MEMORANDUM

Department of Aging and Disability Services
Regulatory Services Policy * Survey and Certification Clarification

TO: Regulatory Services, Regional Directors, State Office Managers, Assisted Living Facility (ALF), Day Activity and Health Services (DAHS), Home and Community Support Services Agency (HCSSA) In-patient Hospice, and Nursing Facility (NF) Program Managers

FROM: Mary T. Henderson
Assistant Commissioner
Regulatory Services

SUBJECT: **S&CC 16-05**-Employee Misconduct Registry (EMR), Nurse Aide Registry (NAR), and Medication Aide Registry (MAR) Referral Process (**Replaces S&CC 14-04**)

APPLIES TO: ALF, DAHS, HCSSA In-Patient Hospice, and NF Program State and Regional Survey Staff

DATE: **June 22, 2016**

This memorandum provides guidance on:

- reportable conduct committed by an unlicensed employee working in an ALF, DAHS, HCSSA in-patient hospice, or NF, and the process for making a referral to the EMR;
- abuse or neglect of a resident, or misappropriation committed in an NF by a medication aide (MA), violations of the MA permit requirements committed in any facility by an MA and the process for making a referral to the MAR; and
- abuse or neglect or exploitation (ANE) of a resident committed in an NF by a certified nurse aide (CNA) and the process for making a referral to the NAR.

Examples of reportable conduct that can be used as guidance may be found in the following attachments:

- **Attachment 1 (A-C) covers the**:
  - failure to protect from abuse;
  - failure to prevent neglect; and
  - failure to protect from psychological harm.
- **Attachment 2 (D-G) covers the**:
  - failure to protect from undue adverse medication consequences and/or the failure to provide medications as prescribed;
  - failure to provide adequate nutrition and hydration to support and maintain health;
  - failure to protect from widespread nosocomial infections; e.g., the failure to practice standard precautions, failure to maintain sterile techniques during invasive procedures and/or the failure to identify and treat nosocomial infections; and
  - failure to correctly identify individuals.

- **Attachment 3 (H-I) covers the**:

  - failure to safely administer blood products and safely monitor organ transplantation;
  - failure to provide safety from fire, smoke and environment hazards and/or the failure to educate staff in handling emergency situations; and
  - failure to provide initial medical screening, stabilization of emergency medical conditions and safe transfer for individuals and women in active labor seeking emergency treatment (Emergency Medical Treatment and Active Labor Act).

The examples in the attachments are for guidance and are not an inclusive list.

I. EMR

A. BACKGROUND:

The EMR is a means of tracking abuse, neglect or exploitation (ANE) of a resident or misappropriation of resident resources or property that rises to the level of reportable conduct committed by unlicensed employees in facilities that DADS regulates. The EMR covers unlicensed employees who provide direct care services, personal care services, attendant care, and any other personal services to a resident. DADS investigates allegations of ANE in an NF, ALF and a DAHS facility. DADS also investigates allegations of ANE when the alleged victim is an in-patient hospice patient in a HCSSA licensed under the Texas Health and Safety Code (HSC) Chapter 142. A substantiated finding of ANE that results in a finding of reportable conduct is entered in the EMR.

B. REASON FOR AN EMR REFERRAL:

Upon determination of a finding of abuse or neglect of a resident or misappropriation of resident property by an unlicensed employee, a Regulatory Services (RS) staff recommends a referral to the EMR if the ANE rises to the level of reportable conduct.

Reportable Conduct Definition. An employee of a facility or agency who is not licensed to perform the services the employee performs may be referred to the EMR when the employee has committed an act of reportable conduct. The HSC Chapter 253, EMR, Sec. 253.001(5), defines the term "Reportable Conduct" to include:

- abuse or neglect that causes or may cause death or harm to an individual using the consumer-directed service option or a consumer;
- sexual abuse of an individual using the consumer-directed service option or a consumer;
- financial exploitation of an individual using the consumer-directed service option or a consumer in an amount of $25 or more; and
- emotional, verbal, or psychological abuse that causes harm to an individual using the consumer-directed service option or a consumer.

While reportable conduct defines the acts of ANE that are the threshold for making a referral to the EMR, the licensing rules for each facility and agency type define what acts constitute ANE or misappropriation of property in a facility setting.

II. MAR

A. BACKGROUND:

The Health and Safety Code, Chapter 242, Subchapter N requires DADS to administer a program for the issuance, denial, renewal, suspension, emergency suspension and revocation of a medication aide permit.

B. REASON FOR AN MAR REFERRAL:

An MA who commits an act of abuse or neglect of an NF resident, misappropriates the property of an NF resident or commits an act that violates the MA permitting standards in Texas Administrative Code, Title 40, Part 1, Chapter 95 in any facility may be referred to the MAR. DADS may revoke, suspend or deny the renewal of an MA's permit. DADS may place the MA on probation or reprimand the MA.

Upon determination of a preliminary finding of abuse or neglect of a resident, or misappropriation of resident property, or violation of the MA permitting standards, an RS staff recommends referral to the Medication Aide Registry.

