

104 CMR 27.00: LICENSING AND OPERATIONAL STANDARDS FOR MENTAL HEALTH FACILITIES

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SUBPART A: SCOPE AND DEFINITIONS

27.01: Legal Authority to Issue

104 CMR 27.00 is promulgated under the authority of M.G.L. c. 19, §§ 1, 7, 8, 18 and 19 and M.G.L. c. 123.

27.02: Scope

Unless the contrary is specified in a particular section, the provisions of 104 CMR 27.00 apply to all facilities that are licensed, contracted for, or operated by the Department of Mental Health (Department).

27.02: Definitions. For purposes of 104 CMR 27.00, the following terms shall have the following meanings:

Facility Director. The superintendent, chief operating officer, program director, or other administrator designated by the facility to have administrative oversight of a facility, or his or her designee.

Facility Medical Director. The senior physician with responsibility for clinical oversight of a

facility or his or her physician designee.

Informed Consent. The knowing consent, voluntarily given by the patient, or his or her legally authorized representative, who can understand and weigh the risks and benefits of the particular treatment, including medication, being proposed.

Patient. A person who has been admitted to a facility pursuant to M.G.L. c. 123 and 104 CMR 27.00.

Specialty Population. An identified group of individuals with clinical needs in addition to their mental health needs that may require the provision of specialized services, staff competencies, or treatment structure in order to receive suitable treatment within a facility. These groups may include, but are not necessarily limited to, individuals with co-occurring mental health and intellectual or developmental disabilities, complex medical needs, or substance use disorder, older adults or children. Having a history of, or coexisting identification with, a specialty population does not necessarily require the provision of specialized services for every admission to a facility.

SUBPART AB: LICENSING

27.03: Licensing: Generally.

(1) Pursuant to M.G.L. ch. 19, the Department is responsible for developing and maintaining a comprehensive area-based system of mental health services for citizens of the Commonwealth. Critical to fulfilling this responsibility is striving to assure that individuals in need of mental health services are able to access those services in a timely manner and a geographically reasonable location. Facilities licensed in accordance with 104 CMR 27.00 fill an essential role in the Commonwealth's mental health service system and as such must be operated so as to meet the mental health needs of the Commonwealth as a whole as such needs may be determined from time to time by the Department.

(2) In determining the needs of the Commonwealth, the Department shall evaluate whether individuals have access to the appropriate services that meet their specific behavioral health care needs in a timely manner and, where possible, a geographically appropriate location. The Department will evaluate factors across the delivery system including but not limited to the number of beds in facilities that are licensed pursuant to 104 CMR 27.00 and in operation, by region and by license type, i.e. general psychiatric services, or services for specialty populations.

~~(3)~~(1) The Department will review the needs of the Commonwealth no less frequently than biannually to determine sufficiency of licensed capacity for general and specialty populations and in conducting such review may consider factors including, but not be limited to, emergency department utilization and wait time, inpatient utilization and wait time, and judicial referrals. In conducting this review, the Department will consult with stakeholders including, but not limited to, commercial and public payers, emergency departments, inpatient facilities, intermediate care providers, and patients, and shall consult with and utilize data from the Department of Public Health, the Center for Health Information and Analysis, and the Health Policy Commission.

(4) All private, county or municipal mental health facilities are subject to licensing by the Department pursuant to M.G.L. c. 19, § 19. A hospital, clinic or nursing home licensed by the Department of Public Health under M.G.L. c. 19, § 19111 which admits persons with mentally illness persons only on voluntary admission statusstatus, need not be licensed by the Department of Mental Health. All other hospitals licensed by the Department of Public Health which admit persons with mental illness on any admission status other than, or in addition to, voluntary status pursuant to 104 CMR 27.00, Subpart C shall also be licensed by the Department of Mental Health.

(2)(5) General and Specialty Populations:

(a) The Department may establish clinical competencies and additional operational standards for care and treatment of patients admitted to facilities licensed pursuant to 104 CMR 27.00, including for specialty populations. Clinical competencies and operational standards established by the Department shall incorporate national and local standards of

practice where such standards of practice exist, and to the extent deemed appropriate by the Department.

(b) No facility shall hold itself out as providing specialized care for such population(s) for which the Department has established clinical competencies and operational standards, nor shall any facility preferentially admit patients within such population(s), unless it has applied for and received a license certifying that the facility meets the applicable clinical competencies and operational standards for care and treatment of the specialty population(s).

(c) Nothing in this section shall permit a facility to have exclusion criteria that would result in the refusal to admit a patient who meets the general admission criteria for the facility, based solely upon the determination that the patient may also meet the criteria for a specialty population.

(6) Types of Licenses. Licensed mental health facilities shall be issued a single license which may incorporate one or more of the following classes:

(a) Class II. License to provide diagnosis and treatment of adults on voluntary admission status under M.G.L. c. 123, § 10.

(b) Class III. License to provide diagnosis and treatment of adults on conditional voluntary admission status under M.G.L. c. 123, §§ 10 and 11, and on involuntary committed status under M.G.L. c. 123, §§ 7 and 8, and to use restraint and seclusion. § 12.

(c) Class IV. License to provide diagnosis and treatment of adults on involuntary committed status under M.G.L. c. 123, § 12, and to use restraint and seclusion.

(c) Class IV. RESERVED

(d) Class V. License to provide evaluation, diagnosis and treatment of patients committed by order of a criminal court to determine competency to stand trial or criminal responsibility or for treatment under M.G.L. c. under M.G.L. c. 123, §§ 15, 16, 17 and 18, and to use restraint and seclusion.

(e) Class VI. License to provide diagnosis and treatment of minors on voluntary or conditional voluntary admission status under M.G.L. c. 123, §§ 10 and 11, and on involuntarily committed status under M.G.L. c. 123, §§ 7 and , 8 and 12, and to use restraint and seclusion.

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(f) Limited Class VI. License to provide diagnosis and treatment of minors age 16 and 17 on adult units on voluntary or conditional voluntary admission status under M.G.L. c. 123, §§ 10 and 11, and on involuntarily committed status under M.G.L. c. 123, §§ 7, and 8 and 12, and to use restraint and seclusion.

(g) Class VII. License to provide diagnosis and treatment of adolescents in an Intensive Residential Treatment Program (IRTP) on conditional voluntary or conditional voluntary admission status under M.G.L. c. 123, §§ 10 and 11, and on involuntarily committed status under M.G.L. c. 123, §§ 7 and 8, and. An IRTP may not be granted a Class VIII license to use restraint and seclusion administer electroconvulsive treatment.

(h) Class VIII. License to administer electroconvulsive treatment in a facility otherwise=

↔ Every licensed facility shall maintain complete records for each patient in accordance withby the provisions of M.G.L. 23, § 36 and 104 CMR 27.17Department.

(4) 7) Duration of License, Change in Ownership or Location.

(a) Licenses issued under 104 CMR 27.03 shall be valid for a term of two years and may be renewed for like terms, subject to limitation, suspension or revocation for cause. Licenses are not transferable from one licensee to another individual or agency or from one location to another.

(5(b) Licenses issued under 104 CMR 27.03 are not transferrable without the approval of the Department. Licensees wishing to transfer a license to another individual or entity or to relocate to another location must submit an application for such change in license to the Department and shall submit the fee established by the Department. , and transfer such to the Department's aApproval of such application shall be subject to upon a determination by the Department that licensee continues to satisfy applicable provisions of 104 CMR 27.00.

(8) Requirements for License or Renewal.

(a) Every applicantfacility applying for a license or for a subsequent renewal of such license shall use the forms prescribed by the Department and shall submit the fee established by the Department. A schedule of licensing fees may be obtained from the Department.

(b) (b) No application for licensure or for renewal of a license shall be approved unless the facility demonstrates, and the Department determines, that the facility it seeks to license is:

1. responsible and suitable to meet the needs of the community in which it is located and of the Commonwealth as a whole; and
2. able to meet the clinical competencies and operational standards for providing care and treatment to the population(s) it will serve.

~~A hospital, clinic or nursing home licensed by the Department of Public Health under M.G.L. c. 111 which admits mentally ill persons only on voluntary admission status pursuant to 104 CMR 27.06, need not be licensed by the Department of Mental Health as Class II. All other hospitals licensed by the Department of Public Health which admit mentally ill persons on any admission status other than, or in addition to, voluntary status shall also be licensed by the Department of Mental Health.~~

(c) Every facility seeking a license or a renewal of such license shall meet all applicable fire, health, building and safety codes, and shall make available upon request copies of all required licenses, permits, certificates of inspection and/or occupancy necessary for the operation of the facility in the location where it is situated.

(d) Every facility seeking a license or a renewal of such license shall demonstrate compliance with the standards of the American Institute of Architecture, or other nationally recognized standards, for facilities of the type licensed.

(e) Every facility seeking a license shall submit the following:

1. a statement of ownership, a plan showing the extent of the property, location and plans of existing buildings, and any plans and specifications of buildings to be erected. or renovated. Notice shall be given to the Department by the applicantfacility or licensee of any changes in these matters.

(f) Every facility seeking a license shall submit written 2. documentation which demonstrates compliance with applicable provisions of the Facility Guidelines Institute Guidelines for Design and Construction of Health Care Facilities, or other

nationally recognized standards, for facilities of the type licensed.

3. **Written plans** describing:

1. a. its plan for delivery and supervision of clinical services. All clinical services, as well as the supervision of such services, shall be performed by personnel qualified by license or experience in the field in which they are performing.

2. b. its plan for assuring adequate and appropriate staffing to meet the needs of the patient population at all times.

3. c. its plan for physical adaptations, such as by providing single occupancy bedrooms, when necessary to address behavioral acuity in its patient population, as needed.

d. its program of orientation and, continuing in-service education and demonstration of competencies for all personnel, both professional and non-professional, who provide care and treatment to patients.

4. A comprehensive strategic plan to prevent, reduce and, wherever possible, eliminate restraint and seclusion as required and defined in 104 CMR 27.12(1).

(d) In its application for a license, or for renewal of a license, the facility shall include a detailed description of its physical facilities as well as its plan for providing age appropriate programming and services. This plan and description shall be subject to approval by the Department. The plan shall include, but not be limited to, psychiatric, medical, nursing, social work and psychological services, occupational therapy, physical therapy, if any, recreational activities and equipment and person-centered treatment. In addition, for facilities licensed as Class VI, Limited VI and VII, the plan shall include educational programs, and youth guided and family driven treatment.

(e) A currently licensed facility seeking to renovate or expand such that there is a change in its capacity, or a significant change in its physical plant, or to significantly alter its service delivery program shall submit for approval such documentation as the Department may reasonably require demonstrating the facility's continued compliance with the provisions of 104 CMR 27.00.

(f) A currently licensed facility shall submit to the Department for approval notice of any changes in its ownership or significant changes in its physical plant or program design, and shall submit documentation of such changes as may be requested by the Department.

(fg) The Department may at any time require a facility which has been granted a license pursuant to 104 CMR 27.00 to demonstrate its compliance with applicable law, accreditation or certification standards, Department regulations, or implementation of any recommendations for corrections or deficiencies, by submitting such documentation or reports or permitting such inspection as may be requested by the Department. The Department may require a validation survey of a licensed facility to verify such compliance.

(9)

(6) Staffing.

(a) The director of a facility licensed as Class II, III, IV, V, VI, Limited VI, VIII or any combination thereof, shall Staffing.

(a) All facilities subject to licensure shall meet the following staffing requirements:

1. The facility shall have sufficient staff who have training and demonstrate competencies in functions consistent with their job responsibilities and, if required, have certification, and who demonstrate competencies, in such specialty services as the facility may provide.

2. The facility shall maintain staffing to meet the operational capacity of the facility at levels deemed adequate by the Department.

3. If the facility is operating below its licensed capacity, it shall specify in its application the reasons for operating below its licensed capacity and the ability to demonstrate its plan to meet the staffing requirements for its full licensed capacity.

4. The nursing and other clinical personnel shall be adequately prepared by education, training and experience to provide care and treatment for persons with mental illness.

(b) Facilities licensed as Class II, III, V, VI, Limited VI, VIII, or any combination thereof, shall meet the following requirements:

1. The facility director shall hold an advanced degree from an accredited college or university in a discipline appropriate to the care and treatment of persons with the mentally illness. If the director of a facility licensed as Class II, III, IV, V, VI, Limited VI, VIII or any combination thereof is not a fully licensed physician, there

shall be a director of psychiatric or medical services for such facility who is a physician fully licensed to practice medicine under Massachusetts law, and who is certified or eligible to be certified by the American Board of Psychiatry and Neurology in psychiatry; provided that in the discretion of the Department, **and subject to such conditions as the Department may impose**, experience and expertise may be considered in lieu of Board certification or eligibility.

2. (b) Facilities licensed as Class II, III, IV, V, VI, Limited VI, VIII or any combination thereof, The facility shall have a physician, under full or limited licensure as defined by Massachusetts law, on the premises at all times; provided, however, that after business hours and during weekends and holidays, this requirement may be satisfied through utilization of telemedicine or other technology pursuant to protocols approved by the Department that assure visual communication with an off-premises physician and adequate on-premises medical and clinical staff. Any such protocol shall require that the facility have an on-call physician who can be physically present at the facility within one hour.

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(c) The director or chief³. There shall be an identified nurse leader of nursing the facility, (e.g.: Director of a facility licensed as Class II, III, IV, V, VI, Limited VI, VIII or any combination thereof, Nursing, Chief Nursing Officer, Vice President of Nursing or Nurse Manager), who shall hold an advanced degree in psychiatric nursing, or an advanced degree in nursing and at least five years of experience in psychiatric nursing leadership, and shall be licensed to practice professional nursing. If such director or chief of nursing If the nurse leader does not hold such a meet the degree or experience or experience requirements, the facility shall provide for a person with such a degree, experience and license to provide supervision to the nurse leader and to coordinate and oversee in-service the training for its nursing personnel.

(d) In facilities licensed as Class II, III, IV, V, VI, Limited VI, VIII or any combination thereof, a⁴. A registered nurse licensed to practice professional nursing under Massachusetts law shall be on duty on each unit of the facility at all times.

(e) The nursing personnel of every facility subject to licensure shall be adequately prepared by education, training and experience to provide care and treatment for patients with mental illness. The facility shall maintain such nursing force at levels deemed adequate by the Department.

(7) Additional Requirements for Class VI, Limited VI, and VII Facilities. In addition to complying with all applicable standards in this title, a(c) A facility licensed as Class VI, Limited VI, or VII shall comply with the following requirements.

(a) In its application for a license, or for renewal of a license, the facility shall include a detailed description of its physical facilities as well as its plan for providing age appropriate programming and services. This plan and description shall be subject to approval by the Commissioner or designee. The plan shall include but not be limited to psychiatric, medical, nursing, social work and psychological services, family-focused treatment, occupational therapy, physical therapy if any, educational programs, recreational activities and equipment, and outdoor facilities.

(b) A child and adolescent psychiatrist certified or eligible to be certified in child and adolescent psychiatry by the American Board of Psychiatry and Neurology or the American Board of Adolescent Psychiatry shall provide on-site supervision of the care and treatment of patients in Class VI and VII facilities and shall be available for consultation and case supervision as needed for patients in Limited Class VI facilities.

(c) The facility VII shall have on its staff, or, as consultants, a pediatrician and a pediatric neurologist, both of whom shall be fully licensed to practice medicine under Massachusetts law.

(d) If the facility employs behavioral management, it must meet the requirements of 104 CMR 27.

(10(7)).

(8) Additional requirementsRequirements for Class VIII Facilities. In addition to complying with all applicable standards in this title, a facility licensed as Class VIII shall comply with the following requirements:

(a) The facility shall establish a written planhave policies and procedures for the administration of electroconvulsive treatment (ECT) in compliance with the standards set forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and with, or other nationally recognized accreditation agency approved by the CommissionerDepartment, and the current practice guidelines established by the American Psychiatric Association.

(b) Monthly Reports. All facilities administering electroconvulsive treatment (ECT)ECT to inpatients or outpatients shall maintain aggregatesuch data as the Department may determine, which shall be available to the DepartmentDepartment for inspection upon request and at =

~~(9)~~ Additional Requirements for Class III through VII Facilities. In addition to complying with all applicable standards in this title, a facility to be licensed as Class III through VII shall include the following in its application for a license or renewal of a license:

(a) the time of the facility's plan to reduce and, wherever possible, eliminate restraint and seclusion as required by 104 CMR 27.12(1);licensing survey.

(11)(b) a comprehensive statement of the facility's policies and procedures for the utilization and monitoring of restraint and seclusion, including a listing of all types of mechanical restraints used by the facility, a statistical analysis of the facility's actual use of such restraint and seclusion, and a certification by the facility of its ability and intent to comply with all applicable statutes and regulations, including 104 CMR 27.12, regarding physical space, staff training, staff authorization, record keeping, monitoring and other requirements for the use of restraint and seclusion.

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~~(40)~~ Additional requirementsRequirements for facilitiesFacilities or Programs that provide certain substance use disorder treatment servicesProvide Certain Substance Use Disorder Treatment Services. In addition to complying with all applicable standards in this title, facilities that provide substance use disorder treatment services, as provided in 104 CMR 27.03(1011), shall comply with the following requirements:

(a) Definitions applicable to 104 CMR 27.03(1011):

Adverse Drug Event means an. An undesirable effect, reasonably associated with use of a drug that may occur as part of the pharmacological action of the drug or may be unpredictable in its occurrence. This definition does not include all adverse events observed during use of a drug;; only those adverse events for which there is some basis to believe there is a causal relationship between the drug and the occurrence of the adverse drug event.

BSAS means the. The Bureau of Substance Abuse Services within the Department of Public Health.

Medically Assisted Treatment for Substance Use Disorders means dispensing. Dispensing of a medication in gradually decreasing doses to alleviate adverse physical or psychological effects incident to withdrawal from the continuous or sustained use of physically addictive substances, including alcohol, prescribed medications and illicit substances. The purpose of medically supervised withdrawal is to bring a patient to an alcohol and/or drug free state within a target period.

Medically Monitored Detoxification Services means. 24-hour per day nursing care, under the direction of a physician, to monitor an individual's withdrawal from alcohol and other drugs and alleviate symptoms.

(b) In addition to complying with all applicable standards in this title, a facility that provides substance use disorder treatment services, as provided in 104 CMR 27.03(11), shall comply with the following requirements, if applicable.

1. A facility that is within a general hospital licensed by the Department of Public Health under M.G.L. c. 111, § 51 that offers a separate, identifiable inpatient substance use disorder treatment unit or program, or that holds itself out as providing substance use disorder treatment or services as a primary or specialty service, shall meet the requirements of 105 CMR 164.012(D)(2).

2. A facility that is not within a general hospital licensed by the Department of Public Health under M.G.L. c. 111, § 51 that offers a separate, identifiable inpatient substance use disorder treatment unit or program, or that holds itself out as providing substance use disorder treatment or services as a primary or specialty service shall apply for and obtain “a BSAS license for a DMHDepartment of Mental Health licensed facility” as provided in 105 CMR 164.012(D)(3).

