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Texas’ Nursing Home Enforcement System

Texas’ nursing home regulation system could well be a national model.

By Lowell A. Keig and Rande Herrell

Texas is recognized for its aggressive regulation of nursing homes. In fact, the American Association of Retired Persons (AARP) has identified Texas’ nursing home regulation system as a national model. Others, however, have expressed the belief that the Texas regulations are “too punitive.” Regardless of these assertions, the fact remains that in 1997 the Texas Legislature passed sweeping legislation, which put into place a strong enforcement system for nursing home regulators.

Chapter 242 of the Texas Health & Safety Code governs the surveying and complaint investigation of Texas nursing facilities. The chapter contains a comprehensive regulatory system designed to ensure that the nearly 95,000 residents in Texas’ 1,274 nursing facilities receive the “highest possible quality of care.” To accomplish this goal, Chapter 242 and the administrative rules adopted by the Texas Department of Human Services (TDHS) pursuant to Chapter 242 establish minimum acceptable levels of care for all licensed nursing facilities in Texas.

TDHS is responsible for conducting surveys of nursing facilities to ensure that they are operating in compliance with the minimum standards. The Department generally surveys each facility in Texas every nine to fifteen months, depending on the facility’s past compliance history. In addition, if TDHS receives a complaint such as an allegation of abuse, neglect, exploitation, or regulatory violation about a facility, it will conduct an investigative survey of that facility.

In the year 2000, TDHS surveyors made a total of 9,545 visits to nursing facilities in Texas. Many of these visits constituted normal licensing surveys. Others were conducted in response to the 9,889 complaints that TDHS received about specific nursing home facilities. The most frequent of these complaints concerned the alleged failure of the facility to provide services to maintain good nutrition, grooming, and personal and oral hygiene; to have sufficient staff; and to prevent the mistreatment, neglect and abuse of residents by facility staff.

In addition to outlining minimum standards and providing for the inspection of facilities, Chapter 242 prescribes “prompt and effective remedies for noncompliance with licensing standards.” The Texas Legislature, therefore, provided TDHS with numerous enforcement mechanisms, including: (1) denial, suspension, or revocation of a facility’s license;
maintained an official role in civil trials when section 242.073 implied that the Attorney General held that the phrase "any legal proceeding" within TDHS explicitly requires the Attorney General to assist section 242.073(a) which, as previously mentioned, extensive role for the Attorney General through section in the context of Chapter 242 as a isolation.

The Role of the Attorney General's Office
The Office of the Attorney General, through its Elder Law & Public Health Division, is involved in many of the nursing home enforcement actions. In fact, section 242.073(a) provides that TDHS and the Attorney General "shall work in close cooperation throughout any legal proceedings requested" by TDHS. In addition, several of Chapter 242's provisions explicitly confer joint enforcement authority to the Attorney General's Office. Specifically, the Attorney General's Office has an articulated role in the collection of civil penalties, the appointment of involuntary trustees, and injunctions.

Civil Penalties

Attorney General Authority
The Attorney General's Office has acted in cooperation with TDHS since 1994 in the collection of civil monetary penalties. However, prior to 1998, section 242.065 did not explicitly provide authority to the Attorney General's Office. In 1997, a nursing home defendant in a civil penalty case brought under section 242.065, Texas v. Evangelical Lutheran Good Samaritan Society, filed a motion to require the Attorney General to demonstrate his authority to file suit and represent TDHS in district court. The district court found in favor of the defendant.

