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CASE REPORT

Increase in Long-Term Care Residents with Serious Mental Illnesses Presents Challenges for Facilities and Staff: Case Reports

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ABSTRACT

Background. The increase in the number of residents with severe mental illness and/or substance use disorder in long-term care facilities in the United States presents serious challenges to those seeking admission to these facilities, their staff, and facility administrators.

Aims. Our purpose is to illustrate the situations for which long-term care facilities have been cited for failure to meet standards of care related to their residents' psychosocial well-being and behavioral expressions.

Methods. Publicly available data was accessed from several U.S. Centers for Medicare and Medicaid Services (CMS) data centers. Data obtained included the percentage of facilities that received citations for seven F-tags (a federal coding system) most relevant to effectively addressing residents' psychosocial well-being and behavioral expression needs. Case reports related to each of the selected standards (F-tags) were identified and summarized, and data on the facility involved was obtained for each case report.

Results. In the first half of fiscal year 2024, 25% of the long-term care facilities surveyed were cited for deficiencies related to protecting residents from abuse or neglect, and 19% were cited for failing to keep residents as free as possible from unnecessary psychotropic medication. The case studies illustrate the wide range of behavioral expressions that need to be addressed, from severe withdrawal and attempts to self-harm to sexual approaches to other residents to purposeful soiling of bed linens and aggression toward staff or other residents. In many instances, it was clear that facility staff did not know the requirements for an adequate response to the situation or how to respond effectively.

Conclusions. The case studies and related data reveal multiple, often interacting, assessment and care challenges that many long-term care staff are not prepared to handle effectively. They demonstrate the adverse impacts of untreated negative behavioral expressions and consequently suggest that staff may be unprepared to manage these multifaceted conditions. Poorly resourced facilities need support to adequately respond to this ever-growing, complex mix of service needs, less than generous reimbursement structures, and resident demographics.

Keywords: psychosocial and behavioral expression, serious mental illness, substance use, long-term care, nursing homes, skilled nursing facility, star ratings, health inspection survey.

Introduction

Long-term care services are essential for individuals who experience a significant loss of capacity due to physical and/or mental health conditions. The definition of long-term care services varies from country to country. However, generally, long-term care services include nursing homes (or skilled nursing facilities [SNFs]), facilities providing lower levels of assistance, such as assisted living facilities, and care in the home with caregivers[1]. This current analysis focuses on the changing patient demographics of individuals residing in higher-level care facilities known as nursing homes or SNFs. The World Health Organization (WHO) estimates that 142 million older adults worldwide need these services[2]. Individuals entering nursing homes have complicated care needs, including physical frailty, physical disability, dementia, chronic diseases, and complex mental health challenges, such as bipolar disorder, schizophrenia, and psychosis. Data from 2019 indicates that 3.6% of the European Union populace over 65 resided in institutional living environments, compared to 2.5% of the United States population in 2016[1, 3].There is a commitment to providing access to quality services to meet the long-term needs of individuals in these facilities[1].

The characteristics of long-term care facility residents have dramatically changed over time[4]. An aging population and a lack of psychiatric care institutions with skilled staff to manage this population are creating a challenge for nursing home leadership to care for these vulnerable residents adequately. A study conducted in the United Kingdom a decade ago noted that adults with serious mental illness (SMI) placed in care settings not equipped to treat mental health needs received custodial but not rehabilitative care and had a higher risk of violence compared to those treated in the appropriate institution[5]. Dynamic shifts in the nursing home workforce create further challenges for many countries. For example, as experienced staff leave, no one may be left to mentor the new workers. Inadequate training or management of behavioral crises has resulted in increased reports of neglect and abuse through government oversight and worker surveys. For example, a cross-sectional survey of Norwegian nursing home nurses was conducted in 2020, asking if they had witnessed one or more incidents of abuse and neglect in the past year[6]. One hundred nursing homes participated, and the survey was completed at a 60% rate. Seventy-six percent of responders had observed one or more incidents of physical or psychological neglect or abuse[6]. In 2017, the WHO conducted a review of 52 studies in 28 developed countries to determine the prevalence of some form of abuse of older adult residents living in an institution. Abuse of older adults in institutional settings averaged 64.2%; that is, two out of every three responding staff reported witnessing or having perpetrated some form of abuse or neglect[7].

