rd Legislature, Regular Session, 2013, and H.B. 3433, 84th Legislature, Regular Session, 2015, amend Texas Health and Safety Code §241.183, requiring the development of perinatal care regions. S.B. 984, 87th Legislature, Regular Session, 2021, amends Texas Health and Safety Code §81.027, directing the Regional Advisory Councils (RACs) to collect specific health care data. S.B. 969, 87th Legislature, Regular Session, 2021, amends Texas Health and Safety Code §81.0445, requiring the RACs to provide public information regarding public health disasters to stakeholders. S.B. 1397, 87th Legislature, Regular Session, 2021, amends Texas Health and Safety Code §773.1141, requiring a RAC with at least one county located on the international border of Texas and at least one county adjacent to the Gulf of Mexico to track all patient transfers and the reasons for the transfers out of its region.

A workgroup was formed to collaborate with DSHS staff to review the public comments received and determine the most appropriate language to ensure the health and safety of trauma patients and prevent any undue burden on the facilities providing trauma care. The workgroup composition included representatives from the Governor's Emergency Medical Services (EMS) and Trauma Advisory Council (GETAC), GETAC Trauma Systems Committee, Regional Advisory Councils (RACs), Texas Hospital Association (THA), Texas Organization of Rural and Community Hospitals (TORCH), and Texas Medical Association (TMA) with diverse backgrounds and geographic locations.

COMMENTS

The 31-day comment period ended September 3, 2024.

During this period, DSHS received comments regarding the proposed rules from 66 commenters, including Baptist Hospital of Southeast Texas; Border Regional Advisory Council; Capital Area of Texas Regional Advisory Council (CATRAC); Children's Hospitals Association of Texas (CHAT); Golden Plains Community Hospital; Harris Health; Southeast Texas Regional Advisory Council (SETRAC); Teaching Hospitals of Texas (THOT); Texas College of Emergency Physicians (TCEP); Texas EMS, Trauma and Acute Care Foundation (TETAF); Emergency Medical Services for Children State Partnership, Texas; Texas Health Resources (THR); Texas Hospital Association (THA); Texas Medical Association (TMA); United Regional Health Care (UHRC) System; The University of Texas Medical Branch (UTMB); and 50 individual commenters. A summary of comments relating to Chapter 157 and DSHS's responses follow.

Comment: One commenter supports not increasing the financial burden for Level IV trauma facilities.

Response: DSHS appreciates the comment. No change is necessary to the rules.

Comment: One commenter recommended revising the definition of "Abandonment" in §157.2(1) because a patient released from a hospital to EMS personnel would be considered an individual of lesser education.

Response: DSHS disagrees and declines to revise the language. EMS personnel work under the direction of a physician EMS Medical Director.

Comment: Several commenters recommended adding "or a department-approved survey organization" to the Level IV hospital with 100 or less trauma patients in §157.2(20) Basic Level IV trauma facility.

Response: DSHS agrees and adds "or a department-approved survey organization."

Comment: Multiple commenters recommended revising the language "evaluate and admit" for the Level IV trauma facility in §157.2(20), §157.126(g)(4)(A) and (B), (h)(8), (h)(19) - (21), (h)(25), (h)(30) - (32), (n), (n)(3) - (4), (o)(3), and (o)(3)(A) - (B).

Response: DSHS agrees and replaces "evaluating and admitting" with "managing" and included changes to §157.125(t) replacing "evaluated" with "managed," (x)(3)(D) replacing "evaluated and admitted" with "managed," and (y)(4)(D) replacing "evaluated and admitted" with "managed by," for consistent language in the rule.

Comment: Two commenters recommended revising the definition of "Bypass" in §157.2(23) by removing the last sentence: "Bypass protocols must have local physician input…be reviewed through the regional performance improvement process."

Response: DSHS acknowledges the comment and revises the definition to "Direction given to prehospital emergency medical services personnel by direct on-line medical control, or off-line medical director protocols to bypass the nearest facility for the most appropriate facility."

Comment: Two commenters recommended replacing "completed within 14 days" with "in process within 14 days" in §157.2(31), Concurrent performance improvement.

Response: DSHS disagrees and declines to revise the language, which would allow unlimited time to complete the review.

Comment: One commenter recommended adding language to clarify the administrator's duties in §157.2(44), Designated facility administrator.

Response: DSHS disagrees and declines to change the language. The language is sufficient.

Comment: Two commenters recommended listing out all designation programs in §157.2(46), Designation.

Response: DSHS disagrees and declines to add the language. The language is inclusive and applies to all types of designation.

Comment: Two commenters recommended less descriptive language in §157.2(51), Diversion.

Response: DSHS disagrees and declines to modify the language. The language is sufficient.

Comment: One commenter recommended adding "saturation" to §157.2(51), Diversion.

Response: DSHS disagrees and declines to add the language. The term "diversion" is aligned with the American College of Surgeons (ACS) and the Emergency Medical Treatment and Active Labor Act (EMTALA).

Comment: One commenter recommended having emergency medicine physicians added to the definition in §157.2(57), Emergency medical services personnel.

Response: DSHS declines to add the language. Legislation is required to add personnel as this aligns with the statute.

Comment: One commenter recommended replacing the term "person" with "an agency" in §157.2(58), Emergency medical services provider.

Response: DSHS acknowledges the comment and replaces "a person" with "an organization that" and revises 157.2(82) language to be consistent.

Comment: Two commenters recommended replacing "trauma" with "emergency health" care systems in §157.2(68), Extraordinary emergency.

Response: DSHS disagrees and declines to modify the language because it aligns with language in Chapter 773.

Comment: One commenter recommended revising the language to reflect working with multiple EMS providers in §157.2(71), First responder organization (FRO).

Response: DSHS agrees and revises the language to "licensed EMS providers."

Comment: Multiple commenters recommended that §157.2(77), "Injury severity score;" §157.2(84), "Major trauma patient;" and §157.2(122), "Severe trauma patient" align with the Association for the Advancement of Automotive Medicine (AAAM) scoring system.

Response: DSHS acknowledges and removes ISS language and specific scores from the definitions with injury descriptions, including §157.2(41), Critically injured person, because the ACS and AAAM scoring descriptions are different.

Comment: Two commenters requested clarification on why the level of harm is a requirement in §157.2(80), Level of harm and suggest revising to "should."

Response: DSHS disagrees and declines to revise the language. The level of harm assists trauma personnel in defining the urgency of review by the program. It is common terminology used by hospitals and medical providers.

Comment: One commenter recommended revising §157.2(82), Licensee, to be specific for a licensed paramedic.

Response: DSHS disagrees with the recommendation and declines to revise the language.

Comment: Two commenters recommended that the rural county population be changed to 68,570 to align with Medicaid in §157.2(119), Rural county.

Response: DSHS declines to modify the language. The county population for a rural area is specified in Texas Health and Safety Code §773.0045 as 50,000.

Comment: Two commenters recommended revising "housed within the department" to "provided by the department" in §157.2(130), State Trauma Registry.

Response: DSHS acknowledges and revises "housed within the department" to "managed by the department."

Comment: Two commenters recommended changing "transferring, or providing," to "transferring, and providing" in §157.2(133), Stroke facility.

Response: DSHS disagrees and declines to revise the language. The use of "or" in the language allows options for the stroke services provided by a stroke facility based on the available resources.

Comment: One commenter recommended using one term throughout the rule language for §157.2(142), Trauma and emergency health care system plan.

Response: DSHS acknowledges and replaces "EMS/trauma" with "trauma and emergency health care system plan" in §157.2(115), Regional medical control; replaces "RAC system plan development" with "development of the regional trauma and emergency health care system plan" in paragraph (145), Trauma facility; revises "system plan development" to "the development of the regional trauma and emergency health care system plan" in paragraph (146), Trauma medical director (TMD); adds "trauma and emergency health care" in §157.123(c)(1); adds "emergency" in §157.123(e)(2)(C); and adds "trauma and emergency health care" in §157.125(h)(1).

Comment: Several commenters recommended requiring trauma medical director (TMD) participation in the RAC by aligning §157.126(b)(5) language with §157.2(146). The TMD participation in the RAC is essential to providing guidance in patient distribution during surges, emergency preparedness, transfers, and medical care.

Response: DSHS agrees and revises the language to require TMD participation in the RAC. The RACs are required to provide a virtual option for meeting attendance to facilitate TMD participation.

Comment: One commenter recommended to remove TMD participation in the RAC from the definition §157.2(146) Trauma medical director, because it is too burdensome.

Response: DSHS acknowledges and adds "or designee" allowing the TMD to appoint an individual to participate in the RAC when they are unable to attend.

Comment: One commenter supported pediatric readiness in the RAC trauma and emergency health care system plan as required in §157.123(c)(1)(I).

Response: DSHS appreciates the comment and no revisions are made in response to this comment.

Comment: Two commenters recommended the following revisions in §157.123(d): (1) require data collection only during a declared disaster and when funded by the department; (2) remove the reporting requirements; (3) the executive commissioner to identify when and what information will be reported; and (4) for the RAC website to have a DSHS link to the data.

Response: DSHS disagrees and declines to revise the language in §157.123(d) as recommended. However, DSHS revises the language reducing the frequency and volume of data collection and reporting to the department to avoid duplication with new federal reporting requirements.

Comment: Two commenters recommended deleting the requirement or deleting the reference to subsections (a) and (b) in §157.123(f)(1) because it is in RAC contracts.

Response: DSHS disagrees and declines to delete the language. The department is required by Texas Health and Safety Code Chapter 773 to develop performance measures for the RACs.

Comment: Two commenters recommended deleting subsections (a) and (b) in §157.123(f)(3) and deleting the regional trauma and emergency health care system plan in §157.123(f)(3) and §157.130(a)(5)(B)(ii).

Response: DSHS disagrees and declines to delete the language. The department is required by Texas Health and Safety Code Chapter 773 to develop performance measures for the RACs.

Comment: Two commenters recommended revising language in §157.123(i) to replace "must maintain virtual options" with "should maintain virtual options."

Response: DSHS disagrees and declines to revise the language. Participation by all health care personnel in the RAC is essential. The virtual option allows health care personnel to participate when they cannot attend in person.

Comment: Several commenters recommended aligning the neurosurgeon or advanced practice provider (APP) response with the ACS standards in §157.125(x)(17) - (18).

Response: DSHS agrees and modifies the language to "and neurosurgical evaluation must occur within 30 minutes for the following criteria: severe traumatic brain injury (TBI) with a Glasgow coma scale (GCS) less than 9 and computed tomography (CT) evidence of TBI; moderate TBI with GCS of 9-12 and CT evidence of potential intracranial lesions; and neurological deficit produced by a potential spinal cord injury. When a neurosurgical APP or neurosurgical resident is utilized, there must be documented evidence of consultation with the neurosurgical attending on-call prior to implementation of the plan of care. This must be continuously monitored by the trauma PIPS program, including the consult times and response times."

Comment: Two commenters recommended removing advanced trauma life support (ATLS) requirement for APPs or adding a department-approved equivalent for ATLS in §157.125(x)(31)(C)(i).

Response: DSHS acknowledges the comments and revises the language in (x)(31)(C), specifying APPs who participate in trauma patient resuscitations must maintain current ATLS which aligns with the ACS 2022 standards. The department-approved equivalent language is included if a comparable course is proposed to meet the requirement.

Comment: Two commenters recommended adding a 90-day deadline for the department to complete and notify the facility of a designation determination in §157.126(c).

Response: DSHS disagrees and declines to modify the language. The rule language is sufficient.

Comment: Two commenters recommended removing "trauma patient care" in §157.126(d)(3)(C) because it is not defined in §157.2, Definitions, for a non-contiguous emergency department.

Response: DSHS disagrees and declines to revise because the rule language is sufficient.

Comment: One commenter recommended a language revision to include trauma patients managed at a facility's remote emergency department in the facility's main campus trauma registry in §157.126(d)(3)(C).

Response: DSHS acknowledges and declines to revise the language. The language is sufficient.

Comment: Two commenters recommended only having one Basic trauma facility designation (Level IV) description in §157.126(g)(4)(A) - (B).

Response: DSHS disagrees and declines to modify the language. The rule language separated by trauma patient volume is necessary to address the considerable variances in the capabilities and resources of the facilities designated at this level. The four levels of trauma designation align with the ACS standards and other designation programs.

Comment: Two commenters recommended replacing National Trauma Data Bank (NTDB) with National Trauma Data Standard (NTDS) in §157.126(g)(4)(B) and (h)(21).

Response: DSHS disagrees and declines to modify the language. The language is sufficient.

Comment: One commenter recommended adding the current year for NTDS definitions in §157.126(h)(2). The commenter is concerned that the State Trauma Registry runs behind the current year of data.

Response: DSHS declines to add the language. This recommendation would need to be addressed in the state trauma registry rules.

Comment: Two commenters recommended removing the EMS wristband number in §157.126(h)(4).

Response: DSHS disagrees and declines to remove the language. The language is sufficient and includes measures for patient tracking.

Comment: Two commenters recommended removing EMS hand-off language in §157.126(h)(5).

Response: DSHS disagrees and declines to remove the language. Effective communication between EMS personnel and the trauma team is essential when transferring patient care.

Comment: Two commenters recommended removing the §157.126(h)(8)(E) management guidelines for trauma due to abuse.

Response: DSHS disagrees and declines to delete the language. Stakeholders requested this language be included while developing the new rule language.

Comment: Multiple commenters support the Pediatric Readiness requirements in §157.126(h)(12) and (h)(12)(A) -(G).

Response: DSHS appreciates the comment. No revisions are made in response to this comment.

Comment: Two commenters recommended revising the language requiring "a written plan of correction addressing identified opportunities in pediatric readiness" in §157.126(h)(12)(A), to "monitoring the results in the Trauma Performance Improvement and Patient Safety (PIPS) plan."

Response: DSHS disagrees and declines to revise the language. The trauma performance improvement (PI) process includes a written plan of correction to address and resolve the identified opportunities.

Comment: One commenter recommended defining "staff" and a threshold for how often the competence should be evaluated in requirement §157.126(h)(12)(B).

Response: DSHS disagrees and declines to modify the language. The language is sufficient and to be defined by the facility.

Comment: One commenter recommended removing §157.126(h)(12)(F) regarding pediatric imaging guidelines addressing pediatric age or weight-based dosing.

Response: DSHS disagrees and declines to remove or revise the language. The language is sufficient and multiple commenters support the new pediatric requirements.

Comment: Two commenters recommended revising the simulation training to "ongoing" from every six months in §157.126(h)(12)(G).

Response: DSHS disagrees and declines to revise the language. The department received multiple comments supporting the pediatric readiness requirements.

Comment: One commenter supports the pediatric readiness language in §157.126(h)(13).

Response: DSHS appreciates the comment No revisions are made in response to this comment.

Comment: Multiple commenters recommended increasing the APP response time from 15 minutes to 30 minutes in §157.126(h)(14).

Response: DSHS agrees and modifies the response time to 30 minutes.

Comment: Multiple commenters recommended revising the TMD defining "the role and expectations of the hospitalist or intensivist" to the TMD "collaborating or overseeing" the physicians in §157.126(h)(16).

Response: DSHS disagrees and declines to revise the language. The TMD has the overall authority for trauma patients and the care provided in the hospital.

Comment: Multiple commenters recommended removing requirement §157.126(h)(17).

Response: DSHS disagrees and declines to revise the language. The Trauma Program Manager (TPM) or designee allows the facility flexibility in meeting the mandatory composition while maintaining trauma program representation on the committee.

Comment: Several commenters recommended revising the language in §157.126(h)(19) and applying the requirement to Medical Staff Services in the hospital.

Response: DSHS acknowledges the comments and declines to revise the language. The requirement aligns with the ACS standards.

Comment: Two commenters recommended removing the TMD requirement to "complete a trauma performance improvement course approved by the department" in §157.126(h)(20).

Response: DSHS disagrees and declines to remove the language. It is essential for the TMD to complete the course to ensure the trauma performance improvement plan and process meets the requirements and improves patient care.

Comment: Multiple commenters recommended adding the same certifications required for nursing staff participating in trauma care to the TPM role in §157.126(h)(21).

Response: DSHS agrees and adds "have current TNCC or ATCN, Emergency Nursing Pediatric Course (ENPC) or Pediatric Advanced Life Support (PALS), Advanced Cardiac Life Support (ACLS) certifications."

Comment: One commenter recommended in §157.126(h)(21) that if the Trauma Registrar has completed the AAAM course it meets the requirement for the TPM.

Response: DSHS disagrees and declines to revise the requirement. Completion of the AAAM course by the TPM provides the knowledge needed to lead the trauma program and oversee the Trauma Registrar and the trauma registry.

Comment: One commenter recommended adding a full-time equivalent (FTE) for the TPM in §157.126(h)(21).

Response: DSHS disagrees and declines to add the language. It is the facility's responsibility to provide the resources and personnel to meet the requirements for a deficiency-free, successful trauma designation program.

Comment: One commenter recommended revising the language in §157.126(h)(25) to allow the TMD to participate in the trauma multidisciplinary peer review committee or hospital performance improvement (PI)/peer committee, instead of being the chairperson.

Response: DSHS disagrees and declines to revise the language. The requirement applies to Level IV facilities managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually. The TMD is required to have the expertise and oversight of trauma care in the facility, which makes them the most appropriate individual to chair the review committee.

Comment: Two commenters recommended adding an FTE for the Level IV Trauma Registrar in §157.126(h)(28)(A).

Response: DSHS disagrees and declines to revise the language. It is the facility's responsibility to provide the resources and personnel to meet the requirements for a deficiency-free, successful trauma designation program.

Comment: Multiple commenters recommended revising language to state "clinical leaders or providers" to generalize the required participants and to increase the training and mass casualty event from once every year to once every three years in §157.126(h)(30).

Response: DSHS disagrees and declines to revise the language. Training and practicing for the mass casualty within the hospital ensures better execution when the event occurs.

Comment: Two commenters recommended adding the TNCC or ATCN, ENPC or PALS, and ACLS certifications and a trauma program manager course to the requirement for the Level IV facilities managing 100 or less trauma patients in §157.126(h)(32)(C).

Response: DSHS agrees and adds the trauma program manager course and TNCC or ATCN, ENPC or PALS, and ACLS certifications to the language.

Comment: One commenter recommended clarification on §157.126(h)(32)(C) limiting the Chief Nursing Officer (CNO) to perform the TPM duties if a separate TPM is not identified, as it does not benefit the trauma program when other registered nurses may be available.

Response: DSHS acknowledges the comment and removes the language related to integrating the trauma functions into

the CNO functions. The trauma program is required to have a trauma program manager as defined in the language. It is the facility's decision if the TPM job functions are integrated into the Chief Nursing Officer (CNO) job functions.

Comment: Multiple commenters recommended modifying the language to require only one unit of blood or changing §157.126(h)(32)(L) to a desired requirement.

Response: DSHS disagrees and declines to revise the language because blood availability is important for trauma and other medical and obstetrical patient populations. The department will consider blood center allotments for trauma facilities limited to one unit of packed red blood cells when determining designation deficiencies.

Comment: Two commenters recommended clarifying "participation" in the RAC in §157.126(h)(32)(M).

Response: DSHS disagrees and declines to revise the language. The rule language is sufficient as participation is defined by the RAC and should be voted upon by the general membership.

Comment: Two commenters recommended maintaining the current survey team composition for Level I and II trauma facilities in §157.126(o)(1).

Response: DSHS agrees and revises the language to include two surgeons, an emergency medicine physician, and a registered nurse with trauma expertise.

Comment: Multiple commenters recommended maintaining the registered nurse surveyor for Level I and II trauma facilities in §157.126(o)(1).

Response: DSHS agrees and revises the language to include two surgeons, an emergency medicine physician, and a registered nurse with trauma expertise.

Comment: Multiple commenters support including the registered nurse surveyor or a trauma registered nurse leader in the survey team composition for all trauma facilities in §157.126(o)(2).

Response: DSHS agrees and adds a surgeon and a registered nurse with trauma expertise.

Comment: Multiple commenters support including the registered nurse surveyor or a trauma registered nurse leader in the survey team composition for all trauma facilities in §157.126(o)(3)(A) - (B).

Response: DSHS acknowledges the comments and revises the language.

Comment: Two commenters recommended including the registered nurse surveyor, removing only physician surveyors from the Level IV facilities, and including a surgeon surveyor with the determinations currently utilized by DSHS and TETAF in §157.126(o)(3)(A).

Response: DSHS acknowledges the comments and revises the surveyor requirements for each facility level, as appropriate for the services provided.

Comment: Several commenters recommended revising §157.126(o)(3)(A) to require only one surveyor, a surgeon or registered nurse, for the Level IV facilities managing 101 or more trauma patients annually.

Response: DSHS acknowledges the comments and revises the surveyor requirements for each facility level, as appropriate for the services provided.

Comment: One commenter recommended changing §157.126(o)(3)(A) to maintain the current survey team composition for Level IV facilities.

Response: DSHS acknowledges the comments and revises the surveyor requirements for each facility level, as appropriate for the services provided.

Comment: One commenter supports the inclusion of emergency medicine physicians or family practice physicians in the survey team composition for the Level IV facilities managing 100 or less trauma patients in §157.126(o)(3)(B).

Response: DSHS appreciates the comment. No revisions are made in response to this comment.

Comment: Multiple commenters recommended maintaining the registered nurse surveyor and only a department-approved survey organization for Level IV designation surveys in §157.126(o)(3)(B).

Response: DSHS agrees to maintain a registered nurse surveyor and revises the language including a registered nurse with trauma expertise. DSHS disagrees with only a department-approved survey organization for the Level IV facilities with a low volume of trauma patients meeting NTDB registry inclusion criteria annually. The Level IV facilities may be evaluated for meeting the requirements by a department survey or a department-approved survey organization, at the discretion of the facility.

Comment: One commenter recommended removing a contiguous regional advisory council (RAC) as a conflict of interest for surveyors in §157.126(p)(1).

Response: DSHS disagrees and declines to revise the language. Trauma facilities may transfer patients to facilities in a contiguous RAC. A higher-level facility receiving patients from these facilities is a conflict of interest for conducting surveys.

Comment: One commenter supports the language in requirement §157.126(p)(2)(A) regarding surveyor conflicts when a direct or indirect financial, personal, or other interest would limit or affect their ability to serve.

Response: DSHS appreciates the comment. No revisions are made in response to this comment.

Comment: One commenter recommended removing the language in §157.126(p)(2)(B) regarding a surveyor who has had a prior working relationship in various capacities with a facility or the personnel in the past four years because it is too prescriptive.

Response: DSHS disagrees and declines to remove the language to decrease any surveyor conflicts or perceived conflicts of interest.

Comment: Two commenters recommended changing "protocols" to "guidelines" in §157.130(a)(4)(C)(ii) and deleting "in all TSAs where EMS is provided and verified by each RAC."

Response: DSHS disagrees and declines to modify the language. No revisions are required as "protocols" is not present in the language. All Trauma Services Areas (TSAs) are included in the language for RACs to receive credit and funding for EMS runs occurring in their area.

Comment: Two commenters recommended clarification on the requirement in §157.130(a)(4)(C)(iii) because EMS reporting to the RAC is overly burdensome.

Response: DSHS disagrees and declines to modify the language. The language requires EMS providers eligible for funds in a specific RAC to participate in the RACs where they provide services and may receive funds.

Comment: Two commenters recommended clarification on which requirement the language refers to in §157.130(a)(4)(D).

Response: DSHS agrees and relocates language from (a)(4)(D) to (a)(4)(G) to align with EMS provider county contract requirement.

Comment: Two commenters recommended deleting "and expectations" from §157.130(a)(5)(B)(ii).

Response: DSHS disagrees because the language "and expectations" is not present.

Comment: Two commenters recommended modifying the language in §157.130(a)(6)(C) from a facility "that fails to maintain its designation," to a facility "that is denied designation."

Response: DSHS disagrees and declines to revise the language to "denied." Trauma designated facilities are required to meet trauma designation requirements when submitting an application to receive trauma funding for trauma patient care.

Comment: Two commenters recommended revising the language in §157.130(a)(6)(E) to include "good standing with their RAC" before receiving any future disbursements.

Response: DSHS disagrees and declines to revise the language. The funding is dispersed by the state of Texas. Therefore, state requirements must be met, and any funds owed by the facility to the state would be reconciled.

DSHS revises §157.2(9) to correct a reference that was missing a parenthesis.

DSHS moves "annually" in the Level IV facility descriptions to follow "inclusion criteria" in §157.2(20), §157.126(g)(4)(A) and (B), (h)(19), (21), (25), (30) - (32), (n), (n)(3) - (4), and (o)(3)(A) and (B) to clarify the requirement is not inclusive of all trauma patients annually, but only those "meeting NTDB registry inclusion criteria annually."

DSHS revises §157.2(32) to make allowances for facilities transferring patients out from the emergency department.

DSHS deletes "and system plan" from the §157.2(142) definition because it is redundant.

DSHS replaces "evaluated" with "managed" in §157.125(t) for consistent language with §157.2(20), §157.126(g)(4)(A) and (B), (h)(8), (h)(19) - (21), (h)(25), (h)(30) - (32), (n), (n)(3) - (4), (o)(3), and (o)(3)(A) and (B).

DSHS removes "in order" from §157.125(t) because it is not necessary.

DSHS deletes "surgeon" in §157.125(x)(18) after neurosurgeon because it is a duplication.

DSHS revises §157.125(y)(19) to "in collaboration with the RAC or their health care system" adding another option for facilities providing education to staff physicians, nurses, and allied health personnel, including APPs.

DSHS deletes "evaluating and" from §157.126(h)(12)(G) and (h)(13) to be consistent with revisions made to the rules. DSHS adds "emergency requests from" to §157.126(h)(15)(A) to further define the use of telemedicine for inpatient units.

DSHS adds "wristband number or patient tracking identifier" to §157.126(h)(18) to ensure documentation of §157.126(h)(4) in medical records.

DSHS revises §157.126(h)(20) to clarify the trauma medical director (TMD) requirements for the Level I, II, and III facilities remain aligned with the current ACS standards. Language was added to the Level IV facilities managing 101 or more trauma patients… "must have a TMD with a defined job description that is a surgeon, emergency medicine physician, or family practice physician that is board-certified in their specialty, current in ATLS, and meet the other ACS standards specific to the TMD for the level of designation requested."

DSHS adds "for the TPM" to §157.126(h)(21) to clarify the education is recommended for the TPM position.

DSHS moves "annually" after "inclusion criteria" in §157.126(o)(3) to be consistent with Level IV rule language in §157.2(20), §157.126(g)(4)(A) - (B), (h)(19) - (21), (h)(25), (h)(30-32), (n), (n)(3) - (4), and (o)(3)(A) - (B).

DSHS revises §157.126(o) to clearly separate and list the survey team members for each designation level. Language was revised to ensure appropriate grammar and consistent language in all survey team descriptions.

DSHS adds "organization" to §157.126(o)(3)(B) for consistent language in the requirement and §157.126(o)(3)(A).

DSHS revises the language in §157.126(n)(4) adding "or" for the option of a department-approved survey organization for consistent language with §157.2(20) Basic Level IV trauma facility.

DSHS removes "in writing" from §157.126(n)(4) because it is implied, and the language is sufficient.

DSHS adds "trauma" to the regional system in §157.126(t)(2)(A) for consistent language with §157.126(t)(2).

SUBCHAPTER A. EMERGENCY MEDICAL SERVICES - PART A

25 TAC §157.2

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Health and Safety Code Chapter 773 (Emergency Health Care Act), which authorizes the Executive Commissioner to adopt rules to implement emergency medical services and trauma care systems; Texas Health and Safety Code Chapter 773, Subchapter G, which provides for the authority to adopt rules related to emergency medical services and trauma services; and Texas Health and Safety Code §1001.075, which authorizes the Executive Commissioner of HHSC to adopt rules and policies for the operation and provision of health and human services by DSHS and for the administration of Texas Health and Safety Code Chapter 1001.

§157.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

(1) Abandonment--Leaving a patient without appropriate medical care once patient contact has been established, unless emergency medical services personnel are following the medical director's protocols, a physician directive, or the patient signs a release; or turning the care of a patient over to an individual of lesser education when advanced treatment modalities have been initiated.

(2) Accreditation--Formal recognition by a national association of a provider's service or an education program based on standards established by that association.

(3) Act--Emergency Health Care Act, Texas Health and Safety Code Chapter 773.

(4) Active pursuit of department designation as a trauma facility--An undesignated facility recognized by the department after applying for designation as a trauma facility and has met the requirement to be eligible for uncompensated trauma care funds.

(5) Acute Stroke-Ready Level IV stroke facility--A hospital reviewed by a department-approved survey organization and meeting the national stroke standards of care for an acute stroke-ready facility as described in §157.133 of this chapter (relating to Requirements for Stroke Facility Designation).

(6) Administrator of record (AOR)--The administrator for an emergency medical services (EMS) provider who meets the requirements of Texas Health and Safety Code §773.05712.

(7) Advanced emergency medical technician (AEMT)--An individual certified by the department and minimally proficient in performing the basic life support skills required to provide emergency prehospital or interfacility care and initiating and maintaining under medical supervision, certain advanced life support procedures, including intravenous therapy and endotracheal or esophageal intubation.

(8) Advanced Level II stroke facility--A hospital that completes a designation survey with a department-approved survey organization, meets the national stroke standards for Non-Comprehensive Thrombectomy Stroke Center, and meets the requirements of an Advanced Level II stroke facility as defined by §157.133 of this chapter.

(9) Advanced Level III trauma facility--A hospital surveyed by a department-approved survey organization that meets the state requirements and American College of Surgeons (ACS) standards for a Level III trauma facility as described in §157.125 of this chapter (relating to Requirements for Trauma Facility Designation Effective Through August 31, 2025) and §157.126 of this chapter (relating to Trauma Facility Designation Requirements Effective on September 1, 2025).

(10) Advanced life support (ALS)--Emergency prehospital or interfacility care that uses invasive medical acts and includes ALS assessment. The provision of advanced life support must be under the medical supervision and control of a licensed physician.

(11) Advanced life support assessment--Assessment performed by an AEMT or paramedic that qualifies as advanced life support based upon initial dispatch information, when it could reasonably be believed the patient was suffering from an acute condition that may require advanced skills.

(12) Advanced life support vehicle--A vehicle designed for transporting the sick and injured and meeting the requirements of §157.11 of this chapter (relating to Requirements for an EMS Provider License) as an ALS vehicle and having sufficient equipment and supplies for providing an advanced level of care based on national standards and the EMS provider's medical director-approved treatment protocols.

(13) Advanced practice provider (APP)--A nurse practitioner or physician assistant reviewed and credentialed by the facility and may have additional credentialing to participate in the designation program.

(14) Air ambulance provider--A person who operates, maintains, or leases a fixed-wing or rotor-wing air ambulance aircraft, equipped and staffed to provide a medical care environment on-board appropriate to the patient's needs. The term air ambulance provider is not synonymous with and does not refer to the Federal Aviation Administration (FAA) air carrier certificate holder unless the air ambulance provider maintains and controls the medical aspects consistent with EMS provider licensure.

(15) Ambulance--A vehicle for transportation of the sick or injured patient to, from, or between places of treatment for an illness or injury and that provides out-of-hospital medical care to the patient.

(16) American College of Surgeons (ACS)--The organization that sets the national standards for trauma centers, trauma verification, the National Trauma Data Standards (NTDS), National Trauma Data Bank (NTDB), Trauma Quality Improvement Program (TQIP), and regional system standards.

(17) Approved survey organization--An organization that has received department authorization to conduct designation surveys, meeting the department's designation survey guidelines and expectations.

(18) Authorized ambulance vehicle--A vehicle authorized to be operated by the licensed provider and meeting all criteria for approval as described in §157.11(e) of this chapter.

(19) Bad debt--The unreimbursed cost for patient care to a hospital providing trauma care.

(20) Basic Level IV trauma facility--A hospital managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually surveyed by a department-approved survey organization and meeting the state requirements and ACS standards, or a hospital managing 100 or less trauma patients meeting NTDB registry inclusion criteria annually surveyed by the department or a department-approved survey organization, and meeting the state designation requirements for a Level IV trauma facility as described in §157.125 and §157.126 of this chapter.

(21) Basic life support (BLS)--Emergency prehospital or interfacility care that uses noninvasive medical acts. The provision of basic life support will have sufficient equipment and supplies for providing basic-level care based on national standards and the EMS provider's medical director-approved treatment protocols.

(22) Basic life support (BLS) vehicle--A vehicle designed for transporting the sick or injured and having sufficient equipment and supplies for providing basic life support based on national standards and the EMS provider's medical director-approved treatment protocols.

(23) Bypass--Direction given to prehospital emergency medical services personnel by direct on-line medical control, or off-line medical director protocols to bypass the nearest facility for the most appropriate facility.

(24) Calculation of the costs of uncompensated trauma care--A calculation of a hospital's total costs of uncompensated trauma care for patients meeting the hospital's trauma activation guidelines and meeting NTDB registry inclusion criteria determined by summing its charges related to uncompensated trauma care as defined in §157.130 of this chapter (relating to Funds for Emergency Medical Services, Trauma Facilities, and Trauma Care Systems, and the Designated Trauma Facility and Emergency Services Account), then

applying the cost-to-charge ratio derived in accordance with generally accepted accounting principles.

(25) Candidate--An individual requesting emergency medical services personnel certification, licensure, recertification, or re-licensure from the department.

(26) Certificant--Emergency medical services personnel with current certification from the department.

(27) Charity care--The unreimbursed cost to a hospital providing health care services for an inpatient, emergency department, transferred, or expired person classified by the hospital as "financially indigent."

(28) Commissioner--The commissioner of the Texas Department of State Health Services.

(29) Comprehensive Level I stroke facility--A hospital surveyed by a department-approved survey organization meeting the national standards of care for a Comprehensive Stroke Center, participates in its local Regional Advisory Council (RAC), participates in the regional stroke plan, and submits data to the department, as requested as defined by §157.133 of this chapter.

(30) Comprehensive Level I trauma facility--A hospital surveyed by a department-approved survey organization meeting the state designation requirements and ACS standards for a Level I trauma facility as described in §157.125 and §157.126 of this chapter.

(31) Concurrent performance improvement--Performance improvement reviews occurring from prehospital, trauma activation, or admission through to discharge. The primary level of review must be completed within 14 days of discharge, 80 percent of the time.

(32) Concurrent trauma registry abstraction--Trauma registry data abstraction and registry data entry occurring after the management of the trauma patient and completed within 60 days after the patient's discharge, 80 percent of the time.

(33) Consumer Protection Division (CPD)--A division within the Texas Department of State Health Services responsible for the oversight of EMS provider licensure, certification, education, and complaint investigation. The division is responsible for the hospital designation process for trauma, stroke, maternal, and neonatal facilities; the RAC system development and advances; and funding, grant management, and distribution of funding for the division.

(34) Contingent designation--A designation awarded to a facility with one to three unmet designation requirements. The department develops a corrective action plan (CAP) for the facility and the facility must complete this plan and meet requirements to remain designated. Contingent designations may require a focused survey to validate requirements are met. The facility must demonstrate requirements are met to maintain designation.

(35) Contingent probationary designation--A designation awarded to a facility with four or more unmet designation requirements. The department develops a CAP for the facility and the facility must complete this plan and meet requirements to remain designated. The facility may be required to submit documentation reflecting the CAP to the department at defined intervals. Contingent probationary designation may require a full survey within 12 to 18 months after the original survey date. The facility must demonstrate requirements are met to maintain designation.

(36) Corrective action plan (CAP)--A plan for the facility developed by the department describing the actions the facility is required to correct.

(37) Cost-to-charges ratio--A ratio covering all applicable hospital costs and charges relating to inpatient care determined by the Texas Health and Human Services Commission from the hospital's Medicaid cost report.

(38) County of licensure--The county in which the physical address of a licensed EMS provider is located, as indicated by the provider on the application for licensure that is filed with the department.

(39) Course medical director--A Texas-licensed physician, approved by the department, with experience in and current knowledge of emergency care who must provide direction over all instruction and clinical practice required in EMS training courses.

(40) Credit hour--Continuing education credit unit awarded for successful completion of a unit of learning activity as defined in §157.32 of this chapter (relating to Emergency Medical Services Education Program and Course Approval).

(41) Critically injured person--An individual suffering with multi-system injuries or major single-system injury; the extent of the injury may be difficult to ascertain but has the potential of producing mortality or major disability.

(42) Definitive care--The phase of care in which therapeutic interventions, treatments, or procedures are performed to stop or control an injury, illness, or disease and promote recovery.

(43) Department--The Texas Department of State Health Services.

(44) Designated facility administrator--Administrator responsible for the oversight, funding, contracts, and leadership of designated programs.

(45) Designated infection control officer--A designated officer who serves as a liaison between the employer and the employees who have been or believe to have been exposed to a potentially life-threatening infectious disease through a person who was treated or transported by the EMS provider.

(46) Designation--A formal recognition by the department of a hospital's capabilities, commitment, care practices, and participation in the RAC to serve as a designated facility.

(47) Designation appeal--The process for a hospital that has been downgraded or denied a specific level of designation to appeal the designation decision.

(48) Designation survey--An on-site or virtual review of a facility applicant to determine if it meets the criteria for a particular level of designation.

(49) Dispatch--The sending of individuals and equipment by EMS for assessment, prompt efficient treatment, and transportation, if required, of a sick or injured patient.

(50) Distance learning--A method of learning remotely without being in regular face-to-face contact with an instructor in the classroom.

(51) Diversion--A procedure put into effect by a health care facility notifying EMS when that facility is unable to provide the level of care demanded by a patient's injuries or condition due to lack of capacity or capabilities, or when the facility has temporarily exhausted its resources and requesting patients be transported to another facility.

(52) Emergency call--A call or other similar communication from a member of the public, as part of a 9-1-1 system or other emergency access communication system, made to obtain emergency medical services.

(53) Emergency care attendant (ECA)--An individual who is certified by the department as minimally proficient in performing emergency prehospital care by providing initial aid that promotes comfort and avoids aggravation of an injury or illness.

(54) Emergency medical services (EMS)--Services used to respond to an individual's perceived need for medical care and to prevent death or aggravation of physiological or psychological illness or injury.

(55) EMS medical director--The licensed physician who provides medical supervision to the EMS personnel of a licensed EMS provider or a recognized first responder organization (FRO) under the terms of the Medical Practice Act (Texas Occupations Code Chapters 151 - 165) and rules promulgated by the Texas Medical Board; may also be called "off-line medical control."

(56) Emergency medical services operator--An individual who, as an employee of a public or private agency, receives emergency calls and may provide medical information or medical instructions to the public during those emergency calls.

(57) Emergency medical services personnel--

(A) emergency care attendant (ECA);

(B) emergency medical technician (EMT);

(C) advanced emergency medical technician (AEMT);

(D) emergency medical technician-paramedic (EMT-P); or

(E) licensed paramedic (LP).

(58) Emergency medical services provider--An organization that uses, operates, or maintains EMS vehicles and EMS personnel to provide emergency medical services.

(59) Emergency medical services times--

(A) Time of call--The date and time a phone rings at a public safety answering point (PSAP) or other designated entity, requesting EMS services.

(B) Dispatch time--The date and time a responding EMS provider is notified by dispatch.

(C) En route--The date and time the EMS vehicle starts moving to respond.

(D) On scene--The date and time a responding EMS vehicle stops moving when it arrives at the location of the response.

(E) At patient side--The date and time the EMS personnel of the responding EMS vehicle arrives at the patient's side.

(F) Transport--The date and time the responding EMS vehicle leaves the location of the response and starts moving toward the destination.

(G) Arrival time--The date and time the responding EMS vehicle arrives with the patient at the destination or transfer point.

(H) Transfer of care--The date and time patient care is transferred to the destination health care staff or transfer point of health care.

(I) Back in service--The date and time the EMS vehicle is back in service and available for another response.

(60) Emergency medical services vehicle--

(A) basic life support (BLS) vehicle;

(B) advanced life support (ALS) vehicle;

(C) mobile intensive care unit (MICU) vehicle;

(D) MICU rotor-wing and MICU fixed-wing air medical vehicles; or

(E) specialized emergency medical service vehicle.

(61) Emergency medical services volunteer--EMS personnel who provide emergency prehospital or interfacility care in affiliation with a licensed EMS provider or a registered FRO without remuneration, except for reimbursement for expenses.

(62) Emergency medical services volunteer provider--An EMS provider with at least 75 percent of personnel as volunteers and is a nonprofit organization. See §157.11 of this chapter regarding fee exemption.

(63) Emergency medical technician (EMT)--An individual certified by the department as minimally proficient in performing emergency prehospital care necessary for basic life support and includes the control of hemorrhaging and cardiopulmonary resuscitation.

(64) Emergency medical technician-paramedic (EMT-P)--An individual certified by the department as minimally proficient in performing emergency prehospital or interfacility care in health care facility's emergency or urgent care clinical setting, including a hospital emergency room and a freestanding emergency medical care facility, by providing advanced life support that includes initiation and maintenance under medical supervision of certain procedures, including intravenous therapy, endotracheal or esophageal intubation or both, electrical cardiac defibrillation or cardioversion, and drug therapy.

(65) Emergency prehospital care--Care provided to the sick and injured within a health care facility's emergency or urgent care clinical setting, including a hospital emergency room and freestanding emergency medical care facility, before or during transportation to a medical facility, including any necessary stabilization of the sick or injured in connection with transportation.

(66) Event--A variation from the established care management guidelines or system operations such as delays in response, delays in care, hospital event such as complications, or death. An event or variation in care creates a need for review of the care or system processes to identify opportunities for improvement.

(67) Event resolution--An event, as described in paragraph (66) of this section, that is identified and reviewed to determine the impact to the patient and if opportunities for improvement in care or the system exist, with a specific action plan tracked with data analysis to demonstrate the action plan created the desired change to achieve the desired goal, and improved outcomes are sustained.

(68) Extraordinary emergency--A serious, unexpected event or situation requiring immediate action to reduce or minimize disruption to established health care services within the EMS and trauma care system.

(69) Field triage--The process of determining which facility is most appropriate for patients based on injury severity, time-sensitive disease factors, and facility availability. Refer to paragraph (104) of this section.

(70) Financially indigent--An uninsured or underinsured patient unable to pay for the trauma services rendered based on the hospital's eligibility system.

(71) First responder organization (FRO)--A group or association of certified EMS personnel that work in cooperation with licensed EMS providers.

(72) Fixed location--The address as it appears on the initial or renewal EMS provider license application in which the patient care records and administrative departments are located.

(73) Governmental entity--A county, a city or town, a school district, or a special district or authority created in accordance with the Texas Constitution, including a rural fire prevention district, an emergency services district, a water district, a municipal utility district, and a hospital district.

(74) Governor's EMS and Trauma Advisory Council (GETAC)--An advisory council appointed by the Governor of Texas that provides professional recommendations to the EMS/Trauma System Section regarding EMS and trauma system development and serves as a forum for stakeholder input.

(75) Inactive EMS provider status--The period of time when a licensed EMS provider is not able to respond to an EMS dispatch.

(76) Industrial ambulance--Any vehicle owned and operated by an industrial facility as defined in the Texas Transportation Code §541.201 and used for initial transport or transfer of company employees who become urgently ill or injured on company premises to an appropriate health care facility.

(77) Injury severity score (ISS)--An anatomical scoring system providing an overall score for trauma patients. The ISS standardizes the severity of trauma injuries based on the three worst abbreviated injury scales (AIS) from the body regions. These regions are the head and neck, face, chest, abdomen, extremity, and external as defined by the Association for the Advancement of Automotive Medicine (AAAM). The highest abbreviated injury score in the three most severely injured body regions have the scores squared, then added together to define the patient's ISS.

(78) Interfacility care--Care provided while transporting a patient between health care facilities.

(79) Legal entity name--The name of the lawful or legally standing association, corporation, partnership, proprietorship, trust, or individual. Has legal capacity to:

(A) enter into agreements or contracts;

(B) assume obligations;

(C) incur and pay debts;

(D) sue and be sued in its own right; and

(E) to be accountable for illegal activities.

(80) Level of harm--A classification system defining the impact of an event to the patient and assists in defining the urgency of review. There are five levels of harm used to define the impact to the patient as defined by the American Society for Health Care Risk Management:

(A) No harm--The patient was not symptomatic or no symptoms were detected, and no treatment or intervention was required.

(B) Mild harm--The patient was symptomatic, symptoms were mild, loss of function or harm was either minimal or intermediate but short-term, and no interventions or only minimal interventions were needed.

(C) Moderate harm--The patient was symptomatic, required intervention such as additional operative procedure, therapeutic treatment, or an increased length of stay, required a higher level of care, or may experience long-term loss of function.

(D) Severe harm--The patient was symptomatic, required life-saving or other major medical or surgical intervention, or may experience shortened life expectancy, and may experience major permanent or long-term loss of function.

(E) Death harm--The event was a contributing factor in the patient's death.

(81) Levels of review--Describes the levels of performance improvement review for an event in the designation program's quality improvement or performance improvement patient safety (PIPS) plan. There are four levels of review:

(A) Primary level of review--Initial investigation of identified events by the facility's designation program performance improvement personnel to capture the event details and to validate and document the timeline, contributing factors, and level of harm. The program manager usually addresses system issues with no level of harm, including identifying the opportunities for improvement and action plan appropriate for the event, and keeping the program medical director updated. This must be written in the facility's performance improvement plan.

(B) Secondary level of review--The level of review by the facility's designation program medical director in which the program personnel prepare the documentation and facts for the review. The program medical director reviews the documentation and either agrees or corrects the level of harm, defines the opportunities for improvement with action plans, or refers to the next level of review.

(C) Tertiary level of review--The third level of review by the facility's designation program to evaluate care practices and compliance to defined management guidelines, identify opportunities for improvement, and define a plan of correction (POC). Minutes capturing the event, discussion, and identified opportunities for improvement with action plans must be documented.

(D) Quaternary level of review--The highest level of review, which may be conducted by an entity external to the facility program as an element of the performance improvement plan. The event, review, and discussion of the event, and identified opportunities for improvement with action plans must be documented.

(82) Licensee--A person who holds a current paramedic license from the department, or an organization that uses, maintains, or operates EMS vehicles and provides EMS personnel to provide emergency medical services, and who holds an EMS provider license from the department.

(83) Major Level II trauma facility--A hospital surveyed by a department-approved survey organization meeting the state designation requirements and ACS standards for a Level II trauma facility as described in §157.125 and §157.126 of this chapter.

(84) Major trauma patient--An individual with injuries, or potential injuries, who benefits from treatment at a trauma facility. The patient may or may not present with alterations in vital signs or level of consciousness, or with obvious, significant injuries, but has been involved in an event that produces a high index of suspicion for significant injury and potential disability. Co-morbid factors such as age or the presence of significant preexisting medical conditions are also considered. The patient initiates a system response to include field triage to the most appropriate designated trauma facility.

(85) Medical control--The supervision of prehospital EMS providers and FROs by a licensed physician. This encompasses on-line (direct voice contact) and off-line (written protocol and procedural review).

(86) Medical oversight--The assistance and management given to health care providers and entities involved in regional EMS/trauma systems planning by a physician or group of physicians designated to provide technical assistance to the EMS provider or FRO medical director.

(87) Medical supervision--Direction given to EMS personnel by a licensed physician under the terms of the Medical Practice Act (Texas Occupations Code Chapters 151 - 165) and rules promulgated by the Texas Medical Board.

(88) Mobile intensive care unit--A vehicle designed for transporting the sick or injured, meeting the requirements of the advanced life support vehicle, and having sufficient equipment and supplies to provide cardiac monitoring, defibrillation, cardioversion, drug therapy, and two-way communication with at least one paramedic on the vehicle when providing EMS.

(89) National EMS Compact--The agreement among states to allow the day-to-day movement of EMS personnel across state boundaries.

(90) National EMS Information System (NEMSIS)--A universal standard for how patient care information resulting from an EMS response is collected.

(91) National Trauma Data Bank (NTDB)--The national repository for trauma registry data, defined by the ACS with inclusion criteria and data elements required for submission.

(92) National Trauma Data Standards (NTDS)--The American College of Surgeons' standard data elements with definitions required for submission to the NTDB, as defined in paragraph (91) of this section.

(93) Non-contiguous emergency department--A hospital emergency department located in a separate building, not contiguous with the designated facility. May be referred to as a satellite emergency department.

(94) Off-line medical director--The licensed physician who provides approved protocols and medical supervision to the EMS personnel of a licensed EMS provider under the terms of the Medical Practice Act (Texas Occupations Code Chapters 151 - 165) and rules promulgated by the Texas Medical Board.

(95) On-line course--A directed learning process comprised of educational information (articles, videos, images, web links), communication (messaging, discussion forums) for virtual learning, and measures to evaluate the student's knowledge.

(96) Operational name--Name under which the business or operation is conducted and presented to the world.

(97) Operational policies--Policies and procedures that are the basis for the provision of EMS and that include such areas as vehicle maintenance; proper maintenance and storage of supplies, equipment, medications, and patient care devices; complaint investigations; multi-casualty incidents; and hazardous materials; but do not include personnel or financial policies.

(98) Operations Committee--Committee serving as the facility's trauma program administrative oversight for designation and responsible for the approval of trauma management guidelines, operational plan, and procedures within the program or system having the potential to impact care practices or designation.

(99) Operative or surgical intervention--Any surgical procedure provided to address trauma injuries for patients taken directly from the scene, emergency department, or other hospital location to an operating suite for patients meeting the hospital's trauma activation guidelines and meeting NTDB registry inclusion criteria.

