

105 CMR: DEPARTMENT OF PUBLIC HEALTH

105 CMR 150.000: STANDARDS FOR LONG-TERM CARE FACILITIES

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150.001: Definitions

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.

Aversive Interventions shall mean any intervention technique based upon behavior modification principles that applies painful, seclusive or intrusive methods, stimuli, or punishments to a 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 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.

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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 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.

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.

Community Support Resident. Note: No resident shall be evaluated or determined to be a Community Support Resident without his or her consent. Any resident meeting criteria as a potential Community Support Resident must be asked if he or she is interested in receiving the mental health and support services available to a Community Support Resident as described in 105 CMR 150.000 and asked to sign a form expressing his or 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;
- (b) Has a current diagnosis of mental illness;
- (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 or she is competent to give such consent), or whose guardian consents (if he or she is not competent) to evaluation to determine if he or 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, 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.

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 shall mean the Department of Public Health.

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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 younger than 22 years old 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 ensure 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:

- (1) Cerebral palsy or epilepsy; or
- (2) Any other condition, other than mental illness, requiring treatment or services similar to those required for these persons:
 - (a) It is manifested before the person reaches 22 years old;
 - (b) It is likely to continue indefinitely;
 - (c) It results in substantial functional limitations in three or more of the following areas of major life activity:
 1. Self-care;
 2. Understanding and use of language;
 3. Learning;
 4. Mobility;
 5. Self-direction; and
 6. Capacity for independent living.

Dietary Services shall mean the planning, preparation and serving of routine and therapeutic diets.

Dietitian shall mean an individual licensed as a dietitian by the Board of Registration of Dietitians and Nutritionists.

Direct Care Worker means a staff member whose work involves extensive resident contact or administrative decisions regarding care. 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. 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 presenting imminent danger of death or serious physical harm to residents, or others.

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.

Guardian shall mean a person appointed by the court to make medical decisions on behalf of an adult who has a clinically diagnosed medical condition and is unable to make or communicate effective decisions about their everyday self-care, health and safety.

Hours of Care per Resident per Day (PPD) shall mean the total number of hours worked by registered nurses, licensed practical nurses, and nursing assistants, including certified nurse aides, and nurse aides in training with direct resident care responsibilities for each 24-hour period, divided by the total census of the facility for each day.

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 new construction, additions, conversions or alterations, an identifiable unit shall mean not more than 41 beds for units providing Level I or II care, and not more than 60 beds for units providing Level III or IV care.

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Levels of Long-term Care Facilities or Units.

- (1) Nursing Care Unit shall mean a unit licensed to provide Intensive Nursing and Rehabilitative Care, Skilled Nursing Care, Skilled Nursing Care for Children, or Supportive Nursing Care.
- (2) Intensive Nursing and Rehabilitative Care Facility (Level I) shall mean a facility or units thereof providing continuous skilled nursing care and an organized program of rehabilitation 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 residents as prescribed therein.
- (3) Skilled Nursing Care Facilities (Level II) shall mean a facility or units thereof that provide continuous skilled nursing care and meaningful availability of rehabilitation services and other therapeutic services in addition to the minimum, basic care and services required in 105 CMR 150.000 for residents who show potential for improvement or restoration to a stabilized condition or who have a deteriorating condition requiring skilled care.
 - (a) Skilled Nursing Care Facilities for Children (SNCFC) (Level II) shall mean a facility or unit/s thereof providing skilled nursing care services and/or intensive supportive nursing care services together with therapeutic treatment and habilitative services to “multiply-handicapped” individuals birth through 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 15 through 22 years of age 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 through 22 years of age in order to provide relief to a family/primary care-giver.
- (4) Supportive Nursing Care Facilities (Level III) shall mean a facility or units thereof providing routine nursing services and periodic availability of skilled nursing, rehabilitation and other therapeutic services, as indicated, in addition to the minimum, basic care and services required in 105 CMR 150.000 for residents whose condition is stabilized to the point where they need only supportive nursing care, supervision and observation.
- (5) Resident Care Unit shall mean a unit licensed to provide Resident Care or Community Support.
- (6) Resident Care Facilities (Level IV) or Rest Home 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 are ambulatory and do not require Level II or III nursing care or other medically related services on a routine basis.
- (7) Community Support Facilities (CSF) shall mean a Resident Care Facility in which the Department determines 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 mean the license issued by the Department for a two-year period to a facility found on inspection to be in full compliance with 105 CMR 150.000, 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.

Licensed Practical Nurse shall mean a nurse who is currently licensed by the Board of Registration in Nursing to practice as a licensed practical nurse in Massachusetts.

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Long-term Care Facility (LTCF) shall mean any institution whether conducted for charity or profit that is advertised, announced or maintained for the express or implied purpose of providing four 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 in 105 CMR 150.000, shall mean a long-term care facility or unit thereof and units within acute hospitals converted under provisions of St. 1988 c. 23, § 32.

Medical Care shall mean services provided by a physician or other primary care provider 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.

Medical Director shall mean a physician who advises on the conduct of medical and medically related services in a facility. In a SNCFC, the Medical Director shall be a pediatrician.

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

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

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.

Nurse Aide shall mean an individual who has successfully completed a nurses' aide training course.

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

Nurse Practitioner shall mean a nurse who is authorized to practice advanced practice registered nursing as a nurse practitioner by the Board of Registration in Nursing.

Occupational Therapist shall mean an individual licensed as an occupational therapist by the Board of Registration of Allied Health Professionals.

Occupational Therapist Assistant shall mean an individual licensed as an occupational therapy assistant by the Board of Registration of Allied Health Professionals.

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 licensed by the Board of Registration in Pharmacy.

Physician shall mean a doctor of medicine or doctor of osteopathy who is registered by the Board of Registration in Medicine to practice medicine in Massachusetts .

Pediatrician shall mean a physician who is board-certified by the American Board of Pediatrics.

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Physician Assistant shall mean a person who is licensed by the Board of Registration of Physician Assistants.

Physical Therapist shall mean an individual who is currently licensed as a physical therapist by the Board of Registration of Allied Health Professionals.

Physical Therapist Assistant shall mean an individual licensed as a physical therapist assistant by the Board of Registration of Allied Health Professionals.

Primary Care Provider shall mean the physician, physician assistant or nurse practitioner responsible for the resident's continuing medical care and periodic reevaluation.

Provisional License shall mean a license issued for not more than 180 days to a facility found on inspection to be in substantial compliance and has demonstrated improvement and evidences potential for achieving full compliance within said period.

Psychiatric Nurse shall mean a registered nurse who is authorized to practice advanced practice registered nursing as a psychiatric clinical nurse specialist by the Board of Registration in Nursing.

Registered Nurse shall mean a nurse who is currently licensed by the Board of Registration in Nursing to practice as a registered nurse in Massachusetts.

Rehabilitation 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 resident to maximum functional level. Only Medicare certified facilities may provided outpatient rehabilitation services. In addition, facilities must obtain written approval from the Department before outpatient rehabilitation services may be provided.

Rehabilitation 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.

Resident shall mean any individual receiving care in a facility or the resident's health care proxy, if the resident has an activated health care proxy.

Responsible Person shall mean an individual 21 years of age or older, who has received a high school diploma, is of good moral character and with ability to make mature and accurate judgments. The responsible person shall also have the ability to communicate orally and in writing in English and the primary language used by residents of a facility.

Single Level Facility shall mean a facility providing 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 resident at the time of admission, during treatment and care in the facility and at the time of discharge.

Social Worker means an individual who is currently licensed to practice social work in Massachusetts pursuant to M.G.L. c. 112, § 131 under the licensure categories of Licensed Independent Practitioner of Clinical Social Work (LICSW), or Licensed Certified Social Worker (LCSW) or Licensed Social Worker (LSW).

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 is licensed by the Board of Registration for Speech-language Pathology and Audiology.

150.001: continued

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.

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 resident care provided in a facility or group of related facilities. No committee member shall have a proprietary interest in the facility.

150.002: Administration

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

(B) Administration.

- (1) Facilities providing Level I care, Level II care in more than one unit, or Level III or IV care in more than two units shall employ a full-time administrator.
- (2) Facilities providing Level II care with only a single unit, and facilities providing Level III or IV care with less than two units shall employ 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 full-time 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 providing Level I, II or III care, the administrator shall be a nursing home administrator licensed by the Board of Registration of Nursing Home Administrators.
- (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 or her alternate shall be posted and available to the individual in charge at all times.

(C) The administrator of the facility shall be responsible to the licensee and shall operate the facility to ensure services required by 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 resident care.

- (1) At all times, each facility shall provide a sufficient number of trained, experienced and competent personnel to provide appropriate care and supervision for all residents and to ensure their personal needs are met. Accurate time records shall be kept on all personnel.
- (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.

150.002: continued

- (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 any other name previously used).
 - (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) 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 residents or other employees.
- (8) Requirement for Personnel to Be Vaccinated against Influenza Virus.
- (a) Definitions.
 1. For purposes of 105 CMR 150.002(D)(8), personnel means an individual or individuals who either work at or come to the licensed facility site and who are 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, whether or not such individual(s) provide direct 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).
 3. For purposes of 105 CMR 150.002(D)(8), mitigation measures mean measures that personnel who are exempt from vaccination must take to prevent viral infection and transmission.
 - (b) Each facility shall ensure all personnel are vaccinated annually with seasonal influenza vaccine, consistent with any guidelines of the Commissioner, unless an individual is exempt from vaccination in accordance with 105 CMR 150.002(D)(8)(f).
 - (c) Each facility also shall ensure all personnel are vaccinated against other pandemic or novel influenza virus(es) as specified in guidelines of the Commissioner, unless an individual is exempt from vaccination in accordance with 105 CMR 150.002(D)(8)(f). Such guidelines may specify:
 1. The categories of personnel to be vaccinated and the order of priority of vaccination of personnel, with priority for personnel with responsibility for direct 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 is exempt from vaccination in accordance with 105 CMR 150.002(D)(8)(f).

150.002: continued

(f) Exemptions.

1. Subject to the provisions set forth in 105 CMR 150.002(D)(8)(f)(2), a facility shall not require an individual to receive an influenza vaccine pursuant to 105 CMR 150.000(D)(8)(b) or (c) if the individual declines the vaccine.
2. For any individual subject to the exemption, a facility shall require such individual take mitigation measures, consistent with guidance from the Department.
3. An individual who is exempt from vaccination shall sign a statement certifying that they are exempt from vaccination and they 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 the vaccine is unavailable for purchase, shipment, distribution, or administration by a third-party or when complying with an order of the Commissioner restricting 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 exemption 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.

(j) 105 CMR 150.002(D) establishes requirements for influenza vaccination of long-term care facility personnel. Nothing in 105 CMR 150.000 shall be read to prohibit facilities from establishing policies and procedures for influenza vaccination of personnel that exceed the requirements set forth in 105 CMR 150.002(D).

(9) A facility may not hire any individual, whom the facility knows or should have reason to know, who cannot perform the duties of his or her job or whose employment could pose a threat to the health, safety or welfare of the residents.

(10) The Department shall be notified as specified in the guidelines of the department of the resignation or dismissal of the administrator, the director of nurses and the name and qualifications of the new employee. In the case of dismissal, notice to the Department shall state the reasons.

(11) Requirement for Personnel to Be Vaccinated against Coronavirus Disease 2019 (COVID-19) Caused by the Virus SARS-CoV-2.(a) Definitions.

1. For purposes of 105 CMR 150.002(D)(11), personnel means an individual or individuals who either work at or come to the licensed facility site and who are 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, whether or not such individual(s) provide direct care.
2. For purposes of 105 CMR 150.002(D)(11), COVID-19 vaccination means being up to date with COVID-19 vaccines as recommended by the Centers for Disease Control and Prevention (CDC).
3. For purposes of 105 CMR 150.002(D)(11), mitigation measures mean measures that personnel who are exempt from vaccination must take to prevent viral infection and transmission.

(b) Each facility shall ensure all personnel have received COVID-19 vaccination in the timeframe specified in Department guidelines, unless an individual is exempt from vaccination in accordance with 105 CMR 150.002(D)(11)(e).

(c) Each facility shall provide all personnel with information about the risks and benefits of COVID-19 vaccination.

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(d) Each facility shall notify all personnel of the COVID-19 vaccination requirements of 105 CMR 150.002(D)(11) and shall, at no cost to any personnel, provide or arrange for vaccination of all personnel who cannot provide proof of current vaccination against COVID-19 unless an individual is exempt from vaccination in accordance with 105 CMR 150.002(D)(11)(e).

(e) Exemptions.

1. Subject to the provisions set forth in 105 CMR 150.002(D)(11)(e)(2), a facility shall not require an individual to receive a COVID-19 vaccine pursuant to 105 CMR 150.002(D)(11)(b) if the individual declines the vaccine.

2. For any individual subject to the exemption, a facility shall require such individual take mitigation measures, consistent with guidance from the Department.

3. An individual who is exempt from vaccination shall sign a statement certifying that they are exempt from vaccination and they received information about the risks and benefits of COVID-19 vaccine.

(f) Unavailability of Vaccine. A facility shall not be required to provide or arrange for COVID-19 vaccination during such times the vaccine is unavailable for purchase, shipment, distribution, or administration by a third-party or when complying with an order of the Commissioner restricting the use of the vaccine. A facility shall obtain and administer COVID-19 vaccine in accordance with 105 CMR 150.002(D)(11) as soon as vaccine becomes available.

