

A Failure of Care:

An Investigation of the
Neurobehavioral Unit at Bear
Mountain at Worcester



DISABILITY LAW CENTER, INC.

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Boston, MA

January 31, 2024

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I. Executive Summary

A. Overview:

This report presents findings by the Disability Law Center (DLC), the Protection and Advocacy system for Massachusetts, concerning staffing, medication practices, and quality of care in the neurobehavioral unit at Bear Mountain at Worcester (Bear Mountain) between October 2021 and October 2023. Bear Mountain is a nursing home in Worcester, Massachusetts that is part of the for-profit chain Bear Mountain Healthcare. Two floors are locked units with long-term patients who have cognitive disabilities, psychiatric disorders, long-term effects from brain injury, dementia, or combinations of these challenges. Our work arose from complaints DLC received of low staffing, overmedication with psychotropic drugs, and neglected residents at Bear Mountain.

DLC finds that Bear Mountain does not employ or engage sufficient professional staff to provide the necessary evaluations, monitoring, and the integrated care and treatment planning to care for this varied and complex population. Instead of experiencing recovery and rehabilitation, each to their fullest potential, residents become institutionalized and dependent. A large number of Bear Mountain residents have schizophrenia diagnoses as well as brain injuries and neurocognitive disorders. Verifying reported clinical diagnoses was beyond DLC's capacity and the scope of this investigation.¹ However, DLC was able to discern, with expert assistance, that Bear Mountain's treatment of schizophrenia, as well as other psychiatric disorders with psychotropic medications and without psychosocial and recovery-oriented treatment, is below the standard of care.

Available financial information, as well as quality of care studies, suggest that for-profit ownership contributes to the problems occurring at Bear Mountain. Largely Medicaid revenue funds high management fees and related party costs. It is typical of for-profit nursing home models to admit residents who have complex needs, while lacking enough capable staff to care for them. As investor-driven for-profit chains expand into long-term care, government oversight is increasingly critical. The Commonwealth must ensure that people with complex needs receive appropriate care, and do not remain in highly segregated, institutionalized environments, but meet their full potential to live lives of high quality in the least restrictive, most integrated setting.

B. Background:

DLC is the Protection and Advocacy (P&A) system for Massachusetts residents with disabilities. As the P&A system, DLC operates pursuant to federal laws that authorize access to facilities to monitor compliance with respect to the rights and safety of individuals with disabilities, and where necessary, to investigate suspected incidents and systemic patterns of abuse or neglect.² This authority extends to all facilities and settings that provide care, treatment and services to individuals with disabilities, including but not limited to nursing facilities.

The federal Nursing Home Reform Act (NHRA) sets standards to ensure that residents of nursing homes receive quality care that will result in their achieving or maintaining their "highest practicable" physical, mental, and psychosocial well-being.³ However, its standards and

implementing regulations are poorly enforced by state oversight agencies, including the Department of Public Health (DPH). Low staffing in nursing homes is associated with high use of antipsychotics, high rates of infections, and high emergency department use⁴ – all evident at Bear Mountain. These problems are worse in investor-owned for-profit institutions such as Bear Mountain,⁵ where nursing home operators may skimp on staffing to reduce expenditures.⁶

Antipsychotics pose health risks to individuals who are older, who have dementia, who have seizure disorders, and/or who use them on a long-term basis, regardless of age.⁷ In addition, psychotropic medications diminish quality of life, as well as the potential for rehabilitation, for nursing home residents who are overly sedated. Medications used for the convenience of overworked staff, rather than treatment, constitute chemical restraint under federal regulations.⁸ Such misuse constitutes abuse or neglect under the protection and advocacy statutes due to the likelihood of physical, cognitive, or psychological harm.⁹

Nationally, there has been evidence of nursing homes overreporting schizophrenia in order to avoid low quality of care ratings for high anti-psychotic usage.¹⁰ In fact, Massachusetts nursing homes have the highest rates of serious psychiatric conditions on the East Coast,¹¹ as well as among the highest rates of antipsychotics usage in the country.¹² Yet the Commonwealth has failed to scrutinize nursing homes based upon high antipsychotics usage. Moreover, the Commonwealth has not established behavioral health treatment and neurorehabilitation standards for nursing homes necessary to protect this population.

C. Methodology:

DLC began monitoring Bear Mountain in October 2021 in response to complaints concerning low staffing levels and the resulting neglect of residents. Bear Mountain, with a neurobehavioral unit for eighty residents, also had a high rate of antipsychotic usage.

We requested and reviewed the facility's data concerning psychotropic medications and found considerable polypharmacy of antipsychotics and high dosages. Use of psychotropic drugs was especially high on the neurobehavioral unit, where residents were diagnosed with brain injuries, psychiatric disorders including schizophrenic disorders, and dementia. The lack of activity observed on the unit's two floors and reports of low staffing raised the concern that medications may be used to sedate residents. It was necessary to review a sample of individual records in order to learn whether this concern was well-founded.¹³

The records DLC reviewed showed a steady reliance on psychotropic medications and a lack of multidisciplinary assessments, treatment, and individualized, person-centered behavioral management. Residents' agitation or delusions, and even assaults, falls and infections, were not adequately assessed. Based upon the review of records, DLC determined there was probable cause to proceed with an investigation of the neurobehavioral unit.¹⁴ Probable cause under the statutes' implementing regulations is defined as "reasonable grounds for belief" that the individual with the disability "has been or may be at significant risk of being subject to abuse or neglect."¹⁵

DLC considered whether treatment failures constituted neglect under the P&A statutes.¹⁶ DLC was also concerned that heavy reliance upon psychotropic medications could constitute abuse. P&A statutes define abuse as risking or causing injury or death to the person with

disability. Abuse includes use of medications as chemical restraint, i.e., out of compliance with federal or state laws and regulations.¹⁷

- Expert Reviews:

DLC staff worked together with a psychiatric nurse consultant who has considerable experience in the mental health field as well as experience administering PASRR evaluations required for nursing home admissions.¹⁸ A neuropsychiatrist reviewed the draft report, as well as a sample of records.¹⁹ DLC also consulted with a former nursing home administrator who had operated brain injury units in the U.S., and now accredits such units in Canada.²⁰

- Scope of Monitoring and Investigation:

Bear Mountain was highly cooperative throughout the monitoring and investigation. DLC conducted six site visits between October 2021 and October 2023. We spoke with residents, guardians, and family members, observed conditions, and met with administrative staff.²¹ We also met with behavioral health staff from Health Drive, an outside agency that provides specialty services at Bear Mountain. We reviewed 11 sets of resident records covering the period January 2020 to October 2022, state inspection reports, plans of correction, facility assessments, staffing data, psychotropic medications data, and cost reports. We conducted research into best practices and industry trends. Prior to issuing this public report, we presented our findings to Bear Mountain and the relevant state agencies: Executive Office of Health & Human Services (EOHHS), DPH, Department of Mental Health (DMH), Department of Developmental Services (DDS), and the Center for Health Information and Analysis (CHIA) for review and comment.

D. Summary of Findings Concerning Bear Mountain:

Bear Mountain neglected the residents reviewed, failing in critical aspects of care. Psychotropic medication practices constituted abuse under federal law. Bear Mountain violated the federal Nursing Home Reform Act and its regulations through the following:

- Failure to provide coordinated, interdisciplinary treatment and a therapeutic environment.²²
- Inadequate staffing or training to address residents' behavioral health issues and monitor psychotropic medications.²³
- Absence of professional consultations and oversight of care.²⁴
- Lack of necessary therapeutic and psychosocial programs to encourage socialization, develop and maintain daily living skills, and facilitate community integration.²⁵
- Overuse of psychotropic medications without sufficient attempts at non-pharmacological interventions or implementing non-pharmacological plans of care.²⁶
- Failure to implement recommendations made by federally required evaluations.
- Ineffectual discharge planning processes.²⁷

Further, DLC found that Bear Mountain failed to:

- Provide reasonable language access under Title VI and DPH regulations.

- Discuss with residents and legal representatives the risks and benefits of psychotropic medications, as required by EOHHS, and include certain risks in written informed consent materials.

In keeping with these findings, DLC makes detailed recommendations for Bear Mountain to improve the therapeutic environment, increase professional consultations and oversight, integrate care, engage in discharge planning, improve language access, and train staff to adequately care for and support individuals with psychiatric conditions, brain injuries and neurocognitive conditions.

DLC recognizes improvements in staffing and programming at the facility during our last monitoring visit in October 2023. We hope that recent developments, combined with other changes reported to us by the facility, and ongoing improvements to state oversight, will contribute towards responding to some of the past violations highlighted by this report. However, we continue to have significant concerns. The deficiencies in clinical care discovered during record reviews were profound. The neurobehavioral program needs clinical leadership to coordinate care, develop therapeutic programming, and fully support residents to realize their full potential. The reforms currently planned by Bear Mountain do not address all fundamental issues, and Massachusetts lacks standards for neurobehavioral units.

E. Call to Action for Increased Oversight and Enforcement:

The Commonwealth of Massachusetts bears a responsibility to uphold safety and quality of care standards in nursing homes like Bear Mountain. DLC calls upon the Commonwealth to take the following key actions:

1. Enforce staffing standards and quality of care and ensure a safe and healthy nursing home environment.
2. Strengthen oversight of appropriate screening and evaluation processes under the federal screening and review requirements.
3. Review the use of antipsychotic medications in high-use nursing homes, with a focus on ensuring high-quality behavioral health services.
4. Strengthen licensing standards for behavioral health treatment and establish licensing standards for neurobehavioral care in nursing facilities.
5. Strengthen oversight of corporate owners' financial operations.
6. Link any financial incentives given to nursing home operators for serving specialized populations to demonstrated compliance with the prevailing standards of care for serving those populations.
7. Promote and develop community placement & transition opportunities, including outreach and education for residents and guardians about community placement possibilities.
8. Reduce reliance on segregated, institutional settings, aligning with the Americans with Disabilities Act's community integration requirements and the U.S. Supreme Court's *Olmstead* decision.²⁸

Detailed findings on quality of care and living conditions at Bear Mountain Worcester, staffing challenges, and state oversight deficiencies are provided in the sections below.

II. Applicable Nursing Home Standards and Systemic Problems

A. Staffing and Quality of Care Standards

The problems DLC uncovered at Bear Mountain relate to quality-of-care concerns particularly dominant in the for-profit nursing home industry, and the Commonwealth's insufficient enforcement of quality-of-care standards and lack of standards for neurobehavioral units in long-term care facilities.

Nursing homes have long been associated with deficient care, understaffing, and an ill-prepared and under resourced workforce responsible for the care of a vulnerable population.²⁹ Following Congressional hearings and a 1986 Institute of Medicine (IOM) study documenting widespread abuse and neglect of nursing home residents,³⁰ Congress enacted broad protections and standards under the Nursing Home Reform Act of 1987.³¹ The statute establishes quality of care standards, survey, and enforcement requirements. Center for Medicare and Medicaid Services (CMS) is the federal agency that oversees nursing homes participating in Medicare and Medicaid and is responsible for ensuring the health and safety of nursing home residents across the country. DPH enforces these federal standards in Massachusetts. DPH has also promulgated licensing standards for long-term care, and EOHHS, which oversees DPH, sets state Medicaid rates for nursing homes.

Maintaining sufficiently trained staff is a cornerstone of quality long-term care. In 2001, CMS provided Congress recommendations for the levels of staffing generally needed to adequately care for nursing home residents: 4.1 hours total care per long-term care resident per day, including 2.8 hours nurses' aide per resident and .75 Registered Nurse (RN) time.³² The majority of nursing homes fall short of federal recommendations,³³ considered the "bare minimum," according to Charlene Harrington, a leading researcher on nursing home staffing levels and quality.³⁴ State minimum staffing standards, including Massachusetts standards, are generally well below the staffing levels recommended by researchers and experts.³⁵

Since April 1, 2021, Massachusetts facilities have been required to provide a minimum of 3.58 hours of total staff time per resident per day, of which at least 0.51 hours must be RN time.³⁶ However, that is a floor, and the Massachusetts regulations, like federal regulations, require each facility to provide appropriate and adequate nursing services and a sufficient number of trained, experienced, and competent personnel to provide appropriate care and supervision for all residents.³⁷ The levels of patient acuity directly affect the staffing truly required to provide appropriate care.³⁸ Each facility is responsible for assessing residents' needs and planning for adequate staffing.³⁹ Nursing turnover rates further influence the time needed for patient care to account for the extra training required,⁴⁰ as do the turnover rates for nurses' aides.

For-profit nursing homes are disproportionately associated with poor quality of care and lower staffing levels,⁴¹ and with higher antipsychotic drug use.⁴² Staffing is one of the higher costs in nursing home operations. Therefore, a leaner staff is more likely to return profits to investors. Particularly in for-profit homes that are investor-owned, the pressure to generate high, short-term profits is a strong incentive to reduce staffing and services, leading to pervasive neglect of nursing home residents.⁴³ In 2016, the *Boston Globe* found that Massachusetts for-profit nursing homes – comprising two-thirds of Massachusetts' nursing homes⁴⁴ – frequently devote less money to nursing care than do the nonprofit homes.⁴⁵

B. Behavioral Health Treatment Standards and Staffing

The residents in Bear Mountain’s neurobehavioral unit have varied conditions that are often co-occurring: psychiatric conditions; psychiatric conditions that are related to brain injuries, such as anxiety or depression; cognitive impairments; and various kinds of dementia and acquired brain injuries. Behavioral health standards for nursing homes certainly apply, but there is a void of standards for the long-term population with acquired brain injuries, including traumatic brain injury. While individuals with brain injury commonly go to nursing homes following acute care and rehabilitation, clinical literature indicates that they rarely receive interdisciplinary and specialized long-term care.⁴⁶

Nursing facilities that admit residents with behavioral health conditions must provide adequate services for them. Federal regulations set forth specific standards to meet behavioral health needs, relating to staffing, training, and the specific skills sets required to meet residents’ needs. Facilities must have sufficient staff with the appropriate competencies and skill sets to meet the behavioral health needs of residents.⁴⁷ Staff must have appropriate training and supervision to care for residents with the mental and psychosocial disorders identified in the facility assessment, and the regulations specifically require competency and skills in implementing non-pharmacological interventions.⁴⁸

Federal regulations further require that each resident must also receive the necessary behavioral health care and services in accordance with a comprehensive assessment and plan of care. Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. Similarly, a resident who has dementia must receive the appropriate treatment and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being.⁴⁹

Massachusetts’ nursing homes have admitted a higher number of individuals with psychiatric diagnoses than the national average,⁵⁰ and as of 2016, had the highest numbers of residents with serious mental illness (SMI, as CMS defines the term) on the East Coast – nearly one third of its residents were considered to have SMI.⁵¹ However, Massachusetts has no specific licensing standards related to behavioral health. Massachusetts long-term care regulations require generally that facilities admit and care for only those individuals in need of long-term care services for whom they can provide care and services appropriate to the individual’s physical, emotional, behavioral, and social needs.⁵² The high number of psychiatric conditions may also be related to Massachusetts’ development of long-term neurobehavioral units, including Bear Mountain, which have also attracted residents of other states lacking such facilities.

As part of a slate of regulatory changes to Medicaid nursing home rates effective October 2022, nursing facilities are eligible for added funds for residents who exhibit behavioral symptoms.⁵³ Additionally, if the facility’s population in FY 2019 included 25% or more residents with a higher severity of symptoms, the facility is eligible for an upward adjustment to its overall nursing and operating standards rates.⁵⁴ Facilities are financially rewarded for a high patient acuity – but not for implementing good practice measures for ameliorating or resolving behavioral health symptoms and maintaining stability.

Massachusetts also has a MassHealth Medicaid rate for “Severe Mental and Neurological Disorder Services,” which includes various assessment and rehabilitative services, and specially trained professionals on-site.⁵⁵ On-site psychiatry and neurology are necessary to adequately care for a population of this complexity. A minority of Massachusetts nursing homes advertising

specialized neuro-rehabilitative or behavioral health management qualify for this rate; all are for-profit nursing homes.⁵⁶ Bear Mountain is among the nursing homes that do not qualify.⁵⁷

Of note, in July 2023 EOHHS began to implement care coordination services for nursing home residents who are found to have SMI under the federally required screening process described below, as well as transition case managers to support discharge planning for residents with SMI. Nursing homes are required to work with and support these services.⁵⁸

C. Screening Requirements for Nursing Home Admissions and Reviews of Individuals with Serious Mental Illness (SMI) or Intellectual Disability/Developmental Disability (ID/DD)

Federal screening and review requirements for SMI and ID/DD are of special importance to DLC's review of Bear Mountain's neurobehavioral unit. The federal Nursing Home Reform Act sought to limit inappropriate nursing home admissions of individuals who have psychiatric disability (termed "serious mental illness" in the statute) and/or intellectual disability/developmental disabilities⁵⁹ (ID/DD) by requiring independent evaluations for such disabilities⁶⁰ and the necessity of nursing home care. CMS regulations set forth requirements for these screening and evaluations, called "Preadmission Screening and Resident Review" (PASRR).⁶¹ Reviews must be conducted prior to a nursing home admission, and for a nursing home resident when there is a significant change in the resident's condition.⁶² Massachusetts defines "significant change" as a major decline or improvement in more than one area of an individual's health, and requiring review of the interdisciplinary care plan; individuals who have been identified with SMI since November 2020 also receive an annual review.⁶³

For people who need nursing home care, the evaluations also identify services and supports to address needs related to the individual's identified disability.⁶⁴ Services that are beyond what would be included in the nursing facility's daily rate are called "specialized services"⁶⁵ and are provided by resources from outside the nursing home.

States define the specific specialized services, and develop their own screens and processes for complying with federal law.⁶⁶ Unfortunately, repeated federal studies have found shortcomings in states' PASRR processes, resulting in continued inappropriate admissions into nursing homes with insufficient services.⁶⁷ These services should also ensure continuity of care to effectively support a return to the community.⁶⁸ In Massachusetts, specialized services for individuals determined to have SMI under PASRR include psychiatric evaluation and psychotherapy services, neuropsychiatric evaluation, and certain substance use disorder treatment services.⁶⁹ DLC requested PASRR screens and evaluations of the residents we reviewed to check the quality of these reviews and the impact of any recommendations for services on patient treatment. Our findings are incorporated into the case discussions and systemic findings below.

D. Psychotropic Drug Use in Nursing Homes and Massachusetts Rates

Despite CMS' express requirement that staff have competencies and skills in nonpharmacological interventions to meet residents' behavioral health needs, psychotropic drugs are a dominant part of nursing homes' approach to behavioral health treatment and dementia care. CMS defines a psychotropic drug as any drug that affects brain activities associated with mental processes and behavior: such drugs include, but are not limited to antipsychotic, antidepressant, anti-anxiety, and hypnotic drugs.⁷⁰ Antipsychotic medications are powerful drugs

approved by the FDA for treating psychosis associated with specific conditions, such as schizophrenia. They also carry the risk of potentially harmful side effects. The risk of adverse consequences increases depending on factors such as the individual's age, and the number and types of other medications prescribed for the individual.⁷¹

Risks are not limited to antipsychotic drugs. Older adults are especially vulnerable to several side effects of antidepressant medications, including cognitive impairment and risk of falls, as well as anti-convulsants, which are prescribed off-label for their sedative effects.⁷² American Psychiatric Association (APA) guidelines warn that long-term use of benzodiazepines is harmful,⁷³ and the American Geriatrics Society also cautions that benzodiazepines and other sedative-hypnotics should not be first choice in treating agitation, insomnia, or delirium.⁷⁴ These classes of drugs pose significant risks to patients and, for those 65 and older, more than double the risk for cognitive impairment, delirium, and falls.⁷⁵

Since 1987, the Nursing Home Reform Act has proscribed the use of psychotropic drugs as chemical restraints to control or sedate nursing home residents for the convenience of staff.⁷⁶

CMS regulations have long required that residents be informed about the risks and benefits of any medication (or other proposed treatment), and have the choice to refuse a medication.⁷⁷ CMS pharmacy regulations have also long required that the resident's drug regime be free of unnecessary medications, which include drugs that are given in excessive doses, for excessive duration, and are not adequately monitored.⁷⁸ Residents who use psychotropic drugs must receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.⁷⁹

Nonetheless, psychotropic drugs are widely used. Nursing homes administer psychotropic drugs to 80 percent of residents nationwide, with 21.1% of residents prescribed antipsychotic drugs.⁸⁰ Poor quality ratings, for-profit ownership, and low staffing levels - particularly of nurses - are associated with higher levels of psychotropic and antipsychotic drug use.⁸¹

At Bear Mountain, administrators in October 2021 reported that nearly the whole population is prescribed psychotropic medication (though according to the documentation provided, it was somewhat less prevalent), with nearly half prescribed antipsychotics. Bear Mountain at Worcester's reported use of antipsychotics for 43.75% of residents in Q3 2022, an increase from 41.67% in Q2 2021. In Massachusetts, the rate is 24.38% (the seventh highest in the country) and rose from 22.2% in Q2 2017.⁸² Especially high rates of antipsychotic usage are found in the nursing homes with neurobehavioral and behavioral units.⁸³

The following summarizes the risks and usage of medications for a range of conditions at Bear Mountain:

Antipsychotics and Dementia

In 2008, the Food and Drug Administration's (FDA) issued a "black box" warning against the use of antipsychotic drugs on elderly patients with dementia because of increased mortality, as well as risk of Parkinsonism, falls, heart attacks, and strokes.⁸⁴ The risks increase with higher doses and may be higher for some drugs than for others.⁸⁵ The standard of care is not to use antipsychotics as the first choice to treat behavioral and psychological symptoms of dementia, such as aggression or other disruptive behaviors.⁸⁶ If antipsychotics must be used, the individual should be closely monitored for side effects including tremors and dehydration, and falls; the drug should be administered in the lowest dose and for the least time needed.⁸⁷

Despite the FDA warnings, nursing homes have often used these drugs to subdue residents exhibiting the behavioral symptoms of dementia,⁸⁸ a highly risky and non-FDA approved, or "off-label" use of such drugs. After a 2011 OIG (Office of Inspector General) report found that

less than half of nursing homes' Medicare drug claims for antipsychotic drugs were medically acceptable,⁸⁹ CMS sought to limit misuse by requiring nursing homes to report antipsychotic drug use for long-stay residents and lowering the homes' quality ratings for high usage.⁹⁰ CMS also developed a focused surveyor instrument on dementia care,⁹¹ and instructed state oversight agencies to emphasize a person-centered approach to dementia care. Nursing homes are warned not to resort to the use of medications as a 'quick fix' for behavioral symptoms, but to employ "a holistic approach that involves a thorough assessment of underlying causes of behaviors and individualized, person-centered assessment" by an interdisciplinary care team, which should include a physician.⁹²

Non-pharmacologic interventions, such as psychosocial interventions, can effectively reduce agitation and behaviors associated with dementia.⁹³ Dementia-specific de-escalation tactics such as Gentle Persuasive Approaches often work well to redirect agitated patients with dementia, and can significantly reduce aggressive behaviors.⁹⁴ These approaches are also promising for managing aggression associated with other conditions, including psychiatric disorders.⁹⁵ However, staff who are stretched thin caring for complex patients are less likely to implement improved care practices such as psychosocial interventions to limit psychotropic drug use.⁹⁶

At Bear Mountain in 2021, twenty-two of 27 residents with dementia received sedatives, antipsychotics, or both, with four receiving antipsychotics expressly for dementia.⁹⁷

Antipsychotics and Treatment of Schizophrenia and Other Psychiatric Conditions

Studies increasingly show negative effects from long-term use of antipsychotics in the treatment of schizophrenia.⁹⁸ Many of these concerns also apply to long-term use for other psychiatric disorders. **Bear Mountain has numerous long-term residents who have significant psychiatric histories, and commonly treats these disorders primarily with psychotropic medications, including antipsychotics.**

The APA practice guidelines recognize the long-term risks of anti-psychotic medications include weight gain, sedation, and movement disorders.⁹⁹ Older individuals may be more sensitive to medication side effects, including tardive dyskinesia.¹⁰⁰ Maintenance on antipsychotics requires careful monitoring for side effects and reevaluation of treatment preferences.¹⁰¹ Long-term usage can even reduce recovery and increase symptoms,¹⁰² and has been associated with lower cognitive functioning.¹⁰³ If antipsychotic medication improves symptoms, such treatment should be implemented in the context of a person-centered treatment plan that includes nonpharmacological treatments for schizophrenia, including specific goal-oriented and problem-solving psychosocial interventions.¹⁰⁴

Psychotropic medications of all classes, including antipsychotics, are used in greater proportions in nursing homes with high rates of SMI.¹⁰⁵ A study of Rhode Island nursing homes found that nursing home residents with dementia were less likely to receive antipsychotics than residents with psychiatric diagnoses, suggesting that quality control targeting prescriptions for dementia had some impact. However, when staff employed behavioral care plans to address behavioral problems, including residents with psychiatric diagnoses, antipsychotic usage was lower.¹⁰⁶ For-profit ownership was also associated with higher antipsychotics use, suggesting that the more staff-intensive behavioral management techniques were less likely to be used with residents in the for-profit facilities.¹⁰⁷

Bear Mountain exhibited a similar phenomenon to the Rhode Island nursing homes: Nearly all (23 of 24) residents with schizophrenia or schizoaffective disorder received antipsychotics (96%), a far higher proportion than the residents with dementia (63%). Large numbers of residents carried other psychiatric diagnoses (bipolar disorder and major depressive disorder, anxiety, and depressive disorders), and were prescribed psychotropic drugs for symptoms of these disorders, including antipsychotics for bipolar disorder. As discussed below, individualized behavioral plans were not employed for residents with psychiatric conditions and/or neurocognitive disorders.

The Rhode Island study is also significant for the noted increasing number of younger residents with psychiatric diagnoses, who are disproportionately persons of color, and who are more likely to live in lower quality, for-profit nursing homes.¹⁰⁸ **Many long-term residents entered Bear Mountain at a young age relative to the nursing home population, often with a combination of psychiatric and neurocognitive disabilities, and histories of alcohol or substance use are common.** In a recent exploratory study in Massachusetts, nursing home administrators observed increased admissions of younger individuals with more acute psychiatric and substance use disorders, and the struggle to serve this population – in particular, the difficulty of finding staff who are qualified to work with them.¹⁰⁹ DLC identified this issue in our correspondence with EOHHS following prior nursing home monitoring work,¹¹⁰ and confirms the impact of staffing challenge in this investigation.

Antipsychotics and TBI

Bear Mountain has a significant population with traumatic brain injury (TBI), a type of acquired brain injury (ABI) who are treated with psychotropic medications, including antipsychotics.¹¹¹ Antipsychotics are frequently prescribed for the treatment of TBI, especially to manage the agitation and aggression that frequently accompanies TBI.¹¹² However, there is not currently any antipsychotic licensed for the treatment of aggression following TBI, and their use is controversial.¹¹³ Studies have found significant risks associated with antipsychotic use following TBI, and minimal benefits. Generally, studies indicate that antipsychotics impair the recovery process after TBI, because they inhibit the progress in compensatory behavior. The potential for progress by adopting compensatory behaviors can exist for years following a TBI. In some cases, the use of antipsychotics can exacerbate TBI-induced behavioral deficits. Risks include delayed motor recovery, reinstatement of deficits after recovery, impaired cognitive function (such as spatial learning), and central nervous system depression and catalepsy.¹¹⁴ Moreover, the use of antipsychotics lowers the threshold for seizures. Risk of seizures is a common consequence of TBI and other kinds of ABI, remaining for years following moderate to severe injuries.¹¹⁵

Overdiagnosis of Schizophrenia

CMS excluded from the 2011 antipsychotic reporting requirements diagnoses of schizophrenia, Huntington's, and Tourette's syndromes because of the accepted use of antipsychotics for these conditions. Years later, a 2021 OIG report found that nearly one-third of residents were reported to CMS as having schizophrenia but did not actually have any Medicare service claims for that diagnosis, strongly suggesting that the diagnoses were falsely inflated to circumvent reporting.¹¹⁶ Seeming inflation of the diagnoses was documented in Virginia and Massachusetts.¹¹⁷ In 2021, a New York Times investigation found examples of blatant

fabrication of schizophrenia diagnosis in order to prescribe antipsychotic medications without triggering the reporting requirement.¹¹⁸

In 2022, CMS conducted pilot audits of nursing facilities believed to have inaccurately coded for schizophrenia. CMS found an absence of comprehensive psychiatric evaluations and behavior documentation. The behaviors that were sporadically noted in their medical records related to dementia, rather than schizophrenia.¹¹⁹

At Bear Mountain in October 2021, 24 residents of 133 residents were diagnosed with schizophrenia or schizoaffective disorder¹²⁰ (with 23 receiving antipsychotics), or 18% of residents. This is a very high rate, compared to the 1% of the population who are diagnosed with schizophrenia.¹²¹ Residents who had schizophrenic diagnoses¹²² constituted 31% of those prescribed antipsychotics in October 2021. There was a wide disparity between the risk adjusted rate, which excludes schizophrenia (29.8%), and the full non-risk adjusted rate (41.67%).