(100) Out of service vehicle--The period of time when a licensed EMS vehicle is unable to respond to an emergency or non-emergency response.

(101) Performance improvement and patient safety (PIPS) plan--The written plan and processes for evaluating patient care, system response, and adherence to established patient management guidelines; defining variations from care or system response; assigning the level of harm and level of review; identifying opportunities for improvement; and developing the CAP. The CAP outlines data analysis and measures to track the action plan to ensure the desired changes are met and maintained to resolve the event. The medical director, program manager, and administrator have the authority and oversight over PIPS.

(102) Plan of correction (POC)--A report submitted to the department by the facility detailing how the facility will correct one or multiple requirements defined as "not met" during a trauma designation survey review that is reported in the survey summary or documented in the self-attestation.

(103) Practical exam--An evaluation that assesses the person's ability to perceive instructions and perform motor responses, also referred to as a psychomotor exam.

(104) Prehospital triage--The process of identifying medical or injury acuity or the potential for severe injury based upon physiological criteria, injury patterns, and high-energy mechanisms and transporting patients to a facility appropriate for the patient's medical or injury needs. Prehospital triage for injured patients or time-sensitive disease events is guided by the approved prehospital triage guidelines adopted by the RAC and approved by the department. May also be referred to as "field triage" or "prehospital field triage."

(105) Primary EMS provider response area--The geographic area in which an EMS agency routinely provides emergency EMS as agreed upon by a local or county governmental entity or by contract.

(106) Primary Level III stroke facility--A hospital designated by the department and meets the department-approved national stroke standards of care for a primary stroke center, participates in its RAC, participates in the regional stroke plan, and submits data as requested by the department.

(107) Protocols--A detailed, written set of instructions by the EMS provider's medical director, which may include delegated standing medical orders, to guide patient care or the performance of medical procedures as approved.

(108) Public safety answering point (PSAP)--The call center responsible for answering calls to an emergency telephone number for ambulance services; sometimes called "public safety access point" or "dispatch center."

(109) Quality management--Quality assessment, quality improvement, and performance improvement activities. See definition of PIPS in paragraph (101) of this section.

(110) Receiving facility--A health care facility to which an EMS vehicle may transport a patient requiring prompt continuous medical care, or a facility receiving a patient being transferred for definitive care.

(111) Recertification--The procedure for renewal of EMS certification.

(112) Reciprocity--The recognition of certification or privileges granted to an individual from another state or recognized EMS system.

(113) Regional Advisory Council (RAC)--A nonprofit organization recognized by the department and responsible for system coordination for the development, implementation, and maintenance of the regional trauma and emergency health care system within its geographic jurisdiction of the Trauma Service Area. A RAC must maintain 501(c)(3) status.

(114) Regional Advisory Council Performance Improvement Plan--A written plan of the RAC's processes to review identified or referred events, identify opportunities for improvement, define action plans and data required to correct the event, and establish measures to evaluate the action plan through to event resolution.

(115) Regional medical control--Physician supervision for prehospital EMS providers in a given trauma service area (TSA) or other geographic area intended to provide standardized oversight, treatment, and transport guidelines, which should, at minimum, follow the RAC's regional trauma and emergency health care system plan components related to these issues and 22 Texas Administrative Code §197.3 (relating to Off-line Medical Director).

(116) Relicensure--The procedure for renewal of a paramedic license as described in §157.40 of this chapter (relating to Paramedic Licensure); the procedure for renewal of an EMS provider license as described in §157.11 of this chapter.

(117) Response pending status--The status of an EMS vehicle that just delivered a patient to a final receiving facility and for which the dispatch center has another EMS response waiting.

(118) Response ready--When an EMS vehicle is equipped and staffed in accordance with §157.11 of this chapter and is immediately available to respond to any emergency call 24-hours per day, seven days per week (24/7).

(119) Rural county--A county with a population of less than 50,000 based on the latest estimated federal census population figures.

(120) Scope of practice--The procedures, actions, and processes EMS personnel are authorized to perform as approved by the EMS provider's medical director.

(121) Scope of services--The types of services and the resources to provide those services that a facility has available.

(122) Severe trauma patient--A person with injuries or potential injuries defined as high-risk for mortality or disability and meeting trauma activation guidelines and meeting NTDB registry inclusion criteria benefitting from definitive treatment at a designated trauma facility. These patients may be identified by an alteration in vital signs or level of consciousness or by the presence of significant injuries and must initiate a level of trauma response defined by the facility, including prehospital triage to a designated trauma facility.

(123) Simulation training--Training, typically scenario-based or skill-based, utilizing simulated patients or system events to improve or assess knowledge, competencies, or skills.

(124) Sole provider--The only licensed EMS provider in a geographically contiguous service area and in which the next closest provider is greater than 20 miles from the limits of the area.

(125) Specialized EMS vehicle--A vehicle designed for responding to and transporting sick or injured persons by any means of transportation other than by standard automotive ground ambulance or rotor or fixed-wing aircraft and that has sufficient staffing, equipment, and supplies to provide for the specialized needs of the patient transported. This category includes watercrafts, off-road vehicles, and specially designed, configured, or equipped vehicles used for transporting special care patients such as critical neonatal or burn patients.

(126) Specialty resource centers--Entities caring for specific types of patients such as pediatric, cardiac, and burn injuries that have received certification, categorization, verification, or other forms of recognition by an appropriate agency regarding the capability to definitively treat these types of patients.

(127) Staffing plan--A document indicating the overall working schedule patterns of EMS or hospital personnel.

(128) Standard of care--Care equivalent to what any reasonable, prudent person of like education or certification level would have given in a similar situation, based on documented, evidence-based practices or adopted standard EMS curricula as adopted by reference in §157.32 of this chapter; also refers to the documented standards of care reflecting evidence-based practice.

(129) State EMS Registry--State repository for the collection of EMS response data as defined in Chapter 103 of this title (relating to Injury Prevention and Control).

(130) State Trauma Registry--Statewide database managed by the department; responsible for the collection, maintenance, and evaluation of medical and system information related to required reportable events as defined in Chapter 103 of this title.

(131) Stroke--A time-sensitive medical condition occurring when the blood supply to the brain is reduced or blocked, caused by a ruptured blood vessel or clot, preventing brain tissue oxygenation.

(132) Stroke activation--The process of mobilizing the stroke care team when a patient screens positive for stroke symptoms; may be referred to as a "stroke alert" or "code stroke."

(133) Stroke facility--A hospital that has successfully completed the designation process and is capable of resuscitating and stabilizing, transferring, or providing definitive treatment to stroke patients and actively participates in its local RAC and system plan.

(134) Stroke medical director (SMD)--A physician meeting the department's requirements for the stroke medical director and having the authority and oversight for the stroke program, including the performance improvement process, data management, and outcome reviews.

(135) Stroke program manager (SPM)--A registered nurse meeting the requirements for the stroke program manager and having the authority and oversight for the stroke program, including the performance improvement process, data management, and outcome reviews.

(136) Substation--An EMS provider station location, not the fixed station, and likely to provide rapid access to a location to which the EMS vehicle may be dispatched.

(137) Telemedicine medical service--A health care service delivered by a physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or technology as defined in Texas Occupations Code §111.001.

(138) Transport mode--As documented on the patient care record, the usage of emergency warning equipment when responding to an EMS dispatch and when transporting a patient to a receiving facility.

(139) Trauma--An injury or wound to a living body caused by the application of an external force or violence, including burn injuries, and meeting the trauma program's trauma activation guidelines.

(140) Trauma activation guidelines--Established criteria identifying the potential injury risk to the human body and defining the resources and response times required to evaluate, resuscitate, and stabilize the trauma patient. The guidelines must meet the national recommendations, but each trauma program defines the activation guidelines for the facility. The facility may choose to have one activation level, two activation levels, or three activation levels.

(A) The highest level of trauma activation is commonly based on physiological changes in the patient's level of consciousness, airway or potential respiratory compromise, hypotension or signs of shock, significant hemorrhage, or evidence of severe trauma.

(B) The second level of trauma activation is commonly based on the patient's physiological stability with anatomical injuries or mechanisms of injury having the potential for serious injuries.

(C) The third level of trauma activation is designed for low-energy or single-system injuries that may require specialty service evaluation and intervention.

(141) Trauma administrator--Administrator responsible for the facility oversight, funding, contracts, and collaborative leadership of the program, and serves as an interface with the chief executive team as defined by the facility's organizational structure.

(142) Trauma and emergency health care system plan--The inclusive system that refers to the care rendered after a traumatic injury or time-sensitive disease or illness where the optimal outcome is the critical determinant. The system components encompass special populations, epidemiology, risk assessments, surveillance, regional leadership, system integration, business or finance models, prehospital care, definitive care facilities, system coordination for patient flow, prevention and outreach, rehabilitation, emergency preparedness and response, system performance improvement, data management, and research. These components are integrated into the regional self-assessment.

(143) Trauma care--Care provided to an injured patient meeting the hospital's trauma activation guidelines and meeting NTDB registry inclusion criteria and the continuum of care throughout the system, including discharge and follow-up care or transfer.

(144) Trauma Designation Review Committee--Committee responsible for reviewing trauma designation appeals, reviewing requirement exception and waiver requests, and outlining specific requirements not met in order to identify potential opportunities to improve future rule amendments.

(145) Trauma facility--A hospital that has successfully completed the designation process, is capable of resuscitating and stabilizing, transferring, or providing definitive treatment to patients meeting trauma activation criteria, and actively participates in its local RAC and the development of the regional trauma and emergency health care system plan.

(146) Trauma medical director (TMD)--A physician meeting the requirements and demonstrating the competencies and leadership for the oversight and authority of the trauma program as defined by the level of designation and having the authority and oversight for the trauma program, including the performance improvement and patient safety processes, trauma registry, data management, peer review processes, outcome reviews, and participation in the RAC (TMD or designee) and the development of the regional trauma and emergency health care system plan.

(147) Trauma patient--Any injured person who has been evaluated by a physician, a registered nurse, or EMS personnel, and found to require medical care in a trauma facility based on local or national medical standards.

(148) Trauma program manager (TPM)--A registered nurse who in partnership with the TMD and hospital administration is responsible for oversight and authority of the trauma program as defined by the level of designation, including the trauma performance improvement and patient safety processes, trauma registry, data management, injury prevention, outreach education, outcome reviews, and research as appropriate to the level of designation.

(149) Trauma Quality Improvement Program (TQIP)--The ACS risk-adjusted benchmarking program using submitted data to evaluate specific types of injuries and events to compare cohorts' outcomes with other trauma centers; assisting in defining opportunities for improvement in specific patient cohorts.

(150) Trauma registrar--An individual meeting the requirements and whose job responsibilities include trauma patient data abstraction, trauma registry data entry, injury coding, and injury severity scoring, in addition to registry report writing and data management skills specific to the trauma registry and trauma program.

(151) Trauma registry--A trauma facility database capturing required elements of trauma care for each patient.

(152) Trauma service area--Described in §157.122 of this subchapter (relating to Trauma Service Areas).

(153) Uncompensated trauma care--The sum of "charity care" and "bad debt." Contractual adjustments in reimbursement for trauma services based upon an agreement with a payor (including Medicaid, Medicare, Children's Health Insurance Program (CHIP), or other health insurance programs) are not uncompensated trauma care.

(154) Urban county--A county with a population of 50,000 or more based on the latest estimated federal census population figures.

(155) Verification--Process used by the ACS to review a facility seeking trauma verification to validate the defined standards are met with documented compliance for successful trauma center verification. If a Level I or Level II facility is not verified by the ACS, the department cannot designate the facility.

(156) When in service--The period of time when an EMS vehicle is responding to an EMS dispatch, at the scene, or en route to a facility with a patient.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Cynthia Hernandez
General Counsel
Department of State Health Services
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SUBCHAPTER G. EMERGENCY MEDICAL SERVICES TRAUMA SYSTEMS

25 TAC §§157.123, 157.130, 157.131

STATUTORY AUTHORITY

The repeals are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Health and Safety Code Chapter 773 (Emergency Health Care Act), which authorizes the Executive Commissioner to adopt rules to implement emergency medical services and trauma care systems; Texas Health and Safety Code Chapter 773, Subchapter G, which provides for the authority to adopt rules related to emergency medical services and trauma services; and Texas Health and Safety Code §1001.075, which authorizes the Executive Commissioner of HHSC to adopt rules and policies for the operation and provision of health and human services by DSHS and for the administration of Texas Health and Safety Code Chapter 1001.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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25 TAC §§157.123, 157.125, 157.126, 157.128, 157.130

STATUTORY AUTHORITY

The amendments and new sections are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Health and Safety Code Chapter 773 (Emergency Health Care Act), which authorizes the Executive Commissioner to adopt rules to implement emergency medical services and trauma care systems; Texas Health and Safety Code Chapter 773, Subchapter G, which provides for the authority to adopt rules related to emergency medical services and trauma services; and Texas Health and Safety Code §1001.075, which authorizes the Executive Commissioner of HHSC to adopt rules and policies for the operation and provision of health and human services by DSHS and for the administration of Texas Health and Safety Code Chapter 1001.

§157.123. Regional Advisory Councils.

(a) The department recognizes a Regional Advisory Council (RAC) as the coordinating entity for the development and advancement of the regional trauma and emergency health care system within the defined trauma service area (TSA) as described in §157.122 of this subchapter (relating to Trauma Service Areas).

(1) The department recognizes only one RAC for each TSA.

(2) Trauma, prehospital, perinatal, stroke, cardiac, disaster response, and emergency health care stakeholders in the TSA must be eligible for participation or membership in the RAC.

(b) A RAC must meet the following requirements to be recognized as a RAC:

(1) maintain incorporation as an entity exempt from federal income tax under §501(a) of the United States Internal Revenue Code of 1986, and its subsequent amendments, by being listed as an exempt organization under §501(c)(3) of the code, and to be eligible to receive, distribute, and utilize the emergency medical services (EMS), uncompensated care, and TSA allotments;

(2) submit required documentation to the department that includes, at a minimum, the following:

(A) a summary of regional trauma, prehospital, pediatric, geriatric, perinatal, stroke, cardiac, and emergency health care system activities;

(B) evidence of an annual summary of the EMS, trauma, and emergency health care system performance improvement plan; and

(C) a completed regional self-assessment by the end of each odd state fiscal year, and a current trauma and emergency health care system plan by the end of each even state fiscal year, with documented evidence the performance criteria are met;

(3) maintain external financial audits and financial statements as defined by the department; and

(4) maintain a current website to communicate with regional stakeholders.

(c) Each RAC must develop and maintain a regionally specific comprehensive trauma and emergency health care system plan. The plan must include all counties within the TSA and must be based on current industry standards and guidelines.

(1) The trauma and emergency health care system plan must address the following elements:

(A) epidemiology data resources available;

(B) integration of regional stakeholders, identified coalitions, and community partners pertinent to the priorities and needs identified through the regional self-assessment;

(C) regional guidelines for prehospital field triage and destination, treatment, transport, and transfer of patients with time-sensitive health care injuries or illnesses;

(D) prevention and outreach activities guided by data available;

(E) system coordination and patient flow;

(F) meaningful participation in regional disaster preparedness, planning, response, recovery, after-action review, data tracking needs, and support of the hospital preparedness stakeholders, including the identified health care coalition and the department;

(G) identification of system-wide health care education sponsored or coordinated through the RAC;

(H) execution of a systems performance improvement plan that aligns with the state system performance improvement plan, and includes regional outcome data;

(I) current pediatric readiness capabilities that identifies opportunities to improve pediatric readiness within the region;

(J) integration of public health and business community stakeholders; and

(K) guidelines to support regional research projects.

(2) All health care entities and identified coalition partners should participate in the regional planning process.

(d) A RAC must maintain the ability to collect and report data from each hospital within the TSA to facilitate emergency preparedness and response planning for a public health disaster, public health emergency, or outbreak of communicable disease, in a manner directed by the department and consistent with Texas Health and Safety Code §§81.027, 81.0443, 81.0444, and 81.0445.

(1) Unless otherwise directed by the department, at least once each calendar quarter, a RAC must collect and report to the department the following data from each hospital in their TSA:

(A) general beds available and occupied;

(B) intensive care unit (ICU) beds available and occupied;

(C) emergency department visits;

(D) hospital admissions;

(E) ventilators available and in use; and

(F) hospital deaths.

(2) The department may request more or less frequent collection or reporting or may request different information from individual RACs to adequately prepare for and respond to any public health disaster, public health emergency, outbreak of communicable disease, or federal reporting requirement relating to emergency preparedness and response.

(3) RACs must make the collected data publicly available by posting the data on the RAC's internet website.

(e) A RAC with at least one county within the region located on the international border of Texas and at least one county within the region adjacent to the Gulf of Mexico must provide guidelines and protocols related to trauma patient transfer and related services meeting the following requirements.

(1) The RAC must develop an advisory committee composed of equal representation from designated trauma facilities within the RAC.

(2) The advisory committee must develop regional protocols for managing the dispatch, triage, transport, and transfer of patients.

(A) The advisory committee must periodically review patient transfers ensuring the applicable protocols are met.

(B) Each hospital and EMS provider operating within this TSA must collect and report to the RAC data on patients transferred outside of the TSA following the developed and approved regional protocols.

(C) The advisory committee and activities must be integrated into the regional trauma and emergency health care system plan.

(f) A RAC must meet the defined performance criteria to ensure the mission of the regional system is maintained. A RAC must:

(1) notify the department and RAC membership within five days of the loss of capabilities to maintain the infrastructure to oversee and maintain the regional systems as required by the provisions within subsections (a) and (b) of this section or the department contract;

(2) provide the department with a plan of correction (POC) no more than 90 days from the onset of the deficiency for the RAC; and

(3) comply with the provisions of subsections (a) and (b) of this section, all current state and system standards as described in this chapter, and all guidelines and procedures as set forth in the regional trauma and emergency health care system plan.

(g) If a RAC chooses to relinquish services, it must provide at least a 30-day written advance notice to the department, all RAC membership, RAC coalition partners, and county judges within the impacted TSA.

(1) The RAC must submit a written plan to the department for approval before the 30-day notice to relinquish services.

(2) The RAC funding and assets must be dissolved in accordance with state and federal requirements.

(3) The department must consider options of realigning the TSA with another RAC to continue services.

(h) The department has the authority to schedule conferences, in-person or virtual, with 10-calendar days advanced notice, to review, inspect, evaluate, and audit all RAC documents to validate the department RAC performance criteria are met.

(i) RACs must maintain virtual options for stakeholder participation in committees or other activities.

§157.125. Requirements for Trauma Facility Designation Effective Through August 31, 2025.

(a) The Emergency Medical Services (EMS)/Trauma Systems Section recommends to the Commissioner of the Department of State Health Services (commissioner) the designation of an applicant facility (facility) as a trauma facility at the level for each location of a facility the department deems appropriate. Trauma designation surveys conducted on or before August 31, 2025, are evaluated on the requirements of this section. For surveys conducted on or after September 1, 2025, see §157.126 of this subchapter (relating to Trauma Facility Designation Requirements Effective on September 1, 2025) for the requirements.

(1) Comprehensive (Level I) trauma facility designation--The facility, including a free-standing children's facility, meets the current American College of Surgeons (ACS) essential criteria for a verified Level I trauma center; meets the "Advanced Trauma Facility Criteria" in subsection (x) of this section; actively participates on the appropriate Regional Advisory Council (RAC); has appropriate services for dealing with stressful events available to emergency/trauma care providers; and submits data to the State Trauma Registry.

(2) Major (Level II) trauma facility designation--The facility, including a free-standing children's facility, meets the current ACS essential criteria for a verified Level II trauma center; meets the "Advanced Trauma Facility Criteria" in subsection (x) of this section; actively participates on the appropriate RAC; has appropriate services for dealing with stressful events available to emergency/trauma care providers; and submits data to the State Trauma Registry.

(3) Advanced (Level III) trauma facility designation--The facility meets the "Advanced Trauma Facility Criteria" in subsection (x) of this section; actively participates on the appropriate RAC; has appropriate services for dealing with stressful events available to emergency/trauma care providers; and submits data to the State Trauma Registry. A free-standing children's facility, in addition to meeting the requirements listed in this section, must meet the current ACS essential criteria for a verified Level III trauma center.

(4) Basic (Level IV) trauma facility designation--The facility meets the "Basic Trauma Facility Criteria" in subsection (y) of this section; actively participates on the appropriate RAC; has appropriate services for dealing with stressful events available to emergency/trauma care providers; and submits data to the State Trauma Registry.

(b) A health care facility is defined in this subchapter as a single location where inpatients receive hospital services or each location if there are multiple buildings where inpatients receive hospital services and are covered under a single hospital license. Each location is considered separately for designation and the department will determine the designation level for that location, based on, but not limited to, the location's own resources and levels of care capabilities; Trauma Service Area (TSA) capabilities; and the essential criteria and requirements outlined in subsection (a)(1) - (4) of this section. The final determination of the level of designation may not be the level requested by the facility.

(c) The designation process consists of three phases.

(1) First phase--The application phase begins with submitting to the department a timely and sufficient application for designation as a trauma facility and ends when the survey report is received by the department.

(2) Second phase--The review phase begins with the department's review of the survey report and ends with its recommendation to the commissioner whether to designate the facility and at what level. This phase also includes an appeal procedure governed by the department's rules for a contested case hearing and by Texas Administrative Procedure Act, Texas Government Code Chapter 2001, and the department's formal hearing procedures in §§1.21, 1.23, 1.25, and 1.27 of this title (relating to Formal Hearing Procedures).

(3) Third phase--The final phase begins with the commissioner reviewing the recommendation and ends with the commissioner's final decision.

(d) For a facility seeking initial designation, a timely and sufficient application must include:

(1) the department's current "Complete Application" form for the appropriate level, with all fields correctly and legibly filled-in and all requested documents attached, hand-delivered, or sent by postal services to the department;

(2) full payment of the designation fee enclosed with the submitted "Complete Application" form;

(3) any subsequent documents submitted by the date requested by the department;

(4) a trauma designation survey completed within one year of the date of the receipt of the application by the department; and

(5) a complete survey report, including patient care reviews, that is within 90 days of the date of the survey and is submitted to the department.

(e) If a hospital seeking initial designation fails to meet the requirements in subsection (d)(1) - (5) of this section, the application is denied.

(f) For a facility seeking re-designation, a timely and sufficient application must include:

(1) the department's current "Complete Application" form for the appropriate level, with all fields correctly and legibly filled-in and all requested documents attached, submitted to the department one year before the expiration of the current designation;

(2) full payment of the designation fee enclosed with the submitted "Complete Application" form;

(3) any subsequent documents submitted by the date requested by the department; and

(4) a complete survey report, including patient care reviews, that is within 90 days of the date of the survey and is submitted to the department and at least 60 days before the expiration of the current designation.

(g) If a health care facility seeking re-designation fails to meet the requirements outlined in subsection (f)(1) - (4) of this section, the original designation will expire on its expiration date.

(h) The department's analysis of the submitted "Complete Application" form may result in recommendations for corrective action when deficiencies are noted and must include a review of:

(1) the evidence of current participation in RAC and regional trauma and emergency health care system planning; and

(2) the completeness and appropriateness of the application materials submitted, including the submission of a non-refundable application fee as follows:

(A) for Level I and Level II trauma facility applicants, the fee is no more than $10 per licensed bed with an upper limit of $5,000 and a lower limit of $4,000;

(B) for Level III trauma facility applicants, the fee is no more than $10 per licensed bed with an upper limit of $2,500 and a lower limit of $1,500; and

(C) for Level IV trauma facility applicants, the fee is no more than $10 per licensed bed with an upper limit of $1000 and a lower limit of $500.

(i) When a "Complete Application" form for initial designation or re-designation from a facility is received, the department will determine the level it deems appropriate for pursuit of designation or re-designation for each facility location based on: the facility's resources and levels of care capabilities, TSA resources, and the essential criteria for Levels I, II, III, and IV trauma facilities. In general, physician services capabilities described in the application must be in place 24-hours a day/7 days a week. In determining whether a physician services capability is present, the department may use the concept of substantial compliance that is defined as having said physician services capability at least 90% of the time.

(1) If a facility disagrees with the level determined by the department to be appropriate for pursuit of designation or re-designation, it may make an appeal in writing within 60 days to the EMS/Trauma Systems Section director. The written appeal must include a signed letter from the facility's governing board with an explanation as to why designation at the level determined by the department would not be in the best interest of the citizens of the affected TSA or the citizens of the State of Texas.

(2) If the department upholds its original determination, the EMS/Trauma Systems Section director will give written notice of such to the facility within 30 days of its receipt of the applicant's complete written appeal.

(3) The facility may, within 30 days of the department sending written notification of its denial, submit a written request for further review. Such written appeal is submitted to the associate commissioner, Consumer Protection Division.

(j) When the analysis of the "Complete Application" form results in acknowledgement by the department that the facility is seeking

an appropriate level of designation or re-designation, the facility may then contract for the survey, as follows.

(1) Level I and II facilities and all free-standing children's facilities must request a survey through the ACS trauma verification program.

(2) Level III facilities must request a survey through the ACS trauma verification program or through a department-approved survey organization.

(3) Level IV facilities must request a survey through a department-approved survey organization, or by a department-credentialed surveyor.

(4) The facility must notify the department of the date of the planned survey and the composition of the survey team.

(5) The facility is responsible for any expenses associated with the survey.

(6) The department, at its discretion, may appoint a designation coordinator to accompany the survey team. In this event, the cost for the designation coordinator is borne by the department.

(k) The survey team composition must be as follows.

(1) Level I or Level II facilities must be surveyed by a team that is multidisciplinary and includes at a minimum: two general surgeons, an emergency physician, and a trauma nurse all active in the management of trauma patients.

(2) Free-standing children's facilities of all levels must be surveyed by a team consistent with current ACS policy and includes at a minimum: a pediatric surgeon, a general surgeon, a pediatric emergency physician, and a pediatric trauma nurse coordinator or a trauma nurse coordinator with pediatric experience.

(3) Level III facilities must be surveyed by a team that is multidisciplinary and includes at a minimum: a trauma surgeon and a trauma nurse (ACS or department-credentialed), both active in the management of trauma patients.

(4) Level IV facilities must be surveyed by a department-credentialed representative, registered nurse, or licensed physician. A second surveyor may be requested by the facility or by the department.

(5) Department-credentialed surveyors must meet the following criteria:

(A) have at least three years' experience in the care of trauma patients;

(B) be currently employed in the coordination of care for trauma patients;

(C) have direct experience in the preparation for and successful completion of trauma facility verification or designation;

(D) have successfully completed a department-approved trauma facility site surveyor course and be successfully re-credentialed every four years; and

(E) have current credentials as follows:

(i) for nurses: Trauma Nurses Core Course (TNCC) or Advanced Trauma Course for Nurses (ATCN); and Pediatric Advanced Life Support (PALS) or Emergency Nurses Pediatric Course (ENPC);

(ii) for physicians: Advanced Trauma Life Support (ATLS); and

(iii) have successfully completed a site survey internship.

(6) All members of the survey team, except department staff, must come from a TSA outside the facility's location and at least 100 miles from the facility. There must be no business or patient care relationship or any potential conflict of interest between the surveyor or the surveyor's place of employment and the facility being surveyed.

(l) The survey team evaluates the facility's compliance with the designation criteria, by:

(1) reviewing medical records; staff rosters and schedules; process improvement committee meeting minutes; and other documents relevant to trauma care;

(2) reviewing equipment and the physical plant;

(3) conducting interviews with facility personnel;

(4) evaluating compliance with participation in the State Trauma Registry; and

(5) evaluating appropriate use of telemedicine capabilities where applicable.

(m) The site survey report in its entirety must be part of a facility's performance improvement program and subject to confidentiality as articulated in the Texas Health and Safety Code §773.095.

(n) The surveyor must provide the facility with a written, signed survey report regarding the evaluation of the facility's compliance with trauma facility criteria. This survey report must be forwarded to the facility within 30 calendar days of the completion date of the survey. The facility is responsible for forwarding a copy of this report to the department if it intends to continue the designation process.

(o) The department must review the findings of the survey report for compliance with trauma facility criteria.

(1) A recommendation for designation must be made to the commissioner based on meeting the designation requirements.

(2) If a facility does not meet the criteria for the level of designation deemed appropriate by the department, the department must notify the facility of the requirements it must meet to achieve the appropriate level of designation.

(3) If a facility does not meet the requirements, the department must notify the facility of deficiencies and recommend corrective action.

(A) The facility must submit to the department a report that outlines the corrective action taken. The department may require a second survey to ensure compliance with the criteria. If the department substantiates action that brings the facility into compliance with the criteria, the department recommends designation to the commissioner.

(B) If a facility disagrees with the department's decision regarding its designation application or status, it may request a secondary review by a designation review committee. Membership on a designation review committee will:

(i) be voluntary;

(ii) be appointed by the EMS/Trauma Systems Section director;

(iii) be representative of trauma care providers and appropriate levels of designated trauma facilities; and

(iv) include representation from the department and the Trauma Systems Committee of the Governor's EMS and Trauma Advisory Council (GETAC).

(C) If a designation review committee disagrees with the department's recommendation for corrective action, the records must be referred to the associate commissioner for recommendation to the commissioner.

(D) If a facility disagrees with the department's recommendation at the end of the secondary review, the facility has a right to a hearing, governed by the department's rules for a contested case hearing and by Texas Administrative Procedure Act, Texas Government Code Chapter 2001, and the department's formal hearing procedures in §§1.21, 1.23, 1.25, and 1.27 of this title (relating to Formal Hearing Procedures).

(p) The facility has the right to withdraw its application at any time before being recommended for trauma facility designation by the department.

(q) If the associate commissioner concurs with the recommendation to designate, the facility receives a letter and a certificate of designation valid for three years. Additional actions, such as a site review or submission of information/reports to maintain designation, may be required by the department.

(r) It is necessary to repeat the designation process as described in this section prior to expiration of a facility's designation or the designation expires.

(s) A designated trauma facility must comply with the provisions of this chapter; all current state and system standards as described in this chapter; all policies, protocols, and procedures as set forth in the system plan; and meet the following requirements.

(1) Continue its commitment to provide the resources, personnel, equipment, and response as required by its designation level.

(2) Participate in the State Trauma Registry. Data submission requirements for designation purposes are as follows.

(A) Initial designation--Six months of data prior to the initial designation survey must be uploaded. Subsequent to initial designation, data should be uploaded to the State Trauma Registry on at least a quarterly basis (with monthly submissions recommended) as indicated in Chapter 103 of this title (relating to Injury Prevention and Control).

(B) Re-designation--The facility's trauma registry should be current with at least quarterly uploads of data to the State Trauma Registry (monthly submissions recommended) as indicated in Chapter 103 of this title.

(3) Notify the department, its RAC, and other affected RACs of all changes that affect air medical access to designated landing sites.

(A) Non-emergent changes must be implemented no earlier than 120 days after a written notification process.

(B) Emergency changes related to safety may be implemented immediately along with immediate notification to department, the RAC, and appropriate air medical providers.

(C) Conflicts relating to helipad air medical access changes must be negotiated between the facility and the EMS provider.

(D) Any unresolved issues must be managed utilizing the nonbinding alternative dispute resolution (ADR) process of the RAC in which the helipad is located.

(4) Within five days, notify the department; its RAC and other affected RACs; and the health care facilities to which it customarily transfers-out trauma patients or from which it customarily receives trauma transfers-in if temporarily unable to comply with a designation. If the health care facility intends to meet the requirements and maintain current designation status, it must also submit to the department a plan for corrective action and a request for a temporary exception to requirements within five days.

(A) If the requested essential requirements exception is not critical to the operations of the health care facility's trauma program and the department determines the facility has intent to meet the requirements, a 30-day to 90-day exception period from the onset date of the deficiency may be granted for the facility to meet requirements.

(B) If the requested essential requirements exception is critical to the operations of the health care facility's trauma program and the department determines the facility has intent to meet requirements, no greater than a 30-day exception period from the onset date of the deficiency may be granted for the facility to meet requirements. Essential requirements that are critical include:

(i) neurological surgery capabilities (Level I, II);

(ii) orthopedic surgery capabilities (Level I, II, III);

(iii) general/trauma surgery capabilities (Level I, II, III);

(iv) anesthesiology (Levels I, II, III);

(v) emergency physicians (all levels);

(vi) trauma medical director (all levels);

(vii) trauma program manager (all levels); and

(viii) trauma registry (all levels).

(C) If the health care facility has not met the requirements at the end of the exception period, the department may at its discretion elect one of the following.

(i) Allow the facility to request designation at the level appropriate to its revised capabilities.

(ii) Propose to re-designate the facility at the level appropriate to its revised capabilities.

(iii) Propose to suspend the facility's designation status. If the facility is amenable to this action, the department will develop a corrective action plan for the facility and a specific timeline for the facility to meet the requirements.

(iv) Propose to extend the facility's temporary exception to criteria for an additional period not to exceed 90 days. The department will develop a corrective action plan for the facility and a specific timeline for the facility to meet the requirements.

(I) Suspensions of a facility's designation status and exceptions to criteria for facilities are documented on the EMS Trauma Systems Section website.

(II) If the facility disagrees with a proposal by the department or is unable or unwilling to meet the department-imposed timelines for completion of specific actions plans, it may request a secondary review by a designation review committee as defined in subsection (o)(3)(B) of this section.

(III) The department may at its discretion choose to activate a designation review committee at any time to solicit technical advice regarding criteria deficiencies.

(IV) If the designation review committee disagrees with the department's recommendation for corrective actions, the case is referred to the associate commissioner for recommendation to the commissioner.

(V) If a facility disagrees with the department's recommendation at the end of the secondary review process, the facility has a right to a hearing, governed by the department's rules for a contested case hearing and by Texas Administrative Procedure Act, Texas Government Code Chapter 2001, and the department's formal hearing procedures in §§1.21, 1.23, 1.25, and 1.27 of this title (relating to Formal Hearing Procedures).

(VI) Designated trauma facilities seeking exceptions to essential criteria have the right to withdraw the request at any time prior to resolution of the final appeal process.

(5) Notify the department; its RAC and other affected RACs; and the health care facilities to which it customarily transfers-out trauma patients or from which it customarily receives trauma transfers-in if it no longer provides trauma services commensurate with its designation level.

(A) If the facility chooses to apply for a lower level of trauma designation, it may do so at any time; however, it is necessary to repeat the designation process. There must be a review by the department to determine if a full survey is required.

(B) If the facility chooses to relinquish its trauma designation, it must provide at least 30 days' notice to the RAC and the department.

(6) Within 30 days, notify the department; its RAC and other affected RACs; and the health care facilities to which it customarily transfers-out trauma patients or from which it customarily receives trauma transfers-in, of the change if it adds capabilities beyond those that define its existing trauma designation level.

(A) It is necessary to repeat the trauma designation process.

(B) There must be a review by the department to determine if a full survey is required.

(t) Any facility seeking trauma designation must have measures in place that define the trauma patient population managed at the facility or at each of its locations, and the ability to track trauma patients throughout the course of care within the facility or at each of its locations to maximize funding opportunities for uncompensated care.

(u) A health care facility may not use the terms "trauma facility," "trauma hospital," "trauma center," or similar terminology in its signs or advertisements or in the printed materials and information it provides to the public unless the health care facility is currently designated as a trauma facility according to the process described in this section.

(v) The department has the right to review, inspect, evaluate, and audit all trauma patient records, trauma performance improvement committee minutes, and other documents relevant to trauma care in any designated trauma facility or applicant facility at any time to verify meeting requirements in the statute and this section, including the designation requirements. The department maintains confidentiality of such records to the extent authorized by the Texas Public Information Act, Texas Government Code Chapter 552, and consistent with current laws and regulations related to the Health Insurance Portability and Accountability Act of 1996. Such inspections must be scheduled by the department when deemed appropriate. The department provides a copy of the survey report, for surveys conducted by or contracted for the department, and the results to the health care facility.

(w) The department may grant an exception to this section if it finds meeting requirements in this section would not be in the best interests of the persons served in the affected local system.

(x) Advanced (Level III) Trauma Facility Requirements. An advanced trauma facility (Level III) provides resuscitation, stabilization, and assessment of injured patients and either provides treatment or arranges for appropriate transfer to a higher level designated trauma facility.

(1) The facility must identify a trauma medical director (TMD) responsible for the provision of trauma care and must have a defined job description and organizational chart delineating the TMD's role and responsibilities. The TMD must be a physician who meets the following:

(A) is a general surgeon;

(B) is currently credentialed in ATLS or an equivalent department-approved course;

(C) is charged with overall management of trauma services provided by the facility;

(D) must have the authority and responsibility for the clinical oversight of the trauma program, including:

(i) credentialing of medical staff who provide trauma care;

(ii) recommending trauma team privileges;

(iii) providing trauma care;

(iv) developing trauma management guidelines;

(v) collaborating with nursing to address educational needs; and

(vi) developing, implementing, and maintaining the trauma performance improvement and patient safety (PIPS) plan with the trauma program manager (TPM);

(E) must be credentialed by the facility to participate in the resuscitation and treatment of trauma patients and must:

(i) have current board-certification or board-eligibility;

(ii) complete nine hours of trauma-related continuing medical education per year;

(iii) comply with trauma management guidelines; and

(iv) participate in the trauma PIPS program;

(F) must participate in a leadership role in the facility, community, and emergency management (disaster) response committee; and

(G) should participate in the development of the regional trauma system plan.

(2) An identified TPM is a registered nurse and must:

(A) successfully complete and remain current in the TNCC or ATCN or an equivalent department-approved course;

(B) successfully complete and remain current in a nationally recognized pediatric advanced life support course (e.g., PALS or ENPC);

(C) have the authority and responsibility to monitor trauma patient care from emergency department (ED) admission

through operative intervention, intensive care unit (ICU) care, stabilization, rehabilitation care, and discharge, including the trauma PIPS program;

(D) have a defined job description and organizational chart delineating the TPM's role and responsibilities;

(E) participate in a leadership role in the facility, community, and regional emergency management (disaster) response committee;

(F) be full-time; and

(G) complete a course designed for their role that provides essential information on the structure, process, organization, and administrative responsibilities of a PIPS program to include a department-approved trauma outcomes and performance improvement course.

(3) The trauma program must have written trauma management guidelines, developed with approval by the trauma multidisciplinary committee and facility's medical staff with evidence of implementation, for:

(A) trauma team activation;

(B) trauma resuscitation guidelines for the roles and responsibilities of team members during a resuscitation;

(C) triage, admission, and transfer of trauma patients; and

(D) trauma management guidelines specific to the trauma population managed by the facility as defined by the State Trauma Registry.

(4) All major, severe, and critical trauma patients must be admitted to an appropriate surgeon and all multi-system trauma patients must be admitted to a general surgeon.

(5) A general surgeon participating in trauma-call coverage must:

(A) be credentialed in ATLS or an equivalent department-approved course at least one time if board-certification maintained; and

(B) be credentialed by the TMD to participate in the resuscitation and treatment of trauma patients and must maintain:

(i) current board-certification or board-eligibility, or must maintain current ATLS or an equivalent department-approved course;

(ii) nine hours of trauma-related continuing medical education per year;

(iii) compliance with trauma management guidelines;

(iv) participation in the trauma PIPS program; and

(v) attendance at 50 percent or more of multidisciplinary and peer review trauma committee meetings.

(6) A non-board-certified general surgeon desiring inclusion in a facility's trauma program must meet the ACS guidelines as specified in its most current version of the "Resources for Optimal Care of the Injured Patient," Alternate Criteria section.

(7) The general surgeon must be present in the ED at the time of arrival of the highest level of trauma activation or within 30 minutes of notification of the trauma activation. This must be continuously monitored by the trauma PIPS program.

(8) In facilities with surgical residency programs, evaluation and treatment may be started by a team of surgeons that must include a post-graduate year four (PGY4) or more senior surgical resident who is a member of that facility's residency program. The attending surgeon must participate in major therapeutic decisions, be present in the emergency department for major resuscitations, be present in the emergency department for the highest and secondary trauma activations, and be present at operative procedures. These must be continuously monitored by the trauma PIPS program.

(9) When the attending surgeon is not activated initially and an urgent surgical consult is necessary, the maximum response time of the attending surgeon is 60 minutes from notification to physical presence at the patient's bedside. This must be continuously monitored by the trauma PIPS program.

(10) There must be a published on-call schedule for obtaining general surgery care. There must be a documented system for obtaining general surgical care for situations when the attending general surgeon on-call is not available. This must be continuously monitored by the trauma PIPS program.

(11) An orthopedic surgeon participating in trauma-call coverage must be credentialed by the TMD to participate in the resuscitation and treatment of trauma patients and must maintain:

(A) current board-certification, board-eligibility, or meet ACS standards as specified in its current addition of "Resources for Optimal Care of the Injured Patient," Alternate Criteria section;

(B) compliance with trauma management guidelines; and

(C) participation in the trauma PIPS program.

(12) An orthopedic surgeon providing trauma coverage must be promptly available (physically present) at the major, severe, or critical trauma patient's bedside within 30 minutes of request by the attending trauma surgeon or emergency physician, from inside or outside the facility. This must be continuously monitored by the trauma PIPS program.

(13) When the orthopedic surgeon is not activated initially and an urgent surgical consult is necessary, the maximum response time of the orthopedic surgeon is 60 minutes from notification to physical presence at the patient's bedside. This must be continuously monitored by the trauma PIPS program.

(14) There must be a published on-call schedule for obtaining orthopedic surgery care. There must be a documented system for obtaining orthopedic surgery care for situations when the attending orthopedic surgeon on-call is not available. This must be continuously monitored by the trauma PIPS program.

(15) The orthopedic surgeon representative to the multidisciplinary trauma committee maintains nine hours of trauma-related continuing medical education per year and attends 50 percent or more of multidisciplinary and peer review trauma committee meetings.

(16) When a Level III facility has either full-time, routine, or limited neurosurgical coverage, a neurosurgeon participating in trauma-call coverage must be credentialed by the TMD to participate in the resuscitation and treatment of trauma patients and must maintain:

(A) current board-certification, board-eligibility, or meet ACS standards as specified in its current addition of "Resources for Optimal Care of the Injured Patient," Alternate Criteria section;

(B) compliance with trauma management guidelines; and

(C) participation in the trauma PIPS program.

(17) A neurosurgeon providing trauma coverage must be promptly available (physically present) at the major, severe, or critical trauma patient's bedside and neurosurgical evaluation must occur within 30 minutes for the following criteria: severe traumatic brain injury (TBI) with a Glasgow coma scale (GCS) less than 9 and computed tomography (CT) evidence of TBI; moderate TBI with GCS of 9-12 and CT evidence of potential intracranial lesion; and neurological deficit produced by a potential spinal cord injury. When a neurosurgical advanced practice provider (APP) or neurosurgical resident is utilized, there must be documented evidence of consultation with the neurosurgical attending on-call prior to implementation of the plan of care. This must be continuously monitored by the trauma PIPS program, including the consult times and response times.

(18) When the neurosurgeon is not notified of the initial activation or was not consulted by the evaluating team and it has been determined by the emergency physician or trauma surgeon that an urgent neurosurgical consult is necessary, the maximum response time of the neurosurgeon is 60 minutes from notification to physical presence at the patient's bedside. This must be continuously monitored by the trauma PIPS program.

(19) There must be a published on-call schedule for obtaining neurosurgical care.

(20) There must be a documented system for obtaining neurosurgical care for situations when the neurosurgeon on-call is not available. This must be continuously monitored by the trauma PIPS program.

(21) The neurosurgeon representative to the multidisciplinary trauma committee must have nine hours of trauma-related continuing medical education per year and attend 50 percent or more of multidisciplinary and peer review trauma committee meetings.

(22) An emergency physician must be available in the emergency department 24-hours a day and physicians providing trauma coverage must meet the following:

(A) be credentialed by the facility to provide emergency medical services; and

(B) be credentialed by the TMD to participate in the resuscitation and treatment of trauma patients of all ages and must maintain:

(i) current board-certification, board-eligibility, or maintain current ATLS or an equivalent department-approved course;

(ii) compliance with trauma management guidelines; and

(iii) participation in the trauma PIPS program.

(23) A board-certified emergency medicine physician providing trauma coverage must have successfully completed an ATLS Student Course or an equivalent department-approved ATLS course at least once.

(24) Current ATLS verification is required for all physicians who work in the emergency department and are not board-certified in Emergency Medicine.

(25) The emergency physician representative to the multidisciplinary trauma committee must have nine hours of trauma-related continuing medical education per year and attend 50 percent or more of multidisciplinary and peer review trauma committee meetings.

(26) The radiology physician on-call must respond within 30 minutes of request, from inside or outside the facility. This system must be continuously monitored by the trauma PIPS program.

(27) The anesthesiology physician on-call must respond within 30 minutes of request, from inside or outside the facility. This system must be continuously monitored by the trauma PIPS program.

(A) Requirements may be fulfilled by a member of the anesthesia care team credentialed by the TMD to participate in the resuscitation and treatment of trauma patients that may include:

(i) current board certification or board eligibility;

(ii) trauma continuing education;

(iii) compliance with trauma management guidelines; and

(iv) participation in the trauma PIPS program.

(B) The anesthesiology physician representative to the multidisciplinary trauma committee that provides trauma coverage to the facility must attend 50 percent or more of multidisciplinary and peer review trauma committee meetings.

(28) All nurses caring for trauma patients throughout the continuum of care have ongoing documented knowledge and skill in trauma nursing for patients of all ages to include trauma specific orientation, annual clinical competencies, and continuing education.

(29) Written guidelines for nursing care of trauma patients for all units (e.g., ED, ICU, Operating Room (OR), Post Anesthesia Care Unit (PACU), Medical/Surgical Units) in the facility must be implemented.

(30) The facility must have a written plan, developed by the facility, for acquisition of additional staff on a 24-hour basis to support units with increased patient acuity, and multiple emergency procedures and admissions (i.e., a written disaster plan.)

(31) The facility must have emergency services available 24-hours a day.

(A) The ED must have a designated physician director.

(B) The ED must have physicians with special competence in the care of critically injured patients, designated as members of the trauma team, and physically present in the ED 24-hours per day. Neither a facility's telemedical capabilities nor the physical presence of advanced practice providers (APPs) satisfies this requirement.

(C) APPs who participate in trauma patient resuscitations and telemedicine-support physicians who participate in the care of major, severe, or critical trauma patients must be credentialed by the facility to participate in the resuscitation and treatment of trauma patients and must maintain:

(i) board-certification or board-eligibility in specialty, or current ATLS or an equivalent department-approved ATLS course;

(ii) nine hours of trauma-related continuing medical education per year;

(iii) compliance with trauma management guidelines; and

(iv) participation in the trauma PIPS program.

(D) The ED physician must be activated on EMS communication with the ED or after a primary assessment of patients who arrive to the ED by private vehicle for the highest level of trauma activation and must respond within 30 minutes from notification of the

trauma activation. This must be monitored in the trauma PIPS program.

(E) A minimum of two registered nurses who have trauma nursing training must participate in the highest level trauma activations.

(F) All registered nursing staff responding to the highest levels of trauma activations must have successfully completed and hold current credentials in an advanced cardiac life support course (e.g., Advanced Cardiac Life Support (ACLS) or an equivalent department-approved course), a nationally recognized pediatric advanced life support course (e.g., PALS or ENPC), and TNCC or ATCN or an equivalent department-approved course. A free-standing children's facility is exempt from the ACLS requirement.

(G) Nursing documentation for trauma activation patients must be systematic and meet the trauma primary and secondary assessment guidelines.

(H) 100 percent of nursing staff must have successfully completed and hold current credentials in an advanced cardiac life support course (e.g., ACLS or an equivalent department-approved course), a nationally recognized pediatric advanced life support course (e.g., PALS or ENPC), and TNCC or ATCN or an equivalent department-approved course, within 18 months of date of employment in the ED.

(I) 100 percent of a free-standing children's facility nursing staff who care for trauma patients must have successfully completed and hold current credentials in a nationally recognized pediatric advanced life support course (e.g., PALS or ENPC) and TNCC or ATCN or an equivalent department-approved course, within 18 months of date of employment in the ED.

(J) Two-way communication with all pre-hospital emergency medical services vehicles must be available.

(K) Equipment and services for the evaluation and resuscitation of, and to provide life support for, critically or seriously injured patients of all ages must include:

(i) airway control and ventilation equipment including laryngoscope and endotracheal tubes of all sizes, bag-valve-mask devices (BVMs), pocket masks, advanced airway management devices, and oxygen;

(ii) mechanical ventilator;

(iii) pulse oximetry and capnography;

(iv) suction device;

(v) electrocardiograph, oscilloscope, and defibrillator;

(vi) internal age-specific paddles;

(vii) all standard intravenous fluids and administration devices, including large-bore intravenous catheters and a rapid infuser system;

(viii) sterile surgical sets for procedures standard for the emergency department such as thoracostomy, venous cutdown, central line insertion, thoracotomy, diagnostic peritoneal lavage (if performed at facility), airway control/cricothyrotomy, etc.;

(ix) drugs and supplies necessary for emergency care;

(x) cervical spine stabilization device;

(xi) length-based body weight and tracheal tube size evaluation system (e.g., a current Broselow tape) and resuscitation medications and equipment that are dose-appropriate for all ages;

(xii) long bone stabilization device;

(xiii) pelvic stabilization device;

(xiv) thermal control equipment for patients and a rapid warming device for blood and fluids; and

(xv) non-invasive continuous blood pressure monitoring devices.