(g) Documentation.

1. A facility shall require and maintain for each individual proof of current vaccination against COVID-19 virus pursuant to 105 CMR 150.002(D)(11)(b) or the individual's exemption statement pursuant to 105 CMR 150.002(D)(11)(e).

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 COVID-19 vaccination for any individual, it shall document the reasons such vaccination could not be provided or arranged for.

(h) 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)(11) in accordance with reporting and data collection guidelines of the Commissioner.

(i) 105 CMR 150.002(D) establishes requirements for COVID-19 vaccination of long-term care facility personnel. Nothing in 105 CMR 150.000 shall be read to prohibit facilities from establishing policies and procedures for COVID-19 vaccination of personnel that exceed the requirements set forth in 105 CMR 150.002(D).

(E) The administrator shall establish procedures for notifying the resident or the resident's legal representative in the event of significant change in a 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 residents except, when necessary for the protection of valuables and to avoid unreasonable responsibility, the administrator may require such valuables be excluded or removed from the premises.

(2) If the facility assumes the responsibility for safekeeping of residents' possessions and valuables, an accurate, written record of all valuables and possessions shall be maintained. A receipt for all items placed in safekeeping shall be provided to the resident or resident's guardian.

(3) If the facility assumes the responsibility for managing a resident's funds, such funds shall be placed in an insured interest bearing account with the clear written understanding 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) Interest earned by any such funds so deposited shall be credited to each resident.

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

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

NON-TEXT PAGE

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- (d) The facility may keep a portion of a 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 and must be administered in accordance with the Department of Transitional Assistance. 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 resident shall be kept.
- (e) No fee or other charges shall be applied to any individual resident for such managing of funds or distribution of interest.
- (f) The facility shall provide the resident or the resident's guardian with an accounting report every three months of financial transactions made in his or her behalf.
- (g) In the event of discharge of a resident, except if the resident's bed is being held for anticipated readmission, all funds of that resident shall be returned to the resident or to the resident's guardian with a written accounting in exchange for a signed receipt. Funds maintained outside of the facility shall be returned within ten business days.
- (h) In the event of the death of a resident, the facility shall provide a complete accounting of that resident's funds to the administrator or executor of the resident's estate.
- (4) 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 resident or the resident's guardian and by a witness. A copy of the list shall be given to the resident, or the resident's guardian.
- (5) The admission of a resident to a long-term care facility and his or her 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 resident without written, signed permission to do so by the resident or the resident's guardian.
- (6) The name, address and the phone number of the resident's emergency contact shall be kept readily available in the resident's chart. The designated individual shall be contacted immediately in an emergency involving the resident. Such notification shall be recorded in writing in the clinical record.
- (F) The administrator shall establish procedures for the notification of the primary care provider and the resident's emergency contact in the event of an emergency.
- (G) The administrator shall be responsible for ensuring 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 events occurring 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 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, as defined in 105 CMR 155.000: *Patient and Resident Abuse Prevention, Reporting, Investigation, Penalties and Registry*.
 - (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 causes serious physical injury to a resident(s).

150.002: continued

(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) The administrator of a nursing facility shall ensure the facility has an automated external defibrillator and 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; and

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

(2) The facility shall contract with or employ a physician who shall be the automated external defibrillation medical director for the facility who shall oversee and coordinate the following:

(a) maintenance and testing of equipment in accordance with manufacturer's guidelines;

(b) certification and training of facility personnel;

(c) periodic performance review of the facility automated external defibrillation activity;

(d) development of policies and procedures consistent with current medical practice regarding the use of automated external defibrillators.

(J) Upon change of ownership, the medications, funds and personal belongings of all 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 of 1970 shall be made, recorded and signed by the licensee and the new owner.

(K) The facility shall provide Resident survey reports, annual reports and such other reports and information as may be required 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 residents shall be in accordance with written policies and procedures developed by each facility and acceptable to the Department. Any restrictions, priorities or special admission criteria shall be applied equally to all potential admissions. All facilities shall comply with state and federal anti-discrimination laws and regulations.

(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, behavioral, 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 primary care provider and the receiving facility.

(1) Residents shall be admitted only on the written order of the primary care provider, who designates the placement as medically and socially appropriate.

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(2) No facility shall admit a resident without written consent of the individual or his or her guardian except in emergencies.

(a) No SNCFC shall admit a 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 guardian (if he or she is not) except in emergencies.

(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 providing health care in their area.

(C) Transfer of Information.

(1) Prior to or at the time of admission, a health care referral form approved by the Department shall be completed for each resident. 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 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) Level IV facilities designated Community Support Facilities or admitting Community Support Residents shall meet the following requirements.

(1) When a resident who has been determined, following his or 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:

(a) Seven days per week, 24 hours per day psychiatric consultation services.

(b) 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.

(c) 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.

(d) Crisis Intervention. When the Administrator of the facility and the social worker agree 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.

(e) On-site 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:

1. If phone consultation is not adequate, on-site evaluation should be provided to the rest home.

2. 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, the referring agency agrees to remove the client from the home, if the Administrator/Responsible Person requests this, while an evaluation is performed.

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

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

5. 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.

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

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(2) All of the services in 105 CMR 150.003(D)(1) 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.

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

(b) 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 electroconvulsive therapy on-site. Mental health residents in need of such therapies shall be admitted or transferred to appropriate inpatient acute or mental health facilities.

(4) Long-term care facilities may not use aversive interventions.

(5) Individuals whose primary diagnosis is substance use disorder shall not be admitted to a facility for purposes of detoxification and shall be treated in an appropriate outpatient, acute care or rehabilitation facility for detoxification prior to admission to a long-term care facility.

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

(1) Residents 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 the child'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 the child'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 Developmental Disability/Other Related Conditions (DD/ORC). No facility certified to participate in the Medicare or Medicaid programs shall admit a resident with DD/ORC with an anticipated length of stay of 30 days or longer unless the facility has verified 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 providing for the reasonable assurance of transfer and inpatient hospital care for residents whenever such transfer is medically necessary. The agreement shall provide for the transfer of acutely ill residents to the hospital ensuring timely admission and provisions for continuity in the care and the transfer of pertinent medical and other information.

(2) Facilities providing 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 resident requiring services not regularly provided to the resident by the facility, arrangements shall be made by the primary care provider and the facility to transfer the resident to a facility providing more appropriate care.

(4) If in the opinion of a facility a resident poses a danger to himself or herself or the health and welfare of other residents or staff, the facility shall arrange for transfer to a facility providing appropriate care.

150.003: continued

- (5) Except in an emergency, the facility shall give at least 24 hours' notice of anticipated or impending transfer to the receiving institution and shall assist in making arrangements for safe transportation.
- (6) No resident shall be transferred or discharged without the primary care provider's order and notification to the resident or the resident's guardian and the resident's emergency contact, except in the case of an emergency. The reason for transfer or discharge shall be noted on the resident's clinical record.
- (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 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 or the written consent of the resident's guardian, solely for the reason 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 occurring on a planned basis and 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 physician's and/or psychiatrist's order that sets out the justification for the resident's transfer or discharge;
 2. the notice given to the resident or the resident's guardian 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 the resident has the right to object to the facility to his or her transfer or discharge. The reasons for such objections shall be noted in the resident's record.
 3. the site to which the resident is to be discharged or transferred;
 4. all reasonable efforts have been taken by the facility to provide counseling to the resident in order to prepare him or her in adjusting to any transfer or discharge;
 5. all reasonable precautions have been taken to eliminate or reduce any harmful effects that may result from the transfer or discharge;
 6. the resident's consent was voluntary.
 - (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 that sets out the justification for the resident's emergency transfer or discharge;
 3. the name of the resident's emergency contact, and that such notification has been made within 24 hours of such transfer or discharge;
- (8) A health care referral form approved by the Department and other relevant information shall be sent to the receiving institution.
- (9) Death of resident.
- (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. Death shall be pronounced within a reasonable time. The deceased resident shall not be discharged from a facility until pronounced dead.
 - (c) Provisions shall be made so deceased residents are removed from rooms with other residents as soon as possible.
 - (d) The deceased resident shall be covered, transported and removed from the facility in a dignified manner.
- (10) All facilities shall comply with 940 CMR 4.09: *Discharge and Transfers*. In addition, all Level I, II and III facilities, as applicable, shall comply with nursing home transfer and discharge regulations, 130 CMR 610.028 through 610.030, MassHealth Fair Hearing Rules, and federal regulations, 42 CFR 483.15.

150.004: Resident Care Policies

(A) All facilities providing Level I, II or III care shall have current, written policies governing the services provided in the facility. All facilities shall develop policies for the following services:

- (1) Emergency Needs of Residents.
 - (a) Admission, transfer and discharge procedures;
 - (b) Primary care provider services;
 - (c) Pharmaceutical services and medications;
 - (d) Dietary services;
 - (e) Rehabilitation services;
 - (f) Social services;
 - (g) Resident activities and recreation;
 - (h) Emergency and disaster plans;
 - (i) Personal comfort, safety, and accommodations;
 - (j) Clinical Records.
- (2) Facilities providing Level I, II or III care shall also develop policies for the following services:
 - (a) Diagnostic services;
 - (b) Nursing services;
 - (c) Carry over services (in a certified facility);
 - (d) Utilization Review.
- (3) Skilled Nursing Care Facilities for Children shall also develop policies for the following services:
 - (a) Education Services;
 - (b) Therapeutic Recreation Services;
 - (c) Individual Service Planning;
 - (d) Behavior Modification Services;
 - (e) Respite Services;
 - (f) Permanency Planning Services.

(B) The administrator shall be responsible for the development of resident care policies with 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 advising the facility in the development and review of all resident care policies. In addition, such committee may participate in an advisory capacity on human rights and programmatic activities relative to resident care.
- (2) The Patient Care Advisory Committee shall be comprised of the following members:
 - (a) The Medical Director 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;
 - (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.

(C) The facility shall review and revise resident care policies at least annually.

(D) In facilities providing Level I, II or III care, each resident shall have a care plan that shall include 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 care plan shall be coordinated by the nursing staff and shall be reviewed in consultation with the resident or resident's guardian, and all relevant disciplines.

- (1) In a SNCFC, the resident's care plan shall include any Individual Education Plan (IEP).

150.004: continued

(2) In Medicare or Medicaid certified facilities providing Level I, II or III care, each resident with DD/ORC shall have a resident care plan which shall include 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 Developmental Services (DDS), 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 DDS service coordinator or a case manager designated by DDS 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 DDS service coordinators or case managers designated by DDS 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.

150.005: Physician Services

(A) Facilities providing Level I, II or III care shall establish a medical director who shall be responsible for the implementation of resident care policies and the coordination of medical care in the facility.

(1) Supervisory and advisory functions shall include: advice on the development of medical and resident care policies concerning resident admissions and discharge, medical records, responsibilities of primary care providers, supportive and preventive services, emergency medical care, and the review of the facility's overall program of resident care.

(2) Staff physicians or the medical director 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 who shall participate in the development of resident care policies, familiarize himself or herself with the condition, needs and care of each resident, 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.

(B) Every resident shall have a primary care provider who is responsible for his or her continuing medical care and periodic reevaluation.

(1) Each resident or resident's guardian shall on admission designate a primary care provider. If the resident does not have a primary care provider, the facility shall designate a primary care provider with the approval of the resident or the resident's guardian.

(2) The addresses and telephone numbers of the resident's primary care provider shall be recorded in the resident's record and be readily available to personnel on duty in case of emergencies.

(C) All facilities shall have written arrangements for emergency physician services when the resident's own primary care provider is not immediately available.

(1) A list of the names and telephone numbers of emergency physicians.

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

(3) Facilities shall establish and follow procedures covering immediate care of the resident, 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 or her findings, treatment, and recommendations shall be recorded in the resident's clinical record. The facility shall notify the resident's primary care provider and record such notification in the clinical record.

150.005: continued

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

(E) Every resident shall have a complete admission physical exam and medical evaluation. Based on this information, the resident's primary care provider shall develop a medical care plan that shall include such information as the following:

(1) Primary Diagnosis.

(a) Other Diagnoses or Associated Conditions.

1. Pertinent findings of physical exam (including vital signs and weight, if ambulatory);
2. Weight shall be included for non-ambulatory patients in a SNCFC;
3. Significant past history;
4. Significant special conditions, disabilities or limitations;
5. Prognosis;
6. Assessment of physical capability (ambulation, feeding assistance bowel and bladder control);
7. Assessment of mental capacity.

(b) Treatment Plan Including.

Medications;
 Special treatments or procedures;
 Rehabilitation 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;
 Documented advance directives, if available.

The care plan for residents in a SNCFC 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 resident'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 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 care plan is completed within the specified time limits prior to admission by the provider who will continue as the the resident's primary care provider, a repeat examination and evaluation following admission to the facility is not required.