While review of Medicare service claims to confirm diagnoses was beyond DLC's capacity and the scope of this investigation, DLC notes both the absence of comprehensive psychiatric evaluations in most of the eleven records reviewed, and the confluence of conditions which could be sources of symptoms, discussed in detail below, suggesting that the diagnoses may not be well-supported.¹²³ For example, people are frequently diagnosed with schizoaffective disorder because of psychotic symptoms, which in fact may be similar to symptoms related to neurologic disorders, such as seizures or Parkinson's Disease, or Lewy Body dementia.

E. State Agencies' Weak Enforcement of Nursing Home Standards

Inadequate oversight and enforcement cannot sufficiently remedy or deter profound deficiencies in nursing home care.¹²⁴ State agencies are responsible for licensing and surveying nursing homes to ensure they meet both state and federal standards.¹²⁵ Surveyors must conduct surveys annually and conduct additional inspections in response to complaints.¹²⁶ The surveyor's notice of deficiency rates its scope and severity. State agencies, sometimes in conjunction with CMS, can and should take responsive enforcement action.¹²⁷ However, surveyors frequently fail to identify nursing home deficiencies, and underrate serious deficiencies in scope and severity.¹²⁸

The Inspector General for the U.S. Department of Health & Human Services has found that in many states, including Massachusetts, surveyors have had difficulty meeting CMS requirements for timely complaint investigations.¹²⁹ Massachusetts' State Auditor confirmed this result, finding that it took an average of *41 days to begin investigations of high priority cases* – whose investigations are required to be completed within 10 days.¹³⁰ A recent U.S. Senate Special Committee on Aging report further found that many states, including Massachusetts, fail to meet annual survey requirements.¹³¹

Bear Mountain's annual survey for 2023 was six months late, following eighteen months after a February 2022 survey which identified 93 deficiencies.

Budgetary constraints generally limit the amount of time available for the surveys and the frequency of surveys.¹³² Massachusetts surveyors are stretched thin,¹³³ and many have limited

experience due to high turnover, attributed to low salaries.¹³⁴ Further, Massachusetts nursing homes can contest citations in an informal dispute resolution (IDR) process which tends to favor the homes. A panel reviews the citations, a majority of whose members either represent or have worked for nursing homes. A substantial number of citations are voided on appeal.¹³⁵

Citations for staffing deficiencies are rarely given, despite the prevalence and impact on patient care.¹³⁶ State surveyors often do not examine resident acuity, which determines the appropriate staffing levels, nor the staffing levels themselves.¹³⁷ A recent *USA Today* investigation found that nurses were often pressured to avoid speaking with surveyors or falsify staffing data, and some feared termination. Others were concerned they would be held personally accountable for poor care caused by understaffing.¹³⁸ Surveyors also reported pressure to reduce citations and fines, often from nursing home groups wielding political influence.¹³⁹

Similarly, there are few survey citations for violations of the antipsychotic administration standards.¹⁴⁰ Even when there are citations, they are classified as causing “no harm” to residents 99.5% of the time nationally – and 100% in Massachusetts.¹⁴¹ A large Center for Medicare Advocacy study describes the pressures and obstacles faced by surveyors in citing nursing homes for misuse of antipsychotics.¹⁴² Assessing compliance surveys relies heavily on record reviews, staff interviews, and are time-consuming. Surveyors responded that they lack the time to do a thorough investigation, aggravated by their own short staffing, and the poor documentation kept by facilities.

Further, many surveyors lacked sufficient pharmaceutical knowledge, clinical experience or training to review for misuse of antipsychotics, or other psychotropics. Surveyor supervisors often reverse or downgrade the few antipsychotic citations made, responding to pressure or concerns that the citation withstand the IDR process.¹⁴³ The lack of clinical experience further limits the surveyors’ ability to evaluate the quality of treatment and adequacy of staffing ratios, training and competencies – particularly relevant for a neurobehavioral program treating complex patients such as Bear Mountain.

III. Bear Mountain at Worcester

Bear Mountain treats complex patients, with multiple and varied needs. It advertises that it is a specialized skilled nursing facility providing neurorehabilitation for traumatic and non-traumatic acquired brain injuries (ABI),¹⁴⁴ ventilator weaning and management and care of medically complex patients.¹⁴⁵ It has two floors for patients with tracheotomies and complex respiratory care, including a twenty-bed ventilator unit. Many of these patients also have psychiatric, neurocognitive diagnoses, and/or ABI. The third and fourth floors are locked units with long-term patients who have cognitive disabilities, psychiatric disorders, long-term effects from brain injury, dementia, or combinations of these challenges. Each floor has the capacity for forty residents, but the census is generally closer to 35 on each floor. In 2022, its census ranged from 134 to 140 patients. Most of the individuals at Bear Mountain are long-term residents: the vast majority of its revenue is from Medicaid, both Massachusetts and out of state, with Medicare following far behind; a very small percentage was private pay.¹⁴⁶

A. Purchase by Bear Mountain HealthCare

In October 2019, Bear Mountain HealthCare, a for-profit LLC corporation, purchased Bear Mountain; at the time it was Wingate at Worcester. Wingate was also a for-profit corporate chain which operates skilled nursing facilities and senior residences. Wingate at Worcester was already performing poorly at the time of purchase; it held the lowest CMS 1 star rating in May 2019. Since the purchase, Bear Mountain has maintained the lowest 1-star rating, consistently scoring the lowest score on health inspection reports.¹⁴⁷

Bear Mountain HealthCare operates seventeen nursing homes in Massachusetts.¹⁴⁸ Bear Mountain HealthCare is in turn owned by a real estate investment trust (REIT), Sabra Healthcare REIT (Sabra REIT),¹⁴⁹ a publicly traded equity capital investment healthcare realty company that is shareholder owned.¹⁵⁰ It is structured as both a limited liability company (which shields the owners from personal liability, such as for malpractice claims) and a limited partnership. As a realty company, it is separated from the licensed operating entities, thereby further avoiding liability.¹⁵¹

B. Staffing and Cost Reports

Under Wingate, the nursing home met the 2001 federal staffing recommendations in October 2019, just before the purchase by Bear Mountain. Following the purchase, after meeting federal recommendations in the fall of 2020, Bear Mountain has dropped below them ever since, with particularly low ratios for certified nursing aides (CNA's).¹⁵² Bear Mountain's 2022 facility assessment calls for CNA staffing numbers that translate into 2.13 hours of CNA daily time per resident based on a census of 135. This estimated need below federal recommendations of 2.8 CNA hours per resident, and even the newly proposed minimum standard of 2.45 which is not yet in effect. Its actual reported staffing consistently falls below that.

CMS began publishing weekend staffing ratios as well as nursing staff and administration turnover rates in 2022. On weekends, Bear Mountain nursing fell below even the Massachusetts minimum staffing standards.¹⁵³ Nursing turnover for RN's during the prior twelve months ranged between 41% and 48%, with a total nursing staff turnover (including nurse aides) ranging between 35% and 54%. These low weekend and high turnover rates further bring down the quality of care for this highly acute and complex population. Thus, on a weekday, an RN

supervisor will cover a floor with an LPN or RN and three to four CNAs on duty for 40 residents, while on the weekends it can drop much lower. Call-outs can also occur at any time.

Massachusetts DPH penalized Bear Mountain for failing to meet Massachusetts minimum staffing requirements from January 2021 through March 2022.¹⁵⁴ As of DLC's last site visit in October 2023, staffing on the neurobehavioral units had improved somewhat from earlier monitoring.¹⁵⁵ As of the publication of this report, Bear Mountain's staffing ratios have improved overall, partly due to a small drop in the census, though they still fall short of the 2001 CMS staffing recommendations.¹⁵⁶

The statistics alone cannot describe the impact of low staffing, nor does it reveal staff absences that are not reflected in the payroll data. Resident's family members reported to DLC in 2022 that on many weekends, one CNA was left to tend for a whole floor. People who needed Hoyer lifts to leave their beds would simply be left in bed all weekend. One spouse and guardian for her husband, a long-time resident at Bear Mountain with a brain injury, reported that when she arrived to see him on weekends, he was routinely left in bed without even the television on for stimulation. It takes little to imagine the physical and behavioral consequences for the bedbound residents: pressure sores, poor hygiene, depression, and agitation.

Meanwhile, Bear Mountain revenue should be used to strengthen staffing and quality of care. The Center for Health Information and Analysis (CHIA) is the state agency which collects Massachusetts health information "to promote a more transparent and equitable health care system." Pursuant to state regulation, CHIA collects cost reports on an annual basis for health care facilities, including nursing facilities, as well as related management and realty entities.¹⁵⁷ The 2020 nursing facility cost report for Bear Mountain reveals a payment of \$949,715 in management fees from Bear Mountain to Bear Mountain Management Co. LLC, and \$423,507 in rental payments, which would presumably have been made to Sabra Health Care REIT. For 2021, the most recent report posted on the state CHIA website, Bear Mountain reported paying \$849,156 in management fees and \$375,504 in rental payments.¹⁵⁸

Notably, Sabra REIT Realty reports list lower rental payments from Bear Mountain to Sabra REIT than do the facility cost reports; however, the rental payments listed in Sabra REIT's reports escalate significantly each year: the \$332,552 rental payment listed from Bear Mountain in 2022 is a **56.6%** increase from the 2020 payment of \$212,342.¹⁵⁹ These disturbing increases in rental payments to the nursing facility owner warrant close scrutiny.

Bear Mountain Management Co.'s 2020 and 2021 cost reports reveal respective annual totals of \$9,735,993 and \$9,369,951 collected from all 18 nursing facilities.¹⁶⁰ The reports indicate that each year, the company paid \$628,320 in salaries to its three partners, who are also owners of all the nursing facilities and Bear Mountain Healthcare.¹⁶¹ In 2020, the company paid out \$245,538 to its nurse administrator (each of the facilities also have their own nurse administrators), as well as another \$219,657 to an individual who bears no stated title or relationship to the company.¹⁶² In 2021, the nursing administrator became a Director of Operations, and her salary increased to \$260,669. A second Director of Operations is also listed for 2021 and paid a total of \$218,440; a Vice President of Finance is also listed and received \$205,269.¹⁶³ The variance between years, lack of information about highly paid positions, and duplication of duties warrant close scrutiny.

CMS recently began producing performance reports of nursing home affiliated entities,¹⁶⁴ including all nursing homes owned by Bear Mountain Healthcare. The July 2023 report shows that for all the money spent upon administration and supposed quality assurance, Bear Mountain Healthcare facilities are doing poorly in staffing and health inspections and have a high turnover of registered nursing and nursing staff.¹⁶⁵

Although facilities are required to submit the facility, management, and realty reports annually, the Massachusetts Center for Health Information and Analysis (CHIA) has not yet published nursing facility cost reports for 2022. Although facilities are required to submit data on an annual basis,¹⁶⁶ CHIA has not processed and/or not disclosed, nor is the 2022 management company report available. Thus, any Commonwealth government oversight of facility financing must rely upon nursing facility data that is over two years old. CHIA fails to carry out its responsibilities for providing complete and timely information for oversight purposes.¹⁶⁷

C. Behavioral Health Treatment and Neurobehavioral Unit at Bear Mountain

According to Bear Mountain's 2022 facility assessment, 87 residents were found to have behavioral health disorders. However, the only staff training is in de-escalation (CPI) and dementia care. Bear Mountain does not provide foundational training in behavioral health or brain injury. In October 2021, Bear Mountain had 27 residents diagnosed with dementia, but at least 68 residents with one or more type of moderate to severe brain injury,¹⁶⁸ and 24 residents with schizophrenic diagnoses, as well as bipolar disorder, major depression and other depressive disorders, mood disorders and anxiety disorders. The facility assessment determined a need for 17 neurorehabilitation staff, but only three are assigned per day.

Bear Mountain does not receive or qualify for the MassHealth Medicaid rate for "Severe Mental and Neurological Disorder Services," which would include various assessment and rehabilitative services, and specially trained professionals on site.¹⁶⁹ On-site psychiatry and neurology are necessary to adequately care for a population of this complexity. The Bear Mountain staff nurses do not receive specific training in brain injury, behavioral health conditions or psychotropic medications and their side effects and are not registered as psychiatric clinical nurse specialists by the Board of Registration in Nursing.

The Neurobehavioral Program director position has not been held by a clinician. From May 2022 to December 2022, the director was a certified recreation director who led another neurobehavioral unit for years. In January 2023, Bear Mountain hired a CNA who had been an activities director for a behavioral health center for ten years. In October 2023, Bear Mountain hired an individual with a bachelor's degree in psychology. The plan for the program is to train support staff called behavioral technicians to run groups and become more actively engaged with residents. As currently constructed, one technician will be assigned for each floor of the unit.

Bear Mountain contracts with Health Drive for behavioral health services. The practitioners are a physician assistant (PA), who has seen residents at Bear Mountain since 2005, and a mental health counselor. These staff are at Bear Mountain on a weekly or biweekly basis. As of the March 2023 site visit, Health Drive behavioral health staff reported seeing all the residents of the neurobehavioral unit, and about half of residents on the remaining two floors. The PA is supervised by a psychiatrist at Health Drive, who does not come onsite to Bear Mountain at Worcester. The PA sees patients on a quarterly or monthly basis, depending on need. She recommends medications which are prescribed by Bear Mountain's medical director or a nurse practitioner.

The medical director is a physician responsible for coordinating medical care for all residents at Bear Mountain, and also has primary responsibility for the care of individual residents. DLC's record reviews confirmed that the medical director often relies on the PA's recommendation to prescribe psychotropic medication without seeing the individual. Bear Mountain also contracts for nurse practitioners from yet another agency, Ideal Health Solutions. Although the nurse practitioners see residents more often than does the medical director, the nurse practitioners

assigned to Bear Mountain rotate weekly.¹⁷⁰ The nurse practitioners are not certified in adult psychiatry. Despite Health Drive's contractual requirement for integrated team meetings, the two practitioners do not join interdisciplinary team meetings at Bear Mountain; this ended during the COVID pandemic and has not resumed.

At Bear Mountain, the majority of residents who have psychiatric conditions, acquired brain injuries, and dementia are prescribed psychotropic medications, as discussed in the above section. Notably, Massachusetts is one of the few states to strengthen the CMS consent requirement for psychotropic medications with written informed consent. EOHHS policy requires staff to discuss risks and benefits of medications with the resident or representative. However, according to guardians and active health care proxies for the Bear Mountain residents who reviewed and signed the consent forms, staff rarely discussed the risks and benefits of medications with them. If staff spoke with them about needing to add a medication or raise a dosage, it was not the more knowledgeable Health Drive PA, but rather the Unit supervisor (an RN) or one of the nurse practitioners.

C. DPH Surveys and Bear Mountain's Plans of Correction

The DPH inspection survey of February 2022 revealed a high degree of patient needs, low numbers of staff and staffing competency challenges, the apparent patterns of neglect at the facility, and the weakness of the survey process. The next survey was done eighteen months later (six months late) in August 2023. Both surveys with plans of correction are attached in Appendix A.¹⁷¹

In February 2022, the DPH surveyor noted repeated instances of neglect of residents' grooming, hygiene, and hydration needs. Several men were unshaven, and residents were observed with very long and dirty fingernails and toenails, and unbrushed teeth. Some were in dehydrated states, with dry mouths, lips with peeling skin, and creased tongues. There were not enough staff to feed the residents on the second-floor unit (for medically complex residents). Residents were not fully clothed, wearing johnny gowns untied at the back and exposing incontinence briefs; others appeared only in shorts. One resident, who depended on staff for assistance with all of her activities of daily living, told the surveyor that there were not enough staff to render the care needed, with long wait times for assistance.

Examples of neglect extended to other areas of care risking health and safety. One resident was noted to receive insufficient wound care, risking infection. For another resident who had the most serious pressure ulcers at Stage 4, treatments were not documented, and the mattress was not properly inflated to apply relief. Another resident had no footrests on his wheelchair and was seen wheeling himself about with his foot dragging on the floor. Staff failed to supply hand splints ordered for another resident whose hands curled from contractures. One resident fell multiple times from her wheelchair to the floor – including once near the nurses' station – and no staff assessed her for injury.

The surveyor noticed multiple medication errors, which were not consistently reported to the medical director. Staff failed to properly care for G-tubes, provide adequate respiratory care, failed to exercise infection control during dressing changes, and failed to use glucometer testing for a diabetic patient. Bear Mountain failed to have an infection control specialist.

The surveyor further noted several serious failures to implement plans of care in a sample of 29 residents. One example in particular illustrates the inactivity on the units. This resident was at risk for serious injuries related to falls, required caregiver assistance for all mobility needs, and had cognitive deficits. The plan of care required activity to manage his impulsive tendencies: prolonged bedrest and inactivity were to be avoided. Staff had to ensure that he was up in his

wheelchair before breakfast every day. On multiple occasions, the surveyor observed the resident lying in bed, watching television, and eating breakfast in bed. The nurses' aide told the surveyor that the resident was rarely out of bed, perhaps only twice a week.

Another extraordinary incident yielded only minimal citation by DPH: A resident, who had severe cognitive impairment and required full assistance for personal care, had vomited a black liquid into and all over his toilet, with the liquid found dried on his hands and gown. The morning shift nurse and CNA arrived at the unit and noticed a very foul odor on the unit emanating from the resident's room. They discovered the resident pale and sweating in the bathroom. Extraordinarily, the night shift nurse had noticed nothing out of the ordinary and documented that all was well on the unit. The resident was taken by ambulance to the emergency room, where it turned out the resident had a severe sepsis infection, bowel obstruction and aspiration pneumonia from inhaling infectious particles.

Clearly this resident had been growing steadily more ill and lived in an infectious environment, all overlooked by staff. However, the facility was only tagged for failure to notify the physician of the emergency room admission, and that few residents were affected by the deficiency. The facility responded in its correction plan that the nurse practitioner had been notified, and DPH accepted this response as resolving the matter. DPH failed to require root analysis of this incident which could only arise from long-standing deficiencies in hygiene and care. Had DPH adequately cited and analyzed this incident, surely a broader plan of correction would have been required.

The survey also cited deficiencies in behavioral health care. With respect to one sampled resident's behavioral care plan, the surveyor found that the facility failed to ensure that it has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents and failed to implement a care plan to meet the resident's needs for behavioral and emotional support.¹⁷² The surveyor noticed the resident in bed in the afternoon in apparent distress, repeatedly slapping his/her bare hip and pulling at the mattress. No staff responded and engaged with the resident. The following day, the surveyor heard repetitive banging from the same resident's room and found the resident trying to move his or her wheelchair but unable to turn the chair. Again, no staff responded. Finally, later that day, the surveyor noticed the resident in the wheelchair banging the wheelchair leg rest in the doorway, trying to exit her room. Yet again, no staff responded.

The Director of Social Services told the surveyor that "Unit Two had a combination of behaviors and residents that required a higher level of care, and that it was too much for one nurse and two CNAs to manage." A nurse confirmed to the surveyor that there were generally not enough staff on the unit to implement the care plan interventions for this resident. Though the resident was clearly in distress multiple times with no staff response, the incident was cited as having only minimal potential for harm with few residents affected. The DPH-approved Plan of Correction only involved "re-educating" staff that care plans for residents who "display behaviors" must include interventions to deescalate behaviors.

Significantly, even though Bear Mountain staff identified that low staffing was a source of the deficiency, it made no plan to increase staff, and DPH did not insist on such a plan.

The Plan of Correction further records several instances where the facility recognized, to its credit, that a noted deficiency applied to many residents. For example, the surveyor cited Bear Mountain for failing to provide a homelike environment to a resident whose room was bare of

any decoration or personal touches. In response, the facility planned to review all resident's rooms to provide a homelike environment to all. These efforts were not evident when DLC monitored a year later; but it did improve subsequently, by the time of DLC's October 2023 monitoring visit.

For all of the above, Bear Mountain was fined a total of \$101,117 with one payment suspension.¹⁷³ Without plans for correction to require sufficient numbers of competent staff to engage with residents and implement plans of care, such situations will be bound to repeat themselves and neglect of care will proceed unabated.

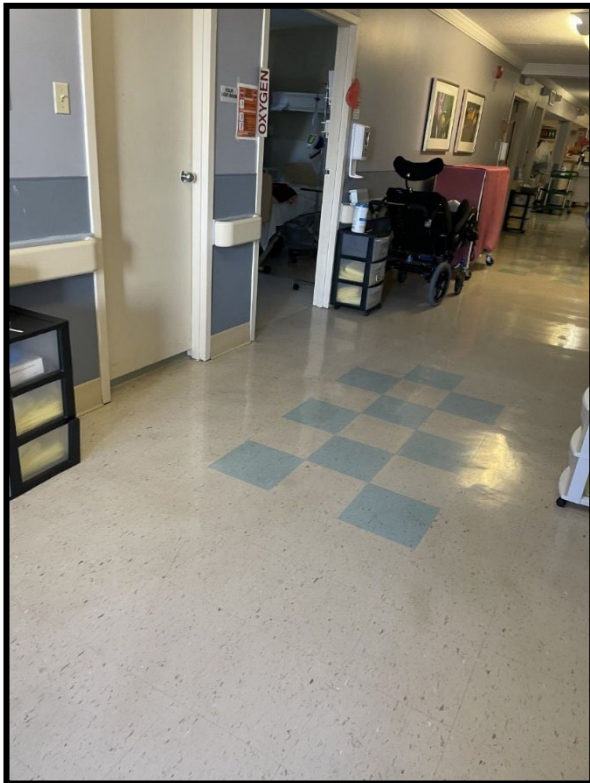
In fact, several Bear Mountain residents in DLC's sample were hospitalized for sepsis infections and effects of urinary tract infections (UTI) following the period of the February 2022 DPH survey. One was hospitalized multiple times in 2022 for sepsis infections, which became increasingly serious, leading to blood infections and organ failure in December 2022; another sample resident was hospitalized for a long-standing leg infection in April 2023.

Eighteen months later in August 2023, the DPH conducted its next annual survey. That survey cited failures to provide privacy for residents, evidence of stained clothing, an uncleaned and unhygienic room (with a foul odor), failures to follow care plans and standards of professional care with respect to G-tube medication administration and catheter care, and medication errors. A plan of correction was approved and implemented. Deficiencies regarding failure to follow behavioral care plans and the alarming incident of a person declining into sepsis infection were not noted. It is certainly possible that incidents of this severity did not occur within the surveyor's patient sample during the three-day survey period. However, without substantial improvements in staffing, training, professional oversight, and support, DLC is not confident that such incidents will not reoccur.

E. Site Visit Observations

When monitoring, federal law grants DLC unaccompanied access to all areas of a facility used by residents. DLC visited the facility in October and November 2021, July 2022, in February and March 2023, and in October 2023. With the exception of the last visit on October 23, 2023, DLC observations were consistent with DPH's 2022 observations of hygiene, inactivity, and the sterile environments of the vast majority of residents' rooms. Rooms were often bare and noticeably bleak, with dirty floors observed on DLC's weekend visit. Strikingly, conditions remained unchanged following the facility's approved plan of correction for the 2022 DPH survey. Smells of feces and/or urine were noted outside some of the rooms on the units. Many people were observed lying in beds in the middle of the day, sleeping or watching television.

Most rooms were like hospital rooms, with bare walls and no personal furniture. Most residents shared a room with one other person, with a curtain between them.



The hallways also had the feel and look of corridors on hospital floors.

The common areas for dining and activities also had little decoration.

Many residents wore johnny gowns in the middle of the day, and several were observed on each floor with the gowns open in the back exposing themselves, underwear, or incontinence briefs. On one visit, a resident was observed wearing a hospital gown instead of a shirt, with her bra exposed from the open back. Staff explained to DLC that there were not enough donated clothes to provide to residents and that laundry was not done on a timely basis. On the last visit, residents were not wearing johnny gowns, though most were not wearing shoes. A number of residents on all the visits were observed with matted hair, long fingernails, and stained clothing, some with dried food spills.

The temperature on the units was always very warm, with the exception of the October 2023 visit. Residents expressed being thirsty to DLC staff and had to go to the nurses' station to get water. Residents ranged widely in their abilities to walk, some were completely independent, and others used wheelchairs or rolling walkers. On all site visits, with the exception of the final announced visit, a striking number of residents were asleep in their beds in the middle of the day. On one occasion, a younger man on one of the neurobehavioral units walked down the hallway, coming very close behind DLC staff. He appeared to have no sense of boundaries and was not observed by facility staff. Such close contact could raise concern for other residents so approached and could be a source of conflict.

The February 2023 visit fell on Valentine's Day. A Valentine's Day party was held for residents on one of the floors of the neurobehavioral unit, that lasted about an hour. There were not enough staff to serve food to the fifteen to twenty residents who attended. Aside from the party and one bingo game on another occasion, DLC observed no activities or programs for residents on its several site visits. A schedule in small print was posted high on a wall in the common room, which functioned as a dining room; but the scheduled common room activities on the days of site of visits did not occur. There were also very few physical activities scheduled. This improved by the October 2023 visit with some new physical activities, such as Movement with Music.

The neurobehavioral program director during the February and March 2023 visits was a CNA. She wheeled a cart with coloring sheets and other table-top activities through the common areas. Some residents colored in the common room, while another dissatisfied person described these disparagingly as "kids' activities."

Residents seemed very appreciative of the opportunity to speak with DLC staff. Some residents were emotional and said that they felt lonely and wished the staff were more supportive. Many expressed that they were bored, others stated one must get used to the conditions, a number wanted to live in the community or return home. One resident on the third floor told DLC staff, after she turned on the television for a group of residents in the common



room, “We watch TV from after lunch to bedtime.” Residents reported more activities and less boredom on DLC’s last visit in October 2023.

The nursing staff’s lack of engagement with residents was striking. During DLC’s March 2023 visit, a woman on the fourth floor seated on a wheelchair was shouting at the unit manager, who was standing about twenty feet away at the nurses’ station. The manager did not engage with her and warned us to be careful. Our psychiatric nurse approached the woman and spoke with her. The woman engaged in conversation at a normal volume. When asked how long she had been there, she answered, “A long time, thirteen years.” When asked how long she had been in a wheelchair, she replied that she had been walking when she arrived there, but then about a year later she fell and has been in a wheelchair ever since.

On the second floor, where many residents require extensive physical assistance from staff, call lights/alarms were observed to go off for wait periods of 5+ minutes (with several staff at the desk and no sense of urgency observed). Throughout the facility, with the exception of the first-floor ventilator unit, nursing staff were primarily at the nursing desk, involved with electronic documentation or the medication carts, but not interacting with residents in the common rooms, the hallways, or in their rooms. Staff told DLC staff that there were staff shortages, and an LPN explained that she had to work long hours but was there to help. Some nursing assistants were observed assisting residents, but many residents asked DLC to turn on televisions, or told them they needed toileting, something to drink, or lunch to be served. It was clear that much more help was needed.

The building is situated in an area of the city that has little green space. The only space outside the building for use by residents is a bench and a picnic table under an awning.