On appeal, however, the Third Court of Appeals held that it could not construe section 242.065 in isolation. Instead, the Court of Appeals construed the section in the context of Chapter 242 as a whole. The Court found that although Chapter 242 gave TDHS the primary responsibility for regulating nursing homes, the Legislature had also articulated an extensive role for the Attorney General through section 242.073(a) which, as previously mentioned, explicitly requires the Attorney General to assist TDHS with legal assistance as necessary. The Court held that the phrase "any legal proceeding" within section 242.073 implied that the Attorney General maintained an official role in civil trials when referred by TDHS, and that this role included lawsuits filed in district court pursuant to section 242.065. Accordingly, the prominent role of the Attorney General in the overall statutory framework of Chapter 242 combined with the historical role of the Attorney General in representing the state in civil matters led the Court to conclude that the Attorney General had authority to file suit in district court for the collection of civil penalties under section 242.065.

Following the Evangelical Lutheran Good Samaritan Society decision, the legislature amended the language of section 242.065 in 1998 to clarify that the "attorney general may institute an action in a district court to collect a civil penalty" on request of TDHS.

Causes of Action
Section 242.065(a) provides that a facility which violates or causes a violation of Chapter 242 or a rule adopted by TDHS under Chapter 242 is "liable for a civil penalty of not less than $1,000 or more than $20,000 for each act of violation." However, the law dictates that TDHS may refer a violation to the Attorney General's Office for the collection of civil penalties only if it determines that the violation "threatens the health and safety of a resident." If the Attorney General's Office determines that there is sufficient evidence of the violation, a lawsuit for the collection of civil penalties may be filed in the district court of the county in which the facility is located.

In Texas v. Sierra Health Systems Management, Inc., the Attorney General's Office filed a lawsuit at the request of TDHS for the collection of civil penalties. The lawsuit arose from a TDHS survey of the facility in 1994 following a resident's death. The resident had been put to bed in a restraint and had been found, ten hours later, hanging by that restraint. During the investigation, the surveyors found that the facility did not have adequate staff to care for the residents. In all, TDHS determined that the facility had failed to meet seven of the minimum standards for nursing home operation and that these violations posed an immediate threat to the health and safety of the residents. In 1997, the defendants agreed to settle the civil penalty lawsuit for $100,000. This marked the first "six figure" civil penalty recovery for the State of Texas based upon nursing home violations. In another example, the
Office of the Attorney General sued defendants in Texas v. Tri-City Care Centers, L.P. for civil penalties based on the violation of twenty minimum licensing standards discovered during a complaint investigation and licensure survey in 1994. The surveyors found that the facility had failed to inform the facility's physician of significant changes in the number, size, and stages of pressure sores of five residents. In addition, the surveyors found that the facility had failed to conduct basic nursing assessments and had not completed care plans for some residents, had failed to provide some residents with the necessary care and services that had been ordered, and had not completed care plans for some residents. The facility had failed to conduct basic nursing assessments and had not completed care plans for some residents. The facility had also failed to obtain a physician's order for the treatment of a resident who had been admitted to the facility with pressure sores on his scrotum. The surveyors further discovered that some residents had experienced severe weight loss and that the facility had failed to employ a Registered Nurse or a Director of Nursing.

After litigating the case for five years, the defendants entered into a consent judgment and settlement agreement with the State of Texas, in which they agreed to pay $300,000. This sum constitutes the largest state settlement against a single nursing home operator in the State of Texas.

Under most circumstances, the amount of the civil penalty is to be determined by the trier of fact. In 1997, the Legislature amended section 242.065 to provide the following factors for the trier of fact to use in assessing the amount of a civil penalty: (1) the seriousness of the violation, including the nature, circumstances, extent, and gravity of the violation and the hazard or potential hazard created by the violation to the health or safety of the resident; (2) the history of violations committed by the person; (3) the amount necessary to deter future violations; (4) the efforts made to correct the violation; (5) any misrepresentation made to the department or to another person regarding the quality of services rendered or to be rendered to the residents or the compliance history of the institution or any institutions owned or controlled by an owner; (6) the culpability of the individual who committed the violation; and (7) any other matter that should, as a matter of justice or equity, be considered.