3. A facility that provides medically monitored detoxification or medically assisted treatment for substance use disorders incidental to the evaluation, diagnostic and treatment services for which it is licensed under this title, and that does not offer a separate, identifiable inpatient substance use disorder treatment unit or program, or holdor hold itself out as providing substance use disorder treatment or services as a primary or specialty service, shall:

a. Adopt and follow BSAS approved protocols for the provision of medically monitored detoxification or medically assisted treatment for substance use disorders;.

b. Include in its application for a license or renewal of a license a description of the medically monitored detoxification or medically assisted treatment for substance use disorders it provides, including a copy of the protocols it has adopted pursuant to 104 CMR 27.03(1011)(b)3.a., a statement of the approximate percentage of its patients who receive such services, and a statement attesting that it does not hold itself out as providing substance use disorder treatment or services as a primary or specialty service.

c. Include in its application for a license a description of its group and individual substance use disorder programming for patients who are dually diagnosed with a mental illness and a substance use disorder, including its plan for assisting patients in obtaining care coordination upon discharge from inpatient acute level care.

(c) In addition to the reporting requirements provided in 104 CMR 32.00, a facility that provides substance use disorder treatment or services as provided in 104 CMR 27.03(1011) shall report any adverse drug events that occur in connection with such

treatment or services to the DMH Director of Licensing no later than the next business day following the occurrence of such adverse event.

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~~(H)~~ Accreditation.

(a) A facility seeking a license as Class II, III, **IV**, V, VI, Limited VI, VIII, or any combination thereof, or a renewal of such license, shall be accredited by the Joint Commission or other nationally recognized accreditation agency approved by the **CommissionerDepartment** utilizing the applicable standards as promulgated by said Joint Commission or agency. Facilities that have not yet attained accreditation **shall must** be in substantial compliance with those standards, and must submit a plan for obtaining accreditation within a reasonable period of time.

(b) A facility seeking a license as Class VII, or a renewal of such license shall be accredited as a residential treatment program by the Joint Commission or other nationally recognized accreditation agency approved by the **CommissionerDepartment**. Facilities that have not yet attained accreditation must be in substantial compliance with the standards for residential treatment programs set forth by said Joint Commission or agency, and must submit a plan for obtaining accreditation within a reasonable period of time.

(1213) Deemed Status. In addition to the Departmental action on license applications as set forth below, and any additional requirements for Class VII facilities set forth in 104 CMR 27.04, the Department may approve licensure of accredited facilities in accordance with the following requirements for deemed status.:

(a) **A In its application for licensure or for renewal of a license, an accredited facility requesting which desires to obtain or retain deemed status shall provide to the Department a copy of the facility's current accreditation letter and the accrediting agency's explanation of its survey findings. The facility shall also:**

1. **Provide the Department with notice of any survey or inspection conducted by the accrediting agency, including notice of the time and place of summation conferences scheduled at the completion of any such survey or inspection;**
2. **Permit Department observers at the summation conferences scheduled at the completion of any survey or inspection conducted by the accrediting agency;**
3. **Provide copies of any accreditation letters, the accrediting agency's explanation of its survey findings received while its license is in effect; and any other accreditation information requested.**

(b) A facility requesting deemed status shall submit for Department review and approval written plans **for, policies and procedures that demonstrate** compliance with Department regulations governing restraint and seclusion, human rights, **and investigation of complaints., interpreter services, and delivery and supervision of clinical services.**

(c) **A facility which has been granted deemed status shall notify the Department of the time and place of the summation conferences scheduled at the completion of an accreditation, and shall permit Department observers to attend such conferences.**

(d)(c) The Department may at any time require a facility which has been granted deemed status to demonstrate its compliance with applicable law, accreditation standards, Department regulations, or implementation of any recommendations for corrections or deficiencies, by submitting such documentation or reports or permitting such inspection as may be requested by the Department. The Department may require a validation survey of an accredited facility to verify such compliance.

(ed) A facility which has been granted deemed status shall immediately notify the Department of any change in its accreditation status.

(fe) The **Commissioner or designeeDepartment** may revoke the deemed status of an accredited facility if:

1. The facility loses its accreditation;
2. The facility fails to cooperate with the Department's validation survey or requests for documentation or reports;
3. The facility fails to cooperate with a Department investigation in accordance with 104 CMR 32.00;
4. The facility is out of compliance with applicable accreditation standards and a significant deficiency is determined to exist;
5. The facility is out of conformity with its plans for compliance with Department regulations on restraint and seclusion, human rights, **and including reasonable access to fresh air, investigation of complaints. and interpreter services.**
6. The facility is out of compliance with other applicable Department regulations.

(gf) A facility whose deemed status has been revoked may be subject to a licensing review or full survey pursuant to 104 CMR 27.00.

(hg) A facility may request an informal administrative review of a decision to deny or revoke deemed status. The facility must request an informal administrative review in writing within 15 days of the date it receives notice of the denial or revocation of its deemed status by the **Commissioner or designee, Department**. The request shall state the reasons why the facility considers the denial or revocation of deemed status incorrect. The written request shall be accompanied by any supporting evidence or arguments.

(ih) The **Commissioner or designee, Department** shall notify the facility, in writing, of the results of the informal administrative review within 20 days of receipt of the request for review. Failure of the **Commissioner or designee, Department** to respond within that time shall be considered confirmation of the denial or revocation of deemed status.

| NON-TEXT PAGE

27.03: continued

(13(i) Following denial or revocation under 104 CMR 27.03(13)(e), the Department may, upon application of the facility, reinstate deemed status to an accredited facility if the Department finds the facility meets the requirements of 104 CMR 27.03(13).

(14) If a facility is not yet accredited by the Joint Commission or if an accredited facility chooses not to apply for deemed status, it shall be subject to a full survey for licensure by the Department.

(14) Provisional (15) Renewal of License. A provisional

(a) Facilities seeking renewal of a license shall be used meet all requirements for licensure specified in 104 CMR 27.00 and 104 CMR 32.00 *Investigations and Reporting Responsibilities*.

(b) Facilities seeking renewal of a license must submit to the Department completed forms and fees required by the Department at least 60 days prior to the expiration of the current license or approval.

(c) If the complete renewal application is timely filed with the Department, the facility's then current license or approval shall not expire until the Department makes a determination on the renewal application.

(16) Provisional Licenses.

(a) The Department may issue a provisional license or approval in response to a new application for a facility not currently in operation or for which compliance cannot be fully determined without an evaluation of the facility in operation. After the granting of

(b) When the Department finds that a facility that is applying for re-licensure has not complied with all applicable regulations, but is in substantial compliance and has submitted an acceptable plan of correction for bringing the facility into full compliance, the Department may issue a provisional license or , provided that:

1. The facility demonstrates to the initial provision of services by Department's satisfaction a good faith intent to meet all the facility, the requirements;
2. The Department shall conduct a timely evaluation of finds that the service offered protects the health and safety of the facility's clients; and
3. The Department finds that the facility to evidences the potential for full compliance within a reasonable period of time, not to exceed six months.

(c) A provisional license or approval is valid for a period not to exceed six months, but may be extended for additional periods not to exceed six months at the Department's discretion, subject to such terms or restrictions as the Department may determine what action regarding licensure should be taken. The Department may issue a provisional license or approval only when a facility submits a written plan for full compliance with the requirements of 104 CMR 27.00. This written plan shall include specific target dates for achieving full compliance.

(15) 17) Departmental Action on License Application.

(a) Upon receipt and review of all required documentation, and after any site visit or survey deemed necessary by the Department, the Department may take one of the following actions:

- (a) 1. Approve the facility for licensure, if
 - a. no deficiencies are outstanding;
- (b) 2. Approve the facility for licensure, subject to demonstrated progress by the program applicant facility in implementing a plan of correction approved by Department; the Department addressing any deficiencies or failure to meet requirements under of 104 CMR 27.03(17)(a)1.
 - b. the application meets criteria of responsibility and suitability for meeting the needs of the community and of the Commonwealth as determined by the Department; and
 - c. the application assures that no patient who meets the clinical criteria for involuntary commitment pursuant to M.G.L. c. 123, § 12(b), and who has been medically cleared for admission, will be rejected for admission; provided, however, that a facility may deny admission to such a patient only if it complies with the provisions of 104 CMR 27.05(3).
- (c) 3. Disapprove the facility for licensure until such time as deficiencies are corrected.

(d) 3. Approve the facility for a provisional license subject to such conditions as noted in 27.03(16), or as the Department deems necessary.

4. Disapprove the facility for licensure until such time as identified deficiencies are corrected.

(b) For applications for license renewal, the Department's determination that the facility is meeting the needs of the community and the Commonwealth shall include:

1. a review of admission data submitted by the facility pursuant to 104 CMR 27.05(3)(e); and

2. an assessment of whether the facility is in compliance with clinical competencies and operational standards as established by the Department and adherence to all licensure requirements set forth herein.

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~~(16)~~ Departmental Surveys and Inspection.

(a) (a) The Department shall conduct a survey at least every two years of each facility to determine the facility's compliance with applicable provisions of the Department's regulations. The survey of a facility granted deemed status shall for the purpose of determining the facility's compliance with Department regulations governing restraint and seclusion, human rights, investigation of complaints, and interpreter services, and its plan for delivery and supervision of clinical services.

(b) Notwithstanding a facility's deemed status, the provisions of 104 CMR 27.03(18)(a), the Department may conduct random, periodic surveys or announced or unannounced inspections of any facility licensed hereunder to determine compliance with accreditation standards or the applicable provisions of 104 CMR. the Department's regulations. Such random survey inspections need not pertain to any actual or suspected deficiency in compliance with accreditation standards or 104 CMR 27.00. applicable provisions of the Department's regulations Refusal to permit inspection inspections shall be sufficient cause for revocation of a facility's license.

(b) Without limiting the generality of the foregoing, the Department shall conduct annual inspections of facilities granted deemed status to determine their compliance with Department regulations governing restraint and seclusion, human rights, investigation of complaints, and interpreter services.

(c) Licensed facilities shall immediately notify the Department of any substantial change in its physical plant, staffing or services, and shall submit documentation of such changes as may be requested by the Department.

(d) (c) The scope of the Department's inspections shall include any aspect of the operation of the facility, and may include, but is not limited to, confidential interviews with patients and staff, and examination and review of all records, including those of current and discharged patients.

(ed) The Department shall provide a copy of the inspection report to the facility director.

(17(e) Plan of Correction: After every inspection in which any violation of the Department's regulations is observed, the Department shall prepare a written deficiency correction order citing every violation observed, a copy of which shall be sent to the licensee. The deficiency correction order shall include a statement of the deficiencies found, the period within which the deficiency must be corrected, and the provision(s) of law and regulation relied upon.

1. The licensee shall submit to the Department a written plan for correction of each violation cited in a deficiency correction order within a time period specified by the Department in the correction oOrder.

2. The plan of correction shall set forth, with respect to each deficiency, the specific corrective step(s) to be taken, a timetable for each step, and the date by which full compliance will be achieved. The timetable and the compliance dates shall be consistent with achievement of compliance in the most expeditious manner possible. The plan of correction shall be signed by either the facility director or his or her designee.

3. Unless the Department states in the deficiency correction order that more urgent corrective action is necessary, based on the seriousness of the deficiency, the licensee shall be given a maximum 30 days from receipt of the correction order to remove the deficiency. The Department may specify a different date by which the corrections shall be completed, in the event that the licensee requests additional time and the Department determines that it is necessary.

4. The Department shall review the plan of correction and will notify the licensee of either the acceptance or rejection of the plan. An unacceptable plan must be amended and resubmitted within ten business days of the date of notice of rejection.

5. Failure to submit an acceptable and timely plan of correction or failure to timely correct in accordance with the Pplan of correction are grounds for an enforcement action, including suspension or revocation of a license.

(19) Revocation, Suspension or Limitation of License.

(a) Failure to comply with the requirements for licensure as set forth in 104 CMR 27.00 may constitute sufficient cause for the Department to **refuse to grant**deny, suspend, revoke, **limit** or restrict the applicability of, or refuse to renew, one or more classes of licenses pursuant to the procedural requirements and provisions of M.G.L. c. 30A. **The Department, under**

(b) In restricting the authorityapplicability of one or more classes of licenses, the Department may issue deficiency correction orders, reprimands or other appropriate orders to obtain compliance with 104 CMR 27.00; provided that such actions may be subject to the procedural requirements and provisions of M.G.L. c. 19, § 19,30A.

(c) **The Department** may take reasonable action, including, but not limited to, temporarily suspending **or restricting** a license prior to a hearing in cases of emergency if it deems that such action would be in the public interest; provided, however, that upon request of an aggrieved party, a hearing pursuant to M.G.L. c. 30A, § 13 shall be held after such action is taken. Any action taken pursuant to 104 CMR 27.03(19)(c) shall remain in effect during the pendency of any proceeding pursuant to M.G.L. c. 30A., unless otherwise determined by the Department.

(18) In restricting(20) Grounds for Denial, Refusal to Renew, Restriction, Suspension or limiting the applicabilityRevocation of one License.

Each of the following, in and of itself, shall constitute full and adequate grounds to deny, revoke, suspend, restrict, **or more classes**refuse renewal of licenses,a license:

(a) Failure to meet the applicable requirements for licensure as specified in 104 CMR 27.00 *et seq.*;

(b) Failure to meet the requirements of applicable federal or state law or regulations, including failure to comply with the laws of the Commonwealth related to taxes and child support, workers compensation, or failure to maintain professional and commercial insurance coverage.

(c) Violation of any applicable requirement of 104 CMR 27.00 and 104 CMR 32.00.

(d) Failure to give proper care and treatment to clients.

(e) Failure to submit an acceptable plan of correction pursuant to 104 CMR 27.03(18).

(f) Failure to remedy or correct a cited violation.

(g) Denial of entry to agents of **the Department** may issue deficiency orders, reprimandsor attempt to impede the work of a duly authorized representative of the Department.

(h) Knowingly making an omission of material information or providing false or misleading statements orally or in writing to the Department.

(i) Operating without a required license or approval or after the expiration of a license or approval if the facility has not timely submitted an application for renewal.

(j) Determination by **There is a reasonable basis for the Department to conclude that there is a discrepancy between the representations by a facility as to the treatment services to be afforded patients and the treatment services actually rendered or to be rendered.**

(k) Conviction of a person with significant financial or management interest in the facility of Medicare or Medicaid fraud **or other appropriate orders**criminal offense related to obtain compliancethe operation of the facility.

(l) Conviction of a facility or licensee or a person **with significant financial or management interest of a violent crime against a person, which indicates that operation of the facility may endanger the public health or safety.**

(m) Other grounds: Nothing herein shall limit the Department's adoption of policies and grounds for denial, refusal to renew, or revocation through formal and informal rule making.

(21) Required Notifications to the Department. In addition to, and notwithstanding, any other provision of 104 CMR 27.00; provided that or 104 CMR 32.00, facilities shall comply with the following notification requirements:

(a) Change of Name, Ownership, or Location. At least 90 days prior to a change in location, name, ownership or control of the facility, the facility shall notify the

Department in writing of the proposed change as provided in 104 CMR 27.03(7). Upon receipt of such actionsnotice, the Department shall determine whether additional action is required.

(b) Change in Accreditation or Certification; Notices of Termination, Immediate Jeopardy, and Corrective Action Orders. A facility shall immediately notify the Department of any change, or notice of change, in its accreditation or Center for Medicare and Medicaid Services (CMS) certification status, including, but not limited to, Notices of Termination, Notices of Immediate Jeopardy, or issuance of corrective action orders by the accrediting entity or CMS.. A facility's response to any such notice, order or other change, or notice of change, in accreditation or certification status shall be delivered to the Department simultaneously with delivery to the accreditation entity or CMS.

(c) Legal Proceedings. The facility shall report in writing to the Department any civil action or criminal charge that is brought against the facility or any person employed by the facility that relates to the delivery of the service or may be subject to the procedural requirements and provisions of M.G.L. c. 30A.affect the continued operation of the facility. The report shall be given to the Department as soon as the facility is aware of the action and no later than 24 hours of the facility becoming aware of any legal action or within 24 hours of service of notice upon the facility or its agent, whichever occurs first.

(19(d) Closure. When a facility plans to cease operation, the facility shall:

1. Notify the Department in writing at least 90 days prior to cessation of operations and closure. Such notification shall specify the date of closure and shall include the facility's plan for closure. This notification requirement shall include closures due to foreclosure or bankruptcy proceedings.
2. In the case of involuntary closure not due to an action of the Department, notify the Department as soon as the facility is aware of the pending closure and prior to cessation of operations and closure.

(e) Interruption or Suspension of Service. If a facility determines that the health, safety or well-being of clients is in imminent danger as a result of conditions existing within the service, program or facility, the facility shall verbally notify the Department immediately, and in writing within one business day, upon becoming aware of the danger to clients. The Department shall consult with the facility regarding the need to interrupt or suspend services.

(f) Change of Program or Service Provision. A facility shall notify the Department in writing at least 30 days before any substantial change in program or service provision as provided in 104 CMR 27.03(7). The Department shall determine whether such change requires re-licensure.

(g) Change of Senior Leadership.: A facility shall notify the Department at least two weeks before a planned change of senior leadership of the facility. In the event of an unplanned departure of a senior leader, the facility shall notify the Department in writing within two business days of the unplanned departure.

(h) Death, Serious Incident, Accident or Fire, Safety and Health Conditions. The facility shall verbally notify the Department immediately, and in writing within one business day, of the following:

1. upon learning of the death of any personpatient currently admitted to the facility, regardless of where the death occurs;
2. any serious incident, including but not limited to, a complaint reportable pursuant to 104 CMR 32.04(2)(a), which occurs under facility auspices, regardless of location.
3. any fire or other event resulting in damage to the facility;
4. any alleged abuse or neglect, or sexual or serious physical assault, which occurs between or among clients at the facility, or which occurs between or among clients and staff regardless of location, including any incident which is reported to another agency or law enforcement, including, but not limited to:
 - a. any reports of child abuse or neglect made under M.G.L. c. 119, § 51A;
 - b. any reports of elder abuse or neglect made under M.G.L. c. 19A, § 15; and
 - c. any reports of abuse of a disabled person made under M.G.L. c. 19C;
5. any condition at the facility which poses a threat to the health or safety of clients or staff; for example, conditions which limit access, unsanitary conditions, fire hazards, loss of essential services such as heat, hot water and electricity, regardless of whether the conditions cause an interruption of service. The facility shall consult with the Department to determine whether the condition requires an interruption or suspension of service;
6. confirmed cases among staff or clients of communicable diseases which are

reportable under 105 CMR 300.000: *Reportable Diseases*; and
7. any complaint communicated to the facility by the Occupational Safety & Health Administration (OSHA) or the state Commonwealth Division of Labor Standards (DLS), as well as any findings, citations, agreements or other notifications from OSHA or DLS in connection with such complaints.

(j) Reports of Abuse and Neglect. When alleged abuse or neglect occurs at the facility, the facility shall verbally notify the Department immediately, and in writing within one business day of:

1. any reports of child abuse or neglect made under M.G.L. c. 119, § 51A;
2. any reports of elder abuse or neglect made under M.G.L. c. 19A, § 15; and
3. any reports of abuse of a disabled person made under M.G.L. c. 19C.

The facility shall document its evaluation of whether any such incident should be reported to any other agency, including professional licensing bodies or law enforcement.

(22) Waiver.

(a) The requirements of 104 CMR 27.03 through 27.1700 *et seq* shall be strictly enforced, and shall not be subject to waiver, except as specifically authorized by the Commissioner or designee Department in accordance with the provisions of 104 CMR 27.03(1822).

(b) No waiver may be granted by the Commissioner or designee without a Department without written documentation supporting the request for a waiver and a determination by the Commissioner or designee Department that:

1. The health, safety, or welfare of neither patients nor staff may be adversely affected by granting the waiver; and that

27.03: continued

2. In justification of the waiver, a substitute provision or alternative standard has been stated and is found by the Department to result in comparable services to the patients, and to which the facility will be held accountable to the same degree and manner as any provision of 104 CMR 27.00.

