Alzheimer's Association: National State Assessment on Dementia Policies
Response on Nursing Facility Care
Submitted: 9/30/22

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1. **Are quality care indicators used in the state's long-term care system, including nursing facility care, assisted living facility care, home care, adult daycare, or any other service provided to people living with dementia?**

We understand that the quality care indicators noted in the above link are available to the public on Care Compare[1] and are not provided directly to any nursing home resident/consumer. Also, while Minimum Data Set (MDS) statistics are also publicly available, few consumers know about these statistics which are more suited to researchers.

We thought you would find it helpful to know that in October 2013, the MA Department of Public Health (DPH) added several questions to MDS Section S for nursing home residents in order to better understand and document the approaches MA nursing homes implemented to reduce the misuse and overuse of antipsychotic drugs. The questions basically cover:

Was there an attempt to reduce the antipsychotic,
Was the reduction maintained, and
Were non-pharmacological resident centered-care techniques used.

- The following MA Circular Letter 13-9-597, effective 10/1/13, required the 3 questions: DHCQ 13-9-597.
- The 10/1/13 Section S questions are included in the following documents:
  Massachusetts MDS Section S Printable Form - 10/1/2013 (RTF)
  Massachusetts MDS Section S User's Manual - 10/1/2013 (RTF)

Psychotropic drugs (antipsychotics, antidepressants, antianxiety medications, and sedatives) have positive outcomes when used as intended. However, they can have a devastating outcome when misused as a chemical restraint. Patients of any age in any healthcare setting can be subjected to chemical restraints to manage what are labeled as "inappropriate" behaviors, but what are really misunderstood "communications" of medical, emotional or other needs. The inappropriate use of antipsychotics and other psychotropic drugs on nursing home residents with dementia remains a significant statewide and national problem.

Continued

Question 1 (continued)

Since the misuse and overuse of antipsychotics, or any psychotropic drug, can be deadly to older adults, MA established additional safeguards over and above the MDS Section S questions.

- 2016 – MA implemented informed written consent before administering psychotropic medications (or any medication used in the treatment of a psychiatric diagnosis or symptom) to nursing home and rest home residents in an effort to protect these vulnerable populations.
- 2017 – 8 hours of dementia care training for nursing home staff in direct contact with the residents, then the participating staff must pass an exam before working with residents. Plus, there's 4 hours of in-service dementia care training each year thereafter.
- 2018 – Dementia Special Care Units initiated: special locked unit for protection, activities 8 hours/day-7 days/week, etc.
- From FY12 - FY22, MA spent over $11M on pay-for-performance and civil monetary penalty fund initiatives for dementia care trainings and other supports. Here is just a partial list of those efforts:
    - ✓ 2012-15: OASIS special dementia care trainings for all nursing home staff;
    - ✓ 2020-21: Abt Associates ran a Dementia Care Training Program at 60 nursing homes for all staff, as well as residents' families.

<u>However, despite the additional MDS questions and all the above efforts, MA still has one of the highest antipsychotic drugging rates for nursing home residents in the US!</u>

- It's also important to call out that certain nursing homes administer these drugs to an extremely large percentage of their resident population. For instance, in 2021, 30-49% of residents in 77 of 360 MA nursing homes and 50-80% of residents in 14 MA nursing homes were given antipsychotics.
- Furthermore, misdiagnosing nursing home residents with schizophrenia, for which antipsychotics are allowed, means dispensing antipsychotics with impunity. Nearly 10%[2] of MA nursing home residents are diagnosed with schizophrenia, even though this ailment occurs in less than 1% of the US population.