Similar to resident populations in European care facilities, older adults in U.S. long-term care facilities have become far more ill and need higher levels of care[4]. There has also been an increase in individuals with dementia diagnoses. Another segment of the long-term care population that has increased dramatically is the proportion of long-term care residents with serious mental illness,

including substance use disorders[8]. The proportion of long-term care residents with serious mental illness, including substance use disorders, almost tripled in the U.S. from 11% in 1985 to 31% in 2015[7]. Of these, 16.5% are under the age of 65[9]. Many of the residents with SMI exhibit challenging behaviors, including aggressive behavior toward staff and engaging in verbal and physical altercations with other residents. Their care needs also present operational challenges to the facilities, including staffing issues, increased survey citations, and increased allegations of abuse and neglect. For those individuals with serious mental illnesses needing long-term care, this situation has led to limited access to facilities with the highest quality ratings[10]. Thus, residents, staff, and the facilities themselves have been affected by the growth of this population in long-term care.

In October 2016, the U.S. Centers for Medicare and Medicaid Services (CMS) released what they called the Final Rule update, increasing emphasis on resident choice, respect for their preferences, encouraging community involvement, promoting residents' rights, and supporting residents' psychosocial well-being[11]. Supporting the heightened focus on psychosocial well-being are clarifications of psychosocial well-being-related definitions and descriptions of how a resident may experience an occurrence. This was the largest regulatory update since the implementation of the State Operations Manual (SOM) following the Omnibus Reconciliation Act (OBRA) in 1985, which set health inspection standards[11]. The guidance implemented with OBRA elevated the standards for quality of care, while this Final Rule update again elevated that work, this time to encompass advocating for the highest psychosocial well-being achievable. Implementation and enforcement were delayed by the COVID-19 pandemic but are now in place.

The CMS focus on addressing psychosocial well-being addresses both resident safety and the quality of care received. For example, overuse of psychotropic medications may result in a change in mental status (delirium), fall with injury, or increased agitation[12]. Staff who are not adequately trained may misperceive these behavioral expressions, resulting in increased incidents of abuse and neglect[13]. Some residents may exhibit behaviors such as aggression or agitation that affect not only their own physical safety but also the safety of other residents. Those who are disoriented may become lost, walk into oncoming traffic, or fall into open water, resulting in serious injury or even death unless safe spaces that prevent this high-risk wandering are provided[5]. In other instances, staff may fail to note residents' withdrawal and depressive state on time; the result may be self-injurious behavior, even suicide. Adequate, timely treatment can prevent them from progressing from mild withdrawal to severe depression, that is, from a common psychosocial concern to a severe mental illness.

Methods

We accessed publicly available long-term care facility inspection (survey) data on citations received and individual case reports of unmet or inadequately managed psychological and behavioral expression needs from two CMS websites: Care Compare[14] (https://www.medicare.gov/care-compare/?providerType=NursingHome) and

Quality, Certification and Oversight Reports (QCOR)[15] (https://qcor.cms.gov/main.jsp) to understand the impact of the enforcement of the new standards on psychosocial wellbeing and behavioral expression needs on residents, staff, and long-term care facilities.

We first selected seven F-tags (federal codes representing a specific standard of care) that reflect psychosocial well-being and behavioral expression concerns and obtained the number of citations issued for the last 18 months (2023 – 2024). Further information on individual surveys and quality ratings of the facilities involved were then obtained using the publicly available QCOR[15] database.

F-TAG SELECTION. Seven critical areas of the federal standards that are integral in supporting the behavioral expression needs of residents in long-term care settings were selected. The F-tag system, ranging from F500 to F949, is a coding framework for health surveys. Although the Long-Term Care Survey Pathway for Behavioral Expression identifies multiple F-tags, we selected seven specific categories that best represent expected approaches to meet these standards (see Table 1).

Table 1. Selected Federal Tag (F-tag) Summary

F600 Freedom from abuse[13]	Staff are required to protect residents from abuse, neglect, misappropriation, and exploitation in any interaction, highlighting that facilities can be cited for incidents despite preventive measures, emphasizing the critical need for oversight.
F740 Behavioral health services[13]	Facilities must provide and coordinate tailored services addressing residents' behavioral health needs based on thorough assessments and individualized care plans, utilizing both internal and external resources for comprehensive care.
F741 Sufficient/Competent Staff for the Behavioral Health Needs[13]	Facilities must ensure staff are trained and competent to address residents' physical, mental, and psychosocial needs, particularly for those with mental disorders. Advocates for non-pharmacological interventions to reduce unnecessary medication use.
F743 Behavioral patterns are prevented unless unavoidable[13]	Facilities need to ensure care plans and assessments prevent negative behaviors like withdrawal, anger, or depression in residents without diagnosed mental issues unless such behaviors are deemed unavoidable
F745 Provision of medically related social services[13]	Facilities must provide medically related social services. These services are essential for assisting residents in achieving or maintaining their highest level of well-being[5].
F758 Free from unnecessary psychotropics and PRN use[13]	Facilities need to justify the use of psychotropic medications—including antipsychotics, antidepressants, antianxiety drugs, and hypnotics—ensuring they are appropriately integrated into residents' individual care plans based on thorough diagnoses. Non-pharmacological interventions should be used in accordance with

