

104 CMR 27.00: LICENSING AND OPERATIONAL STANDARDS FOR
MENTAL HEALTH FACILITIES
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SUBPART A: SCOPE AND DEFINITIONS

27.01: 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:

Deficiency Notice. Written notice and order of correction relating to a finding by the Department that a Facility is not in compliance with the requirements of GL. Ch. 19 s. 19 or 104 CMR 27.00. A deficiency notice may include an order of correction contained within a decision of the director of licensing issued pursuant to 104 CMR 32.00.

Facility. A Department-operated hospital, community mental health center with inpatient unit, or psychiatric unit within a public health hospital; a Department-licensed psychiatric hospital; a Department-licensed psychiatric unit within a general hospital; or an intensive residential treatment program for adolescents that is either designated as a facility under the control of the Department or licensed by the Department.

Facility Director. The superintendent, chief executive officer, 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.

Original License. A license, including a provisional license, issued to a facility not previously licensed, or a license issued to an existing facility in which there has been a change in ownership or location or a change in class of license or specialized service.

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 B: LICENSING

27.03: Licensing; Generally

(1) Pursuant to M.G.L. c. 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 consider the health needs of persons with a mental illness in the commonwealth, including underserved populations and persons with co-occurring mental illness and substance use disorder, and in particular 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) 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. 111 which admits persons with mental illness only on voluntary status, 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.

(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 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 104 CMR 27.03(5) 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) No original license shall be issued to establish or maintain a facility subject to licensure under 104 CMR 27.00, unless there is need for such a facility as determined by the Department, and the applicant has the demonstrated ability, by virtue of current operation or by history to meet such needs.

(7) All licensed facilities shall provide services to commonwealth residents with public health insurance on a non-discriminatory basis and shall report the facility's payer mix to the Department on a quarterly basis in form and format as determined by the Department; provided, however, the Department may accept payer mix reports from existing public data sources including, but not limited to, those from the Center for Health Information and Analysis, to meet these reporting requirements.

(8) 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 status under M.G.L. c. 123, § 10.

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

(c) Class IV. (Reserved)

(d) Class V. License to provide evaluation, diagnosis and treatment of patients committed under M.G.L. c. 123, §§ 15, 16, 17 and 18.

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

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

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

- (h) Class VIII. License to administer electroconvulsive treatment in a facility otherwise licensed by the Department.
- (9) 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.
- (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. Approval of such application shall be subject to determination by the Department that the facility continues to satisfy applicable provisions of 104 CMR 27.00.
- (10) Requirements for License or Renewal.
- (a) Every facility 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) 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 Commonwealth; and
 2. able to meet the clinical competencies and operational standards for providing care and treatment to the population(s) it will serve.
- (c) 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 facility of any changes in these matters.
 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:
 - 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.
 - b. its plan for assuring adequate and appropriate staffing to meet the needs of the patient population at all times.
 - 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, continuing education and demonstration of competencies for all personnel who provide care and treatment to patients.
 - e. Attestation that the facility provides, or for an original license, will provide, services to Commonwealth residents with public health insurance on a non-discriminatory basis.
 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) 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.

(11) 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 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 mental illness. If the director 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. 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, 104 CMR 27.03(11)(b)2. 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.
3. There shall be an identified nurse leader of the facility, (*e.g.*: Director of 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 the nurse leader does not meet the degree 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 the training for its nursing personnel.
4. A registered nurse licensed to practice professional nursing under Massachusetts law shall be on duty on each unit of the facility at all times.

(c) A facility licensed as Class VI, Limited VI or 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.

(12) Additional Requirements for Class VIII Facilities. In addition to complying with all applicable standards in 104 CMR 27.00, a facility licensed as Class VIII shall comply with the following requirements:

(a) The facility shall have policies and procedures for the administration of electroconvulsive treatment (ECT) in compliance with the standards set forth by the Joint Commission, or other nationally recognized accreditation agency approved by the Department, and the current practice guidelines established by the American Psychiatric Association.

(b) All facilities administering ECT to inpatients or outpatients shall maintain such data as the Department may determine, which shall be available to the Department for inspection upon request and at the time of the facility's licensing survey.

(13) Additional Requirements for Facilities or Programs that Provide Certain Substance Use Disorder Treatment Services.

(a) Definitions applicable to 104 CMR 27.03(13):

Adverse Drug Event. 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. Adverse Drug Event 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. The Bureau of Substance Addiction Services within the Department of Public Health.

(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(13), 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 Department of Mental Health licensed facility as provided in 105 CMR 164.012(D)(3).
3. A facility that provides substance use disorder treatment or services incidental to the evaluation, diagnostic and treatment services for which it is licensed under 104 CMR 27.00, and that does not offer a separate, identifiable inpatient substance use disorder treatment unit or program, or holds 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 opioid treatment.
 - b. Include in its application for a license or renewal of a license a description of the inpatient substance use disorder treatment or services it provides, including a copy of the protocols it has adopted pursuant to 104 CMR 27.03(13)(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: *Investigation and Reporting Responsibilities*, a facility that provides substance use disorder treatment or services as provided in 104 CMR 27.03(13) 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.