We submit that stronger oversight is necessary to protect nursing home residents from the dangers of not only antipsychotics, but also all psychotropic drugs --- as you well understand, another psychotropic drug can be substituted for an antipsychotic to still create a chemical restraint. To protect nursing home residents and older adults in any venue, we recommend:
1. Analyze use of antipsychotics and other psychotropics in nursing homes, hospitals, other facilities, and the community, including analyzing schizophrenic diagnoses in elders.
2. Develop MA regulations to support a more robust informed written consent form and appropriate use of psychotropic medications.
3. Provide ongoing staff training on nonpharmacological interventions. Anxiety and depression need the special focus of trained providers, but also of regular staff.
4. Review nursing homes with the highest use, which include nursing homes that have neurobehavioral units for long-term care of individuals who have had traumatic brain injury or strokes, both known precursors for dementia.
5. Relationships with family, friends, providers, peers, and others are important supports.

2. **Does the licensure agency for nursing facilities, assisted living facilities, or other residential care facilities collect and report data related to the number of involuntary discharges or transfers that occur? If so, what is the requirement on the collection of data and does the data reflect that the person is living with dementia?**

   Per federal regulations, the MA Ombudsman Program receives all discharge/transfer notices, and then it's up to the Ombudsman Program on how to record the data. However, residents/families are given the Ombudsman contact info in the notice, and it's a reasonable assumption that most residents/families would outreach to the Ombudsman for support. Since Ombudsmen track such activity as part of the overall Ombudsman statistical reporting[3], there's a good chance the majority of discharges are tracked in this manner. The most recent available statistics from the national Ombudsman's office is 2019, and MA had 214[4] discharges/evictions.

   It's our understanding that it is not required to indicate if the person is living with dementia, but you should contact Carolyn Fenn, MA State Ombudsman (617) 222-7491, to confirm.

3. **Are critical incidents (incidents that result in death, or serious disability, injury or harm to the patient) required to be documented and reported to the licensure agency for nursing facilities, assisted living facilities, home care, adult daycare, or any other service provider for people living with dementia within 24 hours? If so, what are the requirements for reporting and how does the state determine critical incidents?**

   Such critical incidents are required to be documented and reported according to the following federal regulations --- Title 42 Chapter IV, Subchapter G, Part 483, Subpart B Requirements for Long Term Care Facilities[5] noted below. However, we understand that the following procedures are not always operating as intended. Sometimes, out of fear of repercussions, the person providing testimony or alerting authorities does not report situations, i.e. incidences are not always reported to appropriate person.

   § 483.12 Freedom from abuse, neglect, and exploitation.

   …(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

   (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

   (2) Have evidence that all alleged violations are thoroughly investigated.

   (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

   (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. --- Continued ---

Question 3 (continued)

Furthermore, in addition to § 483.12, any incident that results in injury, harm, or change of status is reportable to DPH. The facility makes determination of whether or not it is a critical incident. If the facility fails to report an incident as critical, it can be sanctioned, although the sanctions are relatively mild. The only data we have on such reported incidents is from the 4/13/16 Public Health Council presentation by Commissioner Bharel. She cited that in 2015, there were approximately 11,000 nursing home self-reported incidents and consumer complaints: 9,947 (85%) nursing home self-reported incidents and 1,768 (15%) consumer reported complaints. Compared to the Q4 '15 census of about 40,000[6] nursing home residents, reported incidents and consumer reported complaints impacted about 25% of MA nursing home residents.[7]

4. **Are there any acuity-based staffing requirements or staffing ratios for nursing homes, assisted living facilities, adult daycare centers, Programs for All Inclusive Care (PACE), or any other congregate setting that serves people living with dementia? If so, what are the requirements and are they evidence-based?**

MA does not have acuity-based staffing ratios for nursing home residents. However, there are general acuity-based staffing requirements:

> "…150.007(B)(2)(d) Sufficient nursing personnel to meet resident nursing care needs, based on acuity, resident assessments, care plans, census and other relevant factors as determined by the facility. On and after April 1, 2021, sufficient staffing must include a minimum number of hours of care per resident per day of 3.580 hours, of which at least 0.508 hours must be care provided to each resident by a registered nurse. The facility must provide adequate nursing care to meet the needs of each resident, which may necessitate staffing that exceeds the minimum required PPD..."[8]

There is much evidence-based support for at least 4.1 hours of care per resident per day as a minimum of care, and see this Dignity Alliance Fact Sheet for additional background Nursing Home Staffing Issues.