(F) Each resident shall be re-examined and re-evaluated, and his or her care plan reviewed and revised, if indicated, by the primary care provider to ensure appropriate medical services and resident 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 primary care provider it is deemed unnecessary to see the resident with such frequency, an alternate schedule not to exceed 60 days between visits may be adopted providing the justification is documented in the resident's medical record.
- (2) Level III, Every 60 Days. If after 90 days following admission in the opinion of the primary care provider it is deemed unnecessary to see the resident with such frequency, an alternate schedule not to exceed 90 days between visits may be adopted providing the justification is documented in the resident's medical record.
- (3) Level IV, every six months unless the primary care provider documents fewer visits are necessary.

150.006: Other Professional Services and Diagnostic Services

(A) Each resident or resident's guardian shall have the right to designate other licensed practitioners of his or her choice.

(B) Dental.

(1) All 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 primary care provider and consent of the resident or the resident's guardian.

(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 or herself with the dental condition, needs and care of each resident, 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 residents every six months and develop dental disease prevention programs within the facility. A SNCFC shall ensure each resident has a complete dental examination annually.

(C) Podiatric.

(1) All 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 primary care provider.

(3) All podiatric services shall be documented and recorded in the clinical record.

(D) 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) Residents shall be assisted to prepare for and meet appointments punctually at outpatient departments, clinics and primary care provider offices as 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 by the resident's primary care provider or the facility's staff physician.

(2) All findings and reports shall be recorded in the resident's clinical record.

(3) On-site clinical laboratory testing is limited to Clinical Laboratory Improvement Amendments (CLIA) waived tests. The facility must hold an active CLIA certificate of waiver.

(4) Facilities shall not use or store X-ray equipment.

150.007: Nursing Services

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

(1) Facilities providing 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 providing Level I, II or III care shall be in accordance with written policies and procedures.

(3) 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.

(4) Facilities providing 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.

150.007: continued

(B) Minimum Nursing Personnel Requirement.(1) General.

(a) Nursing personnel shall not serve 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 resident shall be exclusive of non-nursing duties.

(e) The minimum staffing patterns and nursing care hours as contained in 105 CMR 150.007(B) shall mean minimum, basic requirements.

(f) The supervisor of nurses and the nurse as required by 150.007(C)(3), but not the director of nurses, may be counted in the calculation of licensed nursing personnel.

(2) Facilities providing 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 per week for facilities with more than one unit. In facilities with a single unit, the director of nurses may function as supervisor.

(c) A nurse as required by 105 CMR 150.007(C)(3), 24 hours per day, seven days per week for each unit.

(d) Sufficient nursing personnel to meet resident nursing care needs, based on acuity, resident assessments, care plans, census and other relevant factors as determined by the facility. On and after April 1, 2021, sufficient staffing must include a minimum number of hours of care per resident per day of 3.580 hours, of which at least 0.508 hours must be care provided to each resident by a registered nurse. The facility must provide adequate nursing care to meet the needs of each resident, which may necessitate staffing that exceeds the minimum required PPD.

(3) Facilities providing 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 per 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 as required by 105 CMR 150.007(C)(3), 24 hours per day, seven days per week for each unit.

(d) Sufficient nursing personnel to meet resident nursing care needs based on acuity, resident assessments, care plans, census and other relevant factors as determined by the facility. On and after April 1, 2021, sufficient staffing must include a minimum number of hours of care per resident per day (PPD) of 3.580 hours, of which at least 0.508 hours must be care provided to each resident by a registered nurse. The facility must provide adequate nursing care to meet the needs of each resident, which may necessitate staffing that exceeds the minimum required PPD.

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

(4) Facilities providing Level III care shall provide:

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

(b) A nurse as required by 105 CMR 150.007(C)(3) during the day and evening shifts, seven days per week, for each unit.

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

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- (d) Sufficient nursing personnel to meet resident nursing care needs based on acuity, resident assessments, care plans, census and other relevant factors as determined by the facility. On and after April 1, 2021, sufficient staffing must include a minimum number of hours of care per resident per day (PPD) of 3.580 hours, of which 0.508 hours must be care provided to each resident by a registered nurse. The facility must provide adequate nursing care to meet the needs of each resident, which may necessitate staffing that exceeds the minimum required PPD.
 - (e) The facility shall provide additional nursing services, sufficient to meet the needs, in the event a resident has a minor illness and is not transferred to a higher level facility or unit.
- (5) Facilities providing 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 per unit.

NON-TEXT PAGE

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(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 resident care and nursing care practices.

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.

(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 the capacity of a nurse as required by 105 CMR 150.007(C)(3). 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 resident care, the application and evaluation of resident 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) One registered nurse or one licensed practical nurse shall be responsible for the performance of total nursing care of the residents in his or her unit during his or her shift with the assistance of ancillary nursing personnel.

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

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

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

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

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

(6) At no time shall direct resident care be provided by individuals younger than 16 years old, 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. In facilities providing Level I, II or III care, the resident's care plan shall include a comprehensive, nursing care plan for each resident developed by the nursing staff in relation to the resident's total health needs.

(1) The nursing care plan shall be an organized, written daily plan of care for each resident. 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 resident teaching programs, encouragement of resident'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 readily available for use by all personnel involved in resident care.

In a SNCFC, the nursing care plan shall also include consideration of the resident's physical and mental status with respect to his need for recreational and educational stimulation and growth; consideration of the resident's familial situation, and of his or her behavior with other residents, staff, family and visitors.

150.007: continued

- (2) The nursing care plan shall be initiated on admission and shall be based on the primary care provider's medical care plan and the nursing assessment of the resident's needs.
- (3) The plan shall be the responsibility of the director or supervisor of nurses and shall be developed in conjunction with the nursing staff, resident or resident's guardian and representatives of other health disciplines where appropriate.
- (4) All personnel who provide care to a resident shall have a thorough knowledge of the resident's condition and the nursing care plan.
- (5) The plan shall specify priorities of nursing need, which shall be determined through communication with the resident or resident's guardian, the resident's primary care provider, and other staff.
- (6) The plan shall reflect the resident's psycho-social needs and ethnic, religious, social, cultural or other preferences.
- (7) Nursing care plans shall be reviewed, revised and kept current so resident care constantly meets resident needs. Plans shall show written evidence of review and revision at least every 30 days in facilities providing 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 resident's total health care.
- (8) For residents in certified facilities with DD/ORC nursing care plans shall include the carry-over services that integrate all relevant specialized services contained in the resident's DDS Rolland Integrated Services Plan and Specialized Services Provider plan. The plan shall be developed in conjunction with the resident, and/or guardian, representatives of DDS or a case manager designated by DDS and the specialized service providers, reviewed not less frequently than every three months, annually and at the time of significant change.
- (9) Relevant information from the nursing care plan shall be included with other health information when a resident is transferred or discharged.

(E) Restorative Nursing Care.

- (1) All facilities providing 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 resident to achieve or maintain the highest possible degree of function, self-care and independence.
- (2) Nursing personnel shall provide restorative nursing care in their daily care of residents.
- (3) Restorative nursing care 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 residents.
 - (b) Encouraging and assisting bedfast residents 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 residents to keep active and out of bed for reasonable periods of time except when contraindicated the primary care provider's orders or the resident's condition.
 - (e) Maintaining a bowel and bladder training program.
 - (f) Assisting residents to adjust to any disabilities and to redirect their interests if necessary.
 - (g) Assisting residents to carry out prescribed physical therapy, occupational therapy and speech, hearing and language therapy exercises between visits by the therapist.
 - (h) Assisting residents 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).
 - (j) Coordinating restorative nursing care with rehabilitation services, activity programs and other resident care services.

(F) Dietary Supervision.

- (1) Nursing personnel shall have knowledge of the dietary needs, food and fluid intake and special dietary restrictions of residents and shall see residents are served diets as prescribed. Residents' 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.

150.007: continued

(2) Residents 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 each resident:
 - (a) Receives treatments, medications, diet and other services as prescribed and planned in his or her medical, nursing, restorative nursing, dietary, social and other care plans. In certified facilities this shall include carry over services for residents with 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 resident except on written or oral order of a primary care provider.
- (3) Nursing personnel and responsible persons shall constantly be alert to the condition and health needs of residents and shall promptly report to the nurse or person in charge a resident's condition or symptomatology such as dehydration, fever, drug reaction or unresponsiveness.
- (4) Nursing personnel and responsible persons shall assist 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 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, a bath or shower daily.
 - (b) Bed linen changed as required, but at least weekly.
 - (c) Procedures to keep incontinent resident clean and dry.
 - (d) Frequent observation of bedfast resident for skin lesions and special care for all pressure areas.
 - (e) Daily ambulation or such movement as condition permits (as ordered by the primary care provider).
 - (f) A range of recreational activities.
 - (g) Provision for daily shaving of men, based on resident preference.
 - (h) Provision for haircuts for men at least monthly, based on resident preference.
 - (i) Hair shampoos at least once every two weeks. In a SNCFC, 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 properly mended, appropriate for the time of day and season, whether indoors or outdoors. No clothing of highly flammable fabrics shall be permitted.
 - (m) Appropriate staff for walks and other such activities, when necessary, to safeguard ambulatory residents.

(H) Nursing Review and Notes. Each resident's condition shall be reviewed to note change in condition, nursing or other services provided and the resident's response or progress.

- (1) In facilities providing Level II care each resident 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 resident's record unless the resident'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 primary care provider 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, unless the resident's condition warrants more frequent notations.

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(I) Educational Programs. Facilities providing Level I, II or III care shall provide a continuing in-service 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 admitting residents with DD/ORC shall include, as part of the new personnel job orientation and continuing in-service 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 primary care provider, 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. Residents or their guardian 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 150.008.

(3) No drug or medication 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.

(B) There shall be a current written order by an authorized prescriber for all medication or drugs administered to 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), immediately recorded in writing and signed by the same nurse or responsible person. All verbal or telephone orders shall be countersigned by an authorized prescriber within 30 days.

(2) A licensed nurse and the primary care provider together shall review each resident's medications at least every 30 days in a Level I or II facility; every 90 days in a Level III facility; and every six months in a Level IV facility. Any concerns regarding medication side effects or needs for adjustment shall be discussed by the prescribing primary care provider and the facility nurse to develop and implement an appropriate adjustment in the resident's plan of care.

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 an appropriate adjustment in the Mental Health Treatment Plan may be made.

(3) Orders for medications and treatments shall be in effect for the specific number of days indicated by the prescribing primary care provider.

(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 prescribing primary care provider.

(c) Medications not specifically limited to time or number of doses by the prescribing primary care provider 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 facility shall contact the prescribing primary care provider for renewal of orders or other instructions.

(4) Medication may be released to residents or their guardian on discharge. If the medication is abandoned by the resident or guardian, the facility shall dispose of the medication in accordance with Department guidelines.

(C) Supervision and Administration of Medication.

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

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(2) In a Level IV facility or unit and a CSF, medications as specified in guidelines of the Department, 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.

(3) A facility shall not permit self-administration by any resident, where this practice would endanger the resident, another resident or other residents.

(a) All medication 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 primary care provider 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 resident shall not be administered to any other resident.

(6) Medication errors and drug reactions shall be reported to the resident's primary care provider and recorded in the clinical record.

(7) A current medication reference book or electronic access to reference information 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 sufficient size to permit storage without crowding within the nurses' or attendants' station for the proper storage of all 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) 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 of 1970.

(3) 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.

(4) 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.

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

(6) 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).

(7) The label affixed to each individual medication container shall clearly indicate the resident's full name, primary care provider'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.

(8) 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.

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

(10) 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.

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

(12) An automated dispensing machine is permitted, provided its design and capabilities comply with all provisions of 105 CMR 150.008(D) for labeling, storage and supervision.

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- (E) An emergency medication kit shall be provided in all facilities.
- (1) The contents of the kit shall be approved by the Department. In a SNCFC, 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. Drugs requiring refrigeration shall be kept in a separate sealed container under proper refrigeration .
 - (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 primary care provider.
 - (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 approved as stock items or medicine chest items by the Department.
- (G) Records.
- (1) When drugs are transferred with a resident, an accurate record shall be made at the time of discharge including the following: date, name and new address of resident; name of drug, strength, quantity, pharmacy and prescriber's name.
 - (2) An individual narcotic and sedative record shall be maintained for each narcotic, sedative, amphetamine, barbiturate prescribed for each resident. This record shall include:
 - (a) Resident's name.
 - (b) Name of prescriber.
 - (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 of 1970 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.
 - (4) All facilities shall have a method to document and track medication readily accessible upon inspection.

150.009: Dietary Service

- (A) All facilities shall provide adequate dietary services to meet the daily dietary needs of 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 dietitian 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 residents with a nutritionally adequate diet designed to help them reach their proper physical developmental level and their full feeding potential. The care plan 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 residents.
- (1) A full or part-time dietitian shall be employed to direct and supervise the dietary services or there shall be a written agreement with a dietitian on a consultant basis to provide these services.

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- (a) Facilities providing Level I or II care shall provide a dietitian 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 dietitian 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. Facilities providing Level III care shall provide a dietitian for a minimum of two hours per week for each unit.
- (b) Facilities providing Level IV care shall have an arrangement for the provision of dietary services as needed.
- (c) 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.
- (d) A written record shall be kept on file in the facility of dates, time, services rendered and recommendations made by the consultant.
- (2) Facilities providing Level I, II or III care shall provide a fulltime food service supervisor. He or she may be the cook or the chef, but he or she shall spend a portion of his or her time in management functions. Facilities providing 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 or her 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 providing 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 with residents in need of special or therapeutic diets shall provide for such diets to be planned, prepared and served as prescribed by the primary care provider.
- (2) All therapeutic diets shall be planned, prepared and served with consultation from a dietitian.
- (3) All therapeutic diets shall be precise as to the specific dietary requirements or limitations.
- (4) A current diet manual shall be readily available to residents' primary care providers, 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.

