Massachusetts

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105 CMR 150.000: LICENSING OF LONG-TERM CARE FACILITIES

150.001: Definitions

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

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

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

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

150.002: Administration

(B) Administration.

(1) A full-time administrator shall be provided in (a) facilities that provide Level I care, (b) facilities that provide Level II care and consist of more than one unit, and (c) facilities that provide Level BI or IV care and consist of more than two units.

(b) A Program Director shall be provided in a facility (or unit) qualifying as an AIDSSNF. A freestanding AIDSSNF shall provide a full-time Program Director. For AIDSSNF units which are part of a conventional nursing home or hospital, the Program Director shall serve at least 24 hours per week. This individual shall have at least three years of clinical experience in any one, or combination of the following disciplines: nursing, clinical psychology, or social work. Responsibilities of the Program Director shall include but not be limited to general administration of the AIDSSNF facility/unit, program development and supervision.

150.003: Admissions, Transfers and Discharges

(D) Admission of Mental Health Patients or Residents.

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

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

(a) When a resident who has been determined, following his/her consent and evaluation, to be a Community Support Resident, is admitted to a Community Support Facility, or to a Resident Care Facility (by waiver) a written agreement must be signed between certain referring public or private agencies or institutions and the accepting facility. All referring agencies which are also

providers of mental health or psychiatric services must agree in writing to provide or arrange for the following services with another designated provider:

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

150.004: Patient Care Policies

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

* Social services

Other professional services (dental, podiatric, etc.) and diagnostic services

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

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

150.011: Social Services

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

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

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

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

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

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

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

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

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

(4) In addition, all facilities shall provide sufficient ancillary social service personnel under appropriate supervision to meet the emotional and social needs of the patients or residents.
(5) Exception: facilities that provide Level IV care only shall be required to provide social service staff and social services only as indicated by resident's needs.
(a) A CSF, Resident Care Facilities and multi-level facilities with Level IV units with Community Support Residents shall be required to provide or arrange to provide a minimum of one hour of social services per Community Support Resident per month, or more if indicated by the residents' needs.
(b) All social workers providing social services in Level IV facilities shall be licensed according to Board of Registration of Social Work requirements.
1. Effective June 1990, only Master's level licensed social workers will be allowed to provide clinical services, including the development of the Mental Health Treatment Plan for Community Support Residents. LSW social workers currently employed by rest homes to perform this function will be allowed to continue as long as they are receiving appropriate supervision in the development and implementation of clinical services and mental health treatment.
2. L.S.W. social workers providing clinical services must be supervised.
Supervision and consultation must be available to other social work staff as needed. Supervision must be provided by either an LCSW with an MSW degree or by an LICSW.
(c) Each Community Support Resident shall have a written individualized mental health treatment plan jointly developed by the Community Support Resident and the attending Social Worker in consultation with the resident's physician, psychiatrist, Support Services Coordinator, and other involved mental health consultants if needed. The mental health treatment plan shall be developed as soon as possible but no later than two weeks after admission. Each plan shall be first reviewed by a social worker 30 days after it is first developed and every 90 days thereafter.
(e) If a mental health treatment plan is declined by a resident, the attending social worker, in consultation with the resident's psychiatrist and/or physician, shall make all efforts to meet with the resident, to determine how a plan might be developed and/or modified in order to accommodate the resident's objections, concerns, and suggestions. Reasons for partial or total rejection of the plan must be noted in the resident's record.
(6) A SNCFC with a minimum of 40 beds shall provide the services of one full time, MSW, LCSW social worker who has training and/or experience in developmental disabilities and one full time LSW social worker. For every additional 20 beds there shall be provided an additional half-time LSW social worker.
(7) An AIDSSNF shall have, at a minimum 2.0 FTE (80 hours per week) Social Services staff, including a full time Social Services Director.
(a) In an AIDSSNF the Social Services Director shall be an MSW licensed at the LCSW or LICSW level and shall have at least one year of experience in a health care setting. Responsibilities of the Director include but are not limited to: staff supervision, mental health treatment and supportive counseling to individuals and family members, admissions screening and discharge planning.
(b) All social work staff providing clinical services in an AIDSSNF must have an MSW and be licensed at the LCSW level.
(c) Social Service staff shall also provide case management and linkage with service organizations and community groups. Staff providing indirect services may be licensed at the LSW level.