(c) Waivers may be granted for the duration of a facility's license, or for such other period of time as the Department may determine, and may be renewable.

(d) The granting of a waiver for any single facility or period of time shall not require or signify the granting of a waiver for any other facility or period of time.

27.04: Licensing: Intensive Residential Treatment Programs (IRTP)

(1) Adolescent Intensive Residential Treatment Program. An adolescent **intensive residential treatment program** **Intensive Residential Treatment Program** (IRTP) is a residential mental health program which provides comprehensive treatment and education in a secure setting to **mentally ill** adolescents **with serious emotional disturbance or mental illness** and which has the capacity to admit such adolescents **on an involuntary basis** pursuant to the provisions of M.G.L. c. 123 §§ 3, 7 and 8, and 10 and 11. IRTPs **may not receive a Class VIII license** **are not authorized** to administer electroconvulsive treatment.

(2) Eligibility. Only individuals who meet the following criteria may be eligible for admission to an IRTP:

(a) The individual shall be from 13 through 18 years of age. An individual already admitted to an IRTP who becomes 19 years of age may, **upon approval of the Commissioner or designee**, remain there to complete his or her course of treatment; **and**

(b) The individual has been determined to require **long-term (i.e., typically, at least three months or longer) continuing care and** treatment in a secure residential setting; **and**

(c) **Treatment in a less restrictive setting has been determined to be inappropriate for the individual; and**

(d) Failure to place the individual in a secure treatment setting would create a likelihood of serious harm by reason of mental illness.; **and**

(e) **There is no appropriate, less restrictive setting available.**

(3) Admission. Individuals who meet the IRTP eligibility criteria may be admitted to and retained in an IRTP only in accordance with the provisions of M.G.L. c. 123, §§ 3, 7 and 8 or 10 and 11 **or 7 and 8**, and the **regulations promulgated thereunder.** **applicable provisions of 104 CMR 27.00.** For IRTPs operated by or under contract with the Department, individuals may only be admitted upon approval of the Department. Referrals for admission **to an IRTP operated by or under contract with the Department** shall be made through an admissions process, as designated by the Department, and shall contain such clinical information and documentation as the Department may require.

(4) Location. If an IRTP is located on the grounds of a state hospital or in the same building as an **adult** inpatient mental health unit **or an adolescent continuing care inpatient unit**, it shall have program, kitchen and eating facilities separate from those of the state hospital or inpatient unit.

(5) Staffing. Each IRTP shall be staffed at a level sufficient to meet the clinical needs of the patients, as well as the administrative and ancillary services necessary to the operation of the **program** **IRTP**, consistent with the requirements of **JCAHO** **Joint Commission** or other accreditation agency approved by the **Commissioner** **Department**. Among the clinical staff shall be persons **in appropriate disciplines** qualified to provide services **in appropriate disciplines, including, but, which shall include, but are** not limited to: psychiatric and psychological intervention; individual, group and family therapy; **nursing care**; milieu **managementsupport**; medication administration; discharge planning; education; **vocational training; and rehabilitation services**; recreation; **and peer and family support.**

(a) Each IRTP shall have sufficient full-time senior management to provide adequate oversight of program, clinical and psychiatric operations. Senior managers with responsibility for clinical matters shall be mental health professionals, licensed as independent clinicians in their field of training and expertise. At least one member of senior management shall be a licensed mental health professional who is, by training or experience, a specialist in the treatment of adolescents.

(b) Each IRTP shall have a psychiatrist, board certified, (or eligible) in child and adolescent psychiatry, available for consultation and shall have a psychiatrist on site or on call, 24 hours a day, for psychiatric emergencies, including but not limited to seclusion and restraint.

27.04: continued

(c) Each IRTP shall have sufficient qualified **nursing staff registered nurses on each shift** for the administration of regularly prescribed medications, as well as for administration of *pro re nata* (PRN) and emergency medication and conducting examinations pursuant to 104 CMR 27.12.

(d) Each IRTP shall have a sufficient number of independently licensed mental health professionals such that the primary individual and family therapist for each **patient adolescent** shall be so licensed.

(e) Provision shall be made to ensure that sufficient back-up personnel are available to respond within a reasonable time in emergency situations.

(6) General Physical Requirements.

(a) Each **program IRTP** shall provide **outdoor recreational and indoor** space that is safe, comfortable, well-lighted, well-ventilated, adequate in size and of sufficient quality to be utilized in a manner consistent with the overall philosophy and treatment goals of the **program IRTP**.

(b) Each **program IRTP** shall provide sufficient security features to enable the staff to prevent physical harm to patients and to staff **and to prevent escape from the program**, including the capacity to lock the **program to prevent unauthorized access to the community IRTP**.

SUBPART BC: OPERATIONAL STANDARDS FOR MENTAL HEALTH FACILITIES

27.05: General Admission Procedures

(1) For the purpose of involuntary commitment, mental illness is defined as a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, but shall not include **alcoholism or substance abuse which is defined in M.G.L. c. 123, § 35 intellectual or developmental disabilities, autism spectrum disorder, traumatic brain injury or organic disorders, or except as provided in 104 CMR 27.18, alcohol and substance use disorders; provided, however, that the presence of such conditions co-occurring with a mental illness shall not disqualify a person who otherwise meets the criteria for admission to a mental health facility.**

(2) For the purposes of voluntary or conditional voluntary admission to mental health facilities in the Commonwealth, any degree of severity of a mental disorder, including **alcoholism co-occurring substance use disorders**, may qualify a person for admission to a mental health facility at the discretion of the facility director or designee when it is determined that **such admission is necessary and appropriate the person is in need of care and treatment, and that the admitting facility is suitable for such care and treatment.**

(3) Admission Examination. Upon admission, each person (3) **No facility licensed as Class III through VII (including Limited Class VI) shall have exclusion criteria for admission that would result in the rejection of any patient who has been determined by a designated physician at of the facility to meet the clinical criteria for involuntary commitment pursuant to M.G.L. c. 123, § 12(b); provided, however, that a facility that has been certified to treat specialty populations, such as for treating geriatric patients or patients with co-occurring intellectual or developmental disabilities, may preferentially admit such patients. Facilities may not deny admission to a patient for whom it has the clinical competency and staffing to appropriately treat, except as provided in 104 CMR 27.05(3) (b) through (d).**

(a) **A facility licensed as Class III through VII (including Limited Class VI) shall have the capacity to care for patients otherwise meeting admission criteria who have co-occurring medical needs in accordance with clinical competencies and operational standards determined by the Department.**

(b) **A facility may deny admission to a patient if such admission would result in a census exceeding the facility's operational capacity; provided, however, that the facility is able to demonstrate that, despite its best efforts, it is unable to accommodate the additional capacity.**

(c) **A facility may deny admission to a patient if such admission would result in a census exceeding the facility's licensed capacity.**

(d) **A facility may deny admission to a patient whose needs have been determined by the**

facility medical director to exceed the facility's capability at the time admission is sought. The determination shall include the factors justifying denial of admission and why mitigating efforts, such as utilization of additional staff, would have been inadequate. This determination must be recorded in writing and shall be subject to review by the Department.

(e) Facilities shall keep data on patients referred for admission in a form and format and containing data elements as determined by the Department. Such data shall be available for inspection by the Department upon request.

(4) Admission Examination. Upon admission, each patient shall receive a mental status examination and, within 24 hours of admission, a complete psychiatric and physical examination. In the case of admissions to an IRTP, such physical examination shall occur within seven calendar days of admission. As part of the admission examination, staff shall seek to determine from the patient, the patient's record, the patient's legally authorized representative or, if appropriate and authorized, from other sources, whether the patient has a history of trauma, including but not limited to, physical or sexual abuse or witnessing violence. At the completion of each admission examination, the physician shall make an admission diagnosis, and shall enter the findings of such admission examination in the patient's medical record.

(45) Admission Examination for PersonsPatients under the Age of 22.

(a) In addition to the requirements above of 104 CMR 27.05(4), the admission examination for personspatients under the age of 22 shall include a determination as to whether the individualpatient has special educational needs.

(b) If the individualpatient has special educational needs, the facility director shall seek written authorization to provide necessary clinical information to the patient's Local Education Authority (LEA) in order that an educational program can be jointly developed for such patient by the LEA and the facility.

(56) Notice to Family or Others.

(a) Admission of IndividualsPatients Age 16 or Over. In accordance with M.G.L. c. Within123, § 4, the facility director or designee shall, within 48 hours after admission of any patient, including a patient age 16 or 17 who has applied for admission himself or herself, the director of the facility, or designee, shall notify the patient's legally authorized representative and, unless requestedor, if there is no such legally authorized representative and the patient does not do so, theknowingly object, his or her nearest relative regarding the admission of such patient to the facility. In the alternative, a competent patient over the age of 18 may designate any two persons to receive such notification.. Notice may be given by telephone, telegram, letter or other appropriate means.

27.05: continued

(b) AdmissionEmergency or Court Ordered Admissions of all other minors.Minors. Except in an emergency, or pursuant to court order, nothe case of a mature or emancipated minor, except a 16 or 17 year old who has applied for admission himself or herself, shall be admitted to a facility without notice to and consent of the minor's as defined in 104 CMR 25.03, the legally authorized representative. In an emergency or of a minor shall be notified immediately upon receipt of the minor who is admitted pursuant to a court order (includingor an application for admission pursuant to M.G.L. c. 123, § 12 with or without the consent of the legally authorized representative), the legally authorized representative shall be notified forthwith upon receipt of the minor at the facility..

(67) Denial of Admission. Applicants for voluntary or conditional voluntary admission to mental health facilities shall not be denied admission without an explanation of the basis for such refusal, and alternatives shall be offered or recommended by the admitting physician where feasible.

(78) Prohibition of Admission of Individuals underUnder the Age of 19 to Adult Inpatient Units; Exceptions. Except as provided in 104 CMR 27.05(78), no individual under the age of 19 years shall be admitted to an adult unit of a Department operated facility.

(a) The Department may place an individual age 17 or 18 on such an adult inpatient unit where a judge of a court of competent jurisdiction has issued an order for the commitment of the individual to a mental health facility pursuant to the provisions of M.G.L. c. 123, §§ 15, 16, 17, or 18, or where the individual has been committed to the Department of Youth Services, and the Commissioner or designee has determined that one or both of the following factors exist:

1. placement of the individual on an adolescent inpatient unit would create a likelihood of serious harm to the individual or others; or
2. the individual is in need of stricter security than is available on an adolescent inpatient unit.

(b) The factors to be considered in the above determinations include, but are not limited to, the following:

1. the nature, circumstances and seriousness of the offense with which the individual has been charged;
2. the individual's court and delinquency record;
3. the individual's maturity;
4. the individual's history of mental illness;
5. the individual's social history;
6. the risk of harm presented by the individual's placement on an adolescent inpatient unit;
7. the individual's history of victimizing others;
8. the mental health treatment most suitable for the individual.

(c) The statewide specialty Deaf Unit at Westborough State Hospital and the Commonwealth Research and Evaluation Unit at Erich Lindemann Mental Health CenterSpecialty services or units designated by the Department may admit individuals under the age of 19, provided that the Unitsthey ensure appropriate separate physical space and programmatic services for them, as approved by the Commissioner.

(8) Computation of Time. (9) Unless otherwise specified, all computation of days withintime for any action required to be taken under 104 CMR 27.00 SUBPART B shall be in accordance with the following:104 CMR 25.04.

(a) when the time period is less than seven calendar days, Saturdays, Sundays, and legal holidays are not counted;

(b) when the time period is seven calendar days or longer, the time is counted in calendar days, except when the last day is a Saturday, Sunday, or legal holiday, in which case the final day counted is the next business day;

(c) the day on which action or event is initiated is not counted.

27.06: Voluntary and Conditional Voluntary Admission

(1) Eligibility for Voluntary or Conditional Voluntary Admission.

(a) A person may be admitted on a voluntary status pursuant to M.G.L. c. 123 § 10 or a

conditional voluntary admission status pursuant to M.G.L. c. 123 §§ 10 and 11 to a facility upon written application, provided that in the opinion of the facility director, or designee, such personpatient is in need of care and treatment and that the admitting facility is suitable for such care and treatment. qualifies for admission in accordance with 104 CMR 27.05(2), has the capacity to apply for such admission and is desirous of receiving treatment.

27.06: continued

(b) In order to be admitted on voluntary or conditional voluntary admission status, a person must be competent to apply for such admission, and desirous of receiving treatment.

(c) A person's application for voluntary or conditional voluntary status shall only be accepted upon a determination by the admitting or treating physician that the personpatient has attained the age of 16 and is competent, has capacity to apply for such status, and isand is in need of care and treatment, or, if application is made on behalf of the personpatient by a guardian,legally authorized representative that the guardian has specificlegally authorized representative has authority to do so.

1. An application made on behalf of a minor by the minor's parent or guardian may be accepted upon a determination by the admitting or treating physician that the person making such application is in fact the minor's legally authorized representative.
2. (d)An application made on behalf of a patientperson by his health care agent may be accepted upon a determination by the admitting or treating physician that the health care agent is acting pursuant to a valid and invoked health care proxy that has not been revoked by the patient.

(c) For purposes of 104 CMR 27.06, competentcapacity to apply means:

1. that a patient admitted on a voluntary status understands that he or she is in a facility for treatment and that he or she may leave the facility at any time.
2. that a patient admitted on a conditional voluntary status understands that he or she is in a facility for treatment, understands the three-day notice provisions, and understands the facility director'sdirector's right to file a petition for commitment and thereby retain him or her at the facility.

(2) Prior to admission, such person shall be afforded the opportunity for consultation with an attorney, or with a person who is working under the supervision of an attorney, concerning the legal effect of the admission.

(3) Upon admission, the patient and his or her legally authorized representative shall receive information concerning the legal and human rights which he or she retains after admission to the facility.

(4) A patient on voluntary status shall be discharged upon his or her request, or upon the request of the patient's legally authorized representative who applied for the admission of such patient, in as provided in 104 CMR 27.09. Voluntary admission status shall be totally voluntary, and may be terminated by the patient, legally authorized representative, or facility director at any time without notice.

(5) A patient on conditional voluntary admission status, or any parent or guardian a legally authorized representative who applied for the admission of such personpatient, may be required to give three days prior written notice to the facility director of his or her intention to leave such facility or to withdraw such personpatient from the facility. Such Upon submission of a three-day notice, the facility director shall proceed as provided in 104 CMR 27.09(4).

(a) A patient admitted on application of a health care agent pursuant to a health care proxy that has not been affirmed may revoke such proxy orally or in writing, which revocation shall constitute submission of a three-day notice. The submission of a three-day notice by such a patient shall be deemed a revocation of the health care proxy for purposes of 104 CMR 27.06(5)

(b) A three day notice may only be retracted by written notice to the facility director. Such; provided, however, that such retraction shall only be accepted upon a determination by the facility director or designee that the patient has the capacity to apply for conditional voluntary status pursuant to 104 CMR 27.06(1)(c).

(c) A three day notice and any retraction thereof shall become part of the patient's record.

(d) The form and content of such a three day notice, or retraction thereof, shall be deemed sufficient so long as it conveys the patient's intention, without requirement that it be on any particular form of the facility.

(6) Prior to admitting a person on conditional voluntary admission status, the admitting personnel shall inform such person of the three day notice requirements established in M.G.L. c. 123, § 11, and of the facility director's director's right to file a petition for commitment upon notice that the patient wishes to leave, pursuant to M.G.L. c. 123, § 11.

(7) A personpatient who is 16 or 17, or who during the course of hospitalization attains the age of 16, and who has been admitted to a facility as on a voluntary or conditional voluntary patient status by application of a legally authorized representative shall have the same rights as those personpatients 16 or over who have applied and been admitted on their own behalf, including the right to leave the facility upon submission of a three day notice of intent to do so, and the right to remain at the facility, upon written application, despite notice by a legally authorized representative of intention to withdraw such patient.

(8) Application for conditional voluntary admission shall be made only upon such form as the CommissionerDepartment may prescribe.

27.07: Three Day Involuntary Commitment

(1) No person shall be admitted to a facility upon application for involuntary hospitalization pursuant to M.G.L. c. 123, § 12 unless the person, his or her legal guardian with authority to admit to a facility or, if a minor, or his or her legally authorized representative, has been given the opportunity by the facility to apply for admission under M.G.L. c. 123, §§ 10 and 11. For a patient aged 16 or 17, this opportunity must be given to both the patient and his or her legally

27.07: continued

- (1) authorized representative. The right to convert to voluntary or conditional voluntary admission status may be exercised by a patient, his or her legal guardian with specific authority to admit to a facility, or, if a minor, by or his or her legally authorized representative at any time within the three day period. A mental health professional responsible for the patient admitted pursuant to M.G.L. c. 123 §12 shall again inform the patient or legally authorized representative, within three days of admission, of the right to change status, and shall record so, informing the patient or the legally authorized representative in the patient's record.
- (2) Examination Prior to Admission. Persons for whom application has been made for three day involuntary hospitalization by the appropriate party pursuant to M.G.L. c. 123, § 12, and who have not been examined by a designated physician prior to reception at the admitting facility, shall receive such examination immediately after reception at such facility. If the physician determines that failure to hospitalize such person would create a likelihood of serious harm by reason of mental illness he or she may admit such person to the facility for care and treatment.
- (a) For the purposes of this paragraph, "immediately" shall mean within two hours and before the person has been classified as a patient or has been assigned to a bed or ward by the admitting staff. In the event that patient's reception at the facility.
- (a)(b) If the designated physician on call at the facility is engaged in an emergency situation elsewhere, he or she shall conduct such an examination as soon as such emergency no longer requires his or her attention.
- (c) The requirement for examination may be satisfied through utilization of telemedicine or other technology pursuant to protocols approved by the Department that assure verbal and visual observation and communication between the patient and an off-premises designated physician and adequate on-premises clinical staff.
- (3) Upon admission of a person to a facility pursuant to M.G.L. c. 123, § 12(b), the facility shall inform the person and his or her legally authorized representative that it shall, upon request, notify the Committee for Public Counsel Services of the person's name and location, upon which notice the Committee will appoint an attorney to meet with the person.
- (4) Emergency Hearing. The facility shall inform a person/patient admitted pursuant to M.G.L. c. 123, § 12(b) and his or her legally authorized representative of the right to request an emergency court hearing if he or she or his or her legally authorized representative has reason to believe that the admission is the result of an abuse or misuse of the provisions of M.G.L. c. 123, §12(b). The facility shall, upon request, provide the person/patient and his or her legally authorized representative with the form that may be used to request such a hearing and shall take steps to transmit any such completed forms to the court in accordance with the requirements of the court with jurisdiction over the facility.

27.08: Transfer and Transport of Patients

- (1) 104 CMR 27.08 governs the transfer of patients pursuant to M.G.L. c. 123, § 3 and the transport of person/patients pursuant to M.G.L. c. 123, § 21.
- (2) For the purposes of 104 CMR 27.08(3) through (8), "emergency" shall mean those medical, surgical and psychiatric crises which, in the opinion of the facility director, threaten the safety, health or life of the patient or others, and which could not be appropriately treated in the transferring facility.
- (3) Permitted Transfers; Exceptions. Any person/patient admitted to a facility may be transferred from that facility to any other facility, provided that except in an emergency:
- (a) Patients on voluntary admission status under 104 CMR 27.06 shall not be subject to transfer without their written consent; and
- (b) Patients on conditional voluntary admission status under 104 CMR 27.06 may refuse transfer. Such refusal may be considered equivalent to submission of the patient's three day written notice of his or her intention to leave or withdraw from the facility. Upon such refusal, the facility director may file a petition for commitment under the provisions of M.G.L. c. 123, §§ 7 and 8 if the person/patient meets the criteria for

commitment, or may withdraw the notice of transfer provided to the personpatient pursuant to 104 CMR 27.08(8).