	gradual dose reductions supporting residents' freedom from unnecessary use.
F949 Behavioral health training[13]	Facilities must provide ongoing behavioral health training for staff to effectively manage complex resident issues, highlighting the importance of continual education and competency in improving care quality.

QUALITY, CERTIFICATION, AND OVERSIGHT REPORT (QCOR) DATA. CMS publishes survey data on a publicly available website that summarizes all survey activity for healthcare organizations accredited by CMS, including those relating to long-term care facilities. CMS accreditation allows certified healthcare organizations to receive reimbursement for services provided to Medicare beneficiaries and requires these organizations to comply with the standards listed within the State Operations Manual (SOM). The QCOR[15] website (https://qcor.cms.gov/main.jsp) includes the results of health inspection surveys, including adherence to the minimum standards outlined in the SOM. Long-term care facilities are also subject to unannounced health inspections to ensure compliance with these standards[16]. These inspections may occur under various circumstances, including initial certification when they begin operation, routine recertification every 9 to 15 months, or more targeted inspections in response to complaints or for infection control issues[16]. During any inspection, a facility must demonstrate substantial compliance with all regulatory requirements, thus allowing inspectors to survey any aspect of care during any inspection.

Complaint inspections may be triggered by self-reporting reportable incidents, as the SOM requires, or by external complaints filed with state officials[16]. Revisit inspections may also be done following the issuance of a citation for noncompliance at a severity level of 2 or higher. These surveys ensure that facilities meet a baseline quality of care, contributing to the overall safety and efficacy of healthcare delivery.

When a citation is received, the level of severity is identified. These levels range from minimal harm to immediate jeopardy as follows: 1) potential for no more than minimal harm, 2) no actual harm but the potential for more than minimal harm that is not immediate jeopardy, 3) actual harm that is not immediate jeopardy, and 4) immediate jeopardy to resident health, safety, or wellness[13, 16].

CARE COMPARE DATA. We obtained individual survey reports for our case studies and quality ratings (star ratings) of the facilities evaluated from the CMS Care Compare[14] website.

CASE STUDIES. Case studies contribute to a deeper understanding of people and events within the situation of interest; in this case, surveyor reports of their reasons for citing facilities for violations related to the care of residents with serious mental illness and/or substance use disorders. Individual case studies should be specific and bounded[17]. Each case study is considered first as a whole, emphasizing the reasons for the citations issued. This is followed by a cross-case

analysis in which generalizations are made for a deeper understanding of the situation of interest[18] across the multiple cases.

Using random selection to ensure representation across the country, facility reports were cross-referenced into the publicly available Care Compare[14] database to access the survey report. The reports were then reviewed to identify case study examples that meet the criteria of having a resident's behavioral expression as a contributing cause for the F-tag deficiency. All licensed facilities with Medicare-certified beds across rural and non-rural geographical settings were sourced for this sample. The facilities that received these citations are expected to see them as indicative of areas in need of improvement and to implement sustainable corrective action plans within a specified period of time.

QUALITY RATINGS. We also obtained the quality ratings for the facilities that received these citations. Four star ratings are published: health inspection, staffing, quality, and an overall rating[14]. These are defined below:

The *Health Inspection* rating is calculated from reviews of the environment, care plan and care delivery, infection control, human resources, dietary services, medication management, laundry, and administrative services operations of the facility. Any deficiencies that are identified during the health inspection survey may result in a citation, referencing a federal tag (F-tag) number corresponding with the standard of practice noted in the SOM along with the potential or actual level of harm of the deficiency referred to as the Scope and Severity of the citation[16].

Staffing includes total staff hours and turnover rates for the facility. Summary reports note total staffing hours, registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN), and certified nursing assistant (CNA) hours. Additionally, turnover is based on RN, LPN/LVN, CNA, and administrator turnover rates. Staffing data is adjusted on the basis of case mix.