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(6) The dietitian 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 resident) and shall make appropriate recommendations to the residents' primary care providers and 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 dietitian and kept on file for at least 30 days.

(8) Residents to whom therapeutic diets are served shall be identified in the dietary records.

(D) Adequacy of Diets. All diets shall conform to the resident's primary care provider's orders and, shall meet the dietary needs of the resident.

(a) The dietitian, in consultation with the consulting pediatrician and nursing service, shall determine the diet and feeding plan for each resident in a SNCFC for whom a therapeutic diet is not ordered.

(b) When a resident has been receiving infant formula prior to admission to a SNCFC, the resident shall be fed the same type of formula until his or her feeding program is planned and any changes in formula or diet ordered.

(E) Quality of Food.

(1) At least three meals that are nutritious and suited to special needs of 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 resident.

(4) Only pasteurized fluid milk and fluid milk products shall be used or served; dry milk products may be used for cooking purposes only.

(5) 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.

(6) Cracked or dirty eggs shall not be used. Egg nog shall be pasteurized. Eggs shall be refrigerated at all times.

(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 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 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 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.

150.009: continued

(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 residents.

(7) Food shall be served in a home-like, pleasant, clean, relaxing and quiet atmosphere.

(8) Individual tray service shall be provided for residents who are unable to leave their rooms or who do not wish to eat in the dining room.

In a SNCFC, resident 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 visible resident identifier on each tray.

(h) Trays shall rest on firm supports such as overbed tables for bedfast residents or sturdy tables or tray stands of proper height for residents able to be out of bed. T.V. tray stands are not permitted.

(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 residents at all meals, between-meal snacks and bedtime nourishment.

(14) In a SNCFC, resident 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 resident's abilities, feeding plan, age and preferences. No resident who is unable to do so, shall be required to feed himself.

(15) Procedures shall be developed by the SNCFC staff, including rehabilitation services staff, for development and use of special methods of feeding residents 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.

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- (2) On a temporary basis: for an individual with an infectious illness, or when kitchen areas are being remodeled, providing 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 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.
- (6) 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 used for no other purpose, or in a place 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 residents 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.

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- (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 a special formula cannot be purchased in a prepared formula, 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: Rehabilitation Services: Physical Therapy, Occupational Therapy, Speech, Hearing and Language Therapy (and Therapeutic Recreation in a SNCFC)

- (A) Facilities providing Levels I, II or III care shall establish written policies and procedures governing the delivery of rehabilitation services.
 - (1) Facilities providing Level I care, shall have an organized, continuous, rehabilitation services program.
 - (2) Facilities providing Level II care shall provide meaningful availability of rehabilitation services beyond restorative and maintenance nursing care.
 - (3) Facilities providing Level III or IV care should make arrangements for rehabilitation services when needed by residents.
 - (4) A SNCFC shall have an organized continuous, restorative nursing care program including recreation/rehabilitation therapy.
- (B)(1) Direct rehabilitation services shall be provided to residents only upon written order of the resident's primary care provider who shall indicate anticipated goals and frequency of treatments. Such treatment shall be initiated within three days of the written order. In a SNCFC, direct rehabilitation services shall be provided as indicated in the resident's care plan, which has been approved and signed by the resident's primary care provider.
 - (2) The facility shall accept a patient for outpatient rehabilitation 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.
- (C) All rehabilitation services shall be provided or supervised by licensed therapists.
 - (1) Rehabilitation 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 in accordance with the facility's policies and procedures for rehabilitation services.
 - (2) Rehabilitation services provided to residents shall be integrated with the medical nursing, dietary, social, activity and other services to promote restoration of the resident to his or her maximum potential, and reviewed in conjunction with other periodic reviews of the resident's condition.
 - (a) In a SNCFC, the rehabilitation services portion of the resident's care plan shall include a schedule for expected developmental goals. These goals shall be reviewed on a quarterly basis and amended as necessary.
 - (b) In a SNCFC, the rehabilitation services staff shall participate, when appropriate, in planning for continuing care of each resident after discharge. Appropriate consultations shall be provided by rehabilitation services staff, when indicated, to family members who will be involved in care of a resident after discharge.

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(D) Staff.

(1) Facilities providing 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 providing 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 therapist assistant or physical therapy aide on duty, on each unit, during a 12 hour period that 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 that 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.

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

In a SNCFC, there shall be an ongoing program of in-service education for all rehabilitation services staff to enable them to keep pace with advanced technology in the area of rehabilitation 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 residents 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 resident needs.

(5) A facility providing rehabilitation services to outpatients shall provide an adequate number of qualified therapists and the equipment necessary to carry out its program and fulfill its objectives.

(E) 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 resident's clinical record.

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

150.011: Social Services

(A) Facilities providing Level I, II or III care shall provide for appropriate and sufficient social services to meet the social and emotional needs of 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 services meet the requirements set out herein, and 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 residents' care.

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

(E) The social work staffing of facilities shall be based on the number of 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 MSW social worker.

(1) All facilities providing care for more than 80 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 providing care for between 40 and 80 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.

(3) All facilities that provide care for fewer than 40 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 additional social workers and ancillary social service personnel under appropriate supervision to meet the emotional and social needs of the residents.

(5) Facilities providing Level IV care only shall be required to provide social service staff and social services only as indicated by residents' 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 Workers requirements.

1. 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.

2. LSWs providing clinical services must be supervised by either an LCSW 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;

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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 or his or her guardian.

(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 LCSW who has training and/or experience in developmental disabilities and one full time LSW. For every additional 20 beds there shall be provided an additional half-time LSW.

(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 residents and to promote long-range social and health planning.

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

(H) Social Service Plan. Prior to admission, or as soon as possible after admission, there shall be an evaluation of the 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 resident.

In a SNCFC a social service plan shall be part of the resident's care plan and to the extent possible, the plan shall be developed with the resident, the resident's family or guardian and shall reflect permanency planning efforts.

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

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

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

(L) 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.

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

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

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

In a SNCFC, discharge or transfer plans shall be discussed at least annually and in conjunction with care plan annual review. Formal discharge or transfer planning efforts shall be documented in the care plan. Referrals to alternative adult facilities must be indicated when a SNCFC resident turns 20 years old as well as referral to the Bureau of Transitional Planning in accordance with M.G.L. c. 688.

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(N) In a SNCFC, the social worker shall assist in the coordination of family visits to the resident and in arranging residents' visits outside the facility when appropriate and ordered by the resident's primary care provider. The social worker shall also assist in coordinating arrangements for the resident's return to home or other placement.

(O) Facilities shall maintain records of pertinent social information, action taken to meet social needs and written evidence of periodic case review on all residents. Pertinent social data and information about personal and family problems shall be made available only to the resident's primary care provider, appropriate members of the nursing staff, and other key personnel who are directly involved in the resident's care, or to recognized health or welfare agencies. There shall be appropriate policies and procedures for ensuring the confidentiality of such information.

150.012: Activities and Recreation

(A) All facilities shall provide an ongoing program of activities and recreation suited to meet the interests of and support the physical, mental and psychosocial well-being of each resident, including residents with disabilities. The program shall also be suited to meet the needs of residents for whom English is not their primary spoken language.

(1) The activities program shall provide a broad assortment of both facility-sponsored group and individual activities, as well as independent activities, that accommodate residents of various needs and backgrounds.

(2) The activities program shall utilize all possible community, social, recreational, public and voluntary resources to encourage independence and interaction in the community.

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

(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 elderly persons and person with physical, developmental and behavioral disorders; 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 resident reviews, staff meetings and in-service educational programs.

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

In a SNCFC, the resident's care plan must include:

(a) periodic surveys of the resident's interests; and

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

(D) Residents who are able shall be encouraged to pursue activities outside of the facility.

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In a SNCFC, field trips into the community shall be an integral part of each resident's programming.

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

(G) Recreation rooms, living rooms, sitting rooms, dining areas and 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 all residents regardless of their disabilities, have access to them. Recreation equipment and supplies shall be provided in a quantity and variety is sufficient to carry out the facility's activities programs.

(H) Special Activities and Services.

(1) Facilities may provide or contract for certain special personal services for residents such as hairdresser or barber services. These services shall not substitute for routine personal care services the facility is required to provide regularly for all residents. These special personal services shall be available only to 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 residents. Snack shops and gift shops shall be conveniently located and accessible to residents' living and recreational areas and shall be open only to 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 residents.

(a) Snack shops shall not be open to residents during the servicing of regular meals required for all 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 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 residents, a modest assortment of gift items and toiletries. Gift shops shall be staffed by volunteers (including residents if they so desire) and operated under the direction of the activity director.

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

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

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(4) All special services described in 105 CMR 150.012(H) shall be provided as a service to 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 an 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.

(I) 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) Each facility shall develop, through an interdisciplinary team, and adopt written policies and procedures to ensure complete and accurate clinical records are maintained for each resident and readily available as needed, including to the resident and his or her guardian and other providers as permitted by law or authorized by the resident or his or her guardian prior to submitting an application for a license. Each facility shall implement, review and revise, through an interdisciplinary team as needed, but not less than once a year, its written policies and procedures. A facility shall ensure all staff, including temporary staff and volunteers, are trained and determined to be competent as needed for their duties on such policies and procedures.

(B) All records shall be complete, accurate, current, available on the premises of the facility. In addition to the clinical record for each resident, the following records shall be maintained:

- (1) Daily census;
- (2) Resident care policies;
- (3) Incident, fire, epidemic, emergency and other report forms;
- (4) Schedules of names, telephone numbers, dates and alternates for all emergency or "on call" personnel;
- (5) A Resident Roster approved by the Department;
- (6) Orders for all medications, treatments, diets, rehabilitation services and medical procedures ordered for residents. Orders shall be dated, recorded and signed (telephone orders countersigned) by the resident's primary care provider. If electronic signatures are permitted, the facility must ensure their system is designed to ensure integrity, authenticity and non-repudiation;
- (7) A record of narcotic and sedatives;
- (8) A bound Day and Night Report Book with a stiff cover and numbered pages, or electronic record of reports with an audit trail;
- (9) Identification and summary sheets on all residents;
- (10) In a SNCFC, an Individual Service Plan (ISP) shall be developed for each resident.

(C) All facilities shall maintain a separate, complete, accurate and current clinical record in the facility for each 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. The clinical record shall include:

- (1) Identification and Summary Sheet including: resident's name, bed and room number, social security number, age, sex, race, marital status, religion, home address, and date and time of admission; names, addresses and telephone numbers of primary care provider and alternates, of referring agency or institution, and of any other practitioner attending the resident (dentist, podiatrist); name, address and telephone number of emergency contact; 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 guardian.

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- (2) A Health Care Referral Form, Hospital Summary Discharge Sheets and other such information transferred from the agency or institution to the receiving facility.
- (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 resident's condition upon admission, including vital signs on all admissions and weight (if ambulatory); and date and time the resident's primary care provider was notified of the admission. In a SNCFC, all residents including non-ambulatory residents 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 resident's primary care provider.
- (5) Primary Care Provider's Progress Notes including significant changes in the resident's condition, physical findings and recommendations recorded at each visit, and at the time of periodic reevaluation and revision of medical care plans.
- (6) Consultation Reports including consultations by all medical, psychiatric, dental or other professional personnel who are involved in resident care and services. 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; rehabilitation services and special procedures for each 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 residents.
- (9) A Nursing Care Plan for each resident.
- (10) Nurses Notes containing accurate reports of all factors pertaining to the 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, rehabilitation services, activity, and other resident care plans.
- (12) Laboratory and X-ray Reports.
- (13) A list of each resident's clothing, personal effects, valuables, funds or other property.
- (14) Discharge or Transfer Data including a dated, signed primary care provider'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 as described in 105 CMR 150.014.

(D) All clinical records of residents including those receiving outpatient rehabilitation 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.

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

150.014: Utilization Review

(A) Facilities providing Level I or II care shall review the services, quality of care and utilization of their facilities.

(B) The utilization review process or activity shall include a review of all or a sample of residents 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.

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- (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 that 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 long-term 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.
- (D) Medical Care Evaluation Reviews (Special Studies).
- (1) Reviews shall be made on a continuing basis of all or a sample of residents 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, delivery of services 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) An initial review of resident 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 providing Level I or II care and 90 days following admission for facilities providing Level III care. Subsequent reviews shall be made periodically at designated intervals reasonable and consonant with the diagnosis and overall condition of the resident.
 - (7) No physician or physician-physician assistant team or physician-nurse practitioner team shall have review responsibility for any case in which he or she was professionally involved.
 - (8) If physician or physician-assistant team or physician-nurse practitioner team members of the committee decide, after opportunity for consultation with the primary care provider, 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 resident's primary care provider and the resident or his or her guardian.
- (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 primary care provider as indicated.
- (F) The facility shall have in effect a written plan for utilization review that applies to all residents in the facility.
- (1) The plan shall be approved by the governing body.
 - (2) The development of the plan shall be a responsibility of the medical staff 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.
- (2) The administration shall act appropriately upon recommendations made by the utilization review committee.