The facility did not transport residents to parks or other areas for recreation or shopping. On one site visit, staff informed DLC that the van was broken; on another visit, that no one could staff the van. In February 2023, the administrator informed DLC that residents would require too much supervision for the facility to bring them to outside activities, as the residents would need to be on 1:1 and there is not enough staff to support that need. There are no volunteers who come into the facility, and no community-based programming brought in for residents.

Guardians and family members of residents have described rampant, serious infections that spread periodically through the floors, periodic rodent infestations at the facility, and mice and rats running through residents' bedrooms – many of whom are not capable of making a complaint. In February 2023, DLC observed a mouse trapped in a glue trap in a resident's room.

Guardians and family members informed DLC that there had been a neurobehavioral program in earlier years, and more activities for residents. Experienced staff have left Bear Mountain. One guardian, who is a licensed social worker, believed her two clients under guardianship would not need high amounts of medications if they had more activities. She also noted the lack of outings into the community, which existed previously.

On the final (announced) site visit on October 23, 2023, there were some striking improvements in the activities offered. The neurobehavioral unit director had become the activities director, and three more part-time activities staff had been hired for a total of six. A social event for the neurobehavioral program was held during the site visit, with about thirty people attending; enough staff were available to fully support residents. The activities staff were engaged with residents and gave them choices in what they would like. Residents were also more engaged with each other, laughing and joking, both at the party and afterwards in the hallways. Residents who had told DLC in earlier visits that they felt bored, said activities were now regularly held. Residents also showed DLC staff paintings that they had made. Residents could either decorate their rooms or hang the paintings in the common area. DLC observed fewer people sleeping in their rooms and people who were in bed were watching TV or listening to music. More of the walls in residents' rooms were decorated with personal photographs and pictures.

However, during DLC's last visit in October 2023, residents complained of still having very little access to the community and the outdoors. "We don't leave these four walls. I want to get out into the sunshine," one resident told DLC staff. Most of all, residents wanted to return home. DLC spoke individually with about fifteen residents during its last visit. All residents very much wanted to return to the community and were not aware of any plan to do so.

Staffing coverage on the neurobehavioral unit was overall somewhat improved since DLC's first site visit.¹⁷⁴ During the last visit, although people's hygiene appeared to have improved, poor oral hygiene and dental problems were apparent. Many residents wore old or stained clothing, and few wore shoes. Following the October 23rd site visit, the administrator told DLC that staff will soon be able to drive the facility van, and that trips will be planned to bring residents outside the facility.



IV. Bear Mountain Resident Profiles and DLC Individual Findings

DLC reviewed the records of eleven Bear Mountain residents, each of whom were complex patients. They needed, but did not receive, multiple professional services to confer and coordinate their plans of care. Nearly all of them lacked adequate neurologic or psychiatric assessments, which would bring together observations of various symptoms into one or two coherent diagnoses. They also needed ongoing interdisciplinary collaboration between psychiatry, neurology, nursing, medicine, and nutrition. There was no evidence of such communications discussing ongoing needs for monitoring and treatment adjustment.

The ages of the individuals reviewed ranged from early forties to late 60s, with most in their 50s and 60s. Some had lived there for decades. Four of the residents were admitted from a hospital in another state, with three of the longest stay residents from New York. While some psychotropic medication dosages were reduced and others discontinued, all eleven residents were on multiple long-term psychotropic medications. In many cases multiple seizure medications or multiple antipsychotics were prescribed without justification, or consideration of how they would interact.

Most of these residents experienced falls, some of them frequently, generally followed by inadequate assessment and interventions. Careful neurologic evaluations and physical exams were required, but were not done. Records contained no evidence that the PA, or other clinicians, were checking for certain serious symptoms from antipsychotics.¹⁷⁵ Many residents had verbal and, at times, physical conflicts with other residents and staff. Bear Mountain providers did not collaboratively explore the reasons for aggressive episodes, which may relate to seizures, infections, a metabolic imbalance, psychotropics, inactivity, sensory overload, feeling overcrowded, or interpersonal conflict. Infections were frequent among these eleven residents, with a number of them serious enough to warrant hospitalization.

These are DLC's findings, based on its review of residents' records and the reviews by its psychiatric nurse and neuropsychiatrist expert consultants, and DLC's discussions with residents' legal representatives.¹⁷⁶

The following three residents A.B., C.D., and E.F. needed neurological and neuropsychiatric evaluations, behavior management plans and medication reviews. C.D.'s somatic delusions became particularly physically harmful. All would have benefited from increased activities and programming:

Resident A.B.:

A.B. is a Massachusetts resident in his 60s, with a psychiatric history, a history of alcoholism and possible cognitive impairment following a stroke. He is diagnosed with dementia with behavioral disturbance, major depressive disorder with psychotic features, PTSD, seizure disorder and hearing loss. He was admitted to Bear Mountain in June 2020 from a geriatric psychiatric inpatient unit, following a hospital admission for escalating agitation, persecutory delusions, and psychosis, and increasing confusion at another nursing home.

A.B.'s guardian believes he needs more psychiatric support than he can receive at Bear Mountain, and that with this support, he can live in the community. He wants to engage with others and go out into the community, but he is largely idle at Bear Mountain and the facility does not provide outings. He used to have an internet account, helping to connect him to the outside world; but staff stopped assisting him with money management to support the account, so it has been cut off. His guardian believes that his

inactivity contributes to physical aggression, and that while psychotropic medications control the worst of his symptoms he could be on lower doses if given alternative therapies and activities.

A.B. has had episodes of physical aggression and verbal outbursts, including assaulting other residents, inappropriate sexual comments, delusions, and property destruction; he experiences audio hallucinations and dialogues with himself. A noted “trigger” for aggression is institutional living. He told the mental health counselor that he “just doesn’t like feeling like he is in jail,” after he had struck another resident who had entered his room and swung at A.B. because he was “yelling and swearing.”

In 2020, A.B. was sent to a hospital emergency department for sutures to his hand after he put his fist through a window, after staff denied his request to go outside. Later in his stay, he was taken again to the emergency department on a Section 12 emergency admission,¹⁷⁷ after threatening to kill himself by hanging and threatening staff. In the hospital emergency department, he struck and kicked staff. He was kept there for four days, received multiple emergency injections of psychotropic medications, and was held in a four-point restraint. A search for a geriatric psychiatric bed was unsuccessful and he returned to Bear Mountain. Despite the significant change in his condition which should have required a PASRR evaluation, Bear Mountain did not complete one. Six months later, he was admitted to the emergency department again under Section 12 after throwing a chair through a window and threatening to hang himself with a belt.

Despite these serious incidents and the Health Drive PA’s recommendation that A.B. can benefit from a behavior management plan, Bear Mountain did not develop such a plan. Neither have Bear Mountain staff developed an interdisciplinary plan to address his behaviors or symptoms. Although PTSD is repeatedly noted as a diagnosis, the behavior health providers never addressed it with him, and he has received no specific treatment or therapy for it.

The reasons for A.B.’s hallucinations, impulsive aggressive episodes and intense physical outbursts need to be fully explored. These could be related to seizures or other neurologic abnormalities, latent effects of alcoholism, including nutrient deficiencies.¹⁷⁸

Antipsychotics could also be contributing to his physical aggression. A.B. would benefit from a neuropsychiatric evaluation to clearly explore the impact of cognitive impairment on his behaviors and serious mental illness, including PTSD, and to inform solid treatment interventions, medications, and planning for community-based treatment, supports, and housing, which he strongly desires and which his guardian supports.

Resident C.D.:¹⁷⁹

C.D. is a Massachusetts resident in her 60s with a long psychiatric history, as well as medical conditions of Parkinson’s and chronic kidney disease. She was admitted to Bear Mountain’s behavioral unit in 2021 after a six-week stay in a geriatric psychiatric inpatient unit. Clinicians at the inpatient unit confirmed a diagnosis of schizoaffective disorder, and also suspected borderline personality disorder. In the geriatric psychiatric unit, C.D. was active in several therapeutic groups and programs daily. The unit’s discharge plan recommended that she continue to participate in daily activities to provide opportunities for engagement and socialization.

Following C.D.’s transfer, Bear Mountain lacked the therapeutic milieu, integrated care, and sufficient clinical support to maintain C.D.’s stability. After an early episode of extreme agitation, the Health Drive PA recommended “behavior management,” but made no specific recommendations. A thorough analysis of the reasons for agitation was not done, and C.D. escalated with more aggressive behaviors. Staff maintained “safety

measures” but used no behavior management interventions. This became typical of her stay: C.D. was frequently brought to emergency rooms and at times hospitalized, stabilized, then invariably deteriorated again at Bear Mountain with persistent and increasingly profound delusions about her body, also known as somatic delusions. As a result of these delusions, C.D.’s physical health and ability to care for herself deteriorated. In 2022, C.D. became increasingly isolated and lost weight, remaining in bed and rejecting solid food. At this point, it is likely that she developed nutrient deficiencies which may have contributed to her delusions. Bear Mountain did not develop an interdisciplinary or behavioral treatment plan for C.D., nor did it seek an alternative permanent placement for her that would adequately address her needs for psychiatrically supportive treatment integrated with personal care support and nursing supervision, social activities, and that would be closer to her family.

C.D. also suffered due to lack of psychiatric inpatient resources. During one inpatient stay just weeks following her admission to Bear Mountain, C.D. received high doses of sedatives and chemical restraints for agitation and threats. This was only a temporary solution, and did not address the cause of her behaviors. The hospital searched for a geriatric psychiatric hospital bed, but with no beds available, she was discharged back to Bear Mountain because she was calmer with some medication adjustments. Thereafter, Bear Mountain did not follow that hospital’s discharge plan for C.D. The hospital recommended a behavior management plan and provided specific recommendations for the plan,¹⁸⁰ which Bear Mountain did not implement. A PASRR was also conducted following her return to Bear Mountain, because of the significant change in her condition. That PASRR evaluation confirmed SMI and recommended a behaviorally based treatment plan, as well as a neurology assessment, noting a history of seizures and mild cognitive impairment. Again, these recommendations were not implemented. The Health Drive PA recommended medication changes in response to worsening anxiety and auditory hallucinations, but the root causes were not explored. C.D.’s medical history suggests several possible reasons for the psychosis, including Parkinson’s and a seizure disorder, which would potentially worsen with certain psychotropics. C.D. remained unstable, transferring to hospital emergency rooms because of suicidal ideations and command hallucinations on an almost monthly basis for the next several months. Each time, she returned to Bear Mountain after denying suicidal thoughts in the emergency room.

As C.D.’s somatic delusions worsened,¹⁸¹ she lost weight dramatically. The weight loss would undoubtedly lead to nutritional deficiencies, such as the B-vitamins, and in particular, thiamine, which would then lead to neuropsychiatric exacerbations. After losing 22 pounds in February 2022, C.Z. was sent again to an emergency room for psychosis and weight loss, and at last obtained a psychiatric inpatient unit admission for nearly three weeks. The hospital changed her medications, removing one antipsychotic, and her somatic delusions lessened and disappeared, suggesting she had been heavily overmedicated. She improved in her self-care, eating and drinking, and also walked independently and safely without the assistance of a walker.

Yet, a few days after her return to Bear Mountain her somatic delusions returned.¹⁸² Bear Mountain then failed to take advantage of the hospital’s offer to readmit her if there were further issues. Her delusions persisted, and her psychosis increased. She began to refuse to leave her room and reported depression. Bear Mountain’s medical director ordered a neurological evaluation, but noted that Health Drive does not provide the evaluations.

The evaluation was never done. This is particularly harmful in that C.D. has at least two significant neurologic disorders per the chart – Parkinson's and Seizure Disorder. In the summer of 2022, C.D. became upset that her mother's health was worsening; she refused her long-acting antipsychotic medication, became increasingly delusional and stopped eating solid food, stating her teeth and gums fell out, and mainly stayed in bed and was incontinent (her incontinence was not evaluated). This is particularly troubling because urinary incontinence may suggest bladder dysfunction, urinary retention, and urinary tract infections, which can lead to sepsis; also, urinary retention is very painful and, for patients, whose communication is poor, can cause severe agitation. Her functioning continued to decline through the summer, and she required extensive assistance with her activities of daily living.

The Health Drive PA noted her severe depression, poor appetite and weight loss, and psychiatric struggle, and adjusted her mood stabilizer; but neither Health Drive nor facility staff sought a hospital admission. Marked changes are almost always of a physical or metabolic cause. C.D. was also likely malnourished at this time and declined in her neurologic functioning. She refused a blood draw to measure her levels of micronutrients; the nutritionist ordered a multivitamin with minerals, which would only have helped marginally; some of the nutrients need to be given I.V. for better absorption. Her sister, who was her active health care proxy, was not contacted concerning the lab refusals. . .D. stopped walking, told the Health Drive PA she did not eat because her hands shake, and had tactile hallucinations, believing there is a nail sticking out of her mattress into her rectum.

As C.D. became increasingly immobile, her incidents of UTI and other infections increased. She required hospitalization and ICU treatment for septic shock related to UTI in April 2022 following her first period of weight loss, and again in June for sepsis related to a gastrointestinal infection.

Staff failed to coordinate full workups to discern the root causes of her serious symptoms as well as infections, including collaborative consultations from the neurologic, psychiatric, medical and nutritional disciplines. These consultations should have informed an interdisciplinary plan of care. The facility failed to consistently seek hospitalization when C.D. deteriorated beyond the treatment capabilities of the facility. C.D. likely has borderline personality disorder, which can further complicate treatment when it is not addressed therapeutically. Bear Mountain also failed to refer C.D. for PASRR Level 2 evaluations when she met the criteria for significant change in her condition during patterns of emergency room admissions and for each inpatient hospitalization.

Postscript: In December 2022, C.D.'s family notified DLC that C.D. was hospitalized for acute septic shock, her fourth bout that year. Her brother, who saw her the day she arrived at the hospital, was appalled at her neglected condition: not only did she have a raging infection, but she also arrived at the hospital in a neglected, unkempt condition, with vomit on her clothes, matted hair, and long fingernails. DLC obtained the hospital records and confirmed that C.D. was admitted in extremely weak condition with dehydration and in abdominal pain after vomiting at the facility, with low blood pressure, and was found to be critically ill with organ failure. She was further diagnosed with a UTI, colitis, and acute kidney injury. She had altered mental status and confusion due to acute metabolic encephalopathy. She was admitted to the ICU, ultimately stabilized with IV fluids and antibiotics, and returned to Bear Mountain on continued antibiotics for UTI.

C.D. was then re-hospitalized two weeks later with UTI and fever, again with nausea, vomiting, and abdominal pain. Records noted that she appeared malnourished. The hospital diagnosed lithium toxicity in her kidneys, as well as the spread of her UTI to her kidneys. C.D. was stabilized with IV antibiotics. She also received physical therapy and occupational therapy assessments, recommended treatment for decreased mobility, gait locomotion and balance, ADL retraining, transfer training, and strengthening – all of which she long needed. Her family and C.D. did not want her to return to Bear Mountain, and she is now living in a nursing home closer to her family.

Resident E.F.:

E.F. is a New York resident in his 60s, who has resided on Bear Mountain's neurobehavioral unit since 1998. He was discharged from a psychiatric center in New York, where he had been hospitalized for several years, to Bear Mountain (then called Worcester Skilled Care Center) for neurobehavioral programming. E.F. has a history of seizures since childhood, and at the time of his admission was also diagnosed with major depression and a personality disorder. When hospitalized in New York, he was described as having aggressive tendencies and being poorly groomed and incontinent, angry, and verbally abusive, self-mutilating, and hypersexual. The reasons for his behaviors appear not to have been understood.¹⁸³

A report concerning E.F.'s progress for the year 2004 suggests that, at one time, the neurobehavioral program was far more developed at this facility. That year, he attended vocational programs, structured education groups, and spiritual/relaxation/meditation groups. The structured groups targeted such areas as social skills, money management, time management, self-awareness, and independent living skills. E.F. also attended walk/exercise groups, musical entertainment, parties & games. In addition, behavioral incentives and management included a token economy, consistent limit setting, and redirection to quiet areas when assaultive, agitated, or anxious. A behavioral team monitored E.F. with close-observation checks. The progress report concluded that his maladaptive behaviors had decreased and were less physically threatening. According to the report, quiet time and de-escalation effectively prevented more aggressive behaviors. In contrast, E.F.'s records from 2020-2022 show that he was regularly involved in assaults on other residents, and was often the aggressor. There was no formalized behavioral program or behavioral management plan in place to address E.F.'s behaviors, other than instructions to redirect or distract him. E.F. reported considerable delusional content, including tactile hallucinations, which may have been the basis for a schizoaffective disorder diagnosis sometime after his admission, but could also be related to his history of seizures. E.F. continued on an antipsychotic medication which he had been taking for decades; Bear Mountain increased his antipsychotic medication over the year 2022, as well as a benzodiazepine. He was also diagnosed with mild intellectual disability, but never received a PASRR review for ID/DD. E.F. was in need of a multidisciplinary workup, including neurology and psychiatry, to determine the reasons for increased delusions and aggression, and the kinds of individualized programming and techniques which could reduce aggression and promote positive behaviors; or to review the possible impact antipsychotic medication could have upon seizures.

E.F. also has frequently fallen – possibly due to antipsychotics or from seizures. E.F. has been sent to hospital emergency rooms following many of the falls. He fractured a neck vertebra as a result of one fall in 2020. There were no interventions to address his falls and psychotropic medications were not adequately assessed, including the impact on falls risk. A PASRR was completed for SMI, following an admission to a geriatric psychiatric

unit in April 2019, with paranoia, grandiose thinking, and screaming. The PASRR reviewer noted many open and closed cuts and scratches, and that he had been observed scratching off his skin from anxiety and agitation. The reviewer recommended a behaviorally based treatment plan, a neurology consult, structured social activities, and training in activities of daily living skills. Bear Mountain provided none of these were during the period reviewed from January 2020 through October 2022.

E.F.'s records suggest the possibility that his aggressive tendencies diminished in the past from active involvement in behavioral programming and activities, as well as opportunities to separate from congregate activities as needed. E.F. needs neurological and neuropsychiatric evaluation to evaluate the source of aggressive behaviors, cause of hallucinations and should include cognitive testing. Such an evaluation identifying his psychiatric needs and capabilities would be the basis for an effective behavioral plan. It would also establish the basis of delusions, which could be related to his long history of seizures, rather than basis for a schizophrenia diagnosis. A medication regimen should then also be reviewed to determine what would be the most effective treatment, and to assess the impact that benzodiazepines and antipsychotics are having on his risk of falls.

Resident G.H.:

Resident G.H. needs an assessment of her cognitive functioning, evaluations for falls and infections, and active treatment consistent with her intellectual disability:

G.H. is a New York resident in her 50's who has resided at Bear Mountain since 1998. She was admitted at the age of 27 from a New York State psychiatric center following a suicide attempt. G.H. sustained TBI at the age of 4 when she was assaulted by her mother's boyfriend and had severe behavioral disturbances as a child. During the year prior to her admission to Bear Mountain, G.H. had several psychiatric hospitalizations in New York and ultimately was admitted to Bear Mountain's neurobehavioral unit in 1998 after a hospitalization for a suicide attempt.

In July 2000, a Massachusetts PASRR was completed, finding that G.H. qualified as having an intellectual disability and developmental disability with an IQ of 60 related to her TBI at age 4. The evaluator concluded that she may remain in a nursing facility on the condition that she receive specialized services that were not being provided at the time, namely: development of independent living skills, self-help techniques, vocational training, and socialization. A copy of the report was sent to the New York agency serving people with developmental disabilities. A 2011 progress report for G.H. indicated no specialized services were being provided at that time, and none are currently. A mild intellectual disability continues to be noted, which is consistent with the earlier finding of IQ of 60.¹⁸⁴

As of 2020-2022, G.H.'s diagnoses of schizoaffective disorder and borderline personality disorder remained. G.H. has had verbal, and sometimes physical, altercations with other residents, and has engaged staff in brinksmanship over food and facility rules. She can be manipulative, buying and selling items with other residents, then accusing them of stealing the items from her. She has demanded staff attention, crying when staff did not provide her with what she has requested; she can be falsely accusatory, splitting staff, and throws things when she is upset. She has changed roommates due to "irreconcilable differences."

G.H.'s borderline personality disorder is likely a source for these challenging behaviors. It is not uncommon for individuals with remarkable trauma histories such as hers. G.H. lacks an interdisciplinary behavior plan to manage these behaviors, or specific treatments for the disorder, such as dialectical behavioral therapy, which teaches individuals how to

better regulate their emotions. Her cognitive functioning should be assessed again to determine her level of cognitive impairment and she should be referred again to DDS for a PASRR evaluation.

G.H. is fully mobile and independent in her ADL's. However, she is noted to have frequent falls related to psychotropic medications. She is particularly at risk for falls with her combination of antipsychotics. One severe fall resulted in an ankle fracture in April 2022, associated with dizziness, confusion, and low pressure. After this fall, the hospital resolved a UTI, which had proceeded to a sepsis infection (G.H. experiences chronic UTIs). Upon discharge, the hospital recommended discontinuing her benzodiazepine, increasing her physical activity and engagement, and an iron supplement to address her anemia.

As of October 2022, G.H. was still medicated with two antipsychotics, an anticonvulsant (to stabilize her mood) and an anti-anxiety medication. She has now been taking antipsychotics for decades, with no justification. She does not have psychotic symptoms, and these medications may be contributing to insomnia and anxiety, her vulnerability to UTIs, as well as falls. The written informed consents for her and others experiencing chronic UTIs do not include risk of UTIs from antipsychotics.¹⁸⁵ As of October 2022, G.H. had not increased her physical activities, and never received the active treatments recommended in 2000, nor received an updated evaluation for current treatments and skills development appropriate for her ID/DD.

Resident I.J.:

Resident I.J. needs a plan to withdraw from extended pain killers, evaluations for falls and infections, and programming and activities to prepare her to return to the community:

I.J. is a Massachusetts resident in her 60's and has a long history of bipolar disorder and polysubstance use. She was admitted to Bear Mountain in 2021 after having a stroke. At the time she was actively using alcohol and her home was deemed uninhabitable. She has gradually worsened cognitive impairment due to alcohol-related dementia, confirmed in neuropsychiatric evaluation completed in January 2022 for a conservatorship proceeding.¹⁸⁶ Her long-term prescription of Oxycodone at Bear Mountain is extremely concerning, particularly in light of her substance use history. She routinely seeks this medication. There is no plan to titrate and wean her off this medication that is dangerous for her considering her substance use history or determine the source of pain in her leg that the narcotic is supposed to manage. She has also been on a long-term prescription of Xanax, another medication with a strong potential for dependence. Because of the risk of harm from these medications,¹⁸⁷ a withdrawal plan to taper her down from oxycodone and Xanax is critical.

Bear Mountain began discharge efforts for I.J. during the summer of 2022, but her discharge through a Medicaid waiver program has been complicated by the existence of her assets in her home, leading to her considerable frustration.¹⁸⁸ In the meantime, she has fallen multiple times, and refuses to use a walker. She needs a full evaluation to determine the reasons for her falls – which could be related to medical or neurological conditions, or to medications, including the opiates and benzodiazepines. She also suffers frequent urinary and kidney infections; the reasons for these infections must also be evaluated.

I.J. may also have borderline personality disorder, which requires therapy to help her to curb destructive behavior: She has been brought to the emergency room for self-cutting, agitation, and violently throwing objects at staff; she is emotionally unstable and can be

aggressive. Her behavior treatment plan is “therapeutic listening, observation, reflection and reframing.” Because of her mood swings and cognitive process limitations, this is not a realistic plan. I.J. needs a treatment plan informed by her capabilities and limitations, that includes community integration activities and skill building as she readies to reenter the community, and dialectical behavior therapy to support positive behavioral change.

Resident K.L.:

Resident K.L. needs language-accessible services and programming, a neuropsychiatric evaluation and treatment planning:

K.L. is 67 years old, a New York resident, and originally from the Dominican Republic. She came to the United States in the 1980s and trained as a beautician in New York City. However, she became homeless and experienced multiple psychiatric hospitalizations in the New York City area. In the 1990s, K.L. was discharged from a New York psychiatric hospital to a New Jersey nursing facility,¹⁸⁹ and from there was transferred in 2000 to Bear Mountain (then Wingate). K.L. is diagnosed with bipolar disorder, schizoaffective disorder,¹⁹⁰ vascular dementia, diabetes, and hypertension. Although she has no skilled nursing needs, is fully mobile and independent in all her ADL’s, she has lived in skilled nursing facilities for twenty-three years.

K.L. is primarily Spanish speaking. Her records do not reflect that any staff – clinical, recreational, behavioral, or nursing assistant – speak with her in Spanish, or that she receives any interpreter services. Bear Mountain is legally obligated to provide language access services to residents with limited English proficiency,¹⁹¹ and it is standard practice to document the use of interpreter services.¹⁹² Administrative staff informed DLC in both 2021 and 2023 that there are Bear Mountain residents who are primarily Spanish speaking (six residents in 2023) but staff do not utilize Language Line for them because, they appear to speak and understand enough English; in the case of K.L., staff said that she “speaks more English than she lets on.” Occasionally, activities staff who are bilingual are asked to interpret.

K.L.’s records note that she is mainly Spanish speaking – this is noted as a “communication deficit,” along with impaired decision-making, memory deficits, and delusions. Activities staff encourage her to take part in programs that are “less dependent on language.”

DLC staff spoke with K.L., conversing and asking questions first in English, and then translated into Spanish through the assistance of a Spanish interpreter. K.L.’s responses were much more detailed in Spanish. K.L. told DLC that she speaks enough English “to get by,” and that she feels isolated at Bear Mountain with so few residents who speak Spanish.

Clearly, for clinical care and psychiatric assessments K.L. requires and must be afforded an interpreter; it is difficult to imagine an adequate psychiatric assessment without such accommodation. It is also troubling to consider K.L.’s isolation, language deprivation, and overall lack of access to programming due to Bear Mountain’s failure to provide her with language access.

At Bear Mountain, K.L. has a history of asking to go to the hospital for non-emergency perceived illnesses, related to somatic delusions. She has entered other residents’ rooms, puts on other residents’ clothing, and shoes and periodically gets into verbal and physical altercations. She reports restlessness and insomnia and is prescribed trazodone for insomnia.

K.L. is prescribed two antipsychotics to treat delusions, two anticonvulsants, and a sedative. She has frequent falls related to her psychotropic medications. The two antipsychotics pose a special risk because of K.L.'s dementia and age; further, delusions often do not respond well to antipsychotics. In June 2020, the pharmacist recommended reducing one of the antipsychotics (Risperidone) because it has a long half-life, is being given twice daily, and has the potential for adverse effects, but the doctor declined to reduce it because she was stable at the time. This is not an adequate justification to refuse a dose reduction, which is done very gradually and observed.¹⁹³ Health Drive did successfully reduce the other antipsychotic (Abilify) by a small amount in 2021. Delusions are often resistant to antipsychotic treatment, and her delusions persisted despite her being on two antipsychotic medications. It is not likely she is benefiting from them, and they are likely contributing to her insomnia – for which she is receiving yet another drug – and feelings of restlessness.

Records indicate that Bear Mountain has not created an interdisciplinary behavior treatment plan to reduce assaults and confrontations, a treatment plan for her dementia, nor an assessment of how dementia impacts her functioning. K.L. should have a neuropsychiatric evaluation, behavior, and treatment planning, and must be accommodated in her treatment and activities with Spanish interpreter services and bilingual clinical staff. If non-clinical staff will serve as interpreters, they must be provided with the appropriate training to do so. Accessible care will improve evaluation, treatment planning and antipsychotic and anticonvulsant dose reduction efforts, which should be undertaken.

K.L. told DLC that she had questions about when she could be discharged, was anxious to know about her discharge plans, and wished to see the Director of Social Services. DLC staff, K.L., with the assistance of the interpreter, met with the DSS. The DSS informed them that it was the guardian's responsibility to look into discharge to New York and did not discuss the process for discharge in terms accessible to K.L. or allow time for the interpreter to interpret. Coordinated discharge planning education and efforts involving her guardian and New York's nursing home transition program should be undertaken, with full and accessible explanations and education provided to K.L.