(14) Accreditation.

(a) A facility seeking a license as Class II, III, 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 Department utilizing the applicable standards as promulgated by said Joint Commission or agency. Facilities that have not yet attained accreditation 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 Department. 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.

(15) Deemed Status. In addition to the Departmental action on license applications as set forth in 104 CMR 27.03(15)(a) through (i), 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) In its application for licensure or for renewal of a license, an accredited facility which desires to obtain or retain deemed status shall provide 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; provided, however, that in the event of an unannounced survey or inspection, such notice shall be provided as soon as possible after the initiation of 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, policies and procedures that demonstrate compliance with Department regulations governing restraint and seclusion, human rights, investigation of complaints, interpreter services, and delivery and supervision of clinical services.

(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.

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

(e) The Department 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: *Investigation and Reporting Responsibilities*;
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, including

reasonable access to fresh air, investigation of complaints and interpreter services.

6. The facility is out of compliance with other applicable Department regulations.

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

(g) 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 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.

(h) The 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 Department to respond within that time shall be considered confirmation of the denial or revocation of deemed status.

(i) Following denial or revocation under 104 CMR 27.03(15)(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(15).

(16) If a facility is not yet accredited 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.

(17) Renewal of License.

(a) Facilities seeking renewal of a license shall meet all requirements for licensure specified in 104 CMR 27.00 and 104 CMR 32.00 *Investigation 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.

(18) 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 for which compliance cannot be fully determined without an evaluation of the facility operation.

(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, provided that:

1. The facility demonstrates to the Department's satisfaction a good faith intent to meet all the requirements;
2. The Department finds that the service offered protects the health and safety of the facility's patients; and
3. The Department finds that the facility 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. 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.

(19) 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:

1. Approve the facility for licensure, if

- a. no deficiencies are outstanding;
- b. the application meets criteria of responsibility and suitability for meeting the needs 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), or who has been committed pursuant to M.G.L. c. 123, § 12(e) 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).

2. Approve the facility for licensure, subject to demonstrated progress by the facility in implementing a plan of correction approved by the Department addressing any deficiencies or failure to meet requirements under of 104 CMR 27.03(19)(a)1.

3. Approve the facility for a provisional license subject to such conditions as noted in 27.03(18), 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 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.

(20) Departmental Surveys and Inspection; Deficiency Notices, Plans of Correction.

(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 M.G.L. c. 19, § 19 and 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 the provisions of 104 CMR 27.03(20)(a), the Department may, at any time, conduct announced or unannounced inspections of any facility licensed hereunder to determine compliance with accreditation standards or the applicable provisions of the Department's regulations. Such inspections need not pertain to any actual or suspected deficiency in compliance with accreditation standards or applicable provisions of the Department's regulations. Refusal to permit inspections shall be sufficient cause for revocation of a facility's license.

(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.

(d) The Department shall provide a copy of the survey or inspection report and any deficiency notice to the facility director.

The notice shall include a statement of the deficiencies found, and the provision(s) of law and regulation relied upon, and shall specify a reasonable time, not more than 60 days after receipt of the notice, by which time the facility shall remedy or correct each deficiency cited in the notice; provided, however, that in the case of a deficiency which, in the opinion of the Department, is not capable of correction within 60 days, the Department's statement of deficiencies shall require the facility's corrective action plan to propose correction of such deficiency within a reasonable time period. A deficiency notice issued pursuant to 104 CMR 27.03(20)(d) shall also include notice of actions the Department may take in the event facility fails to remedy or correct a cited deficiency by the date specified in the written deficiency notice or fails to remedy or correct a cited deficiency by the date specified in a plan for correction, as accepted or modified by the Department, pursuant to 104 CMR 27.03(20)(e).

(e) Plan of Correction.

The facility shall submit to the Department a written plan for correction of each violation cited in a deficiency notice within a time period specified by the Department in the deficiency notice.

1. 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 the facility director or his or her designee.
2. Unless the Department states in the deficiency notice that more urgent corrective action is necessary, based on the seriousness of the deficiency, the facility shall be given no more than 60 days from receipt of the deficiency notice to remove the deficiency. The Department may specify a different date by which the corrections shall be completed, in the event that the facility requests additional time and the Department determines that it is necessary.
3. The Department shall review the plan of correction and will provide written notice of either the acceptance or rejection of the plan. In such written notice, the Department may modify, or order the modification of, a nonconforming written plan for correction. An nonconforming plan must be amended and resubmitted within ten business days of the date of notice of rejection; provided, however, that
4. Not more than 7 days after the receipt of notice of such a modification of a written plan for correction, the facility may file a written request with the Department for administrative reconsideration of the modified plan for correction or any portion thereof.
5. Nothing in this section shall be construed to prohibit the Department from enforcing a rule, regulation, deficiency notice or plan for correction, administratively or in court, without first affording the facility with formal opportunity to make correction or to seek administrative reconsideration, where, in the opinion of the Department, the violation of such rule, regulation, deficiency notice or plan for correction jeopardizes the health or safety of patients or the public or seriously limits the capacity of a facility to provide adequate care, or where the violation of such rule, regulation, deficiency notice or plan for correction is the second or subsequent such violation occurring during a period of 12 months.