(32) Imaging capability must be available, with an in-house technician 24-hours a day or on-call and responding within 30 minutes of request. This must be continuously monitored by the trauma PIPS program.

(33) Psychosocial support services must be available for staff, patients, and their families.

(34) Operating room services must be available 24-hours a day.

(A) With advanced notice, the operating room must be opened and ready to accept a patient within 30 minutes. This must be continuously monitored by the trauma PIPS program.

(B) Equipment for all trauma patient populations and anticipated special requirements must include:

(i) thermal control equipment for patient and for blood and fluids;

(ii) imaging capability including c-arm image intensifier with technologist available 24-hours a day;

(iii) endoscopes, all varieties, and bronchoscope;

(iv) equipment for long bone and pelvic fixation;

(v) rapid infuser system;

(vi) appropriate monitoring and resuscitation equipment;

(vii) capability to measure pulmonary capillary wedge pressure; and

(viii) capability to measure invasive systemic arterial pressure.

(35) A PACU or surgical ICU must be available for trauma patients following operative interventions and include the following.

(A) Registered nurses and other essential personnel 24-hours a day.

(B) Appropriate monitoring and resuscitation equipment.

(C) Pulse oximetry and capnography.

(D) Thermal control equipment for patients and a rapid warming device for blood and fluids.

(36) An ICU must be available for trauma patients 24-hours a day and include the following.

(A) Designated surgical director or surgical co-director responsible for setting policies and administration related to trauma ICU patients. A physician providing this coverage must be a surgeon credentialed by the TMD to participate in the resuscitation and treatment of trauma patients and must maintain:

(i) board-certification, board-eligibility, or current in ATLS or an equivalent department-approved course;

(ii) trauma continuing medical education;

(iii) compliance with trauma management guidelines; and

(iv) participation in the trauma PIPS program.

(B) Physician, credentialed in critical care by the TMD, on duty in ICU 24-hours a day or immediately available from in-facility. Arrangements for 24-hour surgical coverage of all trauma patients must be provided for emergencies and routine care. This must be continuously monitored by the trauma PIPS program.

(C) Registered nurse-patient minimum ratio of 1:2 on each shift for patients identified as critical acuity.

(D) Appropriate monitoring and resuscitation equipment.

(E) Pulse oximetry and capnography.

(F) Thermal control equipment for patients and a rapid warming device for blood and fluids.

(G) Capability to measure pulmonary capillary wedge pressure.

(H) Capability to measure invasive systemic arterial pressure.

(37) Respiratory services in-house and must be available 24-hours per day.

(38) Clinical laboratory services must be available 24-hours per day and provide the following.

(A) Standard analyses of blood, urine, and other body fluids, including microsampling.

(B) Blood typing and cross-matching, to include massive transfusion guidelines and emergency release of blood guidelines.

(C) Comprehensive blood bank or access to a community central blood bank and adequate facility storage.

(D) Coagulation studies.

(E) Blood gases and pH determinations.

(F) Microbiology.

(G) Drug and alcohol screening.

(H) Infectious disease standard operating procedures.

(I) Serum and urine osmolality.

(39) Special imaging capabilities must be available.

(A) Sonography is available 24-hours per day or on-call and if notified, responds within 30 minutes of notification.

(B) Computerized tomography (CT) is available on-call 24-hours per day and if notified, responds within 30 minutes. This must be continuously monitored by the trauma PIPS program.

(C) Angiography of all types is available 24-hours per day and if on-call, responds within 30 minutes.

(D) Nuclear scanning is available and responds as defined in the trauma management guidelines.

(40) Acute hemodialysis capability is available or transfer agreements are documented if not available.

(41) Established criteria for care of burn patients with a process to expedite the transfer of burn patients to a burn center or higher level of care.

(42) In circumstances where a designated spinal cord injury rehabilitation center exists in the region, early transfer should be considered and transfer agreements in effect.

(43) In circumstances where a moderate to severe head injury center exists in the region, transfer should be considered in selected patients and transfer agreements in effect.

(44) Physician-directed rehabilitation service, staffed by personnel trained in rehabilitation care and properly equipped for care of the injured patient, or transfer guidelines to a rehabilitation facility for patients needing a higher level of care or specialty services, including:

(A) physical therapy;

(B) occupational therapy; and

(C) speech therapy.

(45) Social services must be available to assist with management of trauma patients.

(46) The facility must have a defined trauma PIPS plan approved by the TMD, TPM, and the multidisciplinary committee.

(A) On initial designation, a facility must have completed at least six months of reviews on all qualifying trauma records with evidence of "loop closure" on identified variances. Compliance with internal trauma management guidelines must be evident.

(B) On re-designation, a facility must show continuous PIPS activities throughout its designation and a rolling current three-year period must be available for review at all times.

(C) Minimum PIPS inclusion criteria must include: all trauma team activations (including those discharged from the ED); all trauma deaths; all identified facility events; transfers-in and transfers-out; and readmissions within 48 hours after discharge.

(D) The trauma PIPS program must be organized and include a pediatric-specific component with trauma audit filters.

(i) Review of trauma medical records for appropriateness and quality of care.

(ii) Documented evidence of identification of all variances from trauma management guidelines and system response guidelines, with in-depth critical review.

(iii) Documented evidence of corrective actions implemented to address all identified variances with tracking of data analysis.

(iv) Documented evidence of secondary level of review and participation by the TMD.

(v) Morbidity and mortality review including decisions by the TMD as to whether the trauma management guidelines were followed.

(vi) Documented resolutions "loop closure" of all identified variance to prevent future recurrences.

(vii) Specific reviews of all trauma deaths and other specified cases, including complications, utilizing age-specific criteria.

(viii) Multidisciplinary hospital trauma PIPS committee structure in place.

(E) Multidisciplinary trauma committee meetings for PIPS activities must include department communication, data review, and measures for problem solving.

(F) Multidisciplinary trauma conferences must include all disciplines caring for trauma patients. This conference must be for the purpose of addressing PIPS activities and continuing education.

(G) Feedback regarding trauma patient transfers-in must be provided to all transferring facilities.

(H) Feedback regarding trauma patient transfers-out must be obtained from receiving facilities.

(I) The trauma program must maintain a trauma registry or utilize the State Trauma Registry for data entry of NTDB registry inclusion criteria patients. Trauma registry data must be submitted to the State Trauma Registry on at least a quarterly basis.

(J) The trauma program must participate in the RAC's performance improvement (PI) program, including adherence to regional guidelines, submitting data preapproved by the RAC membership such as summaries of transfer delays and transfers to facilities outside of the RAC.

(K) The trauma program must track the times and reasons for diversion must be documented and reviewed by the trauma PIPS program and multidisciplinary committee.

(L) The trauma program must maintain published on-call schedules must be maintained for general surgeons, orthopedic surgeons, neurosurgeons, anesthesia, radiology, and other major specialists, if available.

(M) The trauma program must have performance improvement personnel dedicated to and specific for the trauma program.

(47) The trauma program must participate in the regional trauma system per RAC requirements.

(48) The trauma program must have a process to expedite the transfer of major, severe, or critical trauma patients to include written management guidelines, written transfer agreements, and participation in a regional trauma system transfer plan for patients needing higher level of care or specialty services.

(49) The facility must have a system for establishing an appropriate landing zone near the facility (if rotor-wing services are available).

(50) The trauma program must provide education and consultations to physicians of the community and outlying areas.

(51) The trauma program must have an identified individual to coordinate the facility's community outreach programs for the public and professionals.

(52) The trauma program must have a public education program to address specific injuries identified by the facility's trauma registry. Documented participation in a RAC injury prevention program is acceptable.

(53) The trauma program must have formal programs in trauma continuing education provided by facility for staff or in collaboration with the RAC, based on needs identified from the trauma PIPS program for:

(A) staff physicians;

(B) nurses;

(C) allied health personnel, including advanced practice providers;

(D) community physicians; and

(E) pre-hospital personnel.

(54) The facility may participate in trauma-related research.

(y) Basic (Level IV) Trauma Facility Requirements. A Basic Trauma Facility (Level IV) provides resuscitation, stabilization, and arranges for appropriate transfer of trauma patients requiring a higher level of definitive care.

(1) The facility must identify a TMD responsible for the provision of trauma care and must have a defined job description and organizational chart delineating the TMD's role and responsibilities. The TMD must be a physician who meets the following:

(A) is currently credentialed in ATLS or an equivalent department-approved course;

(B) is charged with overall management of trauma services provided by the facility;

(C) must have the authority and responsibility for the clinical oversight of the trauma program, including:

(i) credentialing of medical staff who provide trauma care;

(ii) providing trauma care;

(iii) developing trauma management guidelines;

(iv) collaborating with nursing to address educational needs; and

(v) developing and implementing the trauma PIPS plan with the TPM;

(D) must be credentialed by the facility to participate in the resuscitation and treatment of trauma patients and must:

(i) have current board-certification or board-eligibility in surgery, emergency medicine or family medicine, or must maintain current ATLS or an equivalent department-approved course;

(ii) complete nine hours of trauma-related continuing medical education per year;

(iii) comply with trauma management guidelines; and

(iv) participate in the trauma PIPS program;

(E) must participate in a leadership role in the facility, community, and emergency management (disaster) response committee; and

(F) should participate in the development of the regional trauma system plan.

(2) An identified TPM is a registered nurse and must:

(A) successfully complete and remain current in the TNCC or ATCN or an equivalent department-approved course;

(B) successfully complete and remain current in a nationally recognized pediatric advanced life support course (e.g., PALS or the ENPC);

(C) have the authority and responsibility to monitor trauma patient care from ED admission through operative intervention, ICU care, stabilization, rehabilitation care, and discharge, including the trauma PIPS program;

(D) have a defined job description and organizational chart delineating the TPM's role and responsibilities;

(E) participate in a leadership role in the facility, community, and regional emergency management (disaster) response committee;

(F) ensure the TPM hours dedicated to the trauma program maintains a concurrent PIPS process and trauma registry; and

(G) complete a course designed for their role that provides essential information on the structure, process, organization, and administrative responsibilities of a PIPS program to include a department-approved trauma outcomes and performance improvement course.

(3) An identified Trauma Registrar or TPM must have appropriate training (e.g., the Association for the Advancement of Automotive Medicine (AAAM) course) in injury severity scaling. Typically, one full-time equivalent (FTE) employee dedicated to the registry is required to process approximately 500 patients annually.

(4) Written trauma management guidelines must be developed with approval by the TMD, TPM, and the facility's medical staff with evidence of implementation, for:

(A) trauma team activation, including defined response times;

(B) trauma resuscitation, defining the roles and responsibilities of team members during a resuscitation;

(C) triage, admission, and transfer of trauma patients; and

(D) trauma management specific to the trauma population managed by the facility as defined by the trauma registry.

(5) The emergency department must have physician coverage 24-hours per day. The physician providing coverage in the ED must be credentialed by the facility to provide emergency medical services.

(A) A physician providing trauma coverage must be credentialed by the TMD to participate in the resuscitation and treatment of trauma patients of all ages and must maintain:

(i) current board-certification or board-eligibility in emergency medicine or family medicine, or current ATLS or an equivalent department-approved course;

(ii) nine hours of trauma-related continuing medical education per year;

(iii) compliance with trauma management guidelines; and

(iv) participation in the trauma PIPS program.

(B) A board-certified emergency medicine physician providing trauma coverage must have successfully completed an ATLS Student Course or an equivalent department-approved ATLS course, at least once.

(C) Current ATLS verification is required for all physicians who work in the ED and are not board-certified in emergency medicine.

(D) The emergency physician representative to the multidisciplinary committee that provides trauma coverage to the facility must attend 50 percent or more of multidisciplinary and peer review trauma committee meetings.

(6) Radiology physician services must be available.

(7) Anesthesiology may be fulfilled by a member of the anesthesia care team credentialed in assessing emergent situations in trauma patients and providing any indicated treatment if operative services are provided.

(8) All nurses caring for trauma patients throughout the continuum of care must have ongoing documented knowledge and skill in trauma nursing for patients of all ages to include trauma specific orientation, annual clinical competencies, and continuing education.

(9) Written guidelines for nursing care of trauma patients for all units (i.e., ED, ICU, OR, PACU, medical/surgical units) in the facility must be implemented.

(10) The facility must have a written plan, developed by the facility, for acquisition of additional staff on a 24-hour basis to support units with increased patient acuity, multiple emergency procedures, and admissions (i.e., written disaster plan.)

(11) The facility must have emergency services available 24-hours a day.

(A) Physician on-call schedule must be published.

(B) Physicians with special competence in the care of critically injured patients, designated as members of the trauma team and on-call (if not in-house 24/7) must be promptly available within 30 minutes of request from inside or outside the facility. Neither a facility's telemedicine medical service capabilities nor the physical presence of APPs satisfy this requirement with the exception of the following:

(i) A health care facility located in a county with a population of less than 30,000 may satisfy a Level IV trauma facility designation requirement relating to physicians through the use of telemedicine medical service in which an on-call physician who has special competence in the care of critically injured patients provides patient assessment, diagnosis, consultation, or treatment, or transfers medical data to a physician, advanced practice registered nurse, or physician assistants located at the facility; and

(ii) APPs and telemedicine-support physicians who participate in the care of major, severe, or critical trauma patients must be credentialed by the facility to participate in the resuscitation and treatment of trauma patients, to include requirements such as current board-certification or board-eligibility in surgery or emergency medicine, nine hours of trauma-related continuing medical education per year, compliance with trauma management guidelines, and participation in the trauma PIPS program.

(C) The ED physician must be activated on EMS communication with the ED or after a primary assessment of patients who arrive to the ED by private vehicle for the highest level of trauma activation and must respond within 30 minutes from notification. This must be continuously monitored in the trauma PIPS program.

(D) A minimum of one and preferably two registered nurses who have trauma nursing training must participate in initial resuscitation of the highest level of trauma activations.

(E) All registered nursing staff responding to the highest levels of trauma activations must have successfully completed and hold current credentials in an advanced cardiac life support course (e.g., ACLS or an equivalent department-approved course), a nationally recognized pediatric advanced life support course (e.g., PALS or ENPC), and TNCC or ATCN or an equivalent department-approved course.

(F) 100 percent of nursing staff must have successfully completed and hold current credentials in an advanced cardiac life support course (e.g., ACLS or an equivalent department-approved course), a nationally recognized pediatric advanced life support course (e.g.,

PALS or ENPC), and TNCC or ATCN or an equivalent department-approved course, within 18 months of date of employment in the ED.

(G) Nursing documentation for trauma activation patients must be systematic and meet the trauma primary and secondary assessment guidelines.

(H) Two-way communication with all pre-hospital emergency medical services vehicles must be available.

(I) Equipment and services for the evaluation and resuscitation of, and to provide life support for, critically or seriously injured patients of all ages must include:

(i) airway control and ventilation equipment including laryngoscope and endotracheal tubes of all sizes, BVMs, pocket masks, advanced airway management devices, and oxygen;

(ii) mechanical ventilator;

(iii) pulse oximetry and capnography;

(iv) suction device;

(v) electrocardiograph, oscilloscope, and defibrillator;

(vi) all standard intravenous fluids and administration devices, including large-bore intravenous catheters and a rapid infuser system;

(vii) sterile surgical sets for procedures standard for the ED such as thoracostomy, central line insertion, thoracotomy if surgeons participate in trauma care, airway control/cricothyrotomy, etc.;

(viii) drugs and supplies necessary for emergency care;

(ix) cervical spine stabilization device;

(x) length-based body weight & tracheal tube size evaluation system (e.g., a current Broselow tape) and resuscitation medications and equipment that are dose-appropriate for all ages;

(xi) long bone stabilization device;

(xii) pelvic stabilization device;

(xiii) thermal control equipment for patients and a rapid warming device for blood and fluids; and

(xiv) non-invasive continuous blood pressure monitoring devices.

(12) Clinical laboratory services must be available 24-hours per day and provide the following.

(A) Call-back process for trauma activations available within 30 minutes. This must be continuously monitored in the trauma PIPS program.

(B) Standard analyses of blood, urine, and other body fluids, including microsampling.

(C) Blood-typing and cross-matching with a minimum of two units of universal packed red blood cells (PRBCs) immediately available.

(D) Capability for immediate release of blood for a transfusion and measures to obtain additional blood supply.

(E) Coagulation studies.

(F) Blood gases and pH determinations.

(G) Drug and alcohol screening.

(13) Imaging capabilities must be available 24-hours per day. Call-back process for trauma activations must be available within 30 minutes. This must be continuously monitored in the trauma PIPS program.

(14) The trauma program must have a defined trauma PIPS plan approved by the TMD, TPM, and the trauma multidisciplinary committee.

(A) On initial designation, a facility must have completed at least six months of reviews on all qualifying trauma records with evidence of "loop closure" on identified variances. Compliance with internal trauma management guidelines must be evident.

(B) On re-designation, a facility must show continuous PIPS activities throughout its designation and a rolling current three-year period must be available for review at all times.

(C) Minimum PIPS inclusion criteria includes: all trauma team activations (including those discharged from the ED); all trauma deaths; all identified facility events; transfers-in and transfers-out; and readmissions within 48-hours after discharge.

(D) The trauma PIPS program must be organized and include a pediatric-specific component with trauma audit filters.

(i) Review of trauma medical records for appropriateness and quality of care.

(ii) Documented evidence of identification of all variances from trauma management guidelines and system response guidelines, with in-depth critical review.

(iii) Documentation of corrective actions implemented to address all identified variances with tracking of data analysis.

(iv) Documented evidence of secondary level of review and participation by the TMD.

(v) Morbidity and mortality review including decisions by the TMD as to whether the trauma management guidelines were followed.

(vi) Documented resolutions "loop closure" of all identified issues to prevent future recurrences.

(vii) Specific reviews of all trauma deaths and other specified cases, including complications, utilizing age-specific criteria.

(viii) Multidisciplinary facility trauma PIPS committee structure must be in place and include department communication, data review, and measures for problem solving.

(E) Feedback regarding trauma patient transfers-out must be obtained from receiving facilities.

(F) Facility must maintain a trauma registry or utilize the State Trauma Registry for data entry of patients meeting NTDB registry inclusion criteria. Trauma registry data must be submitted to the State Trauma Registry on at least a quarterly basis.

(G) Participation with the RAC's PI program, including adherence to regional guidelines, submitting data preapproved by the membership to the RAC such as summaries of transfer delays and transfers to facilities outside of the RAC.

(H) Times and reasons for diversion must be documented and reviewed by the trauma PIPS program and multidisciplinary committee.

(15) The trauma program must participate in the regional trauma system per RAC requirements.

(16) The trauma program must have processes in place to expedite the transfer of major, severe, or critical trauma patients to include written management guidelines, written transfer agreements, and participation in a regional trauma system transfer plan for patients needing higher level of care or specialty services.

(17) The facility must have a system in place for establishing an appropriate landing zone in close proximity to the facility (if rotor-wing services are available).

(18) Facility may participate in a RAC injury prevention program.

(19) Formal programs in trauma continuing education must be provided by the facility or in collaboration with the RAC or their health care system based on needs identified from the trauma PIPS program for:

(A) staff physicians;

(B) nurses; and

(C) allied health personnel, including APPs.

§157.126. Trauma Facility Designation Requirements Effective on September 1, 2025.

(a) The department designates hospital applicants as trauma facilities, which are part of the trauma and emergency health care system. Hospitals must meet the designation requirements specific to the level of designation requested by September 1, 2025. Trauma designation surveys conducted on or after September 1, 2025, are evaluated on the requirements in this section.

(b) The facility seeking trauma designation submits a completed designation application packet to the department. The department reviews the facility application documents for the appropriate level of designation. The complete designation application packet must include the following:

(1) a trauma designation application for the requested level of trauma designation;

(2) a completed department designation assessment questionnaire;

(3) the documented trauma designation survey summary report that includes findings of requirements met and medical record reviews;

(4) evidence of documented data validation and quarterly submission to the State Trauma Registry and National Trauma Data Bank (NTDB) (if applicable) for the past 12 months;

(5) evidence of the facility's trauma program and Trauma Medical Director (TMD) or designee participation at Regional Advisory Council (RAC) meetings throughout the designation cycle; and

(6) full payment of the non-refundable, non-transferrable designation fee.

(c) The department reviews the designation application packet to determine and approve the facility's level of trauma designation. The department defines the final trauma designation level awarded to the facility and this designation may be different than the level requested based on the designation site survey summary. If the department determines the facility meets the requirements for trauma designation the department provides the facility with a designation award letter and a designation certificate. The facility must display its trauma designation certificate in a public area of the licensed premises that is readily visible to patients, employees, and visitors.

(d) Eligibility requirements for trauma designation.

(1) Health care facilities eligible for trauma designation include:

(A) a hospital in Texas, licensed or otherwise, in accordance with Texas Health and Safety Code Chapter 241;

(B) a hospital owned and operated by the State of Texas; or

(C) a hospital owned and operated by the federal government, in Texas.

(2) Each hospital must demonstrate the capability to stabilize and transfer or treat an acute trauma patient, have written trauma management guidelines for the hospital, have a written operational plan, and have a written trauma performance improvement and patient safety (PIPS) plan.

(3) Each hospital operating on a single hospital license with multiple locations (multi-location license) may apply for trauma designation separately by physical location for each designation.

(A) Hospital departments or services within a hospital must not be designated separately.

(B) Hospital departments located in a separate building not contiguous with the designated facility must not be designated separately.

(C) Each non-contiguous emergency department of a hospital operating on a single hospital license must have trauma patient care and transfers monitored through the main hospital's trauma program.

(e) A facility is defined under subsection (d) of this section as a single location where inpatients receive hospital services and inpatient care.

(1) Each facility location must meet the requirements for designation. The department defines the designation level based on the facility's ability to demonstrate designation requirements are met.

(2) Each facility must submit a separate trauma designation application based on its resources and the level of designation the facility is seeking.

(3) If there are multiple hospitals covered under a single hospital license, each hospital or physical location where inpatients receive hospital services and care may seek designation.

(4) Trauma designation is issued for the physical location and to the legal owner of the operations of the designated facility and is non-transferable.

(f) Facilities seeking trauma designation must meet department-approved requirements and have them validated by a department-approved survey organization.

(g) The four levels of trauma designation are as follows.

(1) Comprehensive trauma facility designation (Level I). The facility, including a free-standing children's facility, must:

(A) meet the current American College of Surgeons (ACS) trauma verification standards for Level I and receive a letter of verification from the ACS;

(B) meet the state trauma designation requirements;

(C) meet the participation requirements for the local RAC;

(D) have appropriate services for dealing with stressful events available to emergency and trauma care providers; and

(E) submit quarterly trauma data to the State Trauma Registry, defined in Chapter 103 (relating to Injury Prevention and Control).

(2) Major trauma facility designation (Level II). The facility, including a free-standing children's facility, must:

(A) meet the current ACS trauma verification standards for Level II and receive a letter of verification from the ACS;

(B) meet the state trauma designation requirements;

(C) meet the participation requirements for the local RAC;

(D) have appropriate services for dealing with stressful events available to emergency and trauma care providers; and

(E) submit quarterly trauma data to the State Trauma Registry, defined in Chapter 103 of this title (relating to Injury Prevention and Control).

(3) Advanced trauma facility designation (Level III). The facility, including a free-standing children's facility, must:

(A) meet the current ACS trauma verification standards for Level III and receive a letter of verification from the ACS, or complete a designation survey conducted by a department-approved survey organization;

(B) meet the state trauma designation requirements;

(C) meet the participation requirements for the local RAC;

(D) have appropriate services for dealing with stressful events available to emergency and trauma care providers; and

(E) submit quarterly trauma data to the State Trauma Registry, defined in Chapter 103 of this title (relating to Injury Prevention and Control).

(4) Basic trauma facility designation (Level IV). The facility, including a free-standing children's facility:

(A) Level IV facilities managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually must:

(i) meet the current ACS trauma verification standards for Level IV and complete a designation survey conducted by a department-approved survey organization;

(ii) meet the state trauma designation requirements;

(iii) meet the participation requirements for the local RAC;

(iv) have appropriate services for dealing with stressful events available to emergency and trauma care providers; and

(v) submit quarterly trauma data to the State Trauma Registry, defined in Chapter 103 of this title (relating to Injury Prevention and Control).

(B) Level IV facilities managing 100 or less trauma patients meeting NTDB registry inclusion criteria annually must:

(i) meet the defined state trauma designation requirements and complete a designation survey with the department or with a department-approved survey organization;

(ii) meet the participation requirements for the local RAC;

(iii) have appropriate services for dealing with stressful events available to emergency and trauma care providers; and

(iv) submit quarterly trauma data to the State Trauma Registry, defined in Chapter 103 of this title (relating to Injury Prevention and Control).

(h) All facilities seeking trauma designation must meet the following requirements.

(1) Facilities must have documented evidence of participation in the local RAC.

(2) Facilities must have evidence of quarterly trauma data submissions to the State Trauma Registry for patients that meet NTDB registry inclusion criteria, following the National Trauma Data Standards (NTDS) definitions and state definitions.

(3) Facilities must have emergency medical services (EMS) communication capabilities.

(4) Facilities must have provisions to capture the EMS wristband number or measures for patient tracking in resuscitation documentation.

(5) Facilities must have provisions to provide and document EMS hand-off.

(6) Facilities must have landing zone capabilities or system processes to establish a landing zone (when rotor-wing capabilities are available) with appropriate staff safety training.

(7) Facilities must have a process to provide feedback to EMS providers.

(8) All levels of trauma facilities must have written trauma management guidelines specific to the hospital that align with evidence-based practices and current national standards, which must be reviewed a minimum of every three years. These guidelines must be specific to the trauma patient population managed by the facility. Guidelines must be established for the following:

(A) trauma activation and response time based on national recommendations;

(B) trauma resuscitation and documentation;

(C) consultation services requests and response;

(D) admission and transfer;

(E) screening, management, and appropriate interventions or referral for both suspected and confirmed abuse of all patient populations; and

(F) massive transfusion.

(9) Facilities must have defined documentation of trauma management guidelines pertinent to the care of trauma patients in all nursing units providing care to the trauma patient.

(10) The written trauma management guidelines must be monitored though the trauma PIPS process.

(11) The trauma program must have provisions for the availability of all necessary equipment and services to administer the appropriate level of care and support for the injured patient meeting the hospital's trauma activation guidelines and meeting NTDB registry inclusion criteria through the continuum of care to discharge or transfer.

(12) All levels of adult trauma facilities must meet and maintain the Emergency Medical Services for Children's Pediatric Readiness Criteria, as evidenced by the following:

(A) annual completion of the on-line National Pediatric Readiness Project assessment (https://pedsready.org), including a writ-

ten plan of correction (POC) for identified opportunities for improvement that is monitored through the trauma PIPS plan until resolution;

(B) pediatric equipment and resources immediately available at the facility, and staff with defined and documented competency skills and training on the pediatric equipment;

(C) education and training requirements for Emergency Nursing Pediatric Course (ENPC) or Pediatric Advanced Life Support (PALS) for the nurses responding to pediatric trauma activations;

(D) assessments and documentation include Glasgow Coma Score (GCS); complete vital signs to include temperature, heart rate, respirations, and blood pressure; pain assessment; and weight recorded in kilograms;

(E) serial vital signs, GCS, and pain assessments are completed and documented for the highest level of trauma activations or when shock, a traumatic brain injury, or multi-system injuries are identified;

(F) pediatric imaging guidelines and processes addressing pediatric age or weight-based appropriate dosing for studies imparting radiation consistent with the ALARA (as low as reasonably achievable) principle; and

(G) documented evidence the trauma facility has completed a pediatric trauma resuscitation simulation with medical staff participation every six months, including a completed critique identifying opportunities for improvement integrated into the trauma performance improvement initiatives and tracked until the identified opportunities are corrected. An adult trauma facility managing 200 or more patients less than 15 years of age with an injury severity score (ISS) of 9 or greater is exempt from this requirement of pediatric trauma simulations. If the facility has responded to an actual pediatric trauma resuscitation event during a six-month period, the facility is exempt from this training but must have documented evidence of participation in the after-action-review.

(13) Free-standing children's trauma facilities must have resources and equipment immediately available for adult trauma resuscitations, adherence to the nursing requirements for Trauma Nurse Core Course (TNCC) or Advanced Trauma Care for Nurses (ATCN), documented evidence the trauma program has completed an adult trauma resuscitation simulation with medical staff participation every six months, including a completed critique identifying opportunities for improvement integrated into the trauma performance improvement initiatives and tracked until the identified opportunities are corrected. Free-standing children's trauma facilities managing 200 adult patients 15 years or older with an ISS of 9 or greater are exempt from this requirement for adult trauma simulations.

(14) Rural Level IV trauma facilities in a county with a population less than 30,000 may utilize telemedicine resources with an Advanced Practice Provider (APP) available to respond to the trauma patient's bedside within 30 minutes of notification, with written resuscitation and trauma management guidelines monitored through the trauma performance improvement and patient safety processes.

(A) The APP must be current in Advance Trauma Life Support (ATLS) training, annually maintain an average nine hours of trauma-related continuing medical education, and demonstrate adherence to the trauma patient management guidelines and documentation standards.

(B) The facility must have a documented telemedicine physician credentialing process.

(C) All assessments, physician orders, and interventions initiated through telemedicine must be documented in the patient's medical record.

(15) Telemedicine in trauma facilities in a county with a population of 30,000 or more, if utilized, must have a documented physician credentialing process, written trauma protocols for utilization of telemedicine including physician response times, and measures to ensure the trauma management guidelines and evidence-based practice are monitored through the trauma performance improvement and patient safety processes.

(A) Telemedicine cannot replace the requirement for the trauma on-call physician to respond to the trauma activations in-person, to conduct inpatient rounds, or to respond to emergency requests from the inpatient units, when requested.

(B) All telemedicine assessments, physician orders, and interventions initiated through telemedicine must be documented in the patient's medical record.

(C) Telemedicine services or the telemedicine physician may be requested to assist in trauma performance improvement committee reviews.

(16) The trauma medical director (TMD) must define the role and expectations of the hospitalist or intensivist in providing care to the admitted injured patient meeting trauma activation guidelines and meeting NTDB registry inclusion criteria.

(17) A trauma program manager (TPM) or designee must be a participating member of the nurse staffing committee.

(18) The facility must maintain medical records facilitating the documentation of trauma patient arrival, level of activation, physician response and team response times, EMS hand-off, wristband number or patient tracking identifier, resuscitation, assessments, vital signs, GCS, serial evaluation of needs, interventions, patient response to interventions, reassessments, and re-evaluation through all phases of care to discharge or transfer out of the facility.

(19) Level I, II, and III facilities, and Level IV facilities managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually must have an organized, effective trauma service recognized in the medical staff bylaws or rules and regulations and approved by the governing body. Medical staff credentialing must include a process for requesting and granting delineation of privileges for the TMD to oversee the providers participating in trauma call coverage, the trauma panel, and trauma management through all phases of care.

(20) Level I, II, and III facilities must have a TMD with requirements aligned with the current ACS standards specific to the level of designation requested and Level IV facilities managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually must have a TMD with a defined job description that is a surgeon, emergency medicine physician, or family practice physician that is board-certified in their specialty, current in ATLS, and meet the other ACS standards specific to the TMD for the level of designation requested. The TMD must complete a trauma performance improvement course approved by the department.

(21) Level I, II, and III facilities, and Level IV facilities managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually must have an identified TPM responsible for monitoring trauma patient care throughout the continuum of care, from pre-hospital management to trauma activation, inpatient admission, and transfer or discharge, to include transfer follow-up as appropriate. The TPM must be a registered nurse with clinical

background in trauma care and must have completed a trauma performance improvement course approved by the department and the Association for the Advancement of Automotive Medicine (AAAM) Injury Scaling Course, and have current TNCC or ATCN, Emergency Nursing Pediatric Course (ENPC) or Pediatric Advanced Life Support (PALS), and Advanced Cardiac Life Support (ACLS) certifications. It is recommended for the TPM to complete courses specific to the TPM role. The role must be only for that facility and cannot cover multiple facilities. The TPM authority and responsibilities are aligned with the current ACS standards for the specific level of designation.

(22) The facility must have an organizational structure that facilitates the TPM's review of trauma care from admission to discharge, allowing for recommendations to improve care through all phases of care, and a reporting structure to an administrator having the authority to recommend and monitor facility system changes and oversee the trauma program.

(23) All levels of trauma facilities must maintain a continuous trauma PIPS plan. The plan must be data-driven and must:

(A) identify variances in care or system response events for review, including factors that led to the event, delays in care, hospital events such as complications, and all trauma deaths;

(B) define the levels of harm;

(C) define levels of review;

(D) identify factors that led to the event;

(E) identify opportunities for improvement;

(F) establish action plans to address the opportunities for improvement;

(G) monitor the action plan until the desired change is met and sustained;

(H) establish a concurrent PIPS process;

(I) meet staffing standards that align with the ACS standards for performance improvement personnel; and

(J) utilize terminology for classifying morbidity and mortality with the terms:

(i) morbidity or mortality without opportunity;

(ii) morbidity or mortality with opportunity for improvement; and

(iii) morbidity or mortality with regional opportunity for improvement.

(24) The trauma PIPS plan must be approved by the TMD, TPM, and the trauma operations committee and be disseminated to all departments providing care to the trauma patient. The departments must ensure staff are knowledgeable of the responsibilities in the trauma PIPS plan and the requested data and information to be presented at the trauma operations committee.

(25) The Level I, II, and III facilities, and Level IV facilities managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually must demonstrate that the TMD chairs the secondary level of performance review, chairs the trauma multidisciplinary peer review committee, and co-chairs the trauma operations committee with the TPM.

(26) The trauma PIPS plan must outline the roles and responsibilities of the trauma operations committee and its membership.

(27) The trauma facility must document and include in its trauma PIPS plan the external review of the trauma verification and designation assessment questionnaire, designation survey documents, the designation survey summary report, including the medical record reviews, and all communication with the department.

(28) Trauma facilities must submit required trauma registry data every 90 days or quarterly to the State Trauma Registry and have documented evidence of data validation and correction of identified errors or blank fields.

(A) All levels of trauma facilities must demonstrate the current ACS standards for staffing requirements for the trauma registry are met.

(B) Trauma facilities utilizing a pool of trauma registrars must have an identified trauma registrar from the pool assigned to the facility to ensure data requests are addressed in a timely manner.

(29) All levels of trauma facilities must demonstrate the registered nurses assigned to care for arriving patients meeting trauma activation guidelines have current TNCC or ATCN, ENPC or PALS, and Advanced Cardiac Life Support certifications. Those new to the facility or the facility's trauma resuscitation area must meet these requirements within 18 months.

(30) Level I, II, and III facilities, and Level IV facilities managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually must have evidence the trauma program surgeons, trauma liaisons, trauma program personnel, operating suite leaders, and critical care medical director and nursing leaders complete a mass casualty response training on their roles, potential job functions, and job action sheets, to ensure competency regarding actions required for surge capacity, capabilities, and patient flow management from resuscitation to inpatient admission, operative suite, and critical care units or intensive care units during a multiple casualty or mass casualty event. If the facility has responded to an actual mass casualty event during a 12-month period, the facility is exempt from this training but must have documented evidence of participation in the after-action review.

(31) Level IV facilities managing 101 or more patients meeting NTDB registry inclusion criteria annually must:

(A) meet the current ACS Level IV standards and defined state requirements;

(B) have 24-hour on-site coverage by an emergency physician credentialed by the hospital and approved by the TMD to participate in the resuscitation and treatment of trauma patients of all ages and respond to trauma activation patients within 30 minutes of request;

(C) have documented guidelines for trauma activations, resuscitation guidelines, documentation standards, and patient transfers, and measures to monitor the guidelines through the trauma performance improvement process. Transfer reviews must include the time of arrival, transfer decision time, transfer acceptance time, transport arrival time, and time transferred;

(D) have documented management guidelines specific to the trauma patients admitted at the facility based on trauma registry data;

(E) have a written trauma PIPS plan that, at minimum, monitors:

(i) trauma team activations;

(ii) trauma team member response times;

(iii) trauma resuscitation guidelines;

(iv) documentation standards;

(v) trauma management guidelines;

(vi) pediatric trauma resuscitation guidelines;

(vii) transfer guidelines; and

(viii) all trauma deaths; and

(F) have provisions for a multidisciplinary trauma peer review committee and a trauma operations committee.

(32) Level IV facilities managing 100 or less trauma patients meeting NTDB registry inclusion criteria annually must:

(A) have 24-hour emergency services coverage by a physician credentialed by the hospital and approved by the TMD to participate in the resuscitation and treatment of trauma patients of all ages and respond to trauma activation patients within 30 minutes of request;

(B) have a TMD overseeing and monitoring the trauma care provided and who is current in ATLS;

(C) have a TPM who is a registered nurse and must:

(i) complete a trauma performance improvement course and a trauma program manager course approved by the department;

(ii) complete a registry AAAM Injury Scoring Course;

(iii) have current TNCC or ATCN, ENPC or PALS, and ACLS certifications; and

(iv) oversee and monitor trauma care provided;

(D) have documented guidelines for trauma team activation with response times, resuscitation guidelines, and documentation standards for resuscitation through admission, transfer, or discharge;

(E) have documented management guidelines specific for the trauma patients admitted to the facility;

(F) have documented transfer guidelines that are monitored to identify the arrival time, decision to transfer time, time of transfer acceptance, time of transport arrival, and time of transfer;

(G) have a trauma PIPS plan that, at minimum, monitors:

(i) trauma team activations;

(ii) trauma team member response times;

(iii) trauma resuscitation guidelines;

(iv) documentation standards;

(v) trauma management guidelines;

(vi) pediatric trauma resuscitation guidelines;

(vii) transfer guidelines; and

(viii) all trauma deaths;

(H) have provisions for a trauma multidisciplinary peer review process and operational oversight integrated into the hospitals performance review or quality review processes;

(I) have provisions for a trauma registry and submit the NTDB data to the State Trauma Registry quarterly to include each patient's ISS;

(J) have conventional radiology available 24-hours per day;

(K) have laboratory services available 24-hours per day for standard analysis of blood, urine, and other body fluids, including microbiologic sampling when appropriate;

(L) have blood bank capabilities including typing and cross-matching and have a minimum of two universal packed red blood cell units available; and

(M) participate in the local RAC.

(i) A facility seeking trauma designation or renewal of designation must submit the completed designation application packet, have the required documents available at the time of the designation survey, and submit the designation survey summary report and medical record reviews following the completed designation survey.

(1) A complete application packet contains the following:

(A) a trauma designation application for the requested level of trauma designation;

(B) a completed department designation assessment questionnaire;

(C) the documented trauma designation survey summary report that includes findings of requirements met and medical record reviews;

(D) evidence of documented data validation and quarterly submission to the State Trauma Registry and NTDB (if applicable) for the past 12 months;

(E) evidence of the facility's trauma program participation at RAC meetings throughout the designation cycle;

(F) full payment of the non-refundable, non-transferrable designation fee and department remit form submitted to the department Cash Branch per the designation application instructions; and

(G) the documentation in subparagraphs (A), (B), (D), and (E) of this paragraph must be submitted to the department and department-approved survey organization no less than 45 days before the facility's scheduled designation survey.

(2) The facility must have the required documents available and organized for the actual designation survey, including:

(A) documentation of a minimum of 12 months of trauma performance improvement and patient safety reviews, including minutes and attendance of the trauma operations meetings and the trauma multidisciplinary peer review committee meetings, all trauma-documented management guidelines or evidence-based practice guidelines, and all trauma-related policies, procedures, and diversion times;

(B) evidence of 12 months of trauma registry submissions to the State Trauma Registry;

(C) documentation of all injury prevention, outreach education, public education, and research activities (if applicable); and

(D) documentation to reflect designation requirements are met.

(3) Not later than 90 days after the trauma designation survey, the facility must submit to the department the following documentation:

(A) the documented trauma designation survey summary report that includes the requirements met and not met, and the medical record reviews; and

(B) a POC, if required by the department, which addresses all designation requirements defined as "not met" in the trauma designation survey summary report, which must include:

(i) a statement of the cited designation requirement not met;

(ii) a statement describing the corrective actions taken by the facility seeking trauma designation to meet the requirement;

(iii) the title of the individuals responsible for ensuring the corrective actions are implemented and monitored;

(iv) the date the corrective actions are implemented;

(v) a statement on how the corrective actions will be monitored and what data are measured to identify change;

(vi) documented evidence the POC is implemented within 60 days of the survey date; and

(vii) any subsequent documents requested by the department.

(4) The application includes full payment of the appropriate non-refundable, non-transferrable designation fee.

(A) For Level I and Level II trauma facility applicants, the fee is no more than $10 per licensed bed with an upper limit of $5,000 and a lower limit of $4,000.

(B) For Level III trauma facility applicants, the fee is no more than $10 per licensed bed with an upper limit of $2,500 and a lower limit of $1,500.

(C) For Level IV trauma facility applicants, the fee is no more than $10 per licensed bed with an upper limit of $1000 and a lower limit of $500.

(5) All application documents except the designation fee are submitted electronically to the department.

(j) Facilities seeking initial trauma designation must complete a scheduled conference call with the department and include the facility's chief executive officer (CEO), CNO, chief operating officer (COO), trauma administrator or executive leader, TMD, and TPM before scheduling the designation survey. The following information must be provided to the department before the scheduled conference call with the department:

(1) job descriptions for the TMD, TPM, and trauma registrar;

(2) trauma operational plan;

(3) trauma PIPS plan;

(4) trauma activation and trauma management guidelines; and

(5) trauma registry procedures.

(k) Facilities seeking designation renewal must submit the required documents described in subsection (i) of this section to the department no later than 90 days before the facility's current trauma designation expiration date.

(l) The application will not be processed if a facility seeking trauma designation fails to submit the required application documents and designation fee.

(m) A facility requesting designation at a different level of care or experiencing a change in ownership or a change in physical address must notify the department and submit a complete designation application packet and application fee.

(n) Level I, II, and III facilities, and Level IV facilities managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually must schedule a designation survey with a department-approved survey organization. All aspects of the designation survey process must follow the department designation survey guidelines. All initial designation surveys must be performed in person unless approval for virtual review is given by the department.

(1) Facilities requesting Level I and II trauma facility designation must request a verification survey through the ACS trauma verification program. This includes pediatric stand-alone facilities.

(2) Level III facilities must request a designation survey through either the ACS trauma verification program or through a department-approved survey organization.

(3) Level IV facilities managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually must schedule a designation survey with a department-approved survey organization.

(4) Level IV facilities managing 100 or less trauma patients meeting the NTDB registry inclusion criteria annually must schedule a designation survey with the department or the facility's executive officers may request a designation survey with a department-approved survey organization.

(5) The facility must notify the department of the date of the scheduled designation survey a minimum of 60 days before the survey.

(6) The facility is responsible for any expenses associated with the designation survey.

(7) The department, at its discretion, may appoint a designation coordinator to participate in the survey process. The designation coordinator's costs are borne by the department.

(o) The survey team composition must be as follows:

(1) Level I or Level II facilities must be reviewed by a team of surveyors who do not practice in Texas and who currently participate in the management or oversight of trauma patients at a verified or designated Level I or II trauma facility. The survey team must include:

(A) two surgeons;

(B) an emergency medicine physician; and

(C) a registered nurse with trauma expertise.

(2) Level III facilities must be reviewed by a team of surveyors currently participating in the management or oversight of trauma patients at a verified or designated Level I, II, or III trauma facility. The survey team must include:

(A) a surgeon; and

(B) a registered nurse with trauma expertise.

(3) Level IV facilities must be reviewed by surveyors determined by the facility's number of trauma patients meeting NTDB registry inclusion criteria annually that are managed by the facility.

(A) Level IV facilities managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually with:

(i) evidence of trauma patients having operative interventions, being admitted to the ICU, or having an ISS of 15 or greater must be reviewed by:

(I) a surgeon; and

(II) a registered nurse with trauma expertise;

(ii) no evidence of operative interventions, but trauma patients are admitted to the ICU and have an ISS of 15 or greater must be reviewed by:

(I) a surgeon, emergency medicine physician, or family practice physician who has the role of TMD or trauma liaison at their facility; and

(II) a registered nurse with trauma expertise;

(iii) no evidence of operative interventions or ICU admissions must be reviewed by:

(I) a surgeon, emergency medicine physician, family practice physician; or

(II) a registered nurse with trauma expertise.

(B) Level IV facilities managing 100 or less trauma patients meeting NTDB registry inclusion criteria annually have the option of requesting a designation survey by:

(i) the department; or

(ii) a department-approved survey organization. If this option is chosen, the survey team must include:

(I) a surgeon, an emergency medicine physician, or family practice physician, currently serving in the role of TMD or trauma liaison; or

(II) a registered nurse with trauma expertise.

(p) Trauma facilities seeking designation or redesignation and department-approved survey organizations must follow the department survey guidelines and ensure all surveyors follow these guidelines.

(1) All members of the survey team for Level III or IV, except department staff, must not be from the same TSA or a contiguous TSA of the facility's location without the written approval from the department. There must be no business or patient care relationship or any known conflict of interest between the surveyor or the surveyor's place of employment and the facility being surveyed.

(2) The facility must not accept surveyors with any known conflict of interest. If a conflict of interest is present, the facility seeking trauma designation must decline the assigned surveyor through the survey organization.

(A) A conflict of interest exists when the surveyor has a direct or indirect financial, personal, or other interest which would limit or could reasonably be perceived as limiting the surveyor's ability to serve in the best interest of the public.

(B) The conflict of interest may include a surveyor who, in the past four years:

(i) has trained or supervised key hospital or medical staff in residency or fellowship;

(ii) collaborated professionally with key members of the facility's leadership team;

(iii) was employed in the same health care system in state or out of state;

(iv) participated in a designation consultation with the facility;

(v) had a previous working relationship with the facility or facility leader;

(vi) conducted a designation survey for the facility; or

(vii) is the EMS medical director for an agency that routinely transports trauma patients to the facility.

(3) If a designation survey occurs with a surveyor who has a known conflict of interest, the trauma designation survey summary report and medical record review may not be accepted by the department.

(4) A survey organization must complete an application requesting to perform designation surveys in Texas and be approved by the department. Each organization must renew its application every four years.

(q) Level I and II facilities using the ACS verification program who receive a Type I or three or more Type II standards not met, and Level III facilities surveyed by a department-approved survey organization with four or more requirements not met, must schedule a conference call with the department.

(r) If a health care facility seeking re-designation fails to meet the requirements outlined in subsection (j) of this section, the original designation expires on its expiration date. The facility must wait six months and begin the process again to continue as a designated trauma facility.

(s) If a facility disagrees with the designation level awarded by the department, the CEO, CNO, or COO may request an appeal, in writing, sent to the EMS/Trauma Systems Section director not later than 30 days after the issuance date of a designation award.

(1) All written appeals are reviewed quarterly by the EMS/Trauma Systems Section director in conjunction with the Trauma Designation Review Committee.

(A) The Trauma Designation Review Committee consists of the following individuals for trauma designation appeals, exception requests, or contingent designation survey summaries:

(i) chair of Governor's EMS and Trauma Advisory Council (GETAC);

(ii) chair of the GETAC Trauma System Committee;

(iii) current president of the Texas Trauma Coordinators Forum;

(iv) two individuals who each have a minimum of 10 years of trauma facility oversight as an administrator, medical director, program manager, or program liaison, all selected by the current chair of GETAC and approved by the EMS/Trauma Systems Section director and Consumer Protection Division (CPD) associate commissioner; and

(v) three department representatives from the EMS/Trauma Systems Section.

(B) The Trauma Designation Review Committee meetings are closed to maintain confidentiality for all reviews.

(C) The GETAC chair and the chair of the Trauma System Committee are required to attend the Trauma Designation Review Committee, in addition to a minimum of three of the other members, to conduct meetings with the purpose of reviewing trauma facility designation appeals, exception requests, and contingent designation survey summaries that identify requirements not met. Agreement from a majority of the members present is required.

(2) If the Trauma Designation Review Committee supports the department's designation determination, the EMS/Trauma Systems Section director gives written notice of the review and determination

to the facility not later than 30 days after the committee's recommendation.

(3) If the Trauma Designation Review Committee recommends a different level of designation, it will provide the recommendation to the department. The department reviews the recommendation and determines the approved level of designation. Additional actions, such as a focused review, re-survey, or submission of information and reports to maintain designation, may be required by the department for identified designation requirements not met or only partially met.

(4) If a facility disagrees with the department's awarded level of designation, the facility may request a second appeal review with the department's CPD associate commissioner. The appeal must be submitted to the EMS/Trauma Systems Section no later than 15 days after the issuance date of the department's designation. If the CPD associate commissioner disagrees with the Trauma Designation Review Committee's recommendation, the CPD associate commissioner decides the appropriate level of designation awarded. The department sends a notification letter of the second appeal decision within 30 days of receiving the second appeal request.

(5) If the facility continues to disagree with the second level of appeal, the facility may request a hearing, governed by the department's rules for a contested case hearing and by Texas Administrative Procedure Act, Texas Government Code Chapter 2001, and the department's formal hearing procedures in §§1.21, 1.23, 1.25, and 1.27 of this title (relating to Formal Hearing Procedures).

(t) All designated facilities must follow the exceptions and notifications process outlined in the following paragraphs.

(1) A designated trauma facility must provide written or electronic notification of any significant change to the trauma program impacting the capacity or capabilities to manage and care for a trauma patient. The notification must be provided to:

(A) all EMS providers that transfer trauma patients to or from the designated trauma facility;

(B) the hospitals to which it customarily transfers out or from which it transfers in trauma patients;

(C) applicable RACs; and

(D) the department.