The amended language implementing these factors became effective on January 1, 1998, and applies only to cases in which the violations giving rise to the lawsuit occurred after the effective date. Because nursing home cases are generally litigated for several years, there are currently no examples of cases in which a trier of fact has been able to utilize these factors. However, the Attorney General's Office had argued prior to their statutory implementation that these factors should be used in determining the amount of civil penalties. For example, in the recent case of Texas v. Finch, involving pre-amendment violations, the Office of the Attorney General requested that the civil penalty be adjusted to reflect the defendant's prior violation history. In response, the arbitrator doubled the amount of the civil penalty from $1,500 to $3,000. The arbitrator's order articulated that the decision to double the civil penalty was based on the fact that civil penalties had previously been imposed on Ms. Finch for violations found at another nursing facility she operated. Therefore, although the violations in Finch occurred prior to the amended language taking effect, the arbitrator in her discretion took the history into account in assessing civil penalties against Ms. Finch.

State actions for civil penalties should be distinguished from private civil lawsuits for injuries to residents. Private lawsuits against nursing homes are often based on such theories as negligence, medical malpractice, or deceptive trade practices. In civil penalty lawsuits under section 242.065, there is no requirement to prove the elements of such causes of action. Moreover, in contrast to private litigation, the Office of the Attorney General does not represent an individual claimant in civil penalty claims.

Arbitration of Disputes

Both a nursing home defendant and TDHS have the option of electing arbitration of various forms of enforcement disputes under section 242.252, including those relating to a license renewal, suspension or revocation of a license, and the assessment of administrative penalties. Arbitration is also available in some—but not all—suits for civil penalties. The law explicitly prohibits arbitration in a civil penalty dispute involving a nursing facility that has had an award levied against it in the previous five years or if a trustee has been appointed to operate the facility.

The State of Texas elected arbitration earlier this year in the lawsuit filed against Pecan Grove Care Center in July 1997. The lawsuit stemmed from a...
complaint investigation of the facility.\textsuperscript{51} Following
the investigation, surveyors alleged that the facility
had failed to properly monitor a resident's blood
sugar in accordance with the physician's orders on
admission.\textsuperscript{52} In addition, the State contended that
the surveyors found the facility had failed to notify
the physician when the resident's blood sugar reached
abnormally high levels.\textsuperscript{53} The resident was eventu-
ally transferred to the hospital emergency room and
died of respiratory failure and shock secondary to
urinary tract sepsis.\textsuperscript{54} Excessive blood sugars were
found to be a factor in the resident's death.\textsuperscript{55} TDHS
determined that the facility had failed to meet the
minimum licensing standards and that this failure
threatened resident health and safety.\textsuperscript{56} At arbitra-
tion, the State requested a civil penalty of $500 per
day for the facility's failure to inform the resident's
physician of high blood glucose readings and the
resident's failure to respond to medication.\textsuperscript{57} The
arbitrator found that, although there was no evidence
of actual harm, there was proof that a threat of harm
existed and this threat sufficed to establish the viola-
tions\textsuperscript{58} The arbitrator ordered the defendant to pay
double civil penalties totaling $3,000 in response to
the violations.\textsuperscript{59}

As previously mentioned, arbitration may also
be elected by a nursing home defendant. In Texas \textit{v.}
Marwitz Bros., the defendant elected arbitration of
a lawsuit for the collection of civil penalties.\textsuperscript{60} The
lawsuit was filed for violations of the minimum stan-
dards that were uncovered during a complaint
investigation of the facility in 1998.\textsuperscript{61} The complaint
investigation was initiated in response to a resident's
hospital admission records, which demonstrated that
the resident's hair had been so matted upon admis-
sion that the hospital staff could not properly clean
it and had to eventually cut some of it off.\textsuperscript{62} In addi-
tion, the resident's ears were wax encrusted.\textsuperscript{63} The
hospital staff used several oral hygiene kits to clean
out the inside of the resident's mouth, which was
encrusted with blackish-brown matter.\textsuperscript{64} Further-
more, the hospital found approximately forty open,
untreated wounds on the resident.\textsuperscript{65} Many of these
wounds were excreting a foul green-to-yellow dis-
charge.\textsuperscript{66} Finally, the hospital staff found that the
resident had infections of her gastrointestinal tube
site, her vagina, and the backs of both of her knees.\textsuperscript{67}
These infections had not been detected or treated at
the nursing facility.\textsuperscript{68} The survey conducted in re-
sponse to this complaint also revealed other
violations.\textsuperscript{69} In total, the facility was cited for violat-
ing four minimum standards.\textsuperscript{70} At arbitration,
the defendant was ordered to pay $29,200 in civil
penalties.\textsuperscript{71}