Then on 2/28/22, the Biden-Harris Administration announced a set of wide-ranging reforms aimed at improving the quality of nursing home care for residents. These reforms address long-standing issues that have plagued nursing home care for decades, including poor staffing, inadequate enforcement, and lack of transparency in nursing home ownership and how taxpayer dollars are spent. As a result of the Feb. '22 announcement, CMS published a proposed staffing rule in the Federal Register, 87 Fed. Reg. 22720 (Apr.15, 2022), https://www.govinfo.gov/content/pkg/FR-2022-04-15/pdf/2022-07906.pdf. The discussion of staffing appears at pages 22789-22795. We submitted testimony for the June 10, 2022 deadline, and CMS is expected to publish a new staffing standard in about a year.

In addition to the necessity of sufficient nursing and CNA staffing, we also must emphasize the valued participation of pastoral counselors, social workers, activity workers, peers, and others in an effort to advocate for a bio-psycho-social framework.

5. **Are there any state policies limiting involuntary discharges or transfers due to dementia-specific behaviors (including court decisions when applicable)? Are there any appeals processes for individuals discharged or transferred from a nursing facility, assisted living facility or any other residential facility due to dementia-specific behaviors? If so, what are the requirements and process for appeal?**

Per federal regulations, a resident can be discharged/transferred for one of six reasons[9] (see footnote). Even though nursing homes sometimes use "dementia-specific behaviors" or "being difficult" as the reason for discharge/transfer, these situations are *not* one of the six reasons per regulations. "…Nursing homes exist in order to care for people with physical and cognitive problems. Many nursing home residents are "difficult" in one way or another. Nevertheless, some nursing homes may attempt to evict a resident who tends to wander aimlessly, or who has severe dementia and is making loud sounds during the night. Such evictions almost always are improper, because a nursing home is an appropriate environment for these residents. The fact that they are arguably "difficult" does not mean that they should be evicted. In most cases, it is pointless to evict a resident from one nursing home merely so they can be transferred to another…"[10]

"…For a "cannot-meet-your-needs" eviction, federal regulations require that the resident's doctor document the resident's unmet needs at the nursing home, the nursing home's attempts to meet those needs, and the ability of the proposed new facility to meet those needs.[11] If the nursing home does not have this documentation, that failure by itself is reason enough for ruling in the resident's favor. If, on the other hand, the nursing home has the documentation, the resident, representative, or attorney should poke holes in its reasoning — pointing out, for example, that the current nursing home should be able to provide the same care that the proposed "new" facility would provide…"[12]

Even if dementia specific behaviors are not identified, a nursing home resident cannot be transferred/discharged involuntarily during the Fair Hearing Appeal process. [Please note that even though the hearing and application state that the process is for "MassHealth" purposes, any resident can use this process for an appeal.]

Furthermore, per Massachusetts law (M.G.L.111 Section 70E)[13], lack of a safe and appropriate new location will delay an involuntary transfer/discharge.

- Another protection provided by the appeals process: Even if the Hearing Officer determines that the resident should be transferred/discharged, the resident would remain in the nursing home until a safe and appropriate new location is approved by the officer.
- Per Federal and Massachusetts law, the nursing home must provide sufficient preparation and orientation to residents to ensure a safe and orderly transfer or discharge.

See this link to the MA Advocates for Nursing Home Reform (MANHR, now a program of Dignity Alliance MA) for further background on involuntary discharges or transfers https://manhr.org/essential-information/managing-the-experience/involuntary-transfers-and-discharges/.

6. **Does the Medicaid long-term care program, through its contract with Managed Care Organizations or any other means, have any quality metrics related to:**
   a. **cognitive assessments** [206.06 (13) Behavioral Health Indicator below]**,**
   b. **diagnosis disclosure** [none]**,**
   c. **staging** [none - exams/tests to learn extent of a cancer, especially whether it has spread from its original site to other parts of body]**,**
   d. **antipsychotics use** [none]**,**
   e. **direct care staffing ratios** [206.13 below]**, or**
   f. **preventable hospitalizations** [none]**?**

   If so, what are the metrics and are they used to influence reimbursement rates?