The *Quality* rating is obtained from an aggregate of 15 defined metrics that include 10 derived from MDS (Minimum Data Set information) submissions and five obtained from Medicare claims data[14,16]. These metrics aim to provide an overall measure reflective of the "broad range of function and health status indicators" within the facility[16]. The ratings encompass both long-stay and short-stay resident populations. The period over which measurements are calculated varies between one and two years, depending on the specific measure and the data source.

Results

The results obtained, including the number of citations issued in 2023-2024 on the selected F-tags, case reports for each of these F-tags related to the challenges of meeting the psychosocial and behavioral expression needs standards, and the characteristics of the facilities involved, including their star ratings, provide a picture of the current situation related to the psychosocial and behavioral expression-related resident needs in long-term care.

CITATIONS. The fiscal reporting year for CMS certification reports is October 1st through September 30th. The data in Table 2 displays survey results for the fiscal year 2023 and the

first half of the fiscal year 2024, updated through April 14, 2024, or approximately six months of data for FY 2024. This table shows that the number of citations issued in 2024 align with 2023 results so far. A key observation from the information in Table 2 is the overall consistency in citations between the fiscal year 2023 and fiscal year 2024 to date. Notably, there is an increase in the citations related to F600 and F745, focusing on resident freedom from abuse, neglect, misappropriation, unnecessary medications, and psychotropics. Interestingly, the percentage of total citations that are F600 tags has fluctuated between 7.5% and a high of 12.9% since the implementation of the Final Rule updates. The survey process is not static, and updates to the publicly reported databases occur periodically.

Table 2. Number of Psychosocial and Behavioral Expression Citations Issued: FY 2023 and 2024 Year-to-Date

		FY2023		FY2024 (first six months)	
F-tag	Description	Number Citations Issued	Percent Providers Cited	Number Citations Issued	Percent Providers Cited
F600	Free from Abuse and Neglect	2,772	13%	1,076	25%
F740	Behavioral Health Services Sufficient	358	2%	116	3%
F741	Competent Staff-Behavioral Health Needs	80	1%	27	1%
F743	No Behavioral Difficulties Unless Unavoidable	9	<1%	2	<1%
F745	Provision of Medically Related Social Service	241	1%	119	3%
F758	Free from Unnecessary Psychotropic Medications/ PRN Use	1,769	11%	708	17%
F949	Behavioral Health Training	65	0%	34	1%

Note: Fiscal Year (FY) 2023 is October 2022 to September 2023; Fiscal Year (FY) 2024 is October 2023 to September 2024.

CASE SUMMARIES BY F-TAG. One case was selected for each of the designated F-tags. Summaries of these cases follow with the characteristics of the facilities cited summarized in Table 3 at the end of the case reports.

Case 1

Citation: F600 Free from Abuse and Neglect

Level: Immediate Harm

Summary of Findings Noted by Surveyor: A resident who had been admitted with diagnoses of dementia, depression, anxiety, and mood disorder was observed inappropriately touching another resident who had impaired cognition. The residents were separated, and the resident was referred to psychiatric services for increasing

inappropriate sexual behaviors. Several weeks later, staff members observed the same resident inappropriately touching another resident. They intervened and notified the police in accordance with facility policy. Increased monitoring of the resident's behavior was initiated, medications were adjusted, and a referral for psychiatric care was made. A month later, the resident was again seen inappropriately touching another resident. Staff intervened again, and the resident was placed on one-to-one supervision and referred for additional diagnostic evaluation, medication change, and psychiatric facility placement. The facility reported all three incidents according to regulatory guidelines and implemented care plan approaches throughout the resident's multiple-year stay. However, the surveyor noted that despite their efforts, the three residents had not been protected but had been subjected to sexual abuse, the reason for this citation.

Case 2

Citation: F740 Behavioral Health Services Sufficient

Level: Immediate Harm

Summary of Findings Noted by Surveyor: Two residents were noted to have received inadequate behavioral health care. The first resident was admitted with diagnoses of bipolar disorder, major depressive disorder, mood affective disorder, suicidal ideation, and a history of suicide attempts. An attempted gradual reduction of a psychotropic medication had failed. The resident's medical record included notes of increasing emotional distress, an increase in anxiety, concern about the pending discontinuation of a PRN (as needed) psychotropic medication, multiple current psychotropic medications, and drug-seeking behaviors that had occurred at the previous facility as well. The behavioral team met with the resident to discuss the medication treatment plan and discontinuation of the PRN medication. The resident reported attempts at self-harm and refused to discuss it any further. Immediately following the care plan meeting with the resident, the behavioral team contacted the resident's family, and the behavioral management practitioner recommended that the staff check on the resident, finding scissor cuts to the resident's wrists. The resident was immediately transferred to the hospital.