In another case in which a defendant elected ar-
bitration, \textit{Texas v. Texas Health Enterprises}, TDHS
investigated a 1997 complaint following a resident's
hospitalization for treatment of eight pressure sores,
including a severe one on her right foot.\textsuperscript{72} A few
weeks later, the resident's right leg was amputated
as a result of the pressure sore.\textsuperscript{73} The resident died
the following month.\textsuperscript{74} The surveyors found that the
facility had recognized the resident's risk of devel-
oping pressure sores due to her condition, but did
not address preventive measures until the resident
had already developed numerous sores.\textsuperscript{75} During the
complaint investigation, surveyors also found that
some residents had pressure sores that were either
undetected or untreated.\textsuperscript{76} Furthermore, the survey-
ors found that the facility was not providing adequate
routine and preventative care, was not satisfying the
nutritional needs of residents, and was not properly
staffing a registered nurse.\textsuperscript{77} The facility was cited
for violating a total of ten minimum standards.\textsuperscript{78} In
response, the Attorney General's Office filed a law-
suit on behalf of TDHS for the collection of civil
penalties. The defendant, Willis Convalescent Cen-
ter, elected arbitration. In the arbitration order, the
arbitrator ordered that Willis Convalescent Center
pay civil penalties in the amount of $195,300.\textsuperscript{79}

When one of the parties elects arbitration, the
arbitrator's order is final, binding, and enforceable
in the same manner as any other judgment of the
court.\textsuperscript{80} There is no right of appeal, unless the party
wishing to appeal demonstrates that the arbitrator's
order was procured by corruption, fraud, or misrep-
resentation, or that the decision of the arbitrator was
arbitrary or capricious and against the great weight
of the evidence.\textsuperscript{81} In fact, there has never been an
appeal from an arbitrator's order relating to the im-
position of civil penalties in Texas.

\textbf{Appointment of Trustees}

Section 242.094 of the Texas Health \& Safety Code
provides that TDHS may request the Attorney Gen-
eral to bring an action for the appointment of a
trustee to operate a home.\textsuperscript{82} A trustee may be re-
quested if the facility is operating without a license,
with a suspended license, or with a revoked license.\textsuperscript{83}
For example, in \textit{Texas v. Trillium Hereford, Inc.},
TDHS requested that a trustee be appointed to a facility that had failed to complete its renewal application and was therefore operating without a license. In addition, when TDHS determines that there is an imminent threat to the health and safety of the residents, a trustee may be requested if license suspension or revocation procedures against the home are pending or TDHS determines that an emergency exists. For example, in 1999, TDHS requested the Attorney General’s Office to bring an action for the appointment of several trustees to operate facilities owned and operated by Sensitive Care, Inc. The facilities were suspended from receiving Medicare funding or reimbursement. TDHS believed that the suspension of Medicare monies was a financial emergency and created an immediate threat to the health and safety of residents by jeopardizing the quality and continuity of care and services provided. Among other factors, TDHS felt that the condition created an immediate risk of staff walkouts and staffing shortages, diminished food supplies, and diminished nursing care supplies. As a result, the Attorney General’s Office, on behalf of TDHS, requested the appointment of four temporary trustees to oversee the operation of the facilities until the State could determine that the facilities had the financial stability to ensure continued compliance with the minimum nursing home standards or until the safe and orderly transfer of the residents from the homes could be accomplished. The court ordered the appointment of the trustees.