Resident M.N.:

M.N. is a Connecticut resident in her 40s who was admitted to Bear Mountain in 2021 after going into cardiac arrest from a heroin overdose and sustaining a brain injury from oxygen loss. M.N. had a tracheotomy and was admitted to Bear Mountain's ventilator unit for short-term rehabilitation.¹⁹⁴ She has remained at Bear Mountain long after she was ready for discharge, because of the difficulty discharging back to a supervised setting in Connecticut with a tracheotomy and G-Tube.

M.N. has a serious psychiatric history as well as a history of substance use. She is treated with antipsychotics for schizoaffective disorder, has major depressive disorder with suicidal ideation and panic disorder. She is at risk for self-cutting and pulls out her body hair when depressed and anxious. Her pre-admission PASRR noted a PTSD diagnosis, but she has not been treated for PTSD at Bear Mountain, despite the strong association between PTSD and substance use disorder. She needs PTSD treatment, especially as the PTSD may have been central to causing her anxiety. M.N. had been previously treated with methadone. Bear Mountain offers no substance use treatment and failed to connect M.N. with any community-based treatment services. She required both a plan to maintain sobriety and treat depression.¹⁹⁵

The pre-admission PASRR recommended evaluations for neurocognitive disorders and annual comprehensive psychiatric evaluations to clarify her psychiatric diagnoses and appropriate treatments, as well as crisis prevention intervention planning, and training for ADLs, and follow-up with a neurologist. Bear Mountain did not carry out any of these professional evaluations, plans, and training during the time period of the records review. The Health Drive PA's evaluations were not of the depth or breadth to be considered a comprehensive psychiatric evaluation and needed to be done in conjunction with a neurological exam.

Seven months after M.N.'s admission, a Connecticut nursing home transitions case manager requested that a neuropsychiatric evaluation be completed for considering her for Connecticut's ABI Medicaid waiver program. This proved difficult to arrange in Massachusetts on Connecticut Medicaid, and six months later the transitions team was seeking the possibility of evaluation in Connecticut by telehealth. It had still not been completed by the close of DLC's records review in October 2022.

In the meantime, M.N. asked to return to Connecticut on a daily basis. Her frustration with her tracheotomy, her long-term stay, her paranoid delusions, as well as her difficulty coping with verbal and racial slurs from other residents (M.N. is African American), all fueled her agitation, impulsive acting out behaviors, and suicidal ideation. M.N. was transferred to emergency rooms under Section 12 on 21 occasions during the period of records reviewed, following altercations with other residents, striking at staff, suicidal ideation, attempts to pull out her trach, elopement, and on one incident of restraint by police in the facility. Bear Mountain offered no substance use treatment onsite or linkages with off-site treatment and did not develop a behavioral support plan to help her learn to manage her frustration. M.N. needs an assessment of her cognitive abilities, substance use treatment support, and consistent behavioral support and management during this prolonged, out-of-state nursing home stay.

The following three residents have ABI and related disorders, and are maintained on high doses psychotropic medications:

Resident O.P.:

O.P. is a Massachusetts resident in his 50s who has lived at Bear Mountain since 2014. He has cognitive deficits and memory loss related to a TBI and cerebrovascular disease, as well as mood disorder, depression and anxiety related to TBI. O.P. can become agitated by loud noises or larger groups but can be redirected. He scores well on cognitive assessments and is independent in his ADLs, and is alert, responsive and well-oriented. He enjoys listening to music, watching movies, card games and socializing with others. His parents are very supportive, speak with him daily and take him home on passes from Bear Mountain. His mother is a psychiatric nurse and is his guardian. O.P. receives two doses of an antipsychotic daily, as well as two anti-convulsants. Bear Mountain records reviewed contain no rationale for two anticonvulsants and no neurologist's consult on the need for two medications, or the impact that the antipsychotics may have on his threshold for seizures, prescribed for their sedative effects. O.P.'s mother has informed DLC of her concerns that he is overly sedated from too many medications. She discussed lowering medications with the unit nurse, who responded that the anti-convulsant should not be lowered because he gets agitated at times. She informed DLC that she and her husband are always available and can calm down their son when needed.

Tellingly, the records document one attempt to lower the dose of the antipsychotic. Two months after the dose is lowered, O.P. told the unit nurse he has been at Bear Mountain

too long and appears “anxious and agitated.” O.P. also had an outburst where he yelled into another resident’s room, believing him to be naked; staff noted in the record the resident was fully clothed. The nurse records no efforts to calm O.P. but notifies the Health Drive PA of his change in behavior. Based on these reports, the Health Drive PA retracted the dose reduction. Staff record no efforts to calm or redirect O.P., or increase psychosocial activities, or to speak with his mother about her son’s behavior or delusions. This was not an appropriate way to address O.P.’s mental status change; it should not have been assumed it was from the tapered medication. It is crucial to see if calming or redirecting will work. Potential reasons for O.P.’s anxiety and agitation could be a side effect from the antipsychotic, or a result of the wrong anticonvulsant. He needed a full multidisciplinary workup to evaluate his change in condition.

O.P. has no skilled care needs and likely could live more independently in a supervised residence, through the ABI residential waiver program. With a supportive behavior management plan, increased psychosocial activities, and family involvement, it is likely that his medications could be reduced. His Bear Mountain records make no mention of discharge planning, which could also be a source of O.P.’s agitation and frustration.

Resident Q.R.:

Q.R. is a Massachusetts resident in his 50s who has lived on the locked neurobehavioral unit since 2005. He has a severe TBI from a motor vehicle accident in 1995, which caused major neurocognitive impairment. He has related mood, anxiety, and psychotic disorders, and now dementia. Q.R. is on multiple psychotropic medications: two antipsychotics, two anti-convulsants, and a benzodiazepine, with no recorded justification for the multiple medications.

Q.R. spends much of his time walking in circles through the facility’s hallways and common areas. He becomes easily agitated and can be assaultive toward staff when asked to participate in routine care. It is noted in his records that he is “uncooperative,” pulls at the fire alarm, and strikes at peers who are in his way when he is walking. Q.R. strikes at staff, wanders into the rooms of other residents and hits walls. Q.R. also falls with some frequency; this could be related to his TBI or effects from antipsychotics.

The assaults on people and strikes on walls should be monitored to determine if they are an automatic result of motor restlessness that he cannot control, or whether there are triggering causes. Although he has been at this facility for eighteen years, the nursing plan provides few details on precursors to agitated and assaultive behaviors, and instead directs staff to determine what those triggers are, and to redirect Q.R. to appropriate behavior. When assaults occur, the nurses’ notes make no reference to an intervention other than “redirect.” Adjusting medications could reduce motor restlessness that may be causing him to strike out.

DLC staff observed Q.R. seated alone in the dining room in the middle of the day on two occasions, appearing overly sedated. He had dried saliva and food encrusted on his clothes. On the first occasion, he told us he was thirsty, and was observed to have dry lips. He could not eat without assistance and needed a drink positioned so that he could drink through a straw. The CNA commented that staff avoid showering or changing clothes because he can respond aggressively.

Q.R. needs interdisciplinary evaluations to determine whether antipsychotics and/or neurological impairments are contributing to motor restlessness and aggression, as well as falls. An individualized history and careful attention to antecedents to aggressive behaviors are also needed to determine if these behaviors are within his control or could be modified by environment. Assessing Q.R.’s functional strengths and weaknesses, and

learning his preferences are also important for developing a behavioral plan for behaviors determined to be within his control.¹⁹⁶ This should be an interdisciplinary care plan, consistently carried out by well-trained staff who maintain a safe and therapeutic environment. The assessments and care planning should include neurology, psychiatry, psychology, nutrition, physical, occupational and speech therapy, and medicine. Bear Mountain should dedicate particular staff to be with Q.R. to carry out behavioral supports and interventions that are determined to be effective and would likely increase his cooperation in his self-care. Developing a well-informed and consistent approach with Q.R. is particularly critical in a congregate setting where aggression poses safety risks to self and others.

Resident S.T.:

S.T. was a Massachusetts resident in his 50s who had been at Bear Mountain since 2007 following an anoxic brain injury related to viral encephalitis. He died after DLC's record review. S.T. was diagnosed with psychosis and anxiety disorder related to the brain injury, and dementia with behavioral disturbance. He was nonverbal, and had an unsteady gait, needing assistance with standing and turning. He used a wheelchair, with which he could propel himself. S.T.'s records raise several concerns relating to psychotropic medications, lack of coordination with outside consultation, multiple serious infections, and injurious falls due to seizure activity.

S.T. had a history of sexually inappropriate behavior and verbal aggression with peers and verbal and physical aggression towards staff; these were likely disinhibitions from his brain injury. During 2022, his behavior improved, and he attended groups and other social activities. Yet, he remained on two antipsychotics, with no plans to further taper following a small dose reduction of one drug in January 2022. Records showed no review of the effect the antipsychotics may have had on his seizure threshold or effectiveness of seizure medications.

S.T. was hospitalized for seizure activity in the spring of 2022, and the dose of phenobarbital was increased. Bear Mountain staff brought S.T. for a neurology follow-up three months later, but the staff accompanying him had no information about his seizure history and had inaccurate records of current medications. The neurologist was not able to confirm that the medication had been increased following his hospitalization, as ordered, or provide further advice. The neurologist noted that S.T. had a vagal nerve implant that was not functional; Bear Mountain had no plan to consult a neurosurgeon about it. The implant potentially could have reduced the need for high amounts of seizure medication.

S.T.'s wife and guardian informed DLC that she repeatedly asked for dental appointments as he suffered multiple broken teeth, which risked leading to abscesses, which could have led to bacteria in the bloodstream and heart damage. The unit supervisor told her S.T. had refused the appointments. However, in her experience, S.T. is agreeable to care with some encouragement. Staff did not ask her to encourage him to accept the appointments.

S.T. suffered from multiple urinary tract infections. The reasons for these were not explored; one of the infections proceeded to a sepsis infection and required hospitalization. According to his wife, S.T. was hospitalized for a longstanding and serious leg infection in the spring of 2023. Following his return to Bear Mountain, he died as the result of a seizure.¹⁹⁷

Regarding discharge planning, the record contains the statement that his guardian is not interested in a less restrictive environment. S.T.'s wife informed DLC that she thought

S.T. could live in a group home but was concerned the staffing ratio would be worse than at a nursing home. DLC informed her that would not be the case, and that she could learn more about options from an independent living center. Clearly his wife would have been receptive to education about community-based options for her husband, and the Medicaid waiver options had not been discussed during quarterly assessments with her, either directly by the Bear Mountain staff, or through referral to other resources, such as the local independent living center.

Resident U.V.:

Resident U.V. remains at Bear Mountain because of lack of ABI waiver housing:

U.V. is a Massachusetts resident in his fifties. He has a TBI, with an associated psychotic disorder and mood symptoms. U.V. has lived at Bear Mountain since 2012 and had periods of agitation and aggression, but has been relatively stable since 2020, according to his record and his guardian. An evaluation would be useful to clarify the reasons for his stability in order to maintain a successful regimen. He was accepted into the ABI residential waiver in April 2022, but continues to wait for a home and remains at Bear Mountain as of the date of this report.

V. Discussion and Systemic Findings

Bear Mountain houses a complex acute and chronic population of individuals with psychiatric conditions, comorbid medical conditions and other behavioral conditions related to brain injury, neurocognitive disorders, and dementia. Bear Mountain has neither adequately trained staff nor an integrated care approach to safely care for this population, promote recovery and rehabilitation to individuals' maximum potential, as contemplated under the Nursing Home Reform Act. The lack of adequate language access accommodations exacerbates the problems in care for residents who have limited English proficiency.

The records reviewed, informed by expert medical input, demonstrate that residents' underlying conditions are often poorly understood. There is evidence of neglect in care planning, hygiene, and health needs, including chronic infections. Residents lack adequate behavioral interventions, and psychotropic medications are not adequately monitored. Prescribing medical staff appear to fail to consider the impact of antipsychotics on co-occurring conditions, such as seizure disorder. They do not consistently justify the use of antipsychotic medications, and fail to try alternative, non-pharmacological interventions. Bear Mountain does not include all the risks of antipsychotic medications in the written informed consent forms,¹⁹⁸ and there is no evidence that staff have discussed with the representatives all the significant risks and benefits of psychotropic medications.

DLC found many instances of risky medication practices that would constitute abuse. Psychotropic medications administered in nursing facilities that are not justified or not adequately monitored, are chemical restraint under federal law. Relying on medications to control behaviors or symptoms without attempting alternative therapies is also chemical restraint.¹⁹⁹

The standard of care for managing behavioral health conditions is through person-centered, multidisciplinary behavioral health treatment plans, with time-sensitive interventions to be implemented by responsible team members. The plans are reevaluated periodically, and if a plan is not effective, it is modified. Such plans also depend upon in-depth professional assessments of psychiatric and medical and neurological conditions and cognitive assessments as appropriate. Such evaluations are necessary to ascertain the causes for such symptoms as delusions or agitation, and to confirm or rule out psychiatric diagnoses; evaluate functional capacity for therapies and skills development; and provide the basis for medication recommendations.²⁰⁰

Bear Mountain does not have such plans in place for residents and does not conduct the necessary assessments. The plans for Bear Mountain residents are far more limited in scope and are not adequately individualized. Instead, residents at Bear Mountain move from crisis to crisis, often involving emergency room admissions. It is not uncommon for residents to become physically threatening to other residents and to staff. These all reflect a severely sub-par level of medical and mental health care.

Congregate living situations for individuals with behavioral challenges require a therapeutic environment, often referred to in the mental health field as a therapeutic milieu.²⁰¹ A well-managed milieu reduces the numbers of incidents of assault, aggression, and inappropriate behaviors. The days are structured with choices of activities and programs to develop and maintain skills, socialization, and connect to community. The interventions used in the milieu, including redirection and de-escalation, are supported by evidence-based practice.

In contrast to the milieu model, the care that DLC observed through onsite visits and records review at Bear Mountain is largely custodial rather than individualized and person-centered. It does not foster a therapeutic environment and lacks the safety of a well-managed milieu. The

residents reviewed, who have had little to fill their days, were on very long-term combinations of psychotropic medications. Alternative approaches to reducing symptoms and behaviors – through person-centered activities, therapies, quiet time, emotional support, and nutritional support – were not attempted, likely because of staff lack of time, knowledge, and training. For many individuals living with the long-term effects of brain injuries, significant programming and individualized attention is needed to make progress. At the same time, therapeutic environments to recover from overstimulation are needed. This is particularly important in a congregate living environment such as Bear Mountain, where most residents must share rooms.

Bear Mountain now appears to be taking positive steps to increase activities on the unit and to train the few dedicated behavioral staff. However, all unit staff need education and resources to better understand the ranges of psychiatric disability and brain injury and their effects. All staff – whether directly employed at Bear Mountain, or by contract – should also be working in interdisciplinary and collaborative teams to work with residents with individualized, person-centered plans of care. These plans should be informed and monitored by neurological, psychiatric, and neuropsychiatric staff and consultants who are regularly on site.²⁰² A PA, with offsite supervision by a psychiatrist, does not have sufficient training to direct the care for the complex population, and is below the standard of care for such a complex population.

All direct care unit staff must have sufficient training, support, and time to work closely and consistently with residents. Staff should also connect residents' families and representatives who can provide positive support and inform treatment approaches. Supportive and informed relationships between staff and residents would foster a therapeutic environment and enable staff to respond constructively to residents' individual needs, informed by their strengths and preferences. Stronger, rehabilitative, and recovery-focused programs at Bear Mountain would help residents to develop their ability to transition to less restrictive, more behavioral-health focused settings.²⁰³ It would also be necessary to develop separate physical spaces to meet the varied needs of this complex population.

Multiple systemic failures have resulted in a neglected population at Bear Mountain. This for-profit system of care has not invested in the range of trained personnel needed to care for complex individuals. Annual DPH inspection surveys were not timely completed, nor carried out with sufficient breadth and depth to identify and address the causes of deficiencies. Despite the large number of individuals in Massachusetts nursing homes with psychiatric conditions, Massachusetts conducts no apparent reviews of a facility's frequent use of emergency rooms under Section 12(a), or of the extra MassHealth funds expended for individuals with behavioral health challenges. The Commonwealth has not reviewed nursing facilities with high rates of antipsychotic usage, despite increased rates. It has not enacted its own licensing standards for behavioral health services or neurorehabilitation units in nursing facilities.

The Commonwealth must assess and address the adequacy of services and staffing in nursing homes, including such specialized units. The Commonwealth must adequately review for-profit systems of care, based on timely cost reporting from facilities and the companies that manage and own them.

The Commonwealth must also increase its oversight of PASRR screening to ensure that people with SMI and ID/DD under PASRR are identified and that recommended services are provided. In at least some instances, PASRR evaluators overlooked evidence of SMI, including emergency room admissions resulting in an inpatient psychiatric bed search,²⁰⁴ or failed to recommend specialized services for individuals with SMI and serious recent psychiatric episodes.²⁰⁵ For the new care coordination services and transition planning services being rolled out in Massachusetts, it is critical that residents with SMI be appropriately identified. Invariably, where the evaluator recommended specialized or in-nursing home services, records DLC

reviewed indicate that Bear Mountain failed to follow recommendations in violation of federal regulation, without documenting objections.²⁰⁶ Bear Mountain also failed to refer to people to PASRR whose conditions have deteriorated significantly, as federal regulation requires.²⁰⁷

The sample of residents DLC reviewed also demonstrates the complications of serving out-of-state residents, and the neglect of at least New York to follow its residents: New York Medicaid funded three residents in the sample who had been at Bear Mountain for decades, with no oversight or follow-up during the years reviewed. For example, a PASRR evaluation found that resident G.H. met criteria for ID/DD and recommended specialized services which New York never funded.²⁰⁸ Massachusetts, for its part, has no policies for procuring out of state payments either for PASRR evaluations or for specialized services.²⁰⁹ New York Medicaid approves out of state nursing home placements where closer, in-state nursing homes refuse admission.²¹⁰ Nearly a third of Bear Mountain's Medicaid revenue comes from out of state. Massachusetts, which administers the Medicaid program for the state in which the individuals are receiving treatment and oversees the nursing homes, must have arrangements in place to fully fund outside evaluations and services, whether identified through PASRR or separately, that are necessary for comprehensive care as well as discharge planning.

With adequate assessments, supports and services in the nursing home, as well as opportunities to be connected with the community, more residents would be ready to discharge to more integrated, less restrictive community-based settings.²¹¹ The Commonwealth must ensure that nursing home social workers, residents, their families, and legal representatives are educated about community-based housing, waivers and supports. New York State must also take action to ensure that PASRR evaluations of New York State residents are funded and are taking place, that specialized services are being provided, and that discharge planning is being undertaken, when possible, with the use of all available transitional services.

DLC's Detailed Findings:

- Bear Mountain has not implemented adequate behavioral interventions. Instead, most individuals reviewed move from crisis to crisis, including frequent emergency room visits, and at times pose threats to, or harm, themselves, and others.
- The failure to approach behavioral health needs with adequate treatment plans and integrated, person-centered care has likely led to over-reliance on psychotropic medications and reliance on long-term use. Bear Mountain medicates residents with psychotropic medications without either attempting alternative non-pharmacological interventions or implementing plans of care which include non-pharmacological interventions.
- Bear Mountain exhibited a culture of depersonalized institutionalization, not a therapeutic milieu supporting mental health and person-centered behavioral interventions. For most of the two-year period under review, the environment was impersonal and hospital-like. DLC saw residents idle much of the day. Bear Mountain has failed to develop needed therapeutic and psychosocial programs to encourage socialization, daily living skills, and community integration. The lack of activities, access to the outdoors, and community connections contributed to psychiatric decline and worsening dementia. The facility should ensure it complies with DPH regulations, requiring 25 sq feet of accessible

outdoor recreational space per licensed bed, not including parking lots. 105 CMR 150.240.

Bear Mountain is now taking steps to improve the residents' environments and increase the choice and number of activities and has invested in activities staff to do so. However, further observation is warranted to determine if these activities are adequately individualized and supported to yield therapeutic effects, and if there is sufficient range of vocational and educational activities. Residents should be supported to participate in such services that exist in the community. DLC observed a positive response from residents and improvements in room environments.

- The lack of integration between Bear Mountain staff, agency behavioral health staff, and agency nurse practitioners results in failures to adequately collaborate on and communicate about behavioral health support needs and interventions, as well as the failure to manage adequately and monitor complex psychotropic medication regimens. It also raises serious medication management concerns.
- Bear Mountain fails to adequately train its staff in psychiatric disorders, brain injury, behavioral management, and psychiatric medications and effects, and does not contract with nurse practitioners with psychiatric specialties. This lack of training and specialized practitioners leads to inadequate behavioral management as well as inadequate medication management and monitoring.
- The low staffing in behavioral health, lack of training in behavioral health medications and interventions, and the failure to integrate staff to plan and coordinate care, results in lack of behavioral management strategy.
- Bear Mountain fails to conduct or recruit neuropsychiatric consultations and assessments when needed for treatment planning, habilitation, and to support planning for transition to the community. It fails to have the necessary professional staff regularly on site to evaluate, treat and monitor its residents with neurobehavioral and psychiatric conditions. Such staff should include neurologists as well as psychiatric staff.
- Bear Mountain does not offer substance abuse treatment to individuals who need these services and support or connect them with such services in the community.
- Of the several residents reviewed who had diagnoses of schizophrenia, nearly all were in place prior to their admission to Bear Mountain. However, the numbers of residents at Bear Mountain who are diagnosed with schizophrenia are quite high compared to the general population, and generally have other conditions which could be the sources for symptoms also associated with schizophrenia. Comprehensive, multidisciplinary diagnostic evaluations are warranted for these complex residents.
- Bear Mountain's reliance on psychotropic medication without sufficient non-pharmacological alternatives and interventions, without responsibly checking for side effects, is below standard of care for treating and managing psychiatric disorders, dementia, and ABI.
- Written informed consents for psychotropic medications do not include all the risks of antipsychotic medications. Residents' representatives reported lack of information about medications, some lacked contact with staff altogether, or were in contact with staff who were not educated in the prescribed medications. Rarely did staff discuss with representatives the reasons for, and risks and benefits of medications, as required by EOHHS.

- The reports and records of infections, health hazards and poor hygiene demonstrate that the most basic health needs, such as infections, are not noticed or addressed. This sets the stage for neglect of behavioral health needs.
- Bear Mountain is in violation of Title VI language access requirements.²¹² It does not use interpreter services for residents who have limited English proficiency, or qualified staff to interpret for residents. Bear Mountain is also in violation of DPH's requirement for a health care facility to develop a language access plan following a determination of need notice.²¹³

The records of a Spanish-speaking resident with limited ability to speak and understand English failed to note any use of interpreter services, or treatment or programming with bilingual staff. With an interpreter present, the resident demonstrated much improved ability to understand and communicate.

- Bear Mountain fails to adequately plan for the discharge and rehabilitation of long-term residents to meet their discharge goals, or to connect residents with community transition resources in Massachusetts or out-of-state. Residents and their representatives (guardians and proxies) lack information about community placement options and supportive services, including access to benefits, personal care assistants, and housing.
- Written informed consents for psychotropic medications do not include all the risks of antipsychotic medications. Residents' representatives reported lack of information about medications, some lacked contact with staff altogether, or were in contact with staff who were not educated in the prescribed medications. Rarely did staff discuss with representatives the reasons for, and risks and benefits of medications, as required by EOHHS.
- DPH annual survey was not completed on a timely basis as required, and the 2022 survey citations were inadequate to remedy the identified problems.
- Federal and state evaluation requirements for residents with SMI or ID/DD are not consistently followed at Bear Mountain. Bear Mountain did not implement most PASRR recommendations for specialized or nursing-facility rate services. Portions of PASRR documentation which would have contained recommendations were missing from the records.
- The UMass evaluator improperly excludes people from the PASRR SMI population, in at least one case overlooking records of emergency hospitalizations for psychiatric reasons.
- Other states fund long-term residents at Bear Mountain with Medicaid but fail to conduct necessary coordination with MassHealth to ensure that residents are regularly reviewed and that PASRR-recommended specialized services are provided. Massachusetts fails to ensure coordination with other states' Medicaid agencies to fund evaluations and services.
- Massachusetts and other states whose residents reside at Bear Mountain fail to conduct the necessary outreach at Bear Mountain to ensure that residents who may be capable of living in the community and desire to do so are appropriately assessed and supported. Residents and their representatives are not adequately informed about community-based living and support options in Massachusetts or the individual's home state.

VI. Responses of Bear Mountain Worcester, EOHHS and CHIA

Response from Bear Mountain Worcester

DLC furnished a draft copy of this report to Bear Mountain on October 24, 2023, and received a response on December 15, 2023. A summary of their response, and DLC's replies to it, are listed below. Bear Mountain's full response is provided in Appendix B to this report.

Bear Mountain Response: Staffing Levels, Workforce Issues and General Assessment:

Bear Mountain denies that it has failed to provide sufficient staffing or specialized staffing. Bear Mountain states that they acquired the property in November 2019 and at the time it was a one-star facility "across the board," and they have faced setbacks which continue to this day in filling vacancies. Further, it contends that it has been subject to "scrupulous oversight" by state and federal regulators and has only been cited once under current ownership, in February 2022.

DLC's Reply:

We respectfully disagree. As noted in our report, the 2001 CMS recommended standard for staffing nursing homes with long term stays is **4.1 hours of total care** per long term resident per day, including **2.8 hours of nurse's aide time** per resident and **.75 RN time** per resident. Arguably this time **should be substantially greater** in a neurobehavioral unit serving persons with greater behavioral needs related to traumatic brain injury, schizophrenia, or other major mental health diagnoses.¹

The most recent data (Q2 2023) from August 2023 shows Bear Mountain with **3.849 hours** per resident day (HRPD) including **2.13 hours** of nurse aide hours per resident day (HRPD) and **.708 HPRD (Hours Per Resident per Day) for RN time, less than the 2001 CMS recommended standard**. This compares with the facility's previous numbers of 3.8 hours, 2.06 hours, and .73 hours, respectively. We acknowledge that beginning in October 2023, the facility improved from two stars (below average) to three stars (average) in its rating for staffing. These are small positive steps forward and may still not be a sufficient level of staffing for the particularly complex individuals admitted to Bear Mountain and remaining long-term. Moreover, the levels

¹ There are new proposed regulations from CMS which use minimum requirements of .55 RN hours per resident day (HRPD) and .45 nurse aid (NA) HRPD. These are minimum staffing requirements regardless of the nature of the facility and the acuity and disabilities of the persons served. We do not know if the final version of the regulations will be the same, less, or more than the levels proposed. Regardless, the proposed regulations state that "...[I]f the acuity needs of residents in a facility require a higher level of care, a higher RN and NA staffing level will also be required." 88 Federal Register 61352-3 (September 6, 2023). See also proposed regulation 42 CFR 483.71 at 88 Federal Register 61429.

As noted in our report, for Level II facilities, state regulations require less than the 2001 CMS standard, 3.58 HRPD of which at least .508 hours must be time provided by a registered nurse. 105 CMR 150.007(B)(3)(d). Bear Mountain was subjected to a 2% downward rate adjustment for January 1, 2021 to March 31, 2022, for failure to meet this staffing level.

still fall short of the federally recommended minimum level. This was a key concern of the federal HHS (Health and Human Services) GAO's 2021 report regarding the CMS staffing ratings scale.² Finally, it is not clear how Bear Mountain merits a 3-star rating for staffing, since it has not made its nursing turnover data available to CMS, a key component of the quality rating.

The surveyors' failure to cite staffing shortages does not mean they did not exist. When the February 2022 survey was carried out, Bear Mountain was subject to a penalty for failing to meet state minimum requirements. DLC discussed in the report the deficiencies in the February 2022 survey relating to staffing, the failure of the surveyor to cite adequately those deficiencies, and the pressures that are often brought to bear on the survey process and personnel.