(21) Failure to Comply with Requirements for Licensure.

- (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 deny, suspend, revoke, or restrict the applicability of, or refuse to renew, one or more classes of licenses.]
- (b) If a facility fails to remedy or correct a cited deficiency by the date specified in the written deficiency notice or fails to remedy or correct a cited deficiency by the date specified in a plan for correction, as accepted or modified by the Department, the Department may:
 1. suspend, limit, restrict or revoke the license of the facility;
 2. impose a fine upon the facility;
 3. pursue any other sanction as the Department may impose administratively upon the facility; or
 4. impose any combination of the penalties set forth in clauses (21)(b)1. to 3., inclusive, of this paragraph.
- (c) A fine imposed pursuant to 104 CMR 27.03(21) shall not exceed \$1,000 per deficiency for each day the deficiency continues to exist beyond the date prescribed for correction.
- (d) A facility has the right to appeal any Department action to suspend, limit, restrict or revoke the license of the facility or to impose a fine upon the facility, pursuant to 104 CMR 27.03(21) under the Standard Adjudicatory Rules of Practice and Procedure pursuant to 801 CMR 1.01 et. seq. by filing with the Director of Licensing a Notice of Claim for an Adjudicatory Proceeding within fourteen (14) days of receipt of notice of such action.

(22) Grounds for Denial, Refusal to Renew, Restriction, Suspension or Revocation of License. Each of the following, in and of itself, shall constitute full and adequate grounds to deny, revoke, suspend, restrict, or refuse renewal of a license:

- (a) Failure to meet the applicable requirements for licensure as specified in 104 CMR 27.00;

- (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: *Investigation and Reporting Responsibilities*.
- (d) Failure to give proper care and treatment to patients.
- (e) Failure to submit an acceptable plan of correction pursuant to 104 CMR 27.03(20).
- (f) Failure to remedy or correct a cited violation.
- (g) Denial of entry to agents of the Department or 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 the Department 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 criminal offense related to the operation of the facility.
- (l) Conviction of a facility or a person with significant financial or management interest in the facility 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 in 104 CMR 27.03(22) shall limit the Department's adoption of policies and grounds for denial, refusal to renew, or revocation through formal and informal rule making.

(23) Required Notifications to the Department. In addition to, and notwithstanding, any other provision of 104 CMR 27.00 or 104 CMR 32.00: *Investigation and Reporting Responsibilities*, 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(9). Upon receipt of such notice, 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 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.
- (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 patients 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 patients. 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(9). 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 patient currently admitted to, or within 30 days of discharge from, 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, or concerning any patient currently admitted to, or within 30 days of discharge from, the facility, 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 patients at the facility, or which occurs between or among patients 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 patients 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 patients 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 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.

(24) Waiver.

(a) The requirements of 104 CMR 27.00 shall be strictly enforced, and shall not be subject to waiver, except as specifically authorized by the Department in accordance with the provisions of 104 CMR 27.03(24).

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

1. The health, safety, or welfare of neither patients nor staff may be adversely affected by granting the waiver; and that
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 (IRTP) is a residential mental health program which provides comprehensive treatment and education in a secure setting to adolescents with serious emotional disturbance or mental illness and which has the capacity to admit such adolescents pursuant to the provisions of M.G.L. c. 123, §§ 7, 8, 10, and 11. IRTPs may not receive a Class VIII license 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 turns 19 years of age may, upon approval of the Commissioner or designee, remain there to complete his or her course of treatment;
 - (b) The individual has been determined to require continuing care and treatment in a secure residential setting;
 - (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, §§ 7 and 8 or 10 and 11, and the 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 inpatient mental health 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 IRTP, consistent with the requirements of Joint Commission or other accreditation agency approved by the Department. Among the clinical staff shall be persons in appropriate disciplines qualified to provide services, which shall include, but are not limited to: psychiatric and psychological intervention; individual, group and family therapy; nursing care; milieu support; medication administration; discharge planning; education; 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, who is 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.
 - (c) Each IRTP shall have sufficient qualified 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 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 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 IRTP.
- (b) Each IRTP shall provide sufficient security features to enable the staff to prevent physical harm to patients and to staff, including the capacity to lock the IRTP.

SUBPART C: 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 intellectual or developmental disabilities, autism spectrum disorder, traumatic brain injury or psychiatric or behavioral disorders or symptoms due to another medical condition as provided in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association, 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 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 the person is in need of care and treatment, and that the admitting facility is suitable for such care and treatment.

(3) No facility licensed as Class III through VII shall have exclusion criteria for admission that would result in the rejection of any patient who has been determined by a designated physician of the facility to meet the clinical criteria for involuntary commitment pursuant to M.G.L. c. 123, § 12(b), or who has been committed pursuant to M.G.L. c. 123 § 12(e); 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 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; provided, however, that such written determination need not contain patient-identifiable information.
- (e) Facilities shall keep data on patients referred for admission in a form and format and containing data elements as determined by the Department; provided, however that facilities shall not be required to maintain patient-identifiable data on individuals not accepted for admission. 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, 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.