In the same case, the Attorney General’s Office requested the emergency disbursement of $450,000 from the Nursing and Convalescent Home Trust Fund to assist the trustees in the operation of the facilities. Texas nursing facilities through general licensing fees and a fee per bed, fund the Trust Fund. The district court may order that funds be disbursed from the Trust Fund if the facility has inadequate funds accessible to a trustee for the operation of the facility; there exists an emergency that presents an immediate threat to the health and safety of the residents; and it is in the best interests of the health and safety of the residents that funds be made immediately available. According to section 242.096(b), however, the trustee may use the funds only to alleviate an immediate threat to the health and safety of the residents. This use includes payments for food, medication, sanitation services, minor repairs, supplies necessary for personal hygiene, or services necessary for the personal care, health, and safety of the residents. The funds disbursed from the Trust Fund eventually must be paid back by the owner of the facility.

The Attorney General’s Office also requested the emergency appointment of an involuntary trustee in Texas v. Senior Living Properties, L.L.C. A TDHS survey of the Electra Healthcare Center revealed that the facility did not have adequate staff to provide the necessary care and services for its residents. Surveyors found that the staffing shortage led to shortcuts in resident care. For example, surveyors witnessed compromised infection control measures, such as failing to properly wash hands and failing to cleanse the resident’s skin after urine and fecal contamination. In addition, surveyors found that residents were not being repositioned regularly and were not given timely baths, resulting in the development of pressure sores on several of the residents. Finally, surveyors discovered that unlicensed individuals were administering medication to impaired residents. As in Sensitive Care, the district court ordered the appointment of the trustee.

Section 242.093 also provides for the appointment of a trustee by agreement. In other words, a facility may request that TDHS appoint a trustee to assume operation of the home, and TDHS may grant that request if it feels that the appointment is appropriate. For example, in Tri-City Care Centers, L.P., the Attorney General’s Office notified the facility of its intent to seek the appointment of an involuntary trustee. The operator of the facility, Linda Finch, opted to enter into a voluntary trusteeship agreement with TDHS.

**Injunctive Relief**

The Attorney General’s Office, on referral from TDHS, may also petition a district court for a temporary restraining order to restrain a person from a violation or threatened violation of the minimum acceptable standards or any other law affecting nursing home residents. Such a petition can be made only if TDHS reasonably believes that the violation or threatened violation creates an immediate threat to the health and safety of a resident. The Attorney General’s Office may also petition the district court for an injunction to restrain a person from a violation or threatened violation of the minimum acceptable standards or any other law affecting...
residents.\textsuperscript{107} As before, TDHS must reasonably believe that the violation creates a threat to the health and safety of a resident.\textsuperscript{108}

According to section 242.063(b), the district court may issue an injunction that prohibits the facility from violating the minimum acceptable standards or any other licensing requirements or that restrains or prevents the establishment, conduct, management, or operation of an institution without a license.\textsuperscript{109} In addition, section 242.063(b) provides that a district court may grant any other injunctive relief requested by the state as long as the court finds that the facility is violating or threatening to violate the standards or licensing requirements and such injunctive relief is warranted by the facts.\textsuperscript{110} Such an injunction, however, has never been pursued by the Office of the Attorney General or ordered \textit{sua sponte} by a district court in any case filed under section 242.065.

The most common practice is for the Attorney General's Office to request a temporary restraining order, a temporary injunction, and a permanent injunction when petitioning the district court for the appointment of an involuntary trustee in a nursing facility under section 242.094. The restraining order and injunctions are requested to prohibit the nursing facility from interfering with a trustee until such time as the trustee is discharged by the court.