MassHealth payments to nursing homes are defined in "101 CMR 206.00 Standard Payments: 7/1/22[14]" which includes over 30 adjustments to MassHealth nursing home base rates. Here are the rate adjustments for the only quality issues stated in issue 6. above:

a. Cognitive Assessments: 206.06 (13) Behavioral Indicator Adjustment

Effective 10/1/21, this Adjustment is determined based on the proportion of MassHealth residents in FY20 coded as 2 or 3 on one or more of MDS 3.0 indicators: Behavioral Health (E0200A, B, or C), Rejection of Care (E0800), or Wandering (E0900).

(a) At least 25% and less than 40% of MassHealth residents 4% upward adjustment
(b) At least 40% and less than 50% of MassHealth residents 6% upward adjustment
(c) At least 50% and less than 50% of MassHealth residents 10% upward adjustment

- Q2 '22 MDS statistics are well below the 25% level, so there are no upward adjustments.[15]

e. Direct Care Staffing Ratios: 206.13

(1) As of October 5, 2020, each nursing home is required to submit information on its staffing levels, including information demonstrating the facility's average hours of care per resident per day (HPRD) to EOHHS, in the manner and format requested by EOHHS via administrative bulletin or other written issuance.

(2) As of January 1, 2021, a nursing facility that fails to meet an average of at least 3.58 HPRD in accordance with 101 CMR 206.13(1), is subject to a downward adjustment equal to 2% of the facility's standard rate for that calendar quarter. The dollar amount resulting from this adjustment will be considered an overpayment pursuant to 130 CMR 450.235: *Overpayments*.

- As of Q1, 2022, latest available staffing statistics[16], only 27% (97 nursing homes) of 356 MA nursing homes met or exceeded the minimum 3.58 HPRD.

Q1, 2022 MA Nursing Home Staffing Statistics:

Total Direct Care Staff HPRD	# Fac.	Cum. Facilities	%	Cum. %
4.10-7.92	34	34	10%	10%
3.58-4.00	63	97	17%	27%
3.50-3.57	21	118	6%	33%
3.00-3.49	147	265	41%	74%
1.22-2.99	91	356	26%	100%

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Dignity Alliance Massachusetts --- 9/30/22
Additional Comments

1. Since 2014, MA nursing homes have been providing 8 hours initial dementia care training, then passing an evaluation, and 4 hours of dementia care training annually thereafter. Even with this additional education, there are still gaps in dementia care training --- and drugging rates are still high. Hence the CMP project noted in item 3. below. However, we thought it was also important to look at the evaluations of the 8-hour trainings. Each nursing home develops their own test/scoring, consequently, some facilities may have a more comprehensive curriculum and exam than other facilities. We strongly recommend a standardized statewide test to ensure a consistent and comprehensive assessment of dementia care skills for staff across all MA nursing homes.

2. It would be worthwhile to review the status of Dementia Special Care Units (DSCU) and advocate for expanding the improvements implemented in these units to all MA nursing homes, throughout a facility, not just a special unit. About 60% of MA nursing home residents have a dementia, and as you well understand, dementia is increasing throughout the Commonwealth.
   - While a great percentage of people in MA assisted living residences (ALRs) receive care for dementia related issues, as opposed to receiving care in nursing homes, it is remarkable to note that there is virtually no regulatory oversight or monitoring of dementia care quality measures in ALRs!