(F) Social service programs shall be coordinated with the resources and services of public and private agencies or institutions in order to stimulate alternative care plans in the community, to provide continuity of care for patients and residents and to promote long-range social and health planning.
(G) Social Services.
(1) Emotional and social factors shall be considered in relation to medical, nursing, and other factors in determining the appropriateness of placement of patients or residents.
(2) Social Service Plan -- Prior to admission, or as soon as possible after admission, there shall be an evaluation of the patient's or resident's social needs and a plan shall be formulated and recorded for providing such care. This plan shall include information regarding pertinent personal, interpersonal and situational problems influencing management and probable duration of stay. To the extent possible, the plan shall be developed with the patient.
(a) In a SNCFC a social service plan shall be part of the patient's Individual Service Plan (ISP) and to the extent possible, the plan shall be developed with the patient, the patient's family and/or his/her legal guardian and shall reflect permanency planning efforts.
(3) Social service needs of patients or residents shall be identified on admission and services provided to meet these during treatment and care in the facility and in planning for discharge.
(4) Assistance shall be provided every resident or patient directly or through referral to, or consultation with, an appropriate agency when there are indications that financial help is needed.
(5) Appropriate action shall be taken and case work services provided to resolve social and emotional problems related to the patient's illness or state of health, his response to treatment, his home and family situation and his adjustment to care in the facility.
(6) Social services shall include provision of educational programs for the facility staff in order to promote the development of a therapeutic community, a congenial atmosphere and healthy interpersonal relationships in all facilities.
(a) In a SNCFC social services staff shall provide educational programs for the facility staff including but not limited to: patient rights, child abuse, mistreatment and neglect and reporting requirements.
(b) In a SNCFC, social services staff shall provide for regularly scheduled parent/guardian educational and support programs and parent (guardian)/child-centered activities.
(7) Discharge or transfer plans and decisions shall consider the patient's or resident's home situation, financial resources, social needs, and community resources as well as his medical and nursing requirements.
In a SNCFC discharge or transfer plans shall be discussed at least annually and in conjunction with the Individual Service Plan (ISP) annual review. Formal discharge or transfer planning efforts shall be documented in the ISP. Referrals to alternative adult facilities must be indicated when a SNCFC patient turns age 20 as well as referral to the Bureau of Transitional Planning in accordance with M.G.L. c. 688.
(8) In a SNCFC, the social worker shall assist in the coordination of family visits to the patient and in arranging patients' visits outside the facility when appropriate and ordered by the physician. The social worker shall also assist in coordinating arrangements for the patient's return to home or other placement.
(H) Facilities shall maintain records of pertinent social information, action taken to meet social needs and written evidence of periodic case review on all patients and residents.
Pertinent social data and information about personal and family problems shall be made available only to the attending physician or physician-physician assistant team or physician-

nurse practitioner team, appropriate members of the nursing staff, and other key personnel who are directly involved in the patient's or resident's care, or to recognized health or welfare agencies. There shall be appropriate policies and procedures for assuring the confidentiality of such information.
(I) In an AIDSSNF the facility/unit shall ensure sufficient and appropriate staffing to provide counseling and therapy for residents with substance abuse problems. These services may be provided through a contractual arrangement with a provider of substance abuse services. The contract agency must assure that the substance abuse staff will work closely with the psychiatric nurse and social work staff in developing and coordinating the mental health component of the resident's Individual Service Plan (ISP).
150.013: Clinical and Related Records
(H) Individual Service Plan (ISP) in a SNCFC.
(2) Long term goals shall be developed at an annual meeting attended by a multi-disciplinary team. Such annual meeting shall be convened inviting parent and/or guardian participation as well as relevant outside resource and support persons. Types of services needed to achieve goals shall be included in the Individual Service Plan (ISP).
(a) The multi-disciplinary team shall include but not be limited to the attending physician or physician-assistant team or physician-nurse practitioner team, a registered nurse, a registered physical therapist, a registered occupational therapist, a speech pathologist, a social worker supervisor, a representative from the individual's educational/habilitative services program and a supervisor of therapeutic recreation services.
150.021: Support Services Plan for Level IV Community Support Facilities
(A) In Level IV facilities with Community Support Residents, the Support Services Coordinator must develop a Support Services Plan. The plan shall be written as soon as possible but no later than two weeks after admission for new resident admissions and as soon as possible for Community Support Residents already residing in a facility. The Support Plan must describe the service needs of the resident, including those service needs specified in his/her Mental Health Treatment Plan. The Support Plan must be developed by the Community Support Resident and the Support Services Coordinator, in consultation with the resident's social worker, physician, psychiatrist, and other staff.
(2) Each plan should be reviewed 30 days after it is first developed, and every 90 days thereafter. At the time of the plan review, goals and objectives should be evaluated, and revised as needed. If objectives have not been met, new strategies may need to be developed. The plan should be adjusted at any time that a significant change is made in the resident's mental health plan that affects the service needs specified in the Support Plan, or that requires new service needs to be met. The Coordinator, in consultation with the Social Worker may revise the Support Plan as often as the Coordinator feels it is inadequate.
(B) Support Services Coordinator. All Level IV facilities with Community Support Residents shall employ a Support Services Coordinator. The Coordinator is responsible for arranging and coordinating Support Services. Support Services is a term applied to a variety of services including health and mental health visits, educational and vocational services, as well as recreational services which are intended to enhance the psychosocial and physical functioning of Community Support Residents. Some of these services will be specified in the resident's Mental Health Treatment Plan. Others can be identified by the resident, the Coordinator or other staff. The Coordinator is responsible for assuring that all of the services received by a Community Support Resident either within the facility or in the community, are consistent with the Mental

Health and Support Services plans. When questions or conflicts arise among the various staff and consultants involved with these residents, it is the responsibility of the Coordinator to arrange and facilitate communication among the others. This may involve arranging meetings among facility staff, referring agency staff, consultant staff or others. It is the role of the Coordinator to minimize duplication of service, and to assure that the Mental Health Plan required by these regulations is the focus of a consistent and well organized care plan. The Coordinator should meet regularly with Community Support Residents as well as with the Social Worker and other facility staff. The Coordinator may also wish to visit other agencies and staff to facilitate linkage and coordination.

Minimum Support Services Coordinator Personnel Requirements:

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

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

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

151.530: Office Space

(B) Consultant Offices.

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

155.003: Definitions

Mandatory reporting individual: any person who is paid for caring for a patient or resident, whether on a permanent or temporary basis, and/or who is:

(23) a social worker;

156.210: Qualifications of the Instructor

(B) Other health care professionals such as dieticians, social workers, physical therapists, occupational therapists, and others may teach lessons or modules of nurses' aides training course.