

105 CMR 150.000: LICENSING OF LONG-TERM CARE FACILITIES

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PREAMBLE

The Department of Public Health is charged with the responsibility of ensuring that the Commonwealth's long term care facilities provide good quality care, quality of life and safety for facility residents. In keeping with this responsibility, the Department has developed rest home regulations intended mainly to address the unmet needs of residents with mental health problems through the establishment of a new facility type referred to as Community Support Facility (CSF). The CSF is required to provide special services, staffing, and medication administration safeguards.

After the effective date of 105 CMR 150.000 only CSFs will be permitted to admit new residents from private or public psychiatric institutions. Community Support Residents (CSRs) below the age of 50 and residing in Level IV facilities or in Level IV units in multi-level facilities prior to the effective date of 105 CMR 150.000 shall not be discharged or transferred due to their age from such facilities or units without their consent (if they are competent to give such consent) or the consent of their guardian (if they are not competent). Such residents are also eligible for all services provided in a CSF as set out in these regulations. The Department will consider and approve waiver requests for admission of residents with mental health problems to non-CSF facilities when special circumstances arise. Special circumstances which may require a waiver request might include: a married couple which desires not to be separated and a resident who would be geographically separated from his/her family, or community supports (eg., church, medical care).

Rest home residents shall have the following rights as set forth in 105 CMR 150.000:

- (1) The right to refuse a social services plan and a support services plan.
- (2) The right to give signed consent for admission and services in a Community Support Facility (if he/she is competent to give such consent) or the written consent of his/her guardian (if he/she is not competent).

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(3) The right to resident protections against arbitrary transfers or discharges related to the change in a facility's designation as a CSF or non-CSF; and

(4) The right to refuse antipsychotic medications.

The Department will monitor the implementation and effect of 105 CMR 150.000 on residents and on Level IV facilities, Level IV units and Community Support Facilities, and by July 1, 1988 will provide a report to the Public Health Council with appropriate recommendations. An opportunity will be offered for interested parties to comment on the implementation of 105 CMR 150.000 through a public meeting, which will be held prior to the Department's report to the Public Health Council.

150.001: Definitions

Acquired Immune Deficiency Syndrome Skilled Nursing Facilities/Units (AIDSSNF) shall mean a 20 bed facility or unit(s) thereof which provides a comprehensive program of skilled nursing services, as well as other specialized non-acute services required by patients diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or any of the HIV-related diseases as classified by the Centers for Disease Control (CDC). These services must be provided as part of a culturally sensitive and multidisciplinary program directed toward assisting residents to maintain their optimal level of physical, cognitive and behavioral functioning and toward maximizing availability and utilization of all treatment options. Where appropriate an AIDSSNF shall also provide a comfortable, secure and supportive environment for the terminally ill patient.

An AIDSSNF is part of the continuum of services including acute medical, psychiatric, substance abuse and community based services required for care of this population and the staff of the AIDSSNF must be actively engaged in case management and linkage with other service providers.

Activities and Recreation Program shall mean regularly scheduled recreational, spiritual, educational, entertainment, craft and work-oriented activities.

Administrator shall mean the person charged with general administration of the facility.

Admissions to Acquired Immune Deficiency Syndrome Skilled Nursing Facilities (AIDSSNFs).

(1) A resident admitted to an AIDSSNF shall meet the following criteria for admission to the facility/unit:

(a) Has been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or any of the HIV-related diseases as classified by the Centers for Disease Control (CDC).

(b) Meets at least one of the following:

1. Requires nursing care on a recurring or continuous basis, that averages at least three hours a day;

2. Has a neurological impairment, and is dependent in at least three of the following activities of daily living: bathing, feeding, dressing, toileting and mobility and therefore requires skilled management.

(c) Requires treatment for a medical condition that can be improved, maintained or stabilized through skilled nursing services and/or requires palliative care for the last stages of illness.

(2) If a patient admitted to an AIDSSNF has a history of active substance abuse, the facility must obtain a substance abuse treatment plan from the referring agency or physician prior to admission. The substance abuse treatment plan shall include at a minimum prescribed medications, counseling, past and present treatments, and a plan to manage the applicant's substance abuse problems in the future. The staff who will be providing substance abuse problem services to patients during their residence in the AIDSSNF must either follow the course of treatment prescribed or develop an appropriate plan of care that takes into account the treatment plan prescribed.

Advisory Physician shall mean a physician who advises on the conduct of medical and medically related services in a facility.

Advisory Physician in a SNCFC shall mean a pediatrician who advises on the conduct of medical and medically related services in a facility.

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Aversive Interventions shall mean any interventive technique based upon behavior modification principles which applies painful, seclusive or intrusive methods, stimuli, or punishments to a patient or resident in order to correct, decrease or eliminate any undesirable behaviors.

BA Social Worker shall mean an individual who holds a bachelor's degree, from an undergraduate program in social work that meets the criteria established by the Council on Social Work Education, or who holds a bachelor's degree from an accredited college or university and has been employed in a social work capacity for one year in a community health or social service agency.

Behavior Modification Trainer shall mean an individual who has a minimum of a bachelor's degree in special education or psychology with training and experience in behavior modification as it relates to the developmentally disabled person.

Carry-over Services shall mean services of a Medicare/Medicaid certified Skilled Nursing Facilities/Nursing Facility (SNF/NF), provided throughout all hours of the resident's day, which complement, reinforce and are consistent with any specialized services [as defined by the resident's Rolland Integrated Service Plan (RISP)] the resident with MR/DD/ORC is receiving or is required to receive by the State.

Certified Facility shall mean a long-term care facility certified to participate in the Medicare or Medicaid programs.

Community Support Resident. Note: No resident shall be evaluated or determined to be a Community Support Resident without his/her consent. Any resident meeting criteria as a potential Community Support Resident must be asked if he/she is interested in receiving the mental health and support services available to a Community Support Resident as described in these regulations and asked to sign a form expressing his/her interest in receiving services and consenting to evaluation and designation.

(1) A Potential Community Support Resident is defined as follows:

An individual in need of Level IV services who meets at least one of the following criteria (These criteria are to assist in identifying residents who may be in need of service and are not sufficient to determine final designation status):

- (a) Has been referred to the facility from a Department of Mental Health or another psychiatric facility, and/or
- (b) Has a current diagnosis of mental illness, and/or
- (c) Receives a major antipsychotic from staff and is unable to self-administer, and/or
- (d) Currently receives mental health services.

(2) A Designated Community Support Resident is defined as a resident who

- (a) Following identification as a potential Community Support Resident, expresses interest in receiving the mental health and support services available to a Community Support Resident as described in 105 CMR 150.000, and consents in writing (if he/she is competent to give such consent), or whose guardian consents (if he/she is not competent) to evaluation to determine if he/she is eligible for the additional services described in 105 CMR 150.000; and
- (b) Is judged on mental health evaluation by a psychiatrist or other mental health clinician as recognized under Massachusetts law, such as a licensed psychologist, licensed independent clinical social worker, or psychiatric nurse mental health clinical specialist authorized under 244 CMR 4.13(3), to exhibit a current mental health problem associated with sufficient behavioral and functional disabilities in activities of daily living, memory, cognition, socialization skills, *etc.* such that the resident could benefit from the services as described in 105 CMR 150.000 as appropriate for a Community Support Resident.

Community Support Resident Support Services Plan shall mean an individualized written plan designed to identify and meet the support services needs of Community Support Residents.

Change of Ownership shall mean in the case of a corporation the transfer of the majority of stock thereof, and in all other cases, transfer of the majority interest therein.

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Department shall mean the Department of Public Health of the Commonwealth of Massachusetts.

Dental Hygienist shall mean an individual who is currently registered with the Massachusetts Board of Registration in Dentistry pursuant to M.G.L. c. 112, § 51.

Dentist shall mean an individual registered by the Board of Registration in Dentistry under M.G.L. c. 112, § 45.

Department of Public Health - Medical Review Team (MRT) shall mean a Department administered multi-disciplinary, interagency team of professionals with clinical training and/or experience in the care and treatment of individuals 22 and under with multiple handicaps. The MRT has responsibility for determining the eligibility of such individuals for nursing home care. The purpose of the MRT review is to assure that only individuals who meet appropriate criteria are certified as eligible for residential care at a long term care facility.

Developmental Disabilities/Other Related Conditions (DD/ORC) shall mean a severe, chronic disability that meets all of the following conditions: It is attributable to:

- (a) Cerebral palsy or epilepsy; or
- (b) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons:
 - 1. It is manifested before the person reaches age 22;
 - 2. It is likely to continue indefinitely;
 - 3. It results in substantial functional limitations in three or more of the following areas of major life activity:
 - a. Self-care;
 - b. Understanding and use of language;
 - c. Learning;
 - d. Mobility;
 - e. Self-direction;
 - f. Capacity for independent living.

Dietary Services shall mean the planning, preparation and serving of routine and therapeutic diets of adequate quantity, quality and nutritional value and prepared in a sanitary manner.

Dietitian shall mean a dietitian who is currently registered by, or a member of, the American Dietetic Association, or is a graduate of a Baccalaureate Degree program with major studies in food and nutrition.

Direct Care Worker means a staff member whose work involves extensive patient contact or administrative decisions regarding care. The term "direct care worker" shall not be limited to those workers employed by the nursing home, and shall include contracted workers who provide direct care to residents. The term "direct care worker" shall include, but not be limited to: the medical director, registered nurses, licensed practical nurses, nurse practitioners, physician assistants, certified nurse aides, activities personnel, feeding assistants, social workers, dietary aides, and all occupational, physical, and speech therapy staff. Office-based practitioners whose primary practice site is not in the long-term care facility are exempt from the definition of direct care workers. Examples of exempt practitioners include but are not limited to: podiatrists, dentists or primary care providers that are part of on-call medical coverage arrangements.

Emergency shall mean a situation or condition which presents imminent danger of death or serious physical harm to patients, residents, or others.

Webster's New Collegiate Dictionary (most recent edition) may be used as a guide to the meaning of words in general usage, and Dorland's,

The American Illustrated Medical Dictionary (most recent edition) may be used as a guide to the meaning of medical terms of art.

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Food Service Supervisor shall mean an individual who is a high school graduate or the equivalent, has completed at least one course in food service supervision and has had at least one year of supervisory experience in the planning, preparation and service of food in a health facility or group feeding situation.

Individual Service Plan (ISP) shall mean a multidisciplinary plan of care setting forth measurable goals and objectives and prescribing an integrated program of individually designed treatments and therapies, activities and experiences necessary to achieve such goals and objectives. The overall objective of the plan shall be to attain or maintain the optimal physical, social and developmental functioning of which the patient is presently or potentially capable.

Infection Control Practitioner shall mean a licensed nurse with a background in chronic or long term care nursing, who is a member of the Association for Practitioners in Infection Control (APIC), and who has at least one year of experience working in infection control.

Levels of Long-term Care Facilities or Units.

(1) Intensive Nursing and Rehabilitative Care Facility (Level I) shall mean a facility or units thereof that provide continuous skilled nursing care and an organized program of restorative services in addition to the minimum, basic care and services required in 105 CMR 150.000. Level I facilities shall comply with the Conditions of Participation for Extended Care Facilities under Title XVIII of the Social Security Act of 1965 (P.L. 89-97) and shall provide care for patients as prescribed therein.

(2) Skilled Nursing Care Facilities (Level II) shall mean a facility or units thereof that provide continuous skilled nursing care and meaningful availability of restorative services and other therapeutic services in addition to the minimum, basic care and services required in 105 CMR 150.000 for patients who show potential for improvement or restoration to a stabilized condition or who have a deteriorating condition requiring skilled care.

NON-TEXT PAGE

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- (a) Skilled Nursing Care Facilities for Children (SNCFC) (Level II) shall mean a facility or unit/s thereof that provides skilled nursing care services and/or intensive supportive nursing care services together with therapeutic treatment and rehabilitative services to multiply handicapped individuals, birth to 22 years of age, who exhibit medical/nursing needs requiring intervention, observation and supervision by a multi-disciplinary team of professionals. Individuals requiring these services who are aged 15 to 22 or who do not meet the definition of "multiply handicapped" may be admitted to adult (Level II or Level III) units with prior approval from the Department's Medical Review Team (MRT) and the Department's licensing agency. A SNCFC is not an appropriate facility or unit for individuals requiring long-term custodial care.
- (b) Respite Care in a Skilled Nursing Care Facility for Children (SNCFC) shall mean temporary, short term care of a multiply handicapped individual birth to 22 years of age in order to provide relief to a family/primary care-giver.
- (3) Supportive Nursing Care Facilities (Level III) shall mean a facility or units thereof that provide routine nursing services and periodic availability of skilled nursing, restorative and other therapeutic services, as indicated, in addition to the minimum, basic care and services required in 105 CMR 150.000 for patients whose condition is stabilized to the point that they need only supportive nursing care, supervision and observation.
- (4) Resident Care Facilities (Level IV) shall mean a facility or units thereof that provides or arranges to provide in addition to the minimum basic care and services required in 105 CMR 150.000, a supervised supportive and protective living environment and support services incident to old age for residents having difficulty in caring for themselves and who do not require Level II or III nursing care or other medically related services on a routine basis. This facility's services and programs seek to foster personal well-being, independence, an optimal level of psychosocial functioning, and integration of residents into community living.
- (5) Community Support Facility (CSF) shall mean a Resident Care Facility in which the Department determines that 50% or more of the facility's residents are Community Support Residents. The Community Support Facility is the only Level IV facility allowed to routinely admit Community Support Residents and will be expected to maintain 50% or more of these residents. The central purpose of a CSF shall be to provide its current Community Support Residents, and new Community Support Resident admissions, with the mental health and support services outlined in 105 CMR 150.001. These services will be provided in order to assure resident security and the provision of appropriate care, as well as to maximize resident independence, prevent reinstitutionalization, and wherever possible provide rehabilitation and integration into the community.

License shall include the following: a biennial license, a provisional license, or, upon a change of ownership, an application for a license for a period of three months when filed with the Department within 24 hours of such change of ownership.

- (1) Biennial License shall mean a license issued for a two-year period to a facility found on inspection to be in full compliance with 105 CMR 150.000.
- (2) Provisional License shall mean a license issued for not more than one hundred and 80 days to a facility that is found on inspection to be in substantial compliance and which has demonstrated improvement and evidences potential for achieving full compliance within said period.

Licensed Practical Nurse shall mean a nurse who is currently licensed pursuant to M.G.L. c. 112, § 74A, to practice as a licensed practical nurse in Massachusetts.

Long-Term Care Facility shall mean any institution whether conducted for charity or profit which is advertised, announced or maintained for the express or implied purpose of providing three or more individuals admitted thereto with long-term resident, nursing, convalescent or rehabilitative care; supervision and care incident to old age for ambulatory persons; or retirement home care for elderly persons. Long-term care facility shall include convalescent or nursing homes, rest homes, infirmaries maintained in towns and charitable homes for the aged. Facility as used herein, shall mean a long-term care facility or unit thereof and units within acute hospitals converted under provisions of St. 1988 c. 23, § 32.

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- (1) Institution shall mean an establishment housed in a single building or in two or more adjacent buildings.
- (2) Identifiable Unit shall mean a section of a facility such as a wing, floor or ward and shall include adjacent rooms where acceptable to the Department. For all facilities constructed after March 19, 1968 and for all new construction, additions, conversions or alterations, an identifiable unit shall correspond to the definition of a unit as stated in the currently applicable construction standards of the Department. For facilities constructed prior to March 19, 1968, an identifiable unit shall mean approximately 40 beds in facilities that provide Level I or II care, and not more than 60 beds in facilities that provide Level III or IV care.
- (3) Convalescent or Nursing Home, Rest Home, Infirmary Maintained in a Town, and Charitable Home for the Aged shall have the same meanings as those terms defined in M.G.L. c. 111, § 71.
- (4) Long-term Care shall mean care of significant duration as distinguished from acute short-term care provided in a general hospital. There shall be four Levels of long-term care facilities under 105 CMR 150.000.
- (5) Hospital Based Long Term Care Facility (HB/LTCF) shall mean a separately licensed unit housed on the premises of an acute hospital. Such facilities shall meet the provisions of 105 CMR 150.000 applicable to Skilled Nursing Facilities except as otherwise provided herein.

Medical Care shall mean services provided by a physician or physician-nurse practitioner team or physician-physician assistant team including: physical examination and diagnosis; orders for treatments, medications, diets, and associated services; emergency care; periodic supervision and review; and determination of appropriateness of care and placement.

Mental Retardation (MR) as defined by the regulations of the Department of Mental Retardation, 115 CMR 1.00 et seq.

Minimum Basic Requirements for Care and Services shall mean the least quantity of personnel and services allowable for each level of care for licensure as prescribed in 105 CMR 150.000. This is not to preclude the fact that additional staff and services will be necessary in certain facilities to meet patient needs.

MSW Social Worker shall mean an individual who has received at least a master's degree from a graduate school of social work accredited by the Council on Social Work Education.

Multiple Level Facility shall mean a facility that provides two, three or four levels of care in one or more identifiable units for each level of care.

Multiply-handicapped Individuals shall mean individuals certified by the MRT for nursing home care who are between birth and age 22, presenting with significant developmental disabilities, skilled nursing care needs and who may also require intensive therapeutic treatment and habilitative interventions. These individuals require a combination of services such as:

- (1) Control and monitoring of seizure activity.
- (2) Use of special medications which require close observation of their effects and/or skill in technique of administering the medication.
- (3) Care and monitoring of indwelling or intermittent catheters/shunts -- cerebral shunts, tracheostomies, urethral catheters.
- (4) Special feeding techniques (oral gavage, gastrostomies) to obtain optimal nutrition and to prevent aspiration.
- (5) Skin care requiring technical skills to prevent ulcerations or excessive chafing, especially pertinent in relation to individuals with musculoskeletal problems requiring use of supportive appliances.
- (6) Observation and maintenance of vital functions -- keeping airways clear, administering oxygen.

Nurse's Aide or Orderly shall mean an individual who has successfully completed a nurses' aide training course or on-the-job training.

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Nursing Care shall mean services provided by licensed nursing personnel (registered nurses and licensed practical nurses) or by ancillary nursing personnel (nurses' aides or orderlies), under the direction of a registered nurse or a licensed practical nurse.

Nurse practitioner shall mean a nurse with advanced training who is authorized to practice by the Board of Registration in Nursing as a nurse practitioner, as provided for in the M.G.L. c. 112, § 80B and regulations of the Board of Registration in Nursing, 244 CMR 4.00 et seq. and registered with the Division of Food and Drugs to practice in accordance with 105 CMR 700.000 et seq.

Occupational Therapist shall mean an individual who is currently a registered member of the American Occupational Therapy Association. Occupational Therapist Assistant shall mean an individual licensed as an occupational therapy assistant by the Commonwealth.

Organized Medical Staff shall mean an organized group of physicians as defined by the Joint Commission on Accreditation of Hospitals.

Patient or Resident shall mean any individual receiving inpatient care or outpatient restorative services in a facility.

Permanency Planning shall mean supporting and maintaining family ties for multiply-handicapped individuals and their biological families; and working toward achieving permanent family ties for multiply-handicapped individuals who have no ties with their biological families.

Pharmacist shall mean a pharmacist who is currently registered to practice pharmacy in Massachusetts pursuant to M.G.L. c. 112, § 24.

Physician shall mean a doctor of medicine or doctor of osteopathy who is registered to practice medicine in Massachusetts pursuant to M.G.L. c. 112, § 2.

Pediatrician shall mean a physician licensed to practice medicine in Massachusetts who is certified or eligible for certification by the American Board of Pediatrics.

Physician assistant shall mean a person who is a graduate of an approved program for the training of physician assistants who is supervised by a registered physician in accordance with the M.G.L. c. 112, §§ 9C to 9H, inclusive, authorized to practice as a physician assistant pursuant to 105 CMR 900.000 et seq. and registered with the Division of Food and Drugs to practice in accordance with 105 CMR 700.000 et seq.

Physical Therapist shall mean an individual who is currently licensed to practice by the Massachusetts Board of Registration in Medicine, and who is either:

- (1) a graduate of a program in physical therapy approved by the Council of Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association or, if foreign trained, has met the necessary requirements or
- (2) has been certified by the Social Security Administration on or after October 30, 1970.

Physical Therapy Assistant shall mean an individual licensed as a physical therapist assistant by the Commonwealth.

Psychiatric Nurse shall mean a registered nurse who is also qualified as a mental health clinical specialist certified under 244 CMR 4.13(3).

Recreational Assistant in a SNCFC shall mean an individual who has an associates degree in a related field and experience in recreation with children.

Recreational Therapist in a SNCFC shall mean an individual who has a bachelor's degree in a related field and experience in recreation with children.

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Registered Nurse shall mean a nurse who is currently registered pursuant to M.G.L. c. 112, § 74, to practice as a registered nurse in Massachusetts.

Responsible Person shall mean an individual 21 years of age or older, who has received a high school diploma, is of good moral character, with ability to make mature and accurate judgments and with no mental or physical disabilities or personality disturbances that could interfere with adequate performance of duties and responsibilities. The responsible person shall also have the ability to communicate orally and in writing in English and the primary language used by patients and residents of a facility. Exception: Persons employed in this capacity on July 1, 1987 shall have at least four years within which to earn a Massachusetts High School Equivalency Certificate or may qualify for a waiver of the High School requirement under 105 CMR 153.030(B) if they can demonstrate at least five years experience as a responsible person.

Restorative Services Unit shall mean a room or rooms specifically equipped for physical therapy, occupational therapy or speech, hearing and language therapy, and staffed by therapists in these specialties.

Restorative Therapy Assistant shall mean an individual licensed as a physical therapist assistant be the Commonwealth.

Restorative Therapy Services shall mean services provided by physical therapists, occupational therapists, and speech, hearing and language therapists for the purpose of maximum reduction of physical or mental disability and restoration of the patient to maximum functional level. Only Medicare certified facilities may provided outpatient restorative services. In addition, facilities must obtain written approval from the Department before outpatient restorative services may be provided.

Satisfaction Survey shall mean a confidential consumer satisfaction survey for long term care facilities.

Single Level Facility shall mean a facility that provides only one level of care in one or more identifiable units.

Social Services shall mean those services provided to meet the medically-related emotional and social needs of the patient or resident at the time of admission, during treatment and care in the facility and at the time of discharge.

Specialized Services shall mean the services specified by the State which, combined with services provided by the Nursing Facility or other service providers, results in treatment which meets the requirements of 42 CFR 483, § 483.440(a)(1).

Speech Pathologist or Audiologist (speech, hearing and language therapist) shall mean an individual who has a current, valid Certificate of Clinical Competence in the appropriate area (speech pathology or audiology) or in the combined areas, granted by the American Speech and Hearing Association or meets the equivalent educational requirements and work experience.

Sponsor shall mean the person or agency legally responsible for the welfare and support of a patient or resident.

Supervising Physician shall mean a physician who provides supervision to a physician assistant, in accordance with the M.G.L. c. 112, §§ 9C through 9H, or who provides supervision to a nurse practitioner, as that term is defined in regulations of the Board of Registration in Nursing, 244 CMR 4.05(9).

Support Services shall mean those services provided for the benefit of Community Support Residents in order to enhance psychosocial and physical functioning, and shall include arranging and coordinating appointments for health and mental health visits, educational and vocational services, as well as recreational services. Support Services also include the provision of counseling, and coordination with the Mental Health Treatment Plan.

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Support Services Coordinator shall mean an individual who has received a BA or BS degree in a human services field of study such as Psychology, Nursing or Social Work and is employed by a Resident Care Facility or a Community Support Facility to provide and coordinate care to Community Support Residents. The Coordinator is responsible for arranging and coordinating Support Services. Support Services is a term applied to a variety of services including health and mental health visits, educational and vocational services, as well as recreational services, which are intended to enhance the psychosocial and physical functioning of Community Support Residents.

Utilization Review Committee shall mean a multi-disciplinary committee consisting of at least two physicians, a registered nurse, and, where feasible, other appropriate health professionals with responsibility to review the patient care provided in a facility or group of related facilities. No member shall have a proprietary interest in the facility.

Words in general usage, such as "accessible," "adequate," "approved," "suitable," "attractively," "competent," "proper," "qualified," "reasonable," "reliable," "reputable," "safe," "sanitary," and "satisfactory," when used herein, shall have their usual meaning, and terms of art, such as "acute," "discharge," etc., when used herein, shall have their medical or other technical meaning; provided that the Department's determination of meaning shall be final.

150.002: Administration

(A) Every licensee shall designate a qualified administrator and shall establish by-laws or policies which describe the organization of the facility, establish authority and responsibility, and identify programs and goals.

- (1) The ownership of the facility and of any applicant or licensee shall be fully disclosed to the Department, including the name and addresses of all owners, or, in the case of corporations, the officers. Holders of all mortgages shall also be reported. Persons holding 10% or more of the stock in a facility shall be reported annually to the Department.
- (2) The licensee shall be responsible for compliance with all applicable laws and regulations of legally authorized agencies.

(B) Administration.

- (1) A full-time administrator shall be provided in (a) facilities that provide Level I care, (b) facilities that provide Level II care and consist of more than one unit, and (c) facilities that provide Level BI or IV care and consist of more than two units.
 - (a) A full-time Administrator shall be provided in a facility which is or includes a SNCF.
 - (b) A Program Director shall be provided in a facility (or unit) qualifying as an AIDSSNF. A freestanding AIDSSNF shall provide a full-time Program Director. For AIDSSNF units which are part of a conventional nursing home or hospital, the Program Director shall serve at least 24 hours per week. This individual shall have at least three years of clinical experience in any one, or combination of the following disciplines: nursing, clinical psychology, or social work. Responsibilities of the Program Director shall include but not be limited to general administration of the AIDSSNF facility/unit, program development and supervision.
- (2) Facilities that provide Level II care with only a single unit, and facilities that provide Level III or IV care with less than two units shall provide an administrator for the number of hours as needed in accordance with the size and services provided by the facility.
- (3) No more than one administrator is required even in facilities providing multiple units or multiple levels of care.
- (4) A full-time administrator shall be on the premises during the working day.
- (5) In facilities that provide Level I, II or III care, the administrator shall be a licensed nursing home administrator.
- (6) The administrator shall be a suitable and responsible person.
- (7) A responsible person shall be designated to act in the absence of the administrator.
- (8) The names and telephone numbers of the administrator and his alternate shall be posted and available to the individual in charge at all times.

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(C) The administrator of the facility shall be responsible to the licensee and shall operate the facility to ensure that services required by patients or residents at each level of care are available on a regular basis and provided in an appropriate environment in accordance with established policies.

(D) The licensee shall be responsible for procurement of competent personnel, and the licensee and the administrator shall be jointly and severally responsible for the direction of such personnel and for establishing and maintaining current written personnel policies, and personnel practices and procedures that encourage good patient or resident care.

(1) At all times, every facility shall provide a sufficient number of trained, experienced and competent personnel to provide appropriate care and supervision for all patients and residents and to ensure that their personal needs are met. Accurate time records shall be kept on all personnel. Personnel time records shall be posted and maintained on a weekly basis.