(5) Admission Examination for Patients Younger Than 22 Years Old.

(a) In addition to the requirements of 104 CMR 27.05(4), the admission examination for patients younger than 22 years old shall include a determination as to whether the patient has special educational needs.

(b) If the patient 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.

(6) Notice to Family or Others.

(a) Admission of Patients 16 Years of Age or Older. In accordance with M.G.L. c. 123, § 4, the facility director or designee shall, within 48 hours after admission of any patient, including a patient 16 or 17 years of age who has applied for admission himself or herself, notify the patient's legally authorized representative or, if there is no such legally authorized representative and the patient does not knowingly object, his or her nearest relative. Notice may be given by telephone, letter or other appropriate means.

(b) Emergency or Court Ordered Admissions of Minors. Except in the case of a mature or emancipated minor as defined in 104 CMR 25.03: *Emancipated and Mature Minors*, the legally authorized representative of a minor shall be notified immediately upon receipt of the minor who is admitted pursuant to court order or an application for admission pursuant to M.G.L. c. 123, § 12.

(7) 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.

(8) Prohibition of Admission of Individuals Younger Than 19 Years Old to Adult Inpatient Units; Exceptions. Except as provided in 104 CMR 27.05(8), no individual younger than 19 years old shall be admitted to an adult unit of a Department operated facility.

(a) The Department may place an individual 17 or 18 years of age 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) Specialty services or units designated by the Department may admit individuals younger than 19 years old, provided that they ensure appropriate separate physical space and programmatic services, as approved by the Commissioner.

(9) Unless otherwise specified, computation of time for any action required to be taken under 104 CMR 27.00 shall be in accordance with 104 CMR 25.04: *Computation of Time*.

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 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 patient qualifies for admission in accordance with 104 CMR 27.05(2), and has the capacity to apply for such admission and is desirous of receiving treatment.

(b) 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 patient has reached 16 years of age, has capacity to apply for such status, and is in need of care and treatment, or if application is made on behalf of the patient by a legally authorized representative that the legally 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. An application made on behalf of a person 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, capacity 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'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.

(5) A patient on conditional voluntary status, or a legally authorized representative who applied for the admission of such patient, 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 patient from the facility. 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 in accordance with M.G.L. c. 201D may revoke such proxy orally or in writing, which revocation shall constitute submission of a

three-day notice; provided, however, that the patient may retract such three-day notice pursuant to 104 CMR 27.06(5)(b). 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; 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 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 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 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 patient who is 16 or 17 years of age, or who during the course of hospitalization attains the age of 16 years of age, and who has been admitted to a facility on a voluntary or conditional voluntary status by application of a legally authorized representative shall have the same rights as those patients 16 years of age or older 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 Department 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, 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 years of age, this opportunity must be given to both the patient and his or her legally authorized representative. The right to convert to voluntary or conditional voluntary status may be exercised by a patient 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 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 104 CMR 27.07(2), "immediately" shall mean within two hours of the patient's reception at the facility.

(b) If the designated physician 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;

provided however, that a patient admitted involuntarily pursuant to M.G.L. c. 123 §12(b), or who is determined to have to capacity to be admitted under conditional voluntary status pursuant to M.G.L. c. 123 §§10 & 11, and has been so admitted, after an examination conducted via telemedicine shall be examined by a designated physician as soon as possible and no later than the next calendar day following the admission.

(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 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 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 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 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 status under 104 CMR 27.06 shall not be subject to transfer without their written consent; and
- (b) Patients on conditional voluntary 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 patient meets the criteria for commitment, or may withdraw the notice of transfer provided to the patient pursuant to 104 CMR 27.08(9).

(4) Absent an emergency, a patient 16 years of age or older on conditional voluntary status at a facility may not be transferred from that facility over his or her objection, 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, over the objection of such minor or patient's legally authorized representative, unless a court of competent jurisdiction enters a commitment order pursuant to M.G.L. c. 123, §§ 7 and 8.

(5) Absent an emergency, a patient younger than 16 years old 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 application for 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 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 shall not extend the period of such commitment.

(8) A patient who is admitted or committed to a facility licensed pursuant to 104 CMR 27.00, who is transferred to a medical facility for treatment of a medical condition during the period of his or her admission or commitment, may be readmitted to the transferring facility under the same legal status pursuant to which the patient was admitted or committed to the transferring facility; provided however, that for a patient who is committed pursuant to a court order, such court order has not expired at the time of readmission.

(9) 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 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 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 with authority to admit the patient to a psychiatric facility may waive the six days' notice requirement.

(e) A copy of the notice of transfer, along with a copy of the patient's underlying admission status documentation, shall accompany the patient to the receiving facility.

(10) Transport of Patients Admitted to a Facility; Limitations of Use of Restraint.

(a) The transport of a patient in a facility may be authorized by 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.