III. NAR

A. BACKGROUND:

DADS as a state survey agency maintains the Nurse Aide Registry required by Title 42, Code of Federal Regulations (CFR) §483.156. When a finding alleges an act of ANE by a CNA, DADS offers the nurse aide an informal review at the regional level and a formal hearing at the state office level prior to entry of a finding and revocation in accordance with 42 CFR §488.335.

B. REASONS FOR A REFERRAL:

A CNA who commits an act of abuse or neglect against an NF resident or who commits an act of misappropriation of resident property in an NF may be referred to the NAR for revocation of the CNA's certificate. If a CNA is also an MA, a dual referral should be made. See MAR Referral process as described in Section II above. Upon determination of a preliminary finding of abuse or neglect of a resident or misappropriation of resident property by a CNA, an RS staff recommends referral to the NAR.

IV. EMR/NAR/MAR REFERRAL PROCESS:

1. **Investigation of Allegations Against (Unlicensed Employees/CNAs/MAs) – Regional Survey Staff Responsibilities**

   (a) The surveyor or investigator conducts an on-site survey to investigate an allegation of ANE (or for NF residents an allegation of violation of the MA permitting standards) or misappropriation of resident property. During the investigation, the surveyor or investigator reviews the following documents, maintaining confidentiality:

   - residents' clinical records;
   - facility complaint documentation;
   - personnel files; and,

- any other indicated documents.

(b) The surveyor or investigator interviews the following individuals:

- the resident;
- the resident's physician;
- the resident's family or legally authorized representative;
- facility staff; and,
- any other indicated persons.

(c) The surveyor or investigator documents the findings and turns in a referral packet to the regional enforcement unit. The referral packet must include the following items as applicable to the regional survey program area:

- Report of Investigation, Form CMS-2567, Statement of Deficiencies and Plan of Correction, and/or DADS Form3724, Statement of Licensing Violations and Plan of Correction;
- complaint intake forms;
- signature page form;
- DADS Form 2380, Inspection Team Work Sheet, or Form CMS-807, Surveyor Note, as applicable;
- photographs, if taken;
- interview statements;
- facility/agency policies and procedures;
- facility/agency documentation of the complaint, if available;
- any other documentation that substantiates the allegation;
- all correspondence; and,
- individual information sheet.

2. Informal Review (IR) – Regional Enforcement Unit Responsibilities

(a) The regional office sends a written notice to the unlicensed employee/CNA/MA with a preliminary finding of ANE. The written notice includes:

- a summary of the findings and facts on which the findings are based;
- a statement of the DADS intent to refer the unlicensed employee/CNA/MA to the EMR/NAR/MAR; and
- a statement that the unlicensed employee/CNA/MA has the right to an IR to dispute the findings.

(b) The unlicensed employee/CNA/MA must submit a written request for an IR and any supporting documentation that refutes the allegation to the regional office within 10 calendar days after the date of receipt of the written notice.
(c) If requested, the regional office schedules the IR with the unlicensed employee/CNA/MA. The regional office may conduct the IR via telephone or in person.
(d) When an IR is requested and conducted, the regional office notifies the unlicensed employee /CNA/MA of its decision within 2 working days after the date the IR is held and follows the procedures below based on the outcome:

- Findings overturned – the regional office sends the unlicensed employee/CNA/MA a written notice of reversal of the proposed findings. No further action is taken.
- Findings upheld – the regional office sends the unlicensed employee/CNA/MA a written notice of adverse action that affirms the findings and notifies him/her that the referral process will proceed. The regional office submits copies of the referral packet to the Professional Credentialing Enforcement Unit (PCEU).

(e) When an unlicensed employee/CNA/MA fails to request an IR or fails to appear at a scheduled IR, the regional office sends a letter to the unlicensed employee/CNA/MA informing the unlicensed employee that the referral process will proceed. The regional office submits a copy of the referral packet to the PCEU.

3. Formal Hearing – PCEU Responsibilities

(a) Upon receipt of the referral packet, the PCEU sends a notice letter advising the unlicensed employee/CNA/MA of the opportunity for a formal hearing with the State Office of Administrative Hearings (SOAH).

(b) The unlicensed employee/CNA/MA must request a hearing within 30 calendar days after receipt of the adverse action notice letter.

(c) If a formal hearing is requested, the Health and Human Services Commission (HHSC) Appeals Division forwards the request to the SOAH to schedule and conduct a formal hearing. If a formal hearing is conducted, the DADS General Counsel notifies the (unlicensed employee/CNA/MA) of the final order within 120 days after the date the request was received. The PCEU enters findings that are upheld in the (EMR/NAR/MAR).

(d) If an unlicensed employee/CNA/MA fails to request a hearing within the specified time frame, PCEU withdraws the request for a hearing or if the appeal is dismissed for any reason, the PCEU enters the finding in the (EMR/NAR/MAR).