(2) There shall be written job descriptions for all positions including qualifications, duties and responsibilities. Work assignments shall be consistent with job descriptions and qualifications.

(3) There shall be an organized orientation program for all new employees to explain job responsibilities, duties and employment policies.

(4) Personnel shall be currently licensed or registered where applicable laws require licensure and registration.

(5) Completed and signed application forms and employee records shall be maintained. They shall be accurate, current and available on the premises. Such records shall include the following:

(a) Pertinent information regarding identification (including maiden name).

(b) Social Security number, Massachusetts license or registration number (if applicable) and year of original licensure or registration.

(c) Names and addresses of educational institutions attended, dates of graduation, degrees or certificates conferred and name at the time of graduation.

(d) All professional experience, on-the-job training and previous employment in chronological order with name and location of employer, dates of employment, and reasons for terminating employment.

(6) Employee records shall contain evidence of adequate health supervision.

(a) A pre-employment physical examination, including a chest x-ray or an intradermal skin test for tuberculosis, and periodic physical examinations at least every two years shall be performed and recorded.

(b) Food personnel shall have routine health examinations in conformance with state and local sanitary codes. Food handler's permits, where required, shall be current.

(c) Accurate records of illnesses and incidents involving personnel while on duty shall be kept.

(7) No individual shall be employed, or employee permitted to work, if infected with a contagious disease in a communicable form that might endanger the health of patients, residents or other employees.

(8) Requirement that Personnel be Vaccinated Against Influenza Virus.

(a) Definitions.

1. For purposes of 105 CMR 250.002(D)(8), personnel means an individual or individuals employed by or affiliated with the facility, whether directly, by contract with another entity, or as an independent contractor, paid or unpaid, including but not limited to employees, members of the medical staff, contract employees or staff, students, and volunteers who either work at or come to the licensed facility site, whether or not such individual(s) provide direct patient care.

2. For purposes of 105 CMR 150.002(D)(8), the requirement for influenza vaccine or vaccination means immunization by either influenza vaccine, inactivated or live; attenuated influenza vaccine including seasonal influenza vaccine pursuant to 105 CMR 150.002(D)(8)(b); and/or other influenza vaccine pursuant to 105 CMR 150.002(D)(8)(c).

(b) Each facility shall ensure that all personnel are vaccinated annually with seasonal influenza vaccine unless an individual declines vaccination in accordance with 105 CMR 150.002(D)(8)(f). When feasible, and consistent with any guidelines of the Commissioner of Public Health and his/her designee, each facility shall ensure that all personnel are vaccinated with seasonal influenza vaccine no later than December 15, 2009 and annually thereafter.

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(c) Each facility also shall ensure that all personnel are vaccinated against other pandemic or novel influenza virus(es) as specified in guidelines of the Commissioner or his/her designee, unless an individual declines vaccination in accordance with 105 CMR 150.002(D)(8)(1). Such guidelines may specify:

1. The categories of personnel that shall be vaccinated and the order of priority of vaccination of personnel, with priority for personnel with responsibility for direct patient care;
2. The influenza vaccine(s) to be administered;
3. The dates by which personnel must be vaccinated; and
4. Any required reporting and data collection relating to the personnel vaccination requirement of 105 CMR 150.002(D)(8)(c).

(d) Each facility shall provide all personnel with information about the risks and benefits of influenza vaccine.

(e) Each facility shall notify all personnel of the influenza vaccination requirements of 105 CMR 150.002(D)(8) and shall, at no cost to any personnel, provide or arrange for vaccination of all personnel who cannot provide proof of current immunization against influenza unless an individual declines vaccination in accordance with 105 CMR 150.002(D)(8)(f).

(f) Exceptions.

1. A facility shall not require an individual to receive an influenza vaccine pursuant to 105 CMR 150.000(D)(8)(b) or (c) if:
 - a. the vaccine is medically contraindicated, which means that administration of influenza vaccine to that individual would likely be detrimental to the individual's health.
 - b. vaccination is against the individual's religious beliefs; or
 - c. the individual declines the vaccine.
2. An individual who declines vaccination for any reason shall sign a statement certifying that he or she received information about the risks and benefits of influenza vaccine.

(g) Unavailability of Vaccine. A facility shall not be required to provide or arrange for influenza vaccination during such times that the vaccine is unavailable for purchase, shipment, or administration by a third party or when complying with an order of the Commissioner of Public Health which restricts the use of the vaccine. A facility shall obtain and administer influenza vaccine in accordance with 105 CMR 150.002(D)(8) as soon as vaccine becomes available.

(h) Documentation.

1. A facility shall require and maintain for each individual proof of current vaccination against influenza virus pursuant to 105 CMR 150.008(D)(8)(b) and (c), or the individual's declination statement pursuant to 105 CMR 150.002(D)(8)(f).
- 2 Each facility shall maintain a central system to track the vaccination status of all personnel.
3. If a facility is unable to provide or arrange for influenza vaccination for any individual, it shall document the reasons such vaccination could not be provided or arranged for.

(i) Reporting and Data Collection. Each facility shall report information to the Department documenting the facility's compliance with the personnel vaccination requirements of 105 CMR 150.002(D)(8), in accordance with reporting and data collection guidelines of the Commissioner or his/her designee.

(9) No individual who is an alcoholic or drug abuser whose current use of alcohol and drugs prevents such individual from performing the duties of the job in question or whose employment, by reason of such current alcohol or drug abuse, would constitute a direct threat to property or the safety of others shall be employed or permitted to work.

(10) The Department shall be notified promptly in writing of the resignation or dismissal of any employee suspected of active addiction (105 CMR 150.002(D)(3)), assault on patients, residents or personnel, or other such causes.

(11) The Department shall be notified promptly in writing of the resignation or dismissal of the administrator, the director of nurses or the supervisor of nurses and the name and qualifications of the new employee. In the case of dismissal, notice to the Department shall state the reasons.

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(E) The administrator shall establish procedures for the notification of the patient, the next of kin or sponsor in the event of significant change in a patient's or resident's charges, billings, benefit status and other related administrative matters.

(1) The administrator shall establish provisions for the safekeeping of personal effects, funds and other property brought to the facility by patients or residents except, when necessary for the protection of valuables and to avoid unreasonable responsibility, the administrator may require that such valuables be excluded or removed from the premises.

(2) If the facility assumes the responsibility for safekeeping of patients' or residents' possessions and valuables, an accurate, written record of all funds, valuables and possessions and a list of all deposits and withdrawals shall be maintained. A receipt for all items placed in safekeeping and for all deposits and withdrawals shall be provided to the patient or resident, his next of kin or sponsor.

If the facility assumes the responsibility for managing a patient's or resident's funds, such funds shall be placed in an insured interest bearing account with the clear written understanding that the facility has only a fiduciary interest in the funds of this account. The account may be either individual or collective at the election of the facility and shall be deposited at the prevailing market rate of interest for deposits in Massachusetts and shall conform to the requirements associated with the particular account.

(a) All the interest earned by any such funds so deposited shall be credited to each patient or resident.

(b) For individual accounts, the interest earned must be prorated to each patient or resident on an actual interest earned basis.

(c) The interest earned on any collective account must be prorated to each patient or resident on the basis of his or her end of quarter or nearest end of the month balance.

(d) The facility may keep a portion of a patient's or resident's money in a personal needs petty cash fund. The amount kept in this petty cash fund shall not be greater than the limit set by Department of Public Welfare regulations 106 CMR 456.804(3) and must be administered in accordance with 106 CMR 456.804(3). The personal needs petty cash fund shall not be co-mingled with any operational petty cash fund the facility may maintain nor shall it be used for facility operational expenses. A record of money spent for each patient or resident shall be kept.

(e) No fee or other charges shall be applied to any individual patient or resident for such managing of funds or distribution of interest.

(f) The facility shall provide the patient or resident or his/her sponsor with an accounting report every three months of financial transactions made in his/her behalf.

(g) In the event of discharge of a patient or resident, except if the patient's or resident's bed is being held for anticipated readmission, all funds of that patient or resident shall be returned to the patient or resident or to the patient's or resident's family or sponsor with a written accounting in exchange for a signed receipt. Funds which are maintained outside of the facility shall be returned within ten business days.

(h) In the event of death of a patient or resident, the facility shall provide a complete accounting of that patient's or resident's funds to the patient's or resident's family or sponsor.

(3) A statement of all funds, valuables and possessions shall be prepared on admission, transfer or discharge and shall be verified, dated and signed by the patient or resident, his next of kin or sponsor and by a witness. A copy of the list shall be given to the patient or resident, or his next of kin or sponsor.

(4) The admission of a patient or resident to a long-term care facility and his presence therein shall not confer on the facility or its owner, administrator, employees or representatives authority to manage, use or dispose of any property (except drugs) of such patient or resident without written, signed permission to do so by the patient or resident, his next of kin or sponsor.

(5) The name, address and the phone number of the next of kin or sponsor in charge of each patient's or resident's affairs shall be kept readily available in the patient's or resident's chart. The designated individual shall be contacted immediately in an emergency or in the case of any serious incident, fire, or severe illness involving the patient or resident. Such notification shall be recorded in writing in the clinical record.

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(F) The administrator shall establish procedures for the notification of the physician or physician-physician assistant team or physician-nurse practitioner team and the patient's or resident's next of kin or sponsor in the event of an emergency.

(G) The administrator shall be responsible for ensuring that all required records, reports and other materials are complete, accurate, current and available within the facility and the following requirements are met:

(1) Each facility shall immediately report to the Department any of the following which occurs on premises covered by its license:

(a) A death that is unanticipated, not related to the natural course of the resident's illness or underlying condition, or that is the result of an error or other incident as specified in the Department's guidelines;

(b) Full or partial evacuation of the facility;

(c) Fire;

(d) Suicide;

(e) Serious criminal act;

(f) Pending or actual strike action by its employees, and contingency plans for operation of the facility;

(g) Reportable conditions and illness as defined in 105 CMR 300.020: Report of a Disease when such illness is:

1. Believed to be part of a suspected or confirmed cluster or outbreak;

2. Believed to be unusual as defined in 105 CMR 300.020: Unusual Illness; or

3. Related to food consumption or believed to be transmissible through food; or,

(h) Other serious incidents or accidents as specified in the Department's guidelines.

(2) Each facility shall immediately report to the Department any suspected instance(s) of resident abuse, neglect, mistreatment or misappropriation of a resident's personal property.

(3) Within seven days of the date of occurrence of the event, each facility shall report to the Department any other incident or accident occurring on premises covered by the facility's license that seriously affects the health or safety of a resident(s) or that causes serious physical injury to a resident(s).

(4) The Department shall establish guidelines for reporting serious incidents and accidents, including the means of reporting.

(5) A facility shall provide the Department with all information that may be relevant to the Department's investigation of any incident or complaint, regardless of how reported to the Department.

(6) A facility shall make all reasonable efforts to facilitate the Department's attempts to interview all potential witnesses who may have information relevant to the Department's investigation of any incident or complaint, regardless of how reported to the Department.

(H) The administrator shall develop and implement policies and procedures governing emergency transport. Such policies and procedures shall include criteria for deciding whether to call the emergency telephone access number 911 or its local equivalent, or a contracted private ambulance service provider, if any, in response to an emergency medical condition. The criteria for determining whether to call 911 versus the contracted provider shall address such factors as the nature of the emergency medical condition, and the time to scene arrival specified in relevant agreements with the contracted provider, if any.

(I) No later than November 30, 2005, the administrator of a nursing facility shall acquire an automated external defibrillator and develop policies and procedures for the rendering of automated external defibrillation in the facility.

(1) All persons certified to provide automated external defibrillation shall

(a) successfully complete a course in cardiopulmonary resuscitation and in the use of an automated external defibrillator that meets or exceeds the standards established by the American Heart Association or the American National Red Cross;

(b) have evidence that course completion is current and not expired.

(2) For the purposes of 105 CMR 150.000, the facility shall contract with or employ a physician who shall be the automated external defibrillation medical director for the facility.

(a) The medical director shall oversee and coordinate the automated external defibrillation activities of the facility including:

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1. maintenance and testing of equipment in accordance with manufacturer's guidelines;
2. certification and training of facility personnel;
3. periodic performance review of the facility automated external defibrillation activity.

(b) The medical director shall integrate the facility automated external defibrillation activity with the local Emergency Medical response system.

(J) No later than January 15, 2007 the administrator of a nursing facility shall develop and implement policies and procedures acceptable to the Department that govern the nursing facility's participation in the Satisfaction Survey conducted by the Department or its designee. These policies and procedures shall include, at a minimum, the provision of the following information to the Department or its designee:

- (1) The name of each facility resident.
- (2) The name or names of each resident's family member or members, legal guardian or other resident designee or designees who acts on behalf of the resident.
- (3) The mailing address and telephone number for each resident's family member or members, legal guardian or other resident designee or designees who acts on behalf of the resident.
- (4) The admission date for each facility resident.

(K) Upon change of ownership, the medications, funds and personal belongings of all patients or residents shall be checked and identified by the licensee and the new owner. A complete count of controlled substances under the federal Comprehensive Drug Abuse Prevention and Control Act shall be made, recorded in the Narcotic and Sedative Book and signed by the licensee and the new owner.

(L) Patient or resident survey reports, annual reports and such other reports and information as may be required shall be submitted to the Department in the manner and within the time period prescribed.

150.003: Admissions, Transfers and Discharges

(A) The admission, transfer and discharge of patients or residents shall be in accordance with written policies and procedures developed by each facility and acceptable to the Department.

(1) Any restrictions, priorities or special admission criteria shall be applied equally to all potential admissions regardless of source of referral, source of payment, race, creed, ethnic origin, sex, age or handicap. All facilities shall comply with state and federal anti-discrimination laws.

(2) Facilities shall adopt policies and procedures to assure compliance with anti-discrimination provisions of 105 CMR 150.000.

(B) Facilities shall admit and care for only those individuals in need of long term care services for whom they can provide care and services appropriate to the individual's physical, emotional and social needs. Prior to admission, an individual's needs shall be evaluated and alternative care plans considered. This evaluation shall be a joint responsibility of the referring agency or institution, the admitting physician and the receiving facility.

(1) Patients or residents shall be admitted only on the written order of a physician, physician assistant, or nurse practitioner who designates the placement as medically and socially appropriate.

If the admission is to be ordered by a physician-nurse practitioner or physician-physician assistant team, the nurse practitioner or physician assistant shall consult his or her supervising physician by telephone prior to writing the admission order.

(2) No facility shall admit a patient or resident without written consent of the individual (if he or she is competent to enter into such an agreement) or his or her next of kin or sponsor (if he or she is not) except in emergencies.

(a) No SNCF shall admit a patient or resident without written consent of the individual (if he or she is competent to enter into such an agreement) or his or her parent or legal guardian (if he or she is not) except in emergencies.

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- (b) A SNCFC may provide respite services only after prior approval by the Department and contingent upon submission of policies and procedures related to respite care. The Department shall be duly notified in regard to any changes in an approved respite service policy or in regard to the termination of a SNCFC respite service.
- (3) In order to promote appropriate placements, facilities shall exchange information on resources and services with other agencies and institutions that provide health care in their area.

(C) Transfer of Information.

- (1) Prior to or at the time of admission, a health care referral for approved by the Department shall be completed for each patient or resident. Patients and residents shall not be admitted without a completed referral form.
- (2) A discharge summary or complete medical evaluation sufficient to provide the care and services required by the patient or resident shall be made available to the receiving facility either prior to or immediately following admission as specified in 105 CMR 150.005(F)(2).

(D) Admission of Mental Health Patients or Residents.

(1) Level II and III facilities admitting or otherwise caring for individuals discharged from mental institutions, including institutions under the control of or affiliated with the Department of Mental Health, shall meet the following conditions for care and supervision.

(a) An on-site analysis of the placement suitability for the individual has been made by a psychiatric social worker or psychiatric nurse.

(b) The patient or resident has had a complete medical examination (including chest X-ray) prior to admission.

(c) The referring agency or institution has signed a written agreement that they will provide qualified psychiatric personnel to supervise and re-examine individuals referred by them until the individual manifests a satisfactory adjustment for a period of 12 months to his new environment. Such examination shall be at least every three months.

(d) Summaries or reports of psychiatric evaluations and examinations, including current status, recommendations for management and medications, are sent to the facility and maintained with the patient's or resident's clinical record. Medications ordered by psychiatrists shall be in accordance with the provisions in 105 CMR 150.008.

(e) Mental hospitals referring individuals have agreed to re-admit the individual or to secure appropriate alternative placement if he fails to achieve a satisfactory adjustment or requires re-admission to a psychiatric facility with 12 months from the date of placement.

(f) The staff of long-term care facilities accepting such individuals has had special training or experience in the field of mental health or the facility provides regular in-service training programs on subjects of mental health for the staff.

(2) Level IV facilities designated Community Support Facilities or admitting Community Support Residents shall meet the following requirements.

(a) When a resident who has been determined, following his/her consent and evaluation, to be a Community Support Resident, is admitted to a Community Support Facility, or to a Resident Care Facility (by waiver) a written agreement must be signed between certain referring public or private agencies or institutions and the accepting facility. All referring agencies which are also providers of mental health or psychiatric services must agree in writing to provide or arrange for the following services with another designated provider:

1. Seven day a week, 24 hour a day psychiatric consultation services.

2. Mental health personnel who will be available on a monthly basis to coordinate their efforts with Community Support Facility staff or other involved professionals in development of the resident's mental health treatment plan. These staff shall meet with other involved professionals if the Coordinator feels it is required to assure coordination.

3. Psychiatric monitoring of the side effects of drug therapies. The psychiatrist from the referring agency or hospital must consult, and meet if necessary, with other professional staff involved in the development and implementation of the resident's mental health treatment plan to coordinate such monitoring with the treatment plan.

4. Crisis Intervention. When the Administrator of the facility and the Social Worker agree that a mental health crisis exists, the referring agency, hospital or designated provider must work with the facility staff in evaluation and development of a planned response to the crisis.

5. Onsite Crisis Intervention and Emergency Services. In those cases where the referring agency is either the Department of Mental Health or a provider of inpatient mental health services, the following procedure must be followed:

a. If phone consultation is not adequate, onsite evaluation should be provided to the rest home.

b. If the Administrator/Responsible Person, in consultation with other staff including physician, psychiatrist and social worker staff feels the crisis intervention services provided are not adequate and an emergency exists but the referring agency does not agree, if the referring agency agrees to remove the client from the home, if the Administrator/Responsible Person requests this, while an evaluation is performed.

c. The Administrator/Responsible Person agrees to arrange for this evaluation within a period of three working days from the time that the disagreement occurs.

d. Both parties agree to abide by the decision of the evaluating clinician.

e. If the evaluating clinician finds that the client may not return to the facility, the referring agency must arrange for alternate placement within a reasonable time.

f. If the evaluating clinician finds that the client may return to the facility, the facility must readmit the client.

All of the services in 105 CMR 150.003(D)(1) and (2) must be available during the 12 month period following the first day of admission. Crisis Intervention and Emergency services must be available for a three year period following the first day of admission.

(b) No individual may be placed in a Community Support Facility without the written consent of the individual (if he/she is competent to give such consent) or the written consent of his/her guardian (if he/she is not competent).

(c) No Community Support Facility shall admit residents from Department of Mental Health facilities until the Community Support Facility has received notice from the facility discharging the resident that it has made a good faith effort to find the least restrictive setting that can serve the client's needs.

(3) Long Term Care facilities may not administer shock therapy on site. Mental health patients or residents in need of such therapies shall be admitted or transferred to appropriate inpatient acute or mental health facilities.

(4) Long Term Care facilities, except SNCFC as specified in 105 CMR 150.015(H), may not use Aversive Interventions. Mental health or retardation clients in need of such therapies shall be admitted or transferred to appropriate mental health or retardation facilities.

(5) Patients whose primary diagnosis is alcohol or drug addiction shall be treated in an appropriate acute care or rehabilitation facility prior to admission to a long term care facility.

(E) Admission of Patients Younger than 22 Years Old.

(1) Patients younger than 22 years old may be admitted to a long term care facility only after prior approval by the Department's Medical Review Team (MRT).

(a) The MRT must approve all requests for respite care of individuals younger than 22 years old at long term care facilities. Such approval is contingent upon reviewing assessments of a patient's medical, nursing, social and developmental needs.

(b) The MRT must approve all admission requests for long term residential care of individuals younger than 22 years old. Such approval is contingent upon reviewing assessments of a patient's medical, nursing, social and developmental needs and consideration given to alternative placement.

(c) An approval may be granted by the MRT, on a case by case basis, to permit individuals who have resided in a pediatric nursing facility prior to their 22nd birthday to continue to reside at the facility until a more appropriate alternative is available.

(2) Facilities seeking MRT approval for admission of a child younger than 16 years old shall meet standards for SNCFC throughout 105 CMR 150.000 that the MRT deems relevant to caring for such child.

(F) Admission of Residents with Mental Retardation or Developmental Disability/Other Related Conditions (MR/DD/ORC). No facility that is certified to participate in the Medicare or Medicaid programs shall admit a resident with MR/DD/ORC with an anticipated length of stay of 30 days or longer unless the facility has verified that a Pre-admission Screening and Annual Resident Review (PASARR) has been completed to determine whether admission is appropriate and whether there is a need for a referral for a specialized services assessment.

(G) Transfer and Discharge.

(1) Facilities providing Level I, II or III care shall enter into a written transfer agreement with one or more general hospitals that provides for the reasonable assurance of transfer and inpatient hospital care for patients whenever such transfer is medically necessary as determined by the attending physician or physician-physician assistant team or physician-nurse practitioner team. The agreement shall provide for the transfer of acutely ill patients to the hospital ensuring timely admission and provisions for continuity in the care and the transfer of pertinent medical and other information.

Every facility providing SNCFC or both shall enter into a written transfer agreement with one or more hospitals which have an organized pediatric department.

(2) Facilities that provide Level I, II or III care shall designate a member of the permanent or consultant staff to be responsible for transfer and discharge planning.

(3) If major changes occur in the physical or mental condition of the patient or resident so that he requires services not regularly provided by the facility, arrangements shall be made by the attending physician or physician-physician assistant team or physician-nurse practitioner team and the facility to transfer the patient or resident to a facility providing more appropriate care.

A SNCFC shall obtain from the patient's guardian, parents or sponsor at the time of admission, written permission to transfer a patient to an acute care hospital or for emergency medical treatment. This written permission shall remain as part of the patient's record.

(4) If in the opinion of a facility or the Department a patient or resident poses a danger to himself or the health and welfare of other residents or staff, the attending physician or physician-physician assistant team or physician-nurse practitioner team and the Department shall be notified and arrangements made for transfer to a facility providing appropriate care.

(5) Except in an emergency, the facility shall give at least 24 hours notice of anticipated or impending transfer to the receiving agency or institution and shall assist in making arrangements for safe transportation.

(6) No patient or resident shall be transferred or discharged without a physician's, physician assistant's, or nurse practitioner's order and notification to the next of kin or sponsor. The reason for transfer or discharge shall be noted on the patient's or resident's clinical record.

If the discharge or transfer is to be ordered by a nurse practitioner or physician assistant, the nurse practitioner or physician assistant shall consult his supervising physician by telephone prior to discharging a patient to an acute facility for a non emergency situation, prior to transferring a patient to another facility and prior to discharging a patient home. A nurse practitioner or physician assistant may discharge a patient to an acute facility in an emergency situation without prior consultation with his supervising physician only if said physician cannot be contacted immediately. Consultation shall take place thereafter without delay so as to maintain continuity of care.

(7) The following additional requirements apply to the transfer and discharge of residents in Level IV facilities. For the purposes of 105 CMR 150.003, any absence from the facility during which it is anticipated that the resident will or may return, will not be considered a transfer or discharge.

(a) No resident shall be discharged or transferred from a Level IV facility or unit without his or her written consent (if he/she is competent to give such consent), or the written consent of the resident's guardian (if he/she is not competent), solely for the reason that the facility in which the resident resides, has been designated as a Community Support Facility or a non-Community Support Facility. The consent shall be filed in the resident's record.

(b) For those discharges which occur on a planned basis and which exclude emergency discharges or unanticipated discharges (which may occur because of a change in the resident's level of care while in hospital), the following documentation is required:

1. The resident's written consent to his/her transfer or discharge (if he/she is competent to give such consent) or the written consent of the resident's guardian (if he/she is not competent), if such transfer or discharge is based solely upon the facility's designation as a Community Support Facility or non-Community Support Facility;
2. the physician's and/or psychiatrist's order which sets out the justification for the resident's transfer or discharge;
3. the notice given to the resident by the facility of the anticipated transfer or discharge. Said notice shall be given at least 30 days prior to the anticipated date of discharge or transfer, and shall contain sufficient explanation for the discharge or transfer, including the facility's plans and procedures for the transfer or discharge. Such notice shall also state that the resident has the right to object to the facility to his/her transfer or discharge. The reasons for such objections shall be noted in the resident's record. If the resident is incompetent, notice of the anticipated discharge or transfer shall be given to the resident's guardian in the same manner, and with the same rights, as set forth above for giving notice to a competent resident.
4. the site to which the resident is to be discharged or transferred;
5. that all reasonable efforts have been taken by the facility to provide counseling to the resident in order to prepare him/her in adjusting to any transfer or discharge;
6. that all reasonable precautions have been taken to eliminate or reduce any harmful effects that may result from the transfer or discharge;
7. that no coercion or overbearing inducement was utilized to obtain the resident's consent.

(c) In the event of an emergency transfer or discharge, the facility shall, within 48 hours after such emergency discharge or transfer, document in the resident's record the following:

1. the nature of the emergency;
2. the physician's and/or psychiatrist's order which sets out the justification for the resident's emergency transfer or discharge;
3. the name of the resident's next of kin, sponsor, or guardian who has been notified of the resident's transfer or discharge, and that such notification has been made within 24 hours of such transfer or discharge;

(d) In the situation where a temporary absence, for example an admission to hospital, becomes a discharge due to a change in the resident's level of care, the documentation outlined under 105 CMR 150.003(G)(7)(b)2., 4., 5., and 6. will be required.

(8) A health care referral form approved by the Department and other relevant information shall be sent to the receiving agency or institution. A discharge report shall be sent to the Department on forms provided by the Department.

(9) Discharge by Death.

- (a) Each long-term care facility shall develop specific procedures to be followed in the event of death.
- (b) A physician shall be notified immediately at the time of death. Deceased shall be pronounced dead by a physician within a reasonable time after death and shall not be discharged from a facility until pronounced dead.
- (c) Provisions shall be made so that deceased are removed from rooms with other patients or residents as soon as possible.
- (d) The deceased shall be covered and shall be transported in the home and removed from the home in a dignified manner.

(10) All facilities providing Level I/II, III or IV care shall comply with the Attorney General's regulations regarding discharges and transfers as set forth in 940 CMR 4.07.

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150.004: Patient Care Policies

(A) All facilities that provide Level I, II or III care shall have current, written policies that govern the services provided in the facility. Facilities that provide only Level IV care shall develop policies for at least those services marked with an asterisk.