(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 Department upon request.

150.015: Resident Comfort, Safety, Accommodations and Equipment

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

(B) Personal Care.

- (1) Every resident shall have a reasonable amount of privacy.
- (2) Residents shall be treated with dignity and kindness at all times.
- (3) Residents' personal effects shall be treated with respect and care.
- (4) 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 conditions permit.

(C) Safety and Personal Protection.

- (1) At all times a responsible staff member shall be on duty and immediately accessible, to whom residents can report injuries, symptoms of illness, emergencies, any other discomfort or complaint, and who is responsible for ensuring prompt, appropriate action is taken.
- (2) 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.
- (3) Facilities providing only Level IV care shall provide a first-aid kit in a convenient place.
- (4) A check-out system shall be maintained for residents leaving the facility. The 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.
- (5) Phones:
 - (a) There shall be at least one functioning telephone available to staff at all times 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.
 - (b) Facilities shall provide access to phone service to residents to make calls in private.
- (6) All hospital beds shall have brakes set and all wheelchairs shall be equipped with brakes.

(D) Fire Protection.

- (1) All facilities shall have an approved quarterly fire inspection by local fire department.
- (2) At least once a year, employees of the long term care facility shall be instructed by the head of the local fire department or his or her representative on their duties in case of fire and this noted in the facility's record.
- (3) Fire extinguishers shall be recharged and so labeled at least once a year.
- (4) The water pressure shall be checked weekly by the individual in charge of the facility, and the pressure recorded in the facility's records.
- (5) Emergency lights shall be checked weekly by the individual in charge of the facility, and if deficient, repaired immediately.

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- (6) All exits shall be clearly identified by exit signs, adequately lighted and free from obstruction.
- (7) Clothes dryers shall be inspected at the time of installation and annually and necessary repairs made immediately.
- (8) Draperies, upholstery and other such fabrics or decorations shall be fire resistant and flame proof.
- (9) No residents shall be permitted to have access to lighter fluid or wooden household matches.
- (10) Routine storage of oxygen tanks shall be permitted only in facilities providing 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) Carriers shall be provided when oxygen is being used or transported.
 - (c) Signs indicating oxygen is available, currently in use or stored shall be conspicuously posted.
 - (d) 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 residents, 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 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) Residents' Accommodations.

- (1) All 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 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 resident's name.
- (4) All resident areas must have adequate lighting, heating and ventilation.
 - (a) Each 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.
 - (c) Adequate heating shall be provided in all rooms used by residents in order to maintain a minimum temperature of 75°F at winter temperatures for the hours between 6:00 A.M through 10:00 P.M.; and a minimum temperature of 70°F at winter temperatures for the hours between 10:00 P.M. through 6:00 A.M.

(G) 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 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 sterilize, disinfect or dispose of equipment and supplies.

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- (4) Every resident shall be provided with the following basic equipment and supplies:
- (a) A comfortable bed. In facilities providing Level I or II care, each 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 providing 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 resident.
 - (d) An adequate supply of clean bed linen, 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 providing Level I or II care, towels and washcloths shall be changed and laundered every day; in facilities providing 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 resident needs.
 - (f) A bedside cabinet that accommodates the needs of the resident.
 - (g) All facilities shall ensure each resident has an individual mouthwash cup, a tooth brush and dentifrice, containers for the care of residents' dentures if necessary, an individual comb and brush, soap dish, bar of soap, shaving equipment, individual sputum containers (when needed), and other equipment for personal care.
 - (h) All facilities shall provide for each resident a permanently located, readily accessible, storage space equipped with a lock and key, th large enough to accommodate small personal possessions such as letters, jewelry, pictures or small amounts of money. Storage space shall be located within each resident's room. A key to secure personal storage space shall be in the possession of each resident, and the facility administrator or his designee shall hold a master key to any such locked space.

(H) Behavior Modification Programs in a SNCFC.

- (1) Time out means a procedure designed to improve a resident's behavior by removing positive reinforcement or by removing the resident physically from the environment when his or her behavior is undesirable.
- (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 time-out procedures shall be conducted only after documented failure of less severe alternatives and with the consent of the resident or his or her guardian; and shall be described in the care plan along with written plans kept on file.

150.016: Environmental Health and Housekeeping(A) 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.

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- (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.

(B) Laundry and Linen Sanitation.

(1) All facilities shall provide appropriate procedures, staff and equipment to assure sufficient clean linen supplies and the proper sanitary washing and handling of linen and the personal laundry of residents.

(2) Handling of Soiled Linen and Laundry.

(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, 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 residents or staff shall also be collected, transported, sorted, washed and dried in a sanitary manner, separate from bed linens.

(3) Handling of Clean Linen.

(a) Clean linen shall be sorted, dried, and folded in an 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 easily accessible to the nurses' station and such closets shall not be used for any other purpose.

(d) When feasible, arrangements shall be made for residents to 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.

(C) 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 resident 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 providing 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.

(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.

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- (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 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-resident 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.

(D) Pets.

- (1) Pets or other types of animals shall not be allowed in areas used for preparation, serving or storage of food; laundries or rehabilitation services units.
- (2) All pets shall be adequately fed, sheltered and maintained in a sanitary manner.
- (3) An ADA qualified service animal is permitted in rehabilitation service units.

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 Office of Public Safety and Inspections.
- (3) 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 Constructed on or Before March 19, 1968.(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 residents with handicaps (such as impaired vision, impaired ambulation, *etc.*) shall be housed on floors that have access to grade level, and no 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 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.

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(3) Resident Bedrooms.

(a) Resident bedrooms must adhere to the following requirements:

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 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. Facilities must maximize the distance between resident beds and ensure that bed placement is in accordance with Department guidelines, if any. Each bed shall be 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 resident occupancy. Rooms without basement foundations shall not be used for resident occupancy, unless there is adequate heating and insulation.
6. All rooms used for residents shall be outside rooms. No room off the kitchen shall be used for resident care, unless another acceptable means of entrance to this room is provided. No resident room shall be used as a passageway.
7. Adequate closet and drawer space shall be provided for each resident. In general, this shall mean closet space of not less than two feet by two feet by the height of the closet per resident for the storage of personal belongings, and either a built-in or freestanding 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 resident's room.
8. All resident bedrooms shall be clearly identified by number on or beside each entrance door.

(b) On and after April 30, 2022, in facilities that provide Level I, II or III care, resident bedrooms must adhere to the following occupancy and square footage requirements:

1. No resident bedroom shall contain more than two beds; and
2. For facilities that provide Level I, II or III care, in the event of new construction or reconstruction, as defined by CMS, of a building or nursing care unit, affected resident bedrooms must:
 - a. Be shaped and sized so that each bed can be placed with a minimum clearance of four feet from any lateral wall, window or radiator on the transfer side of the resident bed and three feet from any lateral wall, window or radiator on the non-transfer side of the resident bed. In single occupancy rooms, an unobstructed passageway of at least three feet shall be maintained at the foot of each bed. In double occupancy rooms, an unobstructed passageway of at least four feet shall be maintained at the foot of each bed. In double occupancy rooms, resident beds must be spaced at least six feet apart.
 - b. The floor area of each of the affected resident bedrooms shall not be less than 110 square feet for single occupancy rooms and 108 square feet per bed for double occupancy rooms.

Facilities that are unable to fully comply with 105 CMR 150.017(3)(b)(1) by April 30, 2022 must demonstrate to the Department that the licensee has made good faith efforts to comply with 105 CMR 150.017(3)(b)(1), in accordance with Department guidelines.

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

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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 resident care; adequate space for the storage of individual resident equipment; adequate facilities for the cleansing, disinfection and sterilization of individual resident 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; and handwashing facilities with hot and cold running water.
- (f) Utility rooms are not required in facilities that provide only Level IV care.
- (g) Janitor's Closets. See 105 CMR 150.016(E)(3).
- (h) Handrails shall be provided on both sides of all indoor and outdoor stairways. Specifications as to height, width and anchorage as listed in 105 CMR 150.600(B) shall apply. They shall have curved returns.
- (4) General Storage. Adequate storage space and equipment shall be provided for 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.
- (5) 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 noncombustible waste receptacle with a foot-operated top.
- (6) Activity Areas. All facilities shall provide on every floor and for every unit a comfortable, pleasant, convenient, well-lit and ventilated sitting room, day room, or solarium with a direct outside exposure that is separate from resident bedrooms. (Exceptions may be allowed upon written approval of the Department.) This room shall be so constructed, arranged and maintained that residents have a place to read, play cards, visit or watch television. This room shall be large enough to meet resident needs and shall be suitably located.
- (7) Rehabilitation 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-lit, well-ventilated and adequately heated and it shall be separate and apart from rooms used for resident living.
- (b) There shall be a 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:
1. Treatment table, footstool and chairs;
 2. Adequate linen supply;
 3. Sanitary waste containers;
 4. Hamper for soiled linen;
 5. Disposable towels;
 6. Curtains or cubicles to assure privacy; and
 7. 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.
- (8) 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 residents. The number shall be appropriate to the size and needs of the facility.

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- (c) Toilet and handwashing sinks shall be provided on a ratio of one toilet and sink per every eight to ten 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 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.) Mixing valves and controls in Level I, II and III facilities shall be mounted outside shower stalls.
 - (e) Toilets, bath or shower compartments shall be separated from all rooms by solid walls or partitions. Adequate provision to insure resident privacy shall be made.
 - (f) Toilets for 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.
 - (j) Hot water supplied to fixtures accessible to residents shall be controlled to maintain a temperature between 110°F and 120°F.
- (9) 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 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°F 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.
- (10) Dining Rooms. All facilities shall provide at least one dining area for 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-lit, 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 nonskid wax shall be used in the dining room area.

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(11) 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 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.

(12) 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.

(13) Architectural and Engineering Details.

(a) Doors, Screens and Windows. No hooks or locks shall be installed on doors used by 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.

(14) Heating and Air Conditioning Equipment.

(a) The heating system shall be in conformity with the rules and regulations outlined by the Office of Public Safety and Inspections 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 resident areas shall be shielded for the safety of residents.

(e) Every facility shall provide by June 21, 2000, 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.

(15) Ventilation. (See 105 CMR 150.015(F)(5).)

(a) Each 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.

(16) 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 527 CMR 12.00: *Massachusetts Electrical Code (Amendments)* and all local regulations.

150.017: continued

- (b) Adequate lighting shall be provided in each resident room to provide an adequate, uniform distribution of light. No electric bulb under 60 watts shall be used for illumination for residents' use.
 - (c) Night lights shall be provided in corridors, stairways, bathrooms, toilets and nurses or attendants' stations and 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 lit.
- (17) 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%.

NON-TEXT PAGE

150.017: continued

(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 resident 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 resident rooms unless the nursing home is 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 residents to off-site habilitative, therapeutic recreational and non-emergency medical services.

150.018: Hospital Based Long-term Care Facilities (HB/LTCF) - Provisions Regarding the Sharing of Services

(A) 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.

(B) Equipment. An HB/LTCF may under written arrangement, 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 resident care provided. Scheduling of daily activities shall be done in such manner as to encourage and facilitate participation of residents in the educational program.

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 or 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 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.

150.021: continued

- (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 a significant change is made in the resident's mental health plan that affects the service needs specified in the Support Plan, or 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.
- (3) No support services plan may be implemented without the written consent of the resident or the resident's guardian.
- (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 ensuring 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 ensure 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 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 105.029 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.

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

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

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

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

(4) Each facility shall appropriately train its volunteers for the tasks 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:

150.024: continued

- (1) Obtain documentation from the employee's former employer certifying 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.
- (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 or her designee.
 - (1) No training shall be considered complete until the staff member or contractor has taken and passed the evaluation.
 - (2) Written documentation 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 operating 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;
 - (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 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.
- (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 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 representative, seeking to be admitted to the DSCU, prior to the resident's admission;
 - (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.

150.029: continued

(2) The DSCU must encompass the entirety of a nursing care unit, as defined by 105 CMR 150.020: *Skilled Nursing Care Facility (Level II) and Supportive Nursing Care Facility (Level III)* and 150.310: *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.

(C) Outdoor Recreation Space.

(1) A DSCU shall have secured outdoor space and walkways allowing 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 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.

150.029: continued

(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.

(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 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 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 150.570: *Central Dining*, at least eight square feet per bed for group activities per 105 CMR 150.510: *General and Special Activity Areas* and at least nine square feet per bed for day room per 105 CMR 150.360: *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.

150.030: Definitions

The following definitions apply to 105 CMR 150.031:

Appropriate Resident means a resident whose primary care provider has:

(1) Diagnosed a terminal illness or condition can reasonably be expected to cause the resident's death within six months, whether or not treatment is provided, provided the primary care provider determines discussion of palliative care services is not contraindicated; or

(2) Determined discussion of palliative care services is consistent with the resident's clinical and other circumstances and the resident's reasonably known wishes and beliefs.

Hospice Care means care provided by an entity licensed pursuant to 105 CMR 141.000: *Licensure of Hospice Programs*.

Palliative Care means the attempt to prevent or relieve pain and suffering and to enhance the resident's quality of life, and may include, but is not limited to, interdisciplinary end-of-life care and consultation with residents and families.