The second resident was a younger adult (under age 40) admitted with a diagnosis of generalized anxiety disorder, traumatic brain injury, and failure to thrive. Behavioral outbursts and expressed desire to slit her wrists were observed. Facility staff removed sharp objects from the room and notified the physician who visited the following day. The facility's social work team assessed the resident and determined that this second resident was not at risk. The resident was referred for psychiatric services five days later. In staff interviews, the facility staff reported that a lethality assessment had not been conducted as required by policy, and the length of time between occurrence and referral for psychiatric services was too long which were noted in the citation issued.

Case 3

Citation: F741 Competent Staff – Behavioral Health Needs

Level: Immediate Harm

Summary of Findings Noted by Surveyor: Two residents were of concern. The first resident

had a history of inappropriate behavioral expression, including name-calling directed at staff, physically threatening and demeaning gestures towards staff, manipulative behaviors, refusing care, and intentionally soiling clothing and linens. Minimal cognitive impairment and need for limited assistance with care were noted, as was a recent weight increase. The first resident enjoyed smoking, coffee, and sweet snacks. A behavioral contract was implemented based on previous discussions involving center staff, the resident's sister, and the resident. The contract noted that poor behavioral expressions, including [purposeful] incontinence or manipulative behaviors, would result in withholding of privileges, such as smoking and going outside to the smoking area. The behavioral contract was not signed by the resident or any facility staff. The care plan did not include directions for intervention or information about a behavioral contract.

The second resident had diagnoses of cerebral palsy, anxiety disorder, depression, and problems with incontinence. The findings reported by the surveyor in the health inspection report noted that staff response to the incontinence was to limit the amount of coffee provided as directed by the resident's sister. Behavioral contracts should contribute to improving behaviors and are not permitted to infringe on resident rights. It was noted that the facility's policies mandated the provision of guidance on support for residents with dementia-related behaviors of concern but no direction on other behaviors unrelated to dementia.

Case 4

Citation: F743 No behavioral difficulties unless unavoidable

Level: Minimal harm

Summary of Findings Noted by Surveyor: This F-tag includes failing to ensure that a resident does *not* develop patterns of negative behavioral expressions unless unavoidable during their stay.

The resident had diagnoses of epilepsy, developmental disorders, and schizophrenia and needed assistance with self-care. Behaviors noted included making loud noises, wandering into other residents' rooms, resulting in discomfort and fear on the part of the other residents, and exit-seeking. The surveyor noted that some of these behaviors were not documented, a sign of potential normalization of negative behaviors. The care plan was also not updated to reflect the resident's evident needs.

Case 5

Citation: F745 provision of medically related social service

Level: Immediate harm

Summary of Findings Noted by Surveyor: Two residents were considered in this report. The first was transferred from the hospital for rehabilitation and discharged to home once the rehabilitation was complete. A cognitive assessment indicated some impairment, but the discharge instructions did not account for this. When the facility administrator and social worker learned that the resident's home had been condemned, they arranged readmission into the facility.

The second resident was also transferred from the hospital to the facility for rehabilitation with diagnoses of schizophrenia, vascular dementia, and major depressive disorder as well. Numerous attempts to contact family

members were unsuccessful. Facility staff attempted to contact the resident's durable power of attorney to discuss discharge to home. They sent the resident home in a transport vehicle, but the driver was uncomfortable leaving the individual at home, so he brought the resident to the hospital. Hospital records indicated that neither the individual with power of attorney nor family members returned calls to the hospital. The discharge plans of these residents were clearly inadequate.

Case 6

Citation: F758 Free from unnecessary psychotropic medication/PRN use

Level: Immediate harm

Summary of Findings Noted by Surveyor: The surveyor noted that the facility did not have a procedure for monitoring behaviors, resulting in their inability to identify indications for psychotropic medications.