- * Admission, transfer and discharge procedures
 - Physician, physician-physician assistant team and physician-nurse practitioner team services
 - Diagnostic services
 - Nursing services
- * Pharmaceutical services and medications
- * Dietary services
- * Restorative services
 - Carry over services (in a certified facility)
- * Social services
 - Other professional services (dental, podiatric, etc.) and diagnostic services
- * Patient or resident activities and recreation
- * Emergency and disaster plans
- * Personal comfort, safety, and accommodations
- * Clinical Records
 - Utilization Review
 - Education Services (in a SNCFC)
 - Therapeutic Recreation Services (in a SNCFC)
 - Individual Service Planning (in a SNCFC)
 - Behavior Modification Services (in a SNCFC)
 - Respite Services (in a SNCFC)
 - Permanency Planning Services (in a SNCFC)

(1) In addition to the policies and procedures outlined under 105 CMR 150.004(A), AIDSSNFs shall have policies and procedures for the provision of the following:

- Intravenous administration
- Specialized nutritional and Dietary Services including total parenteral nutrition
- Administration of drugs still specified for research
- Tracheostomy care
- Respiratory therapy
- Administration of Aerosolized Pentamidine
- Administration of blood products.
- Methadone maintenance and/or other drug treatment modalities appropriate for a long term care setting.

(2) All specialized policies and procedures developed by AIDSSNFs must be in compliance with guidelines as developed by the Division of Health Care Quality, Department of Public Health. In addition, policies and procedures involving services to clients who are substance abuse impaired must be in compliance with guidelines, if any, developed by the Division of Substance Abuse Services of the Department of Public Health.

(B) The administrator shall be responsible for the development of these policies with the advice of professional advisors or consultants, the director or supervisor of nurses and representatives from other disciplines as may be appropriate.

(1) In a SNCFC, there shall be a Patient Care Advisory Committee which advises the facility in the development and review of all patient care policies. In addition, such committee may participate in an advisory capacity on human rights and programmatic activities relative to patient care.

(2) The Patient Care Advisory Committee shall be comprised of the following members:

- (a) The advisory physician from the SNCFC facility
- (b) The administrator and other professional staff person(s) from the SNCFC facility
- (c) One Services for handicapped children clinician from a DPH Regional Health Office
- (d) One Representative from the Department of Education
- (e) One Parent/guardian representative from each SNCFC unit, one of whom may represent a parent advocacy group

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- (f) One Representative from a parent advocacy group
- (g) Minimum of two community professionals who are familiar with issues related to developmental disabilities, one of whom may represent the DPH Regional Health Office
- (h) Other individuals as may be required

(3) The Patient Care Advisory Committee shall meet a minimum of twice a year and minutes shall be maintained.

(4) In an AIDSSNF, there shall be a Patient Care Advisory Committee (PCAC) which shall meet every six months or more often if indicated by patient needs or community interest. This committee shall advise the facility in the development and review of patient care policies and may also participate in an advisory capacity on human rights and programmatic activities relative to patient care. The PCAC shall include but is not limited to the following members: the Program Director/administrator and professional staff; a representative from the AIDS Office of the Department of Public Health and other state agencies involved in developing services for this population; professionals in private practice or from other institutions and community based groups and consumer groups and clients, including where relevant, ethnically or culturally based groups or community representatives.

(C) Policies shall be reviewed and revised at least annually.

(D) In facilities that provide Level I, II or III care, each patient shall have a patient care plan which shall be a composite of the medical, nursing, social service, dietary, rehabilitation, activity and other such plans and services as may be required to provide for the individual's total care. The patient care plan shall be coordinated by the nursing staff and shall be reviewed in conjunction with all relevant disciplines.

(1) In a SNCFC, each patient shall have an Individual Service Plan (ISP) which is coordinated with his/her Individual Education Plan (IEP). This plan will be a composite of the medical, nursing, social service, nutrition, rehabilitation, recreation, education and other such plans and services as may be required to provide for the individual's total care. The ISP shall be coordinated by the social service staff and shall be organized in conjunction with all relevant disciplines.

(2) In an AIDSSNF, each resident shall have an Individual Service Plan (ISP) which shall be coordinated with the patient's care plan and which shall be developed by the multidisciplinary care team. This ISP shall include a substance abuse treatment plan for those clients who have an identified substance abuse problem. In addition the ISP must include a case management plan which documents ongoing planning and linkage with other area providers as well as with community/cultural groups if indicated by the client's needs.

(3) In certified facilities that provide Level I, II or III care, each resident with MR or DD/ORC shall have a resident care plan which shall be a composite of the medical, nursing, social service, dietary, rehabilitation, activity and other such plans and services, including carry-over services that integrate all relevant specialized services contained in the resident's Department of Mental Retardation Rolland Integrated Services Plan ("RISP") and Specialized Services Provider plan, as may be required to provide for the individual's total care.

(a) The facility shall develop the carry-over services goals, objectives, timelines and responsible disciplines portion of the nursing facility resident care plan in conjunction with the DMR service coordinator or a case manager designated by DMR and Specialized Service Provider staff.

(b) Within 90 days of admission and at least annually thereafter, as part of the resident care planning process, the facility staff shall meet with the Specialized Services Providers and other members of the individual's interdisciplinary team as coordinated by the DMR service coordinators or case managers designated by DMR and shall participate in the development and/or review of the Rolland Integrated Service Plan (RISP)

(E) In a facility having both a SNCFC and units for adults, written policies shall be established regarding interactions between children and adults.

(F) All facilities shall have policies and procedures sufficient to deal effectively with emergencies arising from a patient's or resident's mental health crisis.

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(G) AIDSSNFs shall establish a multidisciplinary team which shall include but is not limited to: the attending physician and nurse practitioner; the Director of Nurses; the Director of Social Services; restorative services staff; substance abuse services staff.

Team meetings shall be held regularly and shall involve other staff members as appropriate. The multidisciplinary team shall develop and review all Individual Service Plan (ISPs). The multidisciplinary team shall work closely with the Patient Care Advisory Committee which provides a mechanism for community input into the care planning process.

(H) The AIDSSNF Unit must provide access to sufficient bilingual services to meet the cultural and language needs of its non-English speaking residents.

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150.005: Physician Services

(A) Facilities that provide Level I, II or III care shall establish written policies and procedures governing the delivery of physician and other medically related services.

(B) Facilities that provide Level I, II or III care shall provide medical supervision through a written agreement with (a) an organized medical staff of a hospital, (b) an organized medical staff within the facility, (c) a local medical society, or (d) two or more advisory physicians (at least one of whom does not have a proprietary interest in the facility).

(1) Supervisory and advisory functions shall include: advice on the development of medical and patient care policies concerning patient admissions and discharge, medical records, responsibilities of attending physicians or physician-physician assistant team or physician-nurse practitioner team, supportive and preventive services, emergency medical care, and the review of the facility's overall program of patient care.

(2) Staff or advisory physicians shall spend at least four hours per month in the facility devoted to supervisory and advisory functions.

(3) A SNCFC shall appoint a pediatrician with experience in developmental disabilities as advisory physician who shall participate in the development of patient care policies, familiarize him/herself with the condition, needs and care of each patient, and participate in periodic staff conferences.

(4) In a SNCFC, services of a neurologist, orthoped, psychiatrist, psychologist or any other consultant services shall be provided as needed to those individuals requiring such services.

(5) An AIDSSNF shall have 1.2 full time equivalent (FTE) staff (48 hours per week) engaged in providing medical care. Of this, at least .2 FTE (eight hours per week) must be provided by a physician. These hours shall include provision of all services required of physicians under 105 CMR 150.000. AIDSSNFs are encouraged to utilize nurse practitioners to triage medical problems as they arise, providing a prompt response to patient care needs and utilizing physician time more effectively.

(C) Every patient or resident shall have an attending physician who is responsible for his continuing medical care and periodic reevaluation.

(1) Each patient or resident or (if he is not competent) his next of kin or sponsor shall on admission designate a physician, physician-physician assistant team or physician-nurse practitioner team to serve as his attending physician. If the patient or resident does not have a physician, an attending physician or physician - physician assistant team or physician nurse practitioner team shall be designated by the facility with the approval of the patient or resident or his next of kin or sponsor.

(2) The addresses and telephone numbers of attending physicians, physician-physician assistant teams or physician-nurse practitioner teams at which they can be routinely reached for emergencies, and the addresses and telephone numbers of alternate physicians or physician-physician assistant teams or physician-nurse practitioner teams, providing coverage for an attending physician, physician-physician assistant team or physician-nurse practitioner team in his/their absence shall be recorded in the patient's or resident's record and be readily available to personnel on duty in case of emergencies.

(D) All facilities shall have written arrangements for emergency physician or physician-physician assistant team or physician-nurse practitioner team services when the patient's or resident's own physician or physician-physician assistant team or physician-nurse practitioner team or alternate is not immediately available.

(1) A schedule listing the names and telephone numbers of "emergency" physicians or physician-physician assistant teams or physician-nurse practitioner teams and the specific days each is on call shall be posted at each nurses' or attendants' station.

(2) If medical orders for the immediate care of a patient or resident are not available at the time of admission, the emergency or advisory physician shall be contacted to provide temporary orders until the attending physician assumes responsibility.

(3) Facilities shall establish and follow procedures that cover immediate care of the patient, persons to be notified and reports to be prepared in the case of emergencies.

(4) The date, time and circumstances surrounding each call to an "emergency" physician and his findings, treatment, and recommendations shall be recorded in the patient's or resident's clinical record. The facility shall notify the attending physician and record such notification in the clinical record.

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(E) All medical, psychiatric and other consultations shall be recorded in the patient's or resident's clinical record and dated and signed by the consulting physician or practitioner.

In a SNCFC the Patient Care Advisory Committee shall assist in the development of written policies pertaining to the obtaining of medical and other professional consultations. These policies shall include at least a definition of the respective roles and responsibilities of the Committee and the attending physician or physician-assistant team or physician-nurse practitioner team and the mechanisms for transporting patients to other institutions for consultations, including attendance at specialty clinics.

(F) Every patient or resident shall have a complete admission physical exam and medical evaluation. Based on this information, the attending physician or physician-physician assistant team or physician-nurse practitioner team shall develop a medical care plan that shall include such information as the following:

(1) Primary diagnosis

Other diagnoses or associated conditions

Pertinent findings of physical exam (including vital signs and weight, if ambulatory).

Weight shall be included for non- ambulatory patients in a SNCFC.

Significant past history

Significant special conditions, disabilities or limitations

Prognosis

Assessment of physical capability (ambulation, feeding assistance bowel and bladder control)

Assessment of mental capacity

Treatment plan including:

Medications

Special treatments or procedures

Restorative services

Dietary needs

Order of ambulation and activities

Special requirements necessary for the individual's health or safety

Preventive or maintenance measures

Short and long term goals

Estimated length of stay.

A medical care plan for patients in a SNCFC shall be part of the Individual Service Plan (ISP) and shall include in addition to the above, a developmental history, including evaluation of the patient's physical, emotional and social growth and development, immunization status, and assessments of hearing, speech and vision. Each patient's medical care plan shall include a schedule of appropriate immunizations as recommended by the American Academy of Pediatrics.

(2) The medical care plan shall be completed and recorded in the patient's or resident's clinical record as follows:

(a) Level I or II, within five days prior to admission, up to 48 hours following admission.

(b) Level III or IV, within 14 days prior to admission, up to 72 hours following admission.

(3) If the medical care plan is completed within the specified time limits prior to admission by the physician who will continue as the attending physician, a repeat examination and evaluation following admission to the facility is not required.

(4) If a nurse practitioner or physician assistant performs the complete admission physical exam and medical evaluation, the supervising physician shall review and countersign the evaluation within ten days for Level I and Level II patients and within 30 days for Level III and Level IV patients; the supervising physician shall also complete an onsite physical examination and medical evaluation within this time period. If the supervising physician has been the physician of record during the patient's hospital stay and a work-up has been performed within five days prior to admission, then the initial physical examination by the supervising physician shall not be necessary.

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(G) Each patient or resident shall be re-examined and re-evaluated, and his medical care plan reviewed and revised, if indicated, by the attending physician, physician-nurse practitioner team or physician-physician assistant team to assure appropriate medical services and patient placement. Reviews shall be recorded in the clinical record at least as often as follows:

(1) Level II, every 30 days. If after 90 days following admission in the opinion of the attending physician or physician-physician assistant team or physician-nurse practitioner team it is deemed unnecessary to see the patient with such frequency, an alternate schedule of visits by the physician or physician-physician assistant team or physician-nurse practitioner team may be adopted providing the justification is documented in the patient's medical record. At no time may the alternate schedule exceed 60 days.

In a SNCFC, every 30 days. If after 90 days following admission in the opinion of the attending physician or physician-assistant team or physician-nurse practitioner team, it is deemed unnecessary to see the patient with such frequency, an alternate schedule of visits by the physician or physician-assistant team or physician-nurse practitioner team may be adopted providing the justification is documented in the patient's medical record and ISP. At no time may the alternate schedule exceed 60 days.

(2) Level III, every 60 days. If after 90 days following admission in the opinion of the attending physician or physician-physician assistant team or physician-nurse practitioner team it is deemed unnecessary to see the patient with such frequency, an alternate schedule of visits by the physician or physician-physician assistant team or physician-nurse practitioner team may be adopted providing the justification is documented in the patient's medical record. At no time may the alternate schedule exceed 90 days.

(3) Level IV, every six months, except for Community Support Residents every three months, unless the physician documents that fewer visits are necessary.

(4) If the re-examinations and re-evaluations and reviews of the medical care plan are conducted by a nurse practitioner or physician assistant, the supervising physician shall perform an onsite review and evaluation of each patient in conjunction with the nurse practitioner or physician assistant at least every six months for Level I and Level II patients and at least every 12 months for Level III patients and Level IV patients.

(5) At the time of the supervising physician's on-site visit, the physician shall write a progress note confirming that he/she has personally evaluated the patient, has reviewed the medical care plans developed by the nurse practitioner or physician assistant and has participated in any necessary revisions.

150.006: Other Professional Services and Diagnostic Services

(A) Each patient or resident or (if he is not competent) his next of kin or sponsor shall have the right to designate other licensed practitioners of their choice.

(B) Dental.

(1) All patients and residents shall be assisted to obtain proper dental care including prophylactic, therapeutic and emergency dental services. Such services shall be rendered with the knowledge of the attending physician or physician-physician assistant team or physician-nurse practitioner team.

A SNCFC shall ensure each patient has a complete dental examination annually and periodic dental inspection every six months.

(2) All dental services shall be documented and recorded in the clinical record.

(3) A SNCFC shall appoint a consultant dentist with experience or training in developmental disabilities who shall participate in the development of patient care policies related to dental health, familiarize him/herself with the dental condition, needs and care of each patient, and as necessary, participate in periodic staff conferences. A SNCFC shall retain the services of a dental hygienist to work under the general supervision of the consultant dentist. The dental hygienist shall conduct periodic inspections of patients or residents and develop dental disease prevention programs within the facility.

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(C) Podiatric.

- (1) All patients and residents shall have proper foot care and foot wear.
- (2) When the services of a podiatrist are needed or requested, such services shall be rendered with the knowledge of the attending physician or physician-physician assistant team or physician-nurse practitioner team.
- (3) All podiatric services shall be documented and recorded in the clinical record.

(D) Patients and residents shall be assisted to obtain other routine or special services as their needs may require, such as:

- (1) Eye examinations and eye glasses.
- (2) Auditory testing and hearing aids.

(E) Patients and residents shall be assisted to prepare for and meet appointments punctually at outpatient departments, clinics, physician's offices, etc., when these have been scheduled.

(F) Diagnostic Services.

- (1) Facilities shall make arrangements for the prompt and convenient performance of regular and emergency diagnostic, laboratory, x-ray and other clinical tests or procedures when ordered.
- (2) All diagnostic services shall be ordered by a physician, physician assistant or nurse practitioner and he shall be promptly notified of the test results.
- (3) All findings and reports shall be recorded in the patient's or resident's clinical record.
- (4) No clinical laboratory tests shall be routinely performed in facilities providing Level I, II, III or IV care except simple urine tests customarily performed by nursing personnel for diabetic patients, and tuberculin skin tests.

(G) Staff Training in Resident Care Facilities and Community Support Facilities. All Level IV facilities, regardless of the number of Community Support Residents, are required to provide training on the topic of mental health and illness and the problems of the elderly to all direct care employees. Direct care staff are staff whose work involves extensive patient contact or administrative decisions regarding care. While the Department does not require the training of staff whose work may not involve resident care, for example, cooking or maintenance of the building and grounds, these staff may be included in the training programs at the discretion of the Administrator/ Responsible Person, if the staff person's job involves some resident contact. Employees shall be provided with training sessions of at least two hours duration, every three months. Training programs shall be delivered and documented according to guidelines from the Department. Training and education shall include but need not be limited to: normal aging; the dynamics of mental illness; the etiology, treatment, prevention, and management of mental disorders; resident rights; and crisis intervention. Training and education shall also include those mental health disorders specific to the elderly, and the effects and potential side-effects of drug therapies. Training shall be provided by an instructor with at least two years professional experience (on a full- time or part-time basis) in each of the following three areas: care of the elderly, provision of mental health services, and training or teaching adults. This experience may have been gained concurrently or successively. In addition, the instructor shall have acquired a bachelor's degree in a human services field. The use of master's level clinicians is strongly encouraged.

(H) At a minimum an AIDSSNF shall employ a.2 FTE (8 hours per week) Infection Control Practitioner (ICP) as defined in 105 CMR 150.001: Infection Control Practitioner.

(I) In an AIDSSNF, regular staff training and support groups shall be held which address both educational and emotional needs related to the care of patients with Acquired Immune Deficiency Syndrome (AIDS) or any of the HIV-related diseases as classified by the Centers for Disease Control (CDC).

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150.007: Nursing Services

(A) All facilities shall provide appropriate, adequate and sufficient nursing services to meet the needs of patients or residents and to assure that preventive measures, treatments, medications, diets, restorative services, activities and related services are carried out, recorded and reviewed.

(1) Facilities that provide Level I, II or III care shall provide a 24-hour nursing service with an adequate number of trained and experienced nursing personnel on duty 24 hours per day, seven days a week, including vacation and other relief periods.

(2) Nursing services in facilities that provide Level I, II or III care shall be in accordance with written policies and procedures.

(3) Facilities that provide only Level IV care are not required to provide organized, routine nursing services. However, nursing services shall be provided as needed to residents in the case of minor illness of a temporary nature. Exception: Community Support Facilities and Resident Care Facilities with Community Support Residents shall provide organized, routine nursing services in order to monitor resident medications, potential medication side effects, and general resident physical and psychosocial well-being. Nursing services shall be provided at a minimum of at least 15 hours per 30 residents per month and more if needed, and shall be scheduled so as to assure at least one visit per week. Such services shall be equally distributed across the month.

(B) Minimum Nursing Personnel Requirement.

(1) General.

(a) Nursing personnel shall not service on active duty more than 12 hours per day, or more than 48 hours per week, on a regular basis.

(b) One director of nurses may cover multiple units of the same or different levels of care within a single facility. One supervisor of nurses may cover up to two units of the same or different levels of care within a single facility.

Where a SNCFC unit or units is in combination with an adult nursing program, there shall be a day supervisor whose sole responsibility is to the pediatric nursing program.

(c) Full-time shall mean 40 hours per week, five days per week.

(d) The amount of nursing care time per patient shall be exclusive of non-nursing duties.

(e) The minimum staffing patterns and nursing care hours as contained herein shall mean minimum, basic requirements. Additional staff will be necessary in many facilities to provide adequate services to meet patient needs.

(f) The supervisor of nurses and the charge nurse, but not the director of nurses, may be counted in the calculation of licensed nursing personnel.

(2) Facilities that provide Level I care shall provide:

(a) A full-time director of nurses during the day shift.

(b) A full-time supervisor of nurses during the day shift, five days a week for facilities with more than one unit. In facilities with a single unit, the director of nurses may function as supervisor.

(c) A charge nurse 24 hours per day, seven days a week for each unit.

(d) Sufficient ancillary nursing personnel to meet patient needs.

(e) As a basic minimum, facilities that provide Level I care shall provide a total of 2.6 hours of nursing care per patient per day; at least 0.6 hours shall be provided by licensed nursing personnel and 2.0 hours by ancillary nursing personnel.

(3) Facilities that provide Level II care shall provide:

(a) A full-time director of nurses.

(b) A full-time supervisor of nurses during the day shift, five days a week for facilities with more than one unit. In facilities with only a single unit, the director of nurses may function as supervisor.

A SNCFC shall provide a full-time supervisor of nursing during the day and evening shifts seven days a week, who shall be a registered nurse and shall have had at least one year of nursing experience in pediatrics, preferably with the developmentally disabled population.

(c) A charge nurse 24 hours per day, seven days a week for each unit.

(d) Sufficient ancillary nursing personnel to meet patient needs.

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(e) As a basic minimum, facilities that provide Level II care shall provide a total of 2.0 hours of nursing care per patient per day; at least 0.6 hours shall be provided by licensed nursing personnel and 1.4 hours by ancillary nursing personnel.

1. As a basic minimum, a SNCFC shall provide a total of 5.0 hours of nursing care per patient per day. In facilities housing 40 bed units, at least 1.4 to 1.8 hours shall be provided by licensed nursing personnel and the balance by ancillary nursing personnel. In facilities having less than 40 bed units at least 1.8 to 2.1 hours shall be provided by licensed nursing personnel and the balance by ancillary nursing personnel.

2. A SNCFC shall provided a staff nurse, 24 hours a day, seven days a week for each unit.

3. As a basic minimum an AIDSSNF shall provide 4.4 hours of nursing care per patient per day; at least 2.0 hours of this care must be provided by licensed personnel and 2.4 by ancillary personnel.

4. An AIDSSNF shall employ, at a minimum, one.5 FTE (20 hours per week) psychiatric nurse who shall be responsible for direct patient care as well as staff training. These hours are in addition to the 4.4 hours of direct nursing specified in 105 CMR 150.007(B)(3)(e)3.. The psychiatric nurse shall work closely with the social work and substance abuse counseling staff in developing and coordinating the mental health component of the resident's Individual Service Plan (ISP) as well as in developing programs for staff support.

(4) Facilities that provide Level III care shall provide:

(a) A full-time supervisor of nurses during the day shift, five days a week, in facilities with more than one unit.

(b) A charge nurse during the day and evening shifts, seven days a week, for each unit.

(c) A nurse's aide who is a responsible person, on duty during the night shift.

(d) Sufficient ancillary nursing personnel to meet patient needs.

(e) As a basic minimum, facilities that provide Level III care shall provide a total of 1.4 hours of nursing care per patient per day; at least 0.4 shall be provided by licensed nursing personnel and 1.0 hours by ancillary nursing personnel.

(f) The facility shall provide additional nursing services, sufficient to meet the needs, in the event a patient has a minor illness and is not transferred to a higher level facility or unit.

(5) Facilities that provide Level IV care shall provide:

(a) A responsible person on the premises at all times.

(b) In facilities with less than 20 beds, at least one "responsible person" on active duty during the waking hours in the ratio of one per ten residents.

(c) In facilities with more than 20 beds, at least one "responsible person" on active duty at all times during the 24 hours of the day, seven days a week, per unit.

(d) If none of the responsible persons on duty are licensed nurses, then the facility shall provide a licensed consultant nurse, four hours per month per unit. (In multiple level facilities the director or supervisor of nurses may function in this capacity.)

(e) In all facilities with more than ten Community Support Residents, at least one responsible person awake and on duty at all times on the night shift.

(C) Qualifications and Duties.

(1) Director of Nurses: The Director of Nurses shall be a registered nurse with at least two years of nursing experience, at least one of which has been in an administrative or supervisory capacity. The director of nurses shall be responsible for: development of the objectives and standards of nursing practice and procedures, overall management of nursing personnel, coordination of nursing services, development of staff training programs, and the evaluation and review of patient care and nursing care practices.

In addition to the requirements above, the Director of Nursing of a free-standing SNCFC must have at least one year of nursing experience in pediatrics, preferably with the developmentally disabled population.

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(2) Supervisor of Nurses: The supervisor of nurses shall be a registered nurse with at least two years of nursing experience, one of which has been in a charge nurse capacity. The supervisor of nurses shall be responsible for: the supervision of nursing care and nursing personnel, the supervision and evaluation of staff assignments and performance, the supervision of patient care, the application and evaluation of patient care plans and the integration of nursing care with other professional services.

In cases where a supervisor of nursing is responsible for a SNCFC unit or units, that individual must have a minimum of one year training or experience in pediatrics, preferably with the developmentally disabled population.

(3) Charge Nurse: The charge nurse shall be a registered nurse or a licensed practical nurse; provided that, in a Level I or II unit, a practical nurse licensed by waiver may serve in such capacity only if she/he has received a passing grade either on the Massachusetts written state licensure examination given in the years 1958, 1959, 1960 by the Board of Registration in Nursing or on the federal Public Health Service Proficiency Examination for Practical Nurses Licensed by Waiver given periodically by the Department in accordance with federal regulations. The charge nurse shall be responsible for the performance of total nursing care of the patients in his/her unit during his/her tour of duty with the assistance of ancillary nursing personnel.

(a) In a SNCFC, the charge nurse shall be a registered nurse or a licensed practical nurse, preferably with training and/or experience in pediatric nursing.

(b) In a SNCFC, the staff nurse shall be a registered nurse or licensed practical nurse, preferably with training and/or experience in pediatric nursing.

(4) The Nurse's Aide or the Responsible Person on duty in facilities that provide Level III or IV care shall be readily accessible so that patients or residents can easily report injuries, symptoms, or emergencies. Such person shall be responsible for assuring that appropriate action is taken promptly, and facilities shall be responsible for establishing mechanisms and procedures for the nurse's aide or responsible person to obtain assistance in the case of an emergency.

(5) Licensed practical nurses, nurses' aides and orderlies shall be assigned duties consistent with their training and experience.

A SNCFC or INFC shall provide nurses' aides who have training or experience in caring for children. Assignments shall be made so that each patient is cared for by at least one aide who is assigned to care for him on a continuing basis.

(6) At no time shall direct patient care be provided by individuals under 16 years of age, housekeeping staff or kitchen workers.

(7) Nursing personnel shall not perform housekeeping, laundry, cooking or other such tasks normally performed by maintenance or other personnel.

(D) Nursing Care.

(1) Nursing care shall be an integral part of total health care and shall emphasize the promotion of health, the prevention and treatment of disease and disability, and the teaching counseling and emotional support of patients.

Assignment of nursing staff within a SNCFC shall be made so that each patient is cared for by at least some nursing personnel who are assigned to care for him on a continuing basis.

(2) Nursing Care Plan: In facilities that provide Level I, II or III care, the nursing care shall include a comprehensive, nursing care plan for each patient developed by the nursing staff in relation to the patient's total health needs.