(2) If the designated trauma facility is unable to meet the requirements to maintain its current designation, it must submit to the department a documented POC and a request for a temporary exception to the designation requirements. Any request for an exception must be submitted in writing from the facility's CEO and define the facility's timeline to meet the designation requirements. The department reviews the request and the POC and either grants the exception with a timeline based on access to care, including geographic location, other levels of trauma facilities available, transport times, impact on trauma outcomes, and the regional trauma system, or denies the exception. If the facility is not granted an exception or it does not meet the designation requirements at the end of the exception period, the department elects one of the following:

(A) review the exception request with the Trauma Designation Review Committee with consideration of geographic location, access to trauma care in the local area of the facility, and impact on the regional trauma system;

(B) re-designate the facility at the level appropriate to its revised capabilities;

(C) outline an agreement with the facility to satisfy all designation requirements for the level of care designation within a time specified under the agreement, which may not exceed the first anniversary of the effective date of the agreement; or

(D) accept the facility's relinquishing of its trauma designation certificate.

(3) If the facility is relinquishing its trauma designation, the facility must provide 30 day written advance notice of the relinquishment to the department. The facility informs the applicable RACs, EMS providers, and facilities to which it customarily transfers out or from which it transfers in trauma patients. The facility is responsible for continuing to provide trauma care services or ensuring a plan for trauma care continuity for 30 days following the written notice of relinquishment of its trauma designation.

(u) A designated trauma facility may choose to apply for a higher level of designation at any time. The facility must follow the initial designation process described in subsection (i) of this section to apply for a higher level of trauma designation. The facility must not claim or advertise the higher level of designation until the facility has received written notification of the award of the higher level of designation.

(v) A hospital providing trauma services must not use or authorize the use of any public communication or advertising containing false, misleading, or deceptive claims regarding its trauma designation status. Public communication or advertising is deemed false, misleading, or deceptive if the facility uses these, or similar, terms:

(1) trauma facility, trauma hospital, trauma center, functioning as a trauma center, serving as a trauma center, or similar terminology if the facility is not currently designated as a trauma center or designated trauma center at that level; or

(2) comprehensive Level I trauma center, major Level II trauma center, advanced Level III trauma center, basic Level IV trauma center, or similar terminology in its signs, website, advertisements, social media, or in the printed materials and information it provides to the public that are different than the current designation level awarded by the department.

(w) During a virtual, on-site, or focused designation review conducted by the department or a department-approved survey organization, the department or surveyor has the right to review and evaluate the following documentation to validate designation requirements are met in this section and the Texas Health and Safety Code Chapter 773:

(1) trauma patient medical records;

(2) trauma PIPS plan and process documents;

(3) appropriate committee documentation for attendance, meeting minutes, and documents demonstrating why the case was referred, the date reviewed, pertinent discussion, and any actions taken specific to improving trauma care and outcomes; and

(4) documents relevant to trauma care in a designated trauma facility or facility seeking trauma facility designation to validate evidence designation requirements are met.

(x) The department and department-approved survey organizations must comply with all relevant laws related to the confidentiality of such records.

§157.130. Funds for Emergency Medical Services, Trauma Facilities, and Trauma Care Systems, and the Designated Trauma Facility and Emergency Medical Services Account.

(a) Allocations determination under Texas Health and Safety Code §773.122 and Health and Safety Code Chapter 780.

(1) Department determination. The department determines each year:

(A) eligibility criteria for emergency medical services (EMS), trauma service area (TSA), and hospital allocations; and

(B) the amount of EMS, TSA, and hospital allocations based on language described in Texas Health and Safety Code §773.122 and Chapter 780.

(2) Eligibility requirements. To be eligible for funding from the accounts, all potential recipients must maintain the regional participation requirements.

(3) Extraordinary emergency funding.

(A) To be eligible to receive extraordinary emergency funding, an entity must meet the following requirements:

(i) be a licensed EMS provider, a designated trauma facility, or a recognized first responder organization (FRO);

(ii) submit a completed application and any additional documentation requested by the department; and

(iii) provide documentation of active participation in its local Regional Advisory Council (RAC).

(B) Incomplete applications will not be considered for extraordinary emergency funding.

(4) EMS allocation.

(A) The department contracts with each eligible RAC to distribute the county funds to eligible EMS providers based within counties aligned with the relevant TSA.

(i) The department evaluates submitted support documents per the contract statement of work. Awarded funds must be used in addition to current operational EMS funding of eligible recipients and must not supplant the operational budget.

(ii) Funds are allocated by county to be awarded to eligible providers in each county. Funds are non-transferable to other counties within the RAC if there are no eligible providers in a county.

(B) Eligible EMS providers may contribute funds for a specified purpose within the TSA when:

(i) all EMS providers received communication regarding the intent of the contributed funds;

(ii) the EMS providers voted and approved by majority vote to contribute funds; and

(iii) all EMS providers that did not support contributing funds, receive the eligible funding.

(C) To be eligible for funding from the EMS allocation, providers must:

(i) maintain and comply with all licensure requirements as described in §157.11 of this chapter (relating to Requirements for an EMS Provider License);

(ii) follow RAC regional guidelines regarding patient destination and transport in all TSAs where EMS is provided and verified by each RAC;

(iii) notify the RACs of any potential eligibility to receive funds and meet the RACs' participation requirements, if a provider is contracted to provide EMS within a county of any one TSA and whose county of licensure is another county not in or contiguous with that TSA; and

(iv) provide the department evidence of a contract or letter of agreement with each additional county government or taxing authority in which EMS is provided in any county beyond its county of licensure.

(D) Contracts or letters of agreement must be submitted to the department on or before the stated department contract deadline of the respective year and provide evidence of continued coverage throughout the effective contract dates for which the eligibility of the EMS provider is being considered.

(E) EMS providers with contracts or letters of agreement on file with the department meeting the effective contract dates do not need to resubmit a copy of the contract or letter of agreement unless it has expired or will expire before the effective date of the next contract.

(F) The submitted contracts or letters of agreement must include effective dates to determine continued eligibility.

(G) Inter-facility transfer letters of agreement and contracts or mutual aid letters of agreement and contracts do not meet the requirement of a county contract.

(H) EMS providers are responsible for ensuring all contracts or letters of agreement have been received by the department on or before the listed deadline to be considered for eligibility.

(I) Air ambulance providers must meet the same requirements as ground transport EMS providers to be eligible to receive funds from a specific county other than the county of licensure.

(J) If an EMS provider is licensed in a particular county for a service area considered a geo-political subdivision and whose boundary lines cross multiple county lines, it will be considered eligible for the EMS Allocation for all counties overlapped by that geo-political subdivision's boundary lines. Verification from local jurisdictions will be requested for every county that comprises the geo-political subdivision to determine funding eligibility for each county. The eligibility of EMS providers whose county of licensure is in a geo-political subdivision other than those listed in clauses (i) - (v) of this subparagraph will be evaluated on a case-by-case basis. Geo-political subdivisions include:

(i) municipalities;

(ii) school districts;

(iii) emergency service districts (ESDs);

(iv) utility districts; or

(v) prison districts.

(5) TSA allocation.

(A) The department contracts with eligible RACs to distribute the funds for the operation of the 22 TSAs and for equipment, communications, education, and training for the areas.

(B) To be eligible to distribute funding on behalf of eligible recipients in each county to the TSA, a RAC must be:

(i) officially recognized by the department as described in §157.123 of this subchapter (relating to Regional Advisory Councils);

(ii) in compliance with all RAC performance criteria, have a current RAC self-assessment, and have a current regional trauma and emergency health care system plan; and

(iii) incorporated as an entity exempt from federal income tax under Section 501(a), Internal Revenue Code of 1986, and

its subsequent amendments by being listed as an exempt organization under Section 501(c)(3).

(C) The TSA allocation distributed under this paragraph is based on the relative geographic size and population of each TSA and on the relative amount of trauma care provided.

(6) Hospital allocation. The department distributes funds to designated trauma facilities to subsidize a portion of uncompensated trauma care provided or to enhance the facility's delivery of trauma care.

(A) Funds distributed from the hospital allocations are made based on:

(i) the hospital being designated as a trauma facility by the department as defined in Texas Health and Safety Code Chapter 773;

(ii) the percentage of the hospital's uncompensated trauma care cost for patients meeting the National Trauma Data Bank (NTDB) registry inclusion criteria relative to the total uncompensated trauma care cost reported for the identified patient population by qualified facilities that year;

(iii) availability of funds; and

(iv) submission of a complete application to the department within the stated time frame. Incomplete applications will not be considered.

(B) Additional information may be requested by the department to determine eligibility for funding.

(C) A designated trauma facility in receipt of funding from the hospital allocation that fails to maintain its designation as required in §157.125 of this subchapter (relating to Requirements for Trauma Facility Designation Effective Through August 31, 2025) and §157.126 of this subchapter (relating to Trauma Facility Designation Requirements Effective on September 1, 2025), must return to the department all hospital allocation funds received in the prior 12 months within 90 days of failure to maintain trauma designation.

(D) The department may grant an exception to subparagraph (C) of this paragraph if it finds compliance with this section would not be in the best interest of the persons served in the affected local system.

(E) A facility must have no outstanding balance owed to the department or other state agencies before receiving any future disbursements from the hospital allocation.

(7) Department allocations. The department's process for funding allocations defined in this subsection applies to the account defined in Texas Health and Safety Code Chapter 780 and includes designated trauma facilities and those in active pursuit of trauma designation in the funding allocation.

(8) Department unawarded designation. An undesignated facility in active pursuit of designation but that has not been awarded a trauma designation by the department pursuant to Texas Health and Safety Code §780.004 must return to the department all funds received from the hospital allocation, plus a penalty of 10 percent of the awarded amount.

(b) Calculation methods. Calculation of county portions of the EMS allocation, the RAC portions of the TSA allocation, and the hospital allocation are:

(1) EMS allocation.

(A) EMS allocation is derived by adjusting the weight of the statutory criteria to ensure, as closely as possible:

(i) 40 percent of the funds go to urban counties; and

(ii) 60 percent of the funds go to rural counties.

(B) An individual county's portion of the EMS allocation is based on its geographic size, population, and the number of emergency health care runs, multiplied by adjustment factors determined by the department, so the distribution approximates the required percentages for urban and rural counties.

(C) The formula is:

(i) the county's population multiplied by an adjustment factor;

(ii) plus, the county's geographic size multiplied by an adjustment factor;

(iii) plus, the county's total emergency health care runs multiplied by an adjustment factor;

(iv) divided by 3; and

(v) multiplied by the total EMS allocation.

(D) The adjustment factors are manipulated so the distribution approximates the required percentages for urban and rural counties.

(E) Total emergency health care runs are the number of emergency patient care records electronically transmitted to the department in a given calendar year by EMS providers.

(2) TSA allocation.

(A) The TSA allocation is based on its relative geographic size, population, and trauma care provided as compared to all other TSAs.

(B) The formula is:

(i) the TSA's percentage of the state's total population;

(ii) plus, the TSA's percentage of the state's total geographic size;

(iii) plus, the TSA's percentage of the state's total trauma care;

(iv) divided by 3; and

(v) multiplied by the total TSA allocation.

(C) Total trauma care is the number of trauma patient records electronically transmitted to the department in a given calendar year by EMS providers and hospitals.

(3) Hospital allocation.

(A) Distributions, including unexpended portions of the EMS and TSA allocations, are determined by an annual application process.

(B) An annual application must be submitted each state fiscal year. Incomplete applications will not be considered for the hospital allocation calculation.

(C) Based on the information provided in the approved application, each facility will receive allocations as follows.

(i) An equal amount, not to exceed 20 percent of the available hospital allocation, to reimburse designated trauma facilities and those facilities in active pursuit of designation under the program.

(ii) Any funds not allocated in paragraphs (1) and (2) of this subsection are included in the distribution formula in subparagraph (E) of this paragraph.

(D) If the total cost of uncompensated trauma care for patients meeting NTDB registry inclusion criteria exceeds the amount appropriated from the account, minus the amount referred to in subparagraph (C)(i) of this paragraph, the department allocates funds based on a facility's percentage of uncompensated trauma care costs in relation to the total uncompensated trauma care cost reported by qualified hospitals for the funding year.

(E) The hospital allocation formula for trauma designated facilities is:

(i) the facility's reported costs of uncompensated trauma care;

(ii) minus any collections received by the facility for any portion of the facility's uncompensated trauma care previously reported for the purposes of this section;

(iii) divided by the total reported costs of uncompensated trauma care by eligible facilities; and

(iv) multiplied by the total money available after reducing the amount to be distributed in subparagraph (C)(i) of this paragraph.

(F) The reporting period of a facility's uncompensated trauma care must apply to costs incurred during the preceding calendar year.

(c) Loss of funding eligibility. If the department finds an EMS provider, RAC, or hospital has violated Texas Health and Safety Code Chapter 773 or fails to comply with this chapter, the department may withhold account monies for a period of one to three years, depending upon the seriousness of the infraction.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Cynthia Hernandez
General Counsel
Department of State Health Services
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Proposal publication date: August 2, 2024
For further information, please call: (512) 535-8538

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TITLE 26. HEALTH AND HUMAN SERVICES

PART 1. HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 506. SPECIAL CARE FACILITIES

The Texas Health and Human Services Commission (HHSC) adopts the repeal of §506.61, concerning Inspection and Investigation Procedures, and §506.62, concerning Complaint Against a Texas Department of Health Representative; new §506.61, concerning Integrity of Inspections and Investigations; §506.62, concerning Inspections; §506.63, concerning Complaint Investigations; §506.64, concerning Notice; §506.65, concerning Professional Conduct; and §506.66, concerning Complaint Against an HHSC Representative; and amended §506.71, concerning License Denial, Suspension, Revocation and Probation, and §506.73, concerning Administrative Penalties.

The repeal of §506.61 and §506.62; new §§506.64, 506.65, and 506.66; and amended §506.73 are adopted without changes to the proposed text as published in the May 10, 2024, issue of the *Texas Register* (49 TexReg 3122). These rules will not be republished.

New §§506.61, 506.62, and 506.63, and amended §506.71 are adopted with changes to the proposed text as published in the May 10, 2024, issue of the *Texas Register* (49 TexReg 3122). These rules will be republished.

BACKGROUND AND JUSTIFICATION

The adoption is necessary to update the inspection, complaint investigation, and enforcement procedures for special care facilities. These updates are necessary to hold facilities accountable during the inspection and investigation processes and ensure facilities provide necessary documentation in a timely manner to HHSC representatives. The adopted rules revise enforcement procedures to ensure conformity with current practices and statutes. These updates also ensure consistent practices across HHSC Health Care Regulation, correct outdated language and contact information, and reflect the transition of regulatory authority for special care facilities from the Department of State Health Services to HHSC.

COMMENTS

The 31-day comment period ended June 10, 2024.

During this period, HHSC received comments regarding the proposed rules from four commenters, including Citizens Commission on Human Rights (CCHR), Disability Rights Texas (DRTx), Texas Council for Developmental Disabilities (TCDD), and the Texas Medical Association (TMA). A summary of comments relating to the rules and HHSC's responses follows.

Comment: TCDD recommended HHSC revise §506.63 to add language to require HHSC to notify the reporter in writing within a specific timeframe, and provided as an example, within 48 hours after HHSC makes a decision regarding the investigation.

Response: HHSC revises §506.63 to add language at new subsection (n) stating HHSC notifies a complainant of the investigation's outcome within 10 business days of completing the investigation.

Comment: CCHR recommended HHSC revise §506.63(a) to include a prompt to call 911 in cases for abuse and adding the contact information for the federally mandated protection and advocacy system to the posting required by that subsection to eliminate the need for multiple postings.

Response: HHSC declines to revise §506.63(a) because this subsection is specific to reporting allegations to HHSC. HHSC notes this subsection does not preclude a facility from combining the signage with other required postings.

Comment: Regarding §506.63(c)(1), DRTx stated there is not an indication of a feedback loop to the original reporter if HHSC does not investigate an allegation, refers an investigation to another entity, or does not pursue any action with the investigation. DRTx requested HHSC add language to §506.63(c)(1) requiring HHSC to notify the reporter in writing, within a specific timeframe,

and suggested 48 hours after HHSC makes a decision regarding an investigation's outcome.

Response: HHSC revises §506.63 to add language at new subsection (n) stating HHSC notifies a complainant of the investigation's outcome within 10 business days of completing the investigation. HHSC notes the HHSC Complaint and Incident Intake webpage contains information about the complaint intake process.

Comment: TCDD expressed concern with the use of "may" instead of "shall" in §506.63(c)(1) and (2). TCDD recommended HHSC revise §506.63(c)(1) and (2) by adding language requiring HHSC to provide feedback, within a specified timeframe, to a reporter about whether and why HHSC decided to investigate and, when applicable, to whom HHSC referred the allegation.

Response: HHSC revises §506.63 to add language at new subsection (n) stating HHSC notifies a complainant of the investigation's outcome within 10 business days of completing the investigation. HHSC notes the HHSC Complaint and Incident Intake webpage contains information about the complaint intake processes.

Comment: CCHR requested HHSC inform a complainant of HHSC's decision not to investigate an allegation, and when applicable, to whom HHSC referred the allegation under §506.63(c)(1) and (2). CCHR also requested HHSC add information to this subsection regarding any right for a complainant to appeal and the procedures and timelines for filing an appeal.

Response: HHSC revises §506.63 to add language at new subsection (n) stating HHSC notifies a complainant of the investigation's outcome within 10 business days of completing the investigation. HHSC declines to revise §510.63 further because investigations under §506.63 do not provide an appeal process for a complainant or an alleged violator. HHSC notes the HHSC Complaint and Incident Intake webpage contains information about the complaint intake processes.

Comment: CCHR commented on §506.63(d) and (e) and stated these subsections would be problematic if a regulatory approach was taken in lieu of conducting an actual abuse, neglect, or exploitation investigation because abuse, neglect, and exploitation are potential criminal matters that require patient protection and prompt collection and preservation of evidence.

Response: HHSC notes that it investigates allegations of abuse, neglect, or exploitation involving individuals with disabilities, children, or elderly individuals in accordance with the investigation rules at 25 TAC Chapter 1, Subchapter Q and HHSC policies; investigates other abuse, neglect, and exploitation allegations in accordance with 25 TAC §506.33(c)(2); and reports possible criminal acts to the appropriate law enforcement authorities in accordance with state law and HHSC policies.

Comment: TCDD recommended HHSC revise §506.63(e) to clearly state that unannounced, on-site investigations also apply to investigations of abuse, neglect, or exploitation.

Response: HHSC declines to revise §506.63(e) because HHSC investigates allegations of abuse, neglect, or exploitation involving individuals with disabilities, children, or elderly individuals in accordance with the investigation rules at 25 TAC Chapter 1, Subchapter Q and HHSC policies; and HHSC investigates other abuse, neglect, and exploitation allegations in accordance with 25 TAC §506.33(c)(2). HHSC notes the language at §506.63(e) does not preclude HHSC from conducting an unannounced, on-site investigation regarding other allegations of abuse, neglect, or exploitation in accordance with HHSC policies.

Comment: DRTx stated §506.63(e) seems to address regulatory investigations and recommended adding language to the subsection regarding HHSC's ability to conduct an unannounced, on-site investigation regarding an allegation of abuse, neglect, or exploitation.

Response: HHSC declines to revise §506.63(e) because HHSC investigates allegations of abuse, neglect, or exploitation involving individuals with disabilities, children, or elderly individuals in accordance with the investigation rules at 25 TAC Chapter 1, Subchapter Q and HHSC policies; and HHSC investigates other abuse, neglect, and exploitation allegations in accordance with 25 TAC §506.33(c)(2). HHSC notes the language at §506.63(e) does not preclude HHSC from conducting an unannounced, on-site investigation regarding other allegations of abuse, neglect, or exploitation in accordance with HHSC policies.

Comment: TCDD recommended HHSC revise §506.64(b)(2) to include procedures for how HHSC should conduct a regulatory investigation and that the procedures followed for abuse, neglect, and exploitation investigations should be similarly addressed and clearly identified as abuse, neglect, and exploitation procedures.

Response: HHSC declines to revise §506.64(b)(2) because HHSC investigates allegations of abuse, neglect, or exploitation involving individuals with disabilities, children, or elderly individuals in accordance with 25 TAC Chapter 1, Subchapter Q; and HHSC investigates other abuse, neglect, and exploitation allegations in accordance with 25 TAC §506.33(c)(2).

Comment: DRTx noted the language in §506.64(b)(2) focuses on regulatory issues and stated it is not clear if allegations of abuse, neglect, or exploitation investigated under this section result in a determination, identification of an alleged perpetrator associated with the allegation, or if HHSC takes any disciplinary action against a confirmed perpetrator. DRTx recommended adding language in §506.64(b)(2) to include the process for abuse, neglect, and exploitation allegations.

Response: HHSC declines to revise §506.64(b)(2) because HHSC investigates allegations of abuse, neglect, or exploitation involving individuals with disabilities, children, or elderly individuals in accordance with the investigation rules at 25 TAC Chapter 1, Subchapter Q, and HHSC policies; and HHSC investigates other abuse, neglect, and exploitation allegations in accordance with 25 TAC §506.33(c)(2).

Comment: TMA stated §506.65 appears to impose reporting mandates on HHSC. TMA stated not every issue relating to the conduct of a licensed professional, intern, or application for professional licensure will necessarily warrant reporting to the licensing board. TMA recommended replacing "reports" with "may report" in §506.65 to allow HHSC to exercise discretion in its reporting.

Response: HHSC declines to revise §506.65 because the agency prefers to err on the side of caution regarding conduct of licensed professionals. HHSC notes licensing boards have discretion in responding to any complaint.

Comment: TCDD recommended HHSC revise §506.71(b)(3) to include language referencing the standards for investigation and corrective action for confirmed abuse, neglect, or exploitation.

Response: HHSC declines to revise §506.71(b)(3) because HHSC investigates allegations of abuse, neglect, or exploitation involving individuals with disabilities, children, or elderly individuals in accordance with the investigation rules at 25 TAC Chapter 1, Subchapter Q and HHSC policies; and HHSC investigates other abuse, neglect, and exploitation allegations in accordance with 25 TAC §506.33(c)(2).

Comment: CCHR stated a 30-day minimum probation period under §506.71(i) is too short and questioned whether this probation period would provide a sufficient deterrent to prevent behavior severe enough to warrant a license denial, suspension, or revocation.

Response: HHSC declines to revise §506.71(i) because the language is consistent with Texas Health and Safety Code §248.051(c). In addition, HSC §248.051(d) provides for HHSC to suspend or revoke the license of a special care facility that does not correct items that were in noncompliance or that does not comply with the applicable requirements within the applicable probation period.

Comment: TCDD recommended HHSC add language to §506.73(e) to require HHSC to inform the reporter, alleged victim, and the alleged victim's legally authorized representative (LAR) of the allegation's disposition and appeal procedures within a specified timeline. CCHR commented on §506.73(e) and stated that the alleged perpetrator has a right to receive notice of a violation and any proposed penalty and questioned whether the victims of such conduct that led to an administrative penalty should also be notified of violations and penalties.

Response: HHSC revises §506.63 to add language at new subsection (n) stating HHSC notifies a complainant of the investigation's outcome within 10 business days of completing the investigation. HHSC declines to revise §506.73(e) to add an appeals process because investigations under §506.63 do not provide an appeal process for a complainant or an alleged violator.

Comment: Regarding §506.73(e)(1) and (2), DRTx stated that the reporter, alleged victim, and alleged victim's LAR have a right to know the outcome of an investigation and be informed of how to access the report and of any appeal process. DRTx also noted the current language fails to indicate if any appeal process exists. DRTx recommended HHSC add language to §506.73(e)(1) and (2) to require HHSC to share the outcome of the investigation with the reporter, alleged victim, and the alleged victim's LAR, if appropriate, within a specific timeframe. DRTx also recommended HHSC provide information in §506.73(e)(1) and (2) on the appeal process.

Response: HHSC revises §506.63 to add language at new subsection (n) stating HHSC notifies a complainant of the investigation's outcome within 10 business days of completing the investigation. HHSC declines to revise §506.73(e)(1) because investigations under §506.63 do not provide an appeal process for a complainant or an alleged violator.

HHSC revised §506.61(a)(1) to connect paragraphs (1) and (2) with "or" instead of "and." HHSC made this change to ensure consistency with the freestanding emergency medical care facility rule at 26 TAC §509.81(a) and the limited services rural hospital rule at 26 TAC §511.111(a).

HHSC revised §506.61(a)(2) by adding "unless the facility first informs HHSC" to clarify a facility must first inform HHSC and then obtain HHSC written approval before beginning to record or listen to an internal HHSC discussion.

HHSC revised §506.62(d) and §506.63(g) by adding "video surveillance" to the list of items a special care facility must permit HHSC to examine during any HHSC inspection. The revisions increase consistency with other HHSC rules in this rule project and language in 26 TAC §511.112(e) for a limited services rural hospital.

HHSC made editorial changes to §506.71(c) to renumber paragraph (2)(H) as paragraph (3), because the contents are a separate rule that references paragraph (2) of this subsection.

SUBCHAPTER E. INSPECTIONS AND INVESTIGATIONS

26 TAC §506.61, §506.62

STATUTORY AUTHORITY

The repeals are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation of and provision services by the health and human services agencies, and Texas Health and Safety Code §248.026, which requires HHSC to adopt rules that establish minimum standards for special care facilities.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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Proposal publication date: May 10, 2024
For further information, please call: (512) 834-4591

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26 TAC §§506.61 - 506.66

STATUTORY AUTHORITY

The new sections are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation of and provision services by the health and human services agencies, and Texas Health and Safety Code §248.026, which requires HHSC to adopt rules that establish minimum standards for special care facilities.

§506.61. Integrity of Inspections and Investigations.

(a) In order to preserve the integrity of the Texas Health and Human Services Commission's (HHSC's) inspection and investigation process, a facility:

(1) may not record, listen to, or eavesdrop on any HHSC interview with facility staff or residents that the facility staff knows HHSC intends to keep confidential as evidenced by HHSC taking reasonable measures to prevent from being overheard; or

(2) may not record, listen to, or eavesdrop on any HHSC internal discussions outside the presence of facility staff when HHSC has requested a private room or office or distanced themselves from facility staff unless the facility first informs HHSC and the facility obtains HHSC's written approval before beginning to record or listen to the discussion.

(b) A facility shall inform HHSC when security cameras or other existing recording devices in the facility are in operation during any internal discussion by or among HHSC staff.

(c) When HHSC by words or actions permits facility staff to be present, an interview or conversation for which facility staff are present does not constitute a violation of this rule.

(d) This section does not prohibit an individual from recording an HHSC interview with the individual.

§506.62. Inspections.

(a) The Texas Health and Human Services Commission (HHSC) may conduct an unannounced, on-site inspection of a facility at any reasonable time, including when treatment services are provided, to inspect, investigate, or evaluate compliance with or prevent a violation of:

(1) any applicable statute or rule;

(2) a facility's plan of correction;

(3) an order or special order of the HHSC executive commissioner or the executive commissioner's designee;

(4) a court order granting injunctive relief; or

(5) for other purposes relating to regulation of the facility.

(b) An applicant or licensee, by applying for or holding a license, consents to entry and inspection of any of its facilities by HHSC.

(c) HHSC inspections to evaluate a facility's compliance may include:

(1) initial, change of ownership, or relocation inspections for the issuance of a new license;

(2) inspections related to changes in status, such as new construction or changes in services, designs, or bed numbers;

(3) routine inspections, which may be conducted without notice and at HHSC's discretion, or prior to renewal;

(4) follow-up on-site inspections, conducted to evaluate implementation of a plan of correction for previously cited deficiencies;

(5) inspections to determine if an unlicensed facility is offering or providing, or purporting to offer or provide treatment; and

(6) entry in conjunction with any other federal, state, or local agency's entry.

(d) A facility shall cooperate with any HHSC inspection and shall permit HHSC to examine the facility's grounds, buildings, books, records, video surveillance, and other documents and information maintained by or on behalf of the facility, unless prohibited by law.

(e) A facility shall permit HHSC access to interview members of the governing body, personnel, and residents, including the opportunity to request a written statement.

(f) A facility shall permit HHSC to inspect and copy any requested information, unless prohibited by law. If it is necessary for HHSC to remove documents or other records from the facility, HHSC provides a written description of the information being removed and when it is expected to be returned. HHSC makes a reasonable effort, consistent with the circumstances, to return any records removed in a timely manner.

(g) HHSC shall maintain the confidentiality of facility records as applicable under state and federal law.

(h) Upon entry, HHSC holds an entrance conference with the facility's designated representative to explain the nature, scope, and estimated duration of the inspection.

(i) During the inspection, the HHSC representative gives the facility representative an opportunity to submit information and evidence relevant to matters of compliance being evaluated.

(j) When an inspection is complete, the HHSC representative holds an exit conference with the facility representative to inform the facility representative of any preliminary findings of the inspection, including possible health and safety concerns. The facility may provide any final documentation regarding compliance during the exit conference.

§506.63. Complaint Investigations.

(a) A facility shall provide each resident and applicable legally authorized representative at the time of admission with a written statement identifying the Texas Health and Human Services Commission (HHSC) as the agency responsible for investigating complaints against the facility.

(1) The statement shall inform persons that they may direct a complaint to HHSC Complaint and Incident Intake (CII) and include current CII contact information, as specified by HHSC.

(2) The facility shall prominently and conspicuously post this statement in resident common areas and in visitor's areas and waiting rooms so that it is readily visible to residents, employees, and visitors. The information shall be in English and in a second language appropriate to the demographic makeup of the community served.

(b) HHSC evaluates all complaints. A complaint must be submitted using HHSC's current CII contact information for that purpose, as described in subsection (a) of this section.

(c) HHSC documents, evaluates, and prioritizes complaints directed to HHSC CII based on the seriousness of the alleged violation and the level of risk to residents, personnel, and the public.

(1) Allegations determined to be within HHSC's regulatory jurisdiction relating to health care facilities may be investigated under this chapter.

(2) HHSC may refer complaints outside HHSC's jurisdiction to an appropriate agency, as applicable.

(d) HHSC shall conduct investigations to evaluate a facility's compliance following a complaint of abuse, neglect, or exploitation; or a complaint related to the health and safety of residents.

(e) HHSC may conduct an unannounced, on-site investigation of a facility at any reasonable time, including when treatment services are provided, to inspect or investigate:

(1) a facility's compliance with any applicable statute or rule;

(2) a facility's plan of correction;

(3) a facility's compliance with an order of the executive commissioner or the executive commissioner's designee;

(4) a facility's compliance with a court order granting injunctive relief; or

(5) for other purposes relating to regulation of the facility.

(f) An applicant or licensee, by applying for or holding a license, consents to entry and investigation of any of its facilities by HHSC.

(g) A facility shall cooperate with any HHSC investigation and shall permit HHSC to examine the facility's grounds, buildings, books, records, video surveillance, and other documents and information maintained by, or on behalf of, the facility, unless prohibited by law.

(h) A facility shall permit HHSC access to interview members of the governing body, personnel, and residents, including the opportunity to request a written statement.

(i) A facility shall permit HHSC to inspect and copy any requested information, unless prohibited by law. If it is necessary for HHSC to remove documents or other records from the facility, HHSC provides a written description of the information being removed and when it is expected to be returned. HHSC makes a reasonable effort, consistent with the circumstances, to return any records removed in a timely manner.

(j) HHSC shall maintain the confidentiality of facility records as applicable under state and federal law.

(k) Upon entry, the HHSC representative holds an entrance conference with the facility's designated representative to explain the nature, scope, and estimated duration of the investigation.

(l) The HHSC representative holds an exit conference with the facility representative to inform the facility representative of any preliminary findings of the investigation. The facility may provide any final documentation regarding compliance during the exit conference.

(m) Once an investigation is complete, HHSC reviews the evidence from the investigation to evaluate whether there is a preponderance of evidence supporting the allegations contained in the complaint.

(n) HHSC notifies complainants regarding the investigation's outcome within 10 business days after completing the investigation.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 1, 2024.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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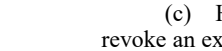

SUBCHAPTER F. ENFORCEMENT

26 TAC §506.71, §506.73

STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation of and provision services by the health and human services agencies, and Texas Health and Safety Code §248.026, which requires HHSC to adopt rules that establish minimum standards for special care facilities.

§506.71. License Denial, Suspension, Revocation and Probation.

(a) Enforcement is a process by which a sanction is proposed, and if warranted, imposed on an applicant or licensee regulated by the Texas Health and Human Services Commission (HHSC) for failure to comply with applicable statutes, rules, and orders.

(b) Denial, suspension or revocation of a license or imposition of an administrative penalty. HHSC has jurisdiction to enforce violations of Health and Safety Code (HSC) Chapter 248 (relating to Special Care Facilities) and this chapter. HHSC may deny, suspend, or revoke a license or impose an administrative penalty for:

(1) failure to comply with any applicable provision of the HSC, including Chapter 248;

(2) failure to comply with any provision of this chapter or any other applicable laws;

(3) the facility, or any of its employees, committing an act which causes actual harm or risk of harm to the health or safety of a resident;

(4) the facility, or any of its employees, materially altering any license issued by HHSC;

(5) failure to comply with minimum standards for licensure;

(6) failure to provide a complete license application;

(7) failure to comply with an order of the HHSC executive commissioner or another enforcement procedure under HSC Chapter 248;

(8) a history of failure to comply with the applicable rules relating to resident environment, health, safety, and rights;

(9) the facility aiding, committing, abetting, or permitting the commission of an illegal act;

(10) the facility, or any of its employees, committing fraud, misrepresentation, or concealment of a material fact on any documents required to be submitted to HHSC or required to be maintained by the facility pursuant to HSC Chapter 248 and the provisions of this chapter;

(11) failure to timely pay an assessed administrative penalty as required by HHSC;

(12) failure to submit an acceptable plan of correction for cited deficiencies within the timeframe required by HHSC;

(13) failure to timely implement plans of corrections to deficiencies cited by HHSC within the dates designated in the plan of correction; or

(14) failure to comply with applicable requirements within a designated probation period.

(c) HHSC may deny a person or entity a license or suspend or revoke an existing license on the grounds that the person or entity has been convicted of a felony or misdemeanor that directly relates to the duties and responsibilities of the ownership or operation of a facility.

(1) In determining whether a criminal conviction directly relates, HHSC shall apply the requirements and consider the provisions of Texas Occupations Code Chapter 53.

(2) The following felonies and misdemeanors directly relate to the duties and responsibilities of the ownership or operation of a health care facility because these criminal offenses indicate an ability or a tendency for the person to be unable to own or operate a facility:

(A) a misdemeanor violation of HSC Chapter 248;

(B) a misdemeanor or felony involving moral turpitude;

(C) a misdemeanor or felony relating to deceptive business practice;

(D) a misdemeanor or felony of practicing any health-related profession without a required license;

(E) a misdemeanor or felony under any federal or state law relating to drugs, dangerous drugs, or controlled substances;

(F) a misdemeanor or felony under Texas Penal Code (TPC) Title 5, involving a patient, resident, or client of any health care facility, a home and community support services agency, or a health care professional;

(G) a misdemeanor or felony under TPC:

(i) Title 4;

(ii) Title 5;

(iii) Title 7;

(iv) Title 8;

(v) Title 9;

(vi) Title 10; or

(vii) Title 11.

(3) Offenses listed in paragraph (2) of this subsection are not exclusive in that HHSC may consider similar criminal convictions from other state, federal, foreign or military jurisdictions that indicate an inability or tendency for the person to be unable to own or operate a facility.

(d) HHSC shall revoke a license on the licensee's imprisonment following a felony conviction, felony community supervision revocation, revocation of parole, or revocation of mandatory supervision.

(e) If HHSC proposes to deny, suspend, or revoke a license, or impose an administrative penalty, HHSC shall send a notice of the proposed action by certified mail, return receipt requested, at the address shown in the current records of HHSC, or HHSC may personally deliver the notice. The notice to deny, suspend, or revoke a license, or impose an administrative penalty, shall state the alleged facts or conduct to warrant the proposed action, provide an opportunity to demonstrate or achieve compliance, and shall state that the applicant or license holder has an opportunity for a hearing before taking the action.

(f) Within 20 calendar days after receipt of the notice, the applicant or licensee may notify HHSC, in writing, of acceptance of HHSC's determination or request a hearing.

(g) A request for a hearing by the applicant or licensee shall be in writing and submitted to HHSC within 20 calendar days after receipt of the notice. Receipt of the notice is presumed to occur on the third day after the date HHSC mails the notice to the last known address of the applicant or licensee.

(1) A hearing shall be conducted pursuant to Texas Government Code Chapter 2001 and Texas Administrative Code Title 1 Chapter 357, Subchapter I (relating to Hearings Under the Administrative Procedure Act).

(2) If an applicant or licensee does not request a hearing in writing within 20 calendar days after receiving the notice of the proposed action described in subsection (e) of this section, the applicant or licensee is deemed to have waived the opportunity for a hearing and HHSC shall take the proposed action.

(h) HHSC may issue an emergency order to suspend a license effective immediately when HHSC has reasonable cause to believe that the conduct of a license holder creates an immediate danger to public health and safety. HHSC shall notify the facility of the emergency action by mail or personal delivery of the notice. On written request of the license holder to HHSC for a hearing, HHSC refers the matter to the State Office of Administrative Hearings.

(i) In lieu of denying, suspending, or revoking the license, HHSC may place the facility on probation for a period of not less than 30 days, if HHSC finds that the facility is in repeated non-compliance with this chapter or HSC Chapter 248, and the facility's noncompliance does not endanger the public's health and safety.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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CHAPTER 510. PRIVATE PSYCHIATRIC HOSPITALS AND CRISIS STABILIZATION UNITS

The Texas Health and Human Services Commission (HHSC) adopts amendments to §510.1, concerning Purpose; §510.2, concerning Definitions; §510.21, concerning General; §510.22, concerning Application and Issuance of Initial License; §510.23, concerning Application and Issuance of Renewal License; §510.24, concerning Change of Ownership; §510.25, concerning Time Periods for Processing and Issuing Licenses; §510.26, concerning Fees; §510.41, concerning Facility Functions and Services; §510.42, concerning Discrimination or Retaliation Standards; §510.43, concerning Patient Transfer Policy; §510.46, concerning Abuse and Neglect Issues; §510.61, concerning Patient Transfer Agreements; §510.62, concerning Cooperative Agreements; §510.101, concerning Fire Prevention and Protection; §510.121, concerning Requirements for Buildings in which Existing Licensed Facilities are Located; §510.122, concerning New Construction Requirements; §510.123, concerning Spatial Requirements for New Construction; §510.125, concerning Building with Multiple Occupancies; §510.127, concerning Preparation, Submittal, Review and Approval of Plans; §510.128, concerning Construction, Surveys, and Approval of Project; §510.129, concerning Waiver Requests, and §510.131, concerning Tables.

Amended §§510.1, 510.2, 510.21 - 510.26, 510.41 - 510.43, 510.61, 510.62, 510.101, 510.121, 510.125 - 510.129, and 510.131 are adopted without changes to the proposed text as published in the May 10, 2024, issue of the *Texas Register* (49 TexReg 3129). These rules will not be republished.

Amended §§510.46, 510.122, and 510.123 are adopted with changes to the proposed text as published in the May 10, 2024,

issue of the *Texas Register* (49 TexReg 3129). These rules will be republished.

BACKGROUND AND JUSTIFICATION

The adoption is necessary to correct cross-references throughout 26 TAC Chapter 510 after the rules were administratively transferred from 25 TAC Chapter 134 to 26 TAC Chapter 510. These non-substantive amendments will maintain accurate references to 25 TAC and 26 TAC. The amendments also correct outdated citations and references to programs that no longer exist; update language to reflect current HHSC organization; and increase consistency with statute, HHSC rules, and HHSC rulemaking guidelines.

COMMENTS

The 31-day comment period ended June 10, 2024.

During this period, HHSC received 26 comments regarding the proposed rules from five commenters, including Citizens Commission on Human Rights (CCHR), Disability Rights Texas (DRTx), International Association of Plumbing and Mechanical Officials Group Texas (IAPMO), Texas Council for Developmental Disabilities (TCDD), and Texas Medical Association (TMA). A summary of comments relating to the rules and HHSC's responses follow.

Comment: CCHR and TCDD recommended HHSC revise the crisis stabilization unit definition at §510.2(6) to allow for the admission of persons under detention and increase consistency with current 26 TAC §306.51(6).

Response: HHSC declines to revise §510.2(6) at this time because this revision is beyond the scope of this rule project.

Comment: DRTx expressed support for HHSC removing the outdated terms "learning disability" and "mental retardation," and recommended HHSC add a definition for "intellectual and developmental disability (IDD)" in §510.2 to ensure the rules apply to individuals with a dual diagnosis of mental illness and IDD.

Response: HHSC declines to add a definition in §510.2 as recommended because this revision is beyond the scope of this rule project.

Comment: DRTx and TCDD recommended HHSC retain the medical error, reportable event, and root cause analysis definitions in §510.2 that HHSC removed in the proposed amended rules.

Response: HHSC declines to reinstate the medical error, reportable event, and root cause analysis definitions in §510.2 because these terms are no longer used in 26 TAC Chapter 510. These definitions related to the patient safety program, which was created by House Bill (H.B.) 1614, 78th Legislature, Regular Session, 2003, and the requirements set forth by H.B. 1614 expired in 2007.

Comment: TCDD recommended HHSC revise §510.21(b)(1) to list all statutes and rules that apply to private psychiatric hospitals and crisis stabilization units and are enforced or enforceable.

Response: HHSC declines to revise §510.21(b)(1) at this time because this revision is beyond the scope of this rule project.

Comment: CCHR, DRTx, and TCDD recommended HHSC revise §510.41(g)(6) to include language regarding voluntary admission, discharge requests, and legal paperwork such as court orders. CCHR and TCDD also recommended HHSC add language in §510.41(g)(6) to include estimates of charges.

Response: HHSC declines to revise §510.41(g)(6) at this time because this revision is beyond the scope of this rule project.

Comment: DRTx recommended HHSC revise §510.45 to retain the phrase "in writing" to provide clarity in how the facility must provide the information to the complainant.

Response: HHSC declines to revise §510.45 at this time because this revision is beyond the scope of this rule project as §510.45 is not included in this project.

Comment: CCHR, DRTx, and TCDD recommended HHSC revise §510.46(c)(2) by adding the contact information for the state's Protection and Advocacy System to the posting requirements for complaints.

Response: HHSC declines to revise §510.46(c)(2) because this paragraph is specific to reporting allegations under Texas Health and Safety Code §161.132. HHSC notes this paragraph does not preclude a facility from combining the signage with other required postings.

Comment: DRTx recommended HHSC revise §510.46(c)(3)(A) and §510.46(c)(3)(B) to specify when to refer allegations of abuse, neglect, or exploitation to law enforcement versus HHSC for investigation.

Response: HHSC declines to revise §510.46(c)(3)(A) and §510.46(c)(3)(B) because §510.46(g)(4) contains the requirements for referring allegations to other agencies, including law enforcement. HHSC notes a facility must also comply with the abuse, neglect, and exploitation reporting requirements under HSC §161.132, Texas Family Code Chapter 261, Texas Human Resources Code Chapter 48, and Texas Civil Practice and Remedies Code §81.006.

Comment: TMA expressed its concern about the timeframe requirements in §510.46(c)(3)(A) and (B) for reporting abuse, neglect, and exploitation and illegal, unprofessional, or unethical conduct because these timeframes may not always be possible or practical. TMA further stated these timeframes may discourage physicians and providers from even looking for signs of abuse, neglect, and exploitation and illegal, unprofessional, or unethical conduct because they may fear being held responsible for reporting under these timeframes or encourage overreporting. TMA recommended against HHSC adopting the proposed reporting timeframe requirements or any finite reporting time limits. TMA also recommended HHSC revert to the "as soon as possible" language stated in HSC §161.132.

Response: HHSC revises §510.46(c)(3)(A) and (B) by removing the 24- and 48-hour reporting timeframe requirements.

Comment: DRTx and TCDD recommended HHSC revise §510.46(e) by adding the HHSC Complaint Intake toll-free number.

Response: HHSC declines to add the toll-free number in §510.46(e) because it is subject to change, leaving an incorrect number in the rule until updated, but revises §510.46(a) to clarify HHSC Complaint and Incident Intake is the appropriate HHSC contact for complaints related to abuse, neglect, and exploitation and illegal, unethical, and unprofessional conduct.

Comment: Regarding §510.46(f)(1), DRTx recommended HHSC revise §510.46(f)(1)(A) and §510.46(f)(1)(B) to ensure the reporter is advised of any appeals process. TCDD recommended HHSC revise §510.46(f)(1)(A) to ensure the reporter is advised of any appeals process and §510.46(f)(1)(B) to ensure

the alleged victim, alleged victim's parent or guardian is also advised of any appeals process.

Response: HHSC declines to revise §510.46(f) at this time because this revision is beyond the scope of this rule project.

Comment: Regarding §510.46(g)(4), CCHR recommended HHSC revise §510.46(g)(4) to clarify HHSC will not investigate a complaint containing allegations that are not a violation of the HSC, including Chapters 571 through 578, Chapter 161.132, 321, 322, or 26 TAC Chapter 510 but shall be referred to law enforcement agencies or other agencies, as appropriate. TCDD stated §510.46(g)(4) lacks language that makes clear that law enforcement should be contacted immediately given that abuse, neglect, and sexual abuse are criminal matters and recommended HHSC revise §510.46(g)(4) to clarify what the proposed §510.46(g)(4) means.

Response: HHSC declines to revise §510.46(g)(4) at this time because these revisions are beyond the scope of this rule project.

Comment: IAPMO recommended HHSC consider adopting the 2024 National Standard Plumbing Code (NSPC) in Subchapter G of this chapter.

Response: HHSC declines to revise Subchapter G at this time because this revision is beyond the scope of this rule project. HHSC notes the agency may incorporate the 2024 NSPC into future rule projects.

Comment: IAPMO recommended HHSC revise §510.122(d)(4) and §510.123 (d)(4)(B) to update the references to the National Association of Plumbing-Heating-Cooling Contractors (PHCC) to the International Association of Plumbing and Mechanical Officials (IAPMO) because PHCC transferred ownership of the National Standard Plumbing Code to IAPMO in 2017, and therefore references to PHCC are outdated.

Response: HHSC revises §510.122(d)(4) and §510.123(d)(4)(B) by replacing PHCC with IAPMO.

SUBCHAPTER A. GENERAL PROVISIONS

26 TAC §510.1, §510.2

STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and HSC §577.010, which requires HHSC to adopt rules and standards necessary and appropriate to ensure the proper care and treatment of patients in a private mental hospital or mental health facility.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER B. APPLICATION AND ISSUANCE OF A LICENSE

26 TAC §§510.21 - 510.26

STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and HSC §577.010, which requires HHSC to adopt rules and standards necessary and appropriate to ensure the proper care and treatment of patients in a private mental hospital or mental health facility.

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SUBCHAPTER C. OPERATIONAL REQUIREMENTS

26 TAC §§510.41 - 510.43, 510.46

STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and HSC §577.010, which requires HHSC to adopt rules and standards necessary and appropriate to ensure the proper care and treatment of patients in a private mental hospital or mental health facility.

§510.46. Abuse and Neglect Issues.

(a) Reporting. Incidents of abuse, neglect, exploitation, or illegal, unethical or unprofessional conduct shall be reported to Texas Health and Human Services Commission (HHSC) Complaint and Incident Intake as provided in subsections (b) and (c) of this section.

(b) Abuse or neglect of a child, and abuse, neglect, or exploitation of an elderly or disabled person. The following definitions apply only to this subsection.

(1) Abuse or neglect of a child, as defined in 25 TAC §1.204(a) and (b) (relating to Abuse, Neglect, and Exploitation Defined).

(2) Abuse, neglect, or exploitation of an elderly or disabled person, as defined in 25 TAC §1.204(a) - (c).

(c) Abuse and neglect of individuals with mental illness, and illegal, unethical, and unprofessional conduct. The requirements of this subsection are in addition to the requirements of subsection (b) of this section.

(1) Definitions. The following definitions are in accordance with Texas Health and Safety Code (HSC) §161.131 and apply only to this subsection.

(A) Abuse--

(i) Abuse (as the term is defined in United States Code (USC) Title 42 Chapter 114 is any act or failure to act by an employee of a facility rendering care or treatment which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with mental illness, and includes acts such as:

(I) the rape or sexual assault of an individual with mental illness;

(II) the striking of an individual with mental illness;

(III) the use of excessive force when placing an individual with mental illness in bodily restraints; and

(IV) the use of bodily or chemical restraints on an individual with mental illness which is not in compliance with federal and state laws and regulations.

(ii) In accordance with HSC §161.132(j), abuse also includes coercive or restrictive actions that are illegal or not justified by the patient's condition and that are in response to the patient's request for discharge or refusal of medication, therapy, or treatment.

(B) Illegal conduct--Illegal conduct (as the term is defined in HSC §161.131(4)) is conduct prohibited by law.

(C) Neglect--Neglect (as the term is defined in 42 USC §10801 et seq.) is a negligent act or omission by any individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to an individual with mental illness or which placed an individual with mental illness at risk of injury or death, and includes an act or omission such as the failure to establish or carry out an appropriate individual program plan or treatment plan for an individual with mental illness, the failure to provide adequate nutrition, clothing, or health care to an individual with mental illness, or the failure to provide a safe environment for an individual with mental illness, including the failure to maintain adequate numbers of appropriately trained staff.