(4) Absent an emergency, and except for a patient underover the age of 16 or under a guardianship with authority to admit to a psychiatric facility, a patient on conditional voluntary admission statusstatus at a facility may not be transferred from that facility over his or her objectionagainst his or her will, or in the case of a minor, or a patient admitted by health care agent pursuant to a properly invoked and affirmed health care proxy, against the willover the objection of such minor or patient's the minor's legally authorized representative, unless a court of competent jurisdiction enters a commitment order pursuant to M.G.L. c. 123, §§ 7 and 8.

27.08: continued

(5) Absent an emergency, a patient under the age of 16 **or under a guardianship with authority to admit to a psychiatric facility**, who has been admitted to a facility pursuant to his or her legally authorized representative's authority, may not be transferred from that facility over the objection of the legally authorized representative, unless a court of competent jurisdiction enters a commitment order pursuant to M.G.L. c. 123, §§ 7 and 8.

(6) In no event shall an **order of commitment application** for **observation admission** pursuant to M.G.L. c. 123, § 12(a) be issued in order to transfer a patient in *lieu* of compliance with the requirements of M.G.L. c. 123, § 3 **or and** 104 CMR 27.08.

(7) **Patients transferred pursuant to M.G.L. c. 123, § 3 and 104 CMR 27.08 shall be admitted to the receiving facility under the same legal status pursuant to which the patient was hospitalized at the transferring facility.** Transfer of a patient committed pursuant to M.G.L. c. 123, § 12 shall not extend the period of such **hospitalization commitment**.

(8) Transfer Procedures.

(a) The approval of the director of the receiving facility shall be obtained by the transferring facility.

(b) The director of the transferring facility shall give six days written notice to the patient to be transferred and, **if applicable**, to **his or her nearest relative, unless the patient knowingly objects**, or his or her legally authorized representative; provided, however, that if such transfer must be made immediately because of an emergency, notice shall be given within 24 hours after the transfer pursuant to M.G.L. c. 123, § 3. The notice, **which shall include the patient or legally authorized representative's right to object as provided in 104 CMR 27.08(4) and (5)**, shall be provided in a form prescribed by the **Commissioner Department**.

(c) **The director shall inform the patient that notice of transfer shall also be given to his or her nearest relative; unless the patient knowingly objects.**

(d) A patient, **or a legally authorized representative of a patient under the age of 18, or duly appointed guardian** with authority to admit the **ward patient** to a psychiatric facility may, **but shall not be required to**, waive the six days' notice requirement.

(de) A copy of the **Notice notice of Transfer transfer**, along with a copy of the patient's underlying admission status documentation, shall accompany the patient to the receiving facility, **and the underlying status shall remain valid upon admission to the receiving facility.**

(9) Transport of **Person Patients** Admitted to a Facility; Limitations of Use of Restraint.

(a) The transport **with restraint** of a **person patient** in a facility **by or under the supervision of the facility's staff** may be authorized by a **physician authorized to order restraint pursuant to 104 CMR 27.12(5)(a)1., or in an emergency when an authorized physician is not available, by a staff person authorized to initiate restraint pursuant to 104 CMR 27.12(5)(a)2., the facility director, or designee**, on a form approved by the Department, for the following purposes:

1. Transfer to another facility pursuant to M.G.L. c. 123, § 3;
2. Movement among separate campuses of a single facility;
3. Evaluation and/or treatment at a medical facility or office and return to the facility;
4. Attendance at court proceedings and return to the facility;
5. Transfer to or from another state pursuant to the Interstate Compact on Mental Health, M.G.L. c. 123, App. §§ 1-1 through 1-4;
6. Other destinations with the approval of the facility director or designee.
- ~~§§ 1-1 through 1-4;~~
- ~~6. Other destinations with the approval of the facility director or designee.~~

(b) **Restraint of a person patient in a facility by or under the supervision of the facility's staff** may not be used in the course of transport, unless such restraint is necessary for the safety of the **person patient** being transported or of others who are likely to come into contact with **him or her**, and in any case **such the person patient being transported**. Such restraint must be by the least restrictive method to assure the safety of the **person patient** or others in accordance with 104 CMR 27.08(9). **Such restraint must be authorized by a physician authorized to order restraint pursuant to 104 CMR 27.12(8)(a)1, or in an emergency when an authorized physician is not available, by a staff person patient**

authorized to initiate restraint pursuant to 104 CMR 27.12(8)(a)2.

1. If the **personpatient** is being transported by the facility, or under the supervision of the facility's staff, then the physician's authorization shall describe the circumstances under which restraint may be used in the course of transport and method of restraint that may be employed.
 - a. No locked mechanical restraint devices requiring the use of a key for their release may be used in the course of transport.
 - b. Only restraint procedures or devices that have been approved by the facility for such purposes may be used for restraint during transport, and monitoring staff must have received appropriate training on such approved procedures and devices.
 - c. No **personpatient** shall be placed in restraints in the course of transport unless a staff member is assigned to provide one-to-one monitoring as provided in 104 CMR 27.12(58)(h)1. through 6.
 - d. During the transport, the monitoring staff person must carry a copy of the form which authorizes the restraint during transport.

27.08: continued

- e. The driver of the vehicle in which the **personpatient** is being transported may not be assigned to provide such monitoring.
- f. No staff member who has not been trained in accordance with 104 CMR 27.12(23) may be authorized to apply restraints to a **personpatient** in the course of transport, or to monitor a **personpatient** who is in restraints in the course of transport.
- g. Except as provided in 104 CMR 27.08(9)(c) and (d), restraint ordered pursuant to 104 CMR 27.08(9) may only last while the **personpatient** is under the supervision of facility staff, and shall terminate if the **personpatient** is admitted to a medical facility, including the emergency department of such medical facility for evaluation or treatment.
- (c) If the **personpatient** is being transported by ambulance, then restraint may be used only in accordance with M.G.L. c. 111C, § 18.
- (d) Nothing in 104 CMR 27.08(9) shall be deemed to regulate the use of restraint by licensed law enforcement personnel in the transport of **personpatients** in the custody of such personnel.
- (e) The use of seatbelts or a “child safety door lock” shall not be considered restraint for purposes of 104 CMR 27.08(9).
- (f) Where the need for restraint during transport for purposes described in 104 CMR 27.08(9)(a) is anticipated, consideration should be given to delaying such transport until such **personpatient** no longer requires restraint, if such delay is reasonable.

27.09: Discharge(1) Discharge Procedures.

- (a) A facility shall arrange for necessary post-discharge support and clinical services. Such measures shall be documented in the medical record.
- (b) A facility shall make every effort to avoid discharge to a shelter or the street. The facility shall take steps to identify and offer alternative options to a patient and shall document such measures, including the competent refusal of alternative options by a patient, in the medical record. In the case of such discharge, the facility shall nonetheless arrange for or, in the case of a competent refusal, identify post-discharge support and clinical services. The facility shall keep a record of all discharges to a shelter or the street, in a form approved by the Department, and submit such information to the Department on a quarterly basis.
- (c) When a patient in a facility operated by or under contract to the Department is a client of the Department pursuant to 104 CMR 29.00 *Application for DMH Services, Referral, Service Planning and Appeals*, the service planning process outlined in 104 CMR 29.00 shall be undertaken prior to discharge.
- (d) A facility shall keep a record of all patients discharged therefrom, and shall provide such information to the Department upon request.

(2) Voluntary Admission Status. A patient voluntarily admitted to a facility under 104 CMR 27.06 shall be discharged **upon his or her request, or upon the request of the patient’s legally authorized representative who applied for the admission of such patient**, without a requirement of a three day notice **upon his or her request.**

(3) Discharge Initiated by Facility Director. The facility director may discharge any patient admitted as a voluntary or conditional voluntary patient at any time he or she deems such discharge in the best interest of such patient; provided, however, that if a legally authorized representative made the application for admission, 14 days’ notice shall be given to such legally authorized representative prior to such discharge, in accordance with M.G.L. c. 123, § 10(a). With the consent of such legally authorized representative, the **superintendentfacility director r** may discharge **athe patient under the age of 16 years** at any time.

(4) Conditional Voluntary Admission Status. A patient admitted to a facility on conditional voluntary **admission statusstatus** under 104 CMR 27.06 shall be discharged by the facility upon his or her request, **but; provided, however** he or she shall give three days’ written notice **of his or her intent to leave the facility** to the facility director. **The, and may be retained at the facility for such three day notice period, during which time the** facility director may require an examination of such patient **to be conducted** to determine his or her **clinical progress and**

suitability for discharge, including such factors as legal competency and family, home or community situation. Such personpatients may be retained at the facility beyond the expiration of the three day notice period if, prior to the expiration of the said three day notice period, the facility director files with the districta court of competent jurisdiction, a petition for the commitment of such personpatient at the saids facility.

27.09: continued

(5) Discharge at Request of Parent or Guardian. Hospitalization of a person under the age of 16 may be terminated at the request of Legally Authorized Representative. A patient admitted by his or her legally authorized representative in the same manner as any other patient, may be discharged at the request of such legally authorized representative consistent with procedures for discharge of a patient admitted upon his or her own authority.

(6) Patients Aged 16 or 17. A **personpatient** who is 16 or 17 years old, or who becomes 16 during the course of hospitalization, and who has been admitted to a facility as a voluntary or conditional voluntary patient by application of a legally authorized representative shall have the same rights pertaining to release, withdrawal and discharge as those **personpatients** over the age of 16 who have applied for and been voluntarily admitted on a voluntary or conditional voluntary status to the facility on their own behalf.

(7) Involuntary Commitment Status.

(a) FourThree day commitmentCommitment. A **personpatient** admitted to a facility under M.G.L. c. 123, § 12, may be discharged by the facility director at any time during such period of hospitalization if the facility director determines that such **personpatient** is not in need of care and treatment in the facility. The **fourthree** day hospitalization period authorized under M.G.L. c. 123, § 12 shall not be extended, and, at the end of such period, a **personpatient** so hospitalized shall be discharged by the facility unless, prior to expiration, such **personpatient** has applied for, and has been admitted on voluntary admissionor conditional voluntary status to the facility, or the facility director has filed a petition for an order of commitment.

(b) Prolonged Commitment. A **personpatient** committed to a facility by order of a court of competent jurisdiction shall be discharged by the facility atupon the expiration of the time period established by the order, unless the commitment order is renewed under the procedures established in M.G.L. c. 123, §§ 7 and 8.

(c) At(c) Except as provided in 104 CMR 27.09(8), at any time during the period of hospitalization, the facility director may discharge such **personpatient** if he or she determines that such **personpatient** is no longer in need of care and treatment.

(8) Forensic Commitment Status.

(a) A **personpatient** committed to facility under M.G.L. c. 123, § 15 shall not be discharged except to the committing court, or upon other court order.

(b) A **personpatient** committed to a facility under M.G.L. c. 123, § 16 shall not be discharged unless appropriate notice has been given by the facility director to the court exercising jurisdiction over such person and to theand district attorney of the district within which the alleged crimehas or crimes occurred. had jurisdiction of the relevant criminal case. If within 30 days of the receipt of such communication the district attorney has not filed a petition for further commitment of such **personpatient**, the **personpatient** may be discharged. If such a petition is filed, a hearing shall take place pursuant to M.G.L. c. 123, § 16(c). The patient shall be held at the facility for such 30-day period unless the district attorney provides written notice that he does not intend to petition for further commitment.

(c) In the event the facility director intends to remove or modify any court ordered restrictions on such a **personpatient**'s movements, he or she shall communicate the intention to remove or modify such restriction in writing to the court. which ordered the commitment and the district attorney who has or had jurisdiction of the relevant criminal case. If within 14 days neither the court does not makenor district attorney makes written objection thereto, such restrictions may be removed or modified.

(d(d) The requirements of (b) and (c) shall not apply to **personpatients** originally committed after a finding of incompetence to stand trial whose criminal charges have been dismissed.

(e) A **personpatient** on commitment status under M.G.L. c. 123, § 16 who was found incompetent to stand trial and whose charges are dismissed may be discharged at any time if the facility director determines that such **personpatient** is no longer in need of care and treatment. The dismissal of criminal charges shall not, however, terminate the underlying commitment order. Any subsequent commitment proceedings for such a **personpatient** shall be under M.G.L. c. 123, §§ 7 and 8.

(f) A **personpatient** hospitalized at a facility pursuant to M.G.L. c. 123, § 18, shall not be discharged except to prison, a correctional facility, or the courtthe custody of the place of

detention from which the personpatient was hospitalized, unless such personpatient's sentence, or other authority under which the personpatient is being held in custody, has expired.

27.10: Treatment

(1) Informed Consent, Consent to Treatment.

(a) Upon admission to a facility for care and treatment, a personpatient shall, upon giving informed consent, receive treatment and rehabilitation in accordance with accepted therapeutic practice, including oral, subcutaneous and intramuscular medication when appropriate and when ordered by a physician. Informed consent means the knowing consent, voluntarily given by the patient, or his or her legally authorized representative, who can understand and weigh the risks and benefits of the particular treatment being proposedwhen appropriate and when ordered by a physician.

(b) Prior to an adjudication of incapacity or invocation and affirmation of a health care proxy, a patient retains the right to accept or refuse treatment.

(c) Informed consent must be documented in the patient's medical record.

(d) Extraordinary Treatmenttreatment, as defined by statute or case law, including but not limited to, treatment with antipsychotic medication, Electroconvulsive Treatment (ECT), psychosurgery, involuntary sterilization or abortion, and other highly intrusive or high risk interventions may not be administered or performed without the patient's specific informed consent. In the case of a patient incapable of givingwho lacks capacity to give informed consent, such interventiontreatment may not be administered or performed without prior review and approval by a court of competent jurisdiction or in the case of a minor or a patient with a properly invoked healthcare proxy, the consent of his or her legally authorized representative...

(e) Prior to an adjudication of incompetence, and court approval of a treatment plan, a patient retains the right to accept or refuse treatment as prescribed.

27.10: continued

(de) For a patient who is believed to **be incompetentlack capacity** to give informed consent to treatment with antipsychotic medication, **and who is not being treated pursuant to consent by the parent of a minor or by a health care agent pursuant to a properly invoked and affirmed health care proxy**, the right to refuse such medication may be overridden prior to an adjudication of **incompetenceincapacity** and court approval of a treatment plan only in rare circumstances to prevent an immediate, substantial and irreversible deterioration of the patient's mental illness. If treatment is to be continued over the patient's objection, and the patient **remains incompetentcontinues to lack capacity**, then an adjudication of **incompetenceincapacity** and court approval of a treatment plan must be sought.

(e) **Chemical restraints may be used only in an emergency situation pursuant to 104 CMR 27.12.**

(2) Electroconvulsive Treatment for Patients under the Age of 16.

(a) Electroconvulsive treatment shall not be administered to any patient under the age of 16 unless the Commissioner or designee concurs.

(b) The approval of the administration of electroconvulsive treatments to patients under 16 shall be based on such written recommendations and independent consultations as the Commissioner or designee deems appropriate under the circumstances of the individual case.

(c) The Commissioner or designee's approval, and the basis **therefortherefore**, shall become a permanent part of the patient's record.

(3) Routine and Preventive Treatment. A patient shall be informed upon admission and at each periodic review of the routine and preventive treatment that is ordinarily performed at, or arranged by, the facility. Routine and preventive treatment includes standard medical examinations, clinical tests, standard immunizations, and treatment for minor illnesses and injuries. A patient who **is capable of giving has capacity to give** informed consent regarding routine and preventive treatment **has the right to may accept or** refuse such treatment, except that **sucha** refusal may be overridden by the facility director, without special court authorization, when the treatment consists of:

27.10: continued

- (a) a complete physical examination, and associated routine laboratory tests, required by law to be conducted upon admission and at least annually thereafter.
- (b) immunizations or treatment required by law or necessary to prevent the spread of infection or disease.

(4) Written Treatment Plan.

(a) The patient has the right to participate in the development and implementation of his or her treatment plan.

(b) As part of the treatment of a patient in a facility, there shall be a written assessment of the needs and strengths and needs of the individual patient and a written, multi-disciplinary treatment plan, which shall be developed with the maximum possible participation of the patient or the patient's legally authorized representative.

(c) The treatment plan, upon acceptance by the patient or his or her legally authorized representative, shall be implemented by the facility staff in good faith within the limits of available resources. There shall be a periodic written assessment of treatment progress, and significant modifications of the treatment plan and the rationale for such modifications shall be recorded by the responsible clinicians.

(d) There shall be a periodic written assessment of treatment progress. Modifications of the treatment plan and the rationale for such modifications shall be documented in the patient's record.

(5) Additional Requirements for Patients Eligible for Public School Education.

(a) Treatment plans for patients who are "children with special needs," as defined in M.G.L. c. 71B shall, where appropriate, take into account the plan for providing special education services developed in accordance with regulations of the Department of Elementary and Secondary Education.

(b) Treatment plans for patients who are eligible for public school education but who are not "children with special needs" as defined in M.G.L. c. 71B, § 1, shall, if appropriate, and in addition to all other requirements for treatment plans, reflect such patient's educational needs.

(6) Behavior Management. Behavior management as defined in 104 CMR 27.10 may only be used in facilities licensed as Class VI, Limited VI or VII or in units of Department facilities that admit patients under 19. Each facility that employs behavior management techniques shall submit a behavior management plan, which shall be subject to Department approval. The plan shall outline the facility's philosophy, policy and procedures for behavior management whereby behavior management interventions are used as an educational process by which staff assist the patients in developing the experience and self control necessary to assume responsibilities, make daily living choices, and learn to live in reasonable conformity with accepted levels of social behavior. The plan shall include a description of acceptable and unacceptable behavior for the patients, as well as the sanctions that will result from unacceptable behavior. The plan shall be submitted to the Human Rights Officer and, where applicable, to the Human Rights Committee, for review.

(a) No behavior modification techniques which involve corporal punishment, infliction of pain or physical discomfort, or deprivation of food or sleep shall be used for behavior management.

(b) Seclusion and restraint, as defined in these regulations, may not be used for behavior management, but may only be used in accordance with 104 CMR 27.12.

(c) The treatment plan for each patient for whom behavior management will be employed shall contain specific, individualized behavior management interventions, consistent with the program's behavior management plan. The treatment plan including behavior management interventions may not be instituted without the consent of the patient or his or her legally authorized representative.

(d) Each behavior management plan shall describe behavior management interventions that may be used. These may include but are not limited to the following:

1. level/point systems of privileges, including procedures for the patient's progress in the program;
2. the type and range of restrictions a staff member can authorize for misbehavior of a patient;
3. the use of the practice of separating a patient from a group or facility activity.