(a) The nursing care plan shall be an organized, written daily plan of care for each patient. It shall include: diagnoses, significant conditions or impairments, medication, treatments, special orders, diet, safety measure, mental condition, bathing and grooming schedules, activities of daily living, the kind and amount of assistance needed, long-term and short-term goals, planned patient teaching programs, encouragement of patient's interests and desirable activities. It shall indicate what nursing care is needed, how it can best be accomplished, and what methods and approaches are most successful. This information shall be summarized on a cardex and be available for use by all personnel involved in patient care.

In a SNCF, the nursing care plan shall also include consideration of the patient's physical and mental status with respect to his need for recreational and educational stimulation and growth; consideration of the patient's familial situation, and of his behavior with other patients, staff, family and visitors. The nursing care plan shall be part of the patient's ISP.

(b) The nursing care plan shall be initiated on admission and shall be based on the physician's or physician-physician assistant team's or physician-nurse practitioner team's medical care plan and the nursing assessment of patient needs.

(c) The plan shall be the responsibility of the director or supervisor of nurses and shall be developed in conjunction with the nursing staff and representatives of other health disciplines where appropriate.

(d) All personnel who provide care to a patient shall have a thorough knowledge of the patient's condition and the nursing care plan.

(e) The plan shall specify priorities of nursing need, which shall be determined through communication with the patient, the physician or physician-physician assistant team or physician-nurse practitioner team, other staff and the family.

(f) The plan shall reflect the patient's psycho-social needs and ethnic, religious, social, cultural or other preferences.

(g) Nursing care plans shall be reviewed, revised and kept current so that patient care constantly meets patient needs. Plans shall show written evidence of review and revision at least every 30 days in facilities that provide Level I or II care, and every 90 days in facilities that provide Level III care. Reviews of nursing care plans shall be performed in conjunction with reviews of other aspects of the patient's total health care.

(h) For residents in certified facilities with MR or DD/ORC nursing care plans shall include the carry-over services that integrate all relevant specialized services contained in the resident's DMR Rolland Integrated Services Plan and Specialized Services Provider plan. The plan shall be developed in conjunction with the resident, and/or guardian, representatives of DMR or a case manager designated by DMR and the Specialized Service providers, reviewed not less frequently than every three months, annually and at the time of significant change.

(i) Relevant information from the nursing care plan shall be included with other health information when a patient is transferred or discharged.

(E) Restorative Nursing Care.

(1) All facilities that provide Level I, II or III care shall provide a program of restorative nursing care as an integral part of overall nursing care. Restorative nursing care shall be designed to assist each patient to achieve or maintain the highest possible degree of function, self-care and independence.

(2) Nursing personnel shall provide restorative nursing services in their daily care of patients.

(3) Restorative nursing services shall include such procedures as:

(a) Maintaining good body alignment, keeping range of motion of weak or paralyzed limbs, proper positioning and support with appropriate equipment -- particularly of bedfast or wheel chair patients.

(b) Encouraging and assisting bedfast patients to change positions at least every two hours during waking hours (7:00 A.M. to 10:00 P.M.) in order to stimulate circulation, and prevent decubiti and contractures.

(c) Maintaining a program of preventive skin care.

(d) Assisting patients to keep active and out of bed for reasonable periods of time except when contraindicated by physician's or physician-physician assistant team's or physician-nurse practitioner team's orders or the patient's condition.

(e) Maintaining a bowel and bladder training program.

(f) Assisting patients to adjust to any disabilities and to redirect their interests if necessary.

(g) Assisting patients to carry out prescribed physical therapy, occupational therapy and speech, hearing and language therapy exercises between visits by the therapist.

(h) Assisting patients to maintain or restore function and activity through proper general exercises and activities appropriate to their condition.

(i) Assisting and teaching the activities of daily living (such as feeding, dressing, grooming and toilet activities).

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(j) Coordinating restorative nursing services with restorative services, activity programs and other patient care services.

(F) Dietary Supervision.

(1) Nursing personnel shall have knowledge of the dietary needs, food and fluid intake and special dietary restrictions of patients and shall see that patients are served diets as prescribed. Patients' acceptance of food shall be observed, and any significant deviation from normal food or fluid intake or refusal of food shall be reported to the nurse in charge and the food service supervisor or dietitian.

(2) Patients requiring assistance in eating shall receive adequate assistance. Help shall be assigned promptly upon receipt of meals, and adaptive self-help devices shall be provided when necessary.

(G) Nursing and Supportive Routines and Practices.

(1) All facilities shall provide sufficient nursing care and supportive care so that each patient or resident:

(a) Receives treatments, medications, diet and other services as prescribed and planned in his medical, nursing, restorative, dietary, social and other care plans. In certified facilities this shall include carry over services for residents with MR or DD/ORC.

(b) Receives proper care to prevent decubiti, contractures and immobility.

(c) Is kept comfortable, clean and well groomed.

(d) Is protected from accident and injury through safety plans and measures.

(e) Is treated with kindness and respect.

(2) No medication, treatment or therapeutic diet shall be administered to a patient or resident except on written or oral order of a physician or physician assistant or nurse practitioner.

(3) Nursing personnel and responsible persons shall constantly be alert to the condition and health needs of patients and residents and shall promptly report to the nurse or person in charge any untoward patient conditions or symptomatology such as dehydration, fever, drug reaction or unresponsiveness.

(4) Nursing personnel and responsible persons shall assist patients or residents to dress and prepare for appointments, medical or other examinations, diagnostic tests, special activities and other events outside the facility.

(5) The following personal care routines shall be provided by all facilities as a part of the patient's or resident's general care and well-being.

(a) A tub bath, shower or full-bed bath as desired or required, but at least weekly. In a SNCFC or INCFC, a bath or shower daily.

(b) Bed linen changed as required, but at least weekly.

(c) Procedures to keep incontinent patients clean and dry.

(d) Frequent observation of bedfast patients for skin lesions and special care for all pressure areas.

(e) Daily ambulation or such movement as condition permits (as ordered by the physician or physician assistant or nurse practitioner).

(f) A range of recreational activities.

(g) Provision for daily shaving of men.

(h) Provision for haircuts for men at least monthly.

(i) Hair shampoos at least once every two weeks. In a SNCFC or INCFC, hair shampoos twice a week.

(j) Daily oral hygiene and dentures or teeth cleaned morning and night.

(k) Foot care sufficient to keep feet clean and nails trimmed.

(l) Appropriate, clean clothing that is properly mended, appropriate to the time of day and season, whether indoors or outdoors. No clothing of highly flammable fabrics shall be permitted.

(m) An attendant for walks and other such activities, when necessary, to safeguard ambulatory patients or residents.

(H) Nursing Review and Notes. Each patient's condition shall be reviewed with special notation of any untoward event, change in condition, nursing or other services provided and the patient's response or progress.

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(1) In facilities that provide Level II care each patient shall be reviewed by the nursing personnel going off duty with the nursing personnel coming on duty at each change of shift. At minimum a weekly progress note shall be recorded in each patient's record unless the patient's condition warrants more frequent notations; the weekly progress note documentation shall be performed by a licensed nurse.

(2) In facilities that provide Level III care, each resident's general condition shall be reviewed each morning. Significant changes of findings shall be noted in the clinical record and the attending physician or physician-physician assistant team or physician-nurse practitioner team notified with a written notation or the time and date of notification. A note summarizing the resident's condition shall be written monthly in the clinical record.

(I) Educational Programs. Facilities that provide Level I, II or III care shall provide a continuing inservice educational program appropriate to the level of care provided in the facility for all nursing personnel. Such a program shall be in addition to a thorough job orientation for new personnel. In addition, facilities that admit residents with MR or DD/ORC shall include, as part of the new personnel job orientation and continuing inservice education, content addressing the theory, skills and techniques required to provide care and services to such residents.

150.008: Pharmaceutical Services and Medications

(A) All facilities shall maintain current written policies and procedures regarding the procurement, storage, dispensing, administration and recording of drugs and medications.

(1) Policies and procedures shall be developed with the advice of a committee of professional personnel including a physician or physician-physician assistant team or physician-nurse practitioner team, a pharmacist and a nurse.

(2) Provision shall be made for the prompt and convenient acquisition of prescribed drugs from licensed community, institutional or hospital pharmacies. Facilities shall make no exclusive arrangements for the supply or purchase of drugs; and patients or residents, their next of kin or sponsor may arrange for the purchase of prescribed medications from pharmacies of their own choice provided medications are dispensed and labeled as specified in 105 CMR 150.000.

(3) No drug or medication that has been removed from the market by the Food and Drug Administration shall be stocked or administered in any facility.

(4) Facilities shall comply with all Federal and State laws and regulations relating to the procurement, storage, dispensing, administration, recording and disposal of drugs.

(5) In an AIDSSNF, if the facility is to be approved to provide methadone maintenance services they shall be in compliance with federal regulations governing methadone maintenance as well as with state guidelines or regulations of the Department of Public Health, Division of Substance Abuse Services.

(B) There shall be a current written order by a physician, physician assistant, or nurse practitioner in the Doctor's Order Book for all medication or drugs administered to patients or residents.

(1) Verbal or telephone orders shall be given only to a licensed nurse (or responsible person in facilities that provide only Level IV care), shall be immediately recorded in writing and signed by the same nurse or responsible person. All verbal or telephone orders shall be countersigned by a physician, physician assistant, or nurse practitioner within 48 hours except for cathartics, aspirin and buffered aspirin.

(2) A licensed nurse and the attending physician together shall review each patient's or resident's medications in conjunction with the routinely scheduled comprehensive review of the patient's or resident's condition. Such reviews shall be scheduled at least as often as follows:

Level I or II, every 30 days,

Level III every 90 days,

In a Level IV facility, at the time of a resident's review by his/her physician, as outlined under 105 CMR 150.005(G)(3), both the physician and the nurse shall review the resident's medications. Any concerns regarding medication side effects or needs for adjustment shall be discussed by the attending physician and the facility nurse to develop and implement an appropriate adjustment in the resident's plan of care.

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If the resident also has an identified psychiatrist and the medication change involves psychiatric medication, the resident's psychiatrist should be consulted. If the resident is a Community Support Resident, any change in psychiatric medication and the rationale for that change must be communicated to the social worker so that an appropriate adjustment in the Mental Health Treatment Plan may be made. In addition, the resident must consent (if she/he is competent to consent) or the resident's guardian (if the resident is not competent to consent) to any medication change as required under 105 CMR 150.011(E)(5)(d)10..

(3) Orders for medications and treatments shall be in effect for the specific number of days indicated by the physician, physician assistant or nurse practitioner.

(a) Orders shall not exceed the facility's stop order policies where applicable.

(b) Orders shall not exceed the limits of 72 hours for narcotics and 14 days for stimulants, depressants, antibiotics and anticoagulants unless specified in writing by the attending physician or physician-physician assistant team or physician-nurse practitioner team.

(c) Medications not specifically limited to time or number of doses by the physician, nurse practitioner, or physician assistant shall automatically be stopped in accordance with the facility's stop order policies or, in the absence of such policies, at the end of 30 days. The physician, physician assistant, or nurse practitioner shall be contacted for renewal of orders or other instructions.

(4) Medication may be released to patients or residents on discharge only on the written authorization of a physician, physician assistant or nurse practitioner. Otherwise they shall be held for disposal (105 CMR 150.008(D)(13)).

(5) If medications for a patient are ordered by a physician assistant or nurse practitioner, all initial orders for medication or significant changes in medications and all orders for Schedule II drugs must be reviewed by the supervising physician as specified in 105 CMR 700.000 et seq.

(6) If medications for a patient are ordered by a physician assistant or nurse practitioner, there shall be a review of medications by the physician assistant or nurse practitioner and the supervising physician as specified in the written guidelines established pursuant to 105 CMR 700.003(C)(3) or more frequently if clinically indicated. At a minimum, there shall be an onsite medication review at the long term care facility by the supervising physician at least once every 90 days.

(C) Supervision and administration of medication shall be as follows:

(1) Every medication administered in a facility shall be administered by a physician, physician assistant, nurse practitioner, registered nurse, or licensed practical nurse, except as provided in 105 CMR 150.008(C)(2).

(2) In a Level IV facility or unit and a CSF, the following medications may be administered by a responsible person who has documented evidence of having satisfactorily completed a training course approved by the Department on the topic of dispensing medications, or may be self-administered if so authorized by a physician or psychiatrist's order:

(a) Any oral medication, which is not included in the schedules of controlled substances established under the Federal Comprehensive Drug Abuse Prevention and Control Act.

(b) Any of the following medications contained in federal schedules of controlled substances: chlordiazepoxide, diazepam, oxazepam, chlorazepate, flurazepam, clonazepam, chloral hydrate, phenobarbital when used in the treatment of seizure disorders, triazolam, lorazepam, alprazolam, temazepam, prazepam, propoxyphene hydrochloride, and propoxyphene napsylate.

(c) The administration of all other controlled substances must be approved by the Department through a written waiver request pursuant to 105 CMR 153.030(B).

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(3) Notwithstanding a physician's order, a licensee shall not permit self-administration by any resident, where, in his/her judgement, this practice would endanger another resident or other residents.

(a) All medication which is to be self-administered shall be kept in the resident's room in a locked cabinet or in a locked drawer.

(b) In the case of a resident with a history of mental illness, a self-administration order must be supported by a written finding by the physician that the resident has the ability to manage the medication on this basis.

(c) Every self-administration order shall be reconsidered as part of the periodic review of medications under 105 CMR 150.0008(B)(2).

(4) All medications shall be accurately recorded and accounted for at all times, and each dose of medication administered shall be properly recorded in the clinical record with a signature of the administering nurse or responsible person.

(5) Medications prescribed for a specified patient or resident shall not be administered to any other patient or resident.

(6) Individual medication cards shall be provided for each medication for each patient. Cards shall be used when administering medications and checked against the physician's orders. Adequate medicine trays shall be provided.

(7) Medication errors and drug reactions shall be reported to the patient's or resident's physician and recorded in the clinical record.

(8) A current medication reference book shall be provided in the facility at each nurse's or attendant's station.

(D) Labeling, Storage and Supervision of Medications.

(1) All facilities shall provide a locked medicine cabinet or closet of a type approved by the Department within the nurses' or attendants' station for the proper storage of all patients' or residents' drugs except those approved for self-administration. Such cabinets or closets shall be used exclusively for the storage of medications and equipment required for the administration of medications.

(2) The locked medicine cabinet or closet shall be located within or close to the nurses' or attendants' station in a place that is removed from areas frequented by patients, residents or visitors.

(3) The medicine cabinet or closet shall be well-lighted, locked at all times with a suitable lock, and maintained in a clean and sanitary manner. It shall be sufficient in size to permit storage without crowding and shall have running water accessible.

(4) There shall be a separately locked, securely fastened compartment within the locked medicine cabinet or closet for the proper storage of prescribed controlled substances under the federal Comprehensive Drug Abuse Prevention and Control Act.

(5) Medications requiring refrigeration shall be properly refrigerated and kept in a separate, locked box within a refrigerator at or near the nurses' or attendants' station.

(6) Poisons and medications for "external use only," including rubbing alcohol, shall be kept in a locked cabinet or compartment separate and apart from internal medications.

(7) Medications shall not be stored in patient's or resident's rooms except drugs approved for self-administration.

(8) The custody of all keys to the medicine cabinets or closets shall at all times be assigned to a licensed nurse (or a responsible person in facilities that provide only Level IV care).

(9) The label affixed to each individual medication container shall clearly indicate the patient's or resident's full name, physician's name or physician assistant's name and his supervising physician's name or nurse practitioner's name and his supervising physician's name, prescription number, name and strength of drug, quantity, dose, frequency and method of administration, date of issue, expiration date of all time-dated drugs, and name, address and telephone number of pharmacy issuing the drug.

(10) Prescription labels shall not be defaced, and medication containers with soiled, damaged, incomplete, illegible, or make shift labels shall be returned to the issuing pharmacy for relabeling or disposal. Containers without labels shall be destroyed as directed by the Department.

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(11) Medications for each patient or resident shall be kept and stored in the containers in which they were originally received; transfer to other containers is forbidden.

(12) Medications having a specific expiration date shall be removed from usage and destroyed at expiration. All medications no longer in use shall be disposed of or destroyed as directed by the Department.

(13) Following a patient's or resident's death, transfer or discharge, all drugs prescribed for that individual, if not transferred with him, shall be disposed of as directed by the Department.

(E) An emergency medication kit shall be provided in all facilities.

(1) The contents of the kit shall be approved by the Department. In accordance with Federal law, narcotics shall be excluded.

In a SNCF, a pediatric emergency kit and emergency resuscitation equipment and medication shall be provided. In addition, a chart listing pediatric doses for emergency drugs shall be included with emergency equipment.

(2) The emergency medication kit shall be kept in a separate, sealed container, which shall be stored in a suitable place when not in use. Exception: Drugs requiring refrigeration shall be kept in a separate sealed container under proper refrigeration (150 CMR 150.008(D)(5)).

(3) Each emergency medication kit shall be prepared, packaged and sealed by a pharmacist and shall contain a list of contents on the outside cover and within the box.

(4) The medications contained in the emergency medication kit shall be used only upon the orders of a physician or physician assistant or nurse practitioner.

(5) After a kit has been opened, it shall be inspected, re-stocked and resealed by the pharmacist within 48 hours prior to further use.

(F) Facilities shall be permitted to stock those drugs and medical supplies that are approved as stock items or medicine chest items by the Department.

(G) Records.

(1) When drugs are transferred with a patient or resident, an accurate record shall be made at the time of discharge including the following: date, name and new address of patient or resident; name of drug, strength, quantity, pharmacy and physician's name or physician assistant's name and his supervising physician's name or nurse practitioner's name and his supervising physician's name.

(2) An individual narcotic and sedative record shall be maintained for each narcotic, sedative, amphetamine, barbiturate or other dangerous drug prescribed for each patient or resident. This record shall be kept in a bound book with numbered pages in a manner approved by the Department and shall include:

(a) Patient's or resident's name.

(b) Name of physician prescribing the medication or the name of the physician assistant or nurse practitioner prescribing the medication and the name of his supervising physician.

(c) Name of medication, quantity prescribed, strength or dosage prescribed, the amount of medication received and the balance on hand.

(d) Date received, prescription number and name of pharmacy that dispensed medication.

(e) Date, time, dosage and method of administration and signature of nurse who administered the medication.

(3) A recorded, dated count of controlled substances under the federal Comprehensive Drug Abuse Prevention and Control Act shall be checked by a nurse or responsible person going off duty on each shift in the presence of a nurse or responsible person reporting on duty and both shall sign the count in the Narcotic and Sedative Book with their legal signatures.

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- (4) All facilities shall maintain a Pharmacy Record Book which is bound with numbered pages and maintained in a form approved by the Department. All deliveries of prescribed medications shall be entered into this book, and entries shall include:
- (a) Patient's or resident's name.
 - (b) Name of physician prescribing the medication or the name of the physician assistant or nurse practitioner prescribing the medication and the name of his supervising physician.
 - (c) Name of pharmacy dispensing medication.
 - (d) Name of medication, prescription number, quantity ordered, quantity received.
 - (e) Date and time received and signature of individual who receives the medication.
- (5) Change of Ownership (See 105 CMR 150.002(G)(4).)

150.009: Dietary Service

(A) All facilities shall provide adequate dietary services to meet the daily dietary needs of patients and residents in accordance with written dietary policies and procedures.

- (1) Dietary services shall be directed by a food service supervisor and shall be organized with established lines of accountability and clearly defined job assignments.
- (2) Dietary services shall be provided directly by the facility, or facilities may contract with an outside food company provided the facility and the food company comply with 105 CMR 150.000; provided the facility or the company has a qualified dietician who serves, as required in 105 CMR 150.000; and provided the facility and the dietitian provide for continuing liaison with physicians and the nursing staff.
- (3) In a SNCFC the dietary services shall provide all patients with a nutritionally adequate diet which is designed to help them reach their proper physical developmental level and their full feeding potential. The Individual Service Plan (ISP) shall indicate procedures instituted to restore an appropriate nutritional level.

(B) All facilities shall provide sufficient numbers of adequately trained personnel to plan, prepare and serve the proper diets to patients or residents.

- (1) A full or part-time dietician shall be employed to direct and supervise the dietary services or there shall be a written agreement with a dietician on a consultant basis to provide these services.
 - (a) Facilities that provide Level I or II care shall provide a dietician for a minimum of four hours a week for a single unit and an additional two hours per week for each additional unit.
 - 1. A SNCFC shall provide a dietician who has training or experience in nutrition of children for a minimum of six hours a week for a single unit and an additional two hours a week for each additional unit.
 - 2. An AIDSSNF shall provide a.5 FTE (20 hours per week) Registered Dietitian with a minimum of two years experience developing specialized, individual nutrition programs and who shall be skilled in the policies and procedures of total parenteral nutrition. For AIDSSNF units which are part of a hospital or conventional long term care facility, this requirement is met if the facility employs a Full-time Registered Dietitian with the required experience.
 - (b) Facilities that provide Level III care shall provide a dietitian for a minimum of two hours per week for each unit.
 - (c) Facilities that provide Level IV care shall have an arrangement for the provision of dietary services as needed.
 - (d) The visits of the dietitian shall be of sufficient duration and frequency to provide consultation, evaluation and advice regarding dietary personnel, menu planning, therapeutic diets, food production and service procedures, maintenance of records, training programs and sanitation.
 - (e) A written record shall be kept on file in the facility of dates, time, services rendered and recommendations made by the consultant.

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- (2) Facilities that provide Level I, II or III care shall provide a fulltime food service supervisor. He may be the cook or the chef, but he shall spend a portion of his time in management functions. Facilities that provide Level IV care shall provide a cook as needed to meet residents' dietary needs.
 - (a) The food service supervisor shall be responsible for supervising food service personnel, the preparation and serving of food and the maintenance of proper records.
 - (b) There shall be proper supervision of the dietary service during all hours of operation. When the food service supervisor is absent during hours when other food service personnel are on duty, a responsible person shall be assigned to assume his job functions.
- (3) All facilities shall employ a sufficient number of food service personnel and their working hours shall be scheduled to meet the dietary needs of the patients.
 - (a) Food service employees shall be on duty over a period of 12 or more hours.
 - (b) Food service employees shall be trained to perform assigned duties.
 - (c) In facilities that provide Level I or II care, food service employees shall not regularly be assigned to duties outside the dietary department.
 - (d) Work assignments and duty schedule shall be posted and kept current.
 - (e) All dietary personnel (including tray servers) shall be 16 years of age or older.
- (4) All food service personnel shall be in good health, shall practice hygienic food handling techniques and shall conform to 105 CMR 590.000: *State Sanitary Code Article X - Minimum Sanitation Standards for Food Service Establishments*.
 - (a) All food service personnel shall wear clean, washable garments, shoes, hairnets or clean caps, and keep their hands and fingernails clean at all times.
 - (b) Personnel having symptoms of communicable disease, including acute respiratory infections, open infected wounds, or known to be infected with any disease in a communicable form or in a carrier state, shall not be permitted to work.
 - (c) Employees shall not use tobacco in any form while engaged in food preparation or service, or while in equipment washing, food preparation or food storage areas.

(C) Therapeutic Diets.

- (1) All facilities that accept or retain patients or residents in need of special or therapeutic diets shall provide for such diets to be planned, prepared and served as prescribed by the attending physician, physician-physician assistant team or physician-nurse practitioner team.
- (2) All therapeutic diets shall be planned, prepared and served with consultation from a dietician.
- (3) All therapeutic diets shall be prescribed, dated and signed by the physician, physician assistant or nurse practitioner and shall be precise as to the specific dietary requirements or limitations.
- (4) A current diet manual shall be readily available to attending physician or physician-physician assistant team or physician-nurse practitioner team, dietary service personnel and the supervisor of the nursing services. There shall be evidence from the diets served that the manual is used and related to posted diets.
- (5) All persons responsible for therapeutic diets shall have sufficient knowledge of food values to make appropriate substitutions when necessary. All substitutions made on the Master Menu for therapeutic diets shall be recorded in writing (105 CMR 150.007(F)).
- (6) The dietician and food service supervisor in conjunction with the nursing staff and other relevant personnel shall review therapeutic diets (with particular attention to their acceptance by the patient) and shall make appropriate recommendations to the attending physician or physician-physician assistant team or physician-nurse practitioner team and other staff. Therapeutic diets shall be reviewed in facilities as follows:
 - (a) Level I and II, at least every 30 days and more frequently if indicated.
 - (b) Level III, at least every three months.
 - (c) Level IV, at least every three months.
- (7) All therapeutic diet menus shall be approved by the dietician and kept on file for at least 30 days.
- (8) Patients to whom therapeutic diets are served shall be identified in the dietary records.

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(D) Adequacy of Diets.

- (1) All diets shall conform to physician's or physician assistant's or nurse practitioner's orders and, to the extent medically possible, shall meet the dietary allowances of the Food and Nutrition Board of the National Research Council adjusted for age, sex and activity.
 - (a) The dietician, in consultation with the consulting pediatrician and nursing service, shall determine the diet and feeding plan for each patient in a SNCFC for whom a therapeutic diet is not ordered.
 - (b) When a patient has been receiving infant formula prior to admission to a SNCFC, the patient shall be fed the same type of formula until his feeding program is planned and any changes in formula or diet ordered.
- (2) The minimum daily food allowance for adults shall be based on the following:
 - (a) Milk: Two or more cups as beverage or in food preparation.
 - (b) Meat Group: Two or more servings of beef, veal, pork, lamb, poultry, fish, cheese or eggs; occasionally, cooked dry beans, dry peas or nuts may be served as alternates. A serving shall be at least a two ounce edible portion of meat or its equivalent.
 - (c) Vegetable and fruit group: Four or more servings of fruits or vegetables per day including: a citrus fruit or other fruit and vegetable important for Vitamin C; a dark green or deep yellow vegetable for Vitamin A, at least every other day; other vegetables and fruits including potatoes. Fruit flavored beverages with or without vitamins added shall not be considered a fulfillment of 105 CMR 150.009(D).
 - (d) Bread and cereal group: Four or more serving of whole grain, enriched or restored.
 - (e) Other foods to round out meals and snacks for individual appetites and to provide additional calories.
- (3) In a SNCFC, the minimum daily food allowance for each patient shall be based on the following:
 - (a) Milk: One pint to one quart daily.
 - (b) Meat Group: Two or more servings of beef, veal, pork, lamb, poultry, fish, cheese or eggs; occasionally, cooked dry beans, dry peas or peanut butter may be served as alternates.
 - (c) Vegetable and Fruit Group: Four or more servings a day including: a citrus fruit or other fruit for Vitamin C; a dark green or deep yellow vegetable for Vitamin A at least every other day; other vegetables and fruits including potatoes. Fruit flavored beverages with or without vitamins added shall not be considered any part of a fulfillment of 105 CMR 150.009(D).
 - (d) Bread and Cereals: Four or more serving of whole grain, enriched or restored.
 - (e) Other foods to round out meals and snacks for individual appetites and to provide for growth and energy requirements.

(E) Quality of Food.