(D) Unethical conduct--Unethical conduct (as the term is defined in HSC §161.131(11)) is conduct prohibited by the ethical standards adopted by state or national professional organizations for their respective professions or by rules established by the state licensing agency for the respective profession.

(E) Unprofessional conduct--Unprofessional conduct (as the term is defined in HSC §161.131(12)) is conduct prohibited under rules adopted by the state licensing agency for the respective profession.

(2) Posting requirements. A facility shall prominently and conspicuously post for display in a public area that is readily visible to patients, residents, volunteers, employees, and visitors a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with HSC §161.132(e). The statement shall be in English and in a second language appropriate to the demographic makeup of the community served and contain the number of the current toll-free telephone number for submitting a complaint to HHSC as specified on the HHSC website.

(3) Reporting responsibility.

(A) Reporting abuse and neglect. A person, including an employee, volunteer, or other person associated with the facility who reasonably believes or who knows of information that would reasonably cause a person to believe that the physical or mental health or welfare of a patient of the facility who is receiving mental health or chemical dependency services has been, is, or will be adversely affected by abuse or neglect (as those terms are defined in this subsection) by any person shall as soon as possible, report the information supporting the belief to HHSC or to the appropriate state health care regulatory agency in accordance with HSC §161.132(a).

(B) Reporting illegal, unprofessional, or unethical conduct. An employee of or other person associated with a facility including a health care professional, who reasonably believes or who knows of information that would reasonably cause a person to believe that the facility or an employee or health care professional associated with the facility, has, is, or will be engaged in conduct that is or might be illegal, unprofessional, or unethical and that relates to the operation of the facility or mental health or chemical dependency services provided in the facility shall as soon as possible, report the information supporting the belief to HHSC or to the appropriate state health care regulatory agency in accordance with HSC §161.132(b).

(4) Training requirements. A facility providing mental health or substance use services shall comply with §568.121 of this title (relating to Staff Member Training) to all employees and associated health care professionals who are assigned to or who provide services in the facility.

(d) Investigations. A complaint under this subsection will be investigated or referred by HHSC as follows.

(1) Allegations under subsection (b) of this section will be investigated in accordance with 25 TAC §1.205 (relating to Reports and Investigations) and 25 TAC §1.206 (relating to Completion of Investigation).

(2) Allegations under subsection (c) of this section will be investigated in accordance with §510.83 of this chapter (relating to Complaint Investigations). Allegations concerning a health care professional's failure to report abuse and neglect or illegal, unprofessional, or unethical conduct will not be investigated by HHSC but will be referred to the individual's licensing board for appropriate disciplinary action.

(3) Allegations under both subsections (b) and (c) will be investigated in accordance with 25 TAC §§1.205 and 1.206 except as noted in paragraph (2) of this subsection concerning a health care professional's failure to report.

(e) Submission of complaints. A complaint made under this section shall be submitted in writing or orally to HHSC.

(f) Notification.

(1) For complaints under subsection (b) of this section, HHSC shall provide notification according to the following:

(A) HHSC shall notify the reporter, if known, in writing of the outcome of the complete investigation.

(B) HHSC shall notify the alleged victim, and the alleged victim's parent or guardian if a minor, in writing of the outcome of the completed investigation.

(2) For complaints under subsection (c) of this section, HHSC shall inform, in writing, the complainant who identifies themselves by name and address of the following:

(A) the receipt of the complaint;

(B) if the complainant's allegations are potential violations of this chapter warranting an investigation;

(C) whether the complaint will be investigated by HHSC;

(D) whether and to whom the complaint will be referred; and

(E) the findings of the complaint investigation.

(g) HHSC reporting and referral.

(1) Reporting health care professional to licensing board.

(A) In cases of abuse, neglect, or exploitation, as those terms are defined in subsection (b), by a licensed, certified, or registered health care professional, HHSC may forward a copy of the completed investigative report to the state agency which licenses, certifies or registers the health care professional. Any information which might reveal the identity of the reporter or any other patients or clients of the facility must be blacked out or deidentified.

(B) A health care professional who fails to report abuse and neglect or illegal, unprofessional, or unethical conduct as required by subsection (c)(3) of this section may be referred by HHSC to the individual's licensing board for appropriate disciplinary action.

(2) Sexual exploitation reporting requirements. In addition to the reporting requirements described in subsection (c)(3) of this section, a mental health services provider must report suspected sexual exploitation in accordance with Texas Civil Practice and Remedies Code §81.006.

(3) Referral follow-up. HHSC shall request a report from each referral agency of the action taken by the agency six months after the referral.

(4) Referral of complaints. A complaint containing allegations which are not a violation of HSC Chapters 571 through 577 or this chapter will not be investigated by HHSC but shall be referred to law enforcement agencies or other agencies, as appropriate.

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SUBCHAPTER D. VOLUNTARY AGREEMENTS

26 TAC §510.61, §510.62

STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and HSC §577.010, which requires HHSC to adopt rules and standards necessary and appropriate to ensure the proper care and treatment of patients in a private mental hospital or mental health facility.

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SUBCHAPTER F. FIRE PREVENTION AND SAFETY REQUIREMENTS

26 TAC §510.101

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and HSC §577.010, which requires HHSC to adopt rules and standards necessary and appropriate to ensure the proper care and treatment of patients in a private mental hospital or mental health facility.

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SUBCHAPTER G. PHYSICAL PLANT AND CONSTRUCTION REQUIREMENTS

26 TAC §§510.121 - 510.123, 510.125, 510.127 - 510.129, 510.131

STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and HSC §577.010, which requires HHSC to adopt rules and standards necessary and appropriate to ensure the proper care and treatment of patients in a private mental hospital or mental health facility.

§510.122. New Construction Requirements.

(a) Facility location. Any proposed new facility shall be easily accessible to the community and to service vehicles such as delivery trucks, ambulances, and fire protection apparatus. No building may be converted for use as a facility which, because of its location, physical condition, state of repair, or arrangement of facilities, would be hazardous to the health and safety of the patients.

(1) Hazardous locations.

(A) Underground and above ground hazards. New facilities or additions to existing facilities shall not be built within 125 feet of right away/easement of hazardous locations including underground liquid butane or propane, liquid petroleum or natural gas transmission lines, high pressure lines, and not under high voltage electrical lines.

(B) Fire hazards. New facilities shall not be built within 300 feet of above ground or underground storage tanks containing liquid petroleum or other flammable liquids used in connection with a bulk plant, marine terminal, aircraft refueling, bottling plant of a liquefied petroleum gas installation, or near other hazardous or hazard producing plants.

(2) Undesirable locations.

(A) Nuisance producing sites. New facilities shall not be located near nuisance producing industrial sites, feed lots, sanitary landfills, or manufacturing plants producing excessive noise or air pollution.

(B) Cemeteries. New facilities shall not be located near a cemetery in a manner that allows direct view of the cemetery from patient windows.

(C) Flood plains. Construction of new facilities shall be avoided in designated flood plains. Where such is unavoidable, access and required functional facility components shall be constructed above the designated flood plain. This requirement also applies to new additions to existing facilities or portions of facilities which have been licensed previously as facilities but which have been vacated or used for purposes other than facilities. This requirement does not apply to remodeling of existing licensed facilities.

(D) Airports. Construction of new facilities shall be avoided in close proximity to airports. When facilities are proposed to be located near airports, recommendations of the Texas Aviation Authority and the Federal Aviation Authority shall apply. A facility may not be constructed within a rectangular area formed by lines perpendicular to and two miles (10,560 feet) from each end of any runway and by lines parallel to and one-half mile (2,640 feet) from each side of any runway.

(b) Environmental considerations. Development of a facility site and facility construction shall be governed by state and local regulations and requirements with respect to the effect of noise and traffic on the community and the environmental impact on air and water.

(c) Facility site.

(1) Paved roads and walkways. Paved roads shall be provided within the lot lines to provide access from public roads to the main entrance, entrances serving community activities, and to service entrances, including loading and unloading docks for delivery trucks. Finished surface walkways shall be provided for pedestrians.

(2) Parking. Off-street parking shall be available for visitors, employees, and staff. Parking structures directly accessible from a facility shall be separated with two-hour fire rated noncombustible construction. When used as required means of egress for facility occupants, parking structures shall comply with National Fire Protection Association 88A, Standard for Parking Structures, 1998 edition. This requirement does not apply to freestanding parking structures.

(A) Number of parking places. In the absence of a formal parking study, one parking space shall be provided for each day shift employee plus one space for one and one-half patient beds. This ratio may be reduced in an area convenient to a public transportation system or to public parking facilities on the basis of a formal parking study. Parking shall be increased accordingly when the size of an existing facility is increased.

(B) Additional parking. Additional parking shall be required to accommodate medical staff, outpatient and other services when such services are provided.

(C) Delivery parking. Separate parking facilities shall be provided for delivery vehicles.

(D) Accessible parking. Parking spaces for persons with disabilities shall be provided in accordance with the Americans with Disabilities Act (ADA) of 1990, Public Law 101-336, 42 United States Code, Chapter 126, and Title 36 Code of Federal Regulations, Part 1191, Appendix A, Accessibility Guidelines for Buildings and Facilities.

(d) Building design and construction requirements. Every building and every portion thereof shall be designed and constructed to sustain all dead and live loads in accordance with accepted engineering practices and standards and the local governing building codes. Where there is no local governing building code, one of the following codes shall be adhered to: Uniform Building Code, 1999 edition, published by the International Conference of Building Officials.

(1) General architectural requirements. All new construction, including conversion of an existing building to a facility, establishing a separately licensed facility in a building with an existing licensed health care occupancy, and establishing a licensed facility in a non-health care occupancy shall comply with Chapter 18 of the National Fire Protection Association 101, Code for Safety to Life from Fire in Buildings and Structures, 2000 edition (NFPA 101), and Subchapters F and G of this chapter (relating to Fire Prevention and Safety Requirements and Physical Plant and Construction Requirements, respectively). The facility shall comply with the requirements of this paragraph and any specific architectural requirements for the particular unit or suite of the facility in accordance with §510.123 of this subchapter (relating to Spatial Requirements for New Construction).

(A) Special design provisions. Special provisions shall be made in the design of a facility in regions where local experience shows loss of life or extensive damage to buildings resulting from hurricanes, tornadoes, or floods.

(B) Foundations. Foundations shall rest on natural solid bearing if satisfactory bearing is available. Proper soil-bearing values shall be established in accordance with recognized requirements. If solid bearing is not encountered at practical depths, the structure shall be supported on driven piles or drilled piers designed to support the intended load without detrimental settlement, except that one-story buildings may rest on a fill designed by a soils engineer. When engineered fill is used, site preparation and placement of fill shall be done under the direct full-time supervision of the soils engineer. The soils engineer shall issue a final report on the compacted fill operation and certification of compliance with the job specifications. All footings shall extend to a depth not less than one foot below the estimated maximum frost line.

(C) Physical environment. A physical environment that protects the health and safety of patients, personnel, and the public shall be provided in each facility. The physical premises of the facility and those areas of the facility's physical structure that are used by the patients (including all stairwells, corridors, and passageways) shall meet the local building and fire safety codes and subchapters F and G of this chapter.

(D) Construction type. A facility may occupy an entire building or a portion of a building, provided the facility portion of the building is separated from the rest of the building in accordance with subparagraph (E) of this paragraph and the entire building or the facility portion of the building complies with new construction requirements (type of construction permitted for facilities by NFPA 101, §18-1.6.2), and the entire building is protected with a fire sprinkler system conforming with requirements of National Fire Protection Association 13, Standard for the Installation of Sprinkler Systems, 1999 Edition (NFPA 13).

(E) Separate buildings. Portions of a building divided horizontally with two-hour fire rated walls which are continuous (without offsets) from the foundation to above the roof shall be considered as a separate building. Communicating openings in the two-hour wall shall be limited to public spaces such as lobbies and corridors. All such openings shall be protected with self-closing one and one-half hour, Class B fire door assemblies.

(F) Design for people with disabilities. Special considerations benefiting staff, visitors, and patients with disabilities shall be provided. Each facility shall comply with the Americans with Disabilities Act (ADA) of 1990, Public Law 101-336, 42 United States Code, Chapter 126, and Title 36 Code of Federal Regulations, Part 1191, Appendix A, Accessibility Guidelines for Buildings and Facilities.

(G) Other regulations. Certain projects may be subject to other regulations, including those of federal, state, and local authorities. The more stringent standard or requirement shall apply when a difference in requirements for construction exists.

(H) Exceeding minimum requirements. Nothing in this subchapter shall be construed to prohibit a better type of building construction, more exits, or otherwise safer conditions than the minimum requirements specified in this subchapter.

(I) Equivalency. Nothing in this subchapter is intended to prevent the use of systems, methods, or devices of equivalent or superior quality, strength, fire resistance, effectiveness, durability, and safety to those prescribed by this subchapter, providing technical documentation which demonstrates equivalency is submitted to the department for approval.

(J) Freestanding buildings (not for patient use). Separate freestanding buildings for nonpatient use such as the heating plant, boiler plant, laundry, repair workshops, or general storage may be of unprotected non-combustible construction, protected non-combustible construction, or fire-resistive construction and be designed in accordance with other occupancy classifications requirements listed in NFPA 101.

(K) Freestanding buildings (for patient use other than sleeping). Buildings containing areas for patient use which do not contain patient sleeping areas and in which care or treatment is rendered to ambulatory inpatients who are capable of judgment and appropriate physical action for self-preservation under emergency conditions, may be classified as ambulatory health care occupancies or business occupancies as listed in NFPA 101 Chapters 20 and 38, respectively, instead of facility occupancy. Such buildings shall be located at least 20 feet from the facility unless protected by an approved automatic sprinkler system.

(L) Energy conservation. In new construction and in major alterations and additions to existing buildings and in new buildings, electrical and mechanical components shall be selected for efficient utilization of energy.

(2) General detail and finish requirements. Details and finishes in new construction projects, including additions and alterations, shall be in compliance with this paragraph, with NFPA 101, Chapter 18, with local building codes, and with any specific detail and finish requirements for the particular unit or suite as contained in §510.123 of this subchapter.

(A) General detail requirements.

(i) Fire safety. Fire safety features, including compartmentation, means of egress, automatic extinguishing systems, inspections, smoking regulations, and other details relating to fire prevention and fire protection shall comply with §510.121 of this subchapter (relating to Requirements for Buildings in which Existing Licensed Facilities are Located), and NFPA 101 Chapter 18 requirements for facilities. The Fire Safety Evaluation System for Health Care Occupancies contained in the National Fire Protection Association 101A, Alternative Approaches to Life Safety, 1998 edition, Chapter 3, shall not be used in new building construction, renovations, or additions to existing facilities.

(ii) Access to exits. Corridors providing access to all patient, diagnostic, treatment, and sleeping rooms and exits shall be at least six feet in clear and unobstructed width (except as allowed by NFPA 101, §18-2.3.3, Exceptions 1 and 2), not less than 7 feet 6 inches in height, and constructed in accordance with requirements listed in NFPA 101 §18-3.6.

(iii) Corridors in other occupancies. Public corridors in outpatient, administrative, and service areas which are designed to other than facility requirements and are the required means of egress from the facility shall be not less than five feet in width.

(iv) Encroachment into the means of egress. Items such as drinking fountains, telephone booths or stations, and vending machines shall be so located as to not project into and restrict exit corridor traffic or reduce the exit corridor width below the required minimum. Portable equipment shall not be stored so as to project into and restrict exit corridor traffic or reduce the exit corridor width below the required minimum.

(v) Doors in means of egress. All door leaves in the means of egress shall be not less than 36 inches wide or as otherwise permitted for facilities by NFPA 101 §18-2.3.5.

(vi) Sliding doors. When sliding doors are provided to a means of egress corridor, the sliding doors shall have break-away

provisions, positive latching devices, and shall be installed to resist passage of smoke.

(vii) Control doors. Designs that include cross-corridor control doors should be avoided. When unavoidable, cross-corridor control doors shall consist of two 32-inch wide leaves which swing in a direction opposite from the other, or of the double acting type, and be provided with view panels.

(viii) Emergency access. Rooms containing bathtubs, showers, or water closets, intended for patient use shall be provided with at least one outswinging door or special frame and hardware which will permit the door to swing out for staff access to a patient who may have collapsed against the door. The width of such doors shall not be less than 36 inches.

(ix) Obstruction of corridors. All doors which swing towards the corridor must be recessed. Corridor doors to rooms not subject to occupancy (any room that you can walk into and close the door behind you is considered occupiable) may swing into the corridor, provided that such doors comply with the requirements of NFPA 101 §7-2.1.4.3.

(x) Stair landing. Doors shall not open immediately onto a stair without a landing. The landing shall be 44 inches deep or have a depth at least equal to the door width, whichever is greater.

(xi) Doors to rooms subject to occupancy. All doors to rooms subject to occupancy shall be of the swing type except that horizontal sliding doors complying with the requirements of NFPA 101 §18-2.2.2.9 are permitted. Door leaves to rooms subject to occupancy shall not be less than 36 inches wide unless noted otherwise.

(xii) Operable windows and exterior doors. Windows that can be opened without tools or keys and outer doors without automatic closing devices shall be provided with insect screens.

(xiii) Glazing. Glass doors, lights, sidelights, borrowed lights, and windows located within 12 inches of a door jamb or with a bottom-frame height of less than 18 inches and a top-frame height of more than 36 inches above the finished floor which may be broken accidentally by pedestrian traffic shall be glazed with safety glass or plastic glazing material that will resist breaking and will not create dangerous cutting edges when broken. Similar materials shall be used for wall openings in activity areas such as recreation and exercise rooms, unless otherwise required for fire safety. Safety glass, tempered or plastic glazing materials shall be used for shower doors and bath enclosures, interior windows and doors. Plastic and similar materials used for glazing shall comply with the flame-spread ratings of NFPA 101 §18-3.3.

(xiv) Fire doors. All fire doors shall be listed by an independent testing laboratory and shall meet the construction requirements for fire doors in National Fire Protection Association 80, Standard for Fire Doors and Fire Windows, 1999 edition. Reference to a labeled door shall be construed to include labeled frame and hardware.

(xv) Elevator doors. Elevator shaft openings shall be protected with a B labeled one-hour fire protection rated doors in buildings less than four stories; and one and one-half hour fire protection rated doors in buildings four or more stories.

(xvi) Elevator lobbies. Elevator lobbies shall have at least 10 feet of clear floor space in front of the elevator doors.

(xvii) Grab bars. Grab bars shall be provided at patient toilets, showers and tubs. The bars shall have sufficient strength and anchorage to sustain a concentrated vertical or horizontal load of 250 pounds. Grab bars are not permitted at bathing and toilet fixtures unless designed and installed to eliminate the possibility of patients harming themselves. Grab bars intended for use by persons with a disability shall also comply with ADA requirements.

(xviii) Soap dishes. Recessed soap dishes shall be provided at all showers and bathtubs.

(xix) Hand washing facilities. Location and arrangement of fittings for hand washing facilities shall permit their proper use and operation. Hand washing fixtures with hands-free operable controls shall be provided within each procedure room, workroom, examination and treatment room and all toilet rooms unless noted otherwise. Hands-free includes blade-type handles, and foot, knee, or sensor operated controls. Particular care shall be given to the clearances required for blade-type operating handles. Lavatories and hand washing facilities shall be securely anchored to withstand an applied vertical load of not less than 250 pounds on the front of the fixture. In addition to the specific areas noted, hand washing facilities shall be provided and conveniently located for staff use throughout the facility where patient care and services are provided.

(xx) Hand drying. Provisions for hand drying shall be included at all hand washing facilities except scrub sinks. There shall be hot air dryers or individual paper or cloth units enclosed in such a way as to provide protection against dust or soil and ensure single unit dispensing.

(xxi) Mirrors. Mirrors shall not be installed at hand washing fixtures where asepsis control and sanitation requirements would be lessened by hair combing.

(xxii) Ceiling heights. The minimum ceiling height shall be eight feet with the following exceptions.

(I) Minor rooms. Ceilings in storage rooms, toilet rooms, and other minor rooms shall be not less than 7 feet 6 inches.

(II) Boiler rooms. Boiler rooms shall have ceiling clearances not less than 2 feet 6 inches above the main boiler header and connecting piping.

(III) Overhead clearance. Suspended tracks, rails, pipes, signs, lights, door closers, exit signs, and other fixtures that protrude into the path of normal traffic shall not be less than 6 feet 8 inches above the finished floor.

(xxiii) Areas producing impact noises. Recreation rooms, exercise rooms, and similar spaces where impact noises may be generated shall not be located directly over patient bed area unless special provisions are made to minimize noise.

(xxiv) Noise reduction. Noise reduction criteria in accordance with the Table 1 in §510.131(a) of this subchapter (relating to Tables) shall apply to partitions, floor, and ceiling construction in patient areas.

(xxv) Rooms with heat producing equipment. Rooms containing heat-producing equipment such as heater rooms, laundries, etc. shall be insulated and ventilated to prevent any occupied floor surface above from exceeding a temperature differential of 10 degrees Fahrenheit above the ambient room temperature.

(xxvi) Chutes. Linen and refuse chutes shall comply with the requirements of National Fire Protection Association 82, Standard on Incinerators and Waste and Linen Handling Systems and Equipment, 1999 edition, and NFPA 101 §18-5.4.

(xxvii) Thresholds and expansion joint covers. Thresholds and expansion joint covers shall be flush with the floor surface to facilitate the use of wheelchairs and carts. Expansion and seismic joints shall be constructed to restrict the passage of smoke and fire and shall be listed by a nationally recognized testing laboratory.

(xxviii) Housekeeping room.

(I) In addition to the housekeeping rooms required in certain suites, sufficient housekeeping rooms shall be provided throughout the facility as required to maintain a clean and sanitary environment.

(II) Each housekeeping room shall contain a floor receptor or service sink and storage space for housekeeping equipment and supplies.

(xxix) Public toilets. In addition to the public toilets required for the main lobby, a public toilet shall be provided convenient to each public and visitor waiting area. This may be a single unisex toilet for small waiting areas.

(B) General finish requirements.

(i) Cubicle curtains and draperies.

(I) Cubicle curtains, draperies and other hanging fabrics shall be noncombustible or flame retardant and shall pass both the small scale and the large scale tests of National Fire Protection Association 701, Standard Methods of Fire Tests for Flame-Resistant Textiles and Films, 1999 edition. Copies of laboratory test reports for installed materials shall be submitted to the Texas Health and Human Services Commission at the time of the final construction inspection.

(II) Cubicle curtains shall be provided to assure patient privacy.

(ii) Flame spread, smoke development and noxious gases. Flame spread and smoke developed limitations of interior finishes shall comply with Table 2 of §510.131(b) of this subchapter and NFPA 101 §10-2.1. The use of materials known to produce large or concentrated amounts of noxious or toxic gases shall not be used in exit accesses or in patient areas. Copies of laboratory test reports for installed materials tested in accordance with National Fire Protection Association 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, 2000 edition, and National Fire Protection Association 258, Standard Research Test Method for Determining Smoke Generation of Solid Materials, 1997 edition, shall be provided.

(iii) Floor finishes. Flooring shall be easy to clean and have wear resistance appropriate for the location involved. Floors that are subject to traffic while wet (such as shower and bath areas, kitchens, and similar work areas) shall have a nonslip surface. In all areas frequently subject to wet cleaning methods, floor materials shall not be physically affected by germicidal and cleaning solutions. The following are acceptable floor finishes:

(I) painted concrete;

(II) vinyl and vinyl composition tiles and sheets;

(III) monolithic or seamless flooring:

(-a-) where required, seamless flooring shall be impervious to water, coved, and installed integral with the base, tightly sealed to the wall, and without voids that can harbor insects or retain dirt particles; and

(-b-) welded joint flooring is acceptable;

(IV) ceramic and quarry tile;

(V) wood floors;

(VI) carpet flooring, which if installed in patient rooms and similar patient care areas, shall be treated to prevent bacterial and fungal growth;

(VII) terrazzo; and

(VIII) poured in place floors.

(iv) Wall finishes. Wall finishes shall be smooth, washable, moisture resistant, and cleanable by standard housekeeping practices. Wall finishes shall comply with requirements contained in Table 2 of §510.131(b) of this subchapter and NFPA 101 §18-3.3.

(I) Wall finishes shall be water resistant in the immediate area of plumbing fixtures.

(II) Wall finishes in areas subject to frequent wet cleaning methods shall be impervious to water, tightly sealed and without voids.

(v) Floor, wall and ceiling penetrations. Floor, wall, and ceiling penetrations by pipes, ducts, and conduits shall be tightly sealed to minimize entry of dirt particles, rodents, and insects. Joints of structural elements shall be similarly sealed.

(vi) Ceiling types. All occupied rooms and spaces shall be provided with finished ceilings. Ceilings which are a part of a rated roof or ceiling assembly or a floor or ceiling assembly shall be constructed of listed components and installed in accordance with the listing. Three types of ceilings that are required in various areas of the facility are the following.

(I) Ordinary ceilings. Ceilings such as acoustical tiles installed in a metal grid which are dry cleanable with equipment used in daily housekeeping activities such as dusters and vacuum cleaners.

(II) Washable ceilings. Ceilings that are made of washable, smooth, moisture impervious materials such as painted lay-in gypsum wallboard or vinyl faced acoustic tile in a metal grid.

(III) Monolithic ceilings. Ceilings which are monolithic from wall to wall (painted solid gypsum wallboard), smooth and without fissures, open joints, or crevices and with a washable and moisture impervious finish.

(vii) Special construction. Special conditions may require special wall and ceiling construction for security in areas such as storage of controlled substances and areas where patients are likely to attempt suicide or escape.

(viii) Materials finishes. Materials known to produce noxious gases when burned shall not be used for mattresses, upholstery, and wall finishes.

(3) General mechanical requirements. This paragraph contains common requirements for mechanical systems; steam and hot and cold water systems; air-conditioning, heating and ventilating systems; plumbing fixtures; piping systems; and thermal and acoustical insulation. The facility shall comply with the requirements of this paragraph and any specific mechanical requirements for the particular unit or suite of the facility in accordance with §510.123 of this subchapter.

(A) Cost. All mechanical systems shall be designed for overall efficiency and life cycle costing, including operational costs. Recognized engineering procedures shall be followed to achieve the most economical and effective results. In no case shall patient care or safety be sacrificed for conservation.

(B) Equipment location. Mechanical equipment may be located indoors or outdoors (when in a weatherproof enclosure), or in separate buildings.

(C) Vibration isolation. Mechanical equipment shall be mounted on vibration isolators as required to prevent unacceptable structure-borne vibration. Ducts, pipes, etc. connected to mechanical equipment which is a source of vibration shall be isolated from the equipment with vibration isolators.

(D) Performance and acceptance. Prior to completion and acceptance of the facility, all mechanical systems shall be tested, balanced, and operated to demonstrate to the design engineer or the design engineer's representative that the installation and performance of these systems conform to the requirements of the plans and specifications.

(i) Material lists. Upon completion of the contract, the owner shall be provided with parts lists and procurement information with numbers and description for each piece of equipment.

(ii) Instructions. Upon completion of the contract, the owner shall be provided with instructions in the operational use of systems and equipment as required.

(E) Heating, ventilating and air conditioning (HVAC) systems. All HVAC systems shall comply with and shall be installed in accordance with the requirements of National Fire Protection Association 90A, Standard for the Installation of Air Conditioning and Ventilating Systems, 1999 edition, (NFPA 90A), NFPA 99, Chapter 5, the requirements contained in this subparagraph, and the specific requirements for a particular unit in accordance with §510.123 of this subchapter.

(i) General ventilation requirements. All rooms and areas in the facility listed in Table 3 of §510.131(c) of this subchapter shall have provision for positive ventilation. Fans serving exhaust systems shall be located at the discharge end and shall be conveniently accessible for service. Exhaust systems may be combined, unless otherwise noted, for efficient use of recovery devices required for energy conservation. The ventilation rates shown in Table 3 of §510.131(c) of this subchapter shall be used only as minimum requirements since they do not preclude the use of higher rates that may be appropriate. Supply air to the building and exhaust air from the building shall be regulated to provide a positive pressure within the building with respect to the exterior.

(I) Cost reduction methods. To reduce utility costs, the building design and systems proposed shall utilize energy conserving procedures including recovery devices, variable air volume, load shedding, systems shut down or reduction of ventilation rates (when specifically permitted) in certain areas when unoccupied, insofar as patient care is not jeopardized.

(II) Economizer cycle. Mechanical ventilation shall be arranged to take advantage of outside air supply by using an economizer cycle when appropriate to reduce heating and cooling systems loads. Innovative design that provides for additional energy conservation while meeting the intent of this section for acceptable patient care will be considered.

(III) Outside air intake locations. Outside air intakes shall be located at least 25 feet from exhaust outlets of ventilating systems, combustion equipment stacks, medical-surgical vacuum systems, plumbing vents, or areas which may collect vehicular exhaust or other noxious fumes. (Prevailing winds and proximity to other structures may require other arrangements.) Plumbing and vacuum vents that terminate five feet above the level of the top of the air intake may be located as close as 10 feet.

(IV) Low air intake location limit. The bottom of outside air intakes serving central systems shall be located as high as practical but at least six feet above ground level, or if installed above the roof, three feet above the roof level.

(V) Contaminated air exhaust outlets. Exhaust outlets from areas (kitchen hoods, ethylene oxide sterilizers, etc.) that exhaust contaminated air shall be above the roof level and arranged to exhaust upward.

(VI) Directional air flow. Ventilation systems shall be designed and balanced to provide directional flow as shown in Table 3 of §510.131(c) of this subchapter. For reductions and shut down of ventilation systems when a room is unoccupied, the provisions in Note 4 of Table 3 of §510.131(c) of this subchapter shall be followed.

(VII) Areas requiring fully ducted systems. Fully ducted supply, return and exhaust air for HVAC systems shall be provided for all general patient care areas and where required for fire safety purposes. Combination systems, utilizing both ducts and plenums for movement of air in these areas shall not be permitted. Such areas include isolation rooms and food preparation areas.

(VIII) Ventilation start-up requirements. Air handling systems shall not be started up and operated without the filters installed in place. This includes the 90% efficiency filters where required. Ducts shall be cleaned thoroughly by an air duct cleaning contractor when the air handling systems have been operating without the required filters in place.

(IX) Humidifier location. When duct humidifiers are located upstream of the final filters, they shall be located at least 15 feet from the filters. Ductwork with duct-mounted humidifiers shall be provided with a means of removing water accumulation. An adjustable high-limit humidistat shall be located downstream of the humidifier to reduce the potential of condensation inside the duct. All duct take-offs should be sufficiently downstream of the humidifier to ensure complete moisture absorption. Reservoir-type water spray or evaporative pan humidifiers shall not be used.

(ii) Filtration requirements. All central air handling systems serving patient care areas, including nursing unit corridors, shall be equipped with filters having efficiencies equal to, or greater than, those specified for those types of areas in Table 4 of §510.131(d) of this subchapter. Filter efficiencies shall be average efficiencies tested in accordance with American Society of Heating, Refrigerating, and Air-conditioning Engineers (ASHRAE), Inc., Standard 52, 1999 edition. All joints between filter segments and between filter segments and the enclosing ductwork, shall have gaskets and seals to provide a positive seal against air leakage. Air handlers serving more than one room shall be considered as central air handlers.

(I) Filtration requirements for air handling units serving single rooms requiring asepsis control. Dedicated air handlers serving only one room where asepsis control is required, including operating rooms, delivery rooms, special procedure rooms, and nurseries shall be equipped with filters having efficiencies equal to, or greater than, those specified for patient care areas in Table 4 of §510.131(d) of this subchapter.

(II) Filtration requirements for air handling units serving other single rooms. Dedicated air handlers serving all other single rooms shall be equipped with nominal filters installed at the return air grille.

(III) Location of multiple filters. Where two filter beds are required by Table 4 of §510.131(d) of this subchapter, filter bed number one shall be located upstream of the air-conditioning equipment and filter bed number two shall be downstream of the supply fan or blowers.

(IV) Location of single filters. Where only one filter bed is required by Table 4 of §510.131(d) of this subchapter, it shall be located upstream of the supply fan. Filter frames shall be durable and constructed to provide an airtight fit with the enclosing ductwork.

(V) Pressure monitoring devices. A manometer or draft gauge shall be installed across each filter bed having a required efficiency of 75% or more including hoods requiring high efficiency particulate air (HEPA) filters.

(iii) Thermal and acoustical insulation for air handling systems. Asbestos insulation shall not be used.

(I) Thermal duct insulation. Air ducts and casings with outside surface temperature below ambient dew point or temperature above 80 degrees Fahrenheit shall be provided with thermal insulation.

(II) Insulation in air plenums and ducts. Linings in air ducts and equipment shall meet the Erosion Test Method described in Underwriters Laboratories, Inc., Standard Number 181.

(III) Insulation flame spread and smoke developed ratings. Interior and exterior insulation, including finishes and adhesives on the exterior surfaces of ducts and equipment, shall have a flame spread rating of 25 or less and a smoke developed rating of 50 or less as required by NFPA 90A Chapters 2 and 3.

(IV) Linings and acoustical traps. Duct lining and acoustical traps exposed to air movement shall not be used in ducts serving critical care areas. This requirement shall not apply to mixing boxes and acoustical traps that have approved nonabrasive coverings over such linings.

(V) Frangible insulation. Insulation of soft and spray-on types shall not be used where it is subject to air currents or mechanical erosion or where loose particles may create a maintenance problem.

(VI) Existing duct linings. Internal linings shall not be used in ducts, terminal boxes, or other air system components supplying operating rooms, delivery rooms, birthing rooms, labor rooms, recovery rooms, nurseries, trauma rooms, isolation rooms, and intensive care units unless terminal filters of at least 90% efficiency are installed downstream of linings.

(iv) Fire damper requirements. Fire dampers shall be located and installed in all ducts at the point of penetration of a two-hour or higher fire rated wall or floor in accordance with the requirements of NFPA 101 §18-5.2.

(v) Smoke damper requirements. Smoke dampers shall be located and installed in accordance with the requirements of NFPA 101 §18-3.7.3, and NFPA 90A Chapter 3.

(I) Fail-safe installation. Smoke dampers shall close on activation of the fire alarm system by smoke detectors installed and located as required by National Fire Protection Association 72, National Fire Alarm Code, 1999 edition (NFPA 72), Chapter 5; NFPA 90A, Chapter 4; and NFPA 101, §18-3.7; the fire sprinkler system; and upon loss of power. Smoke dampers shall not close by fan shut-down alone.

(II) Interconnection of air handling fans and smoke dampers. Air handling fans and smoke damper controls may be interconnected so that closing of smoke dampers will not damage the ducts.

(III) Frangible devices. Use of frangible devices for shutting smoke dampers is not permitted.

(vi) Acceptable damper assemblies. Only fire damper and smoke damper assemblies integral with sleeves and listed for the intended purpose shall be acceptable.

(vii) Duct access doors. Unobstructed access to duct openings in accordance with NFPA 90A §2-3.4, shall be provided in ducts within reach and sight of every fire damper, smoke damper and smoke detector. Each opening shall be protected by an internally insulated door which shall be labeled externally to indicate the fire protection device located within.

(viii) Restarting controls. Controls for restarting fans may be installed for convenient fire department use to assist in evacuation of smoke after a fire is controlled, provided that provisions are made to avoid possible damage to the system because of closed dampers. To accomplish this, smoke dampers shall be equipped with remote control devices.

(ix) Make-up air. If air supply requirements in Table 3 of §510.131(c) of this subchapter do not provide sufficient air for use by exhaust hoods and safety cabinets, filtered make-up air shall be ducted to maintain the required air flow direction in that room. Make-up systems for hoods shall be arranged to minimize short circuiting of air and to avoid reduction in air velocity at the point of contaminant capture.

(4) General piping systems and plumbing fixture requirements. All piping systems and plumbing fixtures shall be designed and installed in accordance with the requirements of the National Standard Plumbing Code, published by the International Association of Plumbing and Mechanical Officials, 2000 edition, and this paragraph.

(A) Piping systems.

(i) Water supply systems. Water service pipe to point of entrance to the building shall be brass pipe, copper tube (not less than type M when buried directly), copper pipe, cast iron water pipe, galvanized steel pipe, or approved plastic pipe. Water distribution system piping within buildings shall be brass pipe, copper pipe, copper tube, or galvanized steel pipe. Piping systems shall be designed to supply water at sufficient pressure to operate all fixtures and equipment during maximum demand.

(I) Valves. Each water service main, branch main, riser, and branch to a group of fixtures shall be valved. Stop valves shall be provided at each fixture.

(II) Backflow preventers. Backflow preventers (vacuum breakers) shall be installed on hose bibbs, laboratory sinks, janitor sinks, bedpan flushing attachments, and on all other fixtures to which hoses or tubing can be attached.

(III) Flushing valves. Flush valves installed on plumbing fixtures shall be of a quiet operating type, equipped with silencers.

(IV) Capacity of water heating equipment. Water heating equipment shall have sufficient capacity to supply water for clinical, dietary and laundry use at the temperatures and amounts specified in Table 5 of §510.131(e) of this subchapter.

(V) Water temperature measurements. Water temperatures shall be measured at hot water point of use or at the inlet to processing equipment.

(VI) Water storage tanks. Water storage tanks shall be fabricated of corrosion-resistant metal or lined with noncorrosive material.

(VII) Hot water distribution. Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times.

(VIII) Emergency water supply. Emergency potable water storage shall be provided. The storage capacity shall

not be less than 500 gallons or 12 gallons per patient bed, whichever is greater. Capacity of hot water storage tanks may be included as part of the required emergency water capacity when valves and piping systems are arranged to make this water available at all times.

(ii) Fire sprinkler systems. Fire sprinkler systems shall be provided in facilities as required by NFPA 101, §18-3.5. All fire sprinkler systems shall be designed, installed, and maintained in accordance with the requirements of NFPA13, and shall be certified as required by §510.127(d)(3)(C) of this subchapter (relating to Preparation, Submittal, Review and Approval of Plans).

(iii) Nonflammable medical gas and clinical vacuum systems. Nonflammable medical gas and clinical vacuum system installations shall be designed, installed and certified in accordance with the requirements of NFPA 99, §4-3 for Level I systems and the requirements of this clause.

(I) Outlets. Nonflammable medical gas and clinical vacuum outlets shall be provided in accordance with Table 6 of §510.131(f) of this subchapter.

(II) Installer qualifications. All installations of the medical gas piping systems shall be done only by, or under the direct supervision of a holder of a master plumber license or a journeyman plumber license with a medical gas piping installation endorsement issued by the Texas State Board of Plumbing Examiners.

(III) Installer tests. Prior to closing of walls, the installer shall perform an initial pressure test, a blowdown test, a secondary pressure test, a cross-connection test, and a purge of the piping system as required by NFPA 99.

(IV) Qualifications for conducting verification tests and inspections. Verification tests and inspections by a party, other than the installer, shall be conducted by individuals who are technically competent and experienced in the field of piped medical gas systems.

(V) Verification tests. Upon completion of the installer inspections and tests and after closing of walls, verification tests of the medical gas piping systems, the warning system, and the gas supply source shall be conducted. The verification tests shall include a cross-connection test, valve test, flow test, piping purge test, piping purity test, final tie-in test, operational pressure tests, and medical gas concentration test.

(VI) Verification test requirements. Verification tests of the medical gas piping system, the warning system, shall be performed on all new piped medical gas systems, additions, renovations, or repaired portions of an existing system. All systems that are breached and components that are added, renovated, or replaced shall be inspected and appropriately tested. The breached portions of the systems subject to inspection and testing shall be all of the new and existing components in the immediate zone or area located upstream of the point or area of intrusion and downstream to the end of the system or a properly installed isolation valve.

(VII) Warning system verification tests. Verification tests of piped medical gas systems shall include tests of the source alarms and monitoring safeguards, master alarm systems, and the area alarm systems.

(VIII) Source equipment verification tests. Source equipment verification tests shall include medical gas supply sources (bulk and manifold) and the compressed air source systems (compressors, dryers, filters, and regulators).

(IX) Written certification. Upon successful completion of all verification tests, written certification for affected piped medical gas systems and piped medical vacuum systems including the supply sources and warning systems shall be provided by a party technically competent and experienced in the field of medical gas pipeline testing stating that the provisions of NFPA 99 have been adhered to and systems integrity has been achieved. The written certification shall be submitted directly to the facility and the installer. A copy shall be forwarded to HHSC by the facility.

(X) Facility responsibility. Before new piped medical gas systems, additions, renovations, or repaired portions of an existing system are put into use, the facility shall be responsible for ensuring that the gas delivered at the outlet is the gas shown on the outlet label and that the proper connecting fittings are checked against their labels.

(XI) Documentation of medical gas and clinical vacuum outlets. Documentation of the installed, modified, extended, or repaired medical gas piping system shall be submitted to HHSC by the same party certifying the piped medical gas systems. The number and type of medical gas outlets (oxygen, vacuum, medical air, nitrogen, nitrous oxide, etc.) shall be documented and arranged tabularly by room numbers and room types.

(iv) Steam and hot water systems.

(I) Boilers. Boilers shall have the capacity, based upon the net ratings as published in The I-B-R Ratings Book for Boilers, Baseboard Radiation and Finned Tube (commercial) by the Hydronics Institute Division of GAMA, to supply the normal requirements of all systems and equipment. The number and arrangement of boilers shall be such that, when one boiler breaks down or routine maintenance requires that one boiler be temporarily taken out of service, the capacity of the remaining boilers shall be sufficient to provide hot water service for clinical, dietary, and patient use, steam for sterilization and dietary purposes, and heating for emergency, recovery, treatment, and general patient rooms. However, reserve capacity for space heating of noncritical care areas (e.g. general patient rooms and administrative areas) is not required in geographical areas where a design dry bulb temperature equals 25 degrees Fahrenheit or higher as based on the 99% design value shown in the Handbook of Fundamentals, 1999 edition, published by ASHRAE, Inc.

(II) Boiler accessories. Boiler feed pumps, heating circulating pumps, condensate return pumps, and fuel oil pumps shall be connected and installed to provide normal and standby service.

(III) Valves. Supply and return mains and risers of cooling, heating, and process steam systems shall be valved to isolate the various sections of each system. Each piece of equipment shall be valved at the supply and return ends except that vacuum condensate returns need not be valved at each piece of equipment.

(v) Drainage systems.

(I) Above ground piping. Soil stacks, drains, vents, waste lines, and leaders installed above ground within buildings shall be drain-waste-vent (DWV) weight or heavier and shall be copper pipe, copper tube, cast iron pipe, or galvanized iron pipe.

(II) Underground piping. All underground building drains shall be cast iron soil pipe, hard temper copper tube (DWV or heavier), acrylonitrile-butodiene-styrene (ABS) plastic pipe (DWV Schedule 40 or heavier), polyvinyl chloride (PVC) plastic pipe (DWV Schedule 40 or heavier), or extra strength vitrified clay pipe (VCP) with compression joints or couplings with at least 12 inches of earth cover.

(III) Drains for chemical wastes. Separate drainage systems for chemical wastes (acids and other corrosive

materials) shall be provided. Materials acceptable for chemical waste drainage systems shall include chemically resistant glass pipe, high silicone content cast iron pipe, VCP, plastic pipe, or plastic lined pipe.

(IV) Drains above sensitive areas. Drainage pipes shall not be located above sensitive clean or sterile areas such as sterile processing, storage of food or of food preparation and serving areas, etc. unless protected from leaks or condensation by an approved method such as drip pans.

(V) Sewers. Building sewers shall discharge into a community sewerage system. Where such a system is not available, a facility providing sewage treatment must conform to applicable local and state regulations.

(vi) Thermal insulation for piping systems and equipment. Insulation shall be provided for the following:

(I) boilers, smoke breeching, and stacks;

(II) steam supply and condensate return piping;

(III) hot water piping and all hot water heaters, generators, converters, and storage tanks;

(IV) chilled water, refrigerant, other process piping, equipment operating with fluid temperatures below ambient dew point, and water supply and drainage piping on which condensation may occur and insulation on cold surfaces shall include an exterior vapor barrier; and

(V) other piping, ducts, and equipment as necessary to maintain the efficiency of the system.

(vii) Pipe and equipment insulation rating. Flame spread shall not exceed 25 and smoke development rating shall not exceed 150 for pipe insulation as determined by an independent testing laboratory in accordance with National Fire Protection Association 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, 2000 edition. Smoke development rating for pipe insulation located in environmental air areas shall not exceed 50.

(viii) Identification. All piping including heating, ventilating, air-conditioning (HVAC) shall be color coded or otherwise marked for easy identification.

(ix) Asbestos insulation. Asbestos insulation shall not be used.

(B) Plumbing fixtures. Plumbing fixtures shall be made of nonabsorptive acid-resistant materials and shall comply with the recommendations of the National Standard Plumbing Code, and this paragraph.

(i) Sink and lavatory controls. All fixtures used by medical and nursing staff and all lavatories used by patients and food handlers shall be trimmed with valves which can be operated without the use of hands. Blade handles used for this purpose shall not be less than four inches in length. Single lever or wrist blade devices may be used.

(ii) Clinical sink traps. Clinical sinks shall have an integral trap in which the upper portion of a visible trap seal provides a water surface.

(iii) Back flow or siphoning. All plumbing fixtures and equipment shall be designed and installed to prevent the back-flow or back-siphonage of any material into the water supply. The over-the-rim type water inlet shall be used wherever possible. Vacuum-breaking devices shall be properly installed when an over-the-rim type water inlet cannot be utilized.

(iv) Drinking fountain. Each drinking fountain shall be designed so that the water issues at an angle from the vertical, the end of the water orifice is above the rim of the bowl, and a guard is located over the orifice to protect it from lip contamination.

(v) Sterilizing equipment. All sterilizing equipment shall be designed and installed to prevent not only the contamination of the water supply but also the entrance of contaminating materials into the sterilizing units.

(vi) Hose attachment. No hose shall be affixed to any faucet if the end of the hose can become submerged in contaminated liquid unless the faucet is equipped with an approved, properly installed vacuum-breaker.

(vii) Bedpan washers and sterilizers. Bedpan washers and sterilizers shall be designed and installed so that both hot and cold water inlets shall be protected against back-siphonage at maximum water level.

(viii) Flood level rim clearance. The water supply spout for lavatories and sinks required in patient care areas shall be mounted so that its discharge point is a minimum of five inches above the rim of the fixture.

(ix) Floor drains or floor sinks. Where floor drains or floor sinks are installed, they shall be of a type that can be easily cleaned by removal of the cover. Removable stainless steel mesh shall be provided in addition to grilled drain cover to prevent entry of large particles of waste which might cause stoppages.

(x) Under counter piping. Under counter piping and above floor drains shall be arranged (raised) so as not to interfere with cleaning of floor below the equipment.

(xi) Ice machines. All ice making machines shall be of the self-dispensing type, unless otherwise specified.

(5) General electrical requirements. This paragraph contains common electrical requirements. The facility shall comply with the requirements of this paragraph and with any specific electrical requirements for the particular unit or suite of the facility in accordance with §510.123 of this subchapter. Electrical systems shall comply with NFPA 99 Chapter 3.

(A) Electrical installations. All new electrical material and equipment, including conductors, controls, and signaling devices, shall be installed in compliance with applicable sections of the National Fire Protection Association 70, National Electrical Code, 1999 edition (NFPA 70), and NFPA 99 and as necessary to provide a complete electrical system. Electrical systems and components shall be listed by nationally recognized listing agencies as complying with available standards and shall be installed in accordance with the listings and manufacturers' instructions.

(i) All fixtures, switches, sockets, and other pieces of apparatus shall be maintained in a safe and working condition.

(ii) Extension cords and cables shall not be used for permanent wiring.

(iii) All electrical heating devices shall be equipped with a pilot light to indicate when the device is in service, unless equipped with a temperature limiting device integral with the heater.

(iv) All equipment, fixtures, and appliances shall be properly grounded in accordance with NFPA 70.

(v) Under-counter receptacles and conduits shall be arranged (raised) to not interfere with cleaning of floor below the equipment.

(B) Installation testing and certification.

(i) Installation testing. The electrical installations, including alarm, nurses calling system and communication systems, shall be tested to demonstrate that equipment installation and operation is appropriate and functional.

(I) Grounding continuity shall be tested as described in NFPA 99 for new or existing work.

(II) A written record of performance tests on special electrical systems and equipment shall show compliance with applicable codes and standards.

(ii) Installation certification. Certifications in affidavit form signed by a registered electrical engineer attesting that the electrical service, electrical equipment, and electrical appliances have been installed in compliance with the approved plans, applicable standards, or both shall be submitted to HHSC when requested.

(C) Electrical safeguards. Shielded isolation transformers, voltage regulators, filters, surge suppressors, and other safeguards shall be provided as required where power line disturbances are likely to affect fire alarm components, data processing, equipment used for treatment, and automated laboratory diagnostic equipment.

(D) Services and switchboards. Main switchboards shall be located in separate rooms, separated from adjacent areas with one-hour fire rated enclosures containing only electrical switchgear and distribution panels and shall be accessible to authorized persons only. These rooms shall be ventilated to provide an environment free of corrosive or explosive fumes and gases, or any flammable and combustible materials. Switchboards shall be located convenient for use and readily accessible for maintenance as required by NFPA 70, Article 384. Overload protective devices shall operate properly in ambient temperatures.