150.031: Provision of Information on Palliative Care and End-of-life Options

- (A) Each long-term care facility shall distribute to appropriate residents, directly or through professionally qualified individuals, culturally and linguistically suitable information regarding the availability of palliative care and end-of-life options. This obligation shall be fulfilled by providing the resident with:
- (1) A Department-based informational pamphlet; or
 - (2) A similar informational pamphlet that meets the specifications in 105 CMR 150.031(B).
- (B) At a minimum, the informational pamphlet shall include:
- (1) A definition and explanation of advanced care planning, palliative care services, and hospice services; and
 - (2) All other requirements as defined in guidelines of the Department.
- (C) Each long-term care facility shall provide the information in 105 CMR 150.031(A) to appropriate residents in a timely manner.
- (D) Each long-term care facility shall have a policy for identifying appropriate residents and ensuring they receive an informational pamphlet. Such policies shall be made available to the Department upon request.
- (E) Each long-term care facility shall inform all primary care providers providing care within or on behalf of the facility of the requirements of M.G.L. c. 111, § 227(c) to offer to provide end-of-life counseling to residents with a terminal illness or condition.
- (F) Where the resident lacks capacity to reasonably understand and make informed decisions, the information in 105 CMR 150.031(A) shall be provided to the person with legal authority to make health care decisions for that resident.
- (G) The long-term care facility (level I through IV) shall make available to the Department proof it is in compliance with 105 CMR 150.031(A) and (C) through (E) upon request or at the time of inspection.

150.100: State and Local Rules

Facilities shall comply with all state laws and local rules and ordinances applicable to construction, alteration and structural changes. In the absence of any ordinance or code, 105 CMR 150.000 shall apply.

150.110: Type of Construction

Facilities shall be of Type IB construction as set forth under M.G.L. c. 111 and the Massachusetts State Building Code (780 CMR 407.1.1: *Other Reference*). 105 CMR 150.110 shall not apply to any facility seeking to upgrade in whole or in part from Level III to a higher level of care if all units, components or additions of said facility were originally constructed as a long-term care facility. 105 CMR 150.110 shall not apply to any unit or units which a hospital seeks to convert to a hospital based long-term care facility as defined in 105 CMR 150.110, provided the unit or units planned for conversion were operating as licensed inpatient unit(s) at any time on or after April 1, 1988.

150.120: Determination of Need Approvals

New construction, conversions, alterations, additions or other structural changes or acquisition of special equipment (not ordinarily provided in long-term-care facilities) in a proposed or existing facility shall not be made until a determination of need, if applicable, has been made by the Department and approval of the final plans and specifications for construction or acquisition of such equipment have been issued by the Department of Public Health.

150.130: Conversions

Conversions of structures not designed, built and licensed as hospitals, convalescent or nursing homes, rest homes, infirmaries maintained in towns, or charitable homes for the aged, to facilities of Level I, II, III or IV care, shall be allowed only with the specific approval of the Department, and only where such conversions will result in compliance with the 105 CMR 150.000.

150.150: Special Requirements: Hospital Based Long-term Care Facilities (HB/LTCF)

(A) The space that constitutes the premises of the licensed long-term care facility and the premises of the licensed hospital shall not be intermingled space. The space that constitutes the hospital shall be contiguous space and the space that constitutes the long-term care facility shall also be contiguous space.

(B) The long-term care facility shall be physically separated from the hospital by means of partitions, doors or other barrier.

(C) The long-term care facility shall not be used as thoroughfare to other parts of the hospital building.

(150.160: Restrictions: Reserved)

150.200: Location

Each facility shall be located on a site subject to the approval of the Department. Sites shall be away from nuisances such as large commercial or industrial developments or similar developments that produce high levels of noise or air pollution; and shall afford a safe and sanitary environment for residents.

150.210: Roads and Walks

Roads and walks shall be provided separately within the lot lines to the main entrance, ambulance entrance, kitchen entrance and the delivery and receiving areas.

150.220: Parking

(A) Parking shall be provided in accordance with the provisions of local zoning and building ordinances, but in no case shall the ratio of off-street parking be less than one parking space for each four beds.

(B) Disabled Parking. At least two parking spaces shall be provided and identified for use by the physically disabled. These spaces shall be in close proximity to the building entrance and shall comply with 521 CMR 1.00: *Architectural Access Board*.

150.230: Provisions for Individuals with Disabilities

(A) Gradients of Walks. Public walks shall be not less than four feet wide and shall have a gradient that complies with 521 CMR 1.00: *Architectural Access Board*.

(B) Walks – Continuous Surface. Walks shall be of a continuing common surface, not interrupted by steps or abrupt changes in level. Wherever walks cross other walks, driveways or parking lots, they shall blend to a common level.

(C) Access from parking areas through a primary building entrance shall be a continuous level or ramped surface without stairs or abrupt changes in level.

150.240: Outdoor Recreation

At least 25 square feet of accessible outdoor recreation area shall be provided per licensed bed. Accessible outdoor recreation areas shall not include parking areas.

150.300: Maximum Number of Beds – Nursing Care Units

- (A) Level I and II nursing units shall consist of not more than 41 beds.
- (B) Level III nursing units shall consist of not more than 60 beds.
- (C) A nursing unit shall not encompass beds on more than one floor.
- (D) An HB/LTCF shall consist of at least 20, but not more than 41, beds.

150.310: Required Supporting Elements – Nursing Care Units

A unit shall have, centrally located within its area, a special care room, if applicable, a staff workstation, a staff toilet, a walk-in medicine room, a clean utility room, a soiled utility room, a linen storage closet, a drinking fountain or water dispenser, a janitor's closet and a room for the storage of supplies and equipment.

150.320: Bedrooms – Nursing Care Units

- (A) Resident bedrooms must adhere to the following:
 - (1) The floor area of resident bedrooms, excluding closet, vestibule and toilet room areas shall not be less than 125 square feet for single occupancy rooms and 90 square feet per bed for multiple occupancy rooms.
 - (2) For HB/LTCFs, the floor area of resident bedrooms, excluding closet, vestibule and toilet room areas shall not be less than 100 square feet for single occupancy rooms and 80 square feet per bed for multiple occupancy rooms.
 - (3) Prior to April 30, 2022, no resident bedroom shall contain more than four beds. However, in the event of new construction or reconstruction, as defined by CMS, of a building or nursing care unit, each of the affected resident bedrooms may not contain more than two beds.
 - (4) Rooms shall be shaped and sized so each bed can be placed at least three feet from any lateral wall and at least three feet from any window or radiator. Beds shall be spaced at least three feet from any other bed. Facilities must maximize the distance between resident beds and ensure that bed placement is in accordance with Department guidelines, if any. An unobstructed passageway of at least four feet shall be maintained at the foot of each bed.
 - (5) Resident bedrooms shall have a floor level above the grade level adjacent to the building.
 - (6) All resident bedrooms shall be along exterior walls with window access to the exterior.
 - (7) All resident bedrooms shall open directly to a main corridor and shall be permanently and clearly identified by number on or beside each entrance door.
 - (8) Each room with more than one bed shall have cubicle curtains or equivalent built-in devices for privacy for each resident.
 - (9) Each resident bedroom shall contain closet interior space of not less than two feet by two feet per resident with at least five feet clear hanging space for the storage of personal belongings. In addition, either a built-in or freestanding multiple-drawer bureau not less than two feet wide with a minimum of one drawer per resident shall be provided.
 - (10) Each resident bedroom shall be sized and dimensioned to accommodate hospital-type beds of not less than 76 inches long and 36 inches wide, a hospital-type bedside cabinet and an easy chair or comfortable straight-back arm chair.
- (B) On and after April 30, 2022, resident bedrooms must adhere to the following occupancy and square footage requirements:
 - (1) No resident bedroom shall contain more than two beds; and
 - (2) For facilities that provide Level I, II or III care, in the event of new construction or reconstruction, as defined by CMS, of a building or nursing care unit, affected resident bedrooms must:

150.320: continued

(a) Be shaped and sized so that each bed can be placed with a minimum clearance of four feet from any lateral wall, window or radiator on the transfer side of the resident bed and three feet from any lateral wall, window or radiator on the non-transfer side of the resident bed. In single occupancy rooms, an unobstructed passageway of at least three feet shall be maintained at the foot of each bed. In double occupancy rooms, an unobstructed passageway of at least four feet shall be maintained at the foot of each bed. In double occupancy rooms, resident beds must be spaced at least six feet apart.

(b) The floor area of each of the affected resident bedrooms shall not be less than 125 square feet for single occupancy rooms and 108 square feet per bed for double occupancy rooms.

Facilities that are unable to fully comply with 105 CMR 150.320(B)(1) by April 30, 2022 must demonstrate to the Department that the licensee has made good faith efforts to comply with 105 CMR 150.320(B)(1), in accordance with Department guidelines.

150.330: Special Care Room – Nursing Care Unit

(A) In each unit, unless all rooms on the unit are single occupancy, one single bedroom shall be provided for occupancy by a resident requiring isolation or intensive care. This room shall be located in close proximity to the nurse's station and shall not have direct access with any other resident room. The room shall be included in the quota and may be generally used until such time as it is used for isolation or intensive care.

(B) The special care room shall be provided with a separate toilet, lavatory and bathing fixture.

150.340: Nurses Station

(A) A nurse's station shall be conveniently located within each nursing unit and shall be located not more than 100 feet from the entrance to any resident room. That maximum distance may be extended to 150 feet if all resident rooms are private.

(B) Each nurse's station shall be sized to accommodate nursing and other clinical staff scheduled to be present during any given shift.

150.350: Medicine Room – Nursing Care Units

(A) A separate, locked medicine room of sufficient square footage to accommodate staff working with medications shall be provided directly off or immediately adjacent to each nurse's station.

(B) Each medicine room shall contain sufficient storage space and be equipped with a counter top and a sink with hot and cold running water.

(C) A separate locked compartment shall be provided for the storage of narcotics and other dangerous drugs.

(D) Each medicine room shall contain a refrigerator for medication which requires refrigeration.

150.360: Activity Area – Nursing Care Units

One day room solarium, sitting room or equivalent area with direct outside exposure shall be provided in each unit. Each such room or area shall have a minimum area of nine square feet for each bed authorized in the corresponding nursing unit.

150.370: Resident Bathrooms and Washrooms

(A) Bathing Facilities. Bathing facilities shall be provided in a ratio of not less than one per 15 residents. One of the bathing facilities in the long-term care facility shall be a freestanding tub. The freestanding tub shall be accessible from two sides and one end with a minimum three-foot clearance. The tub shall be equipped with an acceptable type bath lift, except smaller dimensions may be approved for an HB/LTCF, so long as such facilities can accommodate residents using wheelchairs.

150.370: continued

(B) Shower Construction. Shower floors shall be flush and shall be without curbs. The floor shall be sloped to the center of the shower stall. Mixing valves and controls shall be mounted outside the shower stall. Shower enclosure shall be not less than four feet by four feet or five feet wide by thirty inches deep. A private dressing area adjoining each common shower enclosure shall be provided. All common toilet or bathing facilities shall be separated by solid wall partitions or dividers.

(C) Toilets and Handwashing Facilities.

(1) All resident bedrooms shall be provided with at least one water closet and one lavatory. Each water closet and lavatory may be positioned between adjacent rooms. They must be directly accessible from each room.

(2) One water closet and one lavatory shall be provided for residents of each sex on each unit and shall be located in areas convenient to day rooms and any unit dining rooms. Such areas must be sized to accommodate residents' wheelchairs.

(3) All common toilet facilities shall be separated by solid wall partitions or dividers.

(4) In HB/LTCFs, if each resident room does not have direct access to toilet and handwashing facilities, such facilities shall be provided and located conveniently to the resident rooms at ratios of one toilet fixture to every four residents.

(5) In addition to the requirements of 105 CMR 150.370(C), facilities shall have sufficient equipment to meet the toileting needs of their residents.

(D) Grab Bars Required for Tubs, Showers, and Toilets. All tubs, showers and toilet enclosures shall be equipped with grab bars. Grab bars, accessories and anchorage shall meet the structural and strength requirements in 521 CMR: *Architectural Access Board*.

(E) Hot Water Supply: Maximum Temperature. Hot water supplied to fixtures accessible to residents shall be controlled to maintain a temperature between 110° and 120°F.

150.380: Storage Areas - Nursing Care Units

(A) Linen Closet. A linen storage closet shall be provided in each unit for the storage of daily linen needs.

(B) Janitor Closets.

(1) One janitor's closet shall be provided for each unit. In no event shall there be less than one janitor's closet per floor.

(2) Each janitor's closet shall contain a service sink equipped with hot and cold running water.

(3) Each janitor's closet shall have adequate space for housekeeping equipment and shelving for the storage of cleaning supplies.

(C) General Storage.

(1) In each unit, a storage closet of at least 50-square feet shall be provided for the storage of supplies and equipment. The clear area shall be large enough to permit easy storage of wheel chairs, lockers, resident's lifts and other types of mechanical equipment.

(2) Where oxygen storage is provided it shall be in accordance with the National Fire Protection Association Code.

(D) Smaller dimensions may be approved for HB/LTCFs and long term care facilities with 20 or fewer single occupancy resident bedrooms per unit and no multi-bed rooms.