**Other Enforcement Actions Under Chapter 242**

In addition to the nursing home enforcement provisions in which the Attorney General's Office is involved, TDHS has several other enforcement options if a nursing facility fails to comply with minimum licensing standards. Specifically, the Department may (1) impose administrative monetary penalties on the facility; (2) deny, suspend, or revoke the license of the facility; (3) order the emergency suspension or closure of a facility; or (4) suspend admissions to the facility.\textsuperscript{111} Nursing facilities have the right to appeal each of the enforcement actions available to TDHS, and they frequently exercise this right.

According to section 242.066, TDHS may assess an administrative penalty for a violation of any minimum licensing standard.\textsuperscript{112} Unlike the imposition of civil penalties, administrative penalties may be levied for any violation of minimum licensing standards and not just those that constitute a threat to the health and safety of the residents. In 2000, TDHS imposed administrative penalties in 618 instances.\textsuperscript{113}

With a few exceptions, the administrative penalty may not exceed $10,000 a day for each violation.\textsuperscript{114} The administrative code includes a gradation of penalties in accordance with the relative seriousness of the violation.\textsuperscript{115} For example, if a violation is an "isolated" occurrence that creates an "immediate jeopardy" situation, the facility is subject to an administrative penalty between $3,000 and $6,000.\textsuperscript{116} However, if the violation is determined to be "widespread" in the facility and the violation creates an immediate jeopardy situation, the administrative penalty range is $5,000 to $10,000.\textsuperscript{117} The potential amount of administrative penalty decreases if the violation does not create an immediate jeopardy situation. By way of example, for an isolated violation that poses "actual harm," the amount of the administrative penalty decreases to a range of $500 to $2,000.\textsuperscript{118} Similarly, if there is "no actual harm with a potential for more than minimum harm," the administrative penalty drops to a range of $100 to $600.\textsuperscript{119}

As mentioned above, TDHS also has the option of denying, suspending, or revoking a facility's license. Such remedies may be pursued if TDHS finds that the applicant or license holder violated Chapter 242 or a rule adopted under Chapter 242 in either a repeated or substantial manner.\textsuperscript{120} Furthermore, section 242.0615 provides that a person may be excluded from eligibility for a license because he or she has substantially failed to comply with Chapter 242 and the rules adopted under Chapter 242.\textsuperscript{121} If the person has been excluded from eligibility for a license, TDHS may deny, suspend, or revoke the license of any other facility to which that person holds a license.\textsuperscript{122} If TDHS pursues the denial, suspension, or revocation of a facility's license, the facility is provided the opportunity for a hearing.\textsuperscript{123} The facility may maintain its license and the operation of the facility until the final disposition of the matter, which usually occurs after the appeals process has been completed.\textsuperscript{124}

According to TDHS' \textit{Fiscal Year 2000 Long Term Care Regulatory Annual Report}, of the ninety license denials that were recommended by TDHS in 2000, three licenses were denied and sixty-one were pending appeal at the end of the year.\textsuperscript{125} Furthermore, of the thirty-four license revocations recommended by TDHS in 2000, one license was revoked and
twenty-nine revocations were pending appeal at year's end.126

The statute further provides that, in an emergency, TDHS may suspend a facility's license or order an immediate closing of the institution.127 This option is available if TDHS finds that an institution is operating in violation of the minimum standards and the violations create an immediate threat to the health and safety of a resident.128 This enforcement provision differs from license suspension, revocation, or denial under section 242.061 in that no opportunity for hearing is provided and the facility's license is immediately suspended or the facility is immediately closed. In 2000, TDHS issued five emergency suspensions of licenses.129 There were, however, no emergency closures.130

Finally, if the TDHS Commissioner finds that a facility has committed an act for which a civil penalty may be imposed, he or she may order the institution to immediately suspend admissions.131 If admissions are suspended, the institution is required to post a notice of such suspension on all doors providing entrance to or exit from the facility so long as admissions are suspended.132 According to TDHS, a total of thirty-two suspensions of admissions were instituted in 2000.133