(b) Restraint of a 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 patient being transported or of others who are likely to come into contact with the patient being transported. Such restraint must be by the least restrictive method to assure the safety of the patient or others in accordance with 104 CMR 27.08(10). 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 patient authorized to initiate restraint pursuant to 104 CMR 27.12(8)(a)2.

1. If the patient 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 patient 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(8)(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.
 - e. The driver of the vehicle in which the patient 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(3) may be authorized to apply restraints to a patient in the course of transport, or to monitor a patient who is in restraints in the course of transport.
 - g. Except as provided in 104 CMR 27.08(10)(c) and (d), restraint ordered pursuant to 104 CMR 27.08(10) may only last while the patient is under the supervision of facility staff, and shall terminate if the patient is admitted to a medical facility, including the emergency department of such medical facility for evaluation or treatment.
- (c) If the patient 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(10) shall be deemed to regulate the use of restraint by licensed law enforcement personnel in the transport of patients 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(10).
- (f) Where the need for restraint during transport for purposes described in 104 CMR 27.08(10)(a) is anticipated, consideration should be given to delaying such transport until such patient no longer requires restraint, if such delay is reasonable.
- (g) Unless the patient is fully discharged prior to transport, a patient transported pursuant to 104 CMR 27.08(10) shall remain on the admission status under which the patient was admitted to the facility, until such time as the patient is fully discharged from the facility; provided, however, that an order of transport pursuant to 104 CMR 27.08(10) shall not extend any relevant time period including, but not limited to, expiration of a commitment order, for such admission.

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.

(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 facility director may discharge the patient at any time.

(4) Conditional Voluntary Admission Status. A patient admitted to a facility on conditional voluntary status under 104 CMR 27.06 shall be discharged by the facility upon his or her request; provided, however, he or she shall give three days written notice of his or her intent to leave the facility to the facility director, 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 determine his or her suitability for discharge. Such patients 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 a court of competent jurisdiction, a petition for the commitment of such patient at the s facility.

(5) Discharge at Request of Legally Authorized Representative. A patient admitted by his or her legally authorized representative 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 16 or 17 Years of Age. A patient who is 16 or 17 years of age, or who turns 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 patients 16 years of age or older who have applied for and been admitted on a voluntary or conditional voluntary status to the facility on their own behalf.

(7) Involuntary Commitment Status.

(a) Three day Commitment. A patient 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 patient is not in need of care and treatment in the facility. The three day hospitalization period authorized under M.G.L. c. 123, § 12 shall not be extended and, at the end of such period, a patient so hospitalized shall be discharged by the facility unless, prior to expiration, such patient has applied for, and has been admitted on voluntary or conditional voluntary status to the facility, or the facility director has filed a petition for an order of commitment.

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

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

(8) Forensic Commitment Status.

(a) A patient 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 patient 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 and district attorney which has or 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 patient, the patient may be discharged. 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 patient'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 nor district attorney makes written objection thereto, such restrictions may be removed or modified.

(d) The requirements of 104 CMR 27.09(8)(b) and (c) shall not apply to patients originally committed after a finding of incompetence to stand trial whose criminal charges have been dismissed.

(e) A patient 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 patient 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 patient shall be under M.G.L. c. 123, §§ 7 and 8.

(f) A patient hospitalized at a facility pursuant to M.G.L. c. 123, § 18, shall not be discharged except to the custody of the place of detention from which the patient was hospitalized, unless such patient's sentence, or other authority under which the patient is being held in custody, has expired.

27.10: Treatment

(1) Informed Consent, Consent to Treatment.

(a) Upon admission to a facility a patient shall, upon giving informed consent, receive treatment and rehabilitation in accordance with accepted therapeutic practice, when 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 treatment, as defined by statute or case law, including but not limited to, treatment with antipsychotic medication, may not be administered or performed without the patient's specific informed consent. In the case of a patient who lacks capacity to give informed consent, such treatment 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) For a patient who is believed to lack 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 incapacity 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 continues to lack capacity, then an adjudication of incapacity and court approval of a treatment plan must be sought.

(2) Electroconvulsive Treatment for Patients Younger Than 16 Years Old.

(a) Electroconvulsive treatment shall not be administered to any patient younger than 16 years old unless the Commissioner or designee concurs.

(b) The approval of the administration of electroconvulsive treatments to patients younger than 16 years old 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 therefore, 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 has capacity to give informed consent regarding routine and preventive treatment may accept or refuse such treatment, except that a refusal may be overridden by the facility director, without special court authorization, when the treatment consists of:

(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 strengths and needs of the 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.
 - (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 603 CMR: *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.

27.11: Periodic Review

- (1) Schedule of Periodic Reviews. Every facility shall conduct a periodic review of each patient 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 younger than 19 years old, 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. 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 his or her nearest relative giving the date of 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 Capacity. For each periodic review, the legal capacity of a patient shall be evaluated by the senior reviewing clinician to determine whether he or she has capacity to remain on, or to apply for, voluntary or conditional voluntary status, 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(5) *Evaluation of Ability to Manage Funds*.
- (a) If a patient on voluntary or conditional voluntary status is believed no longer to have 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 by seeking an order of commitment

pursuant to M.G.L. c. 123, §§ 7 and 8, or consent of a legally authorized representative.