- (e) When feasible and appropriate, patients shall participate in the establishment of rules, policies and procedures for behavior management.
- (f) Upon admission, the facility shall provide patients and their legally authorized representatives with a copy of the facility's behavior management plan.
- (g) Any behavior management plan which provides that a patient may be separated from the group or facility activities shall include, but not be limited to, the following:
 1. guidelines for staff in the utilization of such procedures;
 2. persons responsible for implementing such procedures;

27.10: continued

3. the duration of such procedures, including provisions for approval by the facility director or his or her designee of a period longer than 30 minutes;
 4. a requirement that patients shall be observable at all times and that staff shall be in close proximity at all times;
 5. a procedure for staff to directly observe the patient every 15 minutes;
 6. a means of documenting the use of such procedures if used for a period longer than 30 minutes including, at a minimum, length of time, reasons for this intervention, who approved the procedure, and who directly observed the patient at least every 15 minutes.
- (h) A time out room shall not be locked.
- (i) Any room or space used for the practice of separation must be physically safe.

27.11: Periodic Review

(1) Schedule of Periodic Reviews. Every facility shall conduct a periodic review of each **inpatientpatient** upon admission, and for patients whose hospitalizations are expected to be at least 90 days, during the first three months, during the second three months, and annually thereafter until discharge, except that for facilities licensed as Class VI, Limited Class VI and VII and for units of Department facilities that admit patients under 19, such periodic reviews shall be conducted **as clinically indicated but no less frequently than** quarterly.

(2) Notice to Patient and Family. Prior to the periodic review, the facility director or designee shall give reasonable advance written notice to each patient and his or her legally authorized representative **and. If there is no legally authorized representative, the director shall inform the patient that,** unless the patient knowingly objects, **notice of the periodic review shall also be given to thehis or her** nearest relative, giving the date of such review **and requesting their participation in such review.**

(3) Thorough Clinical Examination. Each periodic review shall include a thorough clinical examination, which shall consist of: a mental status examination; a review of the patient's clinical history, including a review of the treatment plan, of response to treatment, and of medications administered; and an evaluation of general behavior and social interaction by clinical personnel from the various disciplines providing treatment. At least once in every 12 month period, a thorough clinical examination shall also include a physical examination.

(4) Evaluation of **CompetencyCapacity.** For each periodic review, the legal **competencycapacity** of a patient shall be evaluated by the senior reviewing clinician **to determine in terms of** whether he or she **is competent has capacity** to remain on, or to apply for, **voluntary or** conditional voluntary **admission statusstatus**, to render informed consent to customary and usual medical care or extraordinary treatment, including administration of antipsychotic medications, or to manage his or her own funds in accordance with the requirements of 104 CMR 30.01(3).4) *Evaluation of Ability to Manage Funds.*

(a) If a patient **is** on voluntary or conditional voluntary **admission statusstatus**, and the **patient** is believed no longer **to be competenthave capacity to remain on that status**, and the patient remains in need of continued hospitalization, then the facility director shall take reasonable steps to obtain alternate authority for continued hospitalization **either** by seeking an order of commitment pursuant to M.G.L. c. 123, §§ 7 and 8, or **consent of a guardianship with authority to admit the ward to a psychiatric facility.legally authorized representative.**

(b) If the question of a patient's **competencycapacity** is raised by a periodic review or if the facility director has reason to believe that a patient who has been under the care of the facility, who is not under guardianship or conservatorship, is unable to care for his or her **person or** property, **he or shethe facility director** shall promptly take reasonable steps to initiate the process **for the appointment ofto obtain** a **guardian or conservatorlegally authorized representative.**

(5) Consideration of Alternatives to **HospitalFacility.** For each periodic review the alternatives to hospitalization should be evaluated, with consideration being given to specific and available resources in the community which the patient could utilize.

(6) Results of the Periodic Review.

(a) Upon completion of every periodic review subsequent to admission, the person in charge of conducting the review shall prepare a full and complete record of all information presented at such review, including medical evidence or information, the reasons for a determination that a patient requires continued care and treatment at the facility, and the consideration given to alternatives to continued hospitalization. This written record of each periodic review shall become part of the patient's permanent medical record.

27.11: continued

(b) If upon completion of the periodic review, it is determined that the patient is in need of further care and treatment, the facility director or designee shall notify the patient and his or her legally authorized representative, or, if there is no such legally authorized representative and the patient does not knowingly object, his or her nearest relative, of that determination, and of the right to leave the facility if he or she was not committed under a court order. If there is no legally authorized representative, the director shall inform the patient that, unless the patient knowingly objects, notice of the determination shall also be given to his or her nearest relative. If said patient is not committed under a court order and does not choose further treatment as an inpatient, within 14 days of said notification the patient shall be discharged or shall be made the subject of a petition for a court ordered commitment. Following any review under the provisions of 104 CMR 27.11, or at any other time, any patient who is no longer in need of care as an inpatient shall, subject to the provisions of 104 CMR 27.09, be discharged.

27.12: Prevention of Restraint and Seclusion and Requirements When Used

- (1) (1) Restraint and seclusion may only be used in facilities operated by the Department, or licensed as Class III through VII; provided, however, that no such seclusion or restraint of a minor may occur except in a facility that has been inspected and specially certified by the Department.
- (1)(2) Prevention/Minimal Use of Restraint and Seclusion. A facility licensed as Class III through VII subject to this section that uses restraint or seclusion shall develop and implement a strategic plan to reduce and, wherever possible, eliminate the use of restraint and seclusion. The strategic plan should be updated at least annually to ensure efforts to reduce or eliminate restraint are ongoing. The facility's strategic plan shall include, at a minimum, the following:
- (a) a posted statement of the facility's commitment to the prevention and minimal use of restraint and seclusion;
 - (b) policies and procedures that support the prevention and minimal use of restraint and seclusion;
 - (c) staff training that focuses on crisis prevention, de-escalation and alternatives to restraint and seclusion;
 - (d) programming and milieu that are consistent with the prevention and minimal use of restraint and seclusion;
 - (e) the development and integration of peer support staff within the program. This should include peer involvement in interventions to reduce the use of restraint and seclusion;
 - (f) the development and use of sensory interventions and therapies designed to calm and comfort patients that utilize sight, touch, sound, taste, smell, pressure, weight or physical activity;
 - (g) the development and use of an individual crisis prevention plan for each patient;
 - (h) assessment of the impact of trauma experience and the potential for retraumatization/re-traumatization for both patients and staff;
 - (i) the regular use of debriefing activities for both patients and staff;
 - (j) the process for addressing patient concerns and complaints about the use of restraint or seclusion;
 - (k) the use of data to monitor and improve quality and prevent and minimize the use of restraint and seclusion, such as identifying times or shifts with a high incidence of restraint or seclusion.
- (23) Staff Training.
- (a) A facility shall ensure that all unit staff and other staff who may be involved in restraint and seclusion receive training, and demonstrate competencies, in the prevention and minimal use of restraint and seclusion during orientation, which prior to participating in any episode of restraint or seclusion. Such training shall be completed no later than one month after hire, and receive shall be included in annual training thereafter. Training shall include, at a minimum, the following:
 1. the harmful emotional and physical effects of restraint and seclusion on patients and staff;

2. the impact of trauma, including sexual and physical abuse and witnessing of violence, on **individuals both patients and staff**;
 3. the impact of restraint or seclusion on **individuals patients** with a history of trauma, including the potential for **retraumatization re-traumatization**;
 4. **calming and soothing**, crisis prevention **and de-escalation** approaches and **de-escalation** strategies;
 5. the use of **the individual individualized** crisis prevention **plan plans**.
- (b) In addition to the training in 104 CMR 27.12(23)(a), staff who may be directly involved in authorizing, ordering, administering or applying, monitoring, or assessing for release from restraint or seclusion shall receive additional training, and annual retraining thereafter. No staff shall be permitted to participate in any restraint or seclusion prior to receiving such additional training. Such training shall include, at a minimum, the following:
1. applicable legal and clinical requirements for restraint and seclusion;
 2. the safe and appropriate initiation of physical contact and application and monitoring of restraint and seclusion;
 3. approaches to facilitate the earliest possible release from restraint or seclusion.
- (c) Following initial training and each annual retraining, a facility shall require each staff member to demonstrate competencies in all areas of training. **Staff shall not participate in an episode of restraint or seclusion prior to completing required training and demonstrating necessary competencies.** A facility shall maintain documentation of staff training and competencies.

27.12: continued

(3) Individual

(4) Individualized Crisis Prevention Planning. A facility shall develop an ~~individual~~~~individualized~~ crisis prevention plan ~~for~~with each patient.

(a) Definition. An ~~individual crisis prevention plan~~~~Individualized Crisis Prevention Plan~~ is an age and developmentally appropriate, patient-specific plan ~~or safety tool~~ that identifies triggers that may signal or lead to agitation or distress in the patient and strategies to help the patient and staff intervene with de-escalation techniques to reduce such agitation and distress and avoid the use of restraint and seclusion.

(b) Development of the ~~Individual~~~~Individualized~~ Crisis Prevention Plan. As soon as possible after admission, facility staff shall collaborate with each patient and his or her legally authorized representative, if any, and, where appropriate, with other sources, such as family members, caregivers, ~~and the patient's health care proxy~~, to complete and implement an ~~individual crisis prevention plan~~~~Individualized Crisis Prevention Plan~~. If the patient refuses or is unable to participate in the initial development of the plan, staff shall develop a plan using available information and shall make continuing efforts to include the patient's participation in review and revision of the plan. Relevant clinical data, including medical risk factors, physical, learning, or cognitive disability, and the patient's history of trauma shall inform the development of the plan. The plan shall include, at a minimum, the following elements:

1. identification of triggers that signal or lead to agitation or distress in the patient and, if not addressed, may result in the use of restraint or seclusion;
2. identification of the particular approaches and strategies that are most helpful to the patient in reducing agitation or distress, such as environmental supports, physical activity, and sensory interventions;
3. in order to minimize trauma or ~~retraumatization~~~~re-traumatization~~ if restraint or seclusion is used, identification of the patient's preferences, such as type of intervention and positioning, gender of staff who administer and monitor the restraint or seclusion, and supportive interventions that may have a calming effect on the patient.

(c) Update and Revision of Plan. The plan shall be updated, as necessary, to reflect changes in such triggers and strategies ~~as well as following any restraint or seclusion episode~~ and shall be reviewed at each treatment plan review.

(d) Access to Plan. A facility shall ensure that all staff on all shifts are aware of and have ready access to the ~~individual~~~~individualized~~ crisis prevention plans for the patients in their care. A copy of the ~~individual crisis prevention plan~~~~Individualized Crisis Prevention Plan~~ and any revisions, thereto, shall be ~~placed~~~~recorded~~ in the patient record ~~and a copy shall be given to the patient and his or her legally authorized representative, if applicable~~.

(4) Debriefing Activities. A(5) Debriefing Activities. Recognizing that an episode of restraint or seclusion is a traumatic event affecting patients, staff, and the milieu, ~~debriefing after such an event is critical~~. Therefore, a facility shall develop procedures to ensure that debriefing activities occur after each episode of restraint or seclusion in order to determine what led to the incident, what might have prevented or curtailed it, ~~and~~ how to prevent future incidents, ~~and to address the emotional needs of patients and staff who were impacted~~. Debriefing activities shall be documented and used in treatment planning, revision of the ~~individual~~~~individualized~~ crisis prevention plan, and ongoing facility-wide restraint and seclusion prevention efforts.

(a) Staff Debriefing. As soon as possible following each episode of restraint or seclusion, supervisory staff and staff involved in the episode shall convene a debriefing. The debriefing shall, at a minimum, include the following:

1. identification of what led to the ~~incident~~~~episode~~;
2. determination of whether the individual crisis prevention plan was used;
3. assessment of alternative interventions that may have avoided the use of restraint or seclusion;
4. determination of whether the patient's physical and psychological needs ~~and right to privacy~~ were appropriately addressed ~~and that the patient's right to privacy was maintained~~;
5. consideration of counseling or medical evaluation and treatment for the involved patient ~~and/or~~ staff for any emotional or physical trauma that may have resulted from the incident;

6. consideration of whether other patients and staff who may have witnessed or otherwise been affected by the incident should be involved in debriefing activities or offered counseling;
7. **considerationdetermination** of whether the legally authorized representative, if any, family members, or others should be notified of and/or involved in debriefing activities;
8. consideration of whether additional supervision or training should be provided to staff involved in the incident;
9. **determination of whether the incident should be referred for senior administrative review because it meets one or more of the criteria outlined in 104 CMR 27.12(4)(c)1. through 6. or otherwise warrants such review.**

27.12: continued

(b) Patient Debriefing. Within 24

1. As soon as possible, but no later than 48 hours after a patient's release from restraint or seclusion, taking into consideration the emotional needs of the patient, the patient shall be asked to debrief and provide comment either in writing or verbally on the episode, including. The debriefing should, at a minimum, include:

- a. a review of the circumstances leading to the episode, ;
- b. consideration of staff or patient actions that may could have helped to prevent it, or that may have contributed to the episode, including the adequacy of the patient's Individualized Crisis Prevention Plan; and
- c. a discussion of the type of restraint or seclusion used, and any physical or psychological effects he or she the patient may be experiencing from the restraint or seclusion.

2. Whenever possible and appropriate, the staff person providing the patient participating in debriefing with the opportunity to comment patient shall not have been involved in the episode of restraint or seclusion. As part of the debriefing, the patient

3. The patient's comments, if any, shall be provided with a copy of included on the restraint debriefing and seclusion order comment form required pursuant to 104 CMR 27.12(5)(i)1. with an attached.

- a. The patient may complete the debriefing and comment form approved by the Commissioner and shall be offered the opportunity to provide comment in writing during the debriefing or afterwards, or may chose not to do so.
- b. The staff person shall provide the patient with any necessary assistance in completing the patient debriefing and comment form.
- c. If the patient does not complete the form, but provides verbal or other response to the episode, the staff person shall document such response on the form. If
- d. Staff efforts to encourage the patient provides verbal or other response to the episode at any other time, the staff person witnessing the responseto provide comments shall document itbe documented on the debriefing and comment form.
- e. Efforts to engage a patient who has refused to participate in writing. debriefing activities after the 48 hour period shall be documented and shall continue as clinically appropriate.

4. The patient debriefing and comment form or other documentation shall be attached to the restraint and seclusion order form and included in the patient record and copies. Copies of the form shall promptly be forwarded to the treatment team and the human rights officer. as soon as possible once completed; provided however, that the treatment team shall review the episode no later than at its next scheduled meeting.

5. The patient shall also be notified of the availability of the complaint procedure outlined in 104 CMR 32.00 *Investigations and Reporting Responsibilities*. The human rights officer shall offer to meet with a patient who has expressed requests such a response to meeting, or whose comments about or description of an episode of restraint or seclusion that suggests a possible rights violation or other harmful consequence.

(c) Senior Administrative Review. The facility director shall ensure that senior Senior administrative and clinical staff who are empowered to make recommendations and decisions about the need for expert consultation, training, performance improvement activities, change in policy, or other appropriate measures conduct regular reviews of all incidents of restraint and seclusion. In addition, such staff shall shall conduct a specific review of aneach episode of restraint or seclusion by the next business day if any of the following apply: . Such review shall include consideration of whether:

1. A patient or staff member experienced significant emotional or physical injury as a result of the episode.;
2. The episode of restraint or seclusion exceeded six hours or episodes of restraint and/or seclusion for a patient exceeded 12 hours in the aggregate in any 48-hour period.;
3. An exception to the restrictions on mechanical restraint of minors has occurred pursuant to 104 CMR 27.12(58)(g)5.;
4. The episode appears to be part of a pattern warranting review.;
5. The episode is marked by unusual circumstances.;
6. The episode resulted in a complaint or reportable incident, including patient or staff injury, pursuant to 104 CMR 32.00 *Investigations and Reporting Responsibilities*.; or

7. the staff involved in the episode requested There were multiple patients restrained or secluded at one time.
- (6) Senior administrative and clinical staff shall conduct regular reviews of all incidents of restraint and seclusion. The purpose of such a review is to determine the need for expert consultation, training, performance improvement activities, change in policy, or other appropriate measures to further reduce and prevent the occurrence of restraint and seclusion.
- (6)(7) Senior administrative reviews shall not become part of the patient's record, but shall be documented and shall inform the implementation of the facility's strategic plan developed pursuant to 104 CMR 27.12(4)(a)9.2).
- (58) Requirements for the Use of Restraint and Seclusion.
- (a) Definitions. For purposes of 104 CMR 27.12, the following definitions shall apply:
1. Authorized Physician. An authorized physician is any physician who has been authorized by the facility director to order medication restraint, mechanical restraint, physical restraint or seclusion, to examine patients in such restraint or seclusion, and to assess for readiness for release and order release from restraint or seclusion.
 2. Authorized Staff Person. An authorized staff person is any member of the licensed clinical staff at a facility who has been authorized by the facility director to initiate or renew mechanical restraint, physical restraint or seclusion pursuant to 104 CMR 27.12(58)(e)2. or (f)1., and to assess for readiness for release and order release from restraint or seclusion.
 3. Restraint. Restraint, for purposes of 104 CMR 27.00, means behavioral restraint, including medication restraint, mechanical restraint and physical restraint. Restraint means bodily physical restriction, mechanical devices, or medication that unreasonably limitlimits freedom of movement. Restraint does not include the use of restraint in association with acute medical or surgical care, adaptive support in response to the patient's assessed physical needs, or standard practices including limitation of mobility related to medical, dental, diagnostic, or surgical procedures and related post-procedure care.

27.12: continued

a. Medication Restraint. Medication restraint occurs when a patient is given a medication **involuntarily or combination of medications to control the patient's behavior or restrict the patient's freedom of movement and which is not the standard treatment or dosage prescribed for the purpose of restraining the patient's condition.**

Medication restraint shall not include:

- i. involuntary administrations of medication when administered in an emergency to prevent immediate, substantial and irreversible deterioration of serious mental illness, provided that the requirements of 104 CMR 27.10(1)(dc) are complied with; or
- ii. for other treatment purposes when administered pursuant to a court approved substituted judgment treatment plan.

b. Mechanical Restraint. Mechanical restraint occurs when a physical device or devices are used to restrain a **person/patient** by restricting the movement of a patient or the movement or normal function of a portion of his or her body.

c. Physical Restraint. Physical restraint occurs when a manual method is used to restrain a **person/patient** by restricting a patient's freedom of movement or normal access to his or her body. **Physical restraint may only include bodily holding of a patient with no more force than is necessary to limit the patient's movement. Physical restraint shall not include: The application of force to physically hold a patient in order to administer a medication against the patient's wishes, including court ordered medication, is considered a physical restraint.**

Physical restraint shall not include:

- i. non-forcible guiding or escorting of a patient to another area of the facility; **where the patient can easily remove or escape the grasp; or**
- ii. taking reasonable steps to prevent a patient at imminent risk of entering a dangerous situation from doing so with a limited response to avert injury, such as blocking a blow, breaking up a fight, or preventing a fall, a jump, or a run into danger;.
- iii. **in the case of intensive residential treatment programs licensed pursuant to 104 CMR 27.04, briefly holding a patient without undue force in order to calm him or her; provided, however, that the facility shall document such brief holds in the patient record and consider the need for post-intervention review.**

4. Seclusion.

a. Seclusion occurs when a patient is involuntarily confined in a room **or isolated area of a facility** and is **physically** prevented from leaving, or reasonably believes that he or she will be prevented from leaving, by means that include, but are not limited to, the following:

- i. manually, mechanically, or electrically locked doors, or "one-way doors," that, when closed and unlocked, cannot be opened from the inside;
- ii. physical intervention of staff;
- iii. coercive measures, such as the threat of restraint, sanctions, or the loss of privileges that the patient would otherwise have, used for the purpose of keeping the patient from leaving the room.

b. Seclusion shall not include voluntary, collaborative separation from a group or activity for the purpose of calming a patient.