In some instances, a facility that violates minimum licensing standards may also be subject to criminal penalties. For example, a nursing facility may be subject to a criminal fine under section 242.064 for operating without a license.134 However, the criminal penalty provision only allows for a fine of $1,000 or less for the first offense and not more than $500 for each subsequent offense.135 Because this fine is relatively low, TDHS customarily pursues penalties in such cases under Chapter 247 of the Health & Safety Code. Chapter 247 deals with assisted living facilities, which are defined as establishments that furnish food and shelter to four or more persons who are unrelated to the proprietor of the establishment and provide personal care services.136 Section 247.021 states that a license is required for operation of an assisted living facility.137 If a facility fails to obtain a license, it is subject to civil penalties of not less than $1,000 or more than $10,000.138 Thus, if a facility (operating as a nursing home, but falling within the definition of an assisted living facility) is operating without a license, TDHS will likely pursue the greater civil penalties under Chapter 247.

Penalties Independent of Chapter 242
A nursing facility may be subject to additional penalties aside from those related to the violation of minimum licensing standards. For example, all nursing facilities that receive Medicaid funding must also comply with federal Medicaid standards as developed by the Centers for Medicare and Medicaid Services (CMS) (f/k/a the Health Care Financing Administration (HCFA)).139 In addition to its role in monitoring compliance with state licensing requirements, TDHS is also responsible for ensuring compliance with federal Medicaid standards. Under some circumstances, if a facility violates Medicaid certification requirements, CMS may choose to terminate the facility's Medicaid provider contract.140 If this occurs, the facility is ineligible to receive Medicaid funding. In addition, CMS may also impose civil penalties and initiate other remedies such as denial of payment for new admissions.

Finally, nursing home operators may find themselves subject to criminal charges involving incarceration for bodily injury or death to a resident. In August 2000, the operator of Crescent Healthcare, a nursing home chain, was indicted in Crane County, Texas on a charge of causing bodily injury to an elderly person.141 The charges, which are third-degree felonies in Texas, were initiated in response to alleged injuries to a seventy-eight-year-old resident at the Crane County Care Center.142

Conclusion
The State of Texas has various tools for enforcement of nursing home standards: civil and administrative penalties; injunctive relief; trusteeships; licensing revocations, denials and suspensions; emergency license suspensions or facility closures; suspensions of admissions; and in some instances, criminal prosecution. If nursing homes believe that enforcement actions taken by the State are not justified by the circumstances, the nursing homes can, and do, invoke appellate procedures. If legislators in other states are reviewing their nursing home enforcement mechanisms, a look at Texas' system may provide alternative measures to their current systems. Moreover, Texas has, and will continue to revise, evaluate and modify its enforcement practices and criteria.

Endnotes
1. Gaiutra Bahadur, Nursing Home Industry Looks

2. Id.

3. Id.


5. Id.


11. Id.


17. Id. § 242.073.


19. See also Tex. R. Civ. P. 12 which provides in relevant part: “A party in a suit or proceeding pending in a court of this state may, by sworn written motion stating that he believes the suit or proceeding is being prosecuted or defended without authority, cause the attorney to be cited to appear before this court and show his authority to act.... Upon his failure to show such authority, the court shall refuse to permit the attorney to appear in the cause, and shall strike the pleadings if no person who is authorized to prosecute or defend appears.”

20. Evangelical Lutheran Good Samaritan Soc’y, 981 S.W.2d at 510.

21. Id.

22. Id.

23. Id. at 511.

24. Id.

25. Id. at 512.


27. Id. § 242.065(a).

28. Id. § 242.065(a), (f).

29. Id. § 242.065(f).


31. Plaintiff’s First Amended Petition for Civil Monetary Penalties, Sierra Health Systems Mgmt., Inc.

32. Texas v. Sierra Health Systems Mgmt., Inc.


34. Settlement Agreement and Mutual Release in Full of All Claims, Texas v. Sierra Health Systems Mgmt., Inc.

36. Id.
37. Id.
38. Id.
39. Id.
40. Consent Judgment, Tri-City Care Ctrs., L.P.


44. Cause No. 324-00-2164.ADR, State Office of Administrative Hearings, Arbitration Order (March 19, 2001) (Landeros, Arb.).