3. We strongly support remodeling of existing nursing homes to single occupancy rooms and downsizing newly constructed nursing “small home” models to be the standard for all future nursing home development in order to better provide residents with privacy and dignity in a more homelike-setting. The one-room setting is particularly important for nursing home residents with dementia, and integrating DSCU standards in these efforts is paramount. We also support the legislation below, and submit them for your consideration going into the new legislative year.
   - S.414/H.727 An act to ensure quality of care in nursing homes - SECTION 4. Chapter 111 of the General Laws is hereby amended by inserting after section 72EE the following section:- Section 72FF --- : reduces the maximum number of beds per room from “no more than four beds” to “no more than two beds”, including additional spacing and other requirements.
   - S.406 An Act relative to small house nursing homes - Essential elements of small homes relate to core values of *real home* (e.g., no more than 12 elders, meals cooked in a central open kitchen, elder-directed living); *meaningful life* (e.g., elder control over time to wake, eat, and sleep, and access to activities in the broader community); and *empowered staff* (e.g., self-managed teams of certified nursing assistants).

4. Abt Associates recently completed a multi-year dementia care training with 60 MA nursing homes. The project was called *Caring for Nursing Home Residents with Dementia* and was supported by Civil Monetary Penalty (CMPs) funds. If you don’t already have the materials developed by the project, we recommend that you acquire them to evaluate the project. Arlene Germain (agermain@manhr.org) was on the review panel, has draft materials, and can discuss further.

5. The recent multiple nursing home closures brings into focus the need to have an orderly review of the MA nursing home bed inventory to ensure a strategic and compassionate resolution to nursing home closures. Dignity Alliance MA has put much thought and effort into protecting nursing home residents and other congregate care residents when a facility closes, and we would welcome your input and participation in these efforts.

Additional Comments - continued

6. It's also important for individuals with dementia to be able to obtain skilled therapy services[17]. Improvement is not necessary to receive Medicare skilled therapy services, but such critical information is not widely known, and we have found that even physical therapists are unaware of this necessary care. The Jimmo vs Sebelius case upheld that skilled therapy services can be provided to maintain function or prevent/slow/decline deterioration; and can cover chronic conditions (illness, disability, or injury), even though the underlying conditions are not expected to improve (e.g. dementia, multiple sclerosis, diabetes, Parkinson's disease, ALS, arthritis, heart disease, stroke, & other serious conditions).
   - If Medicare coverage is denied or terminated early, the individual can appeal to KEPRO, the MA Medicare contractor, 1-888-319-8452.
   - Also, the Center for Medicare Advocacy (CMA), https://medicareadvocacy.org/, helps individuals obtain fair access to Medicare, and CMA was also responsible for bringing the Jimmo vs Sebelius case. CMA has self-help tools and is available by phone 1-202-293-5760 for free advice to navigate problems with Medicare and accessing therapies. There is also an on-line free "Self-Help-Appeals Packet" to facilitate obtaining therapies.

7. Many nursing home residents rely on others for advice or to make crucial decisions on nursing home care and issues. However, MA regulations currently deny residents the right to have the representative of their choice. For example, the definition of "resident" in both *105 CMR 150.000 Standards for Long-Term Care Facilities* and *105 CMR 153.000 Licensure Procedure & Suitability Requirements for Long-Term Care Facilities* limits a resident's choice for a representative to an activated health care proxy.[18] In addition, while both *105 CMR 150.000* and *105 CMR 153.000* have been updated in recent years to provide decision-making rights in most situations to the "resident or resident's legal representative", the option for a resident to choose a family member or friend is not offered.

   S.1482 *An Act ensuring access to a resident representative in long-term care facilities* eliminates any discrepancies between federal and state resident representative options, thereby clarifying and guaranteeing a resident's representation rights. To ensure that residents are aware of their rights, S.1482 also requires a nursing home to notify residents of their representation rights verbally and in writing. The following sample of federal regulations included in S.1482 shows how a resident's options for representation would be expanded:
   - To help support a resident in decision making; access medical, social or other personal information; manage financial matters; or receive notifications, a resident representative includes:
     - ✓ Any individual chosen by the resident.
     - ✓ A person authorized by state or federal law to act on behalf of the resident (including but not limited to agents under power of attorney, representative payees, and other fiduciaries).
     - ✓ A court appointed guardian or conservator of a resident.