(b) Emergency Basis for Medication Restraint, Mechanical Restraint, Physical Restraint or Seclusion. Medication restraint, mechanical restraint, physical restraint or seclusion may be used only in an emergency, such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide. Such emergencies shall only include situations where there is a substantial risk of, or the occurrence of, serious self-destructive behavior, or a substantial risk of, or the occurrence of, serious physical assault. As used in the previous sentence, a substantial risk includes only the serious, imminent threat of bodily harm, where there is the present ability to effect such harm.

1. Restriction on Medication Restraint, Mechanical Restraint, Physical Restraint or Seclusion; Use of **Individual/Individualized** Crisis Prevention Plan. Medication restraint, mechanical restraint, physical restraint or seclusion may be used only after the failure of less restrictive alternatives, including strategies identified in the **individual crisis prevention plan/Individualized Crisis Prevention Plan**, or after a determination that such alternatives would be inappropriate or ineffective under the circumstances, and may be used only for the purpose of preventing the continuation

or renewal of such emergency condition. The preferences in the patient's **individual crisis prevention plan**~~Individualized Crisis Prevention Plan~~, such as type of restraint or seclusion and gender of staff, shall be considered in ordering or initiating restraint or seclusion.

2. Duration of Medication Restraint, Mechanical Restraint, Physical Restraint, or Seclusion. Medication restraint, mechanical restraint, physical restraint or seclusion may only be used for the period of time necessary to accomplish its purpose; but in no event beyond the periods established in 104 CMR 27.12(58)(e), (f) and (g).

27.12: continued

3. PRN Orders Prohibited. No "PRN" or "as required" authorization of medication restraint, mechanical restraint, physical restraint or seclusion may be written.
 4. Seclusion Used with Mechanical Restraint Prohibited. No patient shall be placed in seclusion while in mechanical restraints.
 5. Other Requirements. When an emergency condition exists justifying the use of medication restraint, mechanical restraint, physical restraint or seclusion, such use must conform to all applicable requirements of 104 CMR 27.12.
- (c) Physical and Mechanical Restraint or Seclusion - Physical Conditions.
1. Position in Physical or Mechanical Restraint. A patient shall be placed in a position that allows airway access and does not compromise respiration. A face-down position shall not be used, unless:
 - a. there is a specified patient preference and no psychological or medical contra-indication to its use; or
 - b. there is an overriding psychological or medical justification for its use, which shall be documented.
 2. Personal Needs and Comfort. Provision shall be made for appropriate attention to the personal needs of the patient, including access to food and drink and toileting facilities, by staff **escortassistance** or otherwise, and for the patient's physical and mental comfort.
 3. Personal Dignity. Patients in restraints or seclusion shall be fully clothed, limited only by patient safety considerations related to the type of intervention used, and the restraint devices used shall afford patients maximum personal dignity.
 4. Physical Environment. The physical environment shall be as conducive as possible to facilitating early release, with attention to calming the patient with sensory interventions where possible and appropriate.
 5. Seclusion - Observation. Any room used to confine a patient in seclusion must provide for complete visual observation of the patient so confined.
 6. Mechanical Restraint – Locks Prohibited. No locked mechanical restraint devices requiring the use of a key for their release may be used.
- (d) Medication Restraint – Order. A patient may be given medication restraint only on the order of an authorized physician who has determined, either while present at the time of (*i.e.*, at any time during the course of) the emergency justifying the use of the restraint or after telephone consultation with a physician, registered nurse or certified physician assistant who is present at the time and site of the emergency and who has personally examined the patient, and using all relevant information available regarding the patient, that such medication restraint is the least restrictive, most appropriate alternative available.
1. Such order along with the reasons for its issuance shall be recorded in writing at the time of its issuance.
 2. Such order shall be signed at the time of its issuance by such authorized physician if present at the time of the emergency.
 3. Such order, if authorized by telephone, shall be transcribed and signed at the time of its issuance by the physician, registered nurse or physician assistant who is present at the time of the emergency.
 4. An authorized physician shall conduct **a face-to-face evaluationan in-person examination** of the patient as soon as possible, but no later than within one hour of the initiation of the restraint if the restraint was authorized by telephone. **Such examination must include documentation of both a physical and behavioral assessment conducted of the patient.**
- (e) Initiation of Mechanical Restraint, Physical Restraint or Seclusion.
1. The order that a patient be placed in mechanical restraint, physical restraint, or seclusion shall be made by an authorized physician who is present when an emergency as defined in 104 CMR 27.12(58)(b) occurs, except as provided in 104 CMR 27.12(58)(e)2.
 - a. Such order along with the reasons for its issuance and criteria for release shall be recorded in writing and signed at the time of its issuance by such physician.
 - b. Such order shall authorize use of mechanical restraint, physical restraint or seclusion for no more than **two hoursone hour**, subject to the additional restrictions in 104 CMR 27.12(58)(g).
 - c. Such order shall terminate whenever a release decision is made pursuant to 104 CMR 27.12(5)(h)8(h)8., and shall be subject to the monitoring, examination

and release provisions of 104 CMR 27.12(58)(h).

27.12: continued

2. If an authorized physician is not present when an emergency justifying the use of mechanical restraint, physical restraint or seclusion occurs, a patient may be placed in mechanical restraint, physical restraint or seclusion at the initiation of an authorized staff person, subject to the following conditions and limitations;
 - a. Such initiation shall be subject to the additional restrictions in 104 CMR 27.12(58)(g).
 - b. Such initiation along with the reasons for its issuance shall be recorded in writing and signed at the time of the incident by such authorized staff person.
 - c. Such initiation shall authorize use of mechanical restraint, physical restraint or seclusion for no more than one hour, shall terminate whenever a release decision is made pursuant to 104 CMR 27.12(58)(h)8., and shall be subject to the monitoring, examination and release provisions of 104 CMR 27.12(58)(h).
 - d. An authorized physician shall **examineconduct an in-person examination** of the patient as soon as possible but no later than one hour of such initiation of mechanical restraint, physical restraint, or seclusion. **Such examination must include documentation of both a physical and behavioral assessment conducted of the patient.**
 3. At the time of initiation of restraint, an authorized staff person, or authorized physician shall observe and make written note of the patient's physical status, including respiratory functioning, skin color and condition, and the presence of undue pressure to any part of the body.
- (f) Mechanical Restraint, Physical Restraint or Seclusion – Renewals to Continue Use.
1. Continuation for a Second Hour of Mechanical Restraint, Physical Restraint or Seclusion Initiated by an Authorized Staff Person – Exceptional Circumstances. In exceptional circumstances, where an authorized physician has not examined the patient within the first hour of initiation of restraint or seclusion as required by 104 CMR 27.12(58)(e)2.d., an authorized staff person may issue a single renewal for a second one hour period, subject to the following conditions and limitations:
 - a. Such renewal shall be subject to the additional restrictions in 104 CMR 27.12(58)(g).
 - b. Such renewal may only be issued if such authorized staff person determines that such restraint or seclusion is necessary to prevent the continuation or renewal of an emergency condition or conditions as defined in 104 CMR 27.12(58)(b).
 - c. Such renewal shall authorize use of mechanical restraint, physical restraint or seclusion for no more than one hour, shall terminate whenever a release decision is made pursuant to 104 CMR 27.12(5)(h)8(h)8., and shall be subject to the monitoring, examination and release provisions of 104 CMR 27.12(58)(h).
 - d. An authorized physician shall **examineconduct an in-person examination** of the patient as soon as possible, but no later than within one hour of such renewal of mechanical restraint, physical restraint or seclusion, and may order the restraint to continue for no more than **two hoursone hour** from the initiation of the restraint or seclusion by the authorized staff person, subject to the additional restrictions in 104 CMR 27.12(58)(g).
 2. Continuation of Mechanical Restraint or Seclusion for Additional **TwoOne**-Hour Periods. Subsequent orders for renewals of mechanical restraint or seclusion may be made for up to **twoone**-hour periods only if an authorized physician has examined the patient and ordered such renewal prior to the expiration of the preceding order, subject to the following conditions and limitations.
 - a. Such a renewal order shall be subject to the additional restrictions in 104 CMR 27.12(58)(g).
 - b. Such a renewal order may only be issued if such physician determines that such restraint or seclusion is necessary to prevent the continuation or renewal of an emergency condition or conditions as defined in 104 CMR 27.12(58)(b).
 - c. Each such order shall be recorded in writing and signed by such physician, but only after examination of the patient in restraint or seclusion by such physician.
 - d. Each such order shall authorize continued use of mechanical restraint or seclusion for no more than **two hoursone hour** from the time of expiration of the preceding order, shall terminate whenever a release decision is made pursuant to 104 CMR 27.12(58)(h)8., and shall be subject to the monitoring, examination and release provisions of 104 CMR 27.12(58)(h). **Continuation of a restraint or seclusion requires documentation that the patient's symptoms necessitate the**

continuation of the restraint or seclusion.

27.12: continued

(g) Additional Restrictions and Limitations on the Use of Restraint or Seclusion.

1. No episode of physical restraint shall exceed **two hoursone hour**.
2. No order for the restraint or seclusion of a minor under age nine may exceed one **half** hour.
3. No minor under age nine shall be in seclusion or restraint for more than one hour in any 24-hour period.
4. No minor age nine through 17 shall be in seclusion for more than two hours in any 24-hour period.
5. No minor under age 13 may be placed in mechanical restraint, except under the following conditions:
 - a. The facility medical director is notified prior to the use of such restraint or immediately after the initiation of the restraint, if an emergency as defined in 104 CMR 27.12(58)(b) occurs. The facility medical director shall inquire about the circumstances warranting the use of such restraint, the efforts made to de-escalate the situation, the alternatives to such restraint considered and tried, any preferences indicated in the **individual crisis prevention planIndividual Crisis Prevention Plan**, and whether other measures or resources might be helpful in avoiding the use of mechanical restraint or in facilitating early release.
 - b. The facility director shall also be immediately informed of the use of such restraint and shall report it in writing to the **Commissioner or designeeDepartment** by the next business day.
 - c. All other applicable provisions of 104 CMR 27.12 shall be complied with.
6. Mechanical Restraint or Seclusion Exceeding Six Hours or Multiple Episodes. If an episode of mechanical restraint or seclusion has exceeded five hours and it is expected that a new order will be issued to extend the episode beyond six hours or if there are two or more episodes of any restraint or seclusion for a patient in any 12 hour period, the facility director and facility medical director shall be notified. The facility medical director shall inquire about the circumstances of the episode(s) of restraint or seclusion, the efforts made to facilitate release, and the impediments to such release, and help to identify additional measures or resources that might be beneficial in facilitating release or preventing additional episodes.
7. Mechanical Restraint or Seclusion Exceeding 12 Hours or Total Episodes Exceeding 12 Hours in a 48-Hour Period. If an episode of mechanical restraint or seclusion has exceeded 11 hours and it is expected that a new order will be issued to extend the episode beyond 12 hours, or if episodes of restraint and/or seclusion for a patient have exceeded 12 hours in the aggregate in any 48-hour period, the following shall occur:
 - a. The patient shall receive a medical assessment.
 - b. The facility director and facility medical director shall be notified. The facility medical director shall inquire about the outcome of the measures identified pursuant to 104 CMR 27.12(58)(g)6., in the case of a continuous episode, and about the circumstances that resulted in the continued or multiple use of restraint or seclusion. The facility medical director shall take steps, including consultation with appropriate parties, to identify and implement strategies to facilitate release as soon as possible and/or eliminate the use of multiple episodes, such as psychopharmacological reevaluation or other consultation, assistance with communication, including interpreter services, and consideration of involving family members or other trusted individuals.
 - c. The episode(s) shall be reported to the **Commissioner or designeeDepartment** by the next business day.
8. Release Prior to Expiration of Order. If a patient is released from a restraint or seclusion prior to the expiration of **anthe original** order and an emergency as defined in 104 CMR 27.12(58)(b) occurs prior to such order's expiration, **but no later than one-half hour after release, the patient maya new order must be returned by an authorized staff personobtained prior to reinitiating the use of** restraint or seclusion **without a new order for the time remaining in the order.** . Such return to restraint or seclusion shall be documented in the record. **If the time permitted by the order or one-half hour has elapsed at the time of such emergency, and** the procedures for ordering or initiating restraint or seclusion pursuant to 104 CMR 27.12(58)(e) shall be followed.

27.12: continued

(h) Monitoring and Assessment of Patients in Mechanical Restraint, Physical Restraint or Seclusion; Release.

1. One-on-One Staff Monitoring. Whenever a patient is in physical or mechanical restraint or seclusion, a staff person shall be specifically assigned to monitor such **personpatient** one-on-one.
2. The staff person conducting such monitoring may be immediately outside a space in which a patient is being secluded without mechanical restraint provided that the following conditions are met:
 - a. The staff person must be in full view of the patient (*e.g.*, the patient may approach the seclusion door and see the staff person through a window in the door if he or she wishes to do so); and
 - b. The staff person must be able at all times to observe the patient.
3. The staff person shall monitor a patient in mechanical or physical restraint by being situated so that the staff person is able to hear and be heard by the patient and visually observe the patient at all times. It is not necessary for a staff person monitoring a patient in mechanical or physical restraint to be in full view of the patient,; although if such visibility has been expressed as a preference by the patient, consideration shall be given to honoring such preference.
4. Staff who monitor a patient in physical or mechanical restraint or seclusion shall continually assist and support the patient, including monitoring physical and psychological status and comfort, body alignment, and circulation, taking vital signs when indicated, and monitoring for readiness for release pursuant to 104 CMR 27.12(58)(h)6. Such monitoring activities shall be documented every 15 minutes.
5. Staff who **monitormonitors** a patient in restraint or seclusion shall **continueattempt** appropriate interventions designed to calm the patient throughout the episode of restraint or seclusion and shall ensure that the patient has access to a means of marking the passage of time, either visually or verbally.
6. Monitoring for Readiness for Release.
 - a. Staff conducting monitoring shall continually consider whether a patient in mechanical restraint, physical restraint or seclusion appears ready to be released. **IfWhenever** the staff person believes that the patient may be ready to be released from such restraint or seclusion either because the criteria for release have been met or an emergency condition or conditions as defined in 104 CMR 27.12(58)(b) no longer exists, he or she shall immediately notify an authorized physician or authorized staff person, who shall promptly assess the patient for readiness to be released.
 - b. If a patient falls asleep while in mechanical restraint, staff conducting monitoring shall notify an authorized physician or authorized staff person, who shall release the patient from the restraint or seclusion, unless such efforts are reasonably expected to re-agitate the patient.
 - c. If, at any time during mechanical restraint, physical restraint, or seclusion, a patient is briefly released from such restraint or seclusion to attend to personal needs pursuant to 104 CMR 27.12(58)(c)2., or for other purpose, staff conducting monitoring shall **consider the patient's readiness to be permanently released, rather than returned to the restraint or seclusion, and** notify an authorized staff person **ifas soon as possible, who shall promptly assess** the patient **appears readyfor readiness** to be released.
7. Assessment. An authorized staff person or authorized physician shall assess a patient in mechanical or physical restraint or seclusion for physical and psychological comfort, including vital signs, and readiness to be released at least every 30 minutes and at any other time that it appears that the patient is ready to be released. Such assessments shall be documented in the record.
8. Permanent Release. A patient shall be released from mechanical restraint, physical restraint or seclusion as soon as an authorized physician or authorized staff person determines after examination of the patient or consultation with staff that such mechanical restraint, physical restraint, or seclusion is no longer needed to prevent the continuation or renewal of an emergency condition or conditions as defined in 104 CMR 27.12(58)(b) and, in no event, no later than the expiration of an initial or renewed order for such mechanical restraint or seclusion, unless such order is renewed in accordance with the requirements or 104 CMR 27.12(58)(f). The circumstances considered in making such a determination shall be documented and

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signed by the authorized physician or authorized staff person making the determination.

27.12: continued

(i) Documentation Requirements.

1. The Restraint and Seclusion Order Form. Each facility **subject to these regulations** shall ensure that a restraint and seclusion **order** form is **maintained and completed** on each occasion when a patient is placed **and maintained** in restraint or seclusion. The restraint and seclusion **order** form shall conform to the following requirements:

a. The restraint and seclusion **order** form must be in a form approved by the **CommissionerDepartment**.

b. The **completed** restraint and seclusion **order** form shall be **completed in triplicate, one copy of which shall be** placed in the patient's record, **one. One copy of which** shall be used for the patient's comments pursuant to 104 CMR 27.12(4)(b), and one copy **of which** shall be used for the review by the Commissioner or designee pursuant to 104 CMR 27.12(58)(i)23.

c. Any attachments, **including the patient debriefing and comment form** required by 104 CMR 27.12 shall be **attached toincluded with** each copy of the restraint and seclusion **order** form.

22. Examinations. Examinations of patients conducted pursuant to 104 CMR 27.12 shall be documented in the patient's record.

3. Submission to the Commissioner; Review. At the end of each month, a facility shall submit to the **Commissioner or designeeDepartment** copies of all restraint and seclusion forms with attachments, if any, required by 104 CMR 27.12 and an aggregate report for each facility unit, on a form approved by the **CommissionerDepartment**, containing statistical data on the episodes of restraint and seclusion for the month. The Commissioner or designee shall review such aggregate reports and review a sample of restraint and seclusion forms, and shall maintain statistical records of all uses of restraint or seclusion, organized by facility and unit.

34. Human Rights Committee/Human Rights Officer Review. At the end of each month, copies of all restraint and seclusion **order** forms and attachments **and aggregate reports**, if any, sent to the **Commissioner or designeeDepartment** pursuant to 104 CMR 27.12(58)(i)2.3 shall be sent to the **human rights committeeHuman Rights Committee** of the facility, if operated by or under contract to the Department, and otherwise to the **human rights officerHuman Rights Officer**, which shall review the use of all restraints by the facility or program. The committee or **human rights officerHuman Rights Officer** shall have the authority to:

a. review all pertinent data concerning the behavior that necessitated restraint or seclusion;

b. obtain information about the patient's needs from appropriate staff, relatives and other persons with direct contact or special knowledge of the patient;

c. monitor the use of the individual crisis prevention plan and consider all less restrictive alternatives to restraint and seclusion in meeting the patient's needs;

d. review and refer to the person in charge for action in accordance with 104 CMR 32.00 *Investigations and Reporting Responsibilities* all complaints that the rights of a patient are being abridged by the use of restraint or seclusion; and

e. generally monitor the use of restraint and seclusion in the facility.

27.13: Human Rights

(1) No right protected by the Constitutions or laws of the United States and the Commonwealth of Massachusetts shall be abridged solely on the basis of a patient's admission or commitment to a facility, except insofar as the exercise of such rights have been limited by a court of competent jurisdiction. Furthermore, no **personpatient** shall be deprived of the right to manage his or her affairs, to contract, to hold professional, occupational or vehicle operator's licenses, to make a will, to marry, to hold or convey property or to vote in local, state, or federal elections solely by reason of his or her admission or commitment to a facility.

(2) In cases where there has been an adjudication that a **personpatient is incompetentlacks capacity**, or when a **conservator or guardianlegally authorized representative** has been appointed **foror designated on behalf of** such **personpatient**, such **personpatient's** human rights may be limited only to the extent of the **guardian or conservator's adjudicated responsibility.legally authorized representative's authority**. If at any time during a patient's

treatment, the clinical team believes the patient to **be incompetent lack capacity** to make treatment or other personal or financial decisions, the director or designee shall notify the patient that a recommendation **has beenmay be** made that there be an adjudication or other determination of the **competencycapacity** of such patient.