45. Id.
46. Id.
47. Id.
49. Id. §§ 242.251, 242.252(a). Election of arbitration is also available for disputes relating to the renewal of a license, the suspension of revocation of a license, and the assessment of administrative penalties.


52. Id.
53. Id.
54. Id.
55. Id.
57. Finch, Cause No. 324-00-2164.ADR, State Office of Administrative Hearings, Arbitration Order (March 19, 2001) (Landeros, Arb.).

58. Id.
59. Id.
60. Cause No. 324-97-1546.ADR, State Office of Administrative Hearings.


62. Id.
63. Id.
64. Id.
65. Id.
66. Id.
67. Id.
68. Id.
69. Id.
71. Id.

73. Id.
74. Id.
75. Id.
76. Id.
77. Id.
81. Id. §§ 242.265, 242.267(b).
82. Id. § 242.094(a).
83. Id. § 242.094(a)(1), (2).
87. Id. § 242.094(a)(2).
88. Id.
89. Id.
90. Id.
91. Id.
93. Id. § 242.096(c).
94. Id. § 242.096(b).
95. Id.
97. State’s Original Petition for Temporary Restraining Order, Emergency Disbursement of Trust Fund Monies, Appointment of Temporary Trustee, Temporary and Permanent Injunctions and Civil Penalties, Senior Living Properties, L.L.C.
98. Id.
99. Id.
100. Id.
101. Id.
106. Id.
107. Id. § 242.063(a)(2).
108. Id.
109. Id. § 242.063(b).
110. Id.
112. Id. § 242.066.


116. Id. “Isolated” is defined as “one or a very limited number of residents are affected and/or one or a very limited number of staff are involved, or the situation has occurred only occasionally or in a very limited number of locations. Id. § 19.2112(f)(2)(B)(i). “Immediate jeopardy” is defined as a situation “in which immediate corrective action is necessary because the facility’s non-compliance with one or more requirements has caused, or is likely to cause, serious injury, harm, impairment or death to a resident receiving care in the facility.” Id. § 19.2112(f)(2)(A)(iv).

117. Id. § 19.2112(f)(1). “Widespread” is defined as that circumstance in which “the problems causing the deficiencies are pervasive in the facility and/or represent systemic failure that affected or has the potential to affect a large portion or all of the facility’s residents.” Id. § 19.2112(f)(2)(B)(iii).

118. Id. § 19.2112(f)(1). “Actual harm” is defined as “non-compliance that results in a negative outcome that has compromised the resident’s ability to maintain and/or reach his/her highest practicable physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care and provision of services.” Id. § 19.2112(f)(2)(A)(iii).

119. Id. § 19.2112(f)(1). “No Actual Harm with a Potential for More than Minimum Harm” is defined as “noncompliance that results in minimal physical, mental and/or psychosocial discomfort to the resident and/or has the potential (not yet realized) to compromise the resident’s ability to maintain and/or reach his/her highest practicable physical, mental, and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care and provision of services. Id. § 19.2112(f)(2)(A)(ii).


121. See also id. § 242.0615.

122. Id. § 242.061.

123. Id. § 242.064(a).

124. Id. § 242.064(b).


126. Id.


128. Id.


130. Id.


132. Id.


135. Id.

136. Id. § 242.002(1).

137. Id. § 242.021(a).

138. Id. § 242.045.

139. Requirements of States and Long Term Care Facilities, 42 C.F.R. § 483.


142. Id.