- (1) At least three meals that are nutritious and suited to special needs of patients and residents shall be served daily.
- (2) Meals shall be served at regular times, with not more than a 15-hour span between a substantial evening meal and breakfast. Breakfast shall not be served before 7:00 a.m.; the evening meal shall not be served before 5:00 P.M. When a five-meal plan is in effect, the main evening meal shall not be served before 4:00 P.M.
- (3) Appropriate between-meals snacks and bedtime nourishment shall be offered to each patient or resident.
- (4) Whether a three, four or five-meal-a-day plan is in effect, meals and snacks shall provide nutritional value equivalent to the daily food guide (105 CMR 150.009(D)(2)).
- (5) Only pasteurized fluid milk and fluid milk products shall be used or served; dry milk products may be used for cooking purposes only.
- (6) All milk and milk products for drinking purposes shall be served from the original container or from a sanitary milk dispenser. Milk served from a dispenser shall be homogenized.
- (7) Cracked or dirty eggs shall not be used. Egg nog shall be pasteurized. Eggs shall be refrigerated at all times.

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(F) Planning of Menus and Food Supplies.

- (1) Menus shall be planned and written at least one week in advance. The current week's menus, including routine and special diets, and any substitutions or changes made shall be posted in one or more conspicuous places in the dietary department.
- (2) Records of menus as served shall be filed and maintained for at least 30 days.
- (3) Daily menus shall provide for a sufficient variety of foods, and no daily menu shall be repeated twice in one week.
- (4) Menus shall be adjusted for seasonal changes, and shall reflect dietary restrictions or preferences. Appropriate special menus shall be planned for holidays and birthdays.
- (5) An adequate supply of food of good quality shall be kept on the premises at all times to meet patient or resident needs. This shall mean supplies of staple foods for a minimum of a one-week period and of perishable foods for a minimum of 48 hours.
- (6) All food shall be maintained at safe temperatures. Food that is stored in a freezer shall be wrapped, identified and labeled with the date received and shall be used within the safe storage time appropriate to the type of food and the storage temperature. If not used within an appropriate time limit, the food shall be discarded.
- (7) Records of food purchased and a perpetual inventory of food supplies shall be kept on file.
- (8) Menus shall be planned and food supplies maintained so that a nutritionally adequate alternate meal can be provided at all times. Alternate meal plans shall be varied at least every week and posted with other menus.
- (9) All facilities shall plan and post a Disaster Feeding Plan and staff shall be familiar with it. This plan shall include alternate methods and procedures to be used when equipment is not operable, including proper sanitation of dishes and utensils.

(G) Preparation and Serving of Food.

- (1) All foods shall be prepared by methods that conserve the nutritive value, flavor and appearance.
- (2) A file of tested recipes, adjusted to appropriate yield, shall be maintained, shall be utilized in preparing food and shall correspond to items on the posted menus.
- (3) Foods shall be cut, chopped, ground or blended to meet individual needs.
- (4) House diets shall be appropriately seasoned in cooking and this shall include salt.
- (5) Convenient and suitable utensils, such as forks, knives, tongs, spoons, or scoops, shall be provided and used to minimize direct handling of food at all points where food is prepared or served.
- (6) Equipment shall be provided and procedures established to maintain food at a proper temperature during serving and transportation. Hot foods shall be hot, and cold foods cold, when they reach the patient or residents.
- (7) Food shall be served in a home-like, pleasant, clean, relaxing and quiet atmosphere.
- (8) Individual tray service shall be provided for patients or residents who are unable to leave their rooms or who do not wish to eat in the dining room.

In a SNCFC, patients shall eat in the dining area unless contraindicated by the child's condition.

- (9) Trays.
 - (a) Food shall be served on dishes and shall not be in direct contact with trays.
 - (b) Trays shall be washable and of a type that can be sanitized.
 - (c) Flat trays shall be served with a washable or disposable tray mat.
 - (d) Trays shall be large enough to accommodate all of the dishes necessary for a complete meal, arranged and served attractively.
 - (e) Trays set up in advance of meal time shall be adequately covered to prevent contamination and shall not contain perishable food.
 - (f) Trays shall be stored in a clean and sanitary manner.
 - (g) There shall be a tray tag in a holder on each tray.
 - (h) Trays shall rest on firm supports such as overbed tables for bedfast patients or sturdy tables or tray stands of proper height for patients able to be out of bed. T.V. tray stands are not permitted.

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(10) The main meals of a day -- morning, noon and evening shall be attractively served on non-disposable dinnerware of good quality, such as ceramic, china, china-glass, glass, ironstone, melamine plastic or other materials that are durable and aesthetically pleasing.

(11) An adequate supply of trays, glassware, dishes, and flatware for individual patient or resident use shall be available at all times. Discolored, chipped or cracked dishes, glassware or trays shall not be used. Flatware of good quality shall be provided and kept in good condition.

(12) At the main meal, the main course shall be served on a dinner plate at least eight inches in diameter or its equivalent.

(13) Clean napkins shall be provided for all patients or residents at all meals, between-meal snacks and bedtime nourishment.

(14) In a SNCFC, patients shall be helped to learn to feed themselves a variety of foods of different textures and in appropriate amounts. The amount and type of food and size of servings shall depend on the individual patient's abilities, feeding plan, age and preferences. No patient who is unable to do so, shall be required to feed himself.

(15) Procedures shall be developed by the SNCFC staff, including restorative services staff, for development and use of special methods of feeding patients with disabilities which involve feeding skills.

(H) Single service disposable dishes, cups or cutlery shall not be used except as follows:

(1) On a regular basis: only for between meal food services; in the preparation of individual servings of gelatin desserts, gelatin salads and puddings; in serving fruit juices, vegetable juices, milk, water and plastic holders with disposable inserts for use with hot beverages; and in serving relishes, jellies, condiments and seasonings.

(2) On a temporary basis: for an individual with an infectious illness, or when kitchen areas are being remodelled, providing that prior approval for use over a specified period of time has been received from the Department.

(3) Disposable single service items shall comply with the following:

(a) Cups, dishes, and bowls shall be made of non-absorbent materials such as molded or formed plastic and coated paper.

(b) Single service items shall be rigid and sturdy.

(c) Single service items shall be coordinated according to color and design and shall be aesthetically appealing.

(d) Disposable flatware shall be full sized and heavy weight.

(e) Single service items shall be used only once and then discarded.

(f) All single service items shall be stored according to the manufacturer's instructions and handled and dispensed in a sanitary manner.

(I) Dietary and Food Sanitation.

(1) Sanitary conditions shall be maintained in all aspects of the storage, preparation and distribution of food.

(2) All utensils, equipment, methods of cleaning and sanitizing, storage of equipment or food, the habits and procedures of food handlers, rubbish and waste disposal, toilet facilities and other aspects of maintaining healthful, sanitary and safe conditions relative to food storage, preparation and distribution shall be in compliance with local health codes and 105 CMR 590.000: *State Sanitary Code Article X - Minimum Sanitation Standards for Food Service Establishments.*

(3) Effective written procedures for cleaning, disinfecting and sanitizing all equipment and work areas shall be developed and followed consistently so that all equipment, including pots and pans, and work areas are clean and sanitary at all times.

(4) Effective dishwashing techniques shall be used in all facilities. Kitchen workers shall be instructed in these and shall show evidence of knowing and practicing acceptable sanitary procedures.

(5) All dishes, glasses and utensils used for eating, drinking, preparing and serving of food or drink shall be cleansed and sanitized after each use. After sanitization, all dishes shall be allowed to drain and dry in racks or baskets on a nonabsorbent surface. All facilities shall provide by January 1, 1972, an automatic dishwasher capable of handling the needs of the facility. In a dishwashing machine the temperature of the wash water shall be between 140°F and 160°F, with a final rinse at a temperature of 170°F or higher.

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- (6) The food service area shall not be located in a thoroughfare, and traffic through the food service area shall be limited to authorized personnel.
- (7) Dry or staple food items shall be stored off the floor in a ventilated room not subject to sewage or waste water backflow, or contamination by condensation, leakage, rodents or vermin.
- (8) Poisonous and toxic materials shall be stored in locked cabinets that are used for no other purpose, or in a place that is separate from all food storage areas, food preparation areas and clean equipment and utensils.
- (9) All perishable food, including milk and milk products shall be adequately refrigerated, stored in a sanitary manner and properly spaced for adequate refrigeration.
- (10) Mechanical refrigeration capable of storing perishable and frozen foods shall be provided in sufficient amount to meet the needs of the facility.
- (11) The maximum temperature for the storage of all perishable foods shall be 45°F. Freezers and frozen food compartments of refrigerators shall be maintained at or below minus 10° F.
- (12) A reliable thermometer shall be attached to the inside of each refrigerator, freezer, frozen food compartment, storeroom or other storage space used for perishable food or beverages.
- (13) Food shall be transported from main kitchens to auxiliary kitchens and to patients in suitable containers or conveyors.
- (14) Written reports of inspections by state and local health authorities shall be kept on file in the facility with the notations made of action taken by the facility to comply with any recommendations.
- (15) If pre-prepared meals or meals prepared off the premises are used, dietary areas and equipment shall be designed to accommodate the requirements for safe and sanitary storage, processing and handling.
- (16) Auxiliary kitchens and dishwashing facilities located outside the main dietary area shall comply with the standards specified for the main kitchen and dietary area.
- (17) No drugs shall be stored in the same refrigerator with food, and drugs shall not be added to foods in the kitchen.
- (18) Easily shredded, abrasive material, such as steel wool, shall not be used to clean food preparation equipment or utensils.
- (19) In a SNCFC, only pre-sterilized commercially prepared infant formula packaged for individual servings shall be used as infant formula. Adequate space, equipment and procedures acceptable to the Department for processing, handling and storage of commercially prepared formula shall be provided. In the event that a special formula which cannot be purchased in a prepared form is required, prior approval shall be obtained from the Department for preparation of the formula in the facility.
- (20) Written procedures pertaining to the sanitary use of infant formula shall be developed. Protective nipple caps shall be removed only at the beginning of feeding; any unfinished formula left in a bottle at the time of feeding shall be disposed of immediately.

150.010: Restorative Therapy Services: Physical Therapy, Occupational Therapy, Speech, Hearing and Language Therapy (and Therapeutic Recreation in a SNCFC)

(A) Facilities that provide Levels I, II or III care shall establish written policies and procedures governing the delivery of restorative services.

(B) Restorative Services Units shall ordinarily be permitted only in facilities that provide Level I care. Units may be permitted in facilities that provide Level II care with the written approval of the Department.

- (1) Facilities that provide Level I care, shall have an organized, continuous, restorative services program.
- (2) Facilities that provide Level II care shall provide meaningful availability of restorative therapy services beyond restorative and maintenance nursing care.
- (3) Facilities that provide Level III or IV care should make arrangements for restorative therapy services when needed by patients or residents.
- (4) A SNCFC shall have an organized continuous, restorative services program including recreation/rehabilitation therapy.

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(C) (1) Direct restorative therapy services shall be provided to inpatients only upon written order of a physician, physician assistant, or nurse practitioner who shall indicate anticipated goals and frequency of treatments. Inpatient treatment shall be initiated within three days of the physician's, physician assistant's or nurse practitioner's order.

In a SNCFC, direct restorative therapy services shall be provided as indicated in the patient's ISP which has been approved and signed by the patient's attending physician or physician-physician assistant team or physician-nurse practitioner team.

(2) The facility shall accept a patient for outpatient restorative services only on the order of a referring physician who indicates diagnosis and anticipated goals, and who is responsible for the general medical direction of such services as part of the total care of the patient and for each patient there shall be a written plan of care approved by the referring physician. The plan of care must specify the type, amount, frequency and duration of services to be provided. The plan of care and results of treatment shall be reviewed by the referring physician at least every 60 days or more often if required.

(D) All restorative therapy services shall be provided or supervised by therapists as defined in 105 CMR 150.001: Physical Therapist, Occupational Therapist and Speech Pathologist or Audiologist.

(1) Restorative therapy services may be provided either directly by therapists employed by the facility or through written agreements with hospitals, institutions, clinics, agencies or independently practicing therapists. Therapists shall meet all the requirements set out herein, and services shall be given in accordance with the facility's policies and procedures for restorative therapy services.

(2) Restorative therapy services provided to inpatients shall be integrated with the medical nursing, dietary, social, activity and other services to promote restoration of the patient to his maximum potential, and reviewed in conjunction with other periodic reviews of the patient's condition.

(a) In a SNCFC, the restorative services portion of the patient's Individual Service Plan (ISP) shall include a schedule for expected developmental goals. These goals shall be reviewed on a quarterly basis and amended as determined by the patient's Individual Service Plan (ISP).

(b) In a SNCFC, the restorative services staff shall participate, when appropriate, in planning for continuing care of each patient after discharge. Appropriate consultations shall be provided by restorative services staff, when indicated, to family members who will be involved in care of a patient after discharge.

(E) Staff.

(1) Facilities that provide Level I care shall provide a physical therapist and an occupational therapist, each for a minimum of eight hours per month for each unit for indirect services (such as consultation). Speech, hearing and language therapists shall be provided as needed.

(2) Facilities that provide Level II care shall provide a physical therapist and an occupational therapist, each for a minimum of four hours per month for each unit for indirect services (such as consultation). Speech, hearing and language therapists shall be provided as needed.

(a) A SNCFC shall provide a supervisor of physical therapy services, full time, who shall be a registered physical therapist with a minimum of one year of experience or training in pediatrics.

(b) A SNCFC shall provide a physical therapy assistant or physical therapy aide on duty, on each unit, during a 12 hour period which includes all meal times seven days a week.

(c) A SNCFC shall provide a supervisor of occupational therapy services, full time, who shall be a registered occupational therapist with one year of experience or training in pediatrics.

(d) A SNCFC shall provide a titled occupational therapy assistant or occupational therapy aide, on duty, on each unit, during a 12 hour period which includes all meal times, seven days a week.

(e) A SNCFC shall provide a speech therapist ten to 15 hours per week or as needed, who shall be certified in speech pathology or in the combined areas of speech pathology and audiology.

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(3) In addition to indirect services, therapists and supportive restorative services personnel shall be provided in sufficient numbers and with sufficient skills to provide direct services to meet patients' or residents' needs. Supportive personnel shall be appropriately supervised.

In a SNCFC there shall be an ongoing program of inservice education for all restorative therapy services staff to enable them to keep pace with advanced technology in the area of restorative therapy and habilitative services. There shall be an appropriate orientation training program approved by the Department to enable aides and assistants to work with the patients in the unit.

(4) A SNCFC shall provide a therapeutic recreation therapist, full time, who shall plan and supervise therapeutic recreational services.

A SNCFC, in addition, shall provide a therapeutic recreation assistant and sufficient therapeutic recreation program staff during high activity periods and on weekends to implement recreational programs in accordance with patient needs.

(5) An AIDSSNF shall provide a .5 FTE therapeutic recreation therapist who shall work closely with social service staff in the development of groups and activities as well as in developing and monitoring visiting and day pass policies and procedures.

(6) A facility that provides restorative services to outpatients shall provide an adequate number of qualified therapists and the equipment necessary to carry out its program and fulfill its objectives.

(F) Records and Reports.

(1) Indirect services provided shall be documented by a written summary available for inspection in the facility.

(2) Direct services records shall be filed in the patient's or resident's clinical record (105 CMR 150.013(D)(6)).

(G) A SNCFC shall provide furniture and special restorative equipment as needed, sized and scaled appropriately for children's use.

150.011: Social Services

(A) Facilities that provide Level I, II or III care shall provide for appropriate and sufficient social services to meet the social and emotional needs of patients or residents in accordance with written policies and procedures.

(B) Social Services shall be provided either directly by personnel employed by the facility or through written contracts with public or private social agencies, hospitals, clinics or other institutions, or with individual social workers, provided that services meet the requirements set out herein, and that services are administered in accordance with the facilities' policies and procedures.

(C) Social service supervision shall be provided on a planned basis with sufficient frequency to assure adequate review of social service plans and patients' or residents' care.

(D) Social services whether provided directly by the facility or through written contracts shall be integrated with the medical, nursing, activity and other associated patient or resident care services.

(E) The social work staffing of facilities shall be based on the number of patients or residents in the facility rather than on the level of care of the facility.

Social services shall be provided by a MSW social worker or BA social worker. If social services are provided by a BA social worker, the facility must have a written agreement for social work consultation and supervision from a master's degree social worker.

(1) All facilities that provide care for more than 80 patients or residents shall provide a minimum of one half-time social worker. If the social worker is a BA social worker, the facility shall provide consultation from a MSW social worker for at least eight hours per month.

(2) All facilities that provide care for between 40 and 80 patients or residents shall provide the services of a social worker for a minimum of eight hours per week. If the social worker is a BA social worker, appropriate consultation and supervision shall be provided as needed.

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(3) All facilities that provide care for less than 40 patients or residents shall provide the services of a social worker (MSW or BA) at least four hours per week. If the social worker is a BA social worker, appropriate consultation and supervision shall be provided as needed.

(4) In addition, all facilities shall provide sufficient ancillary social service personnel under appropriate supervision to meet the emotional and social needs of the patients or residents.

(5) Exception: facilities that provide Level IV care only shall be required to provide social service staff and social services only as indicated by resident's needs.

(a) A CSF, Resident Care Facilities and multi-level facilities with Level IV units with Community Support Residents shall be required to provide or arrange to provide a minimum of one hour of social services per Community Support Resident per month, or more if indicated by the residents' needs.

(b) All social workers providing social services in Level IV facilities shall be licensed according to Board of Registration of Social Work requirements.

1. Effective June 1990, only Master's level licensed social workers will be allowed to provide clinical services, including the development of the Mental Health Treatment Plan for Community Support Residents. LSW social workers currently employed by rest homes to perform this function will be allowed to continue as long as they are receiving appropriate supervision in the development and implementation of clinical services and mental health treatment.

2. L.S.W. social workers providing clinical services must be supervised. Supervision and consultation must be available to other social work staff as needed. Supervision must be provided by either an LCSW with an MSW degree or by an LICSW.

(c) Each Community Support Resident shall have a written individualized mental health treatment plan jointly developed by the Community Support Resident and the attending Social Worker in consultation with the resident's physician, psychiatrist, Support Services Coordinator, and other involved mental health consultants if needed.

The mental health treatment plan shall be developed as soon as possible but no later than two weeks after admission. Each plan shall be first reviewed by a social worker 30 days after it is first developed and every 90 days thereafter.

(d) Content of Mental Health Treatment Plan: The individual mental health plan should be the focus of the Community Support Resident's plan of care and all other plans should be consistent with this mental health plan. The support plan should include the parts of the mental health plan which require the development of specific activities, arrangement of services, or other specific actions which should be implemented by the Coordinator in conjunction with other facility based staff. The Mental Health Plan should include the following:

1. an annual psychosocial assessment;
2. a psychosocial history that includes the mental health history and clinical diagnoses of the resident;
3. an assessment of a resident's psychosocial strengths, weaknesses and service needs;
4. recommended short and long term treatment goals and objectives, described in clear, specific, and measurable narrative statements;
5. recommended services, agencies and programs to meet the mental health needs of a resident;
6. a recommended starting date for services and the anticipated duration of these services;
7. evaluation procedures, recordings and criteria for determining a resident's progress and how a resident's mental health needs are being addressed;
8. modification(s) of a resident's treatment plan and psychotropic medications and an explanation of the rationale(s) used for modifying the plan, and medications;
9. written record(s) of the results of mental health or psychiatric consultations and written records of the psychotropic medications a resident has received or is receiving.

10. written consent by the resident (if he/she is competent to give such consent), or by his/her guardian (if he/she is not competent) for the implementation of his/her mental health treatment plan. However, no resident shall receive antipsychotic medications, without his/her consent (if he/she is competent to give such consent), unless the administration of such medications is authorized pursuant to a court order or court approved treatment plan. See, *Rogers v. Commissioner of Mental Health*, 390 Mass. 4890 1983, and related cases.

(e) If a mental health treatment plan is declined by a resident, the attending social worker, in consultation with the resident's psychiatrist and/or physician, shall make all efforts to meet with the resident, to determine how a plan might be developed and/or modified in order to accommodate the resident's objections, concerns, and suggestions. Reasons for partial or total rejection of the plan must be noted in the resident's record.

(6) A SNCFC with a minimum of 40 beds shall provide the services of one full time, MSW, LCSW social worker who has training and/or experience in developmental disabilities and one full time LSW social worker. For every additional 20 beds there shall be provided an additional half-time LSW social worker.

(7) An AIDSSNF shall have, at a minimum 2.0 FTE (80 hours per week) Social Services staff, including a full time Social Services Director.

(a) In an AIDSSNF the Social Services Director shall be an MSW licensed at the LCSW or LICSW level and shall have at least one year of experience in a health care setting. Responsibilities of the Director include but are not limited to: staff supervision, mental health treatment and supportive counseling to individuals and family members, admissions screening and discharge planning.

(b) All social work staff providing clinical services in a AIDSSNF must have an MSW and be licensed at the LCSW level.

(c) Social Service staff shall also provide case management and linkage with service organizations and community groups. Staff providing indirect services may be licensed at the LSW level.

(F) Social service programs shall be coordinated with the resources and services of public and private agencies or institutions in order to stimulate alternative care plans in the community, to provide continuity of care for patients and residents and to promote long-range social and health planning.

(G) Social Services.

(1) Emotional and social factors shall be considered in relation to medical, nursing, and other factors in determining the appropriateness of placement of patients or residents.

(2) Social Service Plan -- Prior to admission, or as soon as possible after admission, there shall be an evaluation of the patient's or resident's social needs and a plan shall be formulated and recorded for providing such care. This plan shall include information regarding pertinent personal, interpersonal and situational problems influencing management and probable duration of stay. To the extent possible, the plan shall be developed with the patient.

(a) In a SNCFC a social service plan shall be part of the patient's Individual Service Plan (ISP) and to the extent possible, the plan shall be developed with the patient, the patient's family and/or his/her legal guardian and shall reflect permanency planning efforts.

(3) Social service needs of patients or residents shall be identified on admission and services provided to meet these during treatment and care in the facility and in planning for discharge.

(4) Assistance shall be provided every resident or patient directly or through referral to, or consultation with, an appropriate agency when there are indications that financial help is needed.

(5) Appropriate action shall be taken and case work services provided to resolve social and emotional problems related to the patient's illness or state of health, his response to treatment, his home and family situation and his adjustment to care in the facility.

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(6) Social services shall include provision of educational programs for the facility staff in order to promote the development of a therapeutic community, a congenial atmosphere and healthy interpersonal relationships in all facilities.

(a) In a SNCFC social services staff shall provide educational programs for the facility staff including but not limited to: patient rights, child abuse, mistreatment and neglect and reporting requirements.

(b) In a SNCFC, social services staff shall provide for regularly scheduled parent/guardian educational and support programs and parent (guardian)/child-centered activities.

(7) Discharge or transfer plans and decisions shall consider the patient's or resident's home situation, financial resources, social needs, and community resources as well as his medical and nursing requirements.

In a SNCFC discharge or transfer plans shall be discussed at least annually and in conjunction with the Individual Service Plan (ISP) annual review. Formal discharge or transfer planning efforts shall be documented in the ISP. Referrals to alternative adult facilities must be indicated when a SNCFC patient turns age 20 as well as referral to the Bureau of Transitional Planning in accordance with M.G.L. c. 688.

(8) In a SNCFC, the social worker shall assist in the coordination of family visits to the patient and in arranging patients' visits outside the facility when appropriate and ordered by the physician. The social worker shall also assist in coordinating arrangements for the patient's return to home or other placement.

(H) Facilities shall maintain records of pertinent social information, action taken to meet social needs and written evidence of periodic case review on all patients and residents.

Pertinent social data and information about personal and family problems shall be made available only to the attending physician or physician-physician assistant team or physician-nurse practitioner team, appropriate members of the nursing staff, and other key personnel who are directly involved in the patient's or resident's care, or to recognized health or welfare agencies. There shall be appropriate policies and procedures for assuring the confidentiality of such information.

(I) In an AIDSSNF the facility/unit shall ensure sufficient and appropriate staffing to provide counseling and therapy for residents with substance abuse problems. These services may be provided through a contractual arrangement with a provider of substance abuse services. The contract agency must assure that the substance abuse staff will work closely with the psychiatric nurse and social work staff in developing and coordinating the mental health component of the resident's Individual Service Plan (ISP).

150.012: Activities and Recreation

(A) All facilities shall provide an organized program of activities and recreation suited to the needs and interests of patients or residents to encourage restoration to self-care, resumption and maintenance of normal activities and a congenial therapeutic environment.

(1) The activities program shall provide a broad assortment of regularly scheduled, purposeful activities, including recreational, spiritual, education, social, craft, and work oriented activities.

(2) The activities program shall utilize all possible community, social, recreational, public and voluntary resources to promote facility-community relationships.

(3) In a SNCFC therapeutic recreation/rehabilitation programming shall be incorporated within the restorative therapy services.

(4) In an AIDSSNF therapeutic recreation shall be incorporated into restorative services.

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(B) All facilities shall provide an activity director who is responsible for developing and implementing the activity program.

(1) The activity director shall possess a high school diploma or its equivalent; have the interest and ability to work with the ill, aged and disabled; and have at least one year's experience or training in directing group activity.

(2) In total, all facilities shall provide at least 20 hours of activity per week, per unit.

(3) In a SNCFC activity programs shall be developed by the supervisor of therapeutic recreation services.

(4) The activity director of the CSF shall in addition to possessing a high school diploma; have an ability to work with the elderly; have at least one year of experience or training in directing group activities; and possess documented experience and training in the planning and providing of special activities and programs for the elderly mentally ill which are geared toward enhancing resocialization and community integration of residents.

(C) Functions of the Activity Director.

(1) The activity director plans, schedules and posts in advance a monthly activity program including group activities, special activities on holidays, religious days, birthdays, and other special occasions; supervises and conducts activities; arranges for religious services; supervises the work of volunteers; and participates in patient reviews, staff meetings and inservice educational programs.

(2) The activity director and other staff shall encourage, but not force, patients and residents to participate in each day's activities and, where appropriate, in program planning; shall seek ways to motivate and interest patients or residents in activities; and shall provide suitable activities for patients or residents unable to leave their rooms.

(3) The activity director shall prepare activity records which shall include: a monthly activity schedule posted in a conspicuous place in each unit and an activity participation record indicating patient or resident participation in and reaction to activities.

In a SNCFC the patient's Individual Service Plan (ISP) must include:

(a) periodic surveys of the patient's interests, and

(b) the extent and level of patient's participation in the recreation program.

(D) Patients or residents who are able shall be encouraged to pursue activities outside of the facility with written approval of the attending physician or physician-physician assistant team or physician-nurse practitioner team.

In a SNCFC field trips into the community shall be an integral part of each resident's programming as indicated in his/her ISP.

(E) Visiting hours shall be flexible and shall be conspicuously posted.

(1) Provisions shall be made for privacy during telephone conversations, during visits with clergymen, relatives or other such visitors.

(2) Facilities shall have a list of the clergymen of the major faiths readily available, and requests to see clergymen shall be honored at all times.

(F) Facilities shall make arrangements with the Division of the Blind of the Massachusetts Department of Education for the provision of recreational therapy for patients or residents who are blind or have impaired vision.