(E) Panelboards. Panelboards serving normal lighting and appliance circuits shall be located on the same floor as the circuits they serve. Panelboards serving critical branch emergency circuits may serve three floors, the floor where the panelboard is located, the floor above and the floor below. Panelboards serving life safety branch circuits may serve three floors, the floor where the panelboard is located, and the floors above and below.

(i) Circuiting shall minimize the number of receptacles on a single branch circuit, in order to limit the effects of a branch circuit outage, caused by one faulted device. Any life-support equipment on that circuit would be lost.

(ii) Loading of branch circuits is limited by NFPA 70, Articles 210, 220, and 384.

(F) Wiring. All conductors for controls, equipment, lighting and power operating at 100 volts or higher shall be installed in accordance with the requirements of NFPA 70, Article 517. All surface mounted wiring operating at less than 100 volts shall be protected from mechanical injury with metal raceways to a height of seven feet above the floor. Conduits and cables shall be supported in accordance with NFPA 70, Article 300.

(G) Lighting.

(i) Lighting intensity for staff and patient needs shall comply with Chapter 17, Institution and Public Building Lighting, Health Care Facilities, of the Illuminating Engineering Society of North America (IES) Lighting Handbook, published by the IES.

(I) Consideration should be given to controlling intensity and wavelength to prevent harm to the patient's eyes (i.e., cataracts due to ultraviolet light).

(II) Approaches to buildings and parking lots, and all spaces within buildings shall have fixtures that can be illuminated as necessary. All rooms including storerooms, electrical and mechanical equipment rooms, and all attics shall have sufficient artificial lighting so that all parts of these spaces shall be clearly visible.

(III) Consideration should be given to the special needs of the elderly. Excessive contrast in lighting levels that makes effective sight adaptation difficult shall be minimized.

(ii) Means of egress and exit sign lighting intensity shall comply with NFPA 101 §§7-8, 7-9 and 7-10.

(iii) Electric lamps which may be subject to breakage or which are installed in fixtures in confined locations when near woodwork, paper, clothing, or other combustible materials, shall be protected by wire guards, or plastic shields.

(iv) Ceiling mounted examination light fixtures shall be suspended from rigid support structures mounted above the ceiling.

(H) Receptacles. Only listed "hospital" grade single-grounding or duplex-grounding receptacles shall be used in all patient care areas. This does not apply to special purpose receptacles.

(i) Installations of multiple ganged receptacles shall be permitted in patient care areas.

(ii) Electrical outlets powered from the critical branch shall be provided in all patient care, procedure and treatment locations in accordance with NFPA 99 §3-4.2.2.2(c). At least one receptacle at each patient treatment or procedure location shall be powered from the normal power panel.

(iii) Replacement of malfunctioning receptacles and installation of new receptacles powered from the critical branch in existing facilities shall be accomplished with receptacles of the same distinct color as the existing receptacles.

(iv) In locations where mobile X-ray or other equipment requiring special electrical configuration is used, the additional receptacles shall be distinctively marked for the special use.

(v) Each receptacle shall be grounded to the reference grounding point by means of a green insulated copper equipment grounding conductor.

(I) Equipment.

(i) Equipment required for safe operation of the facility shall be powered from the equipment system in accordance with the requirements contained in NFPA 99 §3-4.2.2.3.

(ii) Boiler accessories including feed pumps, heat-circulating pumps, condensate return pumps, fuel oil pumps, and waste heat boilers shall be connected and installed to provide both normal and standby service.

(J) Ground fault circuit interrupters (GFCI). GFCIs shall comply with NFPA 70. When GFCIs are used in critical areas, provisions shall be made to ensure that other essential equipment is not affected by activation of one interrupter.

(K) Nurses calling systems. Three different types of nurses calling systems are required to be installed in a facility: a nurses regular calling system; a nurses emergency calling system; and a staff emergency assistance calling system. The facility shall comply with the requirements of this paragraph and any specific requirements for nurses calling systems for the particular unit of the facility in accordance with §510.123 of this subchapter.

(i) A nurses regular calling system is intended for routine communication between each patient and the nursing staff. Activation of the system at a patient's regular calling station will sound a repeating (every 20 seconds) audible signal at the nurse station, indicate type and location of call on the system monitor, and activate a distinct visible signal in the corridor at the patient suites door. In multi-corridor nursing units, additional visible signals shall be installed at corridor intersections. The audible signal shall be canceled and two-way voice communication between the patient room and the nursing staff shall be established at the unit's nursing station when the call is answered by the nursing staff. The visible signals in the corridor shall be canceled upon termination of the call. An alarm shall activate at the nurses station when the call cable is unplugged.

(ii) A nurses emergency calling system shall be installed in all toilets used by all patients to summon nursing staff in an emergency. Activation of the system shall sound a repeating (every 5 seconds) audible signal at the nurse station, indicate type and location of call on the system monitor, and activate a distinct visible signal in the corridor at the patient suites door. In multi-corridor nursing units, additional visible signals shall be installed at corridor intersections. The visible and audible signals shall be cancelable only at the patient calling station. Activation of the system shall also activate distinct visible signals in the clean workroom, in the soiled workroom, medication, charting, clean linen storage, nourishment, nurse lounge and equipment storage. When conveniently located and accessible from both the bathing and toilet fixtures, one emergency call station may serve one bathroom. A nurses emergency call system shall be accessible to a collapsed patient lying on the floor.

(iii) A staff emergency assistance calling system (code blue) is intended to be used by staff to summon additional help in an emergency. In open suites, an emergency assistant call system device shall be located at the head of each bed and in each individual room. The emergency assistance calling device can be shared between two beds if conveniently located. Activation of the system will sound an audible signal at the nursing unit's nurses station, indicate type and location of call on the system monitor and activate a distinct visible signal in the corridor at the patient suites door. In multi-corridor nursing units, additional visible signals shall be installed at corridor intersections. Activation of the system shall also activate visible and audible signals in the clean workroom, in the soiled workroom, medication, charting, clean linen storage, nourishment, equipment storage, and examination or treatment rooms with back up to a continuously staffed area (other than the nurse station or an administrative center) from which assistance can be summoned. The system shall have voice communication capabilities so that the type of emergency or help required may be specified.

(L) Emergency electric service. A Type I essential electrical system shall be provided in each facility in accordance with requirements of NFPA 99, NFPA 101, and National Fire Protection Association 110, Standard for Emergency and Standby Power Systems, 1999 edition. Exception: Crisis stabilization units have the option of providing a Type II essential electrical system in accordance with the requirements of NFPA 99 and NFPA 101.

(i) The number of transfer switches to be used shall be based on reliability, design and load considerations.

(ii) All wiring installation of the emergency system of the essential electrical system shall be mechanically protected in nonflexible metal raceways in compliance with NFPA 70 §517-30(c)(3).

(iii) The stored fuel capacity for emergency generators shall be sufficient to permit continuous operation for at least 24 hours at full load.

(M) Fire alarm system. A fire alarm system which complies with NFPA 101 §18-3.4, and with NFPA 72 Chapter 3 requirements, shall be provided in each facility. The required fire alarm system components are as follows.

(i) A fire alarm control panel (FACP) shall be installed at a continuously attended (24 hour) location. A remote fire alarm annunciator listed for fire alarm service and installed at a continuously attended location and is capable of indicating both visual and audible alarm, trouble and supervisory signals in accordance with the requirements of NFPA 72 may be substituted for the FACP.

(ii) Manual fire alarm pull stations shall be installed in accordance with NFPA 101 §18-3.4.

(iii) Smoke detectors for door release service shall be installed on the ceiling at each door opening in the smoke partition in accordance with NFPA 72 §2-10.6, where the doors are held open with electromagnetic devices conforming with NFPA 101 §18-2.2.6.

(iv) Ceiling mounted smoke detectors shall be installed in room containing the FACP when this room is not attended continuously by staff as required by NFPA 72 §1-5.6.

(v) Smoke detectors shall be installed in supply air ducts in accordance with NFPA 72 §2-10.4.2 and §2-10.5, and with NFPA 90A §4-4.2.

(vi) Smoke detectors shall be installed in return air ducts in accordance with requirements of NFPA 72 §2-10.4.2.2 and §2-10.5, and NFPA 90A §4-4.2(2).

(vii) Fire sprinkler system water flow switches shall be installed in accordance with requirements of NFPA 101 §9-6.2; NFPA 13 §3-10; and NFPA 72 §3-8.5.

(viii) Sprinkler system valve supervisory switches shall be installed in accordance with the requirements of NFPA 72 §3-8.6.

(ix) Audible alarm indicating devices shall be installed in accordance with the requirements of NFPA 101, §18-3.4., and NFPA 72 §6-3.

(x) Visual fire alarm indicating devices which comply with the requirements of §510.122(d)(1)(F) of this subchapter (relating to New Construction Requirements) and NFPA 72 §6-4 shall be provided.

(xi) Devices for transmitting alarm for alerting the local fire brigade or municipal fire department of fire or other emergency shall be provided. The devices shall be listed for the fire alarm service by a nationally recognized laboratory and be installed in accordance with such listing and the requirements of NFPA 72.

(xii) A smoke detection system for spaces open to corridor(s) shall be provided when required by NFPA 101 §18-3.6.1.

(xiii) A fire alarm signal notification which complies with NFPA 101 §9-6.3, shall be provided to alert occupants of fire or other emergency.

(xiv) Wiring for fire alarm detection circuits and fire alarm notification circuits shall comply with requirements of NFPA 70, Article 760.

(xv) A smoke detection system for elevator recall shall be located in elevator lobbies, elevator machine rooms and at the top of elevator hoist ways as required by NFPA 72 §3-9.3.7.

(I) The elevator recall smoke detection system in new construction shall comply with requirements of American Society of Mechanical Engineers/American National Standards Institute (ASME/ANSI) A17.1, Safety Code for Elevators and Escalators, 1996 edition.

(II) The elevator recall smoke detection system in existing facilities shall comply with requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators, 1995 edition.

(xvi) A smoke detection system for initiating smoke removal from atriums shall be located above the highest floor level of the atrium and at return intakes from the atrium in accordance with National Fire Protection Association 92B, Guide for Smoke Management Systems in Malls, Atria, and Large Areas, 1995 edition.

(xvii) Smoke detectors for shut-down of air handling units shall be provided. The detectors shall be installed in accordance with NFPA 90A §4-4.2.

(xviii) New or modified fire alarm systems shall be certified as meeting applicable NFPA standards such as NFPA 101, 72A, 72E, etc. on form FML-009 040392 of the Office of the State Fire Marshal. A copy of the fire alarm system certification shall be submitted to HHSC.

(N) Telecommunications and information systems. Telecommunications and information systems central equipment shall be installed in a separate location designed for the intended purpose. Special air conditioning and voltage regulation shall be provided as recommended by the manufacturer.

(O) Lightning protection systems. When installed, lightning protection systems shall comply with National Fire Protection Association 780, Standard for the Installation of Lightning Protection Systems, 1997 edition.

§510.123. Spatial Requirements for New Construction.

(a) Administration and public suite. The following rooms or areas shall be provided.

(1) Primary entrance. An entrance at grade level shall be accessible and protected from inclement weather with a drive-under canopy for loading and unloading passengers.

(2) Lobby. A main lobby shall be located at the primary entrance and shall include a reception and information counter or desk, waiting spaces, public toilet facilities, public telephones, drinking fountains, and storage room or alcove for wheelchairs.

(3) Admissions area. An admissions area shall include a waiting area, work counters or desk, private interview spaces, and storage room or alcove for wheelchairs. The waiting area and wheelchair storage may be shared with similar areas located in the main lobby.

(4) General or individual offices. Office space shall be provided for business transactions, medical and financial records, and administrative and professional staffs.

(5) Multipurpose rooms. Rooms shall be provided for conferences, meetings, and health education purposes including provisions for showing visual aids.

(6) Storage. Storage for office equipment and supplies shall be provided. The construction protection for the storage room or area shall be in accordance with the National Fire Protection Association 101, Code for Safety to Life from Fire in Buildings and Structures, 1997 edition (NFPA 101) §18-3.1.

(b) Cart cleaning and sanitizing unit. A cart cleaning and sanitizing unit is optional for crisis stabilization units.

(1) Architectural requirements.

(A) Cart cleaning, sanitizing and storage shall be provided for carts serving dietary services and linen services.

(B) Cart facilities may be provided for each service or be centrally located.

(C) Hand washing fixtures shall be provided in cart cleaning, sanitizing and storage areas.

(2) Details and finishes. Details and finishes shall be in accordance with §510.122(d)(2) of this subchapter (relating to New Construction Requirements) and this paragraph.

(A) Flooring in the cart cleaning and sanitizing unit shall be of the seamless type, or ceramic or quarry tile as required by §510.122(d)(2)(B)(iii)(III) or (IV) of this subchapter.

(B) Ceilings in the cart cleaning and sanitizing unit shall be the monolithic type as required by §510.122(d)(2)(B)(vi)(III) of this subchapter.

(3) Piping systems and plumbing fixtures. Piping systems and plumbing fixtures shall be in accordance with §510.122(d)(4) of this subchapter and this paragraph.

(A) Hand washing fixtures shall be provided with hot and cold water. Hot and cold water fixtures shall be provided in cart cleaning and sanitizing locations.

(B) Where floor drains or floor sinks are installed, they shall be of a type that can be easily cleaned by removal of the cover. Removable stainless steel mesh shall be provided in addition to a grilled drain cover to prevent entry of large particles of waste which might cause stoppages. Floor drains and floor sinks shall be located to avoid conditions where removal of covers for cleaning is difficult.

(c) Central sterile supply suite. A central sterile supply suite is optional for crisis stabilization units.

(1) Architectural requirements.

(A) Supply storage. A storage room for clean and sterile supplies shall be provided. The storage room shall have adequate areas and counters for breakdown of prepackaged supplies.

(B) Equipment storage. An equipment storage room shall be provided.

(2) Details and finishes. Details and finishes shall be in accordance with §510.122(d)(2) of this subchapter and this paragraph. Ceilings in supply storage room shall be monolithic type in accordance with §510.122(d)(2)(B)(vi)(III) of this subchapter.

(3) Mechanical Requirements. Mechanical requirements shall be in accordance with §510.122(d)(3) of this subchapter and this paragraph.

(A) The sterile supply room shall include provisions for ventilation, humidity, and temperature control.

(B) Filtration requirements for air handling units serving the central sterile supply suite shall be equipped with filters having efficiencies equal to, or greater than specified in Table 4 of §510.131(d) of this subchapter (relating to Tables).

(C) Duct linings exposed to air movement shall not be used in ducts serving the central sterile supply suite unless terminal filters of at least 90% efficiency are installed downstream of linings. This requirement shall not apply to mixing boxes and acoustical traps that have special coverings over such lining.

(d) Dietary suite.

(1) Architectural requirements.

(A) General. Construction, equipment, and installation shall comply with the standards specified in 25 TAC Chapter 228 (relating to Retail Food Establishments).

(B) Food service facilities. Food services shall be provided by an on-site food preparation system or an off-site food service system or a combination of the two. The following minimum functional elements shall be provided on-site regardless of the type of dietary services.

(i) Dining area. Provide dining space for ambulatory patients, staff, and visitors with a minimum floor space of 15 square feet per person to be seated. The footage requirement does not include serving areas. The dining area and service areas shall be separate from the food preparation and distribution areas.

(ii) Receiving area. This receiving area shall have direct access to the outside for incoming dietary supplies or off-site food preparation service and shall be separate from the general receiving area. The receiving area shall contain a control station and an area for breakout for loading, unloading, uncrating, and weighing supplies. The entrance area to the receiving area shall be covered from the weather.

(iii) Storage spaces. Storage spaces shall be convenient to receiving area and food preparation area and shall be located to exclude traffic through the food preparation area. Regardless of the type of food services provided, the facility shall provide storage of food for emergency use for a minimum of four calendar days.

(I) Storage space. Storage space shall be provided for bulk, refrigerated, and frozen foods.

(II) Cleaning supply storage. This room or closet shall be used to store non-food items that might contaminate edibles. This storage area may be combined with the housekeeping room.

(iv) Food preparation area. Counter space shall be provided for food prep work, equipment, and an area to assemble trays for distribution for patient meals.

(v) Ice making equipment. Ice making equipment shall be provided for both drinks and food products (self-dispensing equipment) and for general use (storage-bin type equipment).

(vi) Hand washing. Hand washing fixtures with hands-free operable controls shall be conveniently located at all food preparation areas and serving areas.

(vii) Food service carts. When a cart distribution system is provided, space shall be provided for storage, loading, distribution, receiving, and sanitizing of the food service carts. The cart traffic shall be designed to eliminate any danger of cross-circulation between outgoing food carts and incoming soiled carts, and the cleaning and sanitizing process. Cart circulation shall not be through food processing areas.

(viii) Ware washing room. A ware washing room equipped with commercial type dishwasher equipment shall be located separate from the food preparation and serving areas. Space shall be provided for receiving, scraping, sorting, and stacking soiled tableware and for transferring clean tableware to the using areas. Hand washing facilities with hands-free operable controls shall be located within the soiled dish wash area. A physical separation to prevent cross traffic between the dirty side and clean side of the dish wash areas shall be provided.

(ix) Pot washing facilities. A three compartmented sink of adequate size for intended use shall be provided convenient to the food preparation area. Supplemental heat for hot water to clean pots and pans shall be by booster heater or by steam jet.

(x) Waste storage room. A food waste storage room shall be conveniently located to the food preparation and ware washing areas but not within the food preparation area. It shall have direct access to the facility's waste collection and disposal facilities. A waste storage room is optional for crisis stabilization units.

(xi) Sanitizing facilities. Storage areas and sanitizing facilities for garbage or refuse cans, carts, and mobile tray conveyors shall be provided. All containers for trash storage shall have tight-fitting lids.

(xii) Housekeeping room. A housekeeping room shall be provided for the exclusive use of the dietary department. Where hot water or steam is used for general cleaning, additional space within the room shall be provided for the storage of hoses and nozzles.

(xiii) Office spaces. An office shall be provided for the use of the food service manager or the dietary service manager. In smaller facilities, a designated alcove may be located in an area that is part of the food preparation area.

(xiv) Toilets and locker spaces. A toilet room shall be provided for the exclusive use of the dietary staff. Toilets shall not open directly into the food preparation areas but must be in close proximity to them. For larger facilities, a locker room or space for lockers shall be provided for staff belongings.

(C) Additional service areas, rooms, and facilities. When an on-site food preparation system is used, in addition to the items required in subparagraph (B), the following service areas, rooms, and facilities shall be provided.

(i) Food preparation facilities. When food preparation systems are provided, there shall be space and equipment for preparing, cooking, and baking.

(ii) Tray assembly line. A patient tray assembly and distribution area shall be located within close proximity to the food preparation and distribution areas.

(iii) Food storage. The food storage room shall be adequate in size to accommodate food for a seven calendar day menu cycle.

(iv) Additional storage areas. Additional areas shall be provided for the storage of cooking wares, extra trays, flatware, plastic and paper products, and portable equipment.

(v) Drying storage area. Provisions shall be made for drying and storage of pots and pans from the pot washing room.

(D) Equipment. Equipment for use in the dietary suite shall meet the following requirements.

(i) Mechanical devices shall be heavy duty, suitable for the use intended, and easily cleaned. Where equipment is movable, provide heavy duty locking casters. Equipment with fixed utility connections shall not be equipped with casters.

(ii) Floor, wall, and top panels of walk-in coolers, refrigerators, and freezers shall be insulated. Coolers and refrigera-

tors shall be capable of maintaining a temperature down to freezing. Freezers shall be capable of maintaining a temperature of 20 degrees below 0 degrees Fahrenheit. Coolers, refrigerators, and freezers shall be thermostatically controlled to maintain desired temperature settings in increments of two degrees or less. Interior temperatures shall be indicated digitally and visible from the exterior. Controls shall include audible and visible high and low temperature alarm. The time of alarm shall be automatically recorded.

(iii) Walk-in units may be lockable from the outside but must have a release mechanism for exit from inside at all times. The interior shall be lighted. All shelving shall be corrosion resistant, easily cleaned, and constructed and anchored to support a loading of at least 100 pounds per linear foot.

(iv) All cooking equipment shall be equipped with automatic shut-off devices to prevent excessive heat buildup.

(E) Vending services. When vending machines are provided, a dedicated room or an alcove shall be located so that access is available at all times.

(2) Details and finishes. Details and finishes shall be in accordance with §510.122(d)(2) of this subchapter and this paragraph.

(A) Details.

(i) Food storage shelves shall not be less than six inches above the finished floor and the space below the bottom shelf shall be closed in and sealed tight for ease of cleaning.

(ii) Operable windows and doors not equipped with automatic closing devices shall be equipped with insect screens.

(iii) Food processing areas in the central dietary kitchen shall have ceiling heights not less than nine feet. Ceiling mounted equipment shall be supported from rigid structures located above the finished ceiling.

(iv) Mirrors shall not be installed at hand washing fixtures in the food preparation areas.

(B) Finishes.

(i) Floors in areas used for food preparation, food assembly, soiled and clean ware cleaning shall be water-resistant and grease-proof. Floor surfaces, including tile joints, shall be resistant to food acids.

(ii) Wall bases in food preparation, food assembly, soiled and clean ware cleaning and other areas which are frequently subject to wet cleaning methods shall be made integral and coved with the floor, tightly sealed to the wall, constructed without voids that can harbor insects, retain dirt particles, and be impervious to water.

(iii) In the dietary and food preparation areas, the wall construction, finishes, and trim, including the joints between the walls and the floors, shall be free of voids, cracks, and crevices.

(iv) The ceiling in food preparation and food assembly areas shall be washable as required by §510.122(d)(2)(B)(vi)(II) of this subchapter.

(v) The ceiling in the food storage room and soiled and clean ware cleaning area shall be of the monolithic type as required by §510.122(d)(2)(B)(vi)(III) of this subchapter.

(3) Mechanical Requirements. Mechanical requirements shall be in accordance with §510.122(d)(3) of this subchapter and this paragraph.

(A) Exhaust hoods handling grease-laden vapors in food preparation centers shall comply with National Fire Protection Association 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1998 edition. All hoods over cooking ranges shall be equipped with grease filters, fire extinguishing systems, and heat-actuated fan controls. Clean out openings shall be provided every 20 feet and at any changes in direction in the horizontal exhaust duct systems serving these hoods. (Horizontal runs of ducts serving range hoods should be kept to a minimum.)

(B) When air change standards in Table 3 of §510.131(c) of this subchapter do not provide sufficient air for proper operation of exhaust hoods (when in use), supplementary filtered makeup air shall be provided in these rooms to maintain the required airflow direction and exhaust velocity. Makeup systems for hoods shall be arranged to minimize "short circuiting" of air and to avoid reduction in air velocity at the point of contaminant capture.

(C) Air handling units serving the dietary suite shall be equipped with filters having efficiencies equal to, or greater than specified in Table 4 of §510.131(d) of this subchapter.

(4) Piping systems and plumbing fixtures. Piping systems and plumbing fixtures shall be in accordance with §510.122(d)(4) of this subchapter and this paragraph.

(A) The kitchen grease traps shall be located and arranged to permit easy access without the need to enter food preparation or storage areas. Grease traps shall be of capacity required and shall be accessible from outside of the building without need to interrupt any services.

(B) Grease traps or grease interceptors shall be located outside the food preparation area and shall comply with the requirements in the International Association of Plumbing and Mechanical Officials National Standard Plumbing Code, 2000 edition.

(C) The material used for plumbing fixtures shall be non-absorptive and acid-resistant.

(D) Water spouts used at lavatories and sinks shall have clearances adequate to avoid contaminating utensils and containers.

(E) Hand washing fixtures used by food handlers shall be trimmed with valves that can be operated without hands. Single lever or wrist blade devices may be used. Blade handles used for this purpose shall not be less than four inches in length.

(F) Drainage and waste piping shall not be installed in the space above the ceiling or installed in an exposed location in food preparation centers, food serving facilities and food storage areas unless special precautions are taken to protect the space below from leakage and condensation from necessary overhead piping.

(G) No plumbing lines may be exposed overhead or on walls where possible leaks would create a potential for food contamination.

(5) Electrical requirements. Electrical requirements shall be in accordance with §510.122(d)(5) of this subchapter and this paragraph.

(A) Exhaust hoods shall have an indicator light indicating that the exhaust fan is in operation.

(B) The electrical circuits to equipment in wet areas shall be provided with five milliampere GFCI.

(e) Emergency treatment room.

(1) Architectural requirements.

(A) Emergency treatment room. As a minimum requirement, a facility shall provide at least one emergency treatment

room to handle emergencies. The emergency treatment room may be located anywhere in the facility and shall meet the following requirements.

(i) The emergency treatment room shall have a minimum clear area of 120 square feet clear floor area exclusive of fixed and movable cabinets and shelves. The minimum clear room dimension exclusive of fixed cabinets and built-in shelves shall be 10 feet. The emergency treatment room shall contain cabinets, medication storage, work counter, examination light, and hand washing fixtures with hands-free operable controls. Exception: Crisis stabilization units are not required to have medication storage in the emergency treatment room.

(ii) Storage space shall be provided within the room or on an emergency cart and be under staff control for general medical emergency supplies and medications. Adequate space shall be provided for emergency equipment.

(B) Secured holding room. When provided, this room shall be constructed to allow for security, patient and staff safety, patient observation, and sound proofing.

(C) Service areas. The following service areas shall be provided.

(i) Soiled workroom. The workroom shall contain a work counter, a clinical sink or equivalent flushing type fixture, hand washing fixture with hands-free operable controls, waste receptacles, and soiled linen receptacles. The soiled workroom in the nursing suite may be shared with the emergency treatment room if it is located conveniently nearby.

(ii) Housekeeping room. The housekeeping room shall be located nearby.

(iii) Patient toilet. A toilet room shall be provided and located nearby.

(2) Details and finishes. Details and finishes shall be in accordance with §510.122(d)(2) of this subchapter and this paragraph.

(A) Flooring used in the treatment room, secure holding area, and soiled workroom shall be of the seamless type as required by §510.122(d)(2)(B)(iii)(III) of this subchapter.

(B) Ceilings in soiled workrooms and secure holding rooms shall be of the monolithic type as required by §510.122(d)(2)(B)(vi)(III) of this subchapter.

(3) Mechanical requirements. Mechanical requirements shall be in accordance with §510.122(d)(3) of this subchapter and this paragraph. Duct linings exposed to air movement shall not be used in ducts serving any treatment rooms and secure holding rooms. This requirement shall not apply to mixing boxes and acoustical traps that have special coverings over such lining.

(4) Piping systems and plumbing fixtures. Piping systems and plumbing fixtures shall be in accordance with §510.122(d)(4) of this subchapter. When provided, medical gas systems shall be in accordance with §510.122(d)(4)(A)(iii) of this subchapter.

(5) Electrical requirements. Electrical requirements shall be in accordance with §510.122(d)(5) of this subchapter and this paragraph.

(A) General.

(i) Each treatment room shall have a minimum of six duplex electrical receptacles. Two duplex electrical receptacles shall be located convenient to the head of the bed.

(ii) Each work counter and table shall have access to two duplex receptacles connected to the critical branch of the emergency electrical system and be labeled with panel and circuit number.

(B) Nurses calling systems. A nurses regular calling system shall be provided for the treatment room in accordance with §510.122(d)(5)(K)(i) of this subchapter.

(f) Employees suite. Lockers, lounges, toilets, and other amenities as determined by the facility shall be provided throughout the facility for employees and volunteers. These amenities are in addition to, and separate from, those required for the medical staff and the public.

(g) Engineering suite and equipment areas.

(1) General. The following areas or rooms shall be provided:

(A) an engineer's office with file space and provisions for protected storage of facility drawings, records, manuals, etc.;

(B) a general maintenance shop for repair and maintenance;

(C) a separate room for building maintenance supplies and equipment and storage of bulk solvents and flammable liquids shall be in a separate building and not within the facility building;

(D) a medical equipment room which includes provisions for the storage, repair, and testing of electronic and other medical equipment;

(E) a separate room or building for yard maintenance equipment and supplies. When a separate room is within the physical plant the room shall be located so that equipment may be moved directly to the exterior. Yard equipment or vehicles using flammable liquid fuels shall not be stored or housed within the facility building; and

(F) sufficient space in all mechanical and electrical equipment rooms for proper maintenance of equipment. Provisions shall also be made for removal and replacement of equipment.

(2) Additional areas or rooms. Additional areas or rooms for mechanical, and electrical equipment shall be provided within the physical plant or installed in separate buildings or weatherproof enclosures with the following exceptions.

(A) An area shall be provided for cooling towers and heat rejection equipment when such equipment is used.

(B) An area for the medical gas park and equipment shall be provided. For smaller medical gas systems, the equipment may be housed in a room within the physical plant in accordance with National Fire Protection Association 99, Standard for Health Care Facilities, 1999 edition (NFPA 99), Chapters 4 and 8.

(C) When provided, compactors, dumpsters, and incinerators shall be located in an area remote from public entrances.

(h) General stores.

(1) General. In addition to storage rooms in individual departments, a central storage room shall also be provided. General stores may be located in a separate building on-site with provisions for protection against inclement weather during transfer of supplies.

(2) Receiving. Central storage areas shall be provided with an off-street unloading and receiving area protected from inclement weather.

(3) General storage room. General storage room with a total area of not less than 12 square feet per inpatient bed shall be provided. The storage room may be within the facility, or separate building on-site. A portion of the storage may be provided off-site.

(4) Outpatient suite storage room. A storage room for the outpatient services shall be provided at least equal to five percent of the total area of the outpatient suite. This required storage room area may be combined with general stores.

(i) Geriatric, Alzheimer, and other dementia nursing suites. When geriatric, Alzheimer, or other dementia nursing suites are provided, the nursing suite shall comply with the requirements in subsection (o) of this section with the following exceptions.

(1) A patient bedroom suite shall be 120 square feet in a single patient bedroom suite and 200 square feet in multiple-bed room suites.

(2) Each patient bedroom shall have storage for extra blankets, pillows, and linen.

(3) Patient bedroom doors shall be a minimum of three feet eight inches in width.

(4) Patients shall have access to at least one bathtub in each nursing suite.

(5) A minimum of two separate social spaces, one appropriate for noisy activities and the other for quiet activities, shall be provided. The combined total area shall be not less than 30 square feet per bed space with not less than 140 square feet for each of the two spaces, whichever is greater. This space may be shared with the dining area or room.

(6) Storage space for wheelchairs shall be provided in the nursing unit.

(j) Imaging suite.

(1) Architectural requirements.

(A) General. When diagnostic imaging services are provided, the minimum the facility shall provide is a diagnostic radiographic (X-ray) room.

(i) Diagnostic radiographic (x-ray) room sizes shall be in compliance with manufacturer's recommendation. When portable x-ray equipment is used, the portable unit shall be stored in a secured room.

(ii) When radiation protection is required for any diagnostic imaging room, a medical physicist licensed under Texas Occupations Code Chapter 602, shall specify the type, location, and amount of radiation protection to be installed for the layout and equipment selections.

(iii) Each X-ray room shall include a shielded control alcove. The control alcove shall be provided with a view window designed to permit full view of the examination table and the patient at all times.

(iv) Warning signs capable of indicating that the equipment is in use shall be provided.

(B) Service areas. The following service areas shall be provided.

(i) Patient waiting area. The area shall be out of traffic and under direct staff visual control.

(ii) Patient toilet rooms. Toilet rooms with hand washing amenities shall be located convenient to the waiting area.

(iii) Patient dressing rooms. Dressing rooms shall be convenient to the waiting areas and X-ray rooms.

(iv) Hand washing facilities. A freestanding hand washing fixture with hands-free controls shall be provided in or near the entrance to each diagnostic and procedure room unless noted otherwise. Hand washing facilities shall be arranged to minimize any incidental splatter on nearby personnel or equipment.

(v) Contrast media preparation. This room shall include a work counter, a sink with hands-free operable controls, and storage. One preparation room may serve any number of rooms. When prepared media is used, this area may be omitted, but storage shall be provided for the media.

(vi) Film processing room. A darkroom shall be provided for processing film unless the processing equipment normally used does not require a darkroom for loading and transfer. When daylight processing is used, the darkroom may be minimal for emergency and special uses. Film processing shall be located convenient to the procedure rooms and to the quality control area.

(vii) Quality control area or room. An area or room for film viewing shall be located near the film processor. All view boxes shall be illuminated to provide light of the same color value and intensity.

(viii) Film storage (active). A room shall include a cabinet or shelves for filing patient film for immediate retrieval.

(ix) Film storage (inactive). A room for inactive film storage shall be provided. It may be outside the imaging suite but must be under the administrative control of imaging suite personnel and be properly secured to protect films against loss or damage.

(x) Storage for unexposed film. Storage amenities for unexposed film shall include protection of film against exposure or damage.

(xi) Storage of cellulose nitrate film. When used, cellulose nitrate film shall be stored in accordance with the requirements of National Fire Protection Association 40, Standard for the Storage and Handling of Cellulose Nitrate Motion Picture Film, 1994 edition.

(xii) Housekeeping room. The room may serve multiple departments when conveniently located.

(2) Details and finishes. Details and finishes shall be in accordance with §510.122(d)(2) of this subchapter and this paragraph.

(A) Details.

(i) Radiation protection shall be designed, tested, and approved by a medical physicist licensed under Texas Occupations Code Chapter 602.

(ii) The design and environmental controls associated with licensable quantities of radioactive material in laboratories, imaging rooms, or both shall be approved by the Texas Department of State Health Services Radiation Control Program prior to licensed authorizations.

(iii) Where protected alcoves with view windows are required, provide a minimum of 1 foot 6 inches between the view window edge or frame and the outside partition edge.

(iv) Imaging procedure rooms shall have ceiling heights not less than nine feet. Ceilings containing ceiling-mounted equipment shall be of sufficient height to accommodate the equipment of fixtures and their normal movement.

(B) Finishes.

(i) Flooring used in contrast media preparation and soiled workroom shall be of the seamless type as required by §510.122(d)(2)(B)(iii)(III) of this subchapter.

(ii) A lay-in type ceiling is acceptable for the diagnostic room.

(3) Mechanical Requirements.

(A) Mechanical requirements shall be in accordance with §510.122(d)(3) of this subchapter and this paragraph.

(B) Air handling units serving the imaging suite shall be equipped with filters having efficiencies equal to, or greater than specified in Table 4 of §510.131(d) of this subchapter.

(4) Piping systems and plumbing fixtures. Piping systems and plumbing fixtures shall be in accordance with §510.122(d)(4) of this subchapter and this paragraph. When automatic film processors are used, a receptacle of adequate size with hot and cold water for cleaning the processor racks shall be provided.

(5) Electrical requirements. Electrical requirements shall be in accordance with §510.122(d)(5) of this subchapter and this paragraph.

(A) General.

(i) Each imaging procedure room shall have at least four duplex electrical receptacles.

(ii) A special grounding system in areas such as imaging procedures rooms where a patient may be treated with an internal probe or catheter shall comply with Chapter 9 of NFPA 99 and Article 517 of NFPA 70.

(iii) General lighting with at least one light fixture powered from a normal circuit shall be provided in imaging procedures rooms in addition to special lighting units at the procedure or diagnostic tables.

(B) Nurses calling system.

(i) Nurses regular calling system. The nurses regular calling system shall be provided for patient dressing rooms in accordance with §510.122(d)(5)(K)(i) of this subchapter.

(ii) Nurses emergency calling system. In toilet rooms used by inpatients and outpatients, a nurses emergency call station shall be provided in accordance with §510.122(d)(5)(K)(ii) of this subchapter.

(iii) Staff emergency assistance calling system. A staff emergency assistance calling system (code blue) shall be provided for staff to summon additional assistance for each imaging procedure room in accordance with §510.122(d)(5)(K)(iii) of this subchapter.

(k) Laboratory suite.

(1) Architectural requirements.

(A) General. The required laboratory testing shall be performed on-site or provided through a contractual arrangement with a laboratory service.

(i) Provisions for laboratory services shall be provided within the facility for urinalysis, blood glucose and electrolytes.

(ii) Each laboratory unit shall meet the requirements of Chapter 10 of NFPA 99 and Chapter 18 of NFPA 101.

(B) Minimum laboratory. When laboratory services are provided off-site by contract, the following minimum areas or rooms shall be provided within the facility.

(i) Laboratory work room. The laboratory workroom shall include a counter and a sink with hands-free operable controls.

(ii) General storage. Cabinets or closets shall be provided for supplies and equipment used in obtaining samples for testing. A refrigerator or other similar equipment shall be provided for specimen storage waiting for transfer to off-site testing.

(iii) Specimen collection room. A blood collection room shall be provided with a counter, space for seating, and hand washing fixture with hands-free operable controls. A toilet and lavatory with hands-free operable controls shall be provided for specimen collection. This room may be outside the laboratory suite if conveniently located.

(C) On-site laboratory. When the facility provides on-site laboratory services, the following areas or rooms shall be provided in addition to the requirements in paragraph (1)(A) and (1)(B) of this subsection.

(i) Laboratory workrooms. The laboratory work room shall include counters, space appropriately designed for laboratory equipment, sinks with hands-free operable controls, vacuum, gases, air, and electrical services as needed.

(ii) General storage. Storage, including refrigeration for reagents, standards, supplies, and stained specimen microscope slides, etc. shall be provided. Separate spaces shall be provided for such incompatible materials as acids and bases, and vented storage shall be provided for volatile solvents.

(iii) Chemical safety. When chemical safety is a requirement, provisions shall be made for an emergency shower and eye flushing devices.

(iv) Flammable liquids. When flammable or combustible liquids are used, the liquids shall be stored in approved containers, in accordance with National Fire Protection Association 30, Flammable and Combustible Liquids Code, 1996 edition.

(v) Radioactive materials. When radioactive materials are employed, storage amenities shall be provided.

(D) Service areas or rooms. The following service areas or rooms shall be provided.

(i) Hand washing amenities. Each laboratory room or work area shall be provided with a hand washing fixture with hands-free operable controls.

(ii) Office spaces. The scope of laboratory services shall determine the size and quantity for administrative areas including offices as well as space for clerical work, filing, and record maintenance. At a minimum, an office space shall be provided for the use of the laboratory service director.

(iii) Staff facilities. Lounge, locker, and toilet amenities shall be conveniently located for male and female laboratory staff. These may be outside the laboratory area and shared with other departments.

(iv) Housekeeping room. A housekeeping room shall be located nearby.

(2) Details and finishes. Details and finishes shall be in accordance with §510.122(d)(2) of this subchapter. Floors in laboratories

shall comply with the requirements of §510.122(d)(2)(B)(iii) of this subchapter except that carpet flooring shall not be used.

(3) Mechanical requirements. Mechanical requirements shall be in accordance with §510.122(d)(3) of this subchapter and this paragraph.

(A) No air from the laboratory areas shall be recirculated to other parts of the facility. Recirculation of air within the laboratory suite is allowed.

(B) When laboratory hoods are provided, they shall meet the following general requirements.

(i) The average face velocity of each exhaust hood shall be at least 75 feet per minute.

(ii) The exhaust shall be connected to an exhaust system to the outside which is separate from the building exhaust system.

(iii) The exhaust fan shall be located at the discharge end of the system.

(iv) The exhaust duct system shall be of noncombustible and corrosion resistant material.

(C) Filtration requirements for air handling units serving the laboratory suite shall be equipped with filters having efficiencies equal to, or greater than specified in Table 4 of §510.131(d) of this subchapter.

(D) Duct linings exposed to air movement shall not be used in ducts serving any laboratory room and clean room unless terminal filters of at least 80% efficiency are installed downstream of linings. This requirement shall not apply to mixing boxes and acoustical traps that have special coverings over such lining.

(4) Piping systems and plumbing fixtures. Piping systems and plumbing fixtures shall be in accordance with §510.122(d)(4) of this subchapter and this paragraph.

(A) General.

(i) Faucet spouts at lavatories and sinks shall have clearances adequate to avoid contaminating utensils and the contents of beakers, test tubes, etc.

(ii) Drain lines from sinks used for acid waste disposal shall be made of acid-resistant material.

(iii) Drain lines serving some types of automatic blood-cell counters must be of carefully selected material that will eliminate potential for undesirable chemical reactions (or explosions) between sodium azide wastes and copper, lead, brass, and solder, etc.

(B) Medical gas systems. When provided, medical gas systems shall comply with §510.122(d)(4)(A)(iii) of this subchapter. The number of outlets in the laboratory for vacuum, gases, and air shall be determined by the functional program requirements.

(l) Laundry suite. Laundry amenities may be provided on-site or off-site. On-site laundry services may be within the facility or in a separate building.

(1) Architectural requirements.

(A) General. The following amenities are required for both on-site or off-site commercial laundry services.

(i) The laundry room shall be equipped and ventilated so as to minimize the dissemination of contaminants.

(ii) Soiled and clean linen processing areas shall be physically separated.

(iii) An adequate amount of hand washing fixtures shall be provided in both the soiled and clean processing areas.

(B) On-site laundry processing. When linen is processed within the facility or in a separate building located on-site, the following minimum requirements shall be provided.

(i) A receiving, holding, and sorting room for control and distribution of soiled linen shall be provided. This area may be combined with the soiled linens processing room. Discharge from soiled linen chutes may be received within this room or in a separate dedicated room.

(ii) A laundry processing room shall be provided which shall contain commercial type equipment capable of processing at least a seven-day laundry supply within the regular scheduled work week.

(iii) A clean linen processing room shall be provided and shall include built-in dryers and folding counters or tables. This area shall have provisions for inspections, folding, packing, and mending of linen.

(iv) A holding room or area for storage and issuing of clean linen shall be provided but may be combined with clean linen processing room.

(C) Off-site laundry processing. When linen is processed off the facility site, the following minimum requirements shall be provided on-site:

(i) a service entrance which shall have protection from inclement weather, for loading and unloading of linen;

(ii) control station for pickup and receiving;

(iii) soiled linen holding room;

(iv) a central clean linen storage room and issuing room in addition to linen storage required at the individual patient suites. This central holding area shall include provisions for inspecting, sorting, and mending; and

(v) cart storage areas, which shall be located out of pedestrian traffic and shall be provided separately for clean and soiled linen.

(D) Service areas for on-site laundry processing. The laundry shall be separated from patient rooms, areas of food preparation and storage, and areas in which clean supplies and equipment are stored. An on-site laundry shall have the following services areas and facilities.

(i) Office space. Office space for director of laundry services.

(ii) Equipment layout for soiled and clean linen. The laundry equipment processing shall be arranged to permit an orderly work flow and minimize cross-traffic that might mix clean and soiled operations.

(iii) Storage. Storage space and cabinets for soaps, stain removers, and other laundry processing agents shall be located in the soiled and clean processing rooms.

(iv) Cart sanitizing. Cart sanitizing shall comply with subsection (b) of this section.

(v) Staff toilets. Toilets may be outside the unit but shall be convenient for staff use and shall contain hand washing fixtures with hands-free operable controls.

(vi) Staff lockers. Lockers may be in laundry suite or part of a central locker area when convenient to the laundry.

(vii) Housekeeping room.

(2) Mechanical Requirements. Mechanical requirements shall be in accordance with §510.122(d)(3) of this chapter and this paragraph.

(A) The ventilation system shall include adequate intake, filtration, exchange rate, and exhaust in accordance with Table 3 and Table 4 of §510.131(c) and (d) of this subchapter.

(B) Filtration requirements for air handling units serving the laundry suite shall be equipped with filters having efficiencies equal to, or greater than specified in Table 4 of §510.131(d) of this subchapter.

(C) Direction of air flow of the HVAC systems shall be from clean to soiled areas.

(D) The ventilation system for soiled processing area shall have negative air pressure while the clean processing area shall have positive pressure.

(m) Medical records suite. The following rooms, areas, or offices shall be provided in the medical records suite:

(1) medical records administrator or technician office;

(2) review and dictating rooms or spaces;

(3) work area which includes provisions for sorting, recording, or microfilming records; and

(4) file storage room. Rooms containing open file systems or moveable filing storage systems shall be considered as hazardous. The construction protection for the storage room or area shall comply with NFPA 101 §18-3.2.

(n) Nursing suite. The nursing suite shall be designed to facilitate care of ambulatory and non-ambulatory inpatients.

(1) Physical environment. A nursing suite shall provide a safe environment for patients and staff.

(A) The environment of the unit shall be characterized by a feeling of openness with emphasis on natural light and exterior views and with the organization of various functions accessible to common spaces while not jeopardizing desirable levels of patient privacy.

(B) Interior finishes, lighting, and furnishings shall present an atmosphere which is as noninstitutional as possible, consistent with applicable fire safety requirements. Security and safety devices should not be present in a manner to attract or challenge tampering by patients.

(2) Architectural requirements. Architectural requirements shall be in accordance with §510.122(d)(1) of this subchapter and this paragraph.

(A) Handicapped accessibility requirements. At least 10 percent of patient room suites, bathing units and toilets, and all public and common use areas shall be designed and constructed to be handicapped accessible. These requirements shall apply in all new construction and when an existing nursing suite or a portion thereof is converted from one service to another.

(B) Patient room suites. A patient room suite shall consist of the patient room and a toilet room or bathroom. Patient room suites shall comply with the following requirements.

(i) Maximum patient room capacity. The maximum patient room capacity shall be two patients. In existing facilities where renovation work is undertaken and the present capacity is more than two patients, the maximum room capacity shall be no more than the present capacity with a maximum of four patients.

(ii) Single-bed patient room. In a single-bed patient room, the minimum clear floor area shall be 100 square feet. The minimum clear floor area in an accessible private patient room shall be 120 square feet. The minimum room dimension shall be not less than 10 feet.

(iii) Multi-bed patient room. In a multi-bed patient room, the minimum clear floor area shall be 80 square feet per bed. Minimum clear floor space in an accessible multi-bed room shall be 110 square feet per bed. Design of multi-bed patient rooms shall not restrict independent patient access to the corridor, lavatory, or bathroom.

(iv) Arrangement of patient rooms. Minor encroachments including columns and wall hung lavatories that do not interfere with functions may be ignored when determining space requirements for patient rooms.

(I) Required clear floor space in patient rooms shall be exclusive of toilet rooms, closets, lockers, built-in cabinets, wardrobes, alcoves, or vestibules.

(II) A clearance of 3 feet 8 inches shall be available at the foot of each bed in multi-bed patient rooms to permit the passage of equipment and beds. A minimum distance of three feet between a wall and the side of a bed and four feet between beds shall be provided. A minimum distance of five feet between a wall and the side of a bed and four feet between beds shall be provided in an accessible semi-private room or one intended for rehabilitation patients. Arrangement of beds shall be such that sufficient space is provided for a bed and maneuvering space for a wheelchair.

(III) Sleeping areas shall have doors for privacy. Design for visual privacy in multi-bed rooms shall not restrict patient access to the room, toilet, or observation by staff.

(v) Patient bathroom. Each patient shall have access to a bathroom without having to enter the general corridor area. Each bathroom shall contain a toilet, hand washing fixtures, and storage shelf or cabinet and serve not more than four patient beds or two patient rooms. Hand washing fixtures may be located in the patient room.

(vi) Bathing rooms. One bathtub or shower shall be provided for each four patient beds or space which is not otherwise served by bathing rooms within patients' rooms. Each tub or shower shall be in an individual room or enclosure which provides space for the private use of the bathing fixture and for drying and dressing.

(vii) Patient storage. Each patient shall have a separate wardrobe, locker, or closet that is suitable for hanging full-length garments and for storing personal effects. A minimum of 12 lineal inches of hanging space shall be provided per patient.

(C) Security rooms. When security rooms are provided by the treatment program narrative, the security rooms shall be single patient suite rooms designed to minimize potential for escape, hiding, injury to self or others, or suicide. Access to toilets, showers, and wardrobes shall be restricted. The patient room suite shall be in accordance with subparagraph (B)(ii) of this paragraph. Security rooms may be centralized on one unit or decentralized among units.

(D) Seclusion suite. There shall be a seclusion suite in each nursing suite intended for short-term occupancy by a single person requiring security and protection from self or others. The seclusion suite shall consist of seclusion rooms, an anteroom or a vestibule, a toilet, and hand washing fixtures.

(i) Each seclusion room shall be located and designed in a manner affording direct visual supervision by nursing staff and shall be constructed to prevent patient hiding, escape, injury, or suicide. There shall be a minimum of one seclusion room for each 24 beds or any portion thereof.

(I) The floor area of each seclusion room shall be not less than 60 square feet. The minimum room dimension shall be six feet.

(II) The seclusion room shall have a minimum ceiling height of nine feet.

(III) The door to each seclusion room shall have no hardware on the room side and shall open out. A vision panel shall be provided in each door to permit staff observation of the entire room while maintaining privacy from the public and other patients. The seclusion room door shall swing out.

(IV) Each seclusion room shall have natural light (skylight or window) in order to maintain a therapeutic environment. Skylight wells or windows shall be not less than 400 square inches in area.

(ii) Access to the seclusion room from any public space such as a corridor shall be through an anteroom. When the seclusion suite is directly accessible from the nurse station, a vestibule may be provided in place of an anteroom. A cased opening to the vestibule in lieu of a door may be provided as long as the arrangement assures privacy from the public and other patients.

(I) The minimum dimension of the anteroom or vestibule shall be eight feet.

(II) The door to the anteroom shall swing in.

(iii) There shall be at least one toilet room directly accessible from the anteroom or vestibule.

(I) The toilet room shall be large enough to safely manage the patient.