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[1] https://www.medicare.gov/care-compare/?providerType=NursingHome&redirect=true.
[2] Minimum Data Set, Q2 '22.
[3] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-27.pdf, page 4: "...42 CFR 483.15(c)(3)(i) requires, in part, that before a facility transfers or discharges a resident, the facility must "notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand...." The facility must also "...send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman."..."
[4] https://ltcombudsman.org/omb_support/nors/nors-data, then click on Nursing Facility Complaints by Complaint Category and Sub-Category. Go to tab "C-Transfer, Discharge, Eviction", then to column I: Planning, notice, procedure, implementation, including abandonment". MA is line 31.
[5] Title 42 of the Code of Federal Regulations, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B

§ 483.15 Admission, transfer, and discharge rights.

(c) *Transfer and discharge* -

(1) *Facility requirements* -

(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless -

(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;

(D) The health of individuals in the facility would otherwise be endangered;

(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(F) The facility ceases to operate.

[6] Q4, 2015 Minimum Data Set for A0800 Gender = 41,595 census, https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports/Minimum-Data-Set-3-0-Frequency-Report.
[7] *State officials move to tighten oversight of nursing homes*, Kay Lazar, February 10, 2016, https://www.bostonglobe.com/metro/2016/02/10/state-officials-move-tighten-oversight-nursing-homes/AHY8er781fMMgj1aNvsnuM/story.html.
[8] https://www.mass.gov/doc/105-cmr-150-standards-for-long-term-care-facilities/download.
The language quoted in (d) above is included in each of Levels I, II, and III care. The typical nursing home is primarily Level 1 care.
150.007: Nursing Services
(B) Minimum Nursing Personnel Requirement…
…(2) Facilities providing Level I care shall provide:…
…(3) Facilities providing Level II care shall provide:…
…(4) Facilities providing Level III care shall provide:…
[9] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B Per 483.15 Admission, Transfer, and Discharge Rights (c) Transfer and Discharge
[10] *25 Common Nursing Home Problems --- And How To Resolve Them*, Justice in Aging, by Eric Carlson, January 2019, page 20, https://justiceinaging.org/wp-content/uploads/2019/01/25-Common-Nursing-Home-Problems-and-How-to-Resolve-Them_Final.pdf

[11] Ibid., https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B, Section 483.15(c)(2)(i)(B) of Title 42 of the Code of Federal Regulations.
[12] Ibid., *25 Common Nursing Home Problems --- And How To Resolve Them*, Justice in Again, page 21.
[13] M.G.L.111 Section 70E, next to last paragraph: "…A resident, who requests a hearing pursuant to section 48 of chapter 118E, shall not be discharged or transferred from a nursing facility licensed under section 71 of this chapter, unless a referee determines that the nursing facility has provided sufficient preparation and orientation to the resident to ensure safe and orderly transfer or discharge from the facility to another safe and appropriate place…"
[14] Emergency Adoption (date filed: July 1, 2022) [found on this website: https://www.mass.gov/regulations/101-CMR-20600-standard-payments-to-nursing-facilities].
[15] As of 9/30/22, the most recent MDS statistics are Q2, '22: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports/Minimum-Data-Set-3-0-Frequency-Report.
[16] https://nursinghome411.org/data/staffing/staffing-q1-2022/ MASSACHUSETTS
[17] https://www.cms.gov/center/special-topic/jimmo-center.html
[18] 105 CMR 150.000: STANDARDS FOR LONG-TERM CARE FACILITIES (Mass. Register #1453 10/1/21 Emergency) https://www.mass.gov/doc/105-cmr-150-standards-for-long-term-care-facilities/download**:**
105 CMR 150.001: "Resident shall mean any individual receiving care in a facility or the resident's health care proxy, if the resident has an activated health care proxy."
105 CMR 153.000 Licensure Procedure & Suitability Requirements for Long-Term Care Facilities (MA REG. #1372, Dated 8/24/18) :
105 CMR 153.004: "Resident. Any individual receiving care in a facility or the resident's health care agent, if the resident has an activated health care proxy. "