(G) Facilities shall provide, maintain and store, without charge to the patients or residents, the following basic supplies and equipment: books, current magazines and newspapers, games, crafts, and radio and television (in appropriate areas). Patients or residents who use their personal radio, television or other such equipment shall not be billed for electricity.

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(H) Recreation rooms, living rooms, sitting rooms, dining areas and patients' or residents' rooms shall ordinarily be sufficient for activities and recreational programs. Additional activity unit or space are not required.

(1) In a SNCFC, indoor play areas shall be provided with a space of at least 12 square feet per bed. Additional outdoor play area shall also be provided.

(2) In a SNCFC therapeutic recreational/rehabilitation areas shall be designed and constructed so that all patients regardless of their disabilities, have access to them. Recreation equipment and supplies shall be provided in a quantity and variety that is sufficient to carry out the facility's activities programs.

(I) Special Activities and Services.

(1) Facilities may provide or contract for certain special personal services for patients or residents such as hairdresser or barber services. These services shall not substitute for routine personal care services that the facility is required to provide regularly for all patients or residents. (105 CMR 150.007(G)(5)). These special personal services shall be requested in writing by the patient, resident or his family and shall be available only to patients or residents within the facility.

(2) Facilities may provide a snack shop or small gift shop (with total retail value of the salable items not to exceed \$150) as an adjunct to recreational, diversional and therapeutic services for patients or residents. No facility shall open such a shop without submitting an application, construction plans and a letter of intent to the Department, and without receiving written approval from the Department on final plans of construction and operation. A facility that submits an application to operate a snack shop or gift shop shall understand that the Department may order such a shop closed without a hearing if it considers that the shop is not rendering recreational, diversional or therapeutic services, or that the shop is operating in violation of the provisions of 105 CMR 150.012(I)(2) through 150.012(I)(6). Snack shops and gift shops shall be conveniently located and accessible to patients' and residents' living and recreational areas and shall be open only to patients and residents and their immediate visitors. Such shops shall be open to facility staff only if this does not interfere with or inconvenience the use by patients or residents.

(a) Snack shops shall not be open to patients or residents during the servicing of regular meals required for all patients or residents.

(b) Snack shops shall serve only: hot and cold beverages, desserts, cookies, crackers and other pre-packaged snacks.

(c) Snack shops shall conform to all regulations relating to sanitation, refrigeration and food quality, and other rules and regulations contained herein relative to general dietary and kitchen services. (105 CMR 150.009 and 150.016).

(d) Food purchase, storage, preparation and service, and the staff for the snack shop shall be completely separate from the facility's general dietary service.

(e) Gift shops may contain greeting cards, newspapers, magazines, articles made by patients or residents, a modest assortment of gift items and toiletries. Gift shops shall be staffed by volunteers (including patients or residents if they so desire) and operated under the direction of the activity director.

(f) If articles made by the residents or patients are sold in the gift shop, the money shall be given or credited to the patients or residents.

(3) Bazaars, fairs and other recreational fund-raising activities shall be solely for the benefit of the patients or residents and shall not be of financial benefit to the facility.

(4) All special services described in 105 CMR 150.012(I) shall be provided as a service to patients or residents, and there shall be no profit or financial benefit to the facility. Accounts for all such services shall be kept entirely separate from other financial records and accounts (including separate purchase of food and supplies), and these accounts shall be available on the premises for inspection and evaluation by the Department. Facilities shall submit, at their own expense, to the Department as annual audit by a Certified Public Accountant of the financial records and accounts of such special services.

(5) The regular staff of the facility shall not be used to provide any of the above special services.

(6) No special services shall be available to the general public.

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(J) All Resident Care Facilities, multi-level facilities with Level IV units with Community Support Residents and Community Support Facilities shall develop in-house activities and programs specific to the mental health needs of Community Support Residents and shall encourage the involvement of Community Support Residents. The activities director shall develop such activities and programs with the input of the resident's Support Services Coordinator and social worker.

150.013: Clinical and Related Records

(A) All facilities shall provide conveniently located and suitably equipped areas for the recording and storage of records.

(B) All records shall be permanent, either typewritten or legibly written in ink (no record shall be written in pencil). No erasures or ink eradicator shall be used or pages removed.

(C) All records shall be complete, accurate, current, available on the premises of the facility for inspection and maintained in a form and manner approved by the Department. The following records shall be maintained:

- (1) Daily census.
- (2) Employee records on all employees.
- (3) Patient care policies.
- (4) Incident, fire, epidemic, emergency and other report forms.
- (5) Schedules of names, telephone numbers, dates and alternates for all emergency or "on call" personnel.
- (6) A Patient or Resident Roster approved by the Department.
- (7) A Doctor's Order Book with a stiff cover and indexed, looseleaf pages. The Doctor's Order Book shall be current and accurate and shall include all medications, treatments, diets, restorative services and medical procedures ordered for patients or residents. Orders shall be dated, recorded and signed (telephone orders countersigned) by the attending physician or nurse practitioner or physician assistant. Facilities may keep Doctors' Order sheets in the patients' or residents' clinical record provided this procedure is so stated in the facility's written policies. The Doctors' Order sheets shall contain all data listed above.
- (8) A bound Narcotic and Sedative Book with a stiff cover and numbered pages.
- (9) A Pharmacy Record Book with stiff cover and numbered pages.
- (10) A bound Day and Night Report Book with a stiff cover and numbered pages.
- (11) Individual patient or resident clinical records in stiff-covered folders.
- (12) Record forms to record medical, nursing, social and other service data.
- (13) Identification and summary sheets on all patients or residents.
- (14) Record forms for listing patients' or residents' clothing, personal effects and valuables.
- (15) In a SNCFC an Individual Service Plan (ISP) shall be developed for each patient.

(D) All facilities shall maintain a separate, complete, accurate and current clinical record in the facility for each patient or resident from the time of admission to the time of discharge. This record shall contain all medical, nursing and other related data. All entries shall be dated and signed. This record shall be kept in an individual folder at the nurses' or attendants' station. The clinical record shall include:

- (1) Identification and Summary Sheet including: patient's or resident's name, bed and room number, social security number, age, sex, race, marital status (married, separated, widowed or divorced), religion, home address, and date and time of admission; names, addresses and telephone numbers of attending physician or physician-physician assistant team or physician-nurse practitioner team and alternates, of referring agency or institution, and of any other practitioner attending the patient or resident (dentist, podiatrist); name, address and telephone number of next of kin or sponsor; admitting diagnosis, final diagnosis, and associated conditions on discharge; and placement. In a SNCFC the data shall include the name, address and telephone number of the parent or legal guardian.
- (2) A Health Care Referral Form, Hospital Summary Discharge Sheets and other such information transferred from the agency or institution to the receiving facility (105 CMR 150.003(C)(1)).

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- (3) Admission Data recorded and signed by the admitting nurse or responsible person including: how admitted (ambulance, ambulation or other); referred by whom and accompanied by whom, date and time of admission; complete description of patient's or resident's condition upon admission, including vital signs on all admissions and weight (if ambulatory); and date and time attending physician or physician-physician assistant team or physician-nurse practitioner team notified of the admission. In a SNCFC, all patients including non-ambulatory patients shall have height and weight recorded upon admission.
- (4) Initial Medical Evaluation and medical care plan including: medical history, physical examination, evaluation of mental and physical condition, diagnoses, orders and estimation of immediate and long-term health needs dated and signed by the attending physician (105 CMR 150.005(F)(1)) or signed by a nurse practitioner or physician assistant and countersigned by the supervising physician within ten days for Level I and Level II patients and within 30 days for Level III and Level IV patients (105 CMR 150.005(F)(4)).
- (5) Physician's or Physician-Physician Assistant Team's or Physician-Nurse Practitioner Team's Progress Notes including: significant changes in the patient's or resident's condition, physical findings and recommendations recorded at each visit, and at the time of periodic reevaluation and revision of medical care plans (105 CMR 150.005(G)).
- (6) Consultation Reports including: consultations by all medical, psychiatric, dental or other professional personnel who are involved in patient or resident care and services, recorded in each patient's or resident's clinical record. Such records shall include date, signature and explanation of the visit, findings, treatments and recommendations.
- (7) Medication and Treatment Record including: date, time, dosage and method of administration of all medications; date and time of all treatments; special diets; restorative therapy services and special procedures for each patient or resident, dated and signed by the nurse or individual who administers the medication or treatment.
- (8) A Record of all fires and all incidents involving patients or residents and personnel while on duty (105 CMR 150.002(D)(6)(c)).
- (9) A Nursing Care Plan for each patient or resident (105.150.007(D)(2)). In a SNCFC, a nursing care plan shall be part of the Individual Service Plan (ISP).
- (10) Nurses Notes containing accurate reports of all factors pertaining to the patient's or resident's needs or special problems and the overall nursing care provided.
- (11) Initial Plans and written evidence of periodic review and revision of dietary, social service, restorative therapy services, activity, and other patient or resident care plans.
- (12) Laboratory and X-ray Reports.
- (13) A list of each patient's or resident's clothing, personal effects, valuables, funds or other property (105 CMR 150.002(E)(2), 150.002(E)(3)).
- (14) Discharge or Transfer Data including: a dated, signed physician's order or physician assistant's order or nurse practitioner's order for discharge; the reason for discharge and a summary of medical information, including physical and mental condition at time of discharge; a complete and accurate health care referral form; date and time of discharge; address of home, agency or institution to which discharged; accompanied by whom; and notation as to arrangements for continued care or follow-up.
- (15) Utilization Review Plan, Minutes, Reports and Special Studies.
- (16) In a SNCFC, an Individual Service Plan (ISP) shall be developed for each patient by a multi-disciplinary team within 30 days following admission and reviewed thereafter every 90 days and more frequently, if indicated. The ISP shall include medical, nursing, dietary, restorative therapies and social services in coordination with educational/ rehabilitative services.
- (17) Certified facilities that admit residents with MR or DD/ORC shall maintain as part of the resident's record the DMR Rolland Integrated Service Plan (RISP) and the Specialized Service Provider Plan.

(E) All clinical records of residents or patients including those receiving outpatient restorative services shall be completed within two weeks of discharge and filed and retained for at least five years. Provisions shall be made for safe keeping for at least five years of all clinical records in the event the facility discontinues operation, and the Department shall be notified as to the location of the records and the person responsible for their maintenance.

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(F) All information contained in clinical records shall be treated as confidential and shall be disclosed only to authorized persons.

(G) All facilities shall employ a medical records librarian or shall designate a trained employee of the facility to be responsible for ensuring that records are properly maintained, completed and preserved.

(H) Individual Service Plan (ISP) in a SNCFC.

(1) An Individual Service Plan (ISP) shall be developed for a patient within 30 days of admission and annually thereafter. The plan shall be comprised of two parts:

- (a) long term goals, annually; and
- (b) 90 day service programs.

(2) Long term goals shall be developed at an annual meeting attended by a multi-disciplinary team. Such annual meeting shall be convened inviting parent and/or guardian participation as well as relevant outside resource and support persons. Types of services needed to achieve goals shall be included in the Individual Service Plan (ISP).

(a) The multi-disciplinary team shall include but not be limited to the attending physician or physician-assistant team or physician-nurse practitioner team, a registered nurse, a registered physical therapist, a registered occupational therapist, a speech pathologist, a social worker supervisor, a representative from the individual's educational/habilitative services program and a supervisor of therapeutic recreation services.

(b) At the initial ISP team meeting, short term patient objectives shall, additionally, be outlined and included in the second part of the patient's ISP, the 90-Day Service Program. This portion of the ISP shall stipulate specific services that shall be provided to the patient related to the attainment of short-term objectives including the staff and consultants and/or agency responsible for each intervention strategy.

(3) Each quarter thereafter, (every 90 days), a meeting shall be convened to review the patient's status and to amend the 90-Day Service Program to reflect actual services delivered to the patient, objectives achieved and new objectives to be attained.

150.014: Utilization Review

(A) Facilities that provide Level I or II care shall review the services, quality of care and utilization of their facilities as detailed below.

(B) The utilization review process or activity shall include a review of all or a sample of patients to determine appropriateness of admissions, duration of stays by level of care, professional services and other relevant aspects of care and services provided by the facility.

(C) Utilization review shall be conducted by one or a combination of the following:

(1) By a utilization review committee, which is multidisciplinary and consists of at least two physicians or physician-physician assistant teams or physician-nurse practitioner teams, a registered nurse and, where feasible, other health professionals.

(2) By a committee or group outside the facility which may be established by the following on the approval of the Department:

- (a) By a medical society.
- (b) By some or all of the hospitals and extended care facilities in the locality.
- (c) By other health care facilities in the locality in conjunction with at least one hospital.

(3) When the above alternatives are not feasible, by a committee sponsored and organized in such a manner as to be approved by the Department.

(4) No member of the utilization review committee shall have a proprietary interest in the facility.

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(D) Medical Care Evaluation Reviews (Special Studies).

- (1) Reviews shall be made on a continuing basis of all or a sample of patients to determine the quality and necessity of care and services provided and to promote efficient use of health facilities and services. Such studies shall be of appropriate type and duration, and at least one study shall be in progress at all times.
- (2) Such studies shall emphasize identification and analysis of patterns of care and services.
- (3) The reviews of professional services furnished shall include such studies as types of services provided, proper use of consultation, promptness of initiation of required nursing and related care, the study of therapeutic misadventures (adverse reactions) and other such studies.
- (4) Data and information needed to perform such studies may be obtained from statistical services, fiscal intermediaries, the facility's records and other such sources.
- (5) Studies and service shall be summarized and recommendations formulated and presented to the administration and other appropriate authorities.
- (6) Reviews shall be made of continuous extended duration.
 - (a) An initial review of patient needs and length of stay by level of care shall be made at an appropriate interval after admission. This interval shall not be longer than 30 days following admission for facilities that provide Level I or II care and 90 days following admission for facilities that provide Level III care. Subsequent reviews shall be made periodically at designated intervals that are reasonable and consonant with the diagnosis and overall condition of the patient.
 - (b) No physician or physician-physician assistant team or physician-nurse practitioner team shall have review responsibility for any case in which he was professionally involved.
 - (c) If physician or physician-physician assistant team or physician-nurse practitioner team members of the committee decide, after opportunity for consultation with the attending physician, that further stay in a given level of care is not medically necessary, there shall be prompt notification (within 48 hours) in writing to the facility, the physician responsible for the patient's care and the patient or his next of kin or sponsor.

(E) To facilitate review, the utilization review committee shall use the complete medical record or a summary of the record and shall use such methods as a utilization review check list and interviews with the attending physicians or physician-physician assistant teams or physician-nurse practitioner teams as indicated.

(F) The facility shall have in effect a currently applicable written plan for utilization review which applies to all patients in the facility, and a copy of the current plan shall be filed with the Department.

- (1) The plan shall be approved by the governing body and the medical staff, if any.
- (2) The development of the plan shall be a responsibility of the medical profession and the administration.
- (3) A written plan for utilization review activities shall include:
 - (a) The organization, objectives and composition of the committee(s) responsible for utilization review.
 - (b) Frequency of meetings
 - (c) The type and content of records to be kept.
 - (d) Description of the method to be used in selecting cases for special studies.
 - (e) A description of the method utilized to determine periodic reviews.
 - (f) Procedures to be followed for preparing committee reports and recommendations including their dissemination and implementation.

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(G) Administrative Responsibilities.

(1) The administration shall provide support and assistance to the utilization review committee in: assembling information, facilitating chart reviews, conducting studies, exploring ways to improve procedures, maintaining committee records, promoting the most efficient use of available health services and facilities and in planning for the patient's continuity of care upon discharge.

(2) The administration shall act appropriately upon recommendations made by the utilization review committee.

(3) In order to encourage the most efficient use of available health services and facilities, assistance to the physician or physician-physician assistant team or physician-nurse practitioner team in timely planning for alternate or post-facility care shall be initiated as promptly as possible, either by the facility's staff, or by arrangement with other agencies. For this purpose, the facility shall make available to the attending physician or physician-physician assistant team or physician-nurse practitioner team current information on resources available for continued post-discharge care for patients and, shall arrange for prompt transfer of appropriate medical and nursing information in order to assure continuity of care upon discharge or transfer of a patient.

(H) Records, reports and minutes shall be kept of the activities of the utilization review committee, and they shall be complete, accurate, current and available within the facility.

(1) The minutes of each meeting shall include:

(a) A summary of the number and types of cases reviewed and findings.

(b) Committee actions and recommendations on extended stay cases and other types of cases.

(c) Interim reports, final conclusions and recommendations resulting from medical care evaluation reviews (special studies).

(2) Reports shall regularly be made by the committee to the medical staff (if any), the administration and the governing body. Information and reports shall be submitted to the Massachusetts Department of Public Health as may be required.

150.015: Patient Comfort, Safety, Accommodations and Equipment

(A) All facilities shall provide for the comfort, safety and mental and physical well-being of patients or residents.

(1) The types and amounts of personal services, assistance in daily activities, protection and accommodations needed by each patient or resident shall be recorded and known to all staff attending that person.

(2) Patients' and residents' personal needs shall be evaluated periodically and appropriate modifications made in services, protective measures and accommodations.

In a SNCFC, the patient's personal needs shall be evaluated and any modifications made in services, protective measures and accommodations shall be reflected in the patient's Individual Service Plan (ISP).

(3) All facilities shall be prohibited from applying any Aversive Interventions to a patient or resident.

(B) Personal Care.

(1) Every patient or resident shall have a reasonable amount of privacy in routine daily living, during visiting hours, in time of crisis or when seriously ill.

(2) Patients and residents shall be treated with dignity and kindness at all times.

(3) Patients' or residents' personal effects shall be treated with respect and care.

(4) Patients and residents shall be encouraged and assisted to dress and move about from sleeping quarters to sitting rooms, dining areas and out-of-doors when their condition permits.

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(C) Safety and Personal Protection.

- (1) At all times a responsible staff member shall be on duty and immediately accessible, to whom patients or residents can report injuries, symptoms of illness, emergencies, any other discomfort or complaint, and who is responsible for ensuring that prompt, appropriate action is taken.
- (2) Restraints shall be used only on a physician's or physician-physician assistant team's or physician-nurse practitioner team's order or physician assistant's order or nurse practitioner's order, and the type of restraint shall be specified by the physician or physician-physician assistant team or physician-nurse practitioner team. Restraints shall not be applied for more than two hours at a time (or the time ordered by the physician). At the end of this time, restraints shall be released and the patient ambulated, toileted (if necessary) etc. When the restraints are removed, the patient shall be made comfortable and his position changed. Supervision shall be provided during the time restraints are removed. Restraints shall not be used or applied in such a manner as to cause injury to the patient. Locked restraints shall not be used at any time. A patient in restraint shall be checked at least every hour. Physical restraint or chemical restraint shall not be used as a punishment or for the convenience of staff.
- (3) There shall be a signal system or a hand bell at each patient's bedside, in sitting rooms, in bathrooms, in shower and tub rooms and in all other patient areas. The method used for signaling shall be approved by the Department.
- (4) Grip bars, properly placed, shall be in all bathrooms, toilets, tub rooms and showers.
In a SNCFC, appropriate adaptive equipment shall be installed in all bathrooms, toilets, tub rooms and showers to ensure patient and staff safety and maximum patient independence.
- (5) Non-skid wax shall be used on all waxed floors. Throw rugs or scatter rugs shall not be used. Non-slip entrance mats may be used. Non-skid treads shall be used on stairs.
- (6) Bedrails shall be provided as needed for restless patients.
- (7) All accidents, epidemic disease, fires and other mishaps shall be reported as stipulated in 105 CMR 150.002(G).
- (8) Facilities that provide only Level IV care shall provide a first-aid kit in a convenient place. The contents of the kit shall be in accordance with the recommendations of the American Red Cross.
- (9) A check-out system shall be maintained for patients or residents leaving the facility. The patient's or resident's name, the destination, the name of the person assuming responsibility, the time of departure, and the estimated time of return shall be recorded.
- (10) There shall be at least one functioning telephone on each floor or in each unit where patients, residents or personnel reside. These telephones shall be free of locks and shall be available for use in emergency for both incoming and outgoing calls. In addition, all facilities shall provide at least one telephone for patient or resident use, which may be coin operated, that is located so as to assure privacy during use; is a single line without an extension; is placed and positioned at a height so that the equipment is fully accessible to individuals in wheelchairs; is equipped with sound amplification for those with hearing disabilities and so identified with instructions for use. For existing facilities, the Division may grant a waiver of 105 CMR 150.015(C)(10) if it is demonstrated that enforcement would result in unreasonable hardship upon the facility. All facilities shall comply with the provisions of 105 CMR 150.015(C)(10) by December 23, 1983 except that if the facility demonstrates that major structural changes are necessary, compliance shall be achieved by June 23, 1984.
- (11) Light switches shall be located adjacent to doors of all patient or resident rooms and all bathrooms.
- (12) All hospital beds shall have brakes set and all wheelchairs shall be equipped with brakes.

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(D) Fire Protection.

- (1) All fires shall be reported to the Department as specified in 105 CMR 150.002(G)(3).
- (2) All facilities shall have an approved quarterly fire report in accordance with the M.G.L. c. 1, § 4.
- (3) At least once a year, employees of the home shall be instructed by the head of the local fire department or his representative on their duties in case of fire and this noted in the facility's record.
- (4) Fire extinguishers shall be recharged and so labeled at least once a year.
- (5) Where sprinkler systems are installed, the water pressure shall be checked weekly by the individual in charge of the facility, and the pressure recorded in the facility's records.
- (6) Emergency lights shall be checked weekly by the individual in charge of the facility, recorded in the facility's records if deficient, and repaired immediately.
- (7) All exits shall be clearly identified by exit signs, adequately lighted and free from obstruction.
- (8) Clothes dryers shall be inspected at the time of installation and annually by the proper authorities. Deficiencies shall be recorded in the facility's records and necessary repairs made immediately.
- (9) Draperies, upholstery and other such fabrics or decorations shall be fire resistant and flame proof.
- (10) No patients or residents shall be permitted to have access to lighter fluid or wooden household matches.
- (11) Routine storage of oxygen tanks shall be permitted only in facilities that provide Level I, II or III care unless specifically approved by the Department.
 - (a) Wherever oxygen is used or stored it shall be in accordance with the National Fire Protection Code.
 - (b) Smoking is prohibited in all rooms, and in areas adjacent to where oxygen is administered, used or stored.
 - (c) Carriers shall be provided when oxygen is being used or transported.
 - (d) Signs indicating that oxygen is available, currently in use or stored shall be conspicuously posted.
 - (e) Oxygen tanks shall be safely stored and labeled when empty.

(E) Emergency and Disaster Plans.

- (1) Every facility shall have a written plan and procedures to be followed in case of fire, or other emergency, developed with the assistance of local and state fire and safety experts, and posted at all nurses' and attendants' stations and in conspicuous locations throughout the facility.
- (2) The plan shall specify persons to be notified, locations of alarm signals and fire extinguishers, evacuation routes, procedures for evacuating helpless patients, and assignment of specific tasks and responsibilities to the personnel of each shift.
- (3) All personnel shall be trained to perform assigned tasks.
- (4) Simulated drills testing the effectiveness of the plan shall be conducted for all shifts at least twice a year.
- (5) Each facility shall ensure that a reliable means is available at all times, in accordance with Department guidelines, for:
 - (a) sending information to the Department regarding incidents and emergencies occurring on the premises, and
 - (b) receiving information from the Department and other state and local authorities in the event of an emergency.

(F) Patients' or Residents' Accommodations.

- (1) All patient or resident areas shall be cheerful, homelike, pleasant, clean, well-kept, free from unpleasant odors, sights and noises, and maintained in good repair.
- (2) Space and furnishing shall provide each resident or patient with comfortable and reasonably private living accommodations. Beds shall be placed to avoid drafts, heat from radiators, unpleasant noises or other discomforts.
- (3) Every bedroom and every bed location shall be permanently, clearly and distinctively identified by a number or letter in addition to the patient's or resident's name.
- (4) All patient or resident areas must be decorated in a cheerful, pleasant way with such items as draperies, bedspreads and slipcovers made of easily laundered material, and kept clean and in good condition.

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(5) All patient or resident areas must have adequate lighting, heating and ventilation so that patients or residents are comfortable in all seasons of the year.

(a) Each patient's or resident's room shall have direct outside exposure with adequate, unobstructed natural light and adequate ventilation.

(b) Adequate artificial lighting shall be available in all rooms, stairways, hallways, corridors, bathrooms toilets, nurses' or attendants' stations. (See 105 CMR 150.017(B)(15)).

(c) Adequate heating shall be provided in all rooms used by patients or residents in order to maintain a minimum temperature of 75°F at winter temperatures for the hours between 6:00 A.M and 10:00 P.M.; and a minimum temperature of 70°F at winter temperatures for the hours between 10:00 P.M. and 6:00 A.M.

(G) Patients' and Residents' Equipment and Supplies.

(1) Equipment and supplies appropriate in quantity and kind shall be provided for the routine care, comfort and special nursing care of patients or residents.

(2) All equipment and supplies shall be kept in good working condition and in a clean and sanitary manner.

(3) All facilities shall use techniques approved by the Department to autoclave, sterilize, disinfect or dispose of equipment and supplies.

(4) Every patient or resident shall be provided with the following basic equipment and supplies:

(a) A comfortable bed. In facilities that provide Level I or II care, each patient or resident shall have a hospital-type bed which shall not be less than 76 inches long and 36 inches wide and shall be equipped with a headboard and swivel lock casters. In facilities that provide Level III and IV care, beds of household size or hospital beds may be used. Cots and folding beds are prohibited.

(b) Bed springs and a clean, comfortable mattress with waterproof covering on all beds. Each mattress shall be at least four inches thick, 36 inches wide and not less than 72 inches long.

(c) At least two comfortable pillows of standard hospital size. Other pillows shall be available if requested or needed by the patients or residents.

(d) An adequate supply of clean, ironed or drip dry bed linen, bed rubbers, blankets, bedspreads, washcloths, and towels of good quality and in good condition. This shall mean a supply of linen equal to at least three times the usual occupancy. In facilities that provide Level I or II care, towels and washcloths shall be changed and laundered every day; in facilities that provide Level III and IV care, at least every week and more frequently, if indicated. Bed linen shall be laundered at least weekly and more frequently if needed.

(e) An easy chair or a comfortable padded or upholstered straight back chair with arms, suited to individual patient or resident needs.

(f) An individual light of at least 60 watts (or its equivalent), which is safe and conveniently located for reading.

(g) A bedside cabinet with a hard-surfaced, washable top, a drawer and a cabinet section with a towel rack that is adequate for patient or resident needs. In facilities that provide Level I or II care, hospital-type bedside cabinets shall be provided and shall contain a towel and wash cloth, a wash basin, an emesis basin and the equipment listed in 105 CMR 150.015(G)(4)(h).

(h) All facilities shall see to it that each patient or resident has the following items: individual mouthwash cup, a tooth brush and dentifrice, containers for the care of patients' or residents' dentures, an individual comb and brush, soap dish, bar of soap, shaving equipment, individual sputum containers (when needed), and other equipment for personal care.