The report mentioned four residents who were affected by this concern. For example, the fourth resident was transferred to this facility following hospitalization after a physical injury. The resident had both severe cognitive impairment and delusions that manifested as maladaptive and disengaged thinking. The resident had an order for psychotropic medication but no appropriate diagnosis related to it. Hospital records showed an antipsychotic was administered without a diagnosis of dementia or psychotic disorder. Furthermore, the resident's behavior was not monitored at the facility to allow a gradual dose reduction, if possible, requiring it to be continued at the current level.

Case 7

Citation: F949 Behavioral health training

Level: Immediate harm

Summary of Findings Noted by Surveyor: A resident was admitted with diagnoses of psychotic disorder with delusions, vascular dementia with behavioral disturbances, and alcohol dependence. During an incident when the resident became physically aggressive with a staff member, the staff member pushed the resident down, resulting in bruising and pain. The staff member had not received training on providing care to residents with such behaviors (this staff member was a contract employee). Inadequate behavioral health training was the reason for this citation.

FACILITY CHARACTERISTICS. Table 3 lists the characteristics of each of these facilities cited for deficiency in response to an F-tag related to psychosocial well-being and/or behavioral expression needs in the case reports summarized. It is noted that the majority of the cases selected received the highest scope and severity rating of jeopardy of immediate harm and that most were initiated in response to a complaint. The star ratings are also noted to be relatively low on average.

Table 3. Characteristics of Facilities Referenced in the Case Studies

Case No. + F-tag	Facility Size	Organization Status	Part of a Continuing Care Retirement Community (CCRC)?	Type of Survey	Level of Harm Cited	Star Rating			
						Overall	Health Inspection	Staffing	Quality Measure
1 F600	75 – 150 beds	Non-profit	Yes	Certification & Complaint	Immediate Harm	2	2	4	4
2 F740	75 – 150 beds	For-profit	No	Certification & Complaint	Immediate Harm	1	1	2	3
3 F741	Less than 75 beds	For-profit	No	Certification	Immediate Harm	1	1	2	1
4 F743	75 – 125 beds	For-profit	No	Certification	Minimal Harm	1	1	1	2
5 F745	Less than 75 beds	For-profit	No	Complaint	Immediate Harm	1	1	1	2
6 F758	75 – 125 beds	For-profit	No	Certification & Complaint	Immediate Harm	1	1	1	3
7 F949	Less than 75 beds	For-profit	No	Certification & Complaint	Immediate Harm	1	1	4	3

CASE STUDY ANALYSIS

An analysis of the case studies reveals multiple situations that reflect the complex challenges in which facility administrators and their staff find themselves. For many, trying to figure out how to balance the demands of these complex needs with the resources available has been overwhelming. The case reports illustrate the multiple, potentially interacting, assessment and care challenges that residents with SMI and substance use disorder may pose for staff charged with their care. In Case 3, for example, the first resident was noted to have purposeful incidents of urinary incontinence, which a staff member associated with the resident's fondness for drinking coffee and consequently restricted the amount of coffee allowed. The surveyor noted that this restriction infringed upon the resident's rights. Although not mentioned in the surveyor's report, it could have also left the resident dehydrated, which does not align with the goal of resident health, well-being, and the highest achievable quality of life. In Case 6, a resident with both dementia and symptoms of psychosis posed a challenge in selecting a psychotropic medication that was effective in treating the hallucinations but could be tolerated by an individual with dementia as well. The resident had been admitted to the facility following hospitalization for a physical injury. The facility was cited for administering a psychotropic medication that was not linked to a specific diagnosis or description of relevant symptoms and the resident's response was not monitored systematically.

The Final Rule has necessitated adjustments in the provision of care to an increasingly diversified resident population, further complicating the already stringent regulatory framework governing these facilities. According to data from CMS[16], in 2023, 98,110 health inspection surveys were conducted across 15,128 licensed skilled nursing providers in the United States, resulting in 136,562 citations[15].

CROSS-CASE ANALYSIS. The case studies illustrate several challenges the facilities have encountered in providing care to residents with serious mental illnesses and/or substance use disorders. The majority of staff in most long-term care facilities are nurse aides and licensed practical nurses who are not prepared to manage behavioral expressions of psychosis. It is noted that many of the residents mentioned in the citations had multiple mental illness-related diagnoses, as well as dementia, which poses several clinical treatment challenges, including the choice of appropriate medications, particularly psychotropic medications, that the resident can tolerate. Secondly, making an effort to address the issue but failing to achieve a response is not credited, nor is taking action without an appropriate diagnosis and plan of care. Effective management is expected, and the welfare of other residents is clearly of concern.