(b) If the question of a patient's capacity 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, the facility director shall promptly take reasonable steps to initiate the process to obtain a legally authorized representative.

(5) Consideration of Alternatives to Facility. 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 medical record.

(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 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) 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.

(2) Prevention/Minimal Use of Restraint and Seclusion. A facility 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 reflect progress in implementation and 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 and family support 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) designation of a comfort or sensory space on the unit for patients to utilize to practice sensory modulation, coping skills, and/ or self-soothing techniques. This

- space should be a dedicated room including, but not limited to, a temporary location where staff may bring appropriate supplies and equipment for patient use;
- (h) the development and use of an individual crisis prevention plan for each patient;
- (i) assessment of the impact of trauma experience and the potential for re-traumatization for both patients and staff;
- (j) the regular use of debriefing activities for both patients and staff;
- (k) the process for addressing patient concerns and complaints about the use of restraint or seclusion;
- (l) 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.

(3) 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 prior to participating in any episode of restraint or seclusion. Such training shall be completed no later than one month after hire, and 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 both patients and staff;
3. the impact of restraint or seclusion on patients with a history of trauma, including the potential for re-traumatization;
4. calming and soothing, crisis prevention and de-escalation approaches and strategies;
5. the use of individualized crisis prevention plans.

(b) In addition to the training in 104 CMR 27.12(3)(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.

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

(a) Definition. An 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 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, to complete and implement an 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 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 individualized crisis prevention plans for the patients in their care. A copy of the Individualized Crisis Prevention Plan and any revisions, thereto, shall be recorded in the patient record and a copy shall be given to the patient and his or her legally authorized representative, if applicable.

(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, 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 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 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 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. determination 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.

(b) Patient Debriefing.

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. 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 could have helped to prevent 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 the patient may be experiencing from the restraint or seclusion.
- 2. Whenever possible and appropriate, the staff participating in debriefing with the patient shall not have been involved in the episode of restraint or seclusion.
- 3. The patient's comments, if any, shall be included on the debriefing and comment form.
 - a. The patient may complete the debriefing and comment form 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.
 - d. Staff efforts to encourage the patient to provide comments shall be documented on the debriefing and comment form.
 - e. Efforts to engage a patient who has refused to participate in 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 form and included in the patient record. Copies of the form shall 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 be notified of the complaint procedure outlined in 104 CMR 32.00: *Investigation and Reporting Responsibilities*. The human rights officer shall offer to meet with a patient who requests such a meeting, or whose comments about or description of an episode of restraint or seclusion suggests a possible rights violation or other harmful consequence.
- (c) Senior Administrative Review. Senior administrative and clinical staff shall conduct a review of each episode of restraint or seclusion by the next business day. 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(8)(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: *Investigation and Reporting Responsibilities*; or
 - 7. 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 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.

(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(2).

(8) 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(8)(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 limits 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.

a. Medication Restraint. Medication restraint occurs when a patient is given a medication 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 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)(c) 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 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 patient by restricting a patient's freedom of movement or normal access to his or her body. 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.

4. Seclusion.

a. Seclusion occurs when a patient is involuntarily confined in a room, 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; provided, however that physical restraint may be used in accordance with 104 CMR 27.12, if it is determined to be necessary to safely administer court authorized treatment.

1. Restriction on Medication Restraint, Mechanical Restraint, Physical Restraint or Seclusion; Use of 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 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 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(8)(e) through (g).

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 assistance 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 an 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.
 5. The requirement for examination pursuant to 104 CMR 27.12(8)(d)(4) 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 authorized physician and adequate on-premises clinical staff only in cases where a physician, registered nurse or certified physician assistant has assessed the patient and determined that:
 - a. the medication restraint has taken effect and the patient is not in need of further restraint;
 - b. the patient has not experienced side effects of the medication restraint; and
 - c. there are no apparent medical or physical conditions, including injury, related to the medication restraint that require an in-person examination.
- (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(8)(b) occurs, except as provided in 104 CMR 27.12(8)(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 hours, subject to the additional restrictions in 104 CMR 27.12(8)(g).
 - c. Such order shall terminate whenever a release decision is made pursuant to 104 CMR 27.12(8)(h)8., and shall be subject to the monitoring, examination and release provisions of 104 CMR 27.12(8)(h).
 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(8)(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(8)(h)8., and shall be subject to the monitoring, examination and release provisions of 104 CMR 27.12(8)(h).
 - d. An authorized physician shall conduct 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.
 - e. The requirement for examination pursuant to 104 CMR 27.12(8)(e)(2)(d) 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 authorized physician and adequate on-premises clinical staff only in cases where restraint or seclusion episode has ended, the patient has been permanently released from restraint or seclusion in accordance with 104 CMR 27.12(h)(8), and there are no apparent medical or physical conditions, including injury, related to the mechanical restraint or seclusion restraint that require an in-person examination.

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(8)(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(8)(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(8)(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(8)(h)8., and shall be subject to the monitoring, examination and release provisions of 104 CMR 27.12(8)(h).
- d. An authorized physician shall conduct 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 hours from the initiation of the restraint or seclusion by the authorized staff person, subject to the additional restrictions in 104 CMR 27.12(8)(g).