(i) All facilities shall provide for each patient or resident a permanently located, readily accessible, storage space equipped with a lock and key, that is large enough to accommodate small personal possessions such as letters, jewelry, pictures or small amounts of money. Storage space shall be located within each patient's or resident's room. A key to secure personal storage space shall be in the possession of each patient or resident, and the facility administrator or his designee shall hold a master key to any such locked space.

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- (5) Other Patient or Resident Equipment that shall be provided:
- (a) A covered metal waste container in each patient or resident bedroom.
 - (b) Bedrails for 75% of the total authorized beds in Levels I and II, and as needed in Level III and IV.
 - In a SNCFC, sideliners shall be provided on all cribs or beds, when indicated.
 - (c) A sufficient number of foot stools.
 - (d) Hospital-type over-bed tables for not less than 25% of the total beds authorized in Level I, II, or III care facilities, and as needed in Level IV care facilities.
 - (e) Bedpans and urinals for not less than 50% of the total beds authorized in Level I, II, III care facilities and in adequate numbers in Level IV care facilities.
 - (f) An adequate number of commode chairs, wheelchairs, walkers, foot soak basins, foot boards, cradles, armboards, and other such equipment to meet patient or resident needs.
 - (g) Flame resistant, washable bedside curtains or portable screens that completely conceal the bed in all multi-bedrooms to ensure patient or resident privacy.
 - (h) In a SNCFC, overbed tables, as needed.
 - (i) In a SNCFC, bedpans and urinals, as needed.
 - (j) In a SNCFC, appropriate adaptive equipment for bathing such as lifts, portable tubs, etc., shall be provided in sufficient numbers to meet the personal care needs of patients.
- (6) The following equipment and supplies shall be readily available as needed for the administration of medications, the performance of treatments, or other use. Items marked with an asterisk shall be disposable (single use) or sterilized by autoclave.
- * Syringes and needles
 - * Instruments
 - Glassware
 - * Rubber goods
 - Thermometers (rectal and oral)
 - * Enema Equipment
 - Stethoscope
 - Blood pressure apparatus
 - Tourniquets
 - Flash Lights
 - Mouth bites
 - A standard scale for weighing
 - * Catheters and catheterization equipment
 - * Suction equipment
 - I.V. poles
 - Sand bags, wheelchairs, walkers, foot boards, cradles, armboards and other such equipment.
- (7) All equipment used for personal care of more than one individual, such as electric shavers, shall be thoroughly cleaned after each use.
- (8) All facilities shall provide adequate space, equipment and procedures for the proper disinfection of beds, springs, mattresses and bed pillows and for the proper sterilization of equipment as needed.
- (9) A SNCFC shall provide a chair or non- ambulatory scale.
- (10) In a SNCFC, accommodations, equipment and supplies shall be appropriate in quantity, kind and size to meet the needs of patients.

(H) Behavior Modification Programs In A SNCFC.

(1) For purposes of 105 CMR 150.015(H) an aversive technique means a thing or event which the patient might find unpleasant which is used to immediately discourage undesired behavior. The use of physical aversive techniques involving active physical interventions, for example water sprays and slaps is prohibited.

Time out means a procedure designed to improve a patient's behavior by removing positive reinforcement or by removing the patient physically from the environment when his/her behavior is undesirable.

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(2) Time-out procedures shall only be used as part of approved behavior modification exercises and only by an individual (or individuals) appropriately trained to carry out such exercises and under the supervision of a behavior modification trainer. Time-out shall not be used for longer than one hour for time-out involving removal from a situation.

(3) Behavior modification programs involving the use of aversive techniques or time-out procedures shall be conducted only after documented failure of less severe alternatives and with the consent of the patient's parents or legal guardian; and shall be described in the Individual Service Plan along with written plans that are kept on file.

150.016: Environmental Health and Housekeeping

(A) Water Supply.

(1) Water used in the care or treatment of patients or for other drinking, domestic, or culinary purpose shall be pure and otherwise fit for such use consistent with established standards of sanitation.

(2) Ice that comes in contact with food or drink shall be made from water of a sanitary quality and shall be stored, handled and dispensed in a sanitary manner.

(3) The volume and pressure of the water supply, in servicing sprinkler installations, shall be sufficient to meet the flow demands of the designed installation.

(4) Domestic hot water heating equipment shall have adequate capacity to supply patient areas, food preparation areas and laundry.

(5) Where the water supply of the facility, in whole or in part, is derived from a private source, the entire system of supply is within the jurisdiction of the Department of Environmental Quality Engineering under M.G.L. c. 111, § 17 and 160. The written approval of said Department is required prior to construction or alteration of any private water supply, and any operating supply is subject to the regulations of said Department and such orders as it may issue from time to time. The Program Director shall report any apparent violation of law in connection with the private water supply of a facility to the Department of Environmental Quality Engineering. Failure to comply with an order of said Department relative to such water supply, if chargeable to the licensee, shall be cause for license denial, license revocation, or other sanction under 105 CMR 150.018(I)(2), unless the licensee shall demonstrate that compliance had been stayed.

(6) The cross-connection of a facility water supply used in the care or treatment of patients or for other drinking, domestic, or culinary purpose with any other water supply requires a permit issued under M.G.L. c. 111, § 160A, by the Department as being pure and otherwise fit for such use. The permit shall be posted in accordance with 105 CMR 150.018(E)(1). The Program Director shall report any apparent violation of M.G.L. c. 111, § 160A, to the Department of Environmental Quality Engineering. Failure to comply with an order of said Department relative to a cross-connection, if chargeable to the licensee, shall be cause for license denial, license revocation, or other sanction under 105 CMR 150.018(I)(2), unless the licensee shall demonstrate that compliance had been stayed.

(7) Nothing contained in 105 CMR 150.016(A)(5) or 150.016(A)(6) shall be construed as a limitation, express or implied, upon the residual authority of the Department to make orders relative to any water supply found to endanger the public health.

(B) Sewage Disposal. All sewage shall be discharged into a municipal sewerage system where such is available; otherwise, the sewage shall be collected, treated, and disposed of by means of a private sewerage system in conformity with 105 CMR 150.016(B)(1) and 150.016(B)(2).

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(1) In the case of a private sewerage system, prior approval by the Department of Environmental Quality Engineering for construction or alteration is required under M.G.L. c. 111, § 17, and any operating system is subject to the provisions of the State Environmental Quality Engineering under M.G.L. c. 21A, § 13. Said Code may be enforced by either the Department of Environmental Quality Engineering or the appropriate local board of health, or by both. The Program Director shall report any apparent violation of M.G.L. c. 111, § 17, or of the State Environmental Code in connection with the private sewerage system of a facility to the Department of Environmental Quality Engineering. Failure to comply with an order by said Department or by a local board relative to such system, if chargeable to the licensee, shall be cause for license denial, license revocation, or other sanction under 105 CMR 150.018(I)(2), unless the licensee shall demonstrate that compliance had been stayed.

(2) Nothing contained in 105 CMR 150.016(B)(1) shall be construed as a limitation, express or implied, upon the residual authority of the Department to make orders relative to any sewerage system found to endanger the public health.

(C) Waste Disposal and Garbage Disposal.

(1) Suitable sanitary procedures and equipment shall be provided for the collection, storage and disposal of all wastes and garbage.

(2) All accumulated soiled dressings, that do not meet the definition of infectious or physically dangerous medical or biological waste as set forth in 105 CMR 180.000: *State Sanitary Code, Chapter VIII*, and other wastes, and all garbage not disposed of by mechanical means shall be stored, both indoors and out-of-doors, in sanitary, rodent-proof, leak-proof, fire-proof, non-absorbent, watertight containers with tight-fitting covers.

(3) Wastes and garbage shall be stored and disposed of at proper intervals in a manner to prevent fire hazard, contamination, transmission of disease, a nuisance, a breeding place for flies and insects, or feeding place for rodents.

(4) Garbage and wastes shall be stored in areas separate from those used for the preparation, storage and service of food.

(5) Equipment for proper cleaning and disinfection of these containers each time they are emptied during all seasons shall be provided.

(6) Requirements governing the disposal of infectious or physically dangerous medical or biological waste as set forth in 105 CMR 480.000: *State Sanitary Code, Chapter VIII* are incorporated herein by reference.

(D) Laundry and Linen Sanitation.

(1) All facilities shall provide appropriate procedures, staff and equipment to assure sufficient clean linen supplies (105 CMR 150.015(F)(4)(d)) and the proper sanitary washing and handling of linen.

(2) Handling of Soiled Linen.

(a) Soiled linen shall be placed in washable or disposable containers, transported in a sanitary manner and stored in separate, well-ventilated areas in a manner to prevent contamination and odors.

(b) Soiled linen shall not be permitted to accumulate excessively in any area of the facility.

(c) Soiled linen shall be handled and stored in such a manner as to prevent contamination of clean linen. Equipment or areas used to transport or store soiled linen shall not be used for the handling or storing of clean linen.

(d) Soiled linen shall not be sorted, laundered, rinsed or stored in bathrooms, patient's or resident's rooms, kitchens or food storage areas.

(e) Handwashing facilities with hot and cold running water, soap dispenser and paper towels shall be available in the laundry area where soiled linen is handled or sorted.

(f) Personal laundry of patients, residents or staff shall also be collected, transported, sorted, washed and dried in a sanitary manner, separate from bed linens.

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(3) Handling of Clean Linen.

- (a) Clean linen shall be sorted, dried, ironed and folded in a specified area separate from soiled linen and in a sanitary manner.
 - (b) Clean linen shall be transported, stored and distributed in a sanitary manner.
 - (c) Clean linen and clothing shall be stored in clean, dry dust-free closets on each floor that are easily accessible to the nurses' station and such closets shall not be used for any other purpose.
 - (d) When feasible, arrangements shall be made so that patients and residents who wish to do so have a safe and convenient place to wash out and dry a small amount of personal laundry.
- (4) Laundry personnel shall be appropriately uniformed and adequate storage space shall be provided for the storage of their street clothing.

(E) Housekeeping and Maintenance.

- (1) All facilities shall provide sufficient housekeeping and maintenance personnel to maintain the interior of the facility in good repair and in a safe, clean, orderly, attractive and sanitary manner free from all accumulation of dirt, rubbish and objectionable odors.
- (2) Nursing, dietary, and other personnel providing patient care shall not be assigned housekeeping duties.
- (3) A separate janitor's closet and housekeeping equipment shall be provided for each floor. Janitor's and housekeeping closets shall be separate from, and shall not open off, utility rooms or toilets.
- (4) All housekeeping and maintenance equipment shall be provided and stored in janitors' closets or other suitable storage areas; they shall never be stored in lavatories, bathrooms, utility rooms, halls or stairs. In facilities that provide Level I, II or III care, the janitors closet shall be adequately lighted and ventilated and shall contain slop sink or floor receptor with hot and cold running water.
In a SNCFC, storage areas or any other areas where hazardous equipment or poisonous solutions are stored, shall be locked.
- (5) Housekeeping equipment and cleaning supplies shall include an adequate supply of wet and dry mops (improvised mops are not permitted), mop pails, brushes, brooms, at least one vacuum cleaner, cleaning cloths and other cleaning supplies.
- (6) Housekeeping and maintenance equipment shall be kept clean, in good condition and maintained in a sanitary manner. Wet mops, dusters and cleaning cloths shall be laundered daily, dry mops twice a week.
- (7) Floors, walls and ceilings shall be cleaned regularly; halls and ceilings shall be maintained free from cracks and falling plaster.
- (8) Deodorizers shall not be used to cover up odors caused by unsanitary conditions or poor housekeeping.
- (9) Storage areas, attics and cellars shall be kept safe and free from accumulations of extraneous materials such as refuse, furniture and old newspapers or other paper goods. Combustibles such as cleaning rags and compounds shall be kept in closed metal containers including those used in patient or residents activities.
- (10) The grounds shall be kept free from refuse and litter, and areas around buildings, sidewalks, gardens and patios kept clear of dense undergrowth, snow and ice.
- (11) A pest control program shall be provided by maintenance personnel of the facility or by contract with a pest control company. Insecticides and rodenticides shall be stored in non-patient and non-food service and storage areas.
- (12) Windows and doors shall be properly screened during the insect breeding season, and harborages and entrances for insects shall be eliminated.
- (13) All windows, including combination windows, shall be washed inside and outside at least twice a year.

(F) Pets.

- (1) Pets or other types of animals shall not be allowed in any of the following areas: patient areas in facilities that provide Level I, II, or III care; kitchens and areas used for preparation, serving or storage of food; laundries or restorative services units.
- (2) No commercial breeding of pets shall be allowed.
- (3) All pets shall be adequately fed, sheltered and maintained in a sanitary manner.

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150.017: Construction and Equipment

(A) New Construction, Alterations and Conversions.

(1) The establishment and construction of new long-term care facilities, conversions of other types of facilities to long-term care facilities, or any alterations or additions to existing facilities now licensed by the Department shall conform to the Department's most current standards of construction and shall be constructed, converted or altered for the specific purpose of providing a specific (level or levels) of long-term care.

(2) New construction, conversions, alterations, additions or other structural changes or acquisition of special equipment in a proposed or existing facility shall not be made until a letter of intent and proper application forms have been filed with the Department and approval of the final plans and specifications for construction or acquisition have been issued by the Department of Public Health and the Department of Public Safety.

(3) Conversion to long-term care facilities of structures not previously licensed by the Department as hospitals, convalescent and nursing homes, rest homes, infirmaries maintained in towns or charitable homes for the aged shall be allowed only in exceptional cases, as determined and approved by the Department and only where such conversion will ensure substantial compliance with 105 CMR 150.000 and current construction standards.

(4) No facility presently licensed as a rest home shall be licensed as a facility that provides Level I, II or III care unless it conforms to the Department's most recent standards for new construction, alterations and conversions.

(B) Construction and equipment requirements for facilities, or units thereof which were NOT constructed under the "Rules and Regulations for the Construction of New Convalescent or Nursing Homes in Massachusetts" effective March 19, 1968, or subsequent revisions of these construction standards.

(1) General.

(a) Facilities shall comply with all state laws and local ordinances applicable to buildings, fire protection, public safety or public health.

(b) In facilities that provide Level I or II care and are not of class one or two construction, all patients or residents with handicaps (such as impaired vision, impaired ambulation, etc.) shall be housed on floors that have access to grade level, and no patients or residents shall be housed above the second floor. Occupancy of rooms above the second floor shall be restricted to employees and members of the immediate family of the licensee.

(2) Nursing Units shall consist of at least the following: an identifiable unit of approximately 40 beds in facilities that provide Level I or II care, and not more than 60 beds in facilities that provide Level III or IV care; a nurses' or attendants' station conveniently located to patient or resident beds; a medicine cabinet or closet; a utility room in facilities that provide Level I, II or III care; storage space for medical supplies and equipment; and a storage closet for linen.

(a) Patient or Resident Bedrooms.

1. Single rooms shall have a minimum of 60 square feet of floor area; multi-bedrooms shall have a minimum of 60 square feet of floor area per bed.

2. Any increase in the quota must provide, in the room or rooms under consideration, that single rooms shall have a minimum of 110 square feet of floor area; multi-bedrooms shall have a minimum of 80 square feet of floor area per bed.

3. No patient or resident bedroom should contain more than four beds although exceptions will be allowed for existing facilities upon written approval of the Department.

4. Each bed shall be placed at least three feet from any other bed and at least three feet from any window or radiator. An unobstructed passageway of at least three feet shall be maintained at the foot of each bed.

5. Rooms below grade level shall not be used for patient or resident occupancy. Rooms without basement foundations shall not be used for patient or resident occupancy unless there is adequate heating and insulation.

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6. All rooms used for patients or residents shall be outside rooms. No room off the kitchen shall be used for patient or resident care unless another acceptable means of entrance to this room is provided. No patient or resident room shall be used as a passageway.

7. Adequate closet and drawer space shall be provided for each patient and resident. In general, this shall mean closet space of not less than two feet by two feet by the height of the closet per patient or resident for the storage of personal belongings, and either a built-in or free standing multiple drawer bureau not less than two-feet, six inches wide with a minimum of one drawer per individual. When feasible, these should be located within the patient's or resident's room.

8. In an AIDS/NF a minimum of 15% of the beds on the unit must be reserved exclusively for patients whose medical or social needs dictate that the room not be shared with any other person.

(b) Nurses' or Attendants' station -- A nurses' or attendants' station shall be provided for every unit in a central location. (Exceptions may be allowed upon written approval of the Department). At a minimum, each nurses' station shall be provided with a desk or counter, chair, sufficient cabinets and an acceptable record holder or chart rack.

(c) Medicine Cabinet or Room. See 105 CMR 150.008(D).

(d) Utility Room.

1. Facilities that provide Level I or II care shall provide a utility room for every unit and for each floor. Facilities that provide Level III care shall provide a utility room for each unit. The utility room shall be physically partitioned from any toilet or bathing area for patients or personnel and shall have a separate entrance directly from a corridor.

2. A minimum of 35 square feet of floor area shall be provided for utility rooms.

3. The following equipment shall be provided in utility rooms: slop sink with gooseneck faucet and hot and cold running water; adequate cupboard and work space; adequate facilities for the storage of clean equipment used in the administration of patient care; adequate space for the storage of individual patient equipment; adequate facilities for the cleansing, disinfection and sterilization of individual patient equipment; adequate facilities for emptying, cleansing and disinfecting bedpans and urinals; an instrument sterilizer; adequate facilities for the proper storage of all rubber goods, such as hot water bottles, ice caps, rectal tubes, catheters, rubber air rings and rubber gloves; handwashing facilities with hot and cold running water.

(e) Utility rooms are not required in facilities that provide only Level IV care.

(f) Janitor's closets. See 105 CMR 150.016(E)(3).

(3) General Storage. Adequate storage space and equipment shall be provided for patients' or residents' towels and wash cloths when not in use, clothing during all seasons of the year, personal effects and valuables; beds, bedsides, bed springs, mattresses, bed pillows and blankets, when not in use; clean linen; glassware, enamelware, instruments, syringes and needles, rubber goods, mouth and rectal thermometer and other such equipment and supplies.

(4) Examination and Treatment Room. If an examination and treatment room is provided, it shall be equipped with a sink with hot and cold running water, soap dispenser, disposal towel dispenser, treatment table, instrument table, instrument sterilizer, locked storage cabinet, a hospital scale, and a non-combustible waste receptacle with a foot-operated top.

(5) Activity Areas. All facilities shall provide on every floor and for every unit a comfortable, pleasant, convenient, well-lighted and ventilated sitting room, day room, or solarium with a direct outside exposure that is separate from patient or resident bedrooms. (Exceptions may be allowed upon written approval of the Department.) This room shall be so constructed, arranged and maintained that patients or residents have a place to read, play cards, visit or watch television. This room shall be large enough to meet patient needs and shall be suitably located.

(6) Restorative Service Units.

- (a) The rooms and areas shall be sized, arranged and equipped so that they are consistent with the programs of treatment within the particular facility. The unit shall be well-lighted, well-ventilated and adequately heated and it shall be separate and apart from rooms used for resident living.
- (b) There shall be a bell or signal system to summon aid in an emergency.
- (c) Adequate storage facilities shall be provided and maintained in a sanitary and safe manner and in good repair.
- (d) A handwashing sink with hot and cold running water shall be provided and equipped with a plaster trap if occupational therapy is given.
- (e) All physical therapy equipment shall be of known quality and serviced at least annually by a qualified person. No repairs shall be made except by a qualified person.
- (f) The following basic equipment shall be provided for the physical therapy unit:
 - Treatment table, footstool and chairs
 - Adequate linen supply
 - Sanitary waste containers
 - Hamper for soiled linen
 - Disposable towels
 - Curtains or cubicles to assure privacy
 - Desk or table and chair for clerical use
- (g) All plumbing and electrical installations required for the administration of physical therapy shall be inspected and approved in writing by the appropriate local or state authorities.

(7) Toilet, Bath and Shower Rooms.

- (a) Adequate toilets, handwashing sinks, baths and showers shall be provided on each floor.
- (b) Toilets and washrooms shall be provided for staff separate from those rooms used by patients or residents. The number shall be appropriate to the size and needs of the facility.
- (c) Toilet and handwashing sinks shall be provided on a ratio of one toilet and sink per every eight to ten patients or residents. There shall be at least one separate toilet for males and one separate toilet for females on each floor. (Exceptions may be made upon written approval of the Department.)
- (d) A shower or tub shall be provided in a ratio of one per 15 patients or residents. Separate showers or tub baths for males and females are required only if they are located in the same room with toilets. (Exceptions may be made upon written approval of the Department.)
- (e) Toilets, bath or shower compartments shall be separated from all rooms by solid walls or partitions. Adequate provision to insure patient privacy shall be made.
- (f) Toilets for patients' or residents' use may not be located off the kitchen.
- (g) Handrails or grab bars shall be provided near showers, tub baths and toilets.
- (h) Toilet, handwashing and bathing equipment and areas must be kept in good repair, and the floor area surrounding the toilet must be maintained in a sanitary manner and in good repair.
- (i) Facilities shall provide all toilet rooms with toilet paper holders and paper, towels, soap dispensers with soap, mirrors and adequate lighting. Paper towels shall not be used in patient or resident bath rooms.
- (j) Hot water supplied to fixtures accessible to patients or residents shall be controlled to provide a maximum temperature of 110 ° F.

(8) Kitchen.

- (a) The main kitchen shall be located in a suitable area. There shall be adequate work space for the sanitary preparation and serving of meals for patients, residents and personnel, in accordance with the size of the facility. All main kitchens shall be provided with a mechanical ventilator.
- (b) Kitchens and other areas when located below grade level and used for the preparation and serving of food shall either have direct access to the outside by means of suitable windows or ventilation shall be provided to permit an air supply and exhaust of at least ten air changes an hour. Ventilating units shall be maintained in a sanitary manner and kept in good repair.

- (c) Adequate sanitary storage space and cabinets shall be provided for the proper storage of all foods, dishes, silverware and cooking equipment and maintained in a sanitary manner and kept in good repair.
 - (d) Auxiliary kitchens shall be provided and adequately equipped when the size of the facility or the physical plant indicates the need, as determined by the Department.
 - (e) A dumb-waiter when provided for the transportation of food shall be suitably located and used exclusively for the transportation of food. It shall be cleaned daily and kept in good repair.
 - (f) Stoves, sinks, counters, cabinets, shelves, tables, refrigerating equipment and all other equipment necessary for the preparation and serving of food shall be provided in accordance with the size of the facility. This equipment shall be so constructed that it can be easily cleaned, maintained in a sanitary manner and kept in good repair.
 - (g) A handwashing sink with hot and cold running water, a soap dispenser and disposable towels in a towel dispenser shall be located in the kitchen area.
 - (h) All facilities shall provide by January 1, 1972, an automatic dishwasher capable of handling the needs of the facility. For dishwashing machines, the temperature of the water shall be between 140 and 160 ° F with a final rinse at a temperature of 170 ° F or higher.
 - (i) Appropriate areas shall be provided for cart washing and can washing.
- (9) Dining Rooms. All facilities shall provide at least one dining area for patients or residents, including wheelchair cases, who can and wish to eat at a table. (Exceptions may be made upon written approval of the Department.) Dining rooms shall be:
- (a) Suitably located in an attractive, well-lighted, ventilated and heated area that is separate from sleeping quarters and areas of congestion.
 - (b) Equipped with tables of sturdy construction with hard surfaced, washable tops.
 - (c) Equipped with comfortable chairs of sturdy construction and of a sanitary type.
 - (d) Provided with floors that have a waterproof and greaseproof covering. Only non-skid wax shall be used in the dining room area.
- (10) Laundry Room.
- (a) All facilities shall provide a laundry that is located in an area separate and apart from any area used for the storage, preparation or serving of food.
 - (b) When total laundry service is to be performed on the premises, sufficient space and equipment for such service shall be provided.
 - (c) When adequate space and equipment are not available on the premises for the proper and sanitary washing of all linens and other washable goods, or if a facility chooses not to perform total laundry service on the premises, a commercial laundry or laundry rental service shall be utilized. Even if such commercial laundry services are used, a laundry room of sufficient size to wash, dry, iron and fold bed, bath and other linen in case of an emergency, as well as to meet the personal needs of the patients or residents, shall be provided.
 - (d) A laundry room shall contain set tubs equipped with hot and cold running water automatic washer, drier, ironing equipment and shelving for the storage of soaps, bleaches and other laundry supplies.
 - (e) All space and equipment shall be adequate to meet the needs of the facility and to assure the proper and sanitary washing of linen and other washable goods.
- (11) Office Space. Appropriate space and equipment shall be provided for administrative activities and for the storage of medical records. Additional space and equipment shall be provided for staff and consultants as needed.
- (12) Architectural and Engineering Details.
- (a) Doors, Screens and Windows. No hooks or locks shall be installed on doors used by patients or residents.
 - Outside doors, windows and openings shall be protected against flies and other insects by the seasonal use of screens.
 - All outside doors and doorways shall be made draft free by the installation of weather stripping or caulking material.
 - (b) Walls and Floors. Interior finished surfaces shall conform to local and state codes. Walls shall have a waterproof, glazed, painted or similar surface that will withstand washing; and floors shall be waterproof, greaseproof and resistant to heavy wear in the following areas: kitchen (main and auxiliary), food preparation and service areas, bathrooms and toilets, utility rooms and laundry.