Putting aside the question of whether federal and state oversight of nursing homes is "scrupulous" – a topic addressed elsewhere in this report -- the CMS benchmarks, and parallel state standards are intended for skilled nursing facilities generally. This facility holds itself out as having a specialized neurobehavioral unit, <https://www.bearmountainhc.com/bear-mountain-at-worcester/neuro-rehabilitation/> serving individuals with long term effects from acquired and traumatic brain injury, dementia, cognitive disabilities, behavioral and psychiatric disorders, or combinations of these challenges.

However, as explained elsewhere in this report, during our monitoring visits, we did not see staffing levels, more robust specialized services, or treatment protocols which would be adequate for this challenging population, in the view of our monitors and our expert consultants. As noted earlier we did see noticeable improvement in our last monitoring visit, and we hope that continued progress will be made in this direction.

DLC acknowledges the workforce crisis has presented significant challenges to a significant number of nursing facilities. To some extent, these difficulties may be ameliorated by rate increases and incentives recently given to providers. These include, but are not limited to, new measurements for patient acuity (CMS Minimum Data Set) and a workforce supplemental rate, and now add-on rates for behavioral indicators and substance abuse disorder diagnoses (each \$50/member/day) and add-ons for facilities with a high concentration of persons with mental and neurological disorders. Even with some improvements, the overall rating of the facility remains at one star ("much below average"). More detail about ratings, inspections, and fines, see <https://www.medicare.gov/care-compare/details/nursing-home/225219?id=0256a2e8-3439-4fa3-8e4b-907f8f769316&city=Worcester&state=MA&zipcode=> and <https://www.medicare.gov/care-compare/inspections/nursing-home/225219/health>

Following state inspections for compliance with Medicare and Medicaid regulations, as of August 2023 the facility had an overall performance score of meeting only 102 out of 132

² U.S. Government Accountability Office, "MEDICARE: Additional Reporting on Key Staffing Information and Stronger Payment Incentives Needed for Skilled Nursing Facilities" GAO-21-408, (July 2021), <https://www.gao.gov/assets/720/715669.pdf>.

requirements in the last three inspection surveys. This is substantially below average; only 3% of Massachusetts facilities received a score of 102 or lower. The statewide facility average score is 116. <https://eohhs.ehs.state.ma.us/nursehome/FacilityOverall.aspx?Facility=0723>

The August 11, 2023, inspection for compliance with Medicaid and Medicare regulations revealed many of the same types of violations and conditions described in our report. <https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/225219/health/standard?date=2023-08-11> Our October 2023 monitoring visit indicated some noticeable improvements over our five previous monitoring visits during the previous 24 months.³

Bear Mountain Response: Ownership Structure:

Bear Mountain states that the implication that its corporate structure may be related to quality of care issues “could not be further from the truth.”

DLC’s Reply:

As a general matter, it is widely accepted that ownership structures in health care, including in nursing homes controlled by for profit ownership, real estate investment trusts (REITs) or private equity, influence business decisions which may affect quality of care.⁴

As to this specific facility, the assets of Sabra Health Care REIT, Inc. (see <https://ir.sabrahealth.com/investors/financials/quarterly-results/default.aspx>), the increasing rental income it receives from Bear Mountain, and the management fees and apparently wasteful administrative expenses of the management company, when considered in comparison to our factual findings related to patient care during our monitoring visits, leave us unconvinced by Bear Mountain that its corporate structure is unrelated to quality of care problems.

Even if the company is drawing 5% of facility revenue as a common practice of for-profit nursing homes in the industry, it is close to one million dollars which could be spent on much needed staffing and training, as described in our report.

³ Following the drafting of our report, state officials returned to the facility in November 2023 for another inspection. The facility was cited for its failure to handle correctly the reporting of an unconfirmed allegation of sexual assault. However, there were no deficiencies cited. In its reply to this report, EOHHS notes that the period of our investigation (October 2021 – October 2023) overlaps with the beginning of key quality control initiatives by the Commonwealth and ends when many of these initiatives are beginning to bear fruit. We are unable to confirm the absence of deficiencies in November 2023, as this was outside of our review period. Our October 2023 monitoring visit revealed noticeable improvements with some continuing areas of concern. Nonetheless, we are encouraged that improvement was confirmed by the November state inspection.

⁴ See e.g., Harrington, “United States’ Nursing Home Finances: Spending, Profitability and Capital Structure,” *International Journal of Social Determinants of Health and Health Services*, 2023, <https://doi.org/10.1177/27551938231221509>.

Bear Mountain Response: Acuity Measurements:

Bear Mountain contends that Bear Mountain provided adequate staffing because they have measured resident acuity using the MassHealth Management Minutes Questionnaire (MMQ) which was in effect until October 1, 2023.

DLC's Reply:

The September 2023 MMQ hours of patient care as well as the direct care staff time devoted a year earlier in September 2022, each fall far short of CMS staffing recommendations. The MMQ is also not well-suited to projecting the true need for staffing for neurobehavioral unit residents. The responses that inform the ratio are based on orders in the records and documentations of disruptive behaviors. Physician orders in the records DLC reviewed did not require skilled observations as required by the MMQ for increased hours of care,⁵ even if this would have been desirable, for example, where psychotropic medications are introduced or being titrated. The MMQ also does not measure the staff time needed to be working with residents to promote self-care and positive behaviors. Finally, a large number of the unit's residents are from out-of-state (including four from DLC's sample of 11 residents) and therefore not subject to the MMQ.

Bear Mountain Response: Training:

Bear Mountain maintains that staff are "substantially trained" to provide care to residents of the neurobehavioral unit. Bear Mountain points to initial or yearly trainings it requires in dementia care and safety care (including replacement behaviors and reducing or eliminating physical intervention). It also provides a training course, presumably during or after orientation, on the mission and philosophy of the unit, and its policies and procedures. In addition, those holding state licenses have their own continuing education requirements associated with licensure. See e.g., <https://www.mass.gov/info-details/mandatory-continuing-education-for-nurses>.

DLC's Reply:

Bear Mountain is a facility with a significant population of persons diagnosed with schizophrenia or other significant psychiatric diagnoses. It relies heavily on pharmacological interventions, yet none of the required training identified by Bear Mountain's response, or revealed our monitoring, specifically addresses psychiatric conditions nor use and effects of psychotropic medication. The facility does not require that nursing staff have specialized training and experience in psychiatry, behavioral health, or treatment of persons diagnosed with SMI. Specifically, the facility does not require that some or all nursing staff hold a master's degree in nursing, be currently licensed to practice in the Commonwealth, and be certified by the American Nurses Association as an Adult Psychiatric-Mental Health Clinical Nurse Specialist - Board Certified (PMHCNS-BC) or be a Psychiatric Mental Health Nurse Practitioner - Board Certified (PMHNP-BC).

⁵ Commonwealth of Massachusetts Division of Medical Assistance Provider Manual Series, Nursing Facility Manual: Appendix E: Instructions for Completing MMQ, NF-53, May 26, 2009, p. E-4, <https://www.mass.gov/doc/appendix-e-instructions-for-completing-mmq/download>.

It is critical that staff be adequately trained. It will be helpful for Bear Mountain to certify at least some of its staff to be brain injury specialists (as it now proposes). Bear Mountain must also provide more significant training in behavior management and analysis. We maintain our recommendation that all staff on the neurobehavioral unit need training in psychiatric conditions and acquired brain injuries, and the effects of psychotropic medications. Its director should have a clinical background in order to ensure adequate care, therapeutic programming, coordination of care and adequate staff competencies and support.

Bear Mountain Response: Behavior Plans, Contractors, and Specialized Services:

Bear Mountain maintains that it provides sufficient personnel to meet the needs of residents, based on both the number and competency of staff. It states that it convenes an interdisciplinary team to develop care plans including non-pharmacological intervention. It also states that each of the residents DLC identified for records reviews had a behavioral and/or mood care plan with non-pharmacological interventions.

DLC's Reply:

In DLC's record reviews, the two most glaring omissions in resident's records were the absence of multidisciplinary, professional evaluations, as discussed in our systemic findings, and the absence of documented person-centered multi-disciplinary behavioral health treatment plans. Such plans should be living documents which include detail such as target behaviors and onset dates, goals, assignments to particular treatment team members and an assessment of the need for evaluations (including neuropsychiatric evaluations and cognitive assessments) and outside expertise.

Behavior plans should be created by staff with psychiatric clinical training, and where appropriate, with input from a neurologist, psychologist (PhD), psychiatrist, master's prepared licensed counselors, master's prepared behavioral specialists, licensed social worker, and/or other licensed and trained professionals. It is also essential that direct care staff, including CNAs and nurses, be familiar with the behavior plan and prepare to provide feedback to allow for necessary adjustments. The PA's involvement is also essential.

Instead, our record review reflects rudimentary nursing care plans, labeled as "behavior plans" or "mood plans" that are being written by staff without formal psychiatric or neurological training. Often and predictably, these plans fail to identify the antecedents or triggers of problematic behavior and consists of repeated instructions to "redirect" the individual without incorporating positive behavioral supports or employing other effective treatment modalities.

Bear Mountain has not responded to the concerns raised in review of multiple resident records, that professional patient assessments and consultations are not provided as needed for complex patients. As noted in the report, a psychiatrist's offsite supervision of a PA for this large number of complex patients, many of whom receive under multiple psychotropic medications, is a suboptimal staffing matrix for diagnostic accuracy, treatment planning, or medication reviews.

Bear Mountain Response: Diagnoses and Medication

Bear Mountain contends that neither the Facility nor its staff are responsible for prescribing medications to residents but rather this responsibility lies with “external providers of their choice.” At the same time, it acknowledges that almost all, if not all, residents use the facility’s contracted providers.

DLC’s Reply:

Bear Mountain is directly and fully responsible for prescribing medications to its residents. It is extremely disturbing that Bear Mountain does not acknowledge this responsibility. Instead, it wrongly asserts that third party providers prescribe medications. In the case of psychotropic medications, Health Drive PA recommends medications and dosage changes, but does not prescribe. Rather it is the medical director, who also serves as the onsite physician for the sample of residents reviewed, as well as nurse practitioners (also contracted by Bear Mountain) who prescribe the medications.

Bear Mountain’s interest in minimizing liability and delegating responsibilities to independent contractors only goes so far. When residents live in a facility, even if prescriptions originate from an outside doctor, the facility medical staff write orders and are obligated to safeguard those patients. The in-person medical staff (nurses, etc.) carry out those prescriptions. The staff who observe the resident must then decide whether those medications are safe and appropriate or not. Responsibility is not limited to an outside physician.

DLC agrees that pharmacists’ reviews are important for flagging concerns about medication interactions and some side effects, but not a substitute for the professional patient assessments and oversight necessary for medication management. The pharmacist’s monthly review of each resident’s chart, for approximately 130 residents, is unlikely to be in sufficient depth and does not include the in-person assessment to substitute for clinical oversight of a patient’s care. Here, pharmacy reviews did not flag many of our expert’s concerns about anticonvulsant levels or potential neurologic toxicity from antipsychotic medications. DLC also noted instances where pharmacist recommendations to reduce a medication were not followed, nor were the justifications to continue the medications noted in the records.

Bear Mountain Response: Diagnoses of Schizophrenia:

Bear Mountain objects to any suggestion that the number of diagnoses of schizophrenia at the facility should be reviewed, and that these diagnoses might be related to larger patterns in the industry, described in the report, of overmedication, and unintended incentives for facilities to diagnose residents with schizophrenia. The facility contends that “nearly all” of the residents with this diagnosis came to Bear Mountain with this diagnosis in place. The incidence of schizophrenia then, it argues, should be no more suspect than the incidence of cancer in a cancer center.

DLC’s Reply:

Bear Mountain correctly notes that diagnoses of schizophrenia are usually made in early adulthood. Our own review of diagnostic records however, revealed that of 24 residents with schizophrenic or schizoaffective disorder diagnoses, 16 had been admitted with these

diagnoses. Assuming then, that one-third of residents with these diagnoses (8 of 24) are only receiving this diagnosis after admission to Bear Mountain, more questions are warranted. This is particularly so when symptoms do not improve with treatment, and individuals have multiple diagnoses or medical conditions that could be the basis for challenging symptoms.

DLC's concern – again as stated in the report - is that a lack of comprehensive psychiatric evaluations and failure to consider of the effects of neurological disorders, dementia, and other histories in the sample, likely yields an overly high diagnosis of schizophrenia. Even if patients entered the facility with such diagnoses, it becomes the facility's responsibility to ensure that ongoing treatment is based on accurate diagnoses.

Bear Mountain Response: Non-Pharmacological Interventions:

Bear Mountain states that it implements non-pharmacological interventions such as psychotherapy through contracted LICSWs and other contracted providers.

DLC's Reply:

DLC noted many instances in the record reviews where calming or de-escalation techniques were not employed in response to agitation or aggressive behaviors, nor were positive behaviors encouraged and supported in behavior management plans. Health Drive does provide supportive counseling, but such counseling, which typically focuses on current issues facing the resident rather than long-term change, does not qualify as psychotherapy.⁶

We acknowledge some improvement seen during our October 2023 visit, but the facility still has considerable distance to go move from a model of custodial care to create a therapeutic milieu with structured programming.

Bear Mountain Response: Informed Consent:

Bear Mountain states that its nurse practitioner or psychiatrist meet and discuss the most significant risks and benefits of each medication with the resident and/or their legal representative after which the resident or representative sign a consent form.

DLC' Reply:

Guardians and active health care proxies for Bear Mountain residents DLC reviewed told us that staff rarely discussed the risks and benefits of medications with them. If staff spoke with them

⁶ See, for example, the Massachusetts psychotherapist-patient privilege statute, which defines a psychotherapist as follows:

“Psychotherapist”, a person licensed to practice medicine, who devotes a substantial portion of his time to the practice of psychiatry. “Psychotherapist” shall also include a person who is licensed as a psychologist by the board of registration of psychologists; a graduate of, or student enrolled in, a doctoral degree program in psychology at a recognized educational institution as that term is defined in section 118, who is working under the supervision of a licensed psychologist; or a person who is a registered nurse licensed by the board of registration in nursing whose certificate of registration has been endorsed authorizing the practice of professional nursing in an expanded role as a psychiatric nurse mental health clinical specialist, pursuant to the provisions of section eighty B of chapter one hundred and twelve.

G.L. c. 233, sec. 20B.

about needing to add a medication or raise a dosage, it was not the more knowledgeable Health Drive PA, but rather the Unit supervisor (an RN) or one of the nurse practitioners. DLC noted very few discussions concerning medications with resident representatives in the patient records reviewed, and those discussions did not fully document the significant risks and benefits discussed. DLC also stands by the observation in the report that the risk of UTIs from antipsychotics are not included in written informed consents, nor are the potential impact of the antipsychotic medication on the threshold for seizures mentioned for those residents who had seizure disorders.

Bear Mountain Response: Infections and Falls:

Bear Mountain contends that it employs robust infection control practices and notes that it has a full-time certified infection control nurse who does rounds daily. The facility also states that residents with identified infections are discussed weekly, that the facility uses state of the art air purifiers and has had successful infection control surveys.

Bear Mountain also states that it provides a comprehensive interdisciplinary review of each fall that occurs, reporting such falls to primary care providers and conducting clinical assessments where necessary, if falls may be related to psychotropic medication.

DLC's Reply:

Bear Mountain has not refuted the multiple serious infections noted in the records, which were longstanding; or the reports of family and guardians of infections on its floors.

The records DLC reviewed do not document Bear Mountain's assertion that all falls are comprehensively reviewed by an interdisciplinary team. DLC's report discusses specific instances where such reviews were necessary and not carried out.

Bear Mountain Response: Facility Environment:

Bear Mountain states that the photos in the report do not show the extent to which rooms are personalized for facility residents or the décor of all common areas. The facility also states that the hospital-like nature of parts of the facility relates to the level of care needed by residents.

As to residents who were inadequately groomed and dressed, Bear Mountain replies that residents may refuse grooming and hygiene or enter common areas before staff have an opportunity to clean and dress them.

DLC's Reply:

State regulations provide: "All resident areas shall be cheerful, homelike, pleasant, clean, well-kept, free from unpleasant odors, sights, and noises, and maintained in good repair. (2) Space and furnishing shall provide each resident with comfortable and reasonably private living accommodations. Beds shall be placed to avoid drafts, heat from radiators, unpleasant noises, or other discomforts." 105 CMR 150.015(F)(1).

The regulations also provide that residents shall have a reasonable amount of privacy, be treated with dignity and kindness, and shall be encouraged and assisted to dress and move about, where their conditions permit. 105 CMR 150.015(B).

As noted in the report, our final monitoring visit in October 2023 showed some improvement in the decoration of hallways and rooms. Our larger concern was personal care issues. In October 2023, there was some improvement in staff responsiveness, but still many residents who were poorly groomed and with poor personal hygiene, with stained clothing or wearing hospital gowns, and still odors in some areas. It takes well-trained and adequate numbers of direct care staff to engage with residents and teach self-care to the extent possible for each resident, and to provide residents with choices and sense of self-control even if staff are assisting them.

Bear Mountain Response: Rodent Control:

Bear Mountain maintains that it has “robust infection control practices.”

DLC’s Reply:

In its response letter, the facility admits that it has a rodent control problem necessitating visits by a pest control company four (4) days a week, to lay down sticky traps “in every room.” It blames the problem on residents who hoard, on nearby road construction and the age of the building, almost 80 years old, and states that it is doing “everything reasonably practicable” to control rodents. The fact remains that we do not routinely see rodent infestation at this level in other skilled nursing facilities that we monitor as the Protection and Advocacy system.

Moreover, the legal standard is not “to do everything reasonably practicable.” Rather it is to “[m]aintain an effective pest control program so that the facility is free of pests and rodents.”⁷

Bear Mountain Response: Substance Abuse Disorders:

Bear Mountain states that it is prepared to address substance addiction disorders. It notes that every staff member receives DPH’s training on opioid and stimulant use disorders. It also reminds DLC that is a skilled nursing facility and not a substance abuse provider licensed by the Bureau of Substance Abuse *[sic]* *[Addiction]* Services.

DLC’s Reply:

The training cited by Bear Mountain consists of online self-paced learning modules required of providers receiving add-on payments for serving residents with a history of substance use disorders. <https://www.maseniorcare.org/member-resources/e-news-updates/care-residents-opioid-stimulant-use-disorders-long-term-care>; <https://www.mass.gov/doc/moud-in-ltc-toolkit/download>. Still, the regulatory training requirement applies to 75% of direct care staff,

⁷ See CMS State Operations Manual, <https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf>, “F925 (Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.”; “PROCEDURES: §483.90(i)(4)..... Evidence of pest infestation in a particular space is an indicator of noncompliance”.

and Bear Mountain states that 100% of all staff have been trained. We acknowledge and appreciate this decision.

Bear Mountain Response: Peer-Based Recovery Support Services:

Bear Mountain states that it has engaged an organization called Unity Recovery to provide “clinical peer-based recovery support services” through Zoom meetings.

DLC’s Reply:

According to its website, Unity Recovery provides online peer-based recovery support groups to the general public, living inside or outside of facilities. Participation is free to the public and it describes its services as being “non-clinical,” rather than clinical.⁸

Remote peer-led Zoom meetings, while useful for some, cannot take the place of evidence-based treatment by licensed drug and alcohol counselors, providing patient-specific assessments, and engaged in relationship building within a recovery community. Bear Mountain residents with substance abuse disorders are unlikely to be equipped to return to the community successfully without this expertise being in place, within the facility. The facility cannot have it both ways – accepting persons with substance use histories and enhanced state rates, but at the same time stating that it does not require specialized expertise on staff.⁹

Bear Mountain Response: Interpreter Services:

Bear Mountain states that it makes (presumably telephonic) interpretation available for residents and staff through The Language Line.

DLC Reply:

Research indicates that in-person interpretation is superior to remote interpretation, and remote/video interpretation may be better than remote/telephonic interpretation.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2842540/>

Bear Mountain’s response does not address the statements discussed in the report, made to DLC by administrative staff, that they do not use Language Line for six primarily Spanish speaking residents because they appear to speak and understand enough English. Indeed, two

⁸ See <https://unityrecovery.org/about-us>. According to its 2021 Form 990, the organization receives over 2 million dollars annually in governmental grants. <https://www.guidestar.org>

⁹ Similar problems exist throughout the nursing home industry. See Shannon Dwin Mitchell et. al., “Patients with Substance Use Disorders Receiving Continued Care in Skilled Nursing Facilities following Hospitalization” [Subst Abus. 2022; 43\(1\): 848–854](#). available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9793431/#:~:text=Much%20work%20remains%20to%20be,order%20to%20create%20a%20culture> (“Much work remains to be done to better equip SNFs for the task of better addressing the needs of patients with SUDs, including building expertise (or at least understanding of) SUDs amongst the staff, expanding OUD medication capacity, and reducing stigma related to substance use disorders in order to create a culture of recovery that promotes health and well-being.”). In addition, there are widespread practices of discrimination against persons who need skilled nursing facilities and who have opioid use disorders. See <https://www.mcknights.com/news/prosecutors-target-nursing-homes-that-reject-patients-needing-opioid-treatment/>

experienced employees told us that they had never used the Language Line, ever. For 2020 and 2021, Bear Mountain reported \$0 in expenditures for interpreters, either in the form of salaries or purchased services.¹⁰ The facility's response also does not address whether the facility has prepared a language access plan as required by law.

Bear Mountain's response does not address our findings regarding K.L., specifically staff's contention that she "speaks more English than she lets on," and that she is being directed to activities that are "less dependent on language." We were unable to find any documented use of an interpreter for K.L. in our records review. As noted, our experience was that K.L. gave much more detailed responses when DLC utilized a Spanish interpreter compared to her responses in English. We concluded that she is socially isolated and assessments and clinical care may have been limited by a failure to utilize interpreters.

Bear Mountain Response: Discharge Planning:

Bear Mountain contends that it has a "robust" discharge planning process. It notes that residents are difficult to discharge, that providers may decline to accept them and that sixteen (16) residents are actively working on a discharge plan.

DLC's Reply:

We agree that discharge planning from skilled nursing facilities and the absence of adequate supports and services is a significant problem in Massachusetts (and elsewhere) which extends beyond the control of any particular facility. This issue requires engagement, commitment, and resources from the Commonwealth.¹¹

We are not able to comment on the sixteen (16) persons with active discharge plans who Bear Mountain notes, nonetheless, remain at the facility. It would be necessary to review records in these cases; identify if they overlap with the cases we reviewed; assess the length of time awaiting discharge; assess if best efforts have been undertaken; and isolate the causes of any barriers to discharge. Any person who has been unnecessarily institutionalized for a considerable length of time should trigger considerable concern by the facility, the state, and the public, over their loss of human rights, as well as the importance of spending health care dollars efficiently.

Our own records review fails to substantiate the facility's assertion that it engages in robust discharge planning, particularly for its long-term residents. All residents asking about return to their communities should be educated and informed, even when they have guardians. Federal law requires that nursing home staff ask all residents on a quarterly basis, including residents with guardians, about their interest in discharge.¹²

The addition, begun in July 2023, of transition case managers from DMH, and Behavioral Health Community Partners through community-based organizations to support case coordination and discharge planning, will bring new resources to this challenge. This includes

¹⁰ See endnote 147.

¹¹ See https://www.centerforpublicrep.org/court_case/simmons-et-al-v-baker-et-al/ and <https://www.centerforpublicrep.org/wp-content/uploads/Complaint-22cv11715.pdf>

¹² 42 CFR § 483.20.

outreach, engagement, assessments, medication reviews, transition planning, and connections to community resources.

However, even with these new resources, we are concerned about the breadth and depth of Bear Mountain's discharge advocacy. As noted in the report, of the sample of eleven (11) Bear Mountain residents whose records we reviewed, four (4) of the residents were from out of state with three (3) of the longest stay individuals being New York state residents. See discussion of E.F., G.H., and K.L. In addition, M.N. is a resident of the state of Connecticut. According to state records, 29% of the facility's Medicaid revenue comes from out-of-state sources. It is especially important that Bear Mountain staff recognize that their discharge planning obligations extend equally to out-of-state residents. Bear Mountain's response does not address the issue of discharge planning for the facility's out-of-state residents.

Bear Mountain Response: Future Plans for Brain Injury Certification:

Bear Mountain states that it is in the process of certifying identified staff on the neurobehavioral unit as certified brain injury specialists through the Brain Injury Association of Massachusetts.

DLC's Reply:

DLC acknowledges and appreciates this decision. Its success may depend on the number and types of staff selected for this certification.

Bear Mountain Response: Future Plans for Behavioral Management Training:

Bear Mountain states that it is in the process of putting all its staff through a 3-hour Fundamentals of Behavior Management course and an Applied Behavioral Analysis course, i.e., "The Point System."

DLC's Reply:

This is a positive step, but it cannot substitute for acquiring direct care staff with licensure, certifications and expertise in psychiatric nursing, psychology, neurology, and behavioral health. In addition, the literature indicates there are significant, complex challenges associated with instituting culture change in nursing homes with a widespread use of antipsychotics. See <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3910400/>

Bear Mountain Responses: Off-Site Transportation & Additional Activities:

Bear Mountain states that it recently refurbished its van to once again facilitate off-site social and community activities and has begun offering special trips, such as personalized shopping trips.

In addition, Bear Mountain states that it has increased the number of therapeutic programs offered to residents, such as money management classes, hygiene classes, ADL classes, and education about healthy eating, exercise, and social skills.

DLC's Replies:

It is difficult to understand how Bear Mountain allowed the facility's van to become non-operational. Still, we believe this is a very significant and important development, which should be recognized. It occurred in the same time frame as the day programming improvements we recognized during our October 2023 monitoring visit. In earlier visits, we concluded that the lack of programming and access to the outdoors or the community was contributing to boredom and frustration of residents which was, in turn, exacerbating baseline behavioral challenges. We acknowledge and appreciate these changes. There is still work to be done - for example, in securing greater access to the outdoors.¹³ However, we believe that if the facility builds upon these reforms, the results will be beneficial for both residents and staff.

Conclusion by DLC:

We thank Bear Mountain for taking the time to review our draft report and to provide detailed comments, including helpful updates about changes planned or underway at the facility. Once again, we also thank Bear Mountain staff for their engagement, courtesy, and professionalism in cooperating with DLC and monitoring visits by our staff and expert.

DLC's concerns are based upon six (6) site visits with multiple DLC staff over two years (October 2021 to October 2023), which included interviews with our own observations, along with interviews of residents and staff, and subsequently, with guardians. We conducted intensive record reviews of eleven residents covering January 2020 to October 2022, which were paired with resident, guardian, and staff interviews. As noted in the report, we also consulted with three highly experienced experts, a psychiatric nurse, a psychiatrist, and a nursing home administrator. The psychiatric nurse visited the facility and all three experts helped guide our field work, our assessment of the prevailing standard of care, and our findings and recommendations. Finally, we conducted extensive research, represented in detailed endnotes in our report, as to how the issues identified compare to common practices, larger issues of nursing home reform and related societal challenges.

We acknowledge that our review was, by necessity, limited by both scope and time. It is possible that other residents, whom we did not observe extensively, or whose records we did not review, received a higher level of care. It is also possible that better protocols have been or will be put into place outside the scope of our review period. We hope so. It is concerning however, that the facility largely does not see, or has not acknowledged, the shortcomings we have documented and identified.

¹³ During our final monitoring visit in October 202, one resident of 8 years reported that they had left the building twice. Another resident of 5 years reported not having been outside in that entire time.

Response from EOHHS and its Agencies, MassHealth, DPH, and DMH.

DLC furnished a draft copy of this report to the Executive Office of Health & Human Services (EOHHS), as well as to DPH, DMH, DDS, and MassHealth on October 24, 2023. DLC received EOHHS' response on December 26, 2023. EOHHS responded on behalf of itself and on behalf of MassHealth, DPH, and DMH, but not DDS. A summary of their response, and DLC's replies to it, are listed below. EOHHS's full response is provided in Appendix B to this report.