If you have questions concerning this memorandum, please contact a policy specialist in the Policy, Rules and Curriculum Development unit at (512) 438-3161.

Sincerely,

[Signature on File]

Mary T. Henderson
Assistant Commissioner, Regulatory Services
MTH:cg

Attachments

cc: Linda Lothringer
Cynthia Bourland
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Regional Directors

Attachment 1 – Reportable Conduct Examples (A-C)

Issue	Triggers
A. A Failure to protect from abuse.	1. Serious injuries such as head trauma or fractures 2. Non-consensual sexual interactions; e.g., sexual harassment, sexual coercion or sexual assault 3. Unexplained serious injuries that have not been investigated 4. Staff striking or roughly handling an individual; 5. Staff yelling, swearing, gesturing or calling an individual derogatory names 6. Bruises around the breast or genital area; 7. Suspicious injuries e.g., black eyes, rope marks, cigarette burns, and unexplained bruising
B. Failure to prevent neglect	1. Lack of timely assessment of individuals after injury 2. Lack of supervision for an individuals with known special needs 3. Failure to carry out a doctor's orders 4. Repeated occurrences such as falls which place the individual at risk of harm without intervention 5. Access to chemical and physical hazards by individuals who are at risk 6. Access to hot water of sufficient temperature to cause tissue injury 7. Non-functioning call system without compensatory measures; 8. Unsupervised smoking by an individual with a known safety risk 9. Lack of supervision of cognitively impaired individuals with known elopement risk 10. Failure to adequately monitor individuals with known severe self-injurious behavior 11. Failure to adequately monitor and intervene for serious medical/surgical conditions 12. Use of chemical/physical restraints without adequate monitoring 13. Lack of security to prevent abduction of infants 14. Improper feeding/positioning of individual with known aspiration risk 15. Inadequate supervision to prevent physical altercations
C. Failure to protect from psychological harm	1. Application of chemical/physical restraints without clinical indications 2. Presence of behaviors by staff such as threatening or demeaning, resulting in displays of fear, unwillingness to communicate, and recent or sudden changes in behavior by individuals 3. Lack of intervention to prevent individuals from creating an environment of fear

Attachment 2 – Reportable Conduct Examples (D-G)

Issue	Triggers
D. Failure to protect from undue adverse medication consequences and/or failure to provide medications as prescribed.	1. Administration of a medication to an individual with a known history of allergic reaction to the medication 2. Lack of monitoring and identification of potential serious drug interaction, side effects, and adverse reactions 3. Administration of contraindicated medications 4. Pattern of repeated medication errors without intervention 5. Lack of diabetic monitoring resulting or likely to result in serious hypoglycemic or hyperglycemic reaction 6. Lack of timely and appropriate monitoring required for drug titration
E. Failure to provide adequate nutrition and hydration to support and maintain health.	1. Food supply that is inadequate to meet the nutritional needs of the individual 2. Failure to provide adequate nutrition and hydration resulting in malnutrition, e.g., severe weight loss, abnormal laboratory values 3. Withholding nutrition and hydration without advance directive 4. Lack of potable water supply
F. Failure to protect from widespread nosocomial infections, e.g., failure to practice standard precautions, failure to maintain sterile techniques during invasive procedures and/or failure to identify and treat nosocomial infections	1. Pervasive improper handling of body fluids or substances from an individual with an infectious disease 2. High number of infections or contagious diseases without appropriate reporting, intervention and care 3. Pattern of ineffective infection control precautions 4. High number of nosocomial infections caused by cross contamination from staff and/or equipment/supplies
G. Failure to correctly identify individuals.	1. Blood products given to the wrong individual 2. Surgical procedure/treatment performed on wrong individual or wrong body part 3. Administration of medication or treatments to wrong individual 4. Discharge of an infant to the wrong individual

Attachment 3 – Reportable Conduct Examples (H-I)

Issue	Triggers
H. Failure to safely administer blood products and safely monitor organ transplantation.	1. Wrong blood type transfused 2. Improper storage of blood products 3. High number of serious blood reactions 4. Incorrect cross match and use of blood products or transplantation organs 5. Lack of monitoring for reactions during transfusions
I. Failure to provide safety from fire, smoke and environmental hazards and/or failure to educate staff in handling emergency situations.	1. Nonfunctioning or lack of emergency equipment and/or power source 2. Smoking in high risk areas 3. Incidents such as electrical shock, and fires 4. Ungrounded/unsafe electrical equipment 5. Widespread lack of knowledge of emergency procedures by staff 6. Widespread infestation by insects/rodents 7. Lack of functioning ventilation, heating or cooling system placing individuals at risk 8. Use of non-approved space heaters, such as kerosene or electrical devices, in resident or patient areas 9. Improper handling/disposal of hazardous materials, chemicals and waste 10. Locking exit doors in a manner that does not comply with NFPA 101 11. Obstructed hallways and exits preventing egress 12. Lack of maintenance of fire or life safety systems 13. Unsafe dietary practices resulting in high potential for food borne illnesses