- (c) If carpeting is used in a facility, it shall conform to standards established by the Department.
- (13) Heating and Air Conditioning Equipment.
- (a) The heating system shall be in conformity with the rules and Regulations outlined by the Department of Public Safety under M.G.L. c. 148.
- (b) Every facility shall be equipped with a heating system that is sufficient to maintain a minimum temperature of 75 ° F throughout the facility at all times at winter temperatures.
- (c) Portable room heaters, such as space heaters, plug-in electric heaters, or heaters using kerosene, gas or other open-flame methods, are prohibited.
- (d) Heating fixtures and all exposed pipes in patient areas shall be shielded for the safety of patients or residents.
- (e) Every facility shall by June 21, 2000 provide air conditioning in dining rooms, activity rooms, day rooms, solariums, sitting rooms or equivalent other common resident areas that is capable of maintaining a maximum temperature of 75 ° F in those areas at all times at summer design temperatures. Temperatures must be maintained at a level which ensures the comfort and health of residents of the facility.
- (14) Ventilation. (See 105 CMR 150.015(F)(5).)
- (a) Each patient or resident room shall have adequate ventilation.
- (b) Bathrooms, toilets and utility rooms shall have direct access to the outside by means of suitable windows or a forced system of exhaust that shall be maintained in a sanitary manner and kept in good repair.
- (15) Lighting.
- (a) Adequate electric lighting maintained in good repair shall be provided throughout the facility in accordance with the provisions of the M.G.L. c. 111, § 72C, as amended, and the recommended Levels of the Illuminating Engineering Society. All electrical installations shall be in accordance with the Commonwealth of Massachusetts, Department of Public Safety, Board of Fire Prevention Regulations, Massachusetts Electrical Code 527 CMR 12.00 and all local regulations.
- (b) Adequate lighting shall be provided in each patient or resident room to provide an adequate, uniform distribution of light. No electric bulb under 60 watts shall be used for illumination for patients' or residents' use.
- (c) Night lights shall be provided in corridors, stairways, bathrooms, toilets and nurses or attendants' stations and patients' or residents' bedrooms. Night lights for hallways stairways and bathrooms shall have at least 15 watt bulbs.
- (d) Outside walks, parking lots and entrances shall be adequately lighted.
- (16) Emergency Electrical Systems. All facilities providing Level I/II care shall provide an emergency source of electricity that meets the following requirements.
- (a) The emergency source of electricity shall be connected to circuits designated in 105 CMR 150.017(B)(16)(c) through (e) for lighting and power to provide electricity during an interruption of normal electric supply that could affect the nursing care, treatment or safety of the occupants.
- (b) The emergency source of electricity shall consist of a generating set, including a prime mover and generator. It shall be located on the facility premises and shall be reserved exclusively for supplying the emergency electrical system. The set shall be of sufficient kilowatt capacity to supply all lighting and power demands of the emergency system. The power factor rating of the generator shall not be less than 80%.
- (c) The emergency electrical system shall be connected to circuits for lighting of nurses' stations, attendants' stations, medicine preparation areas, generator set location and boiler room.
- (d) The emergency electrical system shall be connected to circuits necessary to provide protection of vital equipment and material and for operation of equipment essential to the health and safety of occupants, including but not limited to nurse's call system, alarm system, fire pumps (if installed), sewage or sump lift pumps (if installed), corridor duplex receptacles in patient areas, equipment for maintaining telephone service, paging or speaker systems, refrigerators, freezers, burners and pumps necessary for the operation of one or more boilers and their controls required for heating.
- (e) Where electricity is the only source of power normally used for space heating, the emergency service shall provide for heating of patient rooms unless the nursing home is

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supplied by at least two utility service feeders, each supplied by separate generating sources.

(f) An automatic transfer switch shall be installed to transfer to emergency power within ten seconds.

(C) A SNCFC shall provide a specially adapted vehicle, either purchased or leased, or shall contract for the services of a specially adapted vehicle. Such vehicle shall be properly insured and staffed for the safe transport of patients to offsite habilitative, therapeutic recreational and non-emergency medical services.

150.018: HB/LTCF - Provisions Regarding the Sharing of Services

(A) Administrator-An HB/LTCF shall have a designated administrator who is licensed in Massachusetts as a Nursing Home Administrator and shall meet the provisions of 105 CMR 150.002. For HB/LTCFs of 40-59 beds, the administrator shall serve as necessary to assure the proper administration of the HB/LTCF, but at least 32 hours per week. For HB/LTCF of under 40 beds, the administrator shall serve as necessary to assure the proper administration of the HB/LTCF, but at least 24 hours per week.

(B) Nursing-An HB/LTCF shall have a separate full-time Director of Nursing and shall meet the provisions for nursing services in 105 CMR 150.007. An HB/LTCF shall provide a nursing service separate from the hospital's, and nursing staff shall not be routinely shared between the hospital and the HB/LTCF.

(C) Ancillary Services-Ancillary services, such as dietary and laundry, furnished by an HB/LTCF may be provided to the HB/LTCF by the hospital under specific written arrangements for such services. Services provided under written arrangements with the hospital shall meet all the requirements of 105 CMR 150.009 and 150.010. In the event of an HB/LTCF's non-compliance with regulations or applicable laws, the Commissioner or his/her designee will investigate and, where appropriate, take action against both the hospital and the long term care facility where the services are common.

(D) Equipment-An HB/LTCF shall meet all the provisions of 105 CMR 150.015 and shall furnish necessary equipment to the unit. However, the HB/LTCF shall be permitted to arrange, under written arrangement, to obtain equipment from the hospital for use in the HB/LTCF.

150.019: Education Services (SNCFC)

(A) An educational program shall be provided which shall be approved by the Massachusetts Department of Education.

(B) Opportunity for participation in the approved educational program shall be available to all school-age children within the facility upon admission.

(C) The educational program shall be an integral part of the total patient care provided. Scheduling of daily activities shall be done in such manner as to encourage and facilitate participation of patients in the educational program.

(D) Appropriate physical space, furnishings and teaching materials shall be provided, as required by the Department of Education for approval of the program.

150.020: Supplement A: Limited Nursing Care in Certain Level IV Units

(A) Purpose. The purpose of this supplement is to enable persons who accepted Level IV classification under license or determination of need in reliance upon the heretofore existing reimbursement system applicable to multiple level facilities, if any so desire, to participate in the federally-aided intermediate care facilities program in such Level IV units, subject to certain eligibility criteria and other safeguards herein specified, with the objects that such persons shall not suffer undue hardship and the Commonwealth may maximize federal financial assistance, while preserving insofar as possible the existing level-of-care system created by 105 CMR 150.000 and utilized by the Department in both licensing and determination of need.

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- (B) Statutory Authority. This supplement is adopted under authority of M.G.L. c. 111, §§ 3 and 25F.
- (C) Permission to Provide Limited Nursing Care. No person subject to licensing under 105 CMR 150.000 shall provide organized, routine nursing care in a Level IV unit (see 105 CMR 150.007(A)(3)), except on a limited basis not in excess of 0.6 hours per resident per day, and only upon permission granted in writing upon findings that:
- (1) Such person is eligible under 105 CMR 150.020(D);
 - (2) Such person has agreed in writing to the conditions set forth in 105 CMR 150.020(E); and
 - (3) Such person has maintained the unit and any other units within his control, whether in the subject facility or another facility, in conformity with applicable Department regulations during the 12 month period preceding application under 105 CMR 150.020(F).
- (D) Eligibility. Persons shall be eligible for permission under 105 CMR 150.020(C), only as follows:
- (1) The subject facility was participating in the Limited Nursing Program (Level III-A) as of June 30, 1977;
 - (2) An application for continued participation has been filed with the Director, Division of Long Term Care (hereinafter Division Director) in accordance with procedures set forth in 105 CMR 150.020(F);
 - (3) The subject facility is located in an area where the Program Director, Determination of Need Program (hereinafter Program Director), has determined there is no need for Level II or Level III beds; or the subject facility is located in an area where the Program Director has determined there is a need for Level II or Level III beds and the facility has or will apply to upgrade the Level III-A beds in accordance with procedures set forth in 105 CMR 150.020(F)(3) or 150.020(F)(4).
 - (4) If the provisions of 105 CMR 150.020(D)(1) through 150.020(D)(3), or 105 CMR 150.020(F)(1) through 150.020(F)(4) are not met a facility shall no longer be eligible for participation in the program, and must revert to Level IV status in accordance with procedures for relocation of Level III-A patients established by the Division Director.
- (E) Conditions Attached to Permission. Permission to provide limited nursing care in a Level IV unit pursuant to 105 CMR 150.020(A)(3) shall be subject to the following conditions:
- (1) 105 CMR 150.007(B)(4)(b) and 150.007(B)(4)(c) shall apply to the unit in lieu of 105 CMR 150.007(B)(5) through 150.007(B)(5)(d); in addition in any 60-bed unit, the licensee shall provide a nurse's aide on the day shift to assist the charge nurse (required under 105 CMR 150.007(B)(4)(b));
 - (2) The following subsections of 105 CMR 150.000 normally applicable to Level III units shall apply to the unit instead of the corresponding Level IV subsections: 105 CMR 150.003(E)(1), 150.003(E)(2); 150.004, 150.005(A), 150.005(B), 150.005(G)(3); 150.007(A)(1), 150.007(A)(2), 150.007(C)(3) to 150.007(C)(7), 150.007(D), 150.007(F), 150.007(G), 150.007(H)(2) (Level III standard), and 150.007(I); 150.008(B)(2) (Level III standard and 105 CMR 150.008(C)(1), 150.009(C)(6)(b), 150.010(A), and 150.011(A);
 - (3) The facility shall admit to the unit only residents who require limited nursing care (not in excess of 0.6 hours per resident per day), such determination to be made on the basis of patient classification guidelines to be issued by the Department;
 - (4) The facility shall make every reasonable effort to transfer to an appropriate setting any person who, in accordance with such patient classification guidelines, is determined not to require limited nursing care but instead to require either supportive or skilled nursing care or only normal resident care;

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(F) Application and Other Procedures.

- (1) Any person desiring permission for continued participation in the program shall file an application not later than 5:00 P.M. August 31, 1978, with the Department, Attention: Director, Division of Long Term Care, Room 560, 80 Boylston Street, Boston, Massachusetts, on a form prepared by Department staff and provided to participating facilities by August 7, 1978
- (2) The Division Director or her designee shall have authority to approve such application upon certification from the Program Director that the subject facility is located in an area where there is no current need for Level II or Level III beds, or where pending application will meet the need for Level II or Level III beds if approved.
- (3) The Division Director or her designee will grant temporary approval for continued participation in the program for those facilities located in areas determined to have need for Level II or Level III beds by the Program Director. Such approval shall not extend beyond January 2, 1979, unless an application for upgrading Level III-A beds has been filed with the Determination of Need Program. Facilities that have filed to upgrade Level III-A beds will be permitted to continued in the program pending Public Health Council action on the Determination of Need application.
- (4) Approval pursuant to 105 CMR 150.020(F)(2) shall continue only as long as there is no current need for Level II or Level III beds in the area where the facility is located. Upon certification from the Program Director that there is a current need for Level II or Level III beds in the area where the subject facility is located, the Division Director will grant each facility temporary approval for continued participation in the Level III-A program not to extend beyond the filing day of the next regular Determination of Need filing period, unless on that filing day an application to upgrade Level III-A beds has been filed with the Determination of Need Program. Pending Public Health Council action on such application, the facility will be permitted to continue to participate in the Level III-A program.
- (5) If an application for a determination of need filed in accordance with 105 CMR 150.020(F)(3) or 150.020(F)(4) is denied by the Department the Division Director shall grant the facility approval to continue in the Level III-A program only if the Program Director certifies the determination of need application was pursued diligently and in good faith.

150.021: Support Services Plan for Level IV Community Support Facilities

- (A) In Level IV facilities with Community Support Residents, the Support Services Coordinator must develop a Support Services Plan. The plan shall be written as soon as possible but no later than two weeks after admission for new resident admissions and as soon as possible for Community Support Residents already residing in a facility. The Support Plan must describe the service needs of the resident, including those service needs specified in his/her Mental Health Treatment Plan. The Support Plan must be developed by the Community Support Resident and the Support Services Coordinator, in consultation with the resident's social worker, physician, psychiatrist, and other staff.
- (1) Each Plan must include but is not limited to the following:
 - (a) A narrative statement describing the resident's service needs. These needs must include those specified in the mental health treatment plan. It should also include service needs that are consistent with the mental health treatment plan but are not mental health needs, such as other health needs, educational or vocational needs, and recreational or socialization needs.
 - (b) Within each area of specified need, goals and objectives, as well as time frames for the beginning of services and the achievement of objectives should be developed.
 - (2) Each plan should be reviewed 30 days after it is first developed, and every 90 days thereafter. At the time of the plan review, goals and objectives should be evaluated, and revised as needed. If objectives have not been met, new strategies may need to be developed. The plan should be adjusted at any time that a significant change is made in the resident's mental health plan that affects the service needs specified in the Support Plan, or that requires new service needs to be met. The Coordinator, in consultation with the Social Worker may revise the Support Plan as often as the Coordinator feels it is inadequate.

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(3) No support services plan may be implemented without the written consent of the resident (if he or she is competent to give such consent), or the written consent of the resident's guardian (if he or she is not competent).

(4) If a support services plan is declined by a resident the attending Support Services Coordinator, in consultation with the resident's psychiatrist and physician, shall make all efforts to meet with the resident to determine how a plan might be developed and/or modified in order to accommodate the resident's objections, concerns, and suggestions. Reasons for partial or total rejection of the plan must be noted in the resident's record.

(B) Support Services Coordinator. All Level IV facilities with Community Support Residents shall employ a Support Services Coordinator. The Coordinator is responsible for arranging and coordinating Support Services. Support Services is a term applied to a variety of services including health and mental health visits, educational and vocational services, as well as recreational services which are intended to enhance the psychosocial and physical functioning of Community Support Residents. Some of these services will be specified in the resident's Mental Health Treatment Plan. Others can be identified by the resident, the Coordinator or other staff. The Coordinator is responsible for assuring that all of the services received by a Community Support Resident either within the facility or in the community, are consistent with the Mental Health and Support Services plans. When questions or conflicts arise among the various staff and consultants involved with these residents, it is the responsibility of the Coordinator to arrange and facilitate communication among the others. This may involve arranging meetings among facility staff, referring agency staff, consultant staff or others. It is the role of the Coordinator to minimize duplication of service, and to assure that the Mental Health Plan required by these regulations is the focus of a consistent and well organized care plan. The Coordinator should meet regularly with Community Support Residents as well as with the Social Worker and other facility staff. The Coordinator may also wish to visit other agencies and staff to facilitate linkage and coordination.

Minimum Support Services Coordinator Personnel Requirements:

(1) Two hours of Support Services shall be provided to each Community Support Resident per week (One full time equivalent per 20 Community Support Residents).

(2) In the event that a facility experiences a change in the number of Community Support Residents by five residents more or less, the facility must notify the Department of Public Health to discuss the need for a change in staffing.

(3) The Support Services Coordinator shall receive clinical supervision from the Social Worker, and shall meet at least monthly, preferably weekly, with the Social Worker to discuss the resident's care plans.

(4) The Support Services Coordinator shall, prior to employment by a Community Support Facility, possess a BA or BS degree in a human services field of study such as Psychology, Nursing or Social Work, have documented evidence of having received appropriate training in the psychosocial problems and needs of Community Support Residents, have knowledge of the Support Services available to Community Support Residents, and have adequate training, as determined by the Department, in the effects and side effects of those drug therapies prescribed for Community Support Residents.

(5) Duties of the Support Services Coordinator shall be restricted to the day shift.

150.022: Standards for Dementia Special Care Units

105 CMR 150.022 through 150.029 set forth the minimum dementia staff training requirements for all nursing homes, and set forth the minimum standards with which a Dementia Special Care Unit (DSCU) must comply, and apply only to Level I, II and III facilities licensed under 105 CMR 150.000.

150.023: DSCU Definitions

The following definitions shall apply to 105 CMR 150.022 through 150.029:

Dementia Special Care Unit (DSCU) means a facility licensed pursuant to 105 CMR 150.000, or a unit thereof, that uses any word, term, phrase, or image, or suggests in any way, that it is capable of providing specialized care for residents with dementia, which must comply with 150.022 through 150.029. The purpose of a DSCU is to care for residents with dementia in the long term.

150.023: continued

Direct Care means any service, whether clinical or not, that is provided directly to a resident.

Dementia Special Care Unit Standards means those requirements in 105 CMR 150.022 through 150.029.

Evaluation means a determination by the facility that the individual is competent to provide direct care to residents based on the individual's demonstration of competency in the applicable skills and techniques.

Reasonable Time means during the individual resident's normal waking hours, and absent severe weather conditions.

Relevant Staff Members means direct care workers, therapeutic activity directors and supervisors of direct care workers.

Resident Areas means residents' rooms, common rooms, dining rooms, activities rooms, and any other indoor space meant for resident use.

150.024: Staff Qualifications and Training

(A) The training requirements listed in 105 CMR 150.024 shall supplement training requirements set forth in 105 CMR 150.000 and must be completed in addition to those training requirements.

(B) Each facility must maintain written documentation that all relevant staff members have met the required training standards set forth in 105 CMR 150.025:

(1) Prior to being released from the orientation process (providing care without the supervision of a preceptor), all relevant staff members shall receive a minimum of eight hours of initial training. After initial training is completed and documented, a staff member does not have to receive initial training if he or she changes jobs or begins working in another long term care facility unless the individual has a lapse in employment in long term care for 24 consecutive months or more.

(2) Notwithstanding 105 CMR 150.024, each facility with one or more DSCUs shall ensure that all relevant staff members that were providing care in a DSCU prior to the promulgation of 105 CMR 150.022 through 150.029 have been trained by May 29, 2014.

(3) Notwithstanding 105 CMR 150.024, each facility that does not operate a DSCU shall ensure that all relevant staff members that were providing care in the unit prior to the promulgation of 105 CMR 150.022 through 150.029 have been trained by August 27, 2014.

(4) All relevant staff members providing care in a facility, whether or not that care is provided to residents in a DSCU, shall receive a minimum of four hours of ongoing training each calendar year.

(5) A relevant staff member does not need to receive ongoing training in the same calendar year that he or she receives eight hours of initial training as required by 105 CMR 150.025.

(6) Each facility shall appropriately train its volunteers for the tasks that they will be performing.

(C) The DSCU and the facility shall maintain documentation of staff training, which shall be available for the Department's review.

(D) If a facility hires a relevant staff member who received the training as specified in 105 CMR 150.024 at a different location, and the relevant staff member has not had a lapse in employment in long term care for 24 consecutive months or more, the facility must:

(1) Obtain documentation from the employee's former employer certifying that the employee received the required training and passed the evaluation; or

(2) Train the employee as specified in 105 CMR 150.024.

150.025: Content of Training

(A) All training required for relevant staff members pursuant to 105 CMR 150.024 shall be in accordance with Department guidelines.

150.025: continued

- (B) The training must include a basic introduction to the foundations of dementia and dementia care, as well as any other topics listed in Department guidelines.
- (C) The training must be at least partially interactive, as defined in guidelines of the Department.
- (D) Training must include an evaluation, as deemed appropriate by the facility staff development coordinator or his/her designee.
 - (1) No training shall be considered complete until the staff member or contractor has taken and passed the evaluation.
 - (2) Written documentation that the staff member or contractor has passed the evaluation must be available for the Department's review during inspection.
 - (3) Training shall be appropriate for the population served by facility, and training must include cultural competency as appropriate.
- (E) All training modules, presentations, materials and evaluations must reflect current standards and best practices in the treatment of dementia.

150.026: Therapeutic Activity Directors in Dementia Special Care Units

- (A) A facility that operates one or more DSCUs shall have a therapeutic activity director for the DSCU(s) who is a qualified therapeutic recreation specialist or an activities professional who:
 - (1) Is certified as a therapeutic recreation specialist or as an activities professional by an accrediting body recognized by the Department; or
 - (2) Has two years of experience in a social or recreational program within the last five years, one of which was full-time in a patient or resident activities program in a health care setting; or
 - (3) Is a qualified occupational therapist or occupational therapy assistant.
- (B) The responsibilities of the therapeutic activity director shall include:
 - (1) Developing and implementing the therapeutic activity program individualized for each DSCU resident;
 - (2) Supervising the activities personnel who assist with therapeutic activities;
 - (3) Planning and scheduling therapeutic activities and events;
 - (4) Posting in a conspicuous place a monthly calendar of activities and events;
 - (5) Contributing to each resident's comprehensive assessment and plan of care;
 - (6) Providing sufficient oversight of the activities personnel; and
 - (7) Assisting as necessary with other DSCU services.
- (C) Notwithstanding 105 CMR 150.026(A) if the therapeutic activity director is not certified as a therapeutic recreation specialist or an activities professional by an accrediting body recognized by the Department, or is not a qualified occupational therapist, the therapeutic activity director and the nursing home shall consult with an occupational therapist in the development of a therapeutic activities program that meets the individual needs of each resident in the DSCU.
- (D) The same individual shall not serve as both the therapeutic activity director for the DSCU(s) and the activity director for the facility, except when the DSCU comprises the entirety of the facility.

150.027: Activities in Dementia Special Care Units

- (A) A DSCU shall provide a minimum of eight hours of documented therapeutic activities programming per day, of which at least six hours shall be scheduled activities, seven days per week.
- (B) Therapeutic activities shall be planned throughout the day and evening and incorporate the possible need for therapeutic programming during night hours based upon the needs of individual residents.

150.027: continued

- (C) Therapeutic activities shall be individualized and designed to improve or maintain residents' self-awareness and level of functioning and shall be reasonably suited to the needs and interests of residents. Therapeutic activities shall be provided on an individual and group basis.
- (D) DSCU personnel shall seek ways to engage residents in therapeutic activities.
- (E) The DSCU shall provide, maintain, and store basic supplies and equipment for therapeutic activities.
- (F) A DSCU shall provide sufficient space for therapeutic activities that is contained within the DSCU. The space shall conform to the physical plant requirements listed in 105 CMR 150.029.
- (G) Therapeutic activities shall be:
 - (1) Structured and planned to promote or help sustain the physical and emotional well-being of each resident and maximize functional independence.
 - (2) Based on an assessment of each resident's past and current interests and gross motor, self-care, social, sensory, cognitive, and memory skills;
 - (3) Meaningful, purposeful and cognitively stimulating;
 - (4) Designed to enhance or maintain memory, to the extent practical;
 - (5) Designed to provide opportunities for physical, social and emotional outlets and self expression; and
 - (6) Implemented in accordance with current standards of practice for treatment of residents with dementia and appropriate to the resident's stage of disease.

150.028: Dementia Special Care Unit Disclosure Requirement

- (A) A nursing home that holds itself out to the public or advertises having a DSCU shall complete a DSCU disclosure form, as provided in Department guidelines by May 29, 2014 and then annually on March 1st, regardless of whether the information reported in the form has changed.
- (B) The most current disclosure form shall be provided by the facility to each of the following parties:
 - (1) Each resident or the resident's authorized representative, seeking to be admitted to the DSCU, prior to the resident's admission and upon request;
 - (2) Any member of the public who requests a copy of the disclosure statement.
- (C) The disclosure form must be posted in a conspicuous place in the facility. All pages of the disclosure form must be visible to the public.
- (D) The facility shall make its disclosure form available to any healthcare facility that requests a copy.
- (E) If a facility has received a waiver for one or more of requirements in 105 CMR 150.024 through 150.029, the facility shall include information about each waiver on its disclosure form.

150.029: Physical Environment for Dementia Special Care Units

- (A) General Requirements.
 - (1) A home-like environment is encouraged for design of DSCU. The design and environment of a unit shall assist residents in their activities of daily living, enhance their quality of life, reduce tension, agitation and problem behaviors, and promote their safety.
 - (2) The DSCU must encompass the entirety of a nursing care unit, as defined by 105 CMR 151.020: Skilled Nursing Care Facility (Level II) and Supportive Nursing Care Facility (Level III) and 151.310: Required Supporting Elements -- Nursing Care Units.
 - (3) A DSCU shall meet the requirements listed in 105 CMR 150.029(B) through (K) in addition to the requirements set forth in 105 CMR 150.017.
- (B) Access. The design of the DSCU shall not require visitors or staff to pass through the unit to reach other areas of the facility.

150.029: continued

(C) Outdoor Recreation Space.

- (1) A DSCU shall have secured outdoor space and walkways that allow residents to ambulate, with or without assistive devices such as wheelchairs or walkers, but that prevent undetected egress.
- (2) Such outdoor space and walkways shall be wheelchair accessible.
- (3) Residents shall have access to the secured outdoor space and walkways during reasonable times with supervision appropriate to each resident.
- (4) Outdoor recreation space shall have fencing or barriers that prevent injury and elopement.

(D) Lighting.

- (1) The DSCU shall provide adequate and evenly distributed lighting that minimizes glare and shadows and is designed to meet the specific needs of the residents.
- (2) Artificial lighting shall meet the lighting requirements of the *Guidelines for Design and Construction of Residential Health, Care and Support Facilities* from the Facility Guidelines Institute.

(E) Finishes.

- (1) Finishes shall include high visual contrasts between floors and walls and between doorways and walls in resident use areas. Except for fire exits, door and access ways not in resident use areas may be designed to minimize contrast to obscure or conceal areas the residents should not enter.
- (2) Floors, walls and ceilings shall be non-reflective to minimize glare.
- (3) Flooring shall not include contrasted visual patterns.

(F) Resident Centered Environment. The DSCU shall promote a resident centered environment that includes the following:

- (1) Freedom of movement within the DSCU for the residents including to common areas and to their personal spaces, including bedrooms, at all times;
- (2) Assistive equipment that maximizes the independence of individual residents;
- (3) Comfortable seating in the common use areas;
- (4) Bedroom decoration and furnishings that include residents' personal items based on the resident's needs, preferences and appropriateness;
- (5) In addition to the requirement of 105 CMR 150.015(F)(3), individual identification of each resident's bedroom based on the resident's cognitive level to assist residents in locating their bedrooms, and to permit them to differentiate their bedroom from the bedrooms of other residents; and
- (6) Corridors and passageways through common-use areas kept free of objects that may cause falls, or that may obstruct passage by physically impaired individuals.

(G) Noise Control.

- (1) The DSCU shall have acoustical ceilings in corridors, dining areas and activity areas to reduce noise levels.
- (2) No overhead paging system shall be used in the DSCU except in the case of an emergency.
- (3) The sound signal for the nurses call system shall be adjustable so as to minimize disruption of residents and resident activities.

(H) Egress Control.

- (1) The facility shall develop policies and procedures to ensure the safety of residents who may wander. The procedures shall include actions to be taken to prevent elopement and actions in case a resident elopes.
- (2) Locking devices shall be used on exit doors, as approved by the local building inspector and fire department having jurisdiction over the facility. The locking devices shall be electronic and release when the following occurs:
 - (a) activation of the fire alarm or sprinkler system;
 - (b) loss of electrical power; or
 - (c) use of a keypad located at each locked door for routine staff access. The electronic locking devices shall be connected to the emergency power circuits.

150.029: continued

(3) If the DSCU uses keypads to lock and unlock exits, then directions for their operation shall be posted on the outside of the door to allow individuals access to the unit. However, if the DSCU is the entire nursing home, then directions for the operation of the locks need not be posted on the outside of the door. The DSCUs shall not have entrance and exit doors that are closed with non-electronic keyed locks, nor shall a door with a keyed lock be placed between a resident and the exit.

(I) Safety.

(1) Windows shall be operable and equipped with secure locks under the control of the DSCU staff.

(2) In conjunction with locked windows, the DSCU shall be equipped with a cooling system that is capable of maintaining a maximum temperature of 75°F throughout resident areas at all times at summer design temperatures. Temperatures must be maintained at a level that ensures the comfort and health of residents.

(J) Common Space. A multipurpose room or rooms for dining, group and individual activities, and family visits that comply with the following licensure requirements for common space shall be included in the DSCU. The floor areas of this multipurpose room or rooms shall accommodate the licensure requirements of at least ten square feet per bed for dining per 105 CMR 151.570: *Central Dining*, at least eight square feet per bed for group activities per 105 CMR 151.510: *General and Special Activity Areas* and at least nine square feet per bed for day room per 105 CMR 151.360: *Activity Area -- Nursing Care Units*, for a total of at least 27 square feet per bed.

(K) Implementation. A facility may request additional time to implement physical plant modifications necessary to meet the requirements of 105 CMR 150.029 pursuant to Department guidelines.

REGULATORY AUTHORITY

105 CMR 150.000: M.G.L. c. 111, §§ 3, 71 and 72.