2. Continuation of Mechanical Restraint or Seclusion for Additional Two-Hour Periods. Subsequent orders for renewals of mechanical restraint or seclusion may be made for up to two-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(8)(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(8)(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 hours from the time of expiration of the preceding order, shall terminate whenever a release decision is made pursuant to 104 CMR 27.12(8)(h)8., and shall be subject to the monitoring, examination and release provisions of 104 CMR 27.12(8)(h). Continuation of a restraint or seclusion requires documentation that the patient's symptoms necessitate the continuation of the restraint or seclusion.

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

1. No episode of physical restraint shall exceed two hours.

2. No order for the restraint or seclusion of a minor younger than nine years old may exceed one hour.
 3. No minor younger than nine years old shall be in seclusion or restraint for more than one hour in any 24-hour period.
 4. No minor nine through 17 years of age shall be in seclusion for more than two hours in any 24-hour period.
 5. No minor younger than 13 years old 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(8)(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 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 Department 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(8)(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 Department 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 the original order and an emergency as defined in 104 CMR 27.12(8)(b) occurs prior to such order's expiration, a new order must be obtained prior to reinitiating the use of restraint or seclusion. Such return to restraint or seclusion shall be documented in the record and the procedures for ordering or initiating restraint or seclusion pursuant to 104 CMR 27.12(8)(e) shall be followed.
- (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 patient 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(8)(h)6. Such monitoring activities shall be documented every 15 minutes.
5. Staff who monitors a patient in restraint or seclusion shall attempt 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. Whenever 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(8)(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(8)(c)2., or for other purpose, staff conducting monitoring shall notify an authorized staff person as soon as possible, who shall promptly assess the patient for 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(8)(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(8)(f). The circumstances considered in making such a

determination shall be documented and signed by the authorized physician or authorized staff person making the determination.

(i) Documentation Requirements.

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

- a. The restraint and seclusion form, including the patient debriefing and comment form, must be in a form approved by the Department.
- b. The completed restraint and seclusion form shall be placed in the patient's record. One copy shall be used for the patient's comments pursuant to 104 CMR 27.12(4)(b), and one copy shall be used for the review by the Commissioner or designee pursuant to 104 CMR 27.12(8)(i)3.
- c. Any attachments, including the patient debriefing and comment form required by 104 CMR 27.12 shall be included with each copy of the restraint and seclusion form.

2. 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 Department 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 Department, 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.

4. Human Rights Committee/Human Rights Officer Review. At the end of each month, copies of all restraint and seclusion forms and attachments and aggregate reports, if any, sent to the Department pursuant to 104 CMR 27.12(8)(i)3 shall be sent to the Human Rights Committee of the facility, if operated by or under contract to the Department, and otherwise to the Human Rights Officer, which shall review the use of all restraints by the facility or program. The committee or Human 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: *Investigation 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 patient 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 patient lacks capacity, or when a legally authorized representative has been appointed or designated on behalf of such patient, such patient's human rights may be limited only to the extent of the legally authorized representative's authority. If at any time during a patient's treatment, the

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

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

(5) No facility shall employ corporal punishment, infliction of pain or physical discomfort, or, except as required for medical procedures or treatment, deprivation of food or sleep for any purpose.

(6) 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 patients' 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;

(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 patient'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(6)(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(6)(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(6)(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(6)(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 patient'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(6)(f)3 or 104 CMR 27.13(6)(f)4 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(6)(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.
 - c. In the event a change in circumstances that may affect the patient's ability to safely access the outdoors occurs outside of normal business hours, an on-duty clinician acting on behalf of the treating clinician may, in accordance with 104 CMR 27.13(6)(f)3 and 4, restrict or authorize such access as indicated by the change in circumstances. Any such restriction of access shall be reviewed in accordance with 104 CMR 27.13(6)(f)4.
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: *Investigation and Reporting Responsibilities*.

(7) Any rights set forth in 104 CMR 27.13(6)(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. 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 104 CMR 27.13(7) shall be provided to the facility's human rights officer.

(8) An assessment or decision concerning the exercise of the rights set forth in 104 CMR 27.13(6) (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(8) shall be initiated by the filing of a complaint in accordance with 104 CMR 32.00: *Investigation and Reporting Responsibilities*, and shall be subject to the provisions thereof.

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

(10) 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.

(a) 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:

1. be informed of a search prior to the search;

2. be provided an opportunity to consent to the search; and

3. be present during the search of their property.

(b) If a search of a patient's property needs to be performed in an emergency, when the patient is not present during the search, the patient shall be informed as soon as possible about the search. In addition, the nature of the emergency, the extent and results of the search, and the reason(s) that patient was not present during the search shall be documented in the patient's record.

(c) Nothing in 104 CMR 27.13(10) shall prohibit a facility from having a policy of routine searches of patients on admission or upon returning from authorized or unauthorized time off unit; of periodic ~~facility unit~~ searches for contraband, including searches of patient rooms or property; or implementation of search protocols for visitors, employees, or other persons entering or within the facility. A facility's policy, issued pursuant to 104 CMR 27.13(10)(c), may include searches utilizing a passive drug detection canine.