EOHHS' Response: PASRR Screen, Evaluation and Services:

EOHHS had begun initiatives to improve the PASRR process to better ensure that individuals with SMI are identified. It has revised its Level 1 screening form and begun training hospitals, nursing facilities, and Aging Services Access Points (ASAPs) in its use. It has also developed an online PASRR portal for all Level 1 screens and documentation, which will facilitate oversight and tracking. EOHHS has also revised its Level II SMI evaluation form to more fully document decisions and more closely track the time approved for nursing facility stays; and has added annual resident reviews for all residents who ever were found positive for SMI. EOHHS has also approved clubhouse services as a specialized service and will authorize all DMH-funded services for residents who have ever been found to have SMI, including out-of-state residents. This may include transitional and case management services.

Massachusetts' new care coordination program, "Behavioral Health Community Partners," will ensure access to recommended specialized and behavioral health services. Eight Bear Mountain residents are now receiving behavioral health coordination services.

DLC's Reply:

DLC greatly appreciates the details that EOHHS provides concerning initiatives to improve the PASRR process to better identify individuals with SMI and to ensure that recommended services are provided. DLC maintains its recommendations, based upon reviews of records for residents which largely preceded these measures. It will be essential for DMH to provide support and oversight to the Behavioral Health Community Partners as they engage with nursing home administrators, staff, and residents, to trouble shoot problems with access to residents and necessary health information.

The inclusion of out-of-state residents in these initiatives is a great step forward for the many out of state residents in Massachusetts nursing homes who have behavioral health conditions and diagnoses of SMI. The same needs for service assurance exist for out of state residents who have ever been identified as having ID/DD. This includes Bear Mountain resident M.N. DLC urges DDS – which has not responded to DLC's draft report - to undertake the same measures as DMH.

EOHHS' response: DMH Transition Case Management and In-Reach Supporting Community Transitions:

DMH case managers will work collaboratively with nursing facilities to assist with community transition for any resident who has been identified with SMI and is expected to be discharged within 90 days. Four Bear Mountain residents are currently enrolled. Further, operating out of

Aging Services Access (ASAPs), Community Transition Liaison teams have been authorized to provide further support and to provide education for residents and guardians about community placement options.

DLC's Reply:

DLC appreciates the information provided concerning these important initiatives, which just began late in DLC's review. It will be essential for the improved PASRR process to identify nursing home residents who have SMI to be effective, in order to afford these individuals DMH case management services. Both guardians and residents need information about their options, as well as information and support to complete any necessary applications for community-based services. It is also essential that all residents asking about return to their communities be educated and informed, even when they have guardians.

EOHHS' Response: MassHealth Rates and Incentive Payments:

MassHealth will be revising its method for determining resident acuity for the purpose of determining nursing facility rates. In addition, there are behavioral health and SUD (Substance Use Disorder) add-ons of \$50 per day, in order to adequately reimburse facilities for additional costs associated with caring for residents with complex needs. Bear Mountain receives these behavioral health payments for 69 residents. EOHHS also provides a special rate for severe mental and neurological disorder services, for which Bear Mountain does not qualify. EOHHS maintains that such payments should not be restricted to limited facilities, as it perceives DLC suggests in its draft report.

EOHHS is now adding a \$200 payment for MassHealth residents who have SUD diagnosis and need transportation with staff to an Opioid Treatment Program. MassHealth also adjusts payments based on quality of care.

DLC's Reply:

DLC assumes this method for determining acuity replaces the MMQ. The behavioral health and SUD add-ons are longstanding, and DLC maintains its concern that facilities are rewarded for staff time spent on residents in acute states, but not for staff time spent maintaining stability. DLC maintains its recommendation that EOHHS should establish behavioral health quality of care standards and only reward for acuity if best practices are in place. DLC has not suggested that the payments be restricted to limited facilities, only that the facilities provide quality care needed for behavioral health treatment and supports. We also note that Bear Mountain has maintained an overall lowest score CMS rating for years.

EOHHS' Response: Staffing Requirements:

EOHHS has established through regulation, a minimum staffing standard in Massachusetts, and penalized Bear Mountain January 1, 2021 – March 31, 2022, for failing to meet the required 3.48 Hours Per Patient Day threshold. Bear Mountain met the minimum requirements in August 2023.

EOHHS also describes its Direct Care Cost Quotient (DCC-Q), a regulation which assures facilities are directing funds to direct care costs. <https://www.mass.gov/doc/dccq-report-july-1-2022-june-30-2023/download>.

DLC's Reply:

DLC has cited this penalty in its final report. However, the state's minimum staffing requirements are below the 2001 recommended staffing ratio's; and the neurobehavioral unit has many residents with complex conditions, who would require more care than the minimum.

DLC appreciates the decision to develop this sanction beginning in October 2020. To our knowledge, Massachusetts is one of only four states imposing this type of penalty.¹⁴

EOHHS' Response: Monitoring Behavioral Health in Nursing Homes:

EOHHS cites a significant decline in the use of antipsychotic medication statewide between 2011 and 2015. MassHealth and DPH are now working on policies to increase monitoring of antipsychotics medications in high use nursing homes with a focus on ensuring high-quality behavioral health services and reducing unnecessary use of antipsychotic medications. DPH is further hosting conferences to promote best practices in treating residents with substance use disorders.

DLC's Reply:

DPH's recent initiatives to increase and target monitoring of antipsychotics usage is precisely what is needed, considering the increase in use in Massachusetts since 2015, and the high rates in certain nursing homes. Further, as discussed in the report, the cited drop in the use of antipsychotics must be tempered by the increased diagnosis of individuals with schizophrenia in Massachusetts nursing homes, a rate that had increased from 2011 when CMS excluded schizophrenia from the antipsychotics usage rate, and which likely lacked full validity. DLC supports increased training and support for treatment of residents with substance abuse disorders.

DLC emphasizes the need to strengthen the care provided to nursing home residents with complex neurocognitive and psychiatric disorders in order to stabilize and make ready for discharge to more integrated, less restrictive settings. This will require heightened standards for neurobehavioral and behavioral health services, including staffing and competency requirements.

EOHHS' Response: DPH Surveys of Nursing Facilities:

DPH surveyor teams already meet DLC's recommendations, consisting of at least one nurse surveyor, who has experience treating individuals with mental and emotional disorders, and a non-nurse surveyor, all of whom must have experience with and knowledge of working with residents who have mental or emotional disorders. DPH conducts both standard surveys every 9-15 months and responds to specific complaints. Non-compliance with standards requires DPH follow-up; DPH can also recommend that CMS serve a notice of "immediate jeopardy" if

¹⁴ Harrington, "United States' Nursing Home Finances: Spending, Profitability and Capital Structure," International Journal of Social Determinants of Health and Health Services, 2023 at 8.

conditions are likely to cause serious injury or harm to a resident or employee. DPH summarizes its informal dispute resolution process, and the 2023 surveys and complaint inspections.

DLC's Reply:

DLC discussed its concerns with DPH 2022 and 2023 surveys in the context of systemic investigations related to the Massachusetts survey process, as well as other states. DLC stands by its findings that the February 2022 survey did not identify and cite the root causes for the numerous deficiencies and did not attribute sufficient risk to large numbers of residents. We continue to recommend that DPH survey teams surveying neurobehavioral units include a surveyor with sufficient clinical expertise to review behavioral treatment plans and medication regimens and identify diagnostic reliability. DPH also has not responded to the concern that despite the large number of deficiencies, it did not survey Bear Mountain until eighteen months later. This concern is not limited to one facility; as discussed in the report, many nursing homes in Massachusetts have had delays in survey recertification of up to four years.

Even if Bear Mountain has improved, it remains in the bottom 3% of Massachusetts nursing homes.¹⁵

EOHHS' Response: Language Access:

DPH surveys for non-discrimination clauses to be included in patient admission packets, and expanding the languages of the CNA certification exam if the facility is predominantly non-English speaking.

DLC's Reply:

DPH has not responded to apparent violations of language access in the case of resident K.L., nor to the fact that Bear Mountain is in violation of Massachusetts regulations by failing to provide a language access plan following the change in ownership. Until state agencies develop protocols for more rigorous oversight, DLC lacks confidence that EOHHS or DPH will enforce these vital civil rights protections ensuring equal access to patient care.

Response from CHIA

DLC furnished a draft copy of this report to CHIA on October 25, 2023, and received a response on December 1, 2023. A summary of their response, and DLC's replies to it, are listed below. CHIA's full response is provided in Appendix B to this report.

CHIA's Response:

CHIA is routinizing availability of nursing facility cost reports and reviewing records access response processes to ensure timely production of available records; CHIA collects cost reports for realty companies, including SABRA REIT. CHIA cooperates with government agencies and other entities to ensure records are made available for all lawful purposes.

¹⁵ EOHHS, Bear Mountain at Worcester Overall Performance Summary, <https://eohhs.ehs.state.ma.us/nursehome/FacilityOverall.aspx?Facility=0723> (accessed December 28, 2023).

DLC's Reply:

DLC appreciates CHIA's clarification that it collects realty company cost reports, which initially were not made available to DLC upon request. DLC also appreciates that CHIA is working to improve its process for making cost reports available closer to the agency's receipt of the data; EOHHS also confirmed that there will be improvements made to the submission process for nursing facility cost reports.

EOHHS stated in its response with respect to financial reporting, that EOHHS and CHIA will be collecting additional data on nursing home owners and related entities. All of these efforts will improve both policymakers' and the public's ability to rely on this important information. DLC maintains its recommendations to make cost reports available on a timelier basis, and to publish all cost reports on its website.

VII. Recommendations

Recommendations for Bear Mountain:

1. Provide training for direct care staff in brain injury, other acquired brain injuries and neurological disorders, psychiatric disabilities, psychotropic medications. Train and support staff in strength-based, person-centered approaches to care and behavioral management;
2. Hire and retain sufficient staff to provide consistent, individualized health care and behavioral health supports, and to maintain hygiene and observe for signs of infection. Hiring and retention measures should include financial incentives, retention bonuses, and professional certifications;
3. Provide for on-site neurological and psychiatric oversight and consultation;
4. Require integrated, interdisciplinary team meetings for treatment planning and oversight, involving direct care staff;
5. Provide substance abuse treatment and for residents with histories of alcohol and substance abuse;
6. Provide therapeutic behavioral health and substance abuse treatment programming;
7. Provide programming and support to develop and maintain daily living skills, including self-care, money management, vocational and education counseling and development, and socialization;
8. Ensure language access and comply with all state and federal requirements. Hire bilingual clinical staff, and ensure training and qualifications, of all staff providing interpreter services. Qualified staff should be reimbursed for providing interpreter services;
9. Ensure that residents and legal representatives understand the risks and benefits of medications;
10. Set goals with residents and plans to meet goals for skills development, socialization, and discharge planning;
11. Ensure that all PASRR recommendations are implemented, and that complete PASRR documentation is filed in medical records;
12. Invest in homelike environments, outdoor and indoor seating areas, considering appropriate lighting and heating controls. Continue to promote personalized decorations, with resident involvement and choice. Develop separate therapeutic spaces to allow for reduced sensory stimulation for residents, as well as separate programming areas; and
13. Restore transportation services to community settings, including shopping and parks. Involve resident choice in outings.

Recommendations for EOHHS (DMH, MassHealth, DPH & DDS):

EOHHS:

1. Strengthen licensing requirements for behavioral health services in long-term care facilities to require staffing levels, competencies, training, and services;
2. Maintain higher MassHealth rates for residents with behavioral issues of higher acuity only in facilities with best treatment practices in place;
3. Ensure that Bear Mountain and other facilities are complying with informed consent for psychotropic medication requirements;

4. Ensure that there is coordination with out of state Medicaid agencies to fund PASRR evaluations and services for out of state residents, through policy development and agreements with out of state Medicaid agencies; and
5. Ensure that nursing home residents with neurobehavioral and psychiatric conditions who may be capable of living in the community and desire to do so, are appropriately assessed and supported. The needs of residents for integrated care and supports must be accommodated. Residents and their representatives must be informed about community-based living and support options in Massachusetts or the individual's home state. New community transition efforts (Community Transition Liaisons Program) must be supported to ensure connections with nursing home social workers, residents, and representatives, at Bear Mountain and all nursing homes with neurobehavioral units.

EOHHS and DPH:

1. Conduct an assessment of behavioral health needs of Massachusetts long-term nursing home residents, and assessment of facility services, programming, and staffing, targeting a) nursing homes with high rates of anti-psychotic drug usage, b) frequent use of emergency rooms under Section 12(a), as well as other emergency hospitalizations including inpatient stays, and 3) high rates of MassHealth expenditures for individuals with behavioral health challenges. Such assessment should also consider the service and programming needs in nursing homes to support community transition.

DPH:

1. Conduct an audit of Bear Mountain to determine whether there is current cause to declare jeopardy under 105 CMR 150.0010(C)(1);
2. Review whether current staffing is adequate at Bear Mountain, and review revenue, staffing and billing data;
3. Provide adequate resources for surveying nursing homes to ensure enforcement of state and federal standards. DPH must supply surveyors who have the clinical expertise necessary to review behavioral health treatment, neurobehavioral programs, and psychotropic medication practices;
4. Review IDR appeals data and ensure fairness in the IDT process;
5. Ensure that annual surveys are completed, and complaints responded to on a timely basis, and audit inspections and plans of correction;
6. Ensure that Bear Mountain complies with language access requirements at 105 CMR 130.310; and
7. Ensure that PASRR evaluators identify individuals with SMI, by conducting training and auditing the PASRR process.

DMH and DDS:

1. DMH and DDS must ensure that facilities implement PASRR recommendations for services. DMH should review and support new outside care coordination efforts to implement behavioral health services, evaluations, and PASRR recommended services.

Recommendations for CHIA:

1. CHIA must process nursing facility reports, management company reports, and realty company reports in a timely manner. CHIA should publish management and realty company cost reports on its website to make them available for review.

Recommendations for New York State Office of Mental Health (OMH), Office of Persons with Developmental Disabilities (OPWDD), and Department of Health (DOH):

1. Ensure that PASRR evaluations are conducted for New York Medicaid residents in Massachusetts nursing homes, and that recommended specialized services as well as other necessary care outside nursing home rates, are provided by funding such evaluations and services; and
2. Conduct annual follow-up with New York Medicaid residents' Massachusetts nursing homes regarding adequacy of services. Ensure that nursing home transitional services programs conduct regular outreach with Massachusetts nursing homes where New York residents are placed, including Bear Mountain.

VIII. Conclusion

When we are unwilling or unable to provide long term supports and services in the community, people with significant disabilities are further obscured from public view. Confined to beds in nursing homes and other institutions, those who are too often unseen in the community risk becoming utterly invisible to the public. They become vulnerable to abuse and neglect because of inadequate staffing and clinical expertise, excessive use of medication, substandard conditions, and prolonged isolation.

The public relies on state and regulatory authorities to oversee these institutions and ensure high quality care. This oversight is vitally important in nursing homes which concentrate on serving people with traumatic brain injuries, other neurobehavioral disabilities, or psychiatric diagnoses. Unfortunately, when this oversight falls short, individuals in nursing homes can be left defenseless against the impact of poor conditions, poor quality of care, and staff inadequacies.

The Protection and Advocacy (P&A) system was created by Congress to provide an independent watchdog agency which can contribute to overseeing both these institutions and their regulators. P&As are tasked with conducting deeper investigations than are customary for federal and state agencies and identifying the root causes of abuse and neglect, both within a facility and at a systemic level.

As the Massachusetts P&A, we have undertaken our two-year review of Bear Mountain Worcester with these goals in mind. We have identified major challenges facing this specialized facility, utilizing the following approaches:

- six (6) site visits;
- extensive interviews with residents, guardians, family members and staff;
- record reviews of eleven (11) Bear Mountain residents;
- developing narratives of the lives of these residents;
- factual and legal research and policy analysis; and
- consultation with three experts.

The issues we identified included:

- a lack of properly trained and credentialed staff in psychiatry, psychology, and psychiatric nursing;
- lack of necessary neurological assessments;
- a lack of rigorous multi-disciplinary behavior plans;
- a heavy reliance on antipsychotic medication and possible overdiagnosis of schizophrenia;
- staffing levels which have been insufficiently robust;
- insufficient day programming;
- insufficient access to the outdoors and the community,
- insufficient access to interpreters, and more.

Although the facility made some improvements towards the end of DLC’s two-year review period (ending in October 2023), there is significant work to be done to protect and properly care for the residents of Bear Mountain Worcester’s neurobehavioral units. The most glaring problems continue to be lack of suitable specialized licensed and credentialed staff in psychiatry, neurology, psychology and psychiatric nursing; lack of neurological assessments and detailed interdisciplinary behavioral plans informed by such specialized credentialed staff; stronger staffing ratios for serving this specialized population; and the need to review practices related to antipsychotic use and schizophrenia diagnoses, among other issues.

DLC has also described the state’s oversight of the facility, including both shortcomings and areas of progress. DLC has urged more rigorous state enforcement following findings of deficiencies. We have also asked the Commonwealth to not reward nursing homes with higher Medicaid rates when serving residents with behavioral challenges unless these facilities also comply with higher standards of care. In addition, we have highlighted needs for greater transparency and prompt public access to data on nursing home ownership, expenses, and revenue, given their reliance on Medicare and Medicaid funds. This is particularly important when nursing homes are controlled by private equity, or as is the case here, real estate investment trusts (REITs). Finally, we have called for stronger staffing ratios, greater oversight over staffing and levels of clinical expertise in specialized facilities, and additional oversight over discharge planning. Important policy changes by state agencies are underway, including increased review of antipsychotic medication, and additional resources to facilitate discharge planning, and provisions for sanctions for facilities which fail to meet general staffing ratios. However, those changes do not reach issues such as the need for stronger staffing ratios in specialized facilities, or the need to link rates for specialized facilities to demonstrated adherence to higher prevailing standards of care provided by staff with clinical expertise. Again, there is much more work to be done.

This process always begins with facility owners, state regulators, and members of the public seeing conditions within the facility with greater clarity and helping facility residents become fully visible once again. DLC hopes that our investigation and report have contributed to this endeavor.

Endnotes

¹ We urge the Department of Public Health to pursue this inquiry.

² This mandate was first codified through the passage of the Protection & Advocacy for Individuals with Developmental Disabilities (PADD) Act, 42 U.S.C. 15043. Congress then extended similar protections under the Protection & Advocacy for Individuals with Mental Illness (PAIMI), 42 U.S.C. §§ 10801 et seq., and subsequently extended the protections of the PADD Act to persons with other disabilities, incorporating them by reference into subsequent authorizing legislation, namely: Protection & Advocacy for Individual Rights (PAIR), 29 U.S.C. § 794e (protecting persons with disabilities who do not meet the eligibility criteria for PADD or PAIMI), and the Protection & Advocacy for Individuals with Traumatic Brain Injury (PATBI) Act, 42 U.S.C. § 300d-53.

³ 42 U.S.C. § 1395i-3(b)(2).

⁴ Charlene Harrington, Mary Ellen Dellefield, Elizabeth Halifax, et al., “Appropriate Nurse Staffing Levels for U.S. Nursing Homes,” *Health Services Insights*, 13 (Jan.-Dec. 2020), <https://doi.org/10.1177/1178632920934785>.

⁵ Charlene Harrington, Brian Olney, Helen Carrillo, “Nurse Staffing and Deficiencies in the Largest For-Profit Nursing Home Chains and Chains Owned by Private Equity Companies,” *Health Services Research*, 47(1 Pt 1) (Feb. 2012):106-28, doi: 10.1111/j.1475-6773.2011.01311.x; D.A. Harris, R. Youssef, K.D. Pelland, et al., “Associations Between Resident, Facility and Community Characteristics and Use of Antipsychotic Medications in Rhode Island Nursing Homes,” *Journal of Nursing Home Research* 3 (2017): 110-115, <http://dx.doi.org/10.14283/jnhrs.2017.17>.

⁶ It is critical to consider the context of nursing home industry, oversight and enforcement. While the protection and advocacy statutes and regulations define abuse largely in terms of individual actions or inactions, DLC is concerned not with faulting direct care staff, but rather that nursing home management and owners should meet their responsibilities for providing adequate treatment, and that oversight agencies enforce standards of care. For example, the National Center on Elder Abuse’s report on the mistreatment of nursing home residents found that nursing homes have been associated with deficient care, an ill-prepared and understaffed workforce, substandard infection protocols, and inadequate facility and regulatory oversight. Facility owners and operators share the responsibility for abuse and neglect, even when it is committed by direct care staff. National Center on Elder Abuse, “Research Brief: Elder Mistreatment in Long Term Care” (rev. Aug. 2022), available at https://ncea.acl.gov/NCEA/media/Publication4.0/RB_LTC.pdf.

⁷ Stephen Ralph & Anthony Espinet, “Increased All-Cause Mortality by Antipsychotic Drugs: Updated Review and Meta-Analysis in Dementia and General Mental Health Care,” *Journal Alzheimer’s Disability Reporter*, 2018; 2(1): 1–26, doi: [10.3233/ADR-170042](https://doi.org/10.3233/ADR-170042); Martin Harrow, Thomas Jobe, Liping Tong, “Twenty-year effects of antipsychotics in schizophrenia and affective psychotic disorders,” *Psychological Medicine* 52: 13 (Oct. 2022): 2681–2691. doi: 10.1017/S0033291720004778; Adam H. Dyer, Claire Murphy, Brian Lawlor, et al., “Long-term Antipsychotic Use and Cognitive Decline in Community-dwelling Older Adults with Mild-moderate Alzheimer Disease,” *International Journal of Geriatric Psychiatry*, 36 (2021):1708–1721, <https://doi.org/10.1002/gps.5591>.

⁸ 42 C.F.R. §483.10(e)(1).

⁹ For example, “abuse” is defined as act or failure to act by an employee of a facility rendering care or treatment which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to a individual with mental illness, and includes acts such as the use of bodily or chemical restraints on a [individual with mental illness](#) which is not in compliance with federal and [state](#) laws and regulations. 42 U.S. Code § 10802(1) (PAIMI statute).

¹⁰ U.S. Dept. Health & Human Services Office of Inspector General, Issue Brief: “CMS Could Improve the Data It Uses to Monitor Antipsychotic Drugs in Nursing Homes,” OEI-07-19-00490 (May 2021), available at <https://oig.hhs.gov/oei/reports/OEI-07-19-00490.pdf>; Amanda C. Chen and David C. Grabowski, “Nursing homes underreport antipsychotic use but overreport diagnoses qualifying for appropriate use,” *Health Affairs Scholar*, 1:2 (August 2023), qxad022, <https://doi.org/10.1093/haschl/qxad022>.

Nursing homes subtract the numbers of residents who have schizophrenia from the numbers of residents receiving antipsychotic medication in the report to the Centers for Medicare and Medicaid Services (CMS), the federal oversight agency.

¹¹ Dylan J. Jester, Kathryn Hyer, & John R. Bowblis, “Quality Concerns in Nursing Homes That Serve Large Proportions of Residents With Serious Mental Illness,” *The Gerontologist*, 60(7) (2020): 1312–1321, doi:10.1093/geront/gnaa044.

¹² The rate of antipsychotics administration in Massachusetts is 24.38%, the seventh highest in the country. Long Term Care Community Coalition, “A Decade of Drugging: Supplementary Materials: Antipsychotic Drugging % in

Nursing Homes, Non-Risk-Adjusted (2012-2022)” (2022), available at <https://nursinghome411.org/reports/decade-drugs/>.

¹³ DLC contacted guardians and health care proxies of a sample of residents who were prescribed multiple psychotropic medications and requested releases for records; the residents with health care proxies also provided consent.

¹⁴ Because the residents on the neurobehavioral unit met criteria under one or more of DLC’s authorizing statutes, DLC made its finding under the four statutes which authorize DLC to investigate incidents of abuse and neglect of individuals with mental illness, developmental disabilities, traumatic brain injury, and for residents with other disabilities “when the incidents are reported to the system or there is probable cause to believe that the incident that the incidents occurred.” 42 U.S.C. § 10805(1); 42 USC § 15043(a)(2)(b); 29 U.S.C. § 794e(f)(2); 42 U.S.C.A. § 300d-53.

¹⁵ 42 C.F.R. § 51.2; 45 C.F.R. § 1326.19.

¹⁶ The regulations and statutes protecting individuals with disabilities define neglect to include “a negligent act or omission by an individual responsible for providing treatment which caused or may have caused injury to an individual with disabilities or which placed an individual with disabilities at risk of injury or death,” and includes the failure to: establish or carry out an appropriate individual program plan or treatment plan (including a discharge plan); provide adequate nutrition, clothing, or health care; or to provide a safe environment which also includes failure to maintain adequate numbers of appropriately trained staff, or failure to take appropriate steps to prevent self-abuse, harassment, or assault by a peer. 45 C.F.R. § 1326.19. This regulation defines neglect and abuse of individuals with developmental disabilities; the statute and regulations governing extend to individuals with traumatic brain injury and individuals with disabilities that are not developmental nor significant mental illness. The statute protecting individuals with significant mental illness also applies to this investigation, and defines neglect similarly, but does not expressly include discharge plan, or the failure to prevent self-abuse, harassment, or assault by a peer. 42 U.S.C. § 10802(5). However, the statute is inclusive, so those omissions could also be considered neglect under the Protection and Advocacy for Individuals with Mental Illness Act.

¹⁷ Abuse is defined as “any act or failure to act by an employee of a facility rendering care or treatment which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death” to the person with disability, 42 U.S.C. § 10802(1); 45 CFR § 1326.19.

¹⁸ The psychiatric nurse, Beatrice Coulter, R.N., is an experienced reviewer of PASRR admission and continued stay reviews for individuals currently in nursing facilities or seeking admission who may have SMI under PASRR. Ms. Coulter has also worked extensively in home care and psychiatric supported settings as well as hospital settings, as a nurse, care manager, and in quality assurance. Beatrice Coulter participated in one of the six site visits, in March 2023.

¹⁹ Dr. Leslie Vogel has over 30 years of experience in the field of psychiatric medicine, focusing on Neuropsychiatry and Geriatric Psychiatry. She graduated from Yale University School Of Medicine, earning her medical degree in 1987. She did her internship at the Hospital of the University of Pennsylvania, and her residency at University of Texas at San Antonio. She then did a Fellowship in Consultation-Liaison Psychiatry at Columbia Presbyterian Hospital, and subsequently an additional Fellowship in Developmental Psychobiology at the Columbia University College of Physicians and Surgeons.

Dr. Vogel is certified by the American Board of Psychiatry and Neurology, and is licensed to practice in Massachusetts and New York. She has decades of experience in evaluating and treating complex geriatric patients in the nursing home setting. She has served as Consultant in Psychiatry for a broad spectrum of neurologically, medically and psychiatrically ill patients at the Spaulding Nursing and Therapy Center/Brighton, part of the Spaulding Rehabilitation Network

²⁰ James Lomastro has more than 40 years of experience as a senior administrator in healthcare, human services, behavioral health, and home and community-based services. He has served on numerous advisory boards and committees related to policy, regulatory and program development at local, state, and national level. For 20 years, he was a surveyor at the Commission on Accreditation of Rehabilitation Facilities throughout the U.S. and Canada. Dr. Lomastro has a Ph.D. in Policy, Research and Administration from the Heller School at Brandeis University, with post doctorate work undertaken in Psychosomatic and Behavioral Medicine at Boston University’s School of Medicine. He has served on numerous advisory boards and committees related to policy, regulatory and program development at local, state and national levels.

²¹ Administrators who met with DLC were the nursing home administrators, directors of nursing, and director of social services.

²² 42 U.S.C. 1395i-3(b)(1)(A); 42 C.F.R. § 483.21(b)(2)(iii); 42 C.F.R. § 483.25.

²³ 42 C.F.R. § 483.40(a); 42 C.F.R. §483.45(d); 42 C.F.R. § 483.25.

²⁴ 42 C.F.R. § 483.40(a) & (b); 42 C.F.R. § 483.25.

²⁵ 42 U.S.C. § 1395i-3(b)(2); 42 C.F.R. § 483.40(b).

²⁶ 42 C.F.R. §483.40(a), 42 C.F.R. § 483.45(e), 42 C.F.R. § 483.12(a)(2), 42 C.F.R. § 483.25.

²⁷ 42 CFR § 482.43.