(3) Right to Treatment. Each patient admitted to a facility shall, subject to his or her giving informed consent, receive treatment suited to his or her needs which shall be administered skillfully, safely, and humanely with full respect for dignity and personal integrity.

27.13: continued

(4) Right to Education. Patients under the age of 22, under the care and treatment of the Department, shall receive education and training appropriate to their needs in accordance with M.G.L. c. 71B and 603 CMR 28.00.

(4) No facility shall employ corporal punishment, infliction of pain or physical discomfort, or deprivation of food or sleep for any purpose.

(5) In addition to the foregoing, a patient of a facility:

(a) shall have reasonable access to a telephone to make and receive confidential telephone calls and to assistance, when desired and necessary to implement this right, provided that such calls do not constitute a criminal act or represent an unreasonable infringement of other **personpatients'** right to make and receive phone calls;

(b) shall have the right to send and receive sealed, unopened, uncensored mail, provided, however, that the facility director or designee may direct, for good cause and with documentation of specific facts in the patient's record, that a particular patient's mail be opened and inspected in front of the patient, without it being read by staff, for the sole purpose of preventing the transmission of contraband. Writing materials and postage stamps in reasonable quantities shall be made available for use by patients. Reasonable assistance shall be provided to patients in writing, addressing and posting letters and other documents upon request;

(c) shall have the right to receive visitors of such patient's own choosing daily and in private, at reasonable times. Hours during which visitors may be received may be limited only to protect the privacy of other patients and to avoid serious disruptions in the normal functioning of the facility and shall be sufficiently flexible as to accommodate individual needs and desires of such patients and their visitors;

27.13: continued

(d) shall have the right to a humane psychological and physical environment. Each such patient shall be provided living quarters and accommodations which afford privacy and security in resting, sleeping, dressing, bathing and personal hygiene, reading and writing, and in toileting. 104 CMR 27.13 shall not be interpreted as requiring individual sleeping quarters;

(e) shall have the right to receive, or refuse, visits and telephone calls from his or her attorney or legal advocate, physician, psychologist, clergy or social worker at any reasonable time, regardless of whether the patient initiated or requested the visit or telephone call;

(f) shall have reasonable daily access to the outdoors, as weather conditions reasonably permit, in a manner consistent with the **personpatient's** clinical condition and safety as determined by the treating clinician and with the ability of the facility to safely provide access.

1. For purposes of 104 CMR 27.13(5)(f) reasonable daily access shall mean supervised or unsupervised daily access to the outdoors, individually or in groups.

a. Nothing in 104 CMR 27.13(5)(f) shall be construed to:

i. prohibit a facility from establishing reasonable schedules or designated times for the provision of access to the outdoors, as long as each patient has a reasonable opportunity to access the outdoors on a daily basis, consistent with the provisions of 104 CMR 27.13(5)(f), during one or more of the scheduled or designated times;

ii. require a facility to conduct clinical programming outdoors;

iii. require a facility to provide access to the outdoors "on demand."

b. No patient shall be compelled to participate in clinical programming as a condition of accessing the outdoors.

2. For purposes of 104 CMR 27.13(5)(f), outdoors shall mean a space or area outside of a building, which may include a porch, courtyard, roof deck or open space surrounded by a building, and may be fenced, locked or otherwise secured.

3. A patient's initial psychiatric examination conducted within 24 hours of admission shall include a written assessment of the patient's ability to access the outdoors consistent with his or her clinical condition and safety. Factors that may be considered in such assessments may include, but are not necessarily limited to:

a. acuity of symptoms;

b. medical conditions;

c. forensic legal status, including pending charges and bail status;

d. risk of elopement;

e. need for secure or non-secure space;

f. level of supervision required to ensure safety;

g. ability of the facility to meet the **individual'spatient's** requirements for safety; and

h. adequacy of historical or observational data upon which to make a determination.

4. A patient's status regarding access to the outdoors shall be reviewed at treatment team meetings and reassessed by the treating clinician whenever it appears that there has been a change in circumstances that may affect the patient's ability to safely access the outdoors.

a. A decision made in accordance with 104 CMR 27.13(5)(f)(3) to restrict a patient's access to the outdoors shall be reviewed daily to determine whether there is a change relative to the factors that resulted in the restriction. If such a determination is made, a new assessment shall be conducted.

b. A patient whose access to the outdoors has been restricted in accordance with 104 CMR 27.13(5)(f)(3), may request a new assessment at any time. Such assessment shall be conducted within a reasonable period of time; provided, however, there shall be no requirement to provide more than one assessment in a 24 hour period.

5. The facility shall have a written plan to implement its obligation to provide patients access to the outdoors.

a. The plan shall include the following:

i. procedures, including staffing and other safety requirements, to allow for access to non-secure outdoor space for patients who have been assessed as clinically appropriate and safe to exercise this option;

- ii. procedures, including staffing and other safety requirements, to allow for access to secure outdoor space, if available, for patients who have been assessed as clinically appropriate and safe to exercise this option.
- b. Reasonable efforts to safely provide access to outdoor space, may include, but shall not be limited to:
 - i. reasonable capital expenditures to develop, construct or otherwise acquire outdoor space;
 - ii. reasonable modifications of staffing patterns to permit staff escorts; or
 - iii. reasonable modifications to building access policies to permit patient access to common areas of the facility or proximate to the facility not normally dedicated as patient areas.
- c. If the facility determines that it cannot safely provide secure outdoor access due to staffing or physical plant limitations, it shall:
 - i. identify and document such limitations in the plan;
 - ii. identify what actions the facility will take to address these limitations and the timeframe for the actions.

If the facility determines that the limitations cannot be reasonably remedied, the facility shall identify the reasons for such determination. Such reasons shall be documented with sufficient detail to enable the Department to determine whether they constitute reasonable justification.

d. Upon request of the Department, but no less frequently than in its application for licensure or license renewal, the facility shall demonstrate to the Department's satisfaction that its plan is current and that it has identified, considered and implemented all reasonable actions to safely provide access to outdoor space.

6. The Facility shall have procedures intended to ensure patient and staff safety at such times that patients are exercising their right of access to the outdoors. Such procedures may include, but are not necessarily limited to:

- a. availability of electronic communication for staff supervising patients or for patients accessing the outdoors without staff supervision;
- b. application of appropriate patient to staff ratios, including staffing requirements for patients not accessing the outdoors, taking into account the number of patients accessing the outdoors and any provisions for supervision determined by the treating clinician;
- c. use of security cameras to monitor outdoor areas; and
- d. provisions for altering designated times for access to accommodate inclement weather.

(g) shall, upon admission and upon request at any time thereafter, be provided with the name, address, and telephone number of the Mental Health Legal Advisors Committee, Committee for Public Counsel Services, and authorized Protection and Advocacy organizations, and shall be provided with reasonable assistance in contacting and receiving visits or telephone calls from attorneys or paralegals from such organizations; provided, further, that the facility shall designate reasonable times for unsolicited visits and for the dissemination of educational materials to patients by such attorneys or paralegals;

((h) shall have the right to file complaints and to have complaints responded to in accordance with 104 CMR 32.00 *Investigations and Reporting Responsibilities*.

(6) Any rights set forth in 104 CMR 27.13(5)(a), (c) or (f) may be temporarily suspended, but only by the facility director or designee upon concluding that based on the experience of the patient's exercise of such right, such further exercise of it in the immediate future would present a substantial risk of serious harm to said patient or others and that less restrictive alternatives have either been tried or failed or would be futile to attempt. The Such suspension shall be reviewed at least daily and shall last no longer than the time necessary to prevent the harm, and its imposition shall be documented with specific facts in the patient's record. Notice of suspensions of rights under this section (insert) shall be provided to the facility's Human Rights Officer.

(7) An assessment or decision concerning the exercise of the rights set forth in 104 CMR 27.13(5)(), clauses (a) through (f), inclusive, and the reasons, therefore, shall be documented with specific facts in the patient's record and subject to timely appeal. An appeal brought pursuant to 104 CMR 27.13(7) shall be initiated by the filing of a complaint in accordance with 104 CMR 32.00, and shall be subject to the provisions thereof.

(8) Patients have the right to be free from unreasonable searches of their person or property.

(9) Each facility shall develop a written policy, consistent with applicable law and the requirements of 104 CMR 27.13, regarding patient possessions and the implementation of searches and seizures within the facility. Patients shall be informed of the policy upon admission to the facility. The policy shall, at a minimum, detail circumstances in which a search may be authorized and require that, in all except emergency circumstances, patients:

- (a) be informed of a search prior to the search;
- (b) be provided an opportunity to consent to the search; and
- (c) be present during the search of their property.

If a search of a patient's property needs to be performed in an emergency, in order to avoid imminent risk of harm, and the patient is not present during the search, the nature of the emergency and the reasons the patient is not present should be documented in the patient's record.

(10)(9) Right of Habeas Corpus. Any patient involuntarily committed to any facility who believes or has reason to believe he or she should no longer be retained may make written application to the superior court for a judicial determination of the necessity of continued commitment pursuant to M.G.L. c. 123, § 9(b).

(1011) Rights at Court Hearing. Whenever a court hearing is held under the provisions of M.G.L. c. 123 for the commitment or further retention of a **personpatient** in a facility, such **personpatient** shall have the right to a timely hearing and representation by counsel as provided by law.

(1112) Rights of Aliens. Aliens shall have the same rights under the provisions of M.G.L. c. 123 as citizens of the United States.

(1213) Human Rights Information to Each Patient on Admission. A member of the admitting staff shall give each patient, and, if applicable, his or her legally authorized representative, at the time of admission a copy of the rights set forth in 104 CMR 27.13, or other materials explaining his or her rights prepared in accordance with Departmental guidelines.

(1314) Copies of Rights Posted and Available in Facilities. Each facility shall post a copy of the rights set forth in 104 CMR 27.13 in the admitting room of the facility, in each unit, and in other appropriate and conspicuous places in the facility, and shall make copies available upon request.

27.14: Human Rights Officer; Human Rights Committee

(1) Human Rights Officer. Each facility shall have a person or person employed by or affiliated with the facility appointed to serve as the human rights officer and to undertake the following responsibilities:

- (a) To participate in training programs for human rights officers offered by the Department;
- (b) To inform, train and assist patients in the exercise of their rights;
- (c) To assist patients in obtaining legal information, advice and representation through appropriate means, including referral to attorneys or legal advocates when appropriate;
- (d) In the case of Department facilities, to serve as staff to the facility's human rights committee.

The human rights officer must have no day-to-day duties that are inconsistent with his or her responsibilities as a human rights officer, including carrying out fact-finding activities under 104 CMR 32.00 *Investigations and Reporting Responsibilities*.

In the case of Department facilities, the Commissioner or designee shall appoint the human rights officer. Otherwise, the facility director shall make such appointment.

(2) Human Rights Committee. For each facility operated by, or under contract to the Department, the Commissioner or designee shall establish, impanel and empower a human rights committee in accordance with the provisions of 104 CMR 27.14. Such a human rights committee may be established jointly with other programs in an Area; provided, however, that the number, geographical separateness or programmatic diversity of the programs is not so great as to limit the effectiveness of the committee in meeting the requirements of 104 CMR 27.14.

(3) Each such The majority of members of each human rights committee shall be composed of a minimum of five members, a majority of whom shall be current or former consumers of mental health services, family members of consumers, or advocates; provided, however, that no member shall have who has any direct or indirect financial or administrative interest in the facility or the Department shall notify the facility director or Commissioner, as applicable, in writing.

(4) The general responsibility of each such human rights committee shall be to monitor the activities of the facility with regard to the human rights of the patients in the facility. The specific duties of the committee shall include:

- (a) Reviewing and making inquiry into complaints and allegations of patient mistreatment, harm or violation of patient's rights and referral of such complaints for investigation in accordance with the requirements of 104 CMR 32.00;
- (b) Reviewing and monitoring the use of restraint, seclusion and other physical limitations on movement;
- (c) Reviewing and monitoring the methods utilized by the facility to inform patients and staff of the patient's rights, to train patients served by the program in the exercise of their rights, and to provide patients with opportunities to exercise their rights to the fullest extent of their capabilities and interests;
- (d) Making recommendations to the facility to improve the degree to which the human rights of patients served by the facility are understood and enforced;
- (e) Visiting the facility with prior notice or without prior notice provided good cause exists.

(5) Each such human rights committee shall meet as often as necessary upon call of the chairpersons, or upon request of any two members, but no less often than quarterly. Minutes of all committee meetings shall be kept and shall be available for inspection by the Department upon request. The committee shall develop operating rules and procedures, as necessary.

27.15: Visit

- (1) A visit is a temporary release of any patient, with the exception of those patients committed pursuant to M15M.G.L. c. 123, §§ 15, 17 and 18, to the community for a period of not more than 30 days.
- (2) A patient committed pursuant to M.G.L. c. 123, § 16 may be released on visit only if not restricted by court order, and upon authorization by the facility director after review by senior clinical staff.
- (3) Readmission to Facility. A patient on visit may be readmitted to the facility at any time within 30 days from the day of release without new admission procedures. In the case of persons involuntarily committed, the original commitment order shall remain in effect. Readmission to the facility terminates a visit.
- (4) Every facility shall maintain a record of the names of all patients on visit status.

27.16.: Absence Without Authorization

(1) Classification as AWA. Any patient admitted or committed to a Department facility pursuant to M.G.L. c. 123, §§ 7 and 8, 10 and 11, 12, 15, 16, 17, or 18, who leaves the facility grounds or an off-grounds program or activity without permission and fails to return within a reasonable time, or any patient who, having left the facility with permission, fails to return at the designated time or within a reasonable time thereafter, shall be classified by the facility director as “absent without authorization.” (AWA).

(2) Classification as AWA: Action to be Taken.

(a) Immediate Classification: A patient who is admitted or committed pursuant to M.G.L. c. 123, §§ 7 and 8, 10 and 11, or 12 and who is at a high risk of harm to self or others or a patient who is committed pursuant to M.G.L. c. 123, §§ 15, 16, 17, or 18 **who leaves the facility grounds or an off-grounds program or activity without permission** shall be immediately classified as AWA.

(b) Classification by Midnight Census: A patient who does not meet the criteria of 104 CMR 27.1615(2)(a) shall be classified as AWA if he or she has not returned within a reasonable time based on clinical judgment or by the midnight census, whichever is earlier.

(c) The facility shall take prompt and vigorous measures to secure the patient’s return.

(d) When a patient is classified as AWA, the facility director or designee shall immediately notify the following parties:

1. local and state police. The police shall be provided with the patient’s description, other information that would assist the police in locating the patient, and information of the patient’s tendencies to be assaultive, homicidal, suicidal or to use weapons;
2. the district attorney of the county in which the facility is located;
3. the patient’s next of kin;
4. the patient’s legally authorized representative;
5. any person known to be placed at risk because the patient has left the facility;
6. designated individuals within the Department.

If such notification is made by telephone, it shall be followed by written notification.

(3) Return from AWA: Action to be Taken.

(a) A patient **who had been admitted pursuant to M.G.L. c. 123, §§ 10 and 11 or committed pursuant to M.G.L. c. 123, §§ 7 and 8, and who has not been discharged from the facility as provided in 104 CMR 27.15(4), may return or be returned to the facility under the original patient legal status within six months of being classified as AWA.; provided, however, if a patient was hospitalized pursuant to an order of commitment under M.G.L. c. 123, §§ 7 and 8 that has expired. Such patient may not be retained involuntarily unless he or she is assessed and admitted in accordance with the requirements of M.G.L. c. 123, § 12 and 104 CMR 27.07.**

(b) A patient who was committed to a Department facility pursuant to M.G.L. c. 123, §§ 15, 16, 17 or 18 may return or be returned to the facility under the original legal status; provided, however, that a patient who was committed after a finding of incompetence to stand trial whose charges have been dismissed, and whose commitment has expired, may not be retained involuntarily unless he or she is assessed and admitted in accordance with the requirements of M.G.L. c. 123, § 12 and 104 CMR 27.07.

(c) All parties who were notified at the time of a patient’s classification as AWA, shall be notified of the patient’s return to the facility by the facility director or designee.

(4) Discharge of Patients on AWA: Action to be Taken.

(a) Six months after being classified as AWA, a patient on AWA who is not committed pursuant to M.G.L. c. 123, §§ 15, 16, 17, or 18 may be discharged from the facility upon authorization by the facility director after review by senior clinical staff. **After such six month period, subsequent hospitalization of patients discharged while on AWA status shall require new admission proceedings. However, under specific circumstances; provided, however, that a patient who was committed after a finding of incompetence to stand trial whose charges have been dismissed may be so discharged; provided, further, that, the facility director, in consultation with senior clinical staff, may discharge a patient on AWA status at an earlier date.**

(b) **There Except for a patient who was committed after a finding of incompetence to stand trial whose charges have been dismissed, there shall be no such discharge after a six month period for personof a person on AWA status who has been committed to a Department facility pursuant to M.G.L. c. 123, §§ 15, 16, 17 or 18.**

(c) All parties who were notified at the time of a patient’s classification as AWA, shall

be notified of the facility's decision to discharge the patient pursuant to 104 CMR 27.1615(4)(a).

(5) All incidents of AWA shall receive clinical review and such other review as may be determined by the Commissioner.

27.1716: Records and Records Privacy

(1) Each facility shall maintain a permanent individualpatient record containing all significant clinical information for each personpatient admitted to the facility. "IndividualPatient record" shall refer to the medical and psychiatric record of a patient admitted to a facility providing care and treatment, and shall not include any financial, statistical or bookkeeping records of the facility.

(2) Contents of IndividualPatient Record. An individualA patient record shall include:
(a) identification data, including patient's admission status;

27.17: continued

- (b) admission information, including admission diagnosis;
- (c) health care proxies and advance directives;
- (d) history and results of physical examination and psychiatric examination or mental status;
- (e) consent forms;
- (f) social service and nurses' notes, and psychological reports;
- (g) reports of clinical laboratory examinations and X-rays, if any;
- (h) reports of diagnostic and therapeutic procedures;
- (i) diagnoses recorded in accordance with the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association;
- (j) progress notes;
- (k) reports of periodic reviews;
- (l) conclusions, including primary and secondary final diagnoses and clinical resume;
- (m) all restraint and seclusion orders, including comment forms;
- (n) legal documents, including commitment orders and records of transfer, including notices of transfer, advanced directives, guardianship;
- (o) records of all placements;
- (p) reports of treatment for accidents, injuries or severe illnesses while the patient is in the care of the facility;
- (q) any required risk identifications and assessments;
- (r) requests for and authorizations to disclose information from such individual patient record;
- (s) discharge information; and
- (st) any other information deemed necessary and significant to the care and treatment of the patient.

The patient record shall not include evaluations of competence to stand trial or criminal responsibility conducted pursuant to M.G.L. c. 123, §§ 15 or 16, unless such evaluations have been released to the record by the court that ordered such evaluation.

(3) Maintenance of Records for 20 Years. Each facility shall maintain each individualpatient record for at least 20 years after closing of the record due to discharge or death or the last date of service. Prior to destruction of a record, the facility must notify the Department of Public Health in accordance with the process specified in 105 CMR 130.370. Each facility shall develop and comply with written procedures concerning maintenance and destruction of records.