Discussion

An analysis of mental health and substance use disorder-related admissions to long-term care facilities from 1999 to 2005 indicated an increase in the number of residents with these concerns[19], a demographic shift in the patient population of these facilities that continues today. Fullerton and colleagues (2009)[19] attribute a recent corresponding decline in dementia-related admissions to expanding

long-term care options, such as assisted living centers and memory care units. Xu et al. (2022)[20] postulate that the deinstitutionalization of mental health care has led to a reduction in the availability of inpatient psychiatric beds and services. While deinstitutionalization aimed to increase community-based care, at the same time, federal dollars were prohibited from funding specialized inpatient psychiatric centers, leading to increased referrals to long-term care facilities[21].

Individuals with SMI diagnoses and substance use disorders have been noted to have an earlier age of death[22] and to experience a greater number of comorbid conditions that result in the need for an increased level of care. Disease progression, treatment modalities, drug side effects, and lifestyle choices may contribute to this[23]. Consequent cognitive impairment and social isolation also increase the risk of placement in skilled nursing facilities[19]. Furthermore, a large portion of residents with SMI and drug use disorders are not only younger but also more likely to be dependent on government support as the primary payor[25].

Fashaw et al. (2020)[7] contend that the increasing presence of residents with SMI in long-term care facilities imposes a new and substantial burden on these facilities and their staff. Younger residents demonstrate behavioral expressions that are different from those of the traditional older long-term care residents. This situation may adversely affect the quality of care these facilities provide, as staff must navigate the complex needs of this new population while maintaining care standards for all residents[7]. Furthermore, it has been noted that facilities with higher percentages of residents with SMI are more likely to have lower staffing ratios, lower quality ratings, and more deficiencies for neglect and abuse[24], the result of what appears to be a vicious cycle of lower access to care and placement in facilities with poorer ratings and poorer resident outcomes.

Jester and colleagues (2020)[25] conducted a national review of the presence of SMI within nursing homes, identifying facilities as low-SMI or high-SMI. Those with low SMI reported that zero to 20% of their residents had an SMI diagnosis, while those with high SMI reported that 40% to 60% of their residents had an SMI diagnosis[25]. Facilities with higher levels of residents diagnosed with SMI were noted to have higher proportions of Medicaid-supported residents, more likely to be for-profit, and have lower star ratings compared to the low-SMI facility. For-profit centers are operationally geared towards maximizing profit margins through efficiencies and resource management, while non-profit organizations can reinvest excess revenue back into the organization due to tax exemption rules[21]. The more significant number of lower margin payors (that is, government-supported at lower rates) in a population requiring higher levels of service, with no tax exemption on any excess revenues that could be reinvested, limit resource availability[10]. Limited resources impact the ability to maintain staffing levels, recruit staff, and provide the necessary specialized services[10].

The pre-admission selection process that facilities are permitted to employ contributes to individuals with SMI diagnoses facing difficulty gaining admission to higher star-rated nursing homes[10]. Facilities are required to have the capacity to provide the necessary services and staff to meet the needs of the

residents being admitted as set out in the SOM but are not required to admit everyone who is referred to the facility. The increased number of individuals with complex care needs seriously challenge resource-limited facilities and may influence the quality of care they need to provide.

Recent research and the information presented here have shed light on the current U.S. situation, revealing the multifaceted challenges to safety and effectiveness in assessing and treating these complex residents. The case studies demonstrate the adverse impacts of untreated negative behavioral expressions on community living and the quality of life for residents, families, and staff. Further, the reports consistently suggest that staff may be unprepared to manage these multifaceted conditions, highlighting the opportunity to realign behavioral support, community programming, and staff-centered education in caring for this changing population. Implications of these changes extend beyond the United States, impacting similar populations within developed nations. For example, similar experiences were noted in a study conducted in England, where patients with SMI in long-term care environments experienced a lack of coordination of services and specialized behavioral care support, leading to poorer outcomes than expected[26].

This changing demographic impacts staffing and staff retention within the industry. Healthcare workers typically enter the field with a strong desire to positively impact the lives of others, often choosing to accept lower salaries in exchange for the opportunity to make a meaningful difference. Therefore, it is crucial to cultivate an organizational culture that enhances job satisfaction and reinforces the intrinsic motivations of healthcare staff in long-term care. The disparity between the expected caregiving for frail older adults and the care required for individuals with SMI can lead to increased stress and job dissatisfaction among staff unless addressed. Comprehensive staff training and supportive work environments are essential. This includes training that delves into the physiological and psychological mechanisms behind negative behavioral expressions, providing strategies for effective responses to these behavioral expressions, and supporting stress reduction strategies such as frequent breaks and flexible staffing assignments for front-line staff. By doing so, facilities can ensure that their staff feel valued and supported, thereby improving both retention rates and the overall quality of care provided to residents.