²⁸ The U.S. Supreme Court’s 1999 landmark decision in *Olmstead v. L.C.* (Olmstead) found the unjustified segregation of people with disabilities is a form of unlawful discrimination under the Americans with Disabilities Act (ADA). *Olmstead v. L. C.*, 527 U.S. 581 (1999). The Olmstead requirements to support community integration for qualified individuals apply to public entities, including Medicaid-funded institutions.

²⁹ National Center on Elder Abuse, “Research Brief: Elder Mistreatment in Long-Term Care” at 1 (rev. Aug. 2022), available at https://ncea.acl.gov/NCEA/media/Publication-4.0/RB_LTC.pdf.

³⁰ Institute of Medicine Committee on Nursing Home Regulation, “Improving the Quality of Care in Nursing Homes” (Washington, D.C.: National Academies Press, 1986), doi: 10.17226/646.

³¹ The Nursing Home Reform Act was passed into law as part of the Omnibus Budget Reconciliation Act of 1987, and amended by Public Law 100-203 and 101-508.

³² CMS contracted with Abt Associates, which produced the evaluation, “Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Report To Congress: Phase II Final, Volume I” (December 2001), available at <https://theconsumervoice.org/uploads/files/issues/CMS-Staffing-Study-Phase-II.pdf>. Abt determined that these are thresholds below which facilities are more likely to have quality of care problems. The threshold included combined 1.3 LPNs and RNs (or .55 LPN, utilizing the .75 RN threshold).

In February 2022, spurred by the devastating consequences of the COVID pandemic and reports of continued pervasive deficiencies in quality of care, particularly in the investor-driven for-profit sector of nursing home ownership, the Biden Administration announced that CMS would establish a minimum staffing requirement as well as other protections. The White House, FACT SHEET: “Protecting Seniors by Improving Safety and Quality of Care in the Nation’s Nursing Homes” (February 28, 2022), available at <https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/>. CMS proposed for public comment minimum staffing levels which are not as high as the 2001 recommended staffing levels, but which were proposed as minimum standards which could be implemented to raise staffing levels in a large number of facilities in the near-term. CMS, “Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency,” Federal Register Vol. 88 No. 171, September 6, 2023, 61352-61429. Based on facility assessments (the rule also proposed strengthening facility assessment requirements), if the acuity needs of residents in a facility require a higher level of care, a higher RN and NA staffing level will also be required. *Id.* at 61353.

³³ In 2022, and between 2017 and 2018, 75% of nursing homes fell short of the 2001 federal staffing recommendations. *Id.*; Long Term Care Community Coalition, “LTCCC Alert: Most U.S. Nursing Homes Understaffed, Federal Data Finds,” <https://nursinghome411.org/alert-staffing-q4-2022/#:~:text=In%20a%20new%20staffing%20report,resident%20care%20needs%20are%20met>. A recent report financed by a consulting firm for the health care industry also found that 94% do not meet the minimum recommendations. CliftonLarsonAllen LLP, “Staffing Mandate Analysis In-Depth Analysis on Minimum Nurse Staffing Levels and Local Impact” (July 2022), available at <https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/CLA-Staffing-Mandate-Analysis.pdf>.

The Center for Medicare Advocacy maintains that the 2001 staffing recommendations are dated, and that needs have increased. Toby Edelman, Center for Medicare Advocacy, “Improving Nursing Home Staffing Levels Can and Must Be Done,” (July 21, 2022), available at <https://medicareadvocacy.org/nursing-home-staffing-levels/>. The federal proposed rule, which would be implemented three years following promulgation, will fail to meet minimum quality of care needs. Toby Edelman, “Meaningful Nurse Staffing Ratios in Nursing Homes: If Not Now, When?” (September 7, 2023), available at <https://medicareadvocacy.org/meaningful-nurse-staffing-ratios-in-nursing-homes-if-not-now-when/>.

³⁴ Jayme Fraser and Nick Penzenstadler, “Dying for Care: Many nursing homes are poorly staffed. How do they get away with it?” USA Today, December 1, 2022, <https://www.usatoday.com/in-depth/news/investigations/2022/12/01/skilled-nursing-facilities-staffing-problems-biden-reforms/8318780001>.

³⁵ The National Consumer Voice for Quality Long-term Care, “State Nursing Home Staffing Standards Summary Report,” December 2021, available at https://theconsumervoice.org/uploads/files/issues/CV_StaffingReport.pdf; Charlene Harrington, Mary Ellen Dellefield, Elizabeth Halifax, et al., “Appropriate Nurse Staffing Levels for U.S. Nursing Homes,” *Health Services Insights* 13 (June 2020): 1–14, doi: 10.1177/1178632920934785.

³⁶ 105 CMR 150.007(B).

³⁷ Social Security Act §§ 1819 and 1919.105 CMR 150.007(A), (B) and 150.002(D)(1).

³⁸ Joseph Mattingly, “A Review Exploring the Relationship Between Nursing Home Staffing and Antipsychotic Medication Use,” *Neurol Ther* 4 (Dec. 2015): 169–175, at 170, doi: 10.1007/s40120-015-0032-2.

³⁹ 42 CFR 483.70(e). CMS has proposed strengthening facility assessment requirements, and underscores that in addition to meeting proposed minimum staffing levels, the facility assessment must be used to determine the necessary resources and staff required to care for residents, including competencies and skill sets, and training needs. “Minimum Staffing Standards,” *supra* n.32 at 61373-74, 61429.

⁴⁰ Mattingly, *supra* n.38 at 170; Minimum Nurse Staffing Ratios Report to Congress, *supra* n 32.

⁴¹ Charlene Harrington, Brian Olney, Helen Carrillo, “Nurse Staffing and Deficiencies in the Largest For-Profit Nursing Home Chains and Chains Owned by Private Equity Companies,” *Health Services Research*, 47(1 Pt 1) (Feb. 2012):106-28, doi: 10.1111/j.1475-6773.2011.01311.x.; Margaret J. McGregor, Marcy Cohen, Kimberlyn McGrail, et al., “Staffing Levels in Not-for-profit and For-profit Long-term Care Facilities: Does Type of Ownership Matter?” *Canadian Medical Association Journal* 172(5) (March 1, 2005): 645-9, doi: 10.1503/cmaj.1040131

⁴² Long Term Care Community Coalition, LTCCC Alert: Latest Data Indicate Dangerous Antipsychotic Drugging is Rampant in Nursing Homes, January 11, 2022, <https://nursinghome411.org/alert-apdrugs-q2-2021/>; D.A. Harris, R. Youssef, K.D. Pelland, et al., “Associations Between Resident, Facility and Community Characteristics and Use of Antipsychotic Medications in Rhode Island Nursing Homes,” *Journal of Nursing Home Research* 3 (2017): 110-115, <http://dx.doi.org/10.14283/jnhrs.2017.17>.

⁴³ “Nurse Staffing and Deficiencies,” *supra* n.41; Atul Gupta, Sabrina T. Howell, Constantine Yannelis, et al., “Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes,” NYU Stern School of Business (Nov. 2020); Atul Gupta, Sabrina T. Howell, Constantine Yannelis, et al., “Owner Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes,” National Bureau of Economic Research (Feb. 2021, rev. Aug. 2023), DOI 10.3386/w28474; Matthew Goldstein, Jessica Silver-Greenberg, Robert Gebeloff, “Push for Profits Left Nursing Homes Struggling to Provide Care,” *New York Times*, May 7, 2020, <https://www.nytimes.com/2020/05/07/business/coronavirus-nursing-homes.html>.

⁴⁴ Michael Norton, “CHIA Report - Occupancy Rates, Margins Challenge Nursing Homes,” *Statehouse News Services*, (Nov. 25, 2019), <https://www.chiamass.gov/report-occupancy-rates-margins-challenge-nursing-homes/>.

⁴⁵ Kay Lazar, “A Pattern of Profit and Subpar Care at Mass. Nursing Homes,” *Boston Globe*, May 3, 2016, <https://www.bostonglobe.com/metro/2016/03/26/profit-and-care-massachusetts-nursing-homes/JfpOM6rwcFAObDi2JLcAnN/story.html>.

⁴⁶ National Academies of Sciences, Engineering, and Medicine, “Traumatic Brain Injury: A Roadmap to Accelerating Progress: Chapter 6, Rehabilitation and Long-Term Care Needs After Traumatic Brain Injury,” (National Academies Press: Washington, D.C. February 2022): “Only about 13–25 percent of patients who survive moderate, severe, or penetrating TBI receive comprehensive, interdisciplinary inpatient rehabilitation, and even fewer receive TBI-specialized rehabilitation care (Corrigan et al., 2012). Instead, patients are often discharged to home, where they may or may not receive home health services, or to skilled nursing facilities (SNFs) that do not provide intensive, comprehensive, or specialized therapy and that often limit physician visits to as infrequently as once per month.

⁴⁷ 42 C.F.R. § 483.40(a).

⁴⁸ *Id.*

⁴⁹ 42 C.F.R. § 483.40(b).

⁵⁰ David C. Grabowski, Kelly A. Aschbrenner, Zhanlian Feng et al., “Mental Illness in Nursing Homes: Variations Across States,” *Health Affairs (Millwood)*, 28(3): 689-700, doi:10.1377/hlthaff.28.3.689. While the data is from 2005, several in DLC’s sample at Bear Mountain were admitted by that year.

⁵¹ Dylan J. Jester, Kathryn Hyer, & John R. Bowblis, “Quality Concerns in Nursing Homes That Serve Large Proportions of Residents With Serious Mental Illness,” *The Gerontologist*, 60(7) (2020): 1312–1321, doi:10.1093/geront/gnaa044. When certifying nursing homes, CMS considers residents with schizophrenic disorders, delusional disorders, psychotic mood disorders, and anxiety disorders to have SMI. In 2016, 32.51% of Massachusetts nursing home residents met this definition. *Id.* Another a recent study found that nationally, the number of people being admitted to nursing homes with serious psychiatric diagnoses has increased. Cassandra L. Hua, Portia Y. Cornell, Sheryl Zimmerman, et al., “Trends in Serious Mental Illness in U.S. Assisted Living and the Community: 2007-2017,” *The American Journal of Geriatric Psychiatry*, 29(5) (May 2021): 434-444, <https://doi.org/10.1016/j.jagp.2020.09.011>. This phenomenon is also noted by CMS in its discussion of the

proposed rules, and is the reason CMS has proposed clarifying behavioral health standards and strengthening facility assessment requirements relating to behavioral health services, skill sets and competencies. “Minimum Staffing Standards,” *supra* n.32 at 61369.

⁵² 105 CMR 150.003(B).

⁵³ 101 CMR 206.10(16). These indicators are based on the ratings that the facility submits to CMS in its assessment of residents for the Minimum Data Set.

⁵⁴ Massachusetts State Plan Amendment (SPA) #: 20-0032, IV.N. Behavioral Indicator Adjustment. It is not clear how long such rates, based on FY2019 data, would remain in effect.

⁵⁵ 101 CMR 206.11. Program staff must include a neuropsychologist and neuropsychiatrist, substance use counselors, and certified brain injury specialists, among others, and must provide an individualized therapeutic skill development plan, sensory modulation and cognitive rehabilitation, neuropsychological testing, alcohol and substance use counseling, and community integration, among other services. In addition, to qualify for the rate, at least 90% of resident days must be for residents with mental or neurological disorders. Bear Mountain also provides specialized respiratory services, so although its population of residents with mental and/or neurological disorders is considerable, it is not likely to meet this threshold. Bear Mountain’s 2022 facility assessment indicates that the numbers of residents with behavioral health disorders, which may not include all residents with neurological disorders, is 65%; approximately half its census in 2021 had ABI/TBI/neurological disorders, according to DLC’s review of residents’ diagnoses.

⁵⁶ Care One at Holyoke, Care One at Lowell, and Timberlyn Heights receive the specialized program rate.

⁵⁷ Among the facilities that do not qualify for the rate pursuant to 101 CMR 206.11, in addition to Bear Mountain, are Mission Care at Holyoke, Hillcrest Commons and Sudbury Pines, which each have locked behavioral units. Braintree Manor and West Side House advertise neuro rehabilitation or neurobehavioral services. Berkshire Rehabilitation & Skilled Care Center does not advertise such services, but from monitoring the facility, DLC learned its 57-bed facility serves almost exclusively veterans who have high rates of TBI, PTSD, and psychiatric conditions. With the exception of Hillcrest Commons, all are for-profit nursing homes.

⁵⁸ Behavioral Health Community Partners are community-based organizations, contracted with MassHealth to provide enhanced care coordination for all eligible NF residents. This includes outreach, engagement, assessments, medication reviews, transition planning, and connections to community resources. Transition case managers are teams from DMH. EOHHS, “MassHealth Nursing Facility Bulletin 180: Behavioral Health Community Partners Supports and DMH Case Transition Management Team for Nursing Facility Residents” (July 2023), available at <https://www.mass.gov/doc/nursing-facility-bulletin-180-behavioral-health-community-partners-supports-and-dmh-case-transition-management-team-for-nursing-facility-residents/download>.

⁵⁹ The Institute of Medicine report noted the high degree of behavioral health needs among nursing home residents, and the large increase of people with psychiatric illness in nursing homes by the 1980s, attributed to the closure of psychiatric hospitals. “Improving the Quality of Care in Nursing Homes,” *supra* n.30.

⁶⁰ These disabilities are defined at 42 C.F.R. § 483.102.

⁶¹ 42 C.F.R. §§ 483.100-138.

⁶² 42 U.S.C. § 1396r(7)(B)(iii); 42 C.F.R. § 483.20(e)(2).

⁶³ EOHHS, “MassHealth Nursing Facility Bulletin 143: Updates to Nursing Facility Regulations: Preadmission Screening and Resident Review (PASRR) for Intellectual Disability, Developmental Disability, and/or Serious Mental Illness” (July 2019);

EOHHS, “MassHealth Nursing Facility Bulletin 169: Updates to Nursing Facility Regulations: Preadmission Screening and Resident Review (PASRR) for Intellectual Disability, Developmental Disability, and/or Serious Mental Illness” (October 2021). In Bulletin 169, EOHHS added that that the significant change may qualify someone who had not earlier qualified for positive Level I Screening for SMI or ID, or may result in a change in previous PASRR determinations.

⁶⁴ 42 U.S.C. § 1396r (b)(3)(F)(i) & (ii).

⁶⁵ *Id.*

⁶⁶ For example, for individuals with SMI services could include peer supports, a recovery assistant, transitional case management, or participation in community psychosocial activities. The services may include training staff on individualized approaches to helping the person manage their behaviors. Frank Spinelli, “Financing or Arranging for PASRR Specialized Services for Individuals With Serious Mental Illness: Medicaid and Medicare Options.” (May 11, 2017), available at <https://www.pasrrassist.org/resources/Financing-or-Arranging-for-PASRR-Specialized-Services-for-Individuals-with-Serious-Mental-Illness%3A-Medicaid-and-Medicare-Options>.

⁶⁷ The PASRR Technical Assistance Center conducts these studies and does training and education encouraging use of PASRR both to inclusively identify SMI and ID/DD, to divert from nursing homes when appropriate, and to identify and fund services and supports to be included in an individualized, person-centered plan of care in the nursing facility. See, <https://www.pasrassist.org/reports>. E.g., PASRR Technical Assistance Center, “2016 PASRR National Report: A Review of Preadmission Screening and Resident Review (PASRR) Programs,” March 11, 2017, available at <https://www.pasrassist.org/resources/2016-National-Report%3A-Quality-Measures-and-MDS> (nursing home data indicates that in most states, PASRR significantly under-identifies individuals with SMI)..

⁶⁸ “Financing or Arranging for PASRR Specialized Services,” *supra* n.66; see also “PTAC Resources on Specialized Services,” available at <https://www.pasrassist.org/topics>

⁶⁹ The substance use treatment services are for the provision of methadone, buprenorphine, buprenorphine/naloxone, or naltrexone. EOHHS, “MassHealth Nursing Facility Bulletin 169: Updates to Nursing Facility Regulations: Preadmission Screening and Resident Review (PASRR) for Intellectual Disability, Developmental Disability, and/or Serious Mental Illness” (October 2021). The new care coordination services, if successfully implemented, would improve implementation of recommended specialized services and nursing-facility level services. See *supra* n. 59.

⁷⁰ U.S. Dept Health & Human Services Office of Inspector General, “Long-Term Trends of Psychotropic Drug Use in Nursing Homes,” OEI-07-20-00500, (November 2022), available at <https://oig.hhs.gov/oei/reports/OEI-07-20-00500.asp>.

⁷¹ *Id.* at 1.

⁷² *Id.* at 6.

⁷³ American Psychiatric Association, “The American Psychiatric Association Practice Guideline for the Treatment of Patients With Schizophrenia” (2021) at 28, available at <https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890424841>.

⁷⁴ 86 American Geriatrics Society, “Ten Things Clinicians and Patients Should Question,” (rev. April 23, 2015), available at <https://www.healthinaging.org/tools-and-tips/tip-sheet-ten-things-physicians-and-patients-should-question>.

⁷⁵ Mathematica Policy Research, “Use of Antipsychotics in the Older Patients in Inpatient Settings (AP) Measure: AP Public Comment Summary” (2016), available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Hospital-MDM_AP-Public-Comment-Summary-Report_FINAL.pdf.

⁷⁶ 42 U.S.C. § 1395i-3 (c)(1)(A)(ii).

⁷⁷ As part of the resident’s right to participate in treatment and plan of care, the resident has the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers, and has the right to request, refuse, and/or discontinue treatment. 42 C.F.R. §483.10(c)(5) & (6).

⁷⁸ 42 C.F.R. §483.45(d).

⁷⁹ 42 C.F.R. §483.45(e).

⁸⁰ Long Term Care Community Coalition, “LTCCC Alert: Dangerous Antipsychotic Drugging Persists Despite Federal Partnership,” December 20, 2022, <https://nursinghome411.org/alert-decade-drugs/> (Q2 2021).

⁸¹ “Psychotropic Drug Use in Nursing Homes,” *supra* n.70; Long Term Care Community Coalition, “LTCCC Alert: Latest Data Indicate Dangerous Antipsychotic Drugging is Rampant in Nursing Homes,” January 11, 2022, available at <https://nursinghome411.org/alert-apdrugs-q2-2021/#:~:text=Of%20the%20residents%20receiving%20APs,in%205%2Dstar%20nursing%20homes>.

⁸² Long Term Care Community Coalition, “A Decade of Drugging: Supplementary Materials: Antipsychotic Drugging % in Nursing Homes, Non-Risk-Adjusted (2012-2022)” (2022), available at <https://nursinghome411.org/reports/decade-drugs/>. The rates had decreased from 2012, when the rate was 27%, following CMS measures to curb antipsychotics usage, discussed *infra*.

⁸³ This data is drawn from LTCCC’s non-risk-adjusted antipsychotic rates. <https://nursinghome411.org/data/ap-drugs/>.

⁸⁴ U.S. Food & Drug Administration, “Information for Healthcare Professionals: Conventional Antipsychotics,” (June 2008), available at <https://wayback.archive-it.org/7993/20170722190727/https://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm124830.htm>. See Stephen Ralph & Anthony Espinet, “Increased All-Cause Mortality by Antipsychotic Drugs: Updated Review and Meta-Analysis in Dementia and General Mental Health Care,” *J Alzheimer’s Disability Reporter*, 2018; 2(1): 1–26, doi: 10.3233/ADR-170042; Katie Thomas, Robert Gebeloff, Jessica Silver-Greenberg, “Phony Diagnoses Hide High Rates of Drugging at Nursing Homes,” *New York Times*,

September 11, 2021, <https://www.nytimes.com/2021/09/11/health/nursing-homes-schizophrenia-antipsychotics.html>.

⁸⁵ Donovan T. Maust, “Antipsychotics, Other Psychotropics, and the Risk of Death in Patients With Dementia: Number Needed to Harm,” *JAMA Psychiatry* 72(5) (May 2015): 438-445, doi: 10.1001/jamapsychiatry.2014.3018.

⁸⁶ “Ten Things Clinicians and Patients Should Question,” *supra* n.74.

⁸⁷ See, e.g., T. Scott Stroup & Neil Gray, “Management of Common Adverse Effects of Antipsychotic Medications,” *World Psychiatry* 17(3) (October 2018): 341–356, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6127750/>

⁸⁸ Tanja Richter, Gabriele Meyer, Ralph Mohler, et al., “Psychosocial Interventions for Reducing Antipsychotic Medication in Care Home Residents,” *Cochrane Database of Systematic Reviews* 12(12) (December 2012), doi: 10.1002/14651858.CD008634.pub2.

⁸⁹ U.S. Dept. Health & Human Services Office of the Inspector General, “Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents,” OEI-07-08-00150 (May 2011), available at <https://oig.hhs.gov/oei/reports/oei-07-08-00150.pdf>.

⁹⁰ CMS, “Description of Antipsychotic Medication Quality Measures on Nursing Home Compare,” available at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/AntipsychoticMedicationQM.pdf>. CMS uses quality measures associated with effective, safe, and efficient health care to rate nursing home performance.

⁹¹ This includes individualized assessment of worsening changes and involvement of interdisciplinary care team and family members or representatives. CMS Center for Clinical Standards and Quality/Survey & Certification Group, Memorandum to State Survey Agency Directors: “Focused Dementia Care Survey Tools” (November 27, 2015), available at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SC-Letter-16-04-Focused-Survey-Tools.pdf>.

⁹² CMS Center for Clinical Standards and Quality/Survey & Certification Group, Memorandum to State Survey Agency Directors: “Advanced Copy: Dementia Care in Nursing Homes: Clarification to Appendix P State Operations Manual (SOM) and Appendix PP in the SOM for F309 – Quality of Care and F329 – Unnecessary Drugs,” (May 24, 2013), available at <https://www.cms.gov/medicare/provider-enrollment-and-certification/surveyscertificationgeninfo/downloads/survey-and-cert-letter-13-35.pdf>.

⁹³ “Psychosocial Interventions,” *supra* n. 88. A staff training intervention focusing on alternatives to drugs for agitation led to a 19.1% reduction in neuroleptic prescribing for nursing home residents with dementia. Jane Fossey, Clive Ballard, Edmond Juszcak, et al., “Effect of Enhanced Psychosocial Care on Antipsychotic Use in Nursing Home Residents with Severe Dementia: Cluster Randomised Trial,” *BMJ* 332(7544) (April 2006): 756–8, doi: 10.1136/bmj.38782.575868.7C.

⁹⁴ Jennifer Speziale, Ed Black, Robin Coatsworth-Puspoky, et al., “Moving Forward: Evaluating a Curriculum for Managing Responsive Behaviors in a Geriatric Psychiatry Inpatient Population,” *The Gerontologist*, 49(4) (August 2009): 570-576, <https://doi.org/10.1093/geront/gnp069>; Jacqueline Crandall, Robin Coatsworth-Puspoky, Kimberly Schlegel, et al., “Implementing Gentle Persuasive Approaches: Dementia Education for Staff on In-patient Medicine Units: A Program Evaluation,” *Dementia* 21(4) (May 2022): 1173–1199, doi: 10.1177/14713012211070148.; Jeffrey A. Buchanan, Angela M. Christenson, Carly Ostrom, et al., “Non-Pharmacological Interventions for Persons With Dementia: A Review of the Literature,” *The Behavior Analyst Today* 8:4 (2007): 413-425, available at <https://psycnet.apa.org/fulltext/2008-05985-003.html>.

⁹⁵ “Moving Forward,” *supra* n.94.

⁹⁶ In one study, higher rates of nurses feeling under time pressure (perceiving they had an excessive workload without sufficient time to devote to patient care) contributed to greater prevalence of psychotropic drug use, even beyond nursing staffing levels per se – suggesting patient acuity is an important factor underlying work conditions associated with higher antipsychotic rates. Laura Pekkarinen, Timo Sinervo, Marja Leena-Perala, et al., “Work Stressors and the Quality of Life in Long-Term Care Units,” *The Gerontologist* 44:5 (Oct. 2004): 633-643, doi: 10.1093/geront/44.5.633.

⁹⁷ Four of 15 residents with dementia had dementia without behavioral disturbance and received no psychotropic medication. Five received sedatives alone, and one was prescribed lithium. These medications were not necessarily prescribed for dementia, but the risks are the same, and for all conditions, behavioral and psychosocial are supposed to be primary alternatives to medications.

⁹⁸ Such risks include tardive dyskinesia, cardiovascular disease, and metabolic disturbances. Christopher Cornell, Jose Rubio, John Kane, “What is the risk-benefit ratio of long-term antipsychotic treatment in people with schizophrenia?” *World Psychiatry* 17(2) (June 2018): 149–160, doi: 10.1002/wps.20516. See also, Martin Harrow,

Thomas Jobe, Liping Tong, “Twenty-year effects of antipsychotics in schizophrenia and affective psychotic disorders,” *Psychological Medicine* 52: 13 (Oct. 2022): 2681–2691. doi: 10.1017/S0033291720004778.

⁹⁹ APA Practice Guideline for Treatment of Schizophrenia, *supra* n.73.

¹⁰⁰ *Id.* Older individuals metabolize medications at different rates. *Id.*

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ See Anja P. Husa, Jani Moilanen, Graham K. Murray, et al., “Lifetime antipsychotic medication and cognitive performance in schizophrenia at age 43 years in a general population birth cohort,” *Psychiatry Research* 247 (Jan. 2017): 130-138, <https://doi.org/10.1016/j.psychres.2016.10.085> (reviewing research and reporting longitudinal data for individuals diagnosed with schizophrenia at midlife).

¹⁰⁴ *Id.* Such treatments include cognitive behavioral therapy, psychoeducation (which conveys information about diagnosis, symptoms, psychosocial interventions, medications, and side effects as well as information about stress and coping, crisis plans, early warning signs, and suicide and relapse prevention, and teaching illness management or self-management strategies), and supported employment. *Id.* Marian McDonagh, Tracy Dana, Sarah Kopelovich et al., Psychosocial Interventions for Adults With Schizophrenia: An Overview and Update of Systematic Reviews,” *Psychiatric Services*, 73:3 (March 2022), <https://doi.org/10.1176/appi.ps.202000649> (survey of evidence-based practices informing APA Guidelines). Psychosocial interventions should be goal-oriented, person-centered, and designed to enhance overall functioning and quality of life. Alan S. Bellack, Dialogues in Clinical Neuroscience, “Psychosocial Treatment in Schizophrenia,” 3(2): 136-137 (June 2001), doi: 10.31887/DCNS.2001.3.2/asbellack.

¹⁰⁵ “Quality Concerns in Nursing Homes,” *supra* n.51, using CMS’ definition of SMI used in its nursing home certification process.

¹⁰⁶ “Associations Between Resident, Facility and Community Characteristics,” *supra* n.42.

¹⁰⁷ *Id.*

¹⁰⁸ Ari Ne’emen, Michael Stein, and David Grabowski, “Nursing Home Residents Younger Than Age Sixty-Five Are Unique And Would Benefit From Targeted Policy Making,” *Health Affairs* 41: 10 (May 2022): 1449-1459, <https://doi.org/10.1377/hlthaff.2022.00548>.

¹⁰⁹ Adrita Barooah and Pamela Nadash, Admission and Care of Individuals with Mental Illness in Massachusetts Nursing Homes: An Exploratory Study,” *Journal of Applied Gerontology*, 42(2) (Feb. 2023): 252-258, doi: 10.1177/07334648221131186. This rise in admissions is a widespread phenomenon, also noted by CMS in its proposed rule. M. Barton Laws, Ally Beeman, Sylvia Haigh, et al., “Changes in Nursing Home Populations Challenge Practice and Policy,” *Policy, Politics, and Nursing Home Practice*, 23(4) (August 2022), <https://doi.org/10.1177/15271544221118315>; “Minimum Staffing Standards,” *supra* n.32 at 61369.

¹¹⁰ DLC letter to Marylou Sudders, Secretary EOHHS, “Disability Law Center Findings from Nursing Facility Monitoring Efforts,” September 21, 2022.

¹¹¹ In October 2021, 43 of the 68 residents with TBI as well as other ABI’s were treated with psychotropics; 37 received sedatives, antipsychotics, or both. The severity of the injuries is not known from the diagnostic information.