(II) The toilet room door shall swing out into the anteroom or vestibule.

(III) A water closet and hand washing fixtures shall be provided in the toilet room. An unbreakable wall hung mirror may be provided.

(IV) Doors for the seclusion room and anteroom shall be not less than 3 feet 8 inches in width.

(V) When the interior of the seclusion room is padded, the padding shall be a Class "A." The flame spread rating shall be 0-25 and the smoke development rating shall be 0-450 in accordance with NFPA 101 Chapter 8.

(E) Airborne infection isolation suites. When an isolation suite is provided, the suite may be located within a nursing suite or in a separate isolation unit. Each airborne infection isolation suite shall consist of a work area, a patient room, and a patient bathroom.

(i) The work area may be a separately enclosed anteroom or a vestibule that is open to and is located immediately inside the door to the patient room. It shall have amenities for hand washing, gowning, and storage of clean and soiled materials. One enclosed anteroom may serve multiple isolation rooms.

(ii) Each patient room shall have a clear floor area of 120 square feet exclusive of the work area and shall contain only one bed.

(iii) Each bathroom shall be designed for the use of the handicapped and shall contain bathing fixtures, toilet fixtures and hand washing fixtures. Each bathroom shall be arranged to provide access from the patient room without entering or passing through the work area.

(iv) At least one airborne infection isolation suite with an enclosed anteroom shall be provided.

(v) Ventilation requirements for the isolation rooms shall be in accordance with Table 3 of §510.131(c) of this subchapter.

(vi) Doors to airborne infection isolation rooms shall be provided with self-closing devices.

(F) Social spaces. A minimum of two separate social spaces, one appropriate for noisy activities and the other for quiet activities, shall be provided. The combined total area shall be not less than 40 square feet per bed space with not less than 160 square feet for each of the two spaces, whichever is greater. This space may be shared with the dining area or room.

(G) Group therapy room. A room for group therapy shall be included. The room shall not be less than 250 square feet. The group therapy room may be combined with the quiet space required in subparagraph (F) of this paragraph provided that a space of not less than 370 square feet is available for both the quiet activity room and group therapy activities.

(H) Activity service space. Space for activity services (e.g., music therapy, recreational therapy, art, dance, vocational therapy, educational therapy, etc.) shall be provided at the rate of 15 square feet per occupant of the room and a minimum area of not less than 375 square feet, whichever is greater. Space shall include provisions for hand washing, work counters, storage and displays. Where facilities contain less than 25 beds, the activity services therapy functions may be provided within the noisy activities area as required in subparagraph (F) of this paragraph if a space of not less than 485 square feet is available for both the noisy activity area and activity services area.

(I) Service areas. Service areas shall be located in, or readily available to, each nursing suite. Each service area may be arranged and located to serve more than one nursing suite but at least one service area shall be provided on each nursing floor. A service area is composed of the following.

(i) An administrative center or nurses station with an adjacent but separate dictation space.

(ii) A nurses office.

(iii) An area for charting. The charting area shall be provided with separation needed for acoustical privacy as well as space required for the function. A view window to permit observation of the patient area by the charting nurse or physician may be used provided that it is so located that patient files cannot be read from outside the charting space.

(iv) A medication room, medicine alcove area, or a self-contained medicine dispensing unit under visual control of nursing staff. The room shall have a minimum area of 30 square feet under direct control of the nursing or pharmacy staff. The room, area or unit shall contain a work counter, hand washing fixture with hands-free operable controls, and refrigerator. Provisions for security against unau-

thorized access shall be assured. Standard cup-sinks provided in many self-contained units are not adequate for hand washing.

(v) A small kitchen for patient use. The room shall contain a sink, refrigerator, ice dispenser, microwave, and storage cabinets. This room is to provide nourishment for patients between scheduled meals.

(vi) A multipurpose room for staff and patient conferences, education and demonstrations. The room shall be conveniently accessible to each nursing suite and may serve several nursing suites or departments. The room may be located on another floor if convenient for regular use.

(vii) An examination or treatment room. The room shall have a minimum floor area of 120 square feet excluding space for vestibule, toilet, and closets. The minimum room dimension shall be 10 feet. The room shall contain a lavatory or sink equipped for hand washing, work counter, storage facilities, and a desk, counter, or shelf space for writing. The emergency treatment room may be used for this purpose if it is conveniently located on the same floor as the patient rooms.

(viii) Patient laundry facilities. An automatic washer and an electric dryer shall be provided. This requirement may be omitted in nursing units intended only for adolescents and gero-psychiatric patients.

(ix) Staff lounge with separate female and male dressing areas containing lockers, showers, toilets, and hand washing facilities. These facilities may be on another floor.

(x) Securable closets or cabinet compartments for personal articles of nursing unit staff. The closets or lockers shall be located at or near the nurse station. At a minimum, these shall be large enough for purses and billfolds. Coats may be stored in closets or cabinets on each floor or in a central staff locker area.

(xi) Secured storage area for patients' effects determined potentially harmful (razors, nail files, cigarette lighters, etc.). This area shall be controlled by staff.

(xii) Clean workroom or clean supply room. When used for preparing patient care items, it shall contain a work counter, hand washing facilities, and storage facilities for clean and sterile supplies. When used only for storage and holding as part of a distribution system of clean and sterile supplies, the work counter and hand washing facilities may be omitted.

(xiii) Clean linen storage for each nursing unit. The clean linen area shall contain a work counter and storage space for clean linen. The area shall be a part of the storage and distribution of clean linen. Minimum area for clean linen shall be three square feet of room area per patient bed space. The required area may be concentrated in one central room or divided in several rooms throughout the facility.

(xiv) A soiled workroom or soiled holding room. The room shall contain a clinical sink or equivalent flushing rim fixture, hand washing facilities, both with hot and cold water. The room shall have a work counter and space for separate covered containers for soiled linen and waste. Minimum area for soiled linen shall be three square feet of room area per patient bed space.

(xv) An equipment storage room and storage room for administrative supplies located on each floor which may serve multiple nursing suites.

(xvi) An emergency equipment storage room or alcove under direct visual control of the nursing staff and out of normal traffic.

(xvii) A housekeeping room which may also serve adjacent nursing suites.

(xviii) Stretcher and wheelchair storage space which is located without restricting normal traffic. The space may be located outside the nursing suite.

(xix) An accessible public toilet with hand washing fixtures. The toilets shall be located on each floor containing a nursing suite.

(xx) Staff toilet conveniently located to each nursing suite. At least one staff toilet shall be located on each patient sleeping floor. Toilet may be unisex.

(xxi) An ice dispensing machine for each nursing suite which is located at the nourishment station or the clean work room.

(xxii) Adequate number of drinking fountain fixtures.

(xxiii) Adequate number of telephones available for patients' private conversations.

(xxiv) A visitor room for patients to meet with friends or family with a minimum floor space of 100 square feet.

(xxv) A quiet room for a patient who needs to be alone for a short period of time but does not require a seclusion room. Each quite room shall be not less than 80 square feet. The visitor room may serve this purpose.

(xxvi) Separate consultation room. The room shall have a minimum floor space of 100 square feet, and provided at a room-to-bed ratio of one consultation room for each 12 patient beds. The room(s) shall be designed for acoustical and visual privacy and constructed to achieve a level of voice privacy of 50 STC (which in terms of vocal privacy means that some loud or raised speech is heard only by straining, but is not intelligible).

(xxvii) A conference and treatment planning room for use for patient care planning. This room may be combined with the charting room or use of the multipurpose room.

(3) Details and finishes. Details and finishes shall be in accordance with §510.122(d)(2) of this chapter and this paragraph.

(A) Details.

(i) Egress. Means of egress from each patient suite shall comply with the requirements of NFPA 101 §18-2.

(ii) Patient bathroom and toilet room doors. Door leaves to all patient bathrooms and toilet rooms shall be at least 36 inches wide and shall swing outward or be double acting so that nursing staff may gain access to a patient. Doors lockable from the inside shall have hardware that allows staff to open the door from the outside.

(iii) Vision panels. Vision panels shall be provided in the door between an anteroom and an airborne infection isolation room.

(iv) Windows. Each patient sleeping room shall have an outside window. The windows shall be restricted. Where the operation of windows requires the use of tools or keys, the tools or keys shall be located at each nurses station, on the same floor, and easily accessible to staff. The bottom of the window opening shall not exceed 36 inches above the floor.

(v) Location of patient room windows. Windows shall be located on an outside wall. Windows may face an atrium, an

inner court, or an outer court provided the following requirements are met.

(I) Atria windows. Atria onto which the required windows face shall comply with the requirements of NFPA 101 §8-2.5.6.

(II) Outer courts. Outer court (not enclosed by building on one side) onto which the required windows face shall have a minimum width, at all levels, of not less than three inches for each foot, or fraction thereof, of the height (average height of enclosing walls) of such court, but in no case shall the width be less than five feet. An outer court shall have a horizontal cross sectional area not greater than four times the square of its width.

(III) Inner courts. Inner court (enclosed by building on all sides) onto which the required windows open shall have minimum width, at all levels, of not less than one foot for each foot, or fraction thereof, of the height (average height of enclosing walls) of such courts, but in no case shall the width be less than 10 feet. If operable windows are provided, a horizontal, unobstructed, and permanently open air intake or passage having a cross-sectional area of not less than 21 square feet shall be provided at or near the bottom of the court. Metal decorative grilles not effectively reducing the open area by more than five percent shall be permitted at the ends. Walls, partitions, floor, and floor-ceiling assemblies forming intakes or passages shall be noncombustible and shall be constructed in accordance with NFPA 101 §18-3.1(b) and (c). An inner court shall have a horizontal cross sectional area of not less than one and one-half times the square of its width.

(vi) Visibility. All areas of the nursing suite, including entrances to patient rooms, shall be visible from the nurse station. Observation by video cameras of seclusion rooms, entrances, hallways, and activity areas shall be acceptable.

(vii) Special fixtures, hardware, and tamper-proof screws. Special fixtures, hardware, and tamper-proof screws shall be used throughout the patient nursing suites.

(I) All exposed and accessible fasteners shall be tamper-resistant.

(II) Suitable hardware shall be provided on doors to toilet rooms so that access to these rooms can be controlled by staff. Hardware shall be utilized which is appropriate to prevent patient injury.

(III) Only break-away or collapsible clothes bars in wardrobes, lockers, towel bars, and closets and shower curtain rods shall be permitted. Wire coat hangers shall not be permitted in nursing suites.

(IV) When grab bars are provided, the space between the grab bar and the wall should be filled to prevent a cord being tied around it for hanging. Bars, including those which are part of such fixtures as soap dishes, shall be sufficiently anchored to sustain a concentrated load of 250 pounds.

(viii) Detention screens.

(I) When operable windows are provided in patient sleeping rooms, it may be necessary to provide detention screens on windows or limit the amount of window operation in order to inhibit possible tendency for suicide or elopement. The type and the degree of security required shall be determined by the facility administration.

(II) When detention screens are provided, windows shall be capable of opening with the screens in place. Where glass fragments may create a hazard, safety glazing or other appropriate security features shall be incorporated.

(III) In building housing for certain types of patients, detention rooms, or a security section, the facility shall provide detention screens to confine or protect building inhabitants, when necessary.

(ix) Hand washing amenities. Hand washing amenities shall be conveniently located near the nurses station and in the medication area. One lavatory in an open medication area can meet this requirement.

(x) Elevator lobbies. Elevator lobbies shall be physically separated from the required means of egress with one hour fire rated construction which resist the passage of smoke on all floors containing patient rooms.

(B) Finishes.

(i) Seamless floors with coved wall bases described in §510.122(d)(2)(B)(iii)(III) of this subchapter shall be provided in soiled workrooms.

(ii) Wall bases in the soiled workroom shall be made integral and coved with the floor, tightly sealed to the wall, constructed without voids that can harbor insects, retain dirt particles, and impervious to water.

(iii) Monolithic ceilings described in §510.122(d)(2)(B)(vi)(III) of this subchapter shall be provided in airborne infection isolation rooms, seclusion rooms, and security rooms.

(iv) Ceilings of patient rooms may be acoustically treated; however, they shall be monolithic as described in §510.122(d)(2)(B)(vi)(III) of this subchapter.

(v) Acoustical ceilings shall be provided for corridors in patient areas, nurses' stations, dayrooms, recreation rooms, dining areas, and waiting areas.

(4) Mechanical requirements. Mechanical requirements shall be in accordance with §510.122(d)(3) of this subchapter and this paragraph.

(A) Special consideration shall be given to the type of heating and cooling units, ventilations outlets, and appurtenances installed in patient-occupied areas of nursing suites. The following shall apply.

(B) All air grilles and diffusers shall be of a type that prevents the insertion of foreign objects.

(C) All convector or HVAC enclosures exposed in the room shall be constructed with rounded corners and shall have enclosures fastened with tamper-resistant fasteners.

(D) HVAC equipment shall be of a type that minimizes the need for maintenance within the room.

(E) Outside air shall be supplied to each patient room by a central air handling unit to provide make-up air for air exhausted from the bathroom in accordance with Note 3 of Table 3 of §510.131(c) of this subchapter.

(F) Each patient room bathroom shall be exhausted continuously to the exterior in accordance with Table 3 of §510.131(c) of this subchapter.

(5) Piping systems and plumbing fixtures. Piping systems and plumbing fixtures shall be in accordance with §510.122(d)(4) of this subchapter and this paragraph.

(A) Each patient bathroom shall contain a water closet and a lavatory. The lavatory may be located in a single bed patient room instead of in the bathroom.

(B) An additional lavatory shall be placed in each patient room proper where the bathroom serves more than two beds.

(C) Hand washing fixtures shall be located near the nurses' station and the drug distribution station. One lavatory may serve both areas.

(D) Faucet controls shall not be equipped with handles that may be easily broken off in the patient care areas.

(E) Bedpan washers are not required in patient bathrooms.

(F) Piped medical gas systems are not required unless otherwise noted.

(G) Only special, tamper proof sprinkler heads from which it is not possible to suspend any objects shall be installed.

(6) Electrical requirements. Electrical requirements shall be in accordance with §510.122(d)(5) of this subchapter and this paragraph.

(A) Electric receptacles in nursing units.

(i) Each receptacle shall be grounded to the reference grounding point by means of an insulated copper grounding conductor.

(ii) Each patient bed location shall be supplied by at least two branch circuits, one from the critical branch of the emergency system as required by NFPA 99, §3-4 and one from the normal system. All branch circuits from the normal system shall originate in the same panelboard.

(iii) One duplex receptacle connected to a normal branch circuit and one duplex outlet connected to the critical branch circuit shall be located on opposite sides of the head of each bed. In addition at least one duplex outlet shall be located on each wall. A dedicated outlet shall be provided at the television location.

(iv) Each examination table shall have access to two duplex receptacles.

(v) Each work table or counter shall have access to two duplex receptacles.

(vi) One duplex receptacle shall be installed in the bathroom to permit the use of electrical appliances in front of the mirror.

(vii) Receptacles shall be protected by GFCI breakers installed in distribution panel enclosures serving the nursing suite.

(viii) Duplex receptacles shall be installed not more than 50 feet apart in corridors and within 25 feet of corridor ends.

(ix) When mobile x-ray equipment is provided, special receptacles marked for X-ray use shall be installed in corridors so that mobile equipment may be used anywhere within a patient room using a cord length of 50 feet or less. Where capacitive discharge or battery powered X-ray units are used, special X-ray receptacles will not be required in corridors.

(x) Additional duplex receptacles shall be installed as required to satisfy operational needs of the nursing unit.

(B) Nurses calling systems. When a nurses calling system is provided in a nursing suite, a nurses regular calling system, nurses emergency calling system, and a staff emergency assistance calling system shall comply with §510.122(d)(5)(K) of this subchapter. Provisions shall be made for easy removal of all call buttons or for covering call buttons as required for security. Pull cords shall not exceed 18 inches in length.

(i) Each patient room shall be served by at least one nurses regular calling station for two-way voice communication. Each patient bed shall be provided with a call button. Two call buttons serving adjacent beds may be served by one calling station. In rooms containing two or more calling stations, indicating lights shall be provided at each station. Nurses calling systems shall be equipped with an indicating light at each calling station which remains lighted as long as the voice circuit is operating.

(ii) A nurses emergency calling system shall be provided at each inpatient water closet, bathtub and shower in accordance with §510.122(d)(5)(K)(ii) of this subchapter. When conveniently located one emergency call station may serve one bathroom.

(iii) A staff emergency assistance calling system for staff to summon additional assistance shall be provided in central bathing facility rooms and exam or treatment rooms in accordance with §510.122(d)(5)(K)(iii) of this subchapter.

(iv) All nurse call hardware shall have tamper resistant fasteners.

(v) A call system shall be provided at all seclusion anterooms.

(C) Illumination requirements.

(i) General illumination requirements. Nursing suite corridors shall have general illumination with provisions for reducing light levels at night. Illumination of corridors for egress purposes shall comply with NFPA 101 §§18-2.8 and 18-2.9.

(ii) Illumination of the nurses station. Illumination of the nurses station and all nursing support areas shall be with fixtures powered from the critical branch of the emergency electrical system NFPA 99 §3-4.2.2.2(c).

(iii) Patient suite lighting.

(I) Each patient room shall be provided with general lighting and night lighting. General lighting and night lighting shall be controlled at the room entrance. All controls for lighting in patient areas shall be of the quiet operating type. Control of night lighting circuits may be achieved by automatic means and in such instances control of night lighting at the room entrance shall not be required. At least one general light fixture and night lighting shall be powered from the critical branch of the essential electrical system.

(II) A reading light shall be provided for each patient. Reading light control shall be readily accessible from each patient bed. High heat producing light sources such as incandescent and halogen shall be avoided to prevent burns to patients and/or bed linen. Light sources shall be covered by a diffuser or a lens.

(III) A wall or ceiling mounted lighting fixture shall be provided above each lavatory.

(IV) A ceiling mounted fixture shall be provided in patient bathrooms where the lighting fixture above the lavatory does not provide adequate illumination of the entire bathroom. Some form of fixed illumination shall be powered from the critical branch.

(o) Pharmacy suite.

(1) Architectural requirements.

(A) General. The pharmacy room or suite shall be located for convenient access, staff control, and security for drugs and personnel.

(B) Dispensing area. The pharmacy room or suite shall include the following functional spaces and facilities:

(i) area for pickup, receiving, reviewing and recording;

(ii) extemporaneous compounding area with sufficient counter space for drug preparation and sink with hands-free operable controls;

(iii) work counter space for automated and manual dispensing activities;

(iv) storage or areas for temporary storage, exchange, and restocking of carts; and

(v) security provisions for drugs and personnel in the dispensing counter area.

(C) Manufacturing. The pharmacy room or suite shall provide the following functional spaces and facilities.

(i) When bulk compounding area is required, work space and counters shall be provided.

(ii) When packaging, labeling and quality control is required, an area(s) shall be provided.

(D) Storage. The following spaces shall be provided in cabinets, shelves, and/or separate rooms or closets:

(i) space for bulk storage, active storage, and refrigerated storage;

(ii) storage in a fire safety cabinet or storage room that is constructed under the requirements for protection from hazardous areas in accordance with NFPA 101 Chapter 12, for alcohol or other volatile fluids, when used; and

(iii) storage space for general supplies and equipment not in use.

(E) Administrative area. An administrative area for the pharmacy is optional for crisis stabilization units. The following functional spaces and facilities shall be included for the administrative area.

(i) Office area for the chief pharmacist and any other offices areas required for records, reports, accounting activities, and patients profiles.

(ii) Poison control center with storage facilities for reaction data and drug information centers.

(iii) A room or area for counseling and instruction when individual medication pick-up is available for inpatients or outpatients.

(F) Service areas. The following service areas and items shall be provided.

(i) Intravenous (IV) solutions area. When IV solutions are prepared in a pharmacy, a sterile work area with a laminar-flow workstation designed for product protection shall be provided.

(ii) Satellite pharmacy. When provided, the room shall include a work counter, a sink with hands-free operable controls, storage facilities, and refrigerator for medications.

(iii) Hand washing amenities. A hand washing fixture with hands-free operable controls shall be located in each room where open medication is handled.

(iv) Staff toilets. Toilets may be outside the suite but shall be convenient for staff use.

(2) Mechanical Requirements. Mechanical requirements shall be in accordance with §510.122(d)(3) of this subchapter and this paragraph. When IV solutions are prepared, the required laminar-flow system shall include a non-hygroscopic filter rated at 99.97% (HEPA). A pressure gauge shall be installed for detection of filter leaks or defects.

(3) Piping systems and plumbing fixtures. Piping systems and plumbing fixtures shall be in accordance with §510.122(d)(4) of this subchapter and this paragraph.

(A) Material used for plumbing fixtures shall be non-absorptive and acid-resistant.

(B) Water spouts used at lavatories and sinks shall have clearances adequate to avoid contaminating utensils and the contents of carafes, etc.

(4) Electrical requirements. Electrical requirements shall be in accordance with §510.122(d)(5) of this subchapter and this paragraph.

(A) Under-counter receptacles and conduits shall be arranged (raised) to not interfere with cleaning of the floor below or of the equipment.

(B) Exhaust hoods shall have an indicator light indicating that the exhaust fan is in operation.

(C) Electrical circuits to equipment in wet areas shall be provided with five milliampere GFCI.

(p) Rehabilitation therapy suite.

(1) Occupational therapy. When occupational therapy services are provided, the following shall be included:

(A) an activity room with work areas, counters and a hand washing fixture. Counters shall be wheel chair accessible;

(B) a storage room for supplies and equipment;

(C) secured storage for potential harmful supplies and equipment; and

(D) remote electrical switching for potentially harmful equipment.

(2) Physical therapy. When physical therapy services are provided, the following rooms shall be included.

(A) When services required by the narrative program for thermotherapy, diathermy, ultrasonics, and hydrotherapy, individual treatment areas shall be provided.

(B) An individual treatment area shall be a minimum of 70 square feet of clear floor area exclusive of four foot aisle space. Privacy screens or curtains shall be provided at each treatment station.

(C) A hand washing fixture with hands-free operable controls shall be provided in each treatment room or space. A hand washing fixture may serve several patient stations when cubicles or open room concepts are used and when the fixture is conveniently located.

(D) An area shall be provided for exercise and may be combined with treatment areas in open plan concepts.

(E) Provisions for the collection and storage of wet and soiled linen shall be provided.

(F) A storage area or room for equipment, clean linen, and supplies shall be provided.

(G) When outpatient physical therapy services are provided, the suite shall have as a minimum patient dressing areas, showers, and lockers.

(3) Service areas. The following areas or items shall be provided in a rehabilitative therapy suite but may be shared when multiple rehabilitation services are offered:

(A) patient waiting area with space for wheelchairs;

(B) patient toilet facilities containing hand washing fixtures with hands-free operable controls;

(C) reception and control stations shall be located to provide supervision of activities areas and the control station may be combined with office and clerical spaces;

(D) office and clerical space;

(E) wheelchair and stretcher storage room or alcove which shall be in addition to other storage requirements;

(F) lockable closets, lockers or cabinets for securing staff personal effects;

(G) staff toilets may be outside the suite but shall be convenient for staff use and contain hand washing fixtures with hands-free operable controls; and

(H) housekeeping room, conveniently accessible.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 1, 2024.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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For further information, please call: (512) 834-4591

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CHAPTER 510. PRIVATE PSYCHIATRIC HOSPITALS AND CRISIS STABILIZATION UNITS

The Texas Health and Human Services Commission (HHSC) adopts the repeal of §§510.81, concerning Survey and Investigation Procedures; 510.82, concerning Complaint Against a Texas Department of Health Representative; and 510.83, concerning Enforcement; and new §§510.81, concerning Integrity of Inspections and Investigations; 510.82, concerning Inspections; 510.83, concerning Complaint Investigations; 510.84, concerning Notice; 510.85, concerning Professional Conduct; 510.86, concerning Complaint Against an HHSC Representative; and 510.87, concerning Enforcement.

The repeal of §§510.81 - 510.83 and new §§510.84 - 510.86 are adopted without changes to the proposed text as published in the May 10, 2024, issue of the *Texas Register* (49 TexReg 3186). These rules will not be republished.

New §§510.81 - 510.83, and 510.87 are adopted with changes to the proposed text as published in the May 10, 2024, issue of the *Texas Register* (49 TexReg 3186). These rules will be republished.

BACKGROUND AND JUSTIFICATION

The adoption is necessary to implement House Bill (H.B.) 49, 88th Legislature, Regular Session, 2023. H.B. 49 amended Texas Health and Safety Code (HSC) §577.013 to make certain information related to facility investigations subject to disclosure and create a requirement for HHSC to post certain information related to hospital investigations on the HHSC website.

The adoption is also necessary to update the inspection, complaint investigation, and enforcement procedures for private psychiatric hospitals and crisis stabilization units (PPHCSUs). These updates are necessary to hold PPHCSUs accountable during the inspection and investigation processes and ensure PPHCSUs provide necessary documentation in a timely manner to HHSC representatives. The adopted rules revise enforcement procedures to ensure conformity with current practices and statutes. These updates also ensure consistent practices across HHSC Health Care Regulation, correct outdated language and contact information, and reflect the transition of regulatory authority for PPHCSUs from the Department of State Health Services to HHSC.

COMMENTS

The 31-day comment period ended June 10, 2024.

During this period, HHSC received comments regarding the proposed rules from six commenters, including Citizens Commission on Human Rights (CCHR), Disability Rights Texas (DRTx), Texas Association of Behavioral Health Systems (TABHS), Texas Council for Developmental Disabilities (TCDD), Texas Hospital Association (THA), and Texas Medical Association (TMA). A summary of comments relating to the rules and HHSC's responses follows.

Comment: THA expressed appreciation for HHSC considering comments from the previous public comment period and incorporating some of the feedback THA and other stakeholders provided.

Response: HHSC acknowledges this comment.

Comment: THA stated there was a possible grammatical error or missing words in §510.81(a)(2) and suggested the paragraph instead read, "may not record, listen to, or eavesdrop on any HHSC internal discussions outside the presence of facility staff when HHSC has requested a private room or office or distanced themselves from facility staff unless it first informs HHSC and the facility obtains HHSC's written approval before beginning to record or listen to the discussion."

Response: HHSC revised §510.81(a)(2) by adding "unless the facility first informs HHSC" to clarify that a facility must first inform HHSC and then obtain HHSC's written approval before beginning to record or listen to an HHSC internal discussion.

Comment: THA requested HHSC revise §510.81(b) to clarify that a facility must only inform HHSC of audio-capturing recording devices that are not readily visible. THA stated security cameras are present in many locations in facilities, particularly hallways and common areas, and that it is possible cameras may be present while HHSC staff are having discussions. THA noted cameras in common areas would be visible to anyone and likely

do not capture audio and should not require disclosure by the facility.

Response: HHSC declines to revise §510.81(b) because HHSC staff need enhanced privacy for internal discussion and this paragraph is necessary to protect HHSC staff from intentional or unintentional eavesdropping.

Comment: TABHS requested HHSC clarify to whom the term "individual" applies in §510.81(d) and asked whether the term referred to a facility staff member, a patient, an HHSC representative, or all the above. TABHS also stated it supports the rights of staff members and patients to record conversations with HHSC representatives.

Response: HHSC declines to revise §510.81(d) and notes that "individual" refers to anyone.

Comment: TABHS requested HHSC clarify whether a facility may allow HHSC to interview governing body members, facility personnel, and patients through virtual methods in §510.82(f) and §510.83(h).

Response: HHSC declines to revise §510.82(f) and §510.83(h) because as written, these subsections do not preclude a facility from providing HHSC access to interview governing body members, personnel, and patients through virtual methods.

Comment: THA expressed concern about §510.82(f) and §510.83(h), which require a facility to permit HHSC access to interview members of a facility's governing body, personnel, and patients, including the opportunity to request written statements. THA stated members of facility governing bodies are often community members not involved in the facility's daily operations and subjecting them to interviews may deter community involvement in facility boards. THA further stated that requesting written statements from personnel and governing body members could lead to disputes and potential enforcement actions if statements are not provided or deemed unsatisfactory. THA requested HHSC remove the provisions allowing interviews with governing body members and the requirement for written statements to avoid potential adversarial situations if a facility declines HHSC's request.

Response: HHSC declines to revise §510.82(f) and §510.83(h) because it is important for HHSC staff to have the opportunity to talk to and request statements from relevant individuals, including, at times, members of a facility's governing body. HHSC notes these subsections do not require a written statement and only allows HHSC the opportunity to request one.

Comment: TABHS suggested HHSC add language to §510.82(g) and §510.83(i) to allow a facility to make copies of any documents or other records if needed before HHSC removes that information from the facility, particularly if they are clinician notes and other documentation necessary for patient care.

Response: HHSC declines to revise §510.82(g) and §510.83(i) because as written, these subsections do not prohibit a facility from making copies of any documents or records before HHSC removes them from the facility.

Comment: TABHS requested HHSC add language to §510.82(j) and §510.83(k) to ensure a facility has an opportunity for another exit conference to provide documentation regarding compliance for any preliminary findings that were not discussed during the original exit conference. TABHS stated HHSC currently does not ensure facilities have the right to provide additional documentation for any preliminary findings not discussed during the original exit conference.

Response: HHSC declines to revise §510.82(j) and §510.83(k) because the facility is entitled to due process, which allows for the facility to follow up and provide more documentation after HHSC completes the inspection or issues a citation.

Comment: THA questioned whether HHSC disclosing information to law enforcement agencies as allowed by §510.82(k)(4) and §510.83(m)(4) is appropriate or legally permissible. However, THA noted the statutory language supported this exception. THA stated that the Health Insurance Portability and Accountability Act (HIPAA) provides limited exceptions for disclosures to law enforcement, typically requiring specific legal processes like search warrants or subpoenas. THA further stated that the proposed rule may not comply with HIPAA and HSC §181.004. THA requested HHSC remove §510.82(k)(4) and §510.83(m)(4) because THA does not believe it is appropriate for HHSC to have rules specifically permitting the disclosure of confidential information to a law enforcement agency. Alternatively, THA requested HHSC revise §510.82(k)(4) and §510.83(m)(4) to state "law enforcement agencies as otherwise authorized or required by law."

Response: HHSC revised §510.82(k)(4) and §510.83(m)(4) to add "as allowed by law" to the end of the paragraph.

Comment: CCHR expressed support for the inclusion of language added by H.B. 49, 88th Regular Session, 2023 at §510.82(l) and §510.83(n). H.B. 49 amended Texas Health and Safety Code (HSC) §241.051 to make certain information related to hospital investigations subject to disclosure and create a requirement for HHSC to post certain information related to hospital investigations on the HHSC website.

Response: HHSC acknowledges this comment.

Comment: TMA stated that §510.82(l) and §510.83(n) tracked the governing statute except for §510.82(l)(6) and §510.83(n)(6). TMA further stated Texas Government Code Chapter 552 generally gives the public the right to access government information on request, so §510.82(l)(6) and §510.83(n)(6) would make all inspection and investigation information, other than certain personally identifying information, subject to public disclosure, which conflicts with HSC §577.013(e). TMA recommended that §510.82(l)(6) and §510.83(n)(6) be removed to properly align with HSC §577.013(e).

Response: HHSC declines to remove §510.82(l)(6) and §510.83(n)(6) because these paragraphs state that HHSC will follow the requirements of public information laws, which prohibit disclosure of information made confidential by other laws, such as HSC §577.013(e). These paragraphs do not authorize disclosure of any information contrary to those laws.

Comment: THA expressed concern with the posting requirements at §510.83(a)(2) because the requirements will take time for facilities to implement and there is a possible conflict with an existing rule at 25 TAC §1.191, which also mandates signage to notify patients where they can file complaints. THA requested HHSC withdraw §510.83(a)(2), review the rule at 25 TAC §1.191 alongside proposed §510.83(a)(2), and propose a unified rule that avoids duplicative or conflicting signage mandates. Alternatively, THA proposed an extended implementation period of at least 12 months for facilities to comply with the signage requirements and for HHSC to provide guidance on how to reconcile the two rules.

Response: HHSC declines to remove §510.83(a)(2) because HHSC does not enforce 25 TAC §1.191 regarding PPHCSUs. Section 510.83(a)(2) applies to facilities regulated by HHSC, and 25 TAC §1.191 applies to facilities regulated by DSHS.

Comment: DRTx recommended HHSC revise §510.83(d) by adding language regarding HHSC's duty to complete regulatory investigations regardless of the Centers for Medicare & Medicaid Service (CMS) authorization. DRTx stated that HHSC and other state agencies have the authority and receive state funding to complete their responsibilities for facility investigations and regulatory oversight. DRTx further stated it is the responsibility of the state regulatory agency to protect Texas's vulnerable citizens, and HHSC should investigate allegations meeting the definitions of abuse and neglect in Texas law, even if CMS does not authorize an investigation. DRTx expressed concern with HHSC referring investigations of complaints involving psychiatric facilities that HHSC chose not to investigate to the Joint Commission. DRTx stated the Joint Commission is an accrediting body and does not perform investigations of abuse or neglect consistent with Texas regulations. DRTX also stated CMS does not provide any information about any investigation, review, or action on such referrals. DRTx stated such referrals result in the allegations not being addressed by any investigatory entity.

Response: HHSC declines to revise §510.83(d) because this subsection allows for coordination with CMS in accordance with HSC §222.026(a)(2), but §510.83(d) does not preclude HHSC from conducting investigations independent of CMS or from meeting the agency's responsibilities for conducting investigations in accordance with §510.46, 25 TAC Chapter 1, Subchapter Q, and HHSC internal policies.

Comment: Regarding §510.83(d), CCHR stated Texas has its own unique statutes and HHSC has the right, duty, and budget to investigate complaints that are not related to CMS Conditions of Participation. CCHR stated CMS funding should not play a role in HHSC choosing whether to investigate a complaint. CCHR also noted that it was aware of complaints that were referred to the Joint Commission and complaints should not be referred to the Joint Commission in lieu of investigation because the Joint Commission is an industry paid accreditation organization and not a regulatory organization.

Response: HHSC declines to revise §510.83(d) because this subsection allows for coordination with CMS in accordance with HSC §222.026(a)(2) but does not preclude HHSC from conducting investigations independent of CMS or from meeting the agency's responsibilities for conducting investigations in accordance with Chapter 510 and HHSC internal policies.

Comment: TCDD recommended HHSC revise §510.83(d) to add language regarding HHSC's duty to complete investigations regardless of CMS authorization and language prohibiting HHSC from delegating its investigatory responsibilities to any other entity. TCCD stated in the rule, HHSC did not acknowledge the state regulatory agency's responsibility to protect vulnerable Texans in psychiatric hospitals and CSUs or assert its responsibility for investigations without CMS authorization or payment from any other entity, including CMS. TCDD expressed its concern with the delegation of investigations to the Joint Commission, which TCDD stated is not a regulatory or investigatory body and does not conduct investigations of abuse and neglect consistent with Texas regulations. TCDD stated these referred allegations are not being addressed by any investigatory entity.

Response: HHSC declines to revise §510.83(d) because this subsection allows for coordination with CMS in accordance with HSC §222.026(a)(2), but §510.83(d) does not preclude HHSC from conducting investigations independent of CMS or from meeting the agency's responsibilities for conducting investigations in accordance with Chapter 510 and HHSC internal policies.

Comment: THA requested HHSC extend the timeframe for facilities to submit a plan of correction (POC) under §510.84(b)(2) because THA stated the proposed 10 calendar day timeframe was too compressed to develop an extensive POC and implementation plan. THA suggested language that would lengthen the timeframe to 30 calendar days for deficiencies that did not affect patient health and safety and language to allow flexibility for HHSC to require a shorter timeframe, but no earlier than 10 calendar days, for more urgent issues affecting or potentially affecting patient health and safety.

Response: HHSC declines to revise §510.84(b)(2) because 10 calendar days after receipt of a statement of deficiencies (SOD) is sufficient time to provide HHSC with a POC. HHSC notes a facility is made aware of the issues HHSC found and the potential citations at the exit conference so the facility can begin working on correcting any issues even before receipt of the SOD.

Comment: TMA stated §510.85 appears to impose reporting mandates on HHSC. TMA stated not every issue relating to the conduct of a licensed professional, intern, or application for professional licensure will necessarily warrant reporting to the licensing board. TMA recommended replacing "reports" with "may report" in §510.85 to allow HHSC to exercise discretion in its reporting.

Response: HHSC declines to revise §510.85 because the agency prefers to err on the side of caution regarding conduct of licensed professionals. HHSC notes licensing boards have discretion in responding to any complaint.

Comment: THA expressed concern with §510.86 not including the details related to HHSC's internal procedures regarding complaints against an HHSC representative, currently found at §510.82. THA stated it is important for facilities to understand how HHSC handles complaints against surveyors or investigators, including clear expectations for HHSC's response timeframe. THA requested HHSC include procedural details in the final rule to ensure transparency and provide facilities with an opportunity to provide input. Additionally, THA suggested the rule include clear anti-retaliation language to protect facilities or individuals filing complaints, and proposed language prohibiting retaliation by HHSC or HHSC representatives against facilities or persons filing a complaint against an HHSC representative.

Response: HHSC declines to revise §133.106 as requested because the agency investigates complaints against HHSC representatives immediately on receipt and in accordance with its policies, which include requiring staff to perform their duties in a lawful, professional, and ethical manner.

Comment: TCDD stated §510.87 is missing several pertinent chapters and conflicts with §510.46, which states that HHSC will not investigate allegations that are not a violation of Chapters 571 or 577 and will refer those allegations to law enforcement or another agency. TCCD recommended also referencing HSC Chapters 161, 321, and 322 in §510.87 because these chapters also apply to psychiatric hospitals.

Response: HHSC revised §510.87 as suggested to include HSC Chapters 161, 321, and 322.

Comment: THA expressed concern with §510.87(1)(O) and stated participation in Medicare is voluntary and should not be a criterion for licensing decisions or penalties. THA requested HHSC remove this paragraph because THA stated a facility terminating the facility's Medicare provider agreement should not jeopardize the facility's licensure status or result in penalties.

Response: HHSC revised §510.87(1)(O) to clarify this subparagraph applies if CMS terminates the facility's Medicare provider agreement.

Comment: THA expressed concern with §510.87(2)(B)(ii) because THA stated the category is overly broad and that it is not uncommon for providers to make unintentional billing errors that result in Medicare sanctions, and in those cases the provider repays any amounts owed and associated penalties and is free to continue participating in the Medicare program. Further, THA stated other regulatory infractions of Medicare Conditions of Participation may result in citations and sanctions and penalties that are inconsequential and do not justify denying a facility license.

Response: HHSC declines to revise §510.87(2)(B)(ii) because HHSC has jurisdiction to enforce violations if the facility discloses actions that could result in HHSC denying a license application or suspending or revoking a facility's license.

Comment: THA requested HHSC revise §510.87(2)(B)(iii) to state "federal or state tax liens that are unsatisfied after all avenues of dispute have been exhausted" because THA stated the category is overly broad and stated that the facility may not have had the opportunity to dispute a lien and HHSC could deny the facility's license for an unresolved lien for which a dispute is pending.

Response: HHSC declines to revise §510.87(2)(B)(iii) because unsatisfied federal or state tax liens could indicate that an applicant or licensee cannot meet their financial obligations, which may create health and safety concerns.

Comment: THA requested HHSC remove §510.87(2)(B)(iv) because THA stated the category is overly broad because there is no threshold amount in controversy, it does not account for audit exceptions that are still being disputed, civil judgments may be taken for many reasons that would have no bearing on the fitness to operate a facility, and final judgments could still be on appeal and therefore be technically unsatisfied. Alternatively, THA requested HHSC revise this clause to specify the specific types of judgments that could result in denial and account for final judgments that may be on appeal and suggested for the rule to state "federal Medicare or state Medicaid audit exceptions that are unresolved after all avenues of dispute are exhausted."

Response: HHSC declines to remove or revise §510.87(2)(B)(iv) because this clause provides HHSC regulatory oversight and could also indicate that an applicant or licensee cannot meet their financial obligations, which may create health and safety concerns.

Comment: THA requested HHSC revise §510.87(2)(B)(vi) to state "federal Medicare or state Medicaid audit exceptions that are unresolved after all avenues of dispute are exhausted." THA stated this clause is overly broad because there is no threshold amount in controversy, and it does not account for audit exceptions that are still being disputed.

Response: HHSC declines to revise §510.87(2)(B)(vi) because HHSC has jurisdiction to enforce violations if the facility discloses actions that could result in HHSC denying a license application or suspending or revoking a facility's license.

HHSC revised §510.81(a)(1) to connect paragraphs (1) and (2) with "or" instead of "and." HHSC made this change to ensure consistency with the freestanding emergency medical care facility rule at 26 TAC §509.81 and the limited services hospital rule at 26 TAC §511.111(a).

HHSC revised §510.82(e) and §510.83(g) by adding "video surveillance" to the list of items a facility must permit HHSC to examine during any HHSC inspection or investigation. This change is made so that the list in §510.82(e) and §510.83(g) is consistent with other HHSC rules in this rule project and the list in 26 TAC §511.112(e) for a limited services rural hospital.

HHSC revised §510.82(l)(6) and §510.83(n)(6) to remove the word "request" because the laws are about public information laws and not public information request laws.

HHSC revised §510.82 to add new subsection (p) which states HHSC will notify a complainant within 10 business days after completing the investigation of the investigation's outcome.

SUBCHAPTER E. ENFORCEMENT

26 TAC §§510.81 - 510.83

STATUTORY AUTHORITY

The repeals are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Health and Safety Code §577.010, which requires HHSC to adopt rules and standards necessary and appropriate to ensure the proper care and treatment of patients in a private mental hospital or mental health facility.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 1, 2024.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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Proposal publication date: May 10, 2024
For further information, please call: (512) 834-4591

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26 TAC §§510.81 - 510.87

STATUTORY AUTHORITY

The new sections are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Health and Safety Code §577.010, which requires HHSC to adopt rules and standards necessary and appropriate to ensure the proper care and treatment of patients in a private mental hospital or mental health facility.

§510.81. Integrity of Inspections and Investigations.

(a) In order to preserve the integrity of the Texas Health and Human Services Commission's (HHSC's) inspection and investigation process, a facility:

(1) shall not record, listen to, or eavesdrop on any HHSC interview with facility staff or patients that the facility staff knows HHSC intends to keep confidential as evidenced by HHSC taking reasonable measures to prevent from being overheard; or

(2) shall not record, listen to, or eavesdrop on any HHSC internal discussions outside the presence of facility staff when HHSC has requested a private room or office or distanced themselves from facility staff unless the facility first informs HHSC and the facility obtains HHSC's written approval before beginning to record or listen to the discussion.

(b) A facility shall inform HHSC when security cameras or other existing recording devices in the facility are in operation during any internal discussion by or among HHSC staff.

(c) When HHSC by words or actions permits facility staff to be present, an interview or conversation for which facility staff are present does not constitute a violation of this rule.

(d) This section does not prohibit an individual from recording an HHSC interview with the individual.

§510.82. Inspections.

(a) The Texas Health and Human Services Commission (HHSC) may conduct an inspection of a facility prior to the issuance or renewal of a license.

(1) A hospital is not subject to additional annual licensing inspections subsequent to the issuance of the initial license while the hospital maintains:

(A) certification under Title XVIII of the Social Security Act, 42 United States Code (USC) §1395 et seq.; or

(B) accreditation from The Joint Commission, the American Osteopathic Association, or other national accreditation organization for the offered services.

(2) HHSC may conduct an inspection of a hospital exempt from an annual licensing inspection under paragraph (1) of this subsection before issuing a renewal license to the hospital if the certification or accreditation body has not conducted an on-site inspection of the hospital in the preceding three years and HHSC determines that an inspection of the hospital by the certification or accreditation body is not scheduled within 60 days of the license expiration date.

(b) HHSC may conduct an unannounced, on-site inspection of a facility at any reasonable time, including when treatment services are provided, to inspect, investigate, or evaluate compliance with or prevent a violation of:

(1) any applicable statute or rule;

(2) a facility's plan of correction;

(3) an order or special order of the HHSC executive commissioner or the executive commissioner's designee;

(4) a court order granting injunctive relief; or

(5) for other purposes relating to regulation of the facility.

(c) An applicant or licensee, by applying for or holding a license, consents to entry and inspection of any of its facilities by HHSC.

(d) HHSC inspections to evaluate a facility's compliance may include:

(1) initial, change of ownership, or relocation inspections for the issuance of a new license;

(2) inspections related to changes in status, such as new construction or changes in services, designs, or bed numbers;

(3) routine inspections, which may be conducted without notice and at HHSC's discretion, or prior to renewal;

(4) follow-up on-site inspections, conducted to evaluate implementation of a plan of correction for previously cited deficiencies;

(5) inspections to determine if an unlicensed facility is offering or providing, or purporting to offer or provide, treatment; and

(6) entry in conjunction with any other federal, state, or local agency's entry.

(e) A facility shall cooperate with any HHSC inspection and shall permit HHSC to examine the facility's grounds, buildings, books, records, video surveillance, and other documents and information maintained by or on behalf of the facility, unless prohibited by law.

(f) A facility shall permit HHSC access to interview members of the governing body, personnel, and patients, including the opportunity to request a written statement.

(g) A facility shall permit HHSC to inspect and copy any requested information, unless prohibited by law. If it is necessary for HHSC to remove documents or other records from the facility, HHSC provides a written description of the information being removed and when it is expected to be returned. HHSC makes a reasonable effort, consistent with the circumstances, to return any records removed in a timely manner.

(h) Upon entry, HHSC holds an entrance conference with the facility's designated representative to explain the nature, scope, and estimated duration of the inspection.

(i) During the inspection, the HHSC representative gives the facility representative an opportunity to submit information and evidence relevant to matters of compliance being evaluated.

(j) When an inspection is complete, the HHSC representative holds an exit conference with the facility representative to inform the facility representative of any preliminary findings of the inspection, including any possible health and safety concerns. The facility may provide any final documentation regarding compliance during the exit conference.

(k) HHSC shall maintain the confidentiality of facility records as applicable under state or federal law. Except as provided by subsection (l) of this section, all information and materials in the possession of or obtained or compiled by HHSC in connection with an inspection are confidential and not subject to disclosure, discovery, subpoena, or other means of legal compulsion for their release to anyone other than HHSC or its employees or agents involved in the enforcement action except that this information may be disclosed to:

(1) persons involved with HHSC in the enforcement action against the facility;

(2) the facility that is the subject of the enforcement action, or the facility's authorized representative;

(3) appropriate state or federal agencies that are authorized to inspect, survey, or investigate licensed mental health facility services;

(4) law enforcement agencies as allowed by law; and

(5) persons engaged in bona fide research, if all individual-identifying information and information identifying the facility has been deleted.

(l) The following information is subject to disclosure in accordance with Texas Government Code Chapter 552, only to the extent that all personally identifiable information of a patient or health care provider is omitted from the information:

(1) a notice of the facility's alleged violation, which must include the provisions of law the facility is alleged to have violated, and a general statement of the nature of the alleged violation;

(2) the number of investigations HHSC conducted of the facility;

(3) the pleadings in any administrative proceeding to impose a penalty against the facility for the alleged violation;

(4) the outcome of each investigation HHSC conducted of the facility, including:

(A) reprimand issuance;

(B) license denial or revocation;

(C) corrective action plan adoption; or

(D) administrative penalty imposition and the penalty amount;

(5) a final decision, investigative report, or order issued by HHSC to address the alleged violation; and

(6) any other information required by law to be disclosed under public information laws.

(m) Within 90 days after the date HHSC issues a final decision, investigative report, or order to address a facility's alleged violation, HHSC posts certain information on the HHSC website in accordance with Texas Health and Safety Code §577.013.

§510.83. Complaint Investigations.

(a) A facility shall provide each patient and applicable legally authorized representative at the time of admission with a written statement identifying the Texas Health and Human Services Commission (HHSC) as the agency responsible for investigating complaints against the facility.

(1) The statement shall inform persons that they may direct a complaint to HHSC Complaint and Incident Intake (CII) and include current CII contact information, as specified by HHSC.

(2) The facility shall prominently and conspicuously post this statement in patient common areas and in visitor's areas and waiting rooms so that it is readily visible to patients, employees, and visitors. The information shall be in English and in a second language appropriate to the demographic makeup of the community served.

(b) HHSC evaluates all complaints. A complaint must be submitted using HHSC's current CII contact information for that purpose, as described in subsection (a) of this section.

(c) HHSC documents, evaluates, and prioritizes complaints directed to HHSC CII based on the seriousness of the alleged violation and the level of risk to patients, personnel, and the public.

(1) Allegations determined to be within HHSC's regulatory jurisdiction relating to health care facilities may be investigated under this chapter.

(2) HHSC may refer complaints outside HHSC's jurisdiction to an appropriate agency, as applicable.

(d) HHSC conducts investigations to evaluate a facility's compliance following a complaint of abuse, neglect, or exploitation; or a complaint related to the health and safety of patients. Complaint investigations may be coordinated with the federal Centers for Medicare & Medicaid Services and its agents responsible for the inspection of hospitals to determine compliance with the Conditions of Participation under Title XVIII of the Social Security Act, (42 USC, §1395 et seq.), so as to avoid duplicate investigations.

(e) HHSC may conduct an unannounced, on-site investigation of a facility at any reasonable time, including when treatment services are provided, to inspect or investigate:

(1) a facility's compliance with any applicable statute or rule;

(2) a facility's plan of correction;

(3) a facility's compliance with an order of the HHSC executive commissioner or the executive commissioner's designee;

(4) a facility's compliance with a court order granting injunctive relief; or

(5) for other purposes relating to regulation of the facility.