(4) Format and Storage of Records. IndividualPatient records may be handwritten, printed, typed or in electronic digital format, or any combination thereof, or converted to electronic digital format or an alternative archival method. Handwritten, printed or typed medical records that have been converted to electronic digital format or an alternative archival format may be destroyed before the expiration of the 20 year retention period. The manner of destruction must ensure the confidentiality of patient information. Medical records in electronic digital format shall have the same force and effect as the original records from which they were made. Any form of electronic storage system shall have adequate backup and security provisions to safeguard against data loss, as well as against unauthorized access.

(5) Notice of Privacy Practices. Each facility shall provide each patient with a notice of privacy practices which meets the requirements set forth in 45 CFR 164.520. Additionally, such notice shall describe the facility procedures regarding retention of records.

(6) Reporting Patient Data to the Department. Each facility shall maintain and make available to the Department such statistical and diagnostic data as may be required by the Department.

(7) Confidentiality of Records. Each facility shall employ reasonable physical, technical and administrative safeguards to ensure the confidentiality, integrity and availability of individualpatient records, and shall comply with all applicable federal and state laws and regulations. Except as provided in 104 CMR 27.1716, all records, relating to any personpatients admitted to or treated by a facility shall be private and not open to public inspection.

(8) Inspection by Patient, Legally Authorized Representative or Patient's Attorney.

(a) A patient and the patient's legally authorized representative shall be permitted to inspect the patient's records, unless a licensed health care professional of the Commissioner or designee facility determines that:

1. inspection by the patient is reasonably likely to endanger the life or physical safety of the patient or another person;

2. the record makes reference to another person (other than a health care provider) and inspection is reasonably likely to cause substantial harm to such other person; or
3. inspection by the legally authorized representative is reasonably likely to cause substantial harm to the patient or another person.

Provided, however, that the individual making such determination must be a licensed health care professional.

(b) If access to a record is denied based on the criteria in 104 CMR 27.1716(8)(a), the patient or legally authorized representative shall be informed of, **and have**, the right to appeal. The determination on appeal must be made by a licensed healthcare professional, other than the person who made the initial decision to deny access, and such determination shall be final.

(c) The patient's attorney shall be permitted to inspect the record upon request. The Commissioner or designee may require that the request be in writing and may further require appropriate verification of the attorney-client relationship.

(d) Clinical staff may offer to read or interpret the record, when necessary, for the understanding of the patient or his or her legally authorized representative. However, in no circumstance may **an individual a patient** be denied access to a record solely because he or she declines the offer of clinical staff to read or interpret the record.

(e) The facility director may require the legally authorized representative's consent before permitting a patient under the age of 18 to inspect his or her own records, provided that a patient who is 16 or 17 years old and admitted himself or herself pursuant to M.G.L. c. 123, §§ 10 and 11, may inspect records of the admittance without such consent. The records of **emergency** medical or dental treatment of a patient under 18 years of age who **consented has been determined to such care be an emancipated or mature minor as provided in accordance with 104 CMR 25.04 M.G.L. c. 112, § 12F** shall be confidential between the minor and physician or dentist and shall not be released, **except upon the written authorization of the patient under 18 years of age or a proper judicial order in accordance with M.G.L. c. 112, § 12F.**

(9) **Inspection by or Disclosure to Other Persons.**

(a) The records of a patient shall be open to inspection **or disclosure** upon proper judicial order, whether or not such order is made in connection with pending judicial proceedings.

1. For the purposes of 104 CMR 27.1716(9), the term "proper judicial order" shall mean an order signed by a justice or special justice of a court of competent jurisdiction as defined by the General Laws, or a clerk or assistant clerk of such a court acting upon instruction of such a justice. A subpoena shall not be deemed a "proper judicial order."

2. Whenever practicable, a patient and the patient's legally authorized representative, if any, shall be informed of a court order for the production of the patient's record.

(b) The records of a patient, or parts thereof, shall be open to inspection **or disclosure** by other third parties, upon receipt of written authorization from the patient or the patient's legally authorized representative, provided that such written authorization shall meet the requirements set forth in 45 CFR 164.508.

(c) The Commissioner or designee may permit inspection or disclosure of the records of a patient where he or she has made a determination that **such inspection or disclosure:**

1. **such inspection or disclosure** would be in the best interest of the patient; and
2. **such disclosure** is permitted by the privacy regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA) at 45 CFR Parts 160 and 164.

Prior to authorizing any release of records pursuant to 104 CMR 27.17(9)(c) or (d), the Commissioner or designee must make a determination that it is not possible or practicable to obtain the written authorization of the patient, if competent, or the patient's legally authorized representative.

(d) (d) Without limiting the discretionary authority of the Commissioner or designee to identify other situations where inspection or disclosure is in the patient's best interest, **if it is not possible or practicable to obtain the written authorization of the patient, if competent, or the patient's legally authorized representative, such inspection or disclosure may be made in the patient's best interest in the following cases the following inspections or disclosures are deemed to be in the patient's best interest:**

1. **from a sending facility to a receiving facility for purposes of transfer pursuant to M.G.L. c. 123, § 3;**
2. **to a physician or other health care provider who requires such records for the treatment of a medical or psychiatric emergency; provided however that the patient is**

given notice of the access as soon as possible;

3. to a medical or psychiatric facility currently caring for the patient, when the disclosure is necessary for the safe and appropriate treatment and discharge of the patient;
 4. if the patient has provided consent for a particular treatment or service, to those persons involved in such treatment or service;
 5. between the Department and a contracted vendor regarding individuals being served, payment, and health care operations as permitted by the vendor for purposes related to services provided privacy regulations promulgated under the contract; HIPAA at 45 CFR Parts 160 and 164;
 6. to persons authorized by the Department to monitor the quality of services being provided to the individual;
 7. to enable the patient, or someone acting on his or her behalf, to obtain benefits, protective services, or third party payment for services rendered to such patient;
 82. to obtain authority for a legally authorized representative to act on the patient's behalf, or to obtain a judicial determination of substituted judgment, when a clinical determination has been made that the patient lacks capacity to render informed consent to treatment;
 3. to persons conducting an investigation involving the patient pursuant to 104 CMR 32.00: *Investigation and Reporting Responsibilities*;
 94. to persons engaged in research if such access is approved by the Department pursuant to 104 CMR 31.00: *Human Subject Research Authorization and Monitoring*;
 10. to The Joint Commission or other accrediting bodies;
 115. to make reports of communicable and other infectious disease to the Department of Public Health and/or local board of health consistent with 105 CMR 300.000 *et seq.*; and
 126. in the case of death, to coroners, medical examiners or funeral home directors.
- (e) Records may be disclosed as required by law. In addition to the laws and regulations of the Department, such laws include, but are not limited to:
1. M.G.L. c. 6, §§ 178C through 178Q (Sex Offender Registry Law - **Department operated and contracted facilities only**);
 2. M.G.L. c. 19A, § 15 (**Department Executive Office** of Elder Affairs - abuse of elderly persons, 60 years of age or older);
 3. M.G.L. c. 19C, § 10 (Disabled Persons Protection Commission – abuse of disabled persons between **the ages of 18 and 59, inclusive** years of age);
 4. M.G.L. c. 119, § 51A **and 51B** (Department of Children and Families – abuse or neglect of children younger than 18 years old);
 5. 42 U.S.C. 10806 (Protection and Advocacy for Mentally Ill Individuals); and
 6. M.G.L. c. 221, § 34E (Mental Health Legal Advisors Committee).
- (f) Pursuant to M.G.L. c. 6A, § 16, the Department must offset the costs of the services which it provides directly or through contract by maximizing all Title XIX and other federal, state and private health insurance reimbursement which might be available for such services. Accordingly, **without limiting 104 CMR 27.16(9)(d)1**, records may be disclosed by the Department and/or its agents for the purposes of:
1. benefits/insurance coverage/availability inquiries;
 2. obtaining third party reimbursement;
 3. appeals of reimbursement denials; and
 4. charging fee payers as set forth in 104 CMR 30.04.
- (g) Any **inspection or** disclosure pursuant to **the exceptions outlined in 104 CMR 27.1716(9)(c)** through (f) shall be limited to the minimum information necessary to achieve the **purpose of the exception permitted inspection or disclosure**.
- (10) Notwithstanding the provisions of 104 CMR 27.1716(8) and (9), inspection or disclosure of records or information shall not be permitted in the following circumstances:
- (a) if the record or information was obtained from someone other than a health care provider **on** under a promise of confidentiality, and the requested disclosure would likely reveal the source;
 - (b) on a temporary basis only, **by or to the patient** during the course of research involving treatment, where the **subject of the research patient** agreed to such temporary suspension of access when consenting to participation in the research study;
 - (c) if the subject of the record is in the custody of a correctional institution and the correctional institution has requested that access not be provided for health and safety reasons; **or**
 - (d) if the records are **restricted under the Federal Clinical Laboratory Improvement**

Amendments; or
(e) if the records are created in anticipation of litigation.

27.1817: Interpreter Services

(1) For the purposes of 104 CMR 27.1817, the following words shall have the following meanings:

(a) Competent Interpreter Services means interpreter. Interpreter services performed by a person who is fluent in English and in the language of a non-English speaker, who is trained and proficient in the skill and ethics of interpreting and who is knowledgeable about the specialized terms and concepts that need to be interpreted for purposes of receiving care and treatment.

(b) Facility shall mean a. A Department-operated hospital, community mental health center with inpatient unit, or psychiatric unit within a public health hospital; a Department-licensed psychiatric hospital; or a Department-licensed psychiatric unit within a general hospital.

(c) Non-English Speaker means a. A person who cannot speak or understand, or has difficulty speaking or understanding, English because the speaker primarily or only uses a spoken language other than English.

(2) Each facility shall in connection with the delivery of inpatient services, if an appropriate bilingual clinician is not available, provide competent interpreter services to every non-English speaker who is a patient.

(3) Based on the volume and diversity of non-English-speaking patients served by the facility, the facility shall use reasonable judgment as to whether to employ, or to contract for, the on-call use of one or more interpreters for particular languages when needed, or to use competent telephonic or televiewing interpreter services; provided that such facility shall only use competent telephonic or televiewing interpreter services in situations where either:

(a) there is no reasonable way to anticipate the need for employed or contracted interpreters for a particular language; or

(b) there occurs, in a particular instance, an inability to provide competent services by an employed or contracted interpreter.

(4) Interpreter services shall be available 24 hours a day and seven days a week.

(5) The facility shall not require, suggest, or encourage the use of family members or friends of patients as interpreters and shall not, except in exceptional circumstances, use minor children as interpreters.

(6) The facility shall post signs and provide written notification of the right to and availability of interpreter services to patients in their primary language.

(7) The facility shall develop written policies and procedures that are consistent with 104 CMR 27.1817 and that assist staff and patients in accessing interpreter services.

SUBPART CD: OPERATIONAL STANDARDS FOR SUBSTANCE USE DISORDER TREATMENT FACILITIES

27.1918: Substance Use Disorder Treatment Facility

(1) Scope. The provisions of 104 CMR 27.1918 apply to all Facilities, or units within a Facility, that are operated by the Department of Mental Health to provide substance use disorder treatment for adults who are subject to an order of involuntary commitment under M.G.L. c. 123, § 35. Except as expressly provided herein, no other provisions of 104 CMR 27.00 shall apply to facilities subject to 104 CMR 27.1918.

(2) Commitment Status under M.G.L. c. 123, § 35. A substance use disorder, as defined in 105 CMR 164.006, shall qualify as a category of mental illness for the purpose of involuntary commitment under M.G.L. c. 123, § 35. A substance use disorder shall not qualify as a category of mental illness for the purpose of involuntary commitment under any other section of M.G.L. c. 123.

(3) Substance Use Disorder Treatment Facility (Facility). A substance use disorder treatment facility provides a range of services including medically monitored detoxification, medically assisted treatment and clinical stabilization services for adults age 18 and over who are subject to an order of involuntary commitment under M.G.L. c. 123, § 35.

(4) Approval to Operate. The Facility shall not operate without approval of the Department of Public Health. The Department of Public Health shall have the right to inspect the Facility prior to granting such approval, and at any other time, to determine compliance with applicable requirements of 105 CMR 164.000.

(5) Applicable Standards for Substance Use Disorder Treatment. In addition to the operational standards of this title, the Facility shall also meet the requirements for substance use disorder treatment as set forth in 105 CMR 164.012(D)(3). The Facility may request a waiver of one or more of these requirements in accordance with the provisions of 105 CMR 164.023.

(6) Admission Criteria. A Facility or unit within a Facility may be designated for a specific population, such as male or female, and may restrict admission to members of that population. In addition, only person-patients who meet the following criteria may be admitted to and retained in the Facility:

(a) The individual must be at least 18 years of age.

(b) The individual must be subject to an order of involuntary commitment under the provisions of M.G.L. c. 123, § 35.

Individuals who meet the admission criteria may be admitted to and retained in the Facility only in accordance with the provisions of M.G.L. c. 123, § 35.

(7) Facility Medical Director. The Facility shall designate a psychiatrist as the facility Medical Director who shall be responsible for administering all medical or behavioral health services performed at the Facility. The facility Medical Director shall be fully licensed to practice medicine under Massachusetts law, and shall have completed a minimum of six (6) months' clinical experience with alcohol or other substance use disorders.

(8) Staffing Pattern. The Facility shall establish a staffing pattern that includes staff in sufficient numbers, qualifications and shift coverage to ensure the provision of services, safety of clients and staff and operation of the program in accordance with the requirements of 104 CMR 27.1918.

(9) General Physical Requirements. The Facility shall provide space that is safe, comfortable, well-lit, well-ventilated, adequate in size and of sufficient quality to be utilized in a manner consistent with the overall philosophy and treatment goals of the program. The Facility shall also provide sufficient security features to enable the staff to prevent physical harm to patients and to staff and to prevent elopement from the Facility, including the capacity to lock the Facility to prevent unauthorized access to the community.

(10) Policies and Procedures. The Facility shall have written policies and procedures consistent with the requirements of this title and accepted standards of care for substance use disorder treatment services and applicable law.

(11) Treatment. Each patient shall be informed upon admission of the right to receive treatment upon giving informed consent. The patient shall, upon giving informed consent, receive substance use disorder treatment and services, as needed. If a patient is deemed incapable of giving informed consent, medication treatment may not be administered or performed without authorization by a court of competent jurisdiction or the consent of the patient's legally authorized representative. Prior to an adjudication of incapacity and appointment of a guardian, or activation of a health care proxy, a patient retains the right to accept or refuse medications as prescribed.

(12) Periodic Review. In addition to the clinical reviews required pursuant to 104 CMR 27.1918(21)(a), the Facility shall conduct a periodic review of each patient upon admission and once during the first three months of admission in accordance with M.G.L. c. 123, § 4. Each patient shall be provided advance written notice of the scheduled review and shall have the opportunity to participate to the fullest extent possible. Notice to family members shall be provided upon the express written consent of the patient or the patient's legally authorized representative.

(13) Patient Rights. The legal and civil rights of patients are set forth in 104 CMR 27.13. In addition, a patient receiving substance use disorder treatment shall have the right to have drug screens conducted in a manner that preserves the patient's dignity. The Facility shall safeguard and ensure these rights and shall appoint a human rights officer and establish a human rights committee in accordance with the requirements of 104 CMR 27.14.

(14) Restraint and Seclusion. The Facility shall comply with all standards and requirements for the use of restraint and seclusion as provided in 104 CMR 27.12.

(15) Patient Records. Records of the identity, diagnosis, prognosis or treatment of any patient shall be privileged and confidential and shall only be disclosed in conformity with applicable state and federal laws and regulations regarding the confidentiality of patient records, including, but not limited to, 42 CFR Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records), and 45 CFR Parts 160 and 164 (HIPAA Privacy and Security Rules) and, to the extent not pre-empted by federal law, M.G.L. c. 123, § 36 and 104 CMR 27.1716.

(a) Each patient record shall be maintained and stored in accordance with the requirements of 42 CFR Part 2 and 104 CMR 27.1716(3) and (4).

(b) Each patient receiving substance use disorder treatment shall be provided a notice of privacy practices which meets the requirements of 42 CFR Part 2 and 45 CFR Parts 160 and 164.

(c) Inspection of the record by the patient or others shall be governed by 42 CFR Part 2, and all applicable federal and state laws and regulations.

(16) Complaints and Investigations. Any person in a Facility shall have the right to make a complaint regarding any incident or condition which he or she believes to be dangerous, illegal or inhumane as those terms are defined in 104 CMR 32.00. Complaints shall be reported, reviewed, investigated and resolved in accordance with the requirements of 104 CMR 32.00: *Investigation and Reporting Responsibilities*.

(17) Interpreter Services. The Facility shall provide competent interpreter services for non-English speaking patients in accordance with the requirements of 104 CMR 27.1817. The Facility may contract interpreter services pursuant to a Qualified Service Organization Agreement subject to the requirements of 42 CFR Part 2.

(18) Transfer. A patient who is subject to an order of involuntary commitment under M.G.L. c. 123, § 35 may be transferred to another facility in accordance with the requirements of M.G.L. c. 123, § 3. The receiving facility must be approved by the Department of Public Health to provide substance use disorder treatment to patients involuntarily committed under M.G.L. c. 123, § 35.

(19) Transport. A patient who is subject to an order of involuntary commitment under M.G.L. c. 123, § 35 may be transported for evaluation or treatment to a medical facility, court, or to other destination approved by the facility director, facility medical director, or their designee (s). The provisions of 104 CMR 27.08(9) shall permit and govern the use of restraint during transport.

(20) Absence Without Authorization. A Facility shall have a written plan for an emergency response when a patient leaves the Facility grounds or an off-grounds activity without permission. The Facility's plan shall specify action to be taken by Facility staff, and notice to interested parties, including law enforcement, as permitted by law.

(21) Discharge. A patient who is subject to an order of involuntary commitment under M.G.L. c. 123, § 35 may be released prior to the expiration of the commitment period under the order upon proper judicial order or upon written determination by the facility director that release of that individual will not result in a likelihood of serious harm to the patient or others as a result of the patient's substance use disorder.

(a) A clinical review of the necessity of the commitment shall be conducted on days 30, 45, 60 and 75, as long as the commitment continues. The results of clinical reviews must be documented in the patient's medical record.

(b) Upon discharge, the individual shall be encouraged to consent to, and shall be provided with, a recommended post-discharge treatment plan with identified resources for further treatment. Upon receipt of authorization consistent with 104 CMR 27.1918(11), the Facility shall refer the individual to an appropriate program or service

provider for further treatment.

SUBPART E: TRANSITIONAL PROVISIONS

27.19: Transitional Provisions

A facility licensed under the provisions of 104 CMR 27.00 in effect prior to July 1, 2017 shall demonstrate compliance with any changes in requirements for licensure in effect after July 1, 2017 no later than such facility's submission of an application for license renewal; provided, however, that:

- (1) Any facility licensed under the provisions of 104 CMR 27.00 in effect prior to July 1, 2017 shall submit its plan for compliance with the provisions of 104 CMR 27.03(6)(a), 104 CMR 27.03(16), and 104 CMR 27.05(3) on or before December 31, 2017; and
- (2) The Department may require any such facility to demonstrate its compliance with any provision of 104 CMR 27.00 in response to a complaint filed or deficiency found at any time.
- (3) A Class IV license issued prior to the effective date of these regulations shall remain valid until the facility holding such license applies for and is issued a renewal of its license in accordance with 104 CMR 27.03

REGULATORY AUTHORITY

104 CMR 27.00: M.G.L. c. 19, §§ 1, 7, 8, 18 and 1819; c. 123, § 2.

NON-TEXT PAGE