(11) 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).

(12) 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 patient in a facility, such patient shall have the right to a timely hearing and representation by counsel as provided by law.

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

(14) No patient shall be photographed, interviewed or exposed to public view for purposes of commercial exploitation without the express written consent of the patient or, if applicable, the patient's legal guardian; provided, however, that a patient may be photographed by the facility for purposes of internal security, such as for medication administration or patient identification.

(15) 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 27.14, or other materials explaining his or her rights prepared in accordance with Departmental guidelines.

(16) Copies of Rights Posted and Available in Facilities. Each facility shall post a copy of the rights set forth in 104 CMR 27.14 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 in conflict with his or her responsibilities as a human rights officer, including carrying out fact-finding activities under 104 CMR 32.00: *Investigation and Reporting Responsibilities*.

(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) The majority of members of each human rights committee shall be current or former consumers of mental health services, family members of consumers, or advocates; provided, however, that a member 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:

Investigation and Reporting Responsibilities;

(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: Absence Without Authorization

(1) Classification as AWA. Any patient admitted or committed to a Department facility pursuant to M.G.L. c. 123, §§ 7, 8, 10, 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, 8, 10, 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 27.15(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.
- (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 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; 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) Except for a patient who was committed after a finding of incompetence to stand trial whose charges have been dismissed, there shall be no discharge of 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 27.15(4)(a).

27.16: Records and Records Privacy

- (1) Each facility shall maintain a patient record containing all significant clinical information for each patient admitted to the facility. "Patient 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 Patient Record. A patient record shall include:
 - (a) identification data, including patient's admission status;
 - (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
- (t) 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 patient 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:

Retention of Records. Each facility shall develop and comply with written procedures concerning maintenance and destruction of records.

(4) Format and Storage of Records. Patient 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 patient records, and shall comply with all applicable federal and state laws and regulations. Except as provided in 104 CMR 27.16, all records relating to any patients 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 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.
- (b) If access to a record is denied based on the criteria in 104 CMR 27.16(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 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 younger than 18 years old to inspect his or her own records, provided that a patient who is 16 or 17 years of age 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 drug or medical or dental treatment of a patient younger than 18 years old who has been determined to be an emancipated or mature minor as provided in 104 CMR 25.03: *Emancipated and Mature Minors* shall be confidential between the minor and physician or dentist and shall not be released, except 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 27.16(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. would be in the best interest of the patient; and
 - 2. is permitted by the privacy regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA) at 45 CFR Parts 160 and 164.
- (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, the following inspections or disclosures are deemed to be in the patient's best interest:
 - 1. for purposes of treatment, payment, and health care operations as permitted by the privacy regulations promulgated under HIPAA at 45 CFR Parts 160 and 164;

2. 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*;
4. 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*;
5. 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: *Reportable Diseases, Surveillance, and Isolation and Quarantine Requirements*; and
6. 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);
2. M.G.L. c. 19A, § 15 (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: *Charges for Services*.

(g) Any inspection or disclosure pursuant to 104 CMR 27.16(9)(c) through (f) shall be limited to the minimum information necessary to achieve the permitted inspection or disclosure.

(10) Notwithstanding the provisions of 104 CMR 27.16(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 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 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 created in anticipation of litigation.

27.17: Interpreter Services

(1) For the purposes of 104 CMR 27.17, the following words shall have the following meanings:

- (a) Competent Interpreter Services. 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. 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. 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 27.17 and that assist staff and patients in accessing interpreter services.

SUBPART D: OPERATIONAL STANDARDS FOR SUBSTANCE USE DISORDER TREATMENT FACILITIES

27.18: Substance Use Disorder Treatment Facility

(1) Scope. The provisions of 104 CMR 27.18 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 27.18.

(2) Commitment Status under M.G.L. c. 123, § 35. A substance use disorder, as defined in 105 CMR 164.006: *Definitions*, 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 18 years of age or older 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: *Licensure of Substance Abuse Treatment Programs.*

(5) Applicable Standards for Substance Use Disorder Treatment. In addition to the operational standards of 104 CMR 27.00, 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: *Waivers.*

(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 patients who meet the following criteria may be admitted to and retained in the facility:

(a) The individual must be 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 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 patients and staff and operation of the program in accordance with the requirements of 104 CMR 27.18.

(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 27.18(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 27.16.

(a) Each patient record shall be maintained and stored in accordance with the requirements of 42 CFR Part 2 and 104 CMR 27.16(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 patient 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: *Investigation and Reporting Responsibilities*. Complaints shall be reported, reviewed, investigated and resolved in accordance with the requirements of 104 CMR 32.00.

(17) Interpreter Services. The facility shall provide competent interpreter services for non- English speaking patients in accordance with the requirements of 104 CMR 27.17. 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(10) 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 27.18(11), the Facility shall refer the individual to an appropriate program or service provider for further treatment.

REGULATORY AUTHORITY

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

NON-TEXT PAGE