¹¹² Ann Hoffman, Jeffrey Cheng, Ross Zafonte, et al., “Administration of Haloperidol and Risperidone After Neurobehavioral Testing Hinders the Recovery of Traumatic Brain Injury-Induced Deficits,” *Life Sciences* 83: 17-18: Aug. 31 2008): 83(17-18): 602–607, doi: 10.1016/j.lfs.2008.08.007. This rise in admissions is a widespread phenomenon. M. Barton Laws, Ally Beeman, Sylvia Haigh, et al., “Changes in Nursing Home Populations Challenge Practice and Policy,” *Policy, Practice, and Nursing Home Practice*, 1-11 (2022). A review of psychotropic medicine following moderate or severe TBI found that 25% of 2,130 patients were being administered antipsychotics. David L. Ripley, Sangeeta Driver, Ryan Stork, et al., “Pharmacologic Management of the Patient With Traumatic Brain Injury,” *Rehabilitation After Traumatic Brain Injury* (Chapter 11) (2019), available at <https://www.in.gov/health/overdose-prevention/files/Ripley-et-al-Pharmacologic-Management-of-the-Patient-with-TBI.pdf>.

¹¹³ Deb Shoumitro, Verity Leeson, Leena Aimola, et al., “Aggression Following Traumatic Brain Injury: Effectiveness of Risperidone (AFTER): Study Protocol for a Feasibility Randomised Controlled Trial,” *Trials* 19: 325 (June 21 2018): 1-10, doi.org/10.1186/s13063-018-2601-z

¹¹⁴ “Administration of Haloperidol and Risperidone,” *supra* n.113.

¹¹⁵ Heather MacKenzie MD FRCPC, Cecilia Flores-Sandoval PhD, Amber Harnett MSc RN, *Post-Traumatic Seizure Disorders Following Acquired Brain Injury* in “Evidence-Based Review of Moderate to Severe Acquired Brain Injury,” pp. 1-74 (2023), available at <https://erabi.ca/modules/module-10/>.

¹¹⁶ U.S. Dept. Health & Human Services Office of Inspector General, Issue Brief: “CMS Could Improve the Data It Uses To Monitor Antipsychotic Drugs in Nursing Homes,” OEI-07-19-00490 (May 2021), available at <https://oig.hhs.gov/oei/reports/OEI-07-19-00490.pdf>.

¹¹⁷ MANHR & GBLS Testimony Joint Committee on Public Health Hearing H1981: An Act Relative to Informed Written Consent For Use of Psychotropic Drugs October 29, 2019; J.W. Kerns, K. Winter, R. Sabo, “Increased Reporting of Exclusionary Diagnoses Inflate Apparent Reductions in Long-Stay Antipsychotic Prescribing,” 12/5/17 available at <http://www.tandfonline.com/doi/figure/10.1080/07317115.2017.1395378?scroll=top&needAccess=true>

¹¹⁸ “Phony Diagnoses,” *supra* n.84.

¹¹⁹ CMS will conduct these audits more widely to adjust quality of care ratings and reduce the use of unnecessary antipsychotics. Centers for Medicare & Medicaid Services Center for Clinical Standards and Quality/Survey & Certification Group, “Memorandum to State Survey Agency Directors: Updates to the Nursing Home Care Compare Website and Five Star Quality Rating System: Adjusting Quality Measure Ratings Based on Erroneous Schizophrenia Coding, and Posting Citations Under Dispute,” (January 18, 2023), <https://www.cms.gov/files/document/qso-23-05-nh-adjusting-quality-measure-ratings-based-erroneous-schizophrenia-coding-and-posting.pdf>.

¹²⁰ The MDS Coding for schizophrenia includes schizoaffective disorder, which includes mood disorder symptoms. CMS, RAI Version 3.0 Manual, CH. 3 MDS Items, <https://www.monrotherapyservices.com/wp-content/uploads/2019/11/RAI-Manual-Section-I-Active-Diagnoses.pdf>.

¹²¹ .3% are diagnosed with schizoaffective disorder, which may be included in the total rate of schizophrenia. Even if that is additional, 18% is far higher than the two combined. According to the diagnostic records, of 24 residents with schizophrenic or schizoaffective disorder diagnoses, 16 had been admitted with the diagnoses.

¹²² These disorders were: schizoaffective disorder bipolar type; schizoaffective disorder, unspecified; schizophrenia, and paranoid schizophrenia.

¹²³ According to the diagnostic records, of 24 residents with schizophrenic or schizoaffective disorder diagnoses, 16 had been admitted with the diagnoses. Particularly when symptoms do not improve with treatment, and individuals have multiple diagnoses or medical conditions that could be the basis for symptoms, reevaluation is warranted.

¹²⁴ National Center on Elder Abuse, “Research Brief: Elder Mistreatment in Long-Term Care,” (Aug. 2022), available at https://ncea.acl.gov/NCEA/media/Publication-4.0/RB_LTC.pdf.

¹²⁵ The Nursing Home Reform Act requires regular survey and enforcement of compliance standards. 42 U.S.C. 1395i-3(g)(1)(A) & (2)(A). See Kieran Walsh and Charlene Harrington, “Regulation of Nursing Facilities in the United States: An Analysis of Resources and Performance of State Survey Agencies,” *The Gerontological Society of America* 42 no. 4 (August 2002): 475–486, 476, doi: 10.1093/geront/42.4.475 (discussing state survey agency responsibilities).

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ “Appropriate Nurse Staffing Levels for U.S. Nursing Homes,” *supra* n.35 at 10.

¹²⁹ *Id.* U.S. Department of Health and Human Services Office of Inspector General, “Data Brief: States Continued To Fall Short in Meeting Required Timeframes for Investigating Nursing Home Complaints: 2016-2018,” OEI-01-19-00421 (Sept. 2020), available at <https://oig.hhs.gov/oei/reports/OEI-01-19-00421.pdf>.

¹³⁰ Shira Schoenberg, “Massachusetts Department of Public Health Acknowledges Delays Investigating Nursing Home Complaints,” *MassLive News*, September 21, 2019, <https://www.masslive.com/news/2019/09/massachusetts-department-of-public-health-acknowledges-delays-investigating-nursing-home-complaints.html>.

¹³¹ Nursing homes have up to fifteen months to fill the annual requirement. U.S. Senate Special Committee on Aging, “Uninspected and Neglected: Nursing Home Inspection Agencies are Severely Understaffed, Putting Residents at Risk,” May 13, 2023, available at <https://www.aging.senate.gov/imo/media/doc/UNINSPECTED%20%20NEGLECTED%20-%20FINAL%20REPORT.pdf>. As of June 2023, 32 nursing homes in Massachusetts have not had a recertification survey since 2019. Kerry Kavanaugh and Marina Villeneuve, “Mass. has failed to conduct full inspections of some nursing homes for years, 25 investigates finds,” *Boston 25 News*, June 8, 2023, <https://www.boston25news.com/news/local/mass-has-failed-conduct-full-inspections-some-nursing-homes-years-25-investigates-finds/KEDIS2S4RNCU5H5UD6W22XVAEI/>

¹³² *Id.*

¹³³ Massachusetts surveyors have a high caseload of 504 beds per surveyor – the 14th highest in the country U.S. Senate Special Committee on Aging, *Uninspected and Neglected*, Appendix C. <https://www.aging.senate.gov/imo/media/doc/Appendix%20C.pdf>

¹³⁴ Inspectors are often, but not always, registered nurses, and finding nurses for surveyor positions has become more difficult with the private sector offering better pay and less frequent travel. Fraser and Penzenstadler, “Dying for Care,” *supra* n.34.

¹³⁵ Thirty-six percent of Massachusetts citations appealed over a five-year period (2016-2021) ended up being deleted. Nursing homes have much incentive to appeal to maintain the profits of higher quality of care ratings. Robert Gebeloff, Katie Thomas, and Jessica Silver-Greenberg, “How Nursing Homes’ Worst Offenses Are Hidden From the Public,” *New York Times*, December 9, 2021, <https://www.nytimes.com/2021/12/09/business/nursing-home-abuse-inspection.html>

Over 40% of Massachusetts surveyors indicated that the IDR process favors nursing home operators over patients. U.S. Government Accountability Office, “Nursing Homes: Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment” GAO-10-70, (Dec. 2009),

<https://www.gao.gov/products/gao-10-70>.

¹³⁶ “Dying for Care,” *supra* n.34.

¹³⁷ “Appropriate Nurse Staffing Levels,” *supra* n.35.

¹³⁸ “Dying for Care,” *supra* n.34.

¹³⁹ *Id.*

¹⁴⁰ Nationally, 20% of facility residents are receiving antipsychotics and there are 8.1 citations per 1,000 residents being administered antipsychotics. In Massachusetts, 23% are receiving antipsychotics, and there are just 5.9 citations per 1,000 residents being administered antipsychotics. Long Term Care Community Coalition, “Broken Promises: An Assessment of Nursing Home Oversight” (2021), <https://nursinghome411.org/reports/survey-enforcement/survey-data-report/>.

¹⁴¹ *Id.*

¹⁴² Center for Medicare Advocacy, “Examining Inappropriate Use of Antipsychotic Drugs, Part Two: How Surveyors Describe How, When, and Why They Cite Antipsychotic Drug Deficiencies” (October 24, 2013), available at <https://medicareadvocacy.org/examining-inappropriate-use-of-antipsychotic-drugs-part-two-how-surveyors-describe-how-when-and-why-they-cite-antipsychotic-drug-deficiencies/>. This study garnered responses from over 400 state surveyors, including those in Massachusetts.

¹⁴³ *Id.*

¹⁴⁴ An acquired brain injury is defined as a brain injury occurring after birth. Traumatic brain injuries occur as a result of external force, whereas non-traumatic brain injury occurs as a result of an internal factor, such as stroke, loss of oxygen, an aneurism or infection; they are both types of acquired injury. Brain Injury Association of America, “What is the Difference Between Acquired Brain Injury and Traumatic Brain Injury?,” <https://www.biausa.org/brain-injury/about-brain-injury/nbiic/what-is-the-difference-between-an-acquired-brain-injury-and-a-traumatic-brain-injury>.

¹⁴⁵ Bear Mountain at Worcester website, available at <https://www.bearmountainhc.com/bear-mountain-at-worcester/>

¹⁴⁶ Commonwealth of Massachusetts Center for Health Information and Analysis, “Nursing Facility Cost Report 2020 HCF-1, Bear Mountain at Worcester” (December 31, 2020), available at <https://www.chiamass.gov/long-term-care-facility-cost-reports/#nursing-homes>. A total of \$11,346,746 of Medicaid revenue, with 29% of the revenue from out-of-state; \$4,684,494 from Medicare, \$411, 479 from the PACE program, and \$347, 651 from private insurance and self-pay. The 2021 report notes a similar amount, \$11,518,291 in Medicaid revenue, also with 29% from out of state, and other sources of revenue.

¹⁴⁷ Past reviews are archived at: <https://data.cms.gov/provider-data/archived-data/nursing-homes>. For current reviews, see <https://www.medicare.gov/care-compare/details/nursing-home/225219?city=Worcester&state=MA&zipcode=>

¹⁴⁸ Bear Mountain at Worcester Cost Reports, *supra* n.147.

¹⁴⁹ *Id.* REIT is the acronym for “Real Estate Investment Trust.”

¹⁵⁰ <https://sabrahealth.com/>. Equity REITs are publicly traded companies that own or operate income-producing real estate for the purpose of distributing dividend income to their shareholders. <https://fnrpusa.com/blog/reits-vs-private-equity/>

¹⁵¹ Robert Tyler Braun, Dunc Williams, David G. Stevenson, et al., “The Role Of Real Estate Investment Trusts In Staffing US Nursing Homes,” *Health Affairs*, 42(2) (Feb. 2023): 207-216, doi:

10.1377/hlthaff.2022.00278; Charles Duhigg, “Inquiries at Investor-Owned Nursing Homes,” *New York Times*, October 24, 2007, <https://www.nytimes.com/2007/10/24/business/24retirement.html>; “Push For Profits,” *supra* n.43.

¹⁵²From total staffing ratio in October 2019 of 4.28, staffing fell to 4.0 in January 2021, and continued to slip and remain below federal recommendations, with nurse aides (NA) far below the recommended 2.8 for long-term residents. E.g.: Oct. 2021: 3.38 total nurse staff (1.6 NA); April 2022: 3.31 total (1.8 NA, .57 RN); Jan. 2023: 3.58 total (1.98 NA, .7 RN); April 2023: 3.4 total (1.87 NA, .7 RN); with a drop in census in July 2023, it rose to 3.78 total (2.07 NA .73 RN), though weekend hours were still lower, see n. 143. <https://data.cms.gov/provider-data/archived-data/nursing-homes>.

¹⁵³ January 2022: .69, .46 weekend; April 2022: .57, .44 weekend; July 2022: .63, .47 weekend; October 2022: .63, .50 weekend. *Id.*

¹⁵⁴ See EOHHS Response, Appendix B.

¹⁵⁵ An additional CNA was assigned during the day to the third floor and in the evening to the fourth floor for a total of four CNA’s on these shifts. Licensed coverage was also higher on the fourth floor in the evening (from 1 to 1.7), though dropped somewhat on the third floor (from 2 to 1.7).

¹⁵⁶ Bear Mountain’s total nursing staff levels for October and November 2023 are reported to be 3.84, 3.46 on weekends (2.14 NA, .70 RN, .54 weekend).

¹⁵⁷ 957 CMR 7.03(1).

¹⁵⁸ Center for Health Information and Analysis, “Long Term Care Facility Cost Reports,” available at <https://www.chiamass.gov/long-term-care-facility-cost-reports/#nursing-homes>.

¹⁵⁹ DLC received the SABRA Realty Cost reports pursuant to public records access request.

¹⁶⁰ Bear Mountain Management LLC Cost Report 2020, provided to DLC in response to records access request (available upon request).

¹⁶¹ *Id.* The partners/owners are John Wynne, Scott Ziskin, and Thomas Doyle.

¹⁶² *Id.*

¹⁶³ DLC received the 2020 and 2021 management company cost reports pursuant to public records access requests. These positions are disclosed as five highest paid employees. The three partners were listed as employees in the 2020 cost report, but are not listed in the 2021 report.

¹⁶⁴ CMS Center for Clinical Standards and Quality/Survey & Certification Group, Memorandum to State Survey Agency Directors: “Posting of Nursing Home Ownership/Operatorship Affiliation Data on Nursing Home Care Compare Website and data.cms.gov,” “Focused Dementia Care Survey Tools” (November 27, 2015), available at <https://www.cms.gov/files/document/qso-23-18-nh.pdf>. Data is available on the CMS website, “Nursing Home Affiliated Entity Performance Measures,” at <https://data.cms.gov/quality-of-care/nursing-home-affiliated-entity-performance-measures>.

¹⁶⁵ See data referenced in above note.

¹⁶⁶ 957 CMR 703(1)(a).

¹⁶⁷ Timely reporting will soon be critical to federal oversight and policy-making as well. CMS has recently proposed requiring States to report to CMS and publish annually, at the facility level, on the portion of payments for nursing facility services that are spent on direct care and support staff workforce compensation. “Minimum Staffing Standards,” *supra* n.32 at 61384-61390.

¹⁶⁸ When the injury is noted to be without loss of consciousness, it is likely to have been a milder impact.

¹⁶⁹ 101 CMR 206.11. Program staff must include a neuropsychologist and neuropsychiatrist, substance use counselors, and certified brain injury specialists, among others, and must provide an individualized therapeutic skill development plan, sensory modulation and cognitive rehabilitation, neuropsychological testing, alcohol and substance use counseling, and community integration, among other services. In addition, to qualify for the rate, at least 90% of resident days must be for residents with mental or neurological disorders. Bear Mountain also provides specialized respiratory services, so although its population of residents with mental and/or neurological disorders is considerable, it is not likely to meet this threshold. Bear Mountain’s 2022 facility assessment indicates that the numbers of residents with behavioral health disorders, which may not include all residents with neurological disorders, is 65%; approximately half its census in 2021 had ABI/TBI/neurological disorders, according to DLC’s review of residents’ diagnoses.

¹⁷⁰ During the period of record review 2020-2022, there was one nurse practitioner assigned per day; according to the administrator, there are now two.

¹⁷¹ Dept Health & Human Services CMS, Survey Bear Mountain at Worcester, February 23, 2022, available at <https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/225219/health/standard?date=2022-02-23>.

The DPH survey with correction plan is not available online and is attached as Appendix A. The August 2023 survey with plan of correction is also included in Appendix A.

¹⁷² The behavioral care plan included non-specific interventions for soothing or supporting the resident (such as, to avoid things that are anxiety-provoking when the resident is nervous), to redirect the conversation or task when the resident is upset, and to encourage engagement in physical and social activities.

¹⁷³ ProPublica, Inspections Reports and Penalties Bear Mountain at Worcester, available at <https://projects.propublica.org/nursing-homes/homes/h-225219>. See also <https://www.medicare.gov/care-compare/details/nursing-home/225219?city=Worcester&state=MA&zipcode=&measure=nursing-home-penalties>. The dates of payment suspension, 4/23/22 to 5/18/22, are available at <https://eohhs.ehs.state.ma.us/nursehome/FacilityOverall.aspx?Facility=0723>

¹⁷⁴ See *supra* n. 156.

¹⁷⁵ Neither the PA, nor other clinicians, checked for cogwheeling, dystonia, or other serious extrapyramidal symptoms from antipsychotics.

¹⁷⁶ As noted earlier in the discussion of the scope of this investigation, DLC reviewed records between January 2020 and October 2022, as well as all PASRR evaluations and admission information. The facts provided are current as of the close of the records review, unless DLC received updated information as indicated.

¹⁷⁷ M.G.L. c. 123, Sec. 12(a) allows for an individual to be brought against his or her will to such a hospital for evaluation. Under 12(b), once the patient arrives at the hospital, he/she must be evaluated by a physician (psychiatrist) to determine if he/she needs to be involuntarily committed for no more than 72 hours.

¹⁷⁸ Even if A.B. is now abstinent from alcohol while in a nursing facility, if brain damage has already occurred it is prudent to check thiamine and magnesium levels and to supplement as needed.

¹⁷⁹ DLC obtained hospital and emergency room records for C.D. and is therefore able to supply additional detail for C.D.'s summary.

¹⁸⁰ The discharge plan noted that C.D. responds to behavioral shaping, using a reward plan for good behavior, that she is cooperative if she is doing something that she likes and responds well to limit setting, and benefits from daily social contact, including family calls.

¹⁸¹ C.D. imagined her rectum had crept up to the middle of her back and that she was having bowel movements there, that she had no eyelids, that her skin was falling off, and that she had no lips so she could not hold food in her mouth.

¹⁸² C.D. complained that she had plaster in her throat and her mouth was coming apart and her tongue was gone, her clothes and bed were wet, and she was covered in feces.

¹⁸³ The behaviors may have been related to his seizure disorder, or agitative effects of antipsychotics.

¹⁸⁴ Dilip R. Patel, Maria Demma Cabral, Arlene Ho, et al., "A Clinical Primer on Intellectual Disability," *Translational Pediatrics*, 9 Supp.1 (February 2020): S25-S35, <http://dx.doi.org/10.21037/tp.20>.

¹⁸⁵ "Association Between Urinary Tract Infections and Antipsychotic Drug Use in Older Adults," *Journal of Clinical Psychopharmacology*, 38(4) (August 2018): 296-301, doi: 10.1097/JCP.0000000000000895.

¹⁸⁶ I.J. is the only resident in the sample with a completed neuropsychiatric evaluation.

¹⁸⁷ Benzodiazepenes increase the risk of addiction, falls, sedation, confusion. Opiates increase the risk of these effects, plus can extensively impair bowel function.

¹⁸⁸ The conservator is an attorney who has been attempting to resolve this obstacle to discharge. For Massachusetts' Medicaid (MassHealth) waiver programs, CMS permits Massachusetts to "waive" or set aside certain Medicaid requirements in order to the return of individuals to the community with necessary assistance.

¹⁸⁹ Lincoln Park Care Center took large numbers of New York residents with psychiatric histories being discharged from New York State operated psychiatric hospitals in the 1990's through the early 2000's. Following commencement of litigation against New York's health and mental health agencies by New York's protection & advocacy system and legal team in 2006, New York restricted such discharges and required PASRR reviews for community-based housing and supports. *Joseph S. v. Hogan et al.*, 2:06-cv-01042, U.S. District Court for the Eastern District of New York. The amended complaint and stipulation of settlement is available at <https://clearinghouse.net/case/12664/>

¹⁹⁰ K.L. had the diagnosis of schizoaffective disorder at admission.

¹⁹¹ Title VI of the Civil Rights Act of 1964 (Title VI) protects persons from discrimination based on their race, color or national origin in programs and activities that receive Federal financial assistance. Its national origin nondiscrimination provision requires recipients of Federal financial assistance to take reasonable steps to make their programs, services, and activities accessible by eligible persons who have limited English proficiency (LEP).

¹⁹² See, e.g., Association of American Medical Colleges, Guidelines for Use of Medical Interpreter Services, <https://www.aamc.org/media/24801/download>.

¹⁹³ The facility did not document a history of attempts at reducing the dose of this medication and the effectiveness of individualized non-pharmacological interventions, as the pharmacist recommended.

¹⁹⁴ Because of her tracheotomy, M.N. is not on the neurobehavioral unit but is supposed to receive the same level of services.

¹⁹⁵ Opiates often have anti-depressant effects, and it is possible that was using heroin to “treat” her underlying depression. Now, off the methadone, she may be more prone to depression.

¹⁹⁶ Typically, individuals with severe cognitive impairment are able to benefit from behavior modification with positive reinforcement techniques, with simple and clear rewards. The goal of behavior modification is to address the triggers, maladaptive behavior and the consequences resulting from or following the behavior.

¹⁹⁷ This was the cause of death according to the medical examiner, as conveyed to his widow.

¹⁹⁸ Notably, risk of UTIs from antipsychotics are not included in written informed consents, nor are the potential impact of the antipsychotic medication on the threshold for seizures mentioned for those residents who had seizure disorders.

¹⁹⁹ As discussed in the background portion of this report, chemical restraint are medications that are not need for the treatment of symptoms and used for the convenience of staff. 42 U.S.C. § 1395i-3 (c)(1)(A)(ii); 42 C.F.R. §483.10(e)(1). We consider “convenience of staff” to be related to lack of resources: in time, training, and staffing. Medications are not required if there are possible alternatives. Medications that are not adequately monitored are also unnecessary medications. Corporate management and administrators are responsible for ensuring staffing and training in order to meet these requirements for appropriate treatment.

In addition, staff’s failure to taper I.J. from medications with strong potential for dependence is abuse.

²⁰⁰ Residents’ underlying conditions are often poorly understood: the conditions that could account for delusions, agitations, insomnia, or psychotic behaviors; whether antipsychotic medications contribute; triggers for aggression; or whether, in residents with severe brain injury, behaviors are so automatic or impulsive they require a form of treatment other than behavior management. Similarly, strengths and challenges in executive functioning and cognitive abilities also need assessment for treatment planning.

²⁰¹ For a discussion of the elements of a therapeutic milieu, nurse-led in a psychiatric setting, see C Xavier Belsiyal, Sreevani Rentala, and Anindya Das, “Use of Therapeutic Milieu Interventions in a Psychiatric Setting: A Systematic Review,” *Journal Education & Health Promotion*, 11 (July 2022), doi: 10.4103/jehp.jehp_1501_21.

²⁰² For a discussion of the importance of integrated and interdisciplinary care for addressing the long-term care needs following TBI, including mental health difficulties and substance use disorder, see C. Matney, K. Bowman, D. Berwick, eds. *Rehabilitation and Long-Term Care Needs After Traumatic Brain Injury*, Ch. 6 of National Academies of Sciences, Engineering, and Medicine, “Traumatic Brain Injury: A Roadmap for Accelerating Progress,” (Washington, D.C.: National Academies Press 2022), Academies Press. <https://doi.org/10.17226/25394>.

²⁰³ For example, EOHHS is developing new residences with medical and behavioral health supports in the community for nursing home residents who have had a PASRR review identifying both SMI and the ability to live in the community; DMH is developing Nursing Facility Transition unit. Presentation Kimberly Clouherty, DMH Director of Community Services to Older Behavioral Adult Network, June 9, 2023.

²⁰⁴ A PASRR Level 2 evaluation conducted for A.B. found he did not need meet the criteria for SMI because he did not have sufficient episodes of intensive psychiatric care, overlooking a serious episode where he had been sent to an emergency room six months earlier, restrained physically and chemically while a search was conducted for an inpatient psychiatric bed. A.B.’s PASRR evaluation prior to his admission also determined that he did not meet criteria for SMI; this followed his stay in the geriatric psychiatric unit after exhibiting serious psychiatric symptoms.

²⁰⁵ For example, prior to C.D.’s admission to Bear Mountain, the evaluator did not recommend specialized services, although she had just had a lengthy and complicated stay at a geriatric psychiatric unit. The one PASRR for a significant change in condition followed a hospital stay when her delusions were beginning to return: The assessor recommended a behaviorally based treatment plan for problem behaviors, a quarterly psychiatric diagnostic evaluation, and psychotherapy. While Health Drive provides supportive counseling, it does not provide these recommended services.

²⁰⁶ 42 C.F.R. 483.21(a)(1)(ii)(F). If a facility disagrees with a recommendation, staff must document their objection in the clinical record. 42 C.F.R. 483.21(b)(1)(iii).

²⁰⁷ C.D. suffered multiple episodes of significant deterioration related to her somatic delusions, yet was only referred for a PASRR review following a hospital stay when her delusions were beginning to return.

²⁰⁸ The state in which the individual resides must pay for the PASRR and make the required determinations. 42 C.F.R. § 483.110.

²⁰⁹ The lack of policies was confirmed via DLC's records access requests to EOHHS, DMH, and DDS.

²¹⁰ New York State Medicaid Program, "Out-of-State Skilled Nursing Facilities" (July 2023), available at https://www.emedny.org/ProviderManuals/ResidentialHealth/PDFS/OOS_Skilled_Nursing_Facility_Policy_Guidelines.pdf

²¹¹ In addition to discharge planning requirements under the CMS regulations, nursing homes are obligated to comply with the community integration mandate of Section 504 of the Rehabilitation Act of 1973. As the U.S. Department of Health and Human Services recently stated,

a long-term care facility may violate section 504 if the facility continues an individual's inpatient placement when the individual could live in a more integrated setting and desires to do so. To comply with the integration mandate, inpatient facilities may be required to discharge patients in such circumstances. In the process of planning for such discharges, inpatient facilities (including hospitals) may be required to develop individualized treatment and discharge plans and coordinate with local community-based service providers to ensure that ongoing services, like personal care, without which an individual is at risk of institutionalization and which are offered in the inpatient setting, are available to the individual in the community.

Federal Register, vol. 88, no. 177 (September 14, 2023), 63392, 63487 (footnote omitted).

²¹² 45 CFR § 92.101 DHHS regulations requires that a health care program take reasonable steps to provide meaningful access for individuals with limited English proficiency. Interpreters must be qualified under the regulations to provide services.

²¹³ Bear Mountain was required to submit a language access plan within a year of a determination of need notice. Bear Mountain was subject to such a notice because they changed ownership in 2019. Such a plan must include plan for ensuring that interpreters are training. The facility must also provide ongoing education and training for administrative, clinical, and support staff in culturally and linguistically appropriate services. 105 CMR § 100.310.

Appendix A - Feb. '22 and Aug '23 DPH Surveys and Plans of Correction

<https://www.dlc-ma.org/wp-content/uploads/2024/01/Appendix-A-DPH-Surveys-Plans-of-Correction.pdf>

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Appendix B - Correspondence from Bear Mountain, EOHHS and CHIA

(For DLC's reply to this correspondence, please see the section of this report titled: [Responses of Bear Mountain Worcester, EOHHS and CHIA](#))

<https://www.dlc-ma.org/wp-content/uploads/2024/01/Appendix-B-Correspondence-from-Bear-Mountain-EOHHS-and-CHIA.pdf>

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