Implementing a comprehensive support system that includes ample opportunities for professional development and personal growth will help maintain a motivated and satisfied workforce. This, in turn, contributes to a more effective and compassionate caregiving environment, benefiting staff, residents, and their families alike.

There are some promising innovations in managing SMI in nursing homes globally. For example, in the Netherlands, some nursing homes have been testing different models of care. One has a cooperative agreement with a psychiatric hospital to create a specialty unit with mental health providers and behavioral specialists within the facility. Another has integrated residents into the facility in housing pods, with specially trained staff to offer more freedom of choice and improved quality of life[27].

RESIDENTS. Traditionally, long-term care facilities have provided care primarily to frail, impaired older adults. However, the increasing presence of residents with SMI and a younger demographic has necessitated a reevaluation of psychosocial and programmatic support that have been employed to address varying needs effectively. As evidenced in the case studies, even when tailored care plans are directed to supporting positive behavioral expressions, the manifestations of SMI and substance use disorder-related behaviors can still present significant risks to the resident, other residents, and staff[7, 14]. These behaviors, which may include angry, sexual, or manipulative tendencies, not only compromise the safety of frail and cognitively impaired residents but also divert staff attention from other essential care responsibilities. Consequently, these residents require more specialized care and pose operational challenges to facilities. Shortfalls in staffing, mental health providers, and community resources increase the demands that residents with SMI and substance use disorder-related behaviors place on operations, as well as the safety and security of the residents.

STAFF. The case studies presented are summarized from surveyor reports depicting challenging resident behaviors occurring over time. These reports often reflect resident behavioral expression spilling over into multiple areas, diverting resources, and, in some cases, creating additional stress on facility staff[9]. These occurrences, coupled with surveyor reports highlighting deficiencies in care planning and documentation, also suggest a risk for the potential normalization of negative behaviors among residents, creating challenges in supporting the residents and educating staff.

LONG-TERM CARE FACILITIES. Long-term care facilities are challenged with some of the highest regulatory expectations and enforcement activities across industries. While industry advocates and providers acknowledge the importance of protecting a vulnerable population, the differences in expectations across levels of care are not necessarily equitable. For example, long-term care facilities are required to have a strict self-report policy, often resulting in complaint surveys and deficiency citations. As demonstrated within the F600 case study, even when a facility implements appropriate assessments, interventions, and care plans, there may still be a deficiency citation related to preventing the occurrence from impacting others. These expectations are not the same across other levels of healthcare.

Long-term care facilities are encountering an ever-growing, complex mix of service needs, reimbursement structures, and patient demographics[7, 25]. Admission criteria for skilled care consider the level of assistance needed in completing activities of daily living (ADLs) or a combination of AD assistance in conjunction with cognitive levels. This often results in a vulnerable population requiring physical assistance and verbal cueing. The behavioral expressions of this population differ markedly from the behavioral expressions of individuals with SMI and/or substance use disorders, complicating the delivery of care and education of staff[25]. In this new, changing environment, long-term care facilities are challenged to meet an ever-growing variation in needs and exposure to different behavioral expression encounters.

In the United States, the increasing number of residents dependent upon Medicaid with its lower reimbursement rates as a payor, combined with higher service requirements, result in lower financial margins for the facility[7, 10, 25]. Evidence suggests this can lead to inequities in accessibility and quality of care[10]. Access may be an even larger issue within the European Union. A comparative summary by the European Commission report notes that 35.7% of individuals over the age of 65 in need of long-term care services are not using professional services as a result of financial issues, while 9.7% of the population requiring long-term care services are not able to access services because the needed services were not available (European Commission, 2021).

Conclusion

There is a growing segment of the long-term care population with SMI and substance use disorders who require additional inpatient care services in long-term care facilities due to the reduction in inpatient psychiatric services. As a result, there is an increased need for residential care settings equipped to support individuals with significant mental health and substance use disorders as well as physical and cognitive impairments. As the healthcare industry adapts to these demographic shifts, ongoing research is essential to developing effective care delivery systems, retaining knowledgeable healthcare staff, and obtaining fiscal support from informed policymakers.

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