150.390: Utility Rooms - Nursing Care Units

(A) Separate Clean and Soiled Rooms Required. Each unit shall contain separate clean and soiled utility rooms which shall not be interconnected but shall have separate entrances off the corridor.

(B) Clean Utility Room. The clean utility room shall contain wall hung and base cabinets. The base cabinet shall be equipped with a counter top and sink with hot and cold running water and a gooseneck spout. The minimum area shall be 70-square feet with no dimension less than six feet.

150.390: continued

(C) Soiled Utility Room. The soiled utility room shall contain a service sink with gooseneck faucet and hot and cold running water; either a clinical service sink or a device to ensure adequate waste disposal, and washing and sanitizing of equipment; and a work counter with contiguous space at least 24 inches wide and 36 inches high by four feet long. Handwashing facilities shall be provided. The minimum area shall be 70-square feet with no dimension less than six feet.

(D) Smaller dimensions maybe approved for HB/LTCFs and long term care facility with 20 or fewer single-occupancy resident bedrooms per unit and no multi-bed rooms.

150.400: Maximum Number of Beds - Resident Care Units

Level IV units shall consist of not more than 60 beds.

150.410: Required Supporting Elements - Resident Care Units

All units shall have, centrally located:

- (A) a staff workstation;
- (B) a special care room, if applicable;
- (C) a staff toilet;
- (D) a medicine closet;
- (E) a linen storage closet;
- (F) a drinking fountain or water dispenser;
- (G) a janitor's closet; and
- (H) a room for the storage of supplies and equipment.

150.420: Resident Bedrooms - Resident Care Units

(A) The floor area of resident bedrooms, excluding closet, vestibule and toilet room areas shall be not less than 125-square feet for single occupancy rooms and 90-square feet per bed for multiple occupancy rooms.

(B) No resident bedroom shall contain more than four beds. Multi bedrooms shall be designed to permit no more than three beds side by side parallel to the window wall.

(C) Rooms shall be shaped and sized so each bed can be placed at least three feet from any lateral wall and at least three feet from any window or radiator. Beds shall be spaced at least three feet from any other bed and an unobstructed passageway of at least four feet shall be maintained at the foot of each bed. Variations in bed placement and dimensions shall be permitted only with the approval of the Department.

(D) Resident bedrooms shall have a floor level above the grade level adjacent to the building.

(E) All resident bedrooms shall be along exterior walls with window access to the exterior.

(F) All resident bedrooms shall open directly to a main corridor and shall be permanently and clearly identified by a number on or beside each entrance.

(G) Each room with more than one bed shall have cubicle curtains or equivalent built-in devices for privacy for each resident.

150.420: continued

(H) Each resident bedroom shall contain closet interior space of not less than two feet by two feet per resident with at least five feet clear hanging space for the storage of personal belongings. In addition, either a built-in or free-standing multiple-drawer bureau not less than two feet wide, with a minimum of one drawer per resident, shall be provided.

(I) Each resident bedroom shall be sized and dimensioned to accommodate household size or hospital-type bed, a bedside cabinet and an easy chair or comfortable straight-back arm chair.

(J) Units shall not encompass beds on more than one floor.

150.430: Special Care Room - Resident Care Units

(A) In each unit, unless all rooms on the unit are single occupancy, one single bedroom shall be available for occupancy by a resident requiring isolation. This room shall be located in close proximity to the attendant's station and shall not have direct access with any other resident room. The room shall be included in the quota and may be generally used until such time as it is used for isolation.

(B) This room shall be provided with a separate toilet, lavatory and bathing fixture.

150.440: Attendant's Station

(A) An attendant's station shall be conveniently located within each nursing unit and shall be located not more than 150 feet from the entrance to any resident room.

(B) Each attendant's station shall be sized to accommodate staff scheduled to be present during any given shift.

150.450: Medicine Closet - Resident Care Units

(A) A medicine closet is required within Level IV directly off or immediately adjacent to the attendant's station.

(B) A separate locked compartment shall be provided for the storage of narcotics and other dangerous drugs.

(C) Each medicine closet shall contain a refrigerator for medication which requires refrigeration.

(D) Each medicine closet shall contain sufficient storage space and be equipped with a counter top and a sink with hot and cold running water.

150.460: Activity Areas - Resident Care Units

One day room, solarium, sitting room or equivalent space with direct outside exposure shall be provided in each unit. Each such room or area shall have a minimum area of nine square feet for each bed authorized in the corresponding nursing unit.

150.470: Resident Bathrooms and Washrooms - Resident Care Units

(A) Bathing Facilities. Level IV bathing facilities shall be provided in a ratio of not less than one per 15 residents. A free-standing tub is not required within a Level IV Resident unit.

150.470: continued

(B) Shower Construction. Shower floors shall be flush and shall be without curbs. The floor shall be sloped to the center of the shower stall. Mixing valves and controls shall be mounted outside the shower stall. Shower enclosure shall be not less than four feet by four feet or five feet wide by 30 inches deep. A private dressing area adjoining each common shower enclosure shall be provided.

(C) Toilet and Handwashing Facilities.

(1) All resident bedrooms shall be provided with at least one water closet and one lavatory. Each water closet and lavatory may be positioned between adjacent rooms. They shall be directly accessible from each room.

(2) One water closet and one lavatory shall be provided for residents of each sex in each unit and shall be located in areas convenient to day rooms and any unit dining rooms. Such areas shall be sized to accommodate residents' wheelchairs.

(3) All common toilet facilities shall be separated by solid wall partitions or dividers.

(4) In addition to the requirements of 105 CMR 150.470(C), facilities shall have sufficient equipment to meet the toileting needs of their residents.

(D) Grab Bar Required for Tubs, Showers, and Toilets. All tub, shower and toilet enclosures shall be equipped with grab bars. Grab bars, accessories and anchorage shall meet the structural and strength requirements in 521 CMR: *Architectural Access Board*.

(E) Hot Water Supply. Hot water supplied to fixtures accessible to residents shall be controlled to maintain a temperature between 110° through 120°F.

150.480: Storage Areas - Resident Care Units

(A) Linen Closet. A linen closet shall be provided in each unit for the storage of daily linen needs.

(B) Janitor's Closet.

(1) One janitor's closet shall be provided for each unit. In no event shall there be less than one janitor's closet per floor.

(2) Each janitor's closet shall contain a service sink equipped with hot and cold running water.

(3) Each janitor's closet shall have adequate space for housekeeping equipment and shelving for the storage of cleaning supplies.

(C) General Storage. In each unit, a storage closet of at least 50-square feet shall be provided for the storage of supplies and equipment.

150.500: Storage Areas

(A) General Storage. A general storage room or rooms shall be provided in each facility with a total area of at least ten square feet per bed for 100% of the total beds authorized.

(B) Central Food Storage. A room with a minimum of 150-square feet shall be provided for the storage of non-perishable foods. Shelves shall be non-combustible and not more than 18 inches deep and 72 inches high and two inches from the wall. Food supplies shall not be stored on the floor. In the case of HB/LTCFs, if the hospital and the long-term care facility share dietary services a separate storage area is not required.

150.510: General and Special Activity Areas

(A) General Activity Room.

(1) A general activities room shall be provided for the use of all residents. The area of this room shall be at least eight square feet per bed for 100% of the total beds authorized.

(2) A storage closet shall be provided adjacent to the general activities room for equipment utilized in recreational, diversional and religious activities.

150.510: continued

(B) Beauty Parlor and Barber Shop. A room may be provided for the beauty parlor and barber shop. If provided, such a room shall have a minimum floor area of not less than 120-square feet. Each such room shall contain cabinet and counter space and a shampoo basin sink with a mixing faucet and attached spray.

(C) Snack Shop. Facilities may provide a snack shop commensurate with the size of the facility.

(D) Gift Shop. Facilities may provide a gift shop commensurate with the size of the facility.

150.520: Examination and Treatment Room

(A) A treatment room shall be available in each facility providing Levels I, II or III care. This room may also be used by physicians as an examination room. Use for any other purpose shall be approved in writing by the Department.

(B) The treatment room shall have a minimum area of 125-square feet with no dimension less than ten feet.

(C) The treatment room shall include handwashing facilities with hot and cold running water and be sized and dimensioned to accommodate a treatment table, instrument table, and locked storage cabinet.

150.530: Office Space

(A) Administrative Offices.

(1) Appropriate space and equipment shall be provided for administrative activities and for the storage of medical records.

(2) Separate offices of not less than 80-square feet each shall be provided for the use of the Administrator and the Director of Nurses. An office for the Director of Nurses is not required within a free-standing Level IV facility.

(B) Consultant Offices.

(1) Consideration shall be given to provide separate rooms in Level I and II facilities for the use of full-time consultants, such as a medical director, dietitian, social worker and others.

(2) Consultant's offices, if provided, shall be not less than 100-square feet each.

(3) A room shall be provided for a dietary consultant; it shall be located convenient to the kitchen area.

150.540: Rehabilitation Service Areas

(A) General.

(1) The following rehabilitation service areas shall be permitted only in facilities providing Levels I or II Care.

(2) Rehabilitation service areas shall be sized and arranged to the extent consistent with the program of treatment within the particular facility; however, in each case, the following are the minimums that must be provided for the types of therapy programmed.

(3) Physical environment for rehabilitation service programs also providing services to outpatients shall include:

(a) direct entrance from the outside or direct access from the main lobby that is accessible to persons with disabilities;

(b) parking convenient to the entrance to the rehabilitation program area;

150.540: continued

- (c) resident and staff toilet rooms conveniently located near the rehabilitation service program areas; these toilet rooms must be separate from those serving nursing units;
 - (d) adequate waiting and reception areas;
 - (e) record storage; and
 - (f) office space.
- (4) The following equipment shall be provided in rehabilitation areas:
- (a) treatment table, footstool and chairs;
 - (b) adequate linen supply;
 - (c) sanitary waste containers;
 - (d) hamper for soiled linen;
 - (e) curtains or cubicles to assure privacy; and
 - (f) desk or table and chair for clerical use.

(B) Physical Therapy Room.

- (1) Physical therapy rooms shall have a minimum floor area of 200-square feet with a minimum dimension of not less than ten feet.
- (2) Physical therapy rooms shall be provided with a closet for the storage of supplies and equipment and a handwashing sink with hot and cold running water.
- (3) Additional space may be required to accommodate the outpatient rehabilitation services. The physical therapy room shall include provisions for privacy. Dressing facilities and lockers shall be provided for outpatient use.

150.550: Staff and Public Toilets and Washrooms

- (A) Toilets, including washing facilities, shall be provided for visitors and staff separate from those facilities used by residents.
- (B) Visitor's toilets shall be conveniently located and accessible to the normal visitors' entrance and lobby. This toilet room may also serve administrative staff.
- (C) Staff toilets shall be located in close proximity to the kitchens and employees' locker rooms. Kitchen toilets shall not open directly into food preparation areas and shall not be open to visitors.
- (D) Visitors and staff toilets shall have toilet paper holders, paper towel dispensers, soap dispensers and mirrors.
- (E) At least one public toilet room must be sized and appointed to accommodate the physically disabled.

150.560: Central Kitchen

Each facility must designate a kitchen that meets the following requirements:

- (A) A handwashing sink with hot and cold running water shall be provided together with disposable towels and towel dispenser and a soap dispenser.
- (B) A double-compartment sink with hot and cold running water and an attached 30-inch drain board and backsplash for the preparation and cleaning of fresh vegetables.
- (C) A triple-compartment sink with hot and cold running water and an attached 30-inch drain board on each side, with backsplash, shall be provided for the washing of pots and pans.
- (D) The kitchen floor shall have a floor drain equipped with a grease trap and a backup flow check valve.

150.560: continued

(E) A separate dishwashing area containing a commercial dishwasher with attached dirty and clean work counters shall be provided. Access of food carts containing soiled dishware shall not be through the food preparation area. The dishwasher shall be equipped with a grease trap. A separate entrance to the dishwashing area shall be provided.

(F) Dumbwaiters, when provided, shall open into nourishment kitchens or dining rooms and shall be used exclusively for food transportation.

(G) The rear of all equipment not flush and sealed to the wall shall be at least eight inches from the wall. Not less than eight inches of clear space shall be provided between separately installed units. If units are to be joined, a filler strip must be used. The minimum aisle width shall be 42 inches; except areas where mobile equipment is used shall have a minimum aisle width of 60 inches.

(H) Traffic through the food service department shall be limited to authorized personnel. Food receiving shall be in a separate area with space for scales and counters.

(I) A separate and defined area shall be provided for food cart washing, if food carts are used on the unit.

(J) A separate janitor's closet shall be provided specifically for the kitchen use.

(K) In the case of HB/LTCFs, if the hospital and the long-term care facility share dietary services, a separate central kitchen is not required.

150.570: Central Dining

(A) A minimum of ten square feet per bed for 100% of total authorized beds shall be provided for resident dining areas.

(B) A separate dining room shall be provided for staff and employees.

150.580: Nourishment Kitchen

(A) A nourishment kitchen room or alcove shall be conveniently located on each floor.

(B) The nourishment kitchen shall contain a refrigerator, microwave oven, a toaster, a sink with hot and cold running water, and storage cabinets.

(C) In the case of HB/LTCFs, a nourishment kitchen shall be provided on each unit.