(f) An applicant or licensee, by applying for or holding a license, consents to entry and investigation of any of its facilities by HHSC.

(g) A facility shall cooperate with any HHSC investigation and shall permit HHSC to examine the facility's grounds, buildings, books, records, video surveillance, and other documents and information maintained by, or on behalf of, the facility, unless prohibited by law.

(h) A facility shall permit HHSC access to interview members of the governing body, personnel, and patients, including the opportunity to request a written statement.

(i) A facility shall permit HHSC to inspect and copy any requested information, unless prohibited by law. If it is necessary for HHSC to remove documents or other records from the facility, HHSC provides a written description of the information being removed and when it is expected to be returned. HHSC makes a reasonable effort, consistent with the circumstances, to return any records removed in a timely manner.

(j) Upon entry, the HHSC representative holds an entrance conference with the facility's designated representative to explain the nature, scope, and estimated duration of the investigation.

(k) The HHSC representative holds an exit conference with the facility representative to inform the facility representative of any preliminary findings of the investigation. The facility may provide any final documentation regarding compliance during the exit conference.

(l) Once an investigation is complete, HHSC reviews the evidence from the investigation to evaluate whether there is a preponderance of evidence supporting the allegations contained in the complaint.

(m) HHSC shall maintain the confidentiality of facility records as applicable under state or federal law. Except as provided by (n) of this subsection, all information and materials in the possession of or obtained or compiled by HHSC in connection with an investigation are confidential and not subject to disclosure, discovery, subpoena, or other means of legal compulsion for their release to anyone other than HHSC or its employees or agents involved in the enforcement action except that this information may be disclosed to:

(1) persons involved with HHSC in the enforcement action against the facility;

(2) the facility that is the subject of the enforcement action, or the facility's authorized representative;

(3) appropriate state or federal agencies that are authorized to inspect, survey, or investigate licensed mental health facility services;

(4) law enforcement agencies as allowed by law; and

(5) persons engaged in bona fide research, if all individual-identifying information and information identifying the facility has been deleted.

(n) The following information is subject to disclosure in accordance with Texas Government Code Chapter 552, only to the extent that all personally identifiable information of a patient or health care provider is omitted from the information:

(1) a notice of the facility's alleged violation, which must include the provisions of law the facility is alleged to have violated, and a general statement of the nature of the alleged violation;

(2) the number of investigations HHSC has conducted of the facility;

(3) the pleadings in any administrative proceeding to impose a penalty against the facility for the alleged violation;

(4) the outcome of each investigation HHSC conducted of the facility, including:

(A) reprimand issuance;

(B) license denial or revocation;

(C) corrective action plan adoption; or

(D) administrative penalty imposition and the penalty amount;

(5) a final decision investigative report, or order issued by HHSC to address the alleged violation; and

(6) any other information required by law to be disclosed under public information laws.

(o) Within 90 days after the date HHSC issues a final decision, investigative report, or order to address a facility's alleged violation, HHSC posts certain information on the HHSC website in accordance with Texas Health and Safety Code §577.013.

(p) HHSC notifies complainants regarding the investigation's outcome within 10 business days after completing the investigation.

§510.87. Enforcement.

Enforcement is a process by which a sanction is proposed, and if warranted, imposed on an applicant or licensee regulated by the Texas Health and Human Services Commission (HHSC) for failure to comply with applicable statutes, rules, and orders.

(1) Denial, suspension or revocation of a license or imposition of an administrative penalty. HHSC has jurisdiction to enforce violations of Texas Health and Safety Code (HSC) Chapters 571 through 578 or the rules adopted under these chapters. HHSC may deny, suspend, or revoke a license or impose an administrative penalty for:

(A) failure to comply with any applicable provision of the HSC, including Chapters 161, 321, 322, and 571 through 578;

(B) failure to comply with any provision of this chapter or any other applicable laws;

(C) the facility, or any of its employees, committing an act which causes actual harm or risk of harm to the health or safety of a patient;

(D) the facility, or any of its employees, materially altering any license issued by HHSC;

(E) failure to comply with minimum standards for licensure;

(F) failure to provide a complete license application;

(G) failure to comply with an order of the executive commissioner or another enforcement procedure under HSC Chapters 571 through 578;

(H) a history of failure to comply with the applicable rules relating to patient environment, health, safety, and rights;

(I) the facility aiding, committing, abetting, or permitting the commission of an illegal act;

(J) the facility, or any of its employees, committing fraud, misrepresentation, or concealment of a material fact on any documents required to be submitted to HHSC or required to be maintained by the facility pursuant to HSC Chapters 571 through 578 and the provisions of this chapter;

(K) failure to timely pay an assessed administrative penalty as required by HHSC;

(L) failure to submit an acceptable plan of correction for cited deficiencies within the timeframe required by HHSC;

(M) failure to timely implement plans of corrections to deficiencies cited by HHSC within the dates designated in the plan of correction;

(N) failure to comply with applicable requirements within a designated probation period; or

(O) if the facility is participating under Title XVIII of the Social Security Act, 42 United States Code (USC), §1395 et seq., the Centers for Medicare & Medicaid Services terminating the facility's Medicare provider agreement.

(2) Denial of a license. HHSC has jurisdiction to enforce violations of HSC Chapters 571 through 578 or the rules adopted under this chapter. HHSC may deny a license if the applicant:

(A) fails to provide timely and sufficient information required by HHSC that is directly related to the license application; or

(B) has had the following actions taken against the applicant within the two-year period preceding the license application:

(i) decertification or cancellation of its contract under the Medicare or Medicaid program in any state;

(ii) federal Medicare or state Medicaid sanctions or penalties;

(iii) unsatisfied federal or state tax liens;

(iv) unsatisfied final judgments;

(v) eviction involving any property or space used as a hospital in any state;

(vi) unresolved federal Medicare or state Medicaid audit exceptions;

(vii) denial, suspension, or revocation of a hospital license, a private psychiatric hospital license, or a license for any health care facility in any state; or

(viii) a court injunction prohibiting ownership or operation of a facility.

(3) Order for immediate license suspension. HHSC may suspend a license for 10 days pending a hearing if after an investigation HHSC finds that there is an immediate threat to the health or safety of the patients or employees of a licensed facility. HHSC may issue necessary orders for the patients' welfare.

(4) Probation. In lieu of denying, suspending, or revoking a license, HHSC may place a facility on probation for a period of not less than 30 days, if HHSC finds that the facility is in repeated noncompliance with this chapter or HSC Chapters 571 through 578 and the facility's noncompliance does not endanger the public's health and safety.

(A) HHSC shall provide notice to the facility of the probation and of the items of noncompliance not later than the 10th day before the date the probation period begins.

(B) During the probation period, the facility shall correct the items of noncompliance and report the corrections to HHSC for approval.

(5) Administrative penalty. HHSC has jurisdiction to impose an administrative penalty against a person licensed or regulated under this chapter for violations of applicable chapters of the HSC or this chapter. The imposition of an administrative penalty shall be in accordance with the provisions of HSC §571.025.

(6) Licensure of persons or entities with criminal backgrounds. HHSC may deny a person or entity a license or suspend or revoke an existing license on the grounds that the person or entity has been convicted of a felony or misdemeanor that directly relates to the duties and responsibilities of the ownership or operation of a facility. HHSC shall apply the requirements of Texas Occupations Code Chapter 53.

(A) HHSC is entitled under Texas Government Code Chapter 411 to obtain criminal history information maintained by the Texas Department of Public Safety, the Federal Bureau of Investigation, or any other law enforcement agency to investigate the eligibility of an applicant for an initial or renewal license and to investigate the continued eligibility of a licensee.

(B) In determining whether a criminal conviction directly relates, HHSC shall apply the requirements and consider the provisions of Texas Occupations Code Chapter 53 (relating to Consequences of Criminal Conviction).

(C) The following felonies and misdemeanors directly relate to the duties and responsibilities of the ownership or operation of a health care facility because these criminal offenses indicate an ability or a tendency for the person to be unable to own or operate a facility:

(i) a misdemeanor violation of HSC Chapter 571;

(ii) a misdemeanor or felony involving moral turpitude;

(iii) a misdemeanor or felony relating to deceptive business practices;

(iv) a misdemeanor or felony of practicing any health-related profession without a required license;

(v) a misdemeanor or felony under any federal or state law relating to drugs, dangerous drugs, or controlled substances;

(vi) a misdemeanor or felony under Texas Penal Code (TPC), Title 5, involving a patient or a client of any health care facility, a home and community support services agency, or a health care professional; or

(vii) a misdemeanor or felony under TPC:

(I) Title 4;

(II) Title 5;

(III) Title 7;

(IV) Title 8;

(V) Title 9;

(VI) Title 10; or

(VII) Title 11.

(7) Offenses listed in paragraph (6)(C) of this section are not exclusive in that HHSC may consider similar criminal convictions from other state, federal, foreign or military jurisdictions that indicate an inability or tendency for the person or entity to be unable to own or operate a facility.

(8) HHSC shall revoke a license on the licensee's imprisonment following a felony conviction, felony community supervision revocation, revocation of parole, or revocation of mandatory supervision.

(9) Notice. If HHSC proposes to deny, suspend, or revoke a license, or impose an administrative penalty, HHSC shall send a notice of the proposed action by certified mail, return receipt requested, at the address shown in the current records of HHSC or HHSC may personally deliver the notice. The notice to deny, suspend, or revoke a license, or impose an administrative penalty, shall state the alleged facts or conduct to warrant the proposed action, provide an opportunity to demonstrate or achieve compliance, and shall state that the applicant or license holder has an opportunity for a hearing before taking the action.

(10) Acceptance. Within 20 calendar days after receipt of the notice described in paragraph (9) of this section, the applicant or licensee shall notify HHSC, in writing, of acceptance of HHSC's determination or request a hearing.

(11) Hearing request.

(A) A request for a hearing by the applicant or licensee shall be in writing and submitted to HHSC within 20 calendar days after receipt of the notice described in paragraph (9) of this section. Receipt of the notice is presumed to occur on the third day after the date HHSC mails the notice to the last known address of the applicant or licensee.

(B) A hearing shall be conducted pursuant to Texas Government Code Chapter 2001, and Texas Administrative Code Title 1 Chapter 357, Subchapter I (relating to Hearings under the Administrative Procedure Act).

(12) No response to notice. If an applicant or licensee does not request a hearing in writing within 20 calendar days after receiving notice of the proposed action, the applicant or licensee is deemed to have waived the opportunity for a hearing and HHSC takes the proposed action.

(13) Notification of HHSC's final decision. HHSC shall send the licensee or applicant a copy of HHSC's decision for denial, suspension or revocation of license or imposition of an administrative penalty by certified mail, which shall include the findings of fact and conclusions of law on which HHSC based its decision.

(14) Admission of new patients upon suspension or revocation. Upon HHSC's determination to suspend or revoke a license, the license holder may not admit new patients until the license is reissued.

(15) Decision to suspend or revoke. When HHSC's decision to suspend or revoke a license is final, the licensee must imme-

diately cease operation, unless a stay of such action is issued by the district court.

(16) Return of original license. Upon suspension, revocation or non-renewal of the license, the original license shall be returned to HHSC within 30 calendar days of HHSC's notification.

(17) Reapplication following denial or revocation.

(A) One year after HHSC's decision to deny or revoke, or the voluntary surrender of a license by a facility while enforcement action is pending, a facility may petition HHSC, in writing, for a license. Expiration of a license prior to HHSC's decision becoming final shall not affect the one-year waiting period required before a petition can be submitted.

(B) HHSC may allow a reapplication for licensure if there is proof that the reasons for the original action no longer exist.

(C) HHSC may deny reapplication for licensure if HHSC determines that:

(i) the reasons for the original action continues;

(ii) the petitioner has failed to offer sufficient proof that conditions have changed; or

(iii) the petitioner has demonstrated a repeated history of failure to provide patients a safe environment or has violated patient rights.

(D) If HHSC allows a reapplication for licensure, the petitioner shall be required to meet the requirements as described in §510.22 of this chapter (relating to Application and Issuance of Initial License).

(18) Expiration of a license during suspension. A facility whose license expires during a suspension period may not reapply for license renewal until the end of the suspension period.

(19) Surrender of a license. In the event that enforcement, as defined in this subsection, is pending or reasonably imminent, the surrender of a facility license shall not deprive HHSC of jurisdiction in regard to enforcement against the facility.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 1, 2024.

TRD-202405253
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: November 21, 2024
Proposal publication date: May 10, 2024
For further information, please call: (512) 834-4591

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CHAPTER 745. LICENSING
SUBCHAPTER N. ADMINISTRATOR'S LICENSING
DIVISION 7. REMEDIAL ACTIONS

26 TAC §745.9037

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §745.9037, concerning Under what circumstances may Licensing take remedial action against my administrator's license or administrator's license application.

The amendment to §745.9037 is adopted without changes to the proposed text as published in the July 19, 2024, issue of the *Texas Register* (49 TexReg 5313). This rule will not be republished.

BACKGROUND AND JUSTIFICATION

The amendment is necessary to implement House Bill (H.B.) 4170, 88th Legislature, Regular Session, 2023. H.B. 4170 amended Texas Human Resources Code (HRC) §43.010(b), which makes a person ineligible to apply for another administrator's license for five years after the date HHSC refused to renew the administrator's license. Prior to this amendment, this subsection only applied the five-year ban to when HHSC revoked an administrator's license. The amendment to §745.9037 is necessary for this rule to be consistent with HRC §43.010(b).

COMMENTS

The 31-day comment period ended August 19, 2024.

During this period, HHSC received a comment regarding the proposed rule from one commenter, Texas Alliance of Child and Family Services (TACFS). A summary of the comment relating to the rule and HHSC's response follows.

Comment: The commenter expressed concerns regarding the implementation of the amendment, as the grounds for refusal to renew are subjective and unclear, and the organization believes there is no clear explanation for what it means in §745.9031(a)(3) for an administrator to not be in compliance with the laws or rules governing the license. TACFS believes this makes it difficult for operations to begin serving children and makes it harder for the state to build and retain high-quality residential child-care settings.

Response: HHSC disagrees and declines to revise §745.9037 because it is outside the scope of this rule project. Amended §745.9037(b) will be consistent with current statutory language, and the comment is not relevant to this objective.

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and HRC §43.005, which states the Executive Commissioner for HHSC may adopt rules to administer Chapter 43, HRC.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on October 30, 2024.

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Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: November 19, 2024
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For further information, please call: (512) 751-8438

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CHAPTER 746. MINIMUM STANDARDS FOR CHILD-CARE CENTERS
SUBCHAPTER D. PERSONNEL
DIVISION 1. CHILD-CARE CENTER DIRECTOR

26 TAC §§746.1053, 746.1065, 746.1067, 746.1069

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §746.1053, concerning Will the director's certificate expire; and new §746.1065, concerning What is an interim director, §746.1067, concerning When may a child-care center designate someone as the interim director of the center, and §746.1069, concerning May someone serving as interim director of a child-care center continue to serve as director after the center receives a full license.

Amended §746.1053; and new §§746.1065, 746.1067, and 746.1069 are adopted with changes to the proposed text as published in the July 19, 2024, issue of the *Texas Register* (49 TexReg 5315). These rules will be republished.

BACKGROUND AND JUSTIFICATION

The amendment and new sections are necessary to comply with Senate Bill (S.B.) 1327, 88th Legislature, Regular Session, 2023. S.B. 1327 amended Texas Human Resources Code (HRC), Chapter 42, by adding §42.04201 and amending §42.0761(a). HRC §42.04201 allows a child-care center operating under an initial license to designate an individual who meets all the director qualifications, except the education requirement, to serve as an interim director. Since an initial license is valid for six months from the date that HHSC Child Care Regulation (HHSC CCR) issues it and may be renewed for an additional six months, the statute allows a person to serve as an interim director for up to 12 months. Before the prospective 12-month period expires, the interim director may obtain the education requirements and be designated as a qualified director. If the interim director does not meet the education requirements at the end of the 12-month period, the child-care center must obtain an approved waiver for the requirements or employ a new director. HRC §42.0761(a) adds the term "interim director" to the statute that requires a child-care center to designate a qualified director who is routinely present at the operation.

HHSC CCR is adopting new rules in Chapter 746 to provide a definition of "interim director" and describe the requirements related to qualifying for that designation. HHSC CCR is also adopting an amendment to one rule related to expiring director certificates.

COMMENTS

The 31-day comment period ended August 19, 2024. During this period, HHSC received one comment regarding the proposed rules from one individual. A summary of the comment relating to the rules and the HHSC response follows.

Comment: Regarding §746.1069, one commenter stated that an interim director should be able to obtain a full director qualification after a year if that person submitted information to become a director at the time the child-care center opened.

Response: HHSC disagrees with the comment and declines to revise the rule. HHSC must align the rule with HRC §42.04201, which requires an individual to meet educational requirements or request a waiver to transition from an interim director to a director once the child-care center receives a full license. The statute does not provide an allowance for additional experience in the child-care center in lieu of educational requirements.

In addition, HHSC made minor editorial changes to replace first-person ("I," "me," "we," or "us") and second-person ("you," "your," or "yours") pronouns in §§746.1053, 746.1065, 746.1067, and 746.1069.

STATUTORY AUTHORITY

The amendment and new sections are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §531.033, which requires the Executive Commissioner to adopt rules necessary to carry out HHSC duties under Chapter 531 of Texas Government Code. In addition, HRC §42.042(a) requires HHSC to adopt rules to carry out the requirements of Chapter 42 of HRC.

§746.1053. Will the director's certificate expire?

The director's certificate will not expire unless the director was qualified:

(1) Under (5) or (6) in Figure: 26 TAC §746.1015 of this division (relating to What qualifications must the director of my child-care center licensed for 13 or more children meet?);

(2) Under (4) or (6) in Figure: 26 TAC §746.1017 of this division (relating to What qualifications must the director of my child-care center licensed for 12 or fewer children meet?); or

(3) As an interim director as outlined in §746.1067 of this division (relating to When may a child-care center designate someone as its interim director?).

§746.1065. What is an interim director?

(a) An interim director is an individual designated to serve as the director of a child-care center under §746.1067 of this division (relating to When may a child-care center designate someone as its interim director?).

(b) The interim director has the same responsibilities as a child-care center director as outlined in this chapter.

§746.1067. When may a child-care center designate someone as its interim director?

A child-care center may designate an individual to serve as its interim director if:

(1) The center is operating with an initial license; and

(2) The individual meets all the requirements to serve as director except the educational requirement in:

(A) §746.1015 of this division (relating to relating to What qualifications must the director of my child-care center licensed for 13 or more children meet?); or

(B) §746.1017 of this division (relating to What qualifications must the director of my child-care center licensed for 12 or fewer children meet?).

§746.1069. May someone serving as interim director of a child-care center continue to serve as director after the center receives a full license?

(a) Someone serving as interim director of a child-care center may serve as the center's director after the center receives a full license if:

(1) The individual has completed the educational requirement and fully qualifies to serve as a child-care center director; or

(2) The child-care center obtains a waiver or variance from Child Care Regulation that allows the center to have a director who does not meet the educational requirement.

(b) A child-care center must employ a new director if the individual who served as interim director does not qualify under subsection (a) of this section.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 4, 2024.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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For further information, please call: (512) 438-3269

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TITLE 28. INSURANCE

PART 2. TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

CHAPTER 127. DESIGNATED DOCTOR PROCEDURES AND REQUIREMENTS

SUBCHAPTER A. DESIGNATED DOCTOR SCHEDULING AND EXAMINATIONS

28 TAC §127.1, §127.25

INTRODUCTION. The Texas Department of Insurance, Division of Workers' Compensation (DWC) adopts amended 28 TAC §127.1, concerning designated doctor (DD) examination requests and §127.25, concerning failure to attend a DD examination.

The amendments to §127.1 and §127.25 are adopted without changes to the proposed text published in the May 31, 2024, issue of the *Texas Register* (49 TexReg 3909). Section 127.1 and §127.25 will not be republished.

REASONED JUSTIFICATION. The amendments to 28 TAC §127.1 and §127.25 are necessary to implement House Bill (HB) 2468, 88th Legislature, Regular Session (2023). HB 2468 amended Texas Labor Code §408.0041 to include individuals receiving lifetime income benefits under new Labor Code §408.1615. Section 408.1615 allows insurance carriers to suspend benefits if the first responder does not submit to a DD examination as required by Labor Code §§408.0041(a), 408.0041(f), or 408.1615(h). DWC amends 28 TAC §127.1 and §127.5 to reflect these statutory changes.

Section 127.1 concerns requesting DD examinations. The injured employee or an insurance carrier may ask DWC to order, or DWC on its own motion may order, an examination by a DD to resolve questions about the employee's injury. Section 127.1(d)(2) states that DWC will deny a request for a DD examination under §127.1 if the request would require a DD examination that violates certain statutes. The amendment to §127.1(d)(2) adds a reference to Labor Code §408.1615 as one of these statutes because HB 2468 amended §408.0041 to include individuals receiving lifetime income benefits under §408.1615.

Section 127.25 concerns the suspension, reinitiation, and reinstatement of benefits when an injured employee fails to attend a DD examination. Amending §127.25 is necessary to implement HB 2468. HB 2468 amended Labor Code §408.0041 to include individuals receiving lifetime income benefits under new Labor Code §408.1615. The adopted amendments to §127.25 allow for the suspension of lifetime benefits received under §408.1615 and for the reinstatement of those benefits after completing a missed DD examination.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: DWC received one written comment, and no oral comments. Commenters in support of the proposal with changes were: Texas Mutual Insurance Company (TMIC). There were no commenters were against the proposal.

Comment on §127.1. TMIC recommended providing guidance in the rule to DDs and other system participants regarding the specific information that system participants should provide when requesting a DD examination to address initial lifetime income benefits versus ongoing eligibility for lifetime income benefits under proposed §127.1(b)(8).

Agency Response to Comment on §127.1. DWC declines to make changes to the rule to require certain information from system participants or provide guidance to DDs regarding the assessment of initial lifetime income benefits versus ongoing eligibility for lifetime income benefits because DWC's robust training and outreach programs for DDs make additional educational rule amendments unnecessary. DWC will continue to provide active outreach and guidance on this issue.

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts the amendments to §127.1 and §127.25 under Labor Code §§408.0041, 408.1615, 402.00111, 402.00116, and 402.061.

Labor Code §408.0041 provides that the commissioner may order a DD examination to resolve questions about an individual's injuries. It also provides that an insurance carrier may suspend benefits for a period in which the individual does not attend the required DD examination, and provides for when the insurance carrier must reinstate benefits.

Labor Code §408.1615 provides lifetime income benefits for certain first responders who sustain a serious bodily injury, other than an injury described by §408.161, in the course and scope of the employee's employment or volunteer service as a first responder that renders the employee permanently unemployable.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code.

Labor Code §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to DWC or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 1, 2024.

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Kara Mace
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
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Proposal publication date: May 31, 2024
For further information, please call: (512) 804-4703

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CHAPTER 131. BENEFITS--LIFETIME INCOME BENEFITS

INTRODUCTION. The Texas Department of Insurance, Division of Workers' Compensation (DWC) adopts amended 28 TAC §131.1, concerning the initiation of and request to receive lifetime income benefits, the restructuring of §§131.1 - 131.4 into new Subchapter A, new §§131.10 - 131.14, concerning lifetime income benefits for first responders under Texas Labor Code §408.1615. The amendments and new sections will restructure Chapter 131 into two subchapters. New Subchapter A will include the existing sections of Chapter 131, which are §§131.1 - 131.4. New Subchapter B will include the new sections of Chapter 131, which are §§131.10 - 131.14.

New §§131.10, 131.12, and 131.14 are adopted with changes to the proposed text published in the May 31, 2024, issue of the *Texas Register* (49 TexReg 3911) and will be republished. In response to public comment, DWC revised the definition of "first responders" to "first responder" in §131.10 to be consistent with the term used in Labor Code §408.1615, replaced the term "electronically" with "electronic transmission" in §131.12(c)(1) to maintain consistency with terminology in other rules, changed "division" to "commissioner" in proposed §131.14(b) to be consistent with the Labor Code, changed proposed §131.14(b) to state that once DWC "reviews" information from the insurance carrier versus "upon receipt" of the information, and added language to §131.12(d) that requires the insurance carrier to include on a first responder's annual certification the date by which the certification must be returned to the insurance carrier under §131.12(c).

Sections 131.1 - 131.4, 131.11, and 131.13 are adopted without changes to the proposed text published in the May 31, 2024, issue of the *Texas Register* (49 TexReg 3911) and will not be republished.

REASONED JUSTIFICATION. The amendments to §131.1 and new §§131.10 - 131.14 are necessary to implement House Bill (HB) 2468, 88th Legislature, Regular Session (2023). HB 2468 amended Labor Code §408.0041 and enacted Labor Code §408.1615, which allows certain first responders to receive lifetime income benefits.

The amendments and new sections add definitions and create procedures for a first responder's annual certification to the insurance carrier, the suspension and reinstatement of lifetime income benefits, and the dispute of a first responder's continuing entitlement to lifetime income benefits.

The amendments and new sections also include nonsubstantive editorial and formatting changes to conform the sections to the agency's current style and improve the rule's clarity.

Section 131.1 concerns the initiation of lifetime income benefits by the insurance carrier or at the request of the injured employee and provides for the approval or denial of those benefits. Amending §131.1 was necessary to implement Labor Code §408.1615. Section 408.1615 makes certain first responders eligible for lifetime income benefits. The amendments add a reference to Labor Code §408.1615 in §131.1 to include individuals who are eligible to receive lifetime income benefits under §408.1615.

Section 131.10 concerns definitions in new Labor Code §408.1615. Definitions were added to improve the rule's clarity.

Section 131.11 concerns applicability for new Subchapter B. New §131.11 is necessary to implement Labor Code §408.1615, which created lifetime income benefits for certain first responders. Section 131.11 lists who may be entitled to these benefits under §408.1615.

Section 131.12 concerns a first responder's annual certification to the insurance carrier as required by Labor Code §408.1615. New §131.12 is necessary to implement §408.1615 by listing the content, method, and timing of the certification. To help first responders comply with the certification submission required under §408.1615, new §131.12 requires insurance carriers to provide notice to those receiving benefits under §408.1615 by sending the first responder their certification to complete 30 days before the certification is due. The insurance carrier must include on the certification the anniversary date the first responder's benefits began to accrue and the date by which the first responder must return the certification to the insurance carrier.

Section 131.13 concerns the suspension and reinstatement of lifetime income benefits for first responders under Labor Code §408.1615. New §131.13 is necessary to implement Labor Code §408.1615, which states when an insurance carrier may suspend a first responder's lifetime income benefits under that section and when an insurance carrier must reinstate those benefits. Section 408.1615(i) requires the commissioner, by rule, to ensure that an employee receives reasonable notice of the insurance carrier's basis for the suspension of lifetime income benefits and is provided a reasonable opportunity to complete the annual certification or otherwise respond to the notice. DWC interprets a reasonable opportunity as being 20 days. As a result, new §131.13 requires the insurance carrier to give the first responder a plain-language notice of the basis for the suspension, and requires the first responder to respond to the notice within 20 days of receiving it, before the insurance carrier may suspend the first responder's benefits. In addition, new §131.13 states that if the suspension is due to a missing annual certification, the insurance carrier must reinstate benefits within seven days of receiving the certification. It also states that if the suspension is due to failure to attend a designated doctor (DD) examination, the insurance carrier must follow §127.25 of this title for suspension and reinstatement of the first responder's benefits. If the first responder believes that the insurance carrier's assertion that the first responder was employed is not correct, then the first responder may request dispute resolution under Chapters 140 - 144 and 147 of this title (relating to Dispute Resolution). If the suspension is due to employment in any capacity,

new §131.13 requires the first responder to submit a new request for lifetime income benefits under §131.1. Finally, new §131.13 clarifies that if the insurance carrier suspends or reinstates benefits under §131.13, the insurance carrier must comply with the electronic notification requirements to DWC in §124.2 and Chapter 124, Subchapter B (relating to Insurance Carrier Claim Electronic Data Interchange Reporting to the Division).

Section 131.14 provides for the dispute of a first responder's continuing entitlement to lifetime income benefits. New §131.14 is necessary to implement Labor Code §408.1615, which allows an insurance carrier to review a first responder's continuing entitlement to lifetime income benefits more than once in a five-year period if the insurance carrier provides evidence to DWC that the first responder's annual certification is not accurate, and the commissioner finds that the evidence is sufficient. If the evidence is sufficient, the insurance carrier must request a DD exam to determine whether the first responder remains eligible to receive lifetime income benefits under §408.1615. New §131.14 details this process. Once the commissioner receives the evidence from an insurance carrier, the commissioner will issue an order stating whether the insurance carrier is entitled to require the first responder to submit to a DD examination under §408.1615(h). If a DD exam is completed, the parties may dispute the DD's opinion on the first responder's continuing entitlement to lifetime income benefits through DWC's dispute resolution process.

Parties may request dispute resolution. During the dispute resolution process, parties have the right to request an interlocutory order to suspend benefits or require that they continue while the dispute is pending.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: DWC received three written comments, and no oral comments. Commenters in support of the proposal with changes were: Flahive, Ogden, & Latson (FOL); Office of Injured Employee Counsel (OIEC); and Texas Mutual Insurance Company (TMIC). There were no commenters against the proposal.

General Comment on the termination of a first responder's lifetime income benefits under Labor Code §408.1615. TMIC commented that the proposed rules do not provide guidance on terminating a first responder's lifetime income benefits under Labor Code §408.1615.

Agency Response to Comment. DWC appreciates the comment but declines to make the suggested change. Section 131.14(c) and (d) provide parties with the ability to seek dispute resolution regarding continual entitlement to lifetime income benefits, including the ability to dispute a DD's opinion on this issue. In the dispute resolution process, parties may seek a final decision on the issue of continuing entitlement to lifetime income benefits.

Comment on §131.10. OIEC commented that they support DWC's removal of the definition of "permanently unemployable."

Agency Response to Comment on §131.10. DWC appreciates the comment.

Comment on §131.10. TMIC suggested that DWC consider revising the definition of "first responders" to "first responder" in §131.10 to be consistent with the term used in Labor Code §408.1615.

Agency Response to Comment on §131.10. DWC appreciates and agrees with the suggestion and has revised the defined term to read "first responder."

Comment on §131.12(c)(1). TMIC recommended replacing the term "electronically" with the term "electronic transmission" in §131.12(c)(1) to maintain consistency with terminology in other rules.

Agency Response to Comment on §131.12(c)(1). DWC appreciates the comment and has replaced the term.

Comment on §131.14. FOL commented that, under proposed §131.14(b), the "division" will issue an order stating whether the insurance carrier is entitled to an examination under §408.1615(h). However, under the Labor Code, only the "commissioner" may issue an order or delegate that authority to a designee. There is no authority to delegate the authority to the agency itself.

Agency Response to Comment on §131.14. DWC appreciates the comment and has changed "division" to "commissioner" in §131.14(b).

Comment on §131.12(b). TMIC suggested that DWC revise §131.12(b) to clarify what information is required on a first responder's annual certification to the insurance carrier when the first responder is not working in any capacity. TMIC also suggested permitting an insurance carrier to issue a notice in circumstances where the first responder submits an incomplete certification. TMIC also recommended that, if the first responder does not respond to the notice after 30 days, the insurance carrier be permitted to suspend lifetime income benefits after 30 days and request a DD examination to determine a first responder's ongoing eligibility for these benefits.

Agency Response to Comment on §131.12(b). DWC declines to make the suggested changes. The requirement for the annual certification is a simple, straightforward statement that is either submitted or not. DWC will provide active outreach to first responders to help guide them on the certification and its process. Also, DWC has adopted procedural rules that provide guidance on submitting the annual certification. Labor Code §408.1615 already addresses when an insurance carrier may suspend lifetime income benefits and when an insurance carrier may request a DD exam to determine a first responder's ongoing eligibility for these benefits. Adding additional rules based on an incomplete certification is unnecessary.

Comment on §131.12(c)(2) and (d). As proposed, §131.12(d) requires the insurance carrier to send the certification form to a first responder 30 days before their annual certification is due. Under §131.12(c)(2), a first responder must then submit the certification to the insurance carrier no later than 30 days after the anniversary of the lifetime income benefits accrual date. TMIC commented that the rule appears to reference the same 30-day response date in two different subsections, leading to confusion about whether there are two 30-day periods. TMIC recommended changing the timeframe that the insurance carrier must send the annual certification to the first responder from 30 days to no later than the anniversary date of when the first responder's benefits began to accrue.

Agency Response to Comment on §131.12(c)(2) and (d). DWC declines to make the suggested change. There are two 30-day periods that exist in §131.12, and each is clearly laid out in two different subsections with different titles. Section 131.12(c)(2) states that the first responder must submit the certification to the

insurance carrier no later than 30 days after the date the first responder's benefits began to accrue. Section 131.12(d) requires the insurance carrier to send the first responder the certification to complete 30 days before it is due. Requiring insurance carriers to send the certification to the first responder 30 days before it is due will give first responders notice that they must complete the certification and allows them sufficient time to read, understand, and complete the certification.

Comment on §131.12. OIEC commented that they support the rule requiring an insurance carrier to provide the annual certification to the first responder 30 days before the annual certification is due.

Agency Response to Comment on §131.12. DWC appreciates the comment.

Comment on §131.12(d). TMIC recommended adding language to §131.12(d) that requires the insurance carrier to include on a first responder's annual certification the date the certification must be returned to the insurance carrier under §131.12(c).

Agency Response to Comment on §131.12(d). DWC appreciates the comment and has revised the text to require insurance carriers to include on the certification the date the first responder must return the certification to the insurance carrier.

Comment on §131.13. TMIC recommended that §131.13(c) be revised to clarify that the insurance carrier must reinstate benefits, unless the completed annual certification indicates that the first responder was employed in some capacity during the preceding year, and that the insurance carrier has the right to dispute ongoing entitlement under §131.14.

Agency Response to Comment on §131.13. DWC declines to make the recommended changes. Section 131.13(a) follows Labor Code §408.1615(i), stating that an insurance carrier may suspend lifetime income benefits to a first responder during and for a period in which the first responder fails to complete the annual certification as required by Labor Code §408.1615(e). Section 408.1615(e) requires a first responder receiving lifetime income benefits under §408.1615 to certify to the insurance carrier annually that the first responder was not employed in any capacity during the preceding year. If the first responder was employed in any capacity, §131.13(a)(3) allows the insurance carrier to suspend the payment of lifetime income benefits. Also, §131.13(e) states that, if an insurance carrier suspends benefits under §131.13(a)(3), the first responder must submit a new request for lifetime income benefits under §131.1. As a result, the statute and rules already address the scenario when a completed annual certification indicates that the first responder was employed in some capacity during the preceding year.

Comment on §131.14. FOL suggested that DWC provide the standard it will use to determine if the first responder's annual certification is not accurate. FOL further suggested that the commissioner's order should contain specific findings of facts explaining why the request was denied if it is denied.

Agency Response to Comment on §131.14. DWC declines to make the suggested changes because they are unnecessary and not required by the statute. Labor Code §408.1615(g) states the commissioner will decide if the information contained on the annual certification "may not be accurate." If the insurance carrier disagrees with that determination, it may request dispute resolution. As part of the dispute resolution process, an insurance carrier may request an interlocutory order. DWC declines to adopt a requirement that the commissioner provide specific findings of fact on the order due to the lack of statutory basis for such a requirement in Labor Code §408.1615.

Comment on §131.13. OIEC commented that they support the change in time that a first responder must respond to an insurance carrier before the insurance carrier may suspend lifetime income benefits under §131.13(a) from 30 days to 20 days.

Agency Response to Comment on §131.13. DWC appreciates the comment.

Comment on §131.13. TMIC recommended removing the requirement in §131.13(b) that insurance carriers must send a notice to the first responder if the first responder has not turned in their annual certification, allowing the first responder 20 days to respond before suspending lifetime income benefits under §131.13. TMIC stated that the 20-day notice is inconsistent with Labor Code §408.1615.

Agency Response to Comment on §131.13. DWC declines to make the suggested changes. Labor Code §408.1615(i) states that a first responder's lifetime income benefits may be suspended under certain circumstances. Section 408.1615(i) requires the commissioner to adopt rules that ensure that a first responder receives reasonable notice of the insurance carrier's basis for the suspension and is provided a reasonable opportunity to complete the annual certification under subsection (e), or otherwise respond to the notice. The Labor Code allows suspension under certain circumstances under §408.1615, but it also requires the commissioner to adopt rules that ensure a first responder is allowed a reasonable opportunity to respond. A "reasonable opportunity" to respond to the notice means that the first responder is allowed time to respond by completing their annual certification *before* an insurance carrier may suspend their lifetime income benefits. The people receiving benefits under this rule are first responders who have sustained serious injuries. Giving them 20 days' notice before an insurance carrier may suspend lifetime income benefits is appropriate and aligns with the requirements under Labor Code §408.1615(i).

Comment on §131.13. TMIC recommended that §131.13 be revised to clarify that an insurance carrier may suspend lifetime income benefits immediately in conjunction with a DD opinion concluding that the first responder is no longer eligible for lifetime income benefits. They commented that this change would follow the precedent in §127.25 and Labor Code §408.0041(e) that a DD's report has presumptive weight on the issue that was assigned to the DD, unless the report is overturned during the dispute resolution process. Under this recommendation, if a first responder successfully disputes the DD report, then the dispute decision can order lifetime income benefits to be reinstated, similar to how all other income benefit disputes are generally handled. Likewise, if the first responder's dispute of the DD report is not successful, then lifetime income benefits are terminated until a first responder meets the eligibility requirements again at a later date.

Agency Response to Comment on §131.13. DWC declines to make the recommended changes. Labor Code §408.0041(j) states that an employee is not entitled to lifetime income benefits under §408.1615, and an insurance carrier is authorized to suspend the payment of those benefits, during and for a period in which the employee fails to submit to a DD examination required by §408.0041(a) or (f) or, if applicable, §408.1615(h), unless the commissioner determines that the employee had good cause for failing to submit to the examination. Section 408.0041(j) also states that the commissioner, by rule, must ensure that the em-

ployee receives reasonable notice of the insurance carrier's basis for suspension and that the employee is provided a reasonable opportunity to reschedule a DD examination for good cause. Further, Labor Code §408.1615(i) requires the commissioner to adopt rules that ensure that an employee receives reasonable notice of the insurance carrier's basis for suspension and is provided a reasonable opportunity to respond to the notice. Twenty days is a reasonable opportunity to allow the first responder to respond by rescheduling their DD examination *before* an insurance carrier may suspend benefits. As a result, giving first responders 20 days' notice before an insurance carrier may suspend benefits is appropriate and aligns with the commissioner's requirements under Labor Code §408.1615(i).

Section 131.13(b) does not conflict with §127.25 and §131.13(d) because requiring notice does not change any of those sections' provisions or impair how they function. Section 131.13(d) states that, if an insurance carrier suspends benefits because the first responder fails to attend a DD examination without good cause, the insurance carrier must follow §127.25 for suspension and reinstatement of the first responder's benefits. Section 127.25 allows an insurance carrier to suspend lifetime income benefits if a first responder fails, without good cause, to attend a DD examination. Neither §127.25 nor §131.13(d) disallow the first responder to receive notice by the insurance carrier and to respond to the insurance carrier. Requiring notice and an opportunity to respond simply ensures that the injured first responder's benefits are not needlessly and unjustly interrupted. As a result, requiring insurance carriers to send a first responder 20 days' notice to allow the first responder to reschedule a DD examination under §131.13(b) does not conflict with §131.13(d) and §127.25.

DWC declines to make TMIC's suggested change that §131.13 be revised to clarify that an insurance carrier may suspend lifetime income benefits immediately in conjunction with a DD opinion concluding that the first responder is no longer eligible for lifetime income benefits. As with reasonable notice before suspending a first responder's lifetime income benefits for submitting a late annual certification or rescheduling a missed DD exam, Labor Code §408.1615(i) requires the commissioner to adopt rules that ensure a first responder receives reasonable notice of an insurance carrier's basis for suspension and be provided a reasonable opportunity to respond to the notice. Adopted §131.13 provides the first responder a timeframe to have a reasonable opportunity to respond to the notice before an insurance carrier may suspend lifetime income benefits.

Comment on §131.13. FOL commented that the proposed 20-day notice requirement in §131.13(b)(2) prevents a political subdivision from suspending lifetime income benefits immediately. Further, if the injured employee notifies the insurance carrier of the DD exam or simply requests a benefit review conference, the political subdivision must continue to pay benefits. FOL commented that this exceeds the statute, as notice is not a precondition for suspension. FOL stated that continued payments without entitlement results in unjustified payments, violating constitutional limits on public funds, when the "carrier" is a self-insured political subdivision or state agency.

Agency Response to Comment on §131.13. DWC declines to make the suggested changes. A political subdivision or state agency that is self-insuring its workers' compensation liabilities is acting as a workers' compensation insurance carrier and must comply with the workers' compensation statutes and rules. Labor Code §408.0041(j) requires the commissioner, by rule, to ensure that the first responder receives reasonable notice of the insurance carrier's basis for suspension and that the employee be provided a reasonable opportunity to reschedule a DD examination for good cause. Further, Labor Code §408.1615(i) requires the commissioner to adopt rules that ensure a first responder receives reasonable notice of the insurance carrier's basis for suspension and be provided a reasonable opportunity to respond to the notice under all scenarios in which a first responder's lifetime income benefits may be suspended under §408.1615(i). A "reasonable opportunity" to respond to the notice is one that gives the first responder time to respond *before* an insurance carrier may suspend benefits. As a result, giving first responders 20 days' notice before an insurance carrier may suspend lifetime income benefits is appropriate and aligns with the commissioner's requirements under Labor Code §408.1615(i).

Comment on §131.14. TMIC suggested that DWC recognize the insurance carrier's ability to request a DD examination to evaluate a first responder's ongoing eligibility for lifetime income benefits at least every five years, as well as those circumstances where a first responder has failed to submit the annual certification and lifetime income benefits have been suspended.

Agency Response to Comment on §131.14. DWC declines to make the suggested changes. Labor Code §408.1615(f) states that an insurance carrier may periodically review a first responder's continuing entitlement to lifetime income benefits no more than once during any five-year period, subject to the exception contained in Labor Code §408.1615(g) regarding an annual certification that may not be accurate. Because the insurance carrier's ability to request a DD examination is specified in the Labor Code, DWC declines to duplicate that authority in the rules.

Labor Code §408.1615(f) and (g) do not mention a situation where a first responder does not submit a timely annual certification. DWC disagrees that Labor Code §408.1615 permits an insurance carrier to request a DD examination before the five-year time period in Labor Code §408.1615(f) if the first responder does not timely submit the annual certification.

Comment on §131.14. FOL commented that it's not clear if the insurance carrier must continue to pay lifetime income benefits if the insurance carrier requests a DD appointment prior to five years, that request is denied, and it seeks dispute resolution to dispute that denial.

Agency Response to Comment on §131.14. DWC declines to add to the rule text to address an issue that is already clear in the statute. Labor Code §408.0041(f) states that, unless otherwise ordered by the commissioner, the insurance carrier must pay benefits based on the opinion of the DD during the pendency of any dispute. If the most recent DD examination on the issue of entitlement to lifetime benefits has found that the first responder meets the requirements for qualification, the insurance carrier must pay benefits during the pendency of any dispute.

Comment on §131.13. OIEC asked DWC to reconsider adding a good cause exception to an insurance carrier's ability to suspend lifetime income benefits found in proposed Rule 131.13. OIEC commented that DWC provides a good cause exception for failing to attend a DD examination in Rule 131.13(a)(2) because Labor Code §408.1615(i) requires DWC to consider a good cause exception for any statutorily mentioned scenario for suspension. OIEC suggested that the word "unless" in the statute modifies any of the preceding list of scenarios, not only failing to attend a DD examination. OIEC suggested adding new Rule 131.13(b) as follows: (b) The insurance carrier may not suspend lifetime in-

come benefits if the commissioner determines that there is good cause.

Agency Response to Comment on §131.13. DWC appreciates the comment but declines to make the suggested change. Under Labor Code §408.1615(i), the good cause exception only applies to §408.0041(j), where a first responder fails to submit to a DD examination under §408.0041(a) or (f) or §408.1615(h), and to §408.0041(k-1) where a DD report indicates that the first responder is no longer entitled to lifetime income benefits. If DWC applied the good cause exception to each scenario under which suspension could occur in §408.1615(i), DWC would have to apply the good cause exception for situations where the first responder has worked in some capacity, which is incompatible with the rest of the language in the statute, particularly with the wording "permanently unemployable."

Comment on §131.14. OIEC commented that it supports DWC's inclusion of a dispute resolution option for parties who disagree with DWC's order regarding whether an insurance carrier is entitled to request an examination under Labor Code §408.1615(h).

Agency Response to Comment on §131.14. DWC appreciates the comment.

General Comment on Rule Guidance and Training Addressing a Physically Traumatic Injury to the Brain. OIEC commented that they would like DWC to create rules addressing a physically traumatic injury to the brain in §408.161(a)(6). OIEC recommended rules and training for DDs to determine whether a physically traumatic injury to the brain results in a permanent major neurocognitive disorder, whether the injured employee requires occasional supervision in performing daily tasks or self-care, and whether the injured employee is permanently unemployable. OIEC also recommended that the rule clarify that the DD is qualified to render those opinions. Alternatively, if the DD is not competent to render those decisions, OIEC commented that the training should include guidance for the DD to refer the matter to qualified occupational specialists or others for necessary opinions.

Agency Response to Comment. DWC declines to make the requested changes because they are out of scope of this rule. In addition, DWC's rules already address qualifications for DDs to evaluate traumatic brain injuries, including the ability to refer those injuries to specialists when necessary. Also, DWC already provides in-depth training for DDs in performing their duties.

SUBCHAPTER A. GENERAL PROVISIONS

28 TAC §§131.1

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts new Subchapter A, Chapter 131; amendments to §131.1; and relocating §§131.1 - 131.4 under Subchapter A under Labor Code §§408.0041, 408.161, 408.1615, 402.00111, 402.00116, and 402.061.

Labor Code §408.0041 provides that the commissioner may order a DD exam to resolve questions about an individual's injuries. It also provides that an insurance carrier may suspend benefits for a period in which the individual does not attend the required DD exam, and provides for when the insurance carrier must reinstate benefits.

Labor Code §408.161 provides lifetime income benefits for certain injuries.

Labor Code §408.1615 provides lifetime income benefits for certain first responders who sustain a serious bodily injury, other than an injury described by §408.161, in the course and scope of the employee's employment or volunteer service as a first responder that renders the employee permanently unemployable.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code.

Labor Code §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to DWC or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Kara Mace
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
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For further information, please call: (512) 804-4703

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SUBCHAPTER B. LIFETIME INCOME BENEFITS--CERTAIN FIRST RESPONDERS

28 TAC §§131.10 - 131.14

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts new §§131.10 - 131.14 under Labor Code §§408.0041, 408.1615, 402.00111, 402.00116, and 402.061.

Labor Code §408.0041 provides that the commissioner may order a DD exam to resolve questions about an individual's injuries. It also provides that an insurance carrier may suspend benefits for a period in which the individual does not attend the required DD exam, and provides for when the insurance carrier must reinstate benefits.

Labor Code §408.1615 provides lifetime income benefits for certain first responders who sustain a serious bodily injury, other than an injury described by §408.161, in the course and scope of the employee's employment or volunteer service as a first responder that renders the employee permanently unemployable.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code.

Labor Code §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to DWC or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

§131.10. Definitions.
In Subchapter B of this chapter:

(1) "First responder" means "first responder" as defined in Labor Code §408.1615.

(2) "Serious bodily injury" means "serious bodily injury" as defined in Penal Code §1.07.

§131.12. First Responder's Annual Certification to Insurance Carrier.

(a) Requirement. A first responder receiving lifetime income benefits under §408.1615 must file a certification with the insurance carrier annually.

(b) Content. The certification must state that the first responder was not employed in any capacity during the preceding year.

(c) Method and Timing. The first responder must submit the certification to the insurance carrier in the form and manner prescribed by the division:

(1) by first class mail, by personal delivery, or by electronic transmission; and

(2) no later than 30 days after the anniversary of the date the first responder's lifetime income benefits began to accrue.

(d) Notice. Every year, 30 days before the first responder's annual certification is due, an insurance carrier must send the annual certification to complete to the first responder. The certification must include the anniversary date the first responder's lifetime income benefits began to accrue and the date by which the first responder must return the certification to the insurance carrier.

§131.14. Dispute of Continuing Entitlement of Lifetime Income Benefits.

(a) If the insurance carrier disputes the accuracy of the first responder's annual certification under Labor Code §408.1615(g), the insurance carrier must provide a copy of the annual certification along with supporting evidence to the commissioner and to the first responder.

(b) Upon review of the information in subsection (a) of this section, the commissioner will issue an order stating whether the insurance carrier is entitled to an examination under Labor Code §408.1615(h).

(c) The parties may dispute the determination of the division through the dispute resolution processes outlined in Chapters 140 - 144 and 147 of this title (relating to Dispute Resolution).

(d) After receiving the designated doctor's report under Labor Code §408.1615(h), a party may dispute the designated doctor's opinion on continuing entitlement to lifetime income benefits through the dispute resolution processes outlined in Chapters 140 - 144 and 147 of this title (relating to Dispute Resolution).

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Kara Mace
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
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