150.590: Central Laundry

(A) When total laundry service is to be performed on the premises, sufficient space and equipment for such service shall be provided.

(B) When total laundry service is not to be performed on the premises, a laundry room of not less than 70-square feet shall be provided. Each such room shall contain a washer, a dryer, a double-compartment tub and shelving for the storage of soaps, bleaches and other laundry supplies.

(C) In the case of HB/LTCFs, if the hospital and the long-term care facility share laundry services, a separate central laundry is not required.

(D) Linen Storage.

(1) A central linen room shall be provided within each facility with a clear area of at least six feet by nine feet. Shelving of at least 18 inches in depths shall be provided.

150.590: continued

- (2) A central soiled linen room shall be provided within each facility with a clear area of at least six feet by nine feet and shall be equipped with handwashing facilities.
- (3) Laundry chutes, when provided, shall terminate in the soiled linen room. Sufficient space shall be provided to accommodate a laundry hamper.
- (4) The soiled linen room must be adjacent to the laundry room if total laundry service is to be performed on the premises.
- (5) Smaller dimensions may be approved for a long term care facility with 20 or fewer single-occupancy resident bedrooms per unit and no multi-bed rooms.

150.600: Corridors

(A) Corridors.

- (1) Corridors in areas used primarily by residents in nursing homes shall not be less than eight feet wide. Corridor width in all other corridors shall comply with 780 CMR 10.00: *Means of Egress* and International Building Code section 1018.2.
- (2) Existing corridors in an HB/LTCF may be retained as long as they are at least four feet wide.

(B) Handrails shall be provided on both sides of corridors. Handrails shall be firmly anchored and shall not project more than 3½ inches into the required minimum width of the corridor and shall be no less than 30 inches above the finished floor. They shall have curved returns.

(C) A facility shall not permit the installation of any fixed appurtenance with may become an obstacle to traffic or reduce the required minimum width of corridor, ramp or stair.

150.610: Ramps

(A) Width of interior ramps in areas used by residents shall conform to width under 105 CMR 150.600(A). Outside ramps shall be not less than four feet in width.

(B) Ramp surfaces shall be constructed and maintained in such a manner as to prevent slipping thereon.

(C) Street or ground floors having exits to the exterior above grade shall have at least one ramp leading to grade to accommodate residents using wheelchair and litter residents.

(D) Handrails shall be provided on both sides of all ramps. Specification as to height, anchorage and curved returns as listed in 105 CMR 150.600(B) shall apply.

(E) Ramps shall have a gradient of not greater than 8%.

150.620: Stairs and Stairways

(A) Surfaces of treads and landings shall be constructed and maintained so as to prevent slipping.

(B) Handrails shall be provided on both sides of all indoor and outdoor stairways. Specifications as to height, width and anchorage as listed in 105 CMR 150.600(B) shall apply. They shall have curved returns.

(C) Steps in stairways shall not have abrupt (square) nosing, and risers shall be tapered back approximately 1½ inches at bottom of each riser. Risers where possible should not exceed seven inches.

150.630: Doors and Doorways

- (A) All doors used by residents shall be swing-type at least 41.5 inches in clear width except toilet room doors which shall be at least 32 inches in clear width and, if in-swinging, have pivots and manually operated emergency release. Doors in exit stairway enclosures shall be at least 32 inches in clear width. Resident toilet room doors shall be allowed to be surface mounted sliding doors provided that their specifications comply with the Life Safety Code.
- (B) Locks shall not be installed on doors used by residents, unless each lock can be operated without key or tools on both sides of the door.
- (C) All outside doors and doorways shall be made draft-free by the installation of weather stripping or caulking material.
- (D) Kitchen doors shall be a minimum of 42 inches wide.

150.640: Windows

- (A) The total glass area of windows in each resident room shall be not less than 10% of the entire floor area of such room.
- (B) In order to furnish natural fresh air, the windows in each resident bedroom shall be operable. Exceptions to this standard will be considered in cases of fully air conditioned facilities or areas.
- (C) Windows with sills less than 30 inches from the finished floor shall be provided with readily removable window guards or special safety beams for the protection of residents.
- (D) Operable windows shall be provided with screens constructed from not less than 16 mesh wire screening.
- (E) All outside windows shall be made draft-free by the installation of either weather stripping or caulking material.

150.650: Carpeting

Carpet or carpet assemblies, where installed, shall be wall-to-wall and may be provided in all areas except those normally considered to be "wet areas", such as laundries, bathrooms, utility rooms, kitchens.

150.660: Room Surface Finishes

- (A) Interior finished surfaces shall conform to local and state codes and to 105 CMR 150.000.
- (B) Interior wall surfaces of all areas assigned for resident housing, care, and recreation, exclusive of shower enclosures, kitchen, food preparation areas, dishwashing areas, bathrooms, toilets, utility rooms, and nourishment kitchens, shall be finished with a smooth, non-absorbent, washable surface. Walls of kitchens, food preparation areas, bathrooms, toilets utility rooms, nourishment kitchen and dishwashing areas shall be finished to a height of at least 72 inches from the finished floor with an impervious material.
- (C) Floors of bathrooms, toilets, showers, food preparation areas, utility rooms and nourishment kitchens shall be covered with an impervious material.
- (D) Cove bases shall be provided for all floors where tile covering is directed; cove bases shall not project more than a standard cove base beyond the surface of the finished floor or wall.

150.670: Ceiling Heights In Resident Areas

The ceiling height in areas used by residents shall be a minimum of eight feet.

150.700: Heating and Air Conditioning Systems

- (A) Every facility shall be equipped with a heating system which is sufficient to maintain a minimum temperature of 75°F throughout the facility at all times at winter design temperatures.
- (B) Heating fixtures and all exposed pipes shall be shielded for the safety of residents.
- (C) Each heating fixture shall be equipped with hand controls unless an individual automatic room control is provided.
- (D) Every facility whose architectural plans are approved after the promulgation of 105 CMR 150.700(D) for new construction or major renovations such as the installation of a heating air conditioning and ventilation system or complete interior reconstruction shall be equipped with a cooling system which is capable of maintaining a maximum temperature of 75°F throughout the resident areas affected by the new construction or renovation 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.

150.710: Ventilation Systems

- (A) Positive mechanical exhaust ventilation shall be provided, regardless of natural ventilation, and must be capable of assuring the minimum number of air changes per hour for the following areas as required under the provisions of the M.G.L. c. 111, § 72C:
 - (1) Kitchens, dishwashing areas and diet kitchens shall have at least ten air changes per hour.
 - (2) Bathrooms, toilets and showers shall have at least ten air changes per hour.
 - (3) Rooms for soiled linen shall have at least ten air changes per hour.
 - (4) Utility rooms, janitor’s closets, laundry rooms and nurse’s stations shall have at least ten air changes per hour.
- (B) All storage rooms, including food storage rooms, oxygen storage rooms, boiler rooms and rooms in which mechanical equipment is stored, shall have separate and independent venting systems providing not less than ten air changes per hour.
- (C) Ducts for ventilating bathrooms, toilets, rooms for soiled linen, laundry rooms and garbage storage rooms shall not be interconnected with other duct systems, but shall lead to the outside independently.
- (D) All ducts penetrating floors or fire rated walls shall be fire dampered at the point of penetration.
- (E) Corridors and exit halls shall not be used as plenums for the supply or return air to heating or air conditioning systems.
- (F) Exhaust air intakes or hoods shall be located at cooking, dishwashing and high steam of fume-producing areas.

150.720: Water Supply

- (A) The volume and pressure of the water supply shall be sufficient to supply water to all fixtures with a minimum pressure of 15 pounds per square inch at the farthest point of usage during maximum demand periods.
- (B) Domestic hot water heating equipment shall have adequate capacity to supply the following:

| | Resident Area | Food Preparation Area | Laundry |
|------------------|---------------|-----------------------|---------|
| Gallons/hour/bed | 6½ | 4 | 4½ |
| Temp. °F | 110-120 | 180 | 180 |

150.720: continued

(C) Water shall be obtained from an approved municipal water system or, in areas where wells are the source of supply, they shall be designed and constructed with the approval of the Department.

150.730: Sewerage

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 an independent sewerage system designed and constructed with the approval of the Department.

150.740: Elevators

(A) Each facility with residents housed on other than the street floor shall provide at least one elevator of hospital type.

(B) Each facility with a capacity of more than 82 beds above the street floor shall provide no less than two elevators, one of which shall be of hospital type.

(C) Each facility of one-story construction, in which ancillary resident services are located in the basement or below grade, shall provide a hospital type elevator to accommodate resident transportation to those areas.

(D) The interior cab dimension shall be not less than 5' 0" x 7' 6" and the door opening not less than 44 inches.

150.750: Refrigeration

(A) Mechanical refrigeration, capable of storing perishable and frozen foods shall be provided. At least 1½ cubic feet of refrigerated storage space and ½ cubic foot of freezer space shall be provided for each authorized bed.

(B) 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 -10°F.

(C) Thermometers shall be attached to the inside of all refrigerators, freezers, frozen food compartments and refrigerated rooms. Thermometers in refrigerated rooms shall be readable from the outside of these rooms.

150.800: Lighting

(A) Electric lighting shall be provided throughout the facility in accordance with the provisions of M.G.L. c. 111, § 72C and the recommended levels of the Illuminating Engineering Society. All electrical installations shall be in accordance with 527 CMR 12.00: *Massachusetts Electrical Code (Amendments)*.

(B) Adequate lighting fixtures shall be installed in each resident room to provide uniform distribution of light.

(C) Outside walks, parking lots and entrances shall be adequately lighted.

150.810: Night Lights

(A) Night lights shall be provided in corridors, stairways, bathrooms, toilets, nurse's stations, attendant's station and resident bedrooms.

(B) Night lights in resident rooms shall be appropriately located and not less than 12 inches above the finished floor. Fixtures shall be recessed into the wall and shall have slotted covers to produce a subdued light.

150.810: continued

(C) Night lights in residents' toilets shall be not less than 15 watts. Fixtures shall be mounted not less than 12 inches from the finished floor.

(D) All night lights shall be controlled either by a switch at the entrance to the resident bedroom or from the nurse's station.

150.820: Reading Lights

A reading light shall be provided for each resident. If wall-mounted reading lights are provided they shall be not less than 64 inches from the finished floor and be mounted directly over each bed. If a reading lamp located on the bedside cabinet is provided, it shall be sufficiently stable and secure so as to minimize the risk of fire. The light switch for the reading light shall be located for easy operation by a resident lying in bed.

150.830: Emergency Electrical Systems

(A) An emergency source of electricity shall be connected to circuits designated in 105 CMR 150.830(C) through 150.830(E) for lighting and power to provide electricity during an interruption of the normal electric supply could affect the nursing care, treatment or safety of the occupants.

(B) The emergency source of electricity shall consist of a generating set, including the prime mover and generator. It shall be located on the 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 be not less than 80%.

(C) Emergency electrical connections shall be provided to circuits for lighting of stairways, corridors, exit ways and exterior approaches thereto, exit and direction signs, nurse's stations, attendant's stations, medicine preparation areas, kitchen, dining and recreation areas, generator set location and boiler room.

(D) Emergency electrical connections shall be provided for protection of vital equipment and materials and for operation of equipment essential to health and safety of the occupants, including but not limited to nurse's call, alarm system, fire pump (if installed), sewerage or sump lift pumps (if installed), one duplex receptacle per bed, corridor duplex receptacles, one elevator, equipment for maintaining telephone service, paging or speaker systems, refrigerators, freezers, and equipment such as burners and pumps necessary for 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 resident rooms unless the nursing home is 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.

150.840: Electrical Outlets

(A) Resident rooms shall have not less than one duplex receptacle per bed and in addition, one receptacle on a wall other than the bed headwall. Duplex receptacles shall be installed so as to meet the needs in any given area.

(B) Outlets for portable tray carts shall be provided.

150.850: Call Systems

(A) A nurse's and attendant's calling station shall be installed at each resident bedside, in each resident's toilet, bath and shower room, and in the following additional areas: resident dining room, treatment room, physical therapy rooms, special care room, activity rooms, television rooms, and sitting rooms, consultation rooms and beauty parlor and barber shop.

(B) The nurse's call in the toilet, bath and shower rooms shall be an emergency call. A nurse's call station pull cord shall be reachable by a resident lying on the floor near each toilet and each shower enclosure.

(C) All calls shall register at the nurse's or attendant's station and actuate a visible signal in the corridor by the room where the call originates.

(D) In rooms containing two or more calling stations, indicating lights shall be provided at each calling station.

(E) Nurse's call systems which provide two-way communication shall be equipped with an indicating light at each calling station which lights and remains lighted as long as the voice circuit is operative.

(F) In an HB/LTCF, the call system shall not be routinely connected to the hospital call and paging system.

(G) If a wireless nurse call system is used in lieu of an analog wired call system or digital wired call system, it shall comply with UL Standard 1069: *Hospital Signaling and Nurse Call Equipment*.

150.1000: Severability

The provisions of 105 CMR 150.000 are severable. If any provision in 105 CMR 150.00 declared unconstitutional or invalid by a court of competent jurisdiction, the validity of the remaining portions shall not be so affected.

REGULATORY AUTHORITY

105 CMR 150.000: M.G.L. c. 111, §§ 